



parison of developing a new licensing examination independent of the national examination. On June 24, BLA reported that the cost of administering CLARB's UNE, not including the costs of the supplemental California exam and exam administration costs, would be \$144,000 in 1992, \$154,000 in 1993, and \$165,000 in 1994. The rough estimates given to BLA by an exam contractor of the cost of developing, administering, and scoring a new BLA examination were \$150,000-\$175,000 for 1992, \$159,000-\$185,000 for 1993, and \$168,540-\$196,680 for 1994.

On July 15, the Northern California Chapter of the American Council of Landscape Architects conveyed to BLA its unanimous recommendation that BLA "continue to participate fully in CLARB and continue to use the UNE examination plus the California section added to the examination. Further, the board should continue to press for examination improvements." The organization noted that CLARB conducted its task analysis in direct response to California's concerns, and has indicated that it will revise its exam based on the task analysis results; national reciprocity is very important to many landscape architects; and use of the UNE would probably be less expensive than BLA's preparation of its own exam. Finally, the group noted: "We consider it unwise to repeat the experience of the architects when the State withdrew from NCARB, and eventually returned to the NCARB process." (See CRLR Vol. 9, No. 2 (Spring 1989) pp. 44-45 for a description of the Board of Architectural Examiners' unsuccessful experiment in administering its own exam.)

Thus, after considering CLARB's task analysis and its representation that it would periodically repeat that procedure, PSI's analysis of California landscape architecture—which, the Board agreed, generally matches the CLARB analysis, and the cost estimates, BLA voted at its August meeting to enter into a one-year contract with CLARB for the new UNE examination which will be provided by CLARB in June 1992.

**Proposed Regulatory Action.** BLA recently announced its plans to amend sections 2610, 2649, and 2671, Title 16 of the CCR. BLA's proposed change to section 2649 would increase the Board's examination application fee from \$325 to \$425, and increase the fee for an original license certificate from \$300 to \$400; the proposed fees constitute the maximum amounts authorized by Business and Professions Code section 5681. The Board's proposed amendments to section 2671 would require

that a landscape architect include his/her name and the words "landscape architect" in all public presentations. Finally, BLA proposes to amend section 2610 to change the deadline for filing an application for the licensing exam from the current requirement of at least ninety days prior to the date of the examination to on or before March 15 of the year in which the application is made. The Board was scheduled to hold a public hearing on these proposed amendments on October 18.

In other regulatory action, BLA submitted an important rulemaking package to the Office of Administrative Law (OAL) on September 16. The Board's repeal of existing section 2620, adoption of new sections 2620 and 2620.5, and amendment of section 2649 will clarify the educational and experience requirements necessary to sit for BLA's licensing exam and increase selected fees. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 82; Vol. 11, No. 2 (Spring 1991) p. 79; and Vol. 11, No. 1 (Winter 1991) pp. 65-66 for background information.)

**ASLA Requests Regulatory Determination.** The August 9 *California Regulatory Notice Register* contained a notice of a request for regulatory determination submitted to OAL by the American Society of Landscape Architects (ASLA). Specifically, ASLA questions BLA's policy which allows applicants for its licensing test to qualify for the examination by meeting either education or experience requirements. OAL will determine if this policy is a "regulation" as defined in Government Code section 11342(b), and thus subject to the requirements of the Administrative Procedure Act. OAL was scheduled to make this determination by October 23.

## LEGISLATION:

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at page 82:

**AB 1893 (Lancaster),** as amended August 19, authorizes BLA to adopt guidelines for the delegation of its authority to grade the examinations of licensure applicants to any vendor under contract to the Board. This bill was signed by the Governor on October 7 (Chapter 654, Statutes of 1991).

**AB 1996 (Campbell).** Under existing law, in any action for indemnity or damages arising out of the professional negligence of a person licensed as a professional architect, engineer, or land surveyor, the plaintiff's attorney is required to attempt to obtain consultation with at least one professional architect, engineer, or land surveyor who is not a

party to the action; the attorney is then required to file specified certifications. As introduced March 8, this bill would specify that these provisions also apply to actions arising out of the professional negligence of landscape architects. This bill is pending in the Assembly Judiciary Committee.

**SB 173 (Bergeson).** Under existing law, state and local agency heads may contract for specified services based on demonstrated competence and professional qualifications rather than competitive bidding. As introduced January 14, this bill would add landscape architectural services to the list of specified services. This bill is pending in the Senate Transportation Committee.

## RECENT MEETINGS:

At BLA's August 2 meeting, the Board agreed to pursue legislation which would allow BLA to mandate the inclusion of the license expiration date on all official stamps; legally define the term "landscape architect"; and authorize BLA to mandate continuing education.

## FUTURE MEETINGS:

December 6 in Sacramento.  
January 17 in Burbank.

## MEDICAL BOARD OF CALIFORNIA

*Executive Director: Ken Wagstaff*  
(916) 920-6393  
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The Medical Board of California (MBC) is an administrative agency within the state Department of Consumer Affairs (DCA). The Board, which consists of twelve physicians and seven nonphysicians appointed to four-year terms, is divided into three autonomous divisions: Licensing, Medical Quality, and Allied Health Professions.

The purpose of MBC and its three divisions is to protect the consumer from incompetent, grossly negligent, unlicensed, or unethical practitioners; to enforce provisions of the Medical Practice Act (California Business and Professions Code section 2000 *et seq.*); and to educate healing arts licensees and the public on health quality issues. The Board's regulations are codified in Division 13, Title 16 of the California Code of Regulations (CCR).

The functions of the individual divisions are as follows:

MBC's Division of Licensing (DOL) is responsible for issuing regular, limited, and probationary licenses and certificates under the Board's jurisdiction;



## REGULATORY AGENCY ACTION

administering the Board's continuing medical education program; approving undergraduate and graduate medical education programs for physicians; and administering physician and surgeon examinations.

The Division of Medical Quality (DMQ) reviews the quality of medical practice carried out by physicians and surgeons. This responsibility includes enforcement of the disciplinary and criminal provisions of the Medical Practice Act. It also includes the suspension, revocation, or limitation of licenses after the conclusion of disciplinary actions. The division operates in conjunction with fourteen Medical Quality Review Committees (MQRC) established on a geographic basis throughout the state. Committee members are physicians, other health professionals, and lay persons assigned by DMQ to review matters, hear disciplinary charges against physicians, and receive input from consumers and health care providers in the community.

The Division of Allied Health Professions (DAHP) directly regulates five non-physician health occupations and oversees the activities of eight other examining committees and boards which license non-physician certificate holders under the jurisdiction of the Board. The following allied health professions are subject to the jurisdiction of DAHP: acupuncturists, audiologists, hearing aid dispensers, medical assistants, physical therapists, physical therapist assistants, physician assistants, podiatrists, psychologists, psychological assistants, registered dispensing opticians, research psychoanalysts, speech pathologists, and respiratory care practitioners.

DAHP members are assigned as liaisons to one or two of these boards or committees, and may also be assigned as liaisons to a board regulating a related area such as pharmacy, optometry, or nursing. As liaisons, DAHP members are expected to attend two or three meetings of their assigned board or committee each year, and to keep the Division informed of activities or issues which may affect the professions under the Medical Board's jurisdiction.

MBC's three divisions meet together approximately four times per year, in Los Angeles, San Diego, San Francisco, and Sacramento. Individual divisions and subcommittees also hold additional separate meetings as the need arises.

On August 13, Governor Wilson announced three new appointments to MBC. Dr. Clarence Avery of Oakland was appointed to DMQ; Avery, 65, is currently on staff at the Veterans Home of California in Yountville. Dr. Michael

Weisman of Del Mar, also appointed to DMQ, is a professor of medicine at the UCSD School of Medicine. Finally, Dr. Robert del Junco of Whittier was appointed to DOL. Del Junco, 34, is currently in private practice in Orange. The terms for these positions expire on June 1, 1995, and all require Senate confirmation.

### MAJOR PROJECTS:

**DMQ Implementation of SB 2375 and Auditor General's Recommendations.** At its September meeting, DMQ reviewed Board actions to implement recommendations made by the Office of the Auditor General (OAG) in a report on MBC's complaint processing system. Completed in April 1991, the OAG report reviews MBC's implementation of SB 2375 (Presley), a 37-part physician discipline system reform bill recently enacted by the legislature (Chapter 1597, Statutes of 1990). (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 82-84; Vol. 11, No. 2 (Spring 1991) pp. 81-82; and Vol. 11, No. 1 (Winter 1991) pp. 66-67 for extensive background information on SB 2375 and the OAG report.)

Among other things, SB 2375 requires the Board to set a goal that by January 1, 1992, it will complete investigations within an average of six months from receipt of the complaint. After studying a sample of MBC complaint cases resolved from December 1989 through November 1990, OAG concluded that this goal would be exceeded by eight months. A major cause of DMQ's failure to meet SB 2375's timeframe is the fact that it took an average of 117 days for a case to be assigned to an investigator. Of the 312 cases examined by OAG, 70 (22%) were unassigned for six months or longer. Cases remained unassigned because supervisors believed their investigative staff were working at maximum caseload capacity. To reduce the time taken to investigate cases, OAG recommended that the Board evaluate its investigators' caseload to determine the optimal level enabling them to complete investigations more promptly, and to seek staffing commensurate with that level.

Toward this end, DMQ Enforcement Chief Vern Leeper reported that the Board's recommendation for additional investigative staff was supported in the Governor's fiscal year 1991-92 budget. Fourteen new investigators and ten support positions were approved. To date, ten of the investigator positions have been filled and the remaining four positions were to be filled by November 1.

According to Executive Director Ken Wagstaff, these additional staff members should allow the Board to reduce investigator caseloads from the 27-29 reported by OAG to about 23 cases per investigator. MBC believes that by early 1992, this reduction should facilitate completion of investigations within an average of six months from the date a decision is made to investigate. However, as noted in OAG's report, SB 2375 requires the Board to establish a goal of completing its investigation of cases in an average of six months from receipt of the complaint, not from the unspecified point at which DMQ decides a complaint is worthy of formal investigation. Leeper contends that time consumed in preliminary activities such as obtaining records should not be included in SB 2375's six-month investigation period. Pursuant to a decision DMQ made at its May meeting, DMQ staff plans to seek legislation to "clarify" this six-month goal during 1992.

At their September meetings, both DMQ and the full Board were addressed by Health Quality Enforcement Section (HQES) Chief Al Korobkin. Created by SB 2375, HQES is a unit within the Attorney General's Office which specializes in prosecuting medical discipline cases. HQES' goal is to file accusations against physicians within sixty days of receipt of a completed investigation from MBC. However, OAG found that HQES attorneys usually spend over 200 days preparing an accusation. Korobkin explained that the new unit has been deluged with a substantial backlog of investigated cases which must be prosecuted. The fact that HQES is severely understaffed is one cause of this backlog. Because of an error in calculating the number of attorney positions needed to process medical discipline cases, HQES failed to obtain adequate attorney staffing at the outset when it was created on January 1, 1991. Korobkin discovered that HQES' staffing needs, which should have been calculated based on the average number of hours required to prosecute an MBC case in recent years (102 hours) were instead based on the average number of hours to prosecute all administrative cases for the Department of Consumer Affairs (36.6 hours). Because of the miscalculation, HQES is currently authorized a staff of only 29 attorneys and paralegals.

At the September meeting, Korobkin announced that HQES will be seeking 31 additional staff positions, including twenty permanent attorney positions, seven limited-term attorney positions for 36 months, and four paralegals, and



is requesting the increase for fiscal year 1992-93. The total annual cost of adding the new positions to HQES will be approximately \$4 million. In addition, HQES is asking the Department of Finance for revenue to immediately staff as many of those 31 positions as soon as possible, based on the amount of money MBC has budgeted for Attorney General services.

MBC staff announced other actions taken in response to OAG's recommendations. For example, DMQ intends to seek legislative action in 1992 authorizing it to take disciplinary action against a physician who fails to provide requested medical records within a reasonable time. In response to OAG's finding that DMQ lacks clear criteria for closing cases with and without merit, the Board agreed to review and clarify those criteria. Finally, Board staff stated that its revised consumer services representative (CSR) desk manual, which will cover all functions of MBC's new Central Complaint and Investigation Control Unit (CCICU), is scheduled for completion by January 1992.

**MBC to Raise Licensing Fees Again to Finance Enhanced Discipline System.** On August 1, the Office of Administrative Law (OAL) approved MBC's amendments to sections 1351.5 and 1352, Division 13, Title 16 of the CCR. These amendments increase the Board's license and biennial renewal fees to \$400. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 84 for background information.) At that time, the \$400 figure represented the statutory maximum. However, on September 3, Governor Wilson signed AB 1553 (Filante), which increases the statutory maximum on MBC licensing fees to \$500 biennially (see *infra* LEGISLATION).

Following the September presentation by Al Korobkin which indicated the pressing need for additional staffing of HQES (see *supra*), MBC Executive Director Ken Wagstaff proposed another fee increase to \$500 every other year, the new statutory maximum under AB 1553, to be effective April 1, 1992. Wagstaff also recommended that the Board sponsor legislation to raise the statutory cap to \$600; Wagstaff explained that the increase to \$500 biennially will not be enough to sustain HQES through 1994 (when the backlog is expected to subside) and enable MBC to maintain two months' worth of operating expenses in its reserve fund, as required by statute.

After much discussion and some opposition to continually raising licensing fees to meet funding obligations with no long-term plan, the full Board voted

to commence another rulemaking proceeding to raise MBC's licensure and biennial renewal fees to \$500, effective April 1, 1992. Staff was directed to publish the regulatory proceeding and schedule a public hearing for the Board's November meeting, look into the need for legislation to raise the statutory cap to \$600 biennially, investigate alternatives to raising licensing fees (such as a cost recovery mechanism or a system of fines for minor violations), and draft a letter to physicians explaining the reasons for the fee increases to be reviewed at the November meeting.

**Other Discipline System Issues.** In addition to establishing investigation deadlines and creating the HQES, SB 2375 (Presley) added Government Code section 11529, permitting DMQ to issue an interim order suspending a license or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. As of its September meeting, DMQ had applied the new provision to suspend the licenses of four physicians without having to go to court for a temporary restraining order.

SB 2375 also added section 802.5 to the Business and Professions Code, requiring all coroner's offices to report findings indicating that a death may have been the result of gross negligence or incompetence by a licensed physician or podiatrist. It also provides more protection to coroner informants. Before January 1, 1991, informants were granted conditional immunity from damages, if the informant reasonably believed that the information was true and acted in good faith and without malice. Under SB 2375, coroner informants have absolute immunity. MBC will accept all coroner reports regardless of the qualification of the informant.

SB 2375 also added sections 803.5 and 803.6 to the Business and Professions Code, requiring district attorneys, city attorneys, or other prosecuting attorneys to notify the appropriate licensing agency any time felony charges are filed against a physician or podiatrist. To implement these new laws, MBC has mailed a notice regarding the new reporting requirements to all prosecutors and coroner's officers.

**Implementation of SB 2036.** SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990) amended Business and Professions Code section 651 to provide that a physician licensed by MBC may include a statement in his/her advertising that he/she is certified or eligible for certification by a private or public board or parent association if that board or association is a member of

the American Board of Medical Specialties (ABMS), a board or association with equivalent requirements approved by MBC, or a board or association with an Accreditation Council for Graduate Medical Education (ACGME) approved postgraduate training (PGT) program that provides complete training in that specialty or subspecialty.

For the past several months, DOL has been drafting and revising proposed regulations to guide its approval of specialty/subspecialty boards for purposes of physician advertising. On July 12 in Los Angeles and August 16 in San Francisco, DOL held public hearings to receive comments on its draft regulations to implement SB 2036. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 86-87 for detailed background information on the draft regulations.) The draft rules were subsequently revised to address these comments, which included the following.

First, several witnesses expressed concern that the draft regulations allow a physician who is eligible for certification to so advertise. They felt that physicians who advertise board certification should in fact be certified, and not just eligible for certification. Although SB 2036 appears to allow physicians who are eligible for certification to so advertise, the phrase "or eligible for certification" was deleted from DOL's draft.

Second, DOL received approximately forty comments complaining that the initial draft requires a specific number of years of training regardless of the type of specialty. Because the number of years of residency training required for board certification in some specialty areas is greater than others, these witnesses maintained that requiring a set number of years is irrational. These comments also expressed concern about the proposed rules' requirement that the residency training take place in an institution affiliated with a medical school. In response, the proposed regulations were amended to state that the specialty board shall require all applicants who are seeking certification to have satisfactorily completed a PGT program accredited by the ACGME or the Canadian Council on Medical Education (CCME) in a specialty or subspecialty area of medicine in which the physician is seeking certification. If the training required of applicants seeking certification by the specialty board is other than ACGME- or CCME-accredited PGT, then the specialty board shall have training standards equivalent in scope, content, and duration to those of an ACGME- or



CCME-accredited program in a related specialty or subspecialty.

Third, several comments expressed concern about the requirement that the specialty board administer a 16-hour examination and that the exam consist of both a written and oral component. These witnesses argued that these requirements are unfair, because many ABMS exams are not 16 hours long, and some include only a written or oral component, not both. The proposed regulation was amended to read as follows: "The specialty board shall require physicians who are seeking certification to successfully pass a written and/or an oral examination which tests the applicants' knowledge and skills in the specialty or subspecialty area of medicine. All or part of the exam may be delegated to a testing organization. The exams shall be a minimum of sixteen (16) hours in length. Those specialty boards which require, as a prerequisite for certification, prior passage of an ABMS exam in a related specialty or subspecialty area, may grant up to eight hours credit for the ABMS qualifying board exam toward the sixteen (16) hour testing requirement."

At its September meeting, the Board approved the amended draft regulations in concept, and instructed staff to commence a rulemaking proceeding. The proposed regulations were filed with OAL on September 24, and a public hearing before DMQ, the body which will formally adopt the regulations, was scheduled for November 20.

In addition, two alternatives have been suggested for MBC's internal administration of the specialty board application review function. The first option is to have the specialty board apply to DOL for approval and recognition as a specialty board whose members could then advertise board certification. The second alternative would involve DMQ staff and have an enforcement angle. After the regulations become effective, if a physician advertises board certification and it comes to the Board's attention that the particular specialty being advertised does not meet the criteria established in the regulations, the physician would be required to cease and desist advertising board certification and could be subject to disciplinary proceedings if he/she does not. These alternatives were scheduled for further discussion at the November meeting.

**Proposal to Increase Required PGT Before Licensure.** For at least two years, DOL has been considering whether—and how—to seek legislation which increases the postgraduate train-

ing (PGT) required for licensure from the existing one year to two years. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 85; Vol. 11, No. 2 (Spring 1991) pp. 82–83; and Vol. 10, No. 4 (Fall 1990) pp. 82–83 for background information.) Recently, DOL has been concerned not about whether to increase the PGT requirement, but how to phrase and implement it so it does not appear to be discriminatory against graduates of medical schools other than those approved by the AMA's ACGME or Canada's CCME. When it proposed to increase PGT to two years for *all* medical school graduates, DOL was confronted with objections from representatives of residents at California medical schools who pointed out that approximately 40 states permit residents with a degree from a U.S. or Canadian approved medical school to be licensed after only one year of PGT. DOL's research also indicates that approximately 35 states require residents with a degree from an unapproved school to complete one or two years more than the minimum one-year requirement.

When DOL approached Assemblymember William Filante last year about sponsoring such legislation, Filante requested that DOL instead spend a year studying the impacts of an increased PGT requirement and a variety of options for the imposition of additional training for physician licensure. Thus, under AB 3272 (Filante) (Chapter 1629, Statutes of 1990), DOL is required to submit a report to the legislature on the results of its study by January 1, 1992.

At its September meeting, DOL reaffirmed a tentative decision made at its May meeting to seek legislation increasing the PGT requirement within the following parameters:

-All applicants for California physician licensure must complete three years of approved (U.S./Canadian accredited) clinical training, one of which must be at the postgraduate level.

-If an applicant has not completed two years of approved clinical training at the undergraduate level, one additional year of approved postgraduate training must be satisfactorily completed in order to qualify for California licensure. (In other words, students who do not attend ACGME/CCME-accredited medical schools must complete two years of PGT in order to be eligible for licensure.)

-Any applicant who has completed a minimum of one year of approved clinical training at the postgraduate level may be considered for a provisional license which will allow him/her to prac-

tice medicine to the extent that it is incident to and a necessary part of the applicant's duties as approved by the training program. The provisional certificate would be valid until the approved clinical training requirements have been met.

Once again, representatives of the California Association of Interns and Residents (CAIR) expressed concerns about the proposal. CAIR opposes efforts to increase PGT requirements for any applicants because it does not believe DOL has demonstrated any need for enhanced PGT or documented any problem which would be resolved by an increased PGT requirement. CAIR unsuccessfully urged DOL to reject the compromise proposal outlined above until staff identifies the problem being addressed and the effectiveness of an increased PGT requirement in resolving that problem.

Also in September, DOL adopted guidelines and definitions which are to be followed by the Director of Medical Education at a residency institution in completing the "L3" form certifying that an applicant has satisfactorily completed a PGT program. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 85 and Vol. 11, No. 2 (Spring 1991) pp. 82–83 for background information.) Specifically, the Medical Director signing the L3 form is now declaring, under penalty of perjury, that the licensure applicant completed the training program "satisfactorily," that is, "the physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care."

**DOL Rulemaking on Clinical Training Programs for Foreign Medical Graduates and Students.** In November 1990, DOL adopted amendments to regulatory sections 1324 and 1325.5, which revise the standards for DOL-approved postgraduate clinical training programs for foreign medical graduates (FMGs). These amendments proved controversial because the California Medical Association (CMA) and every medical school in California argued for abolition of the so-called "section 1324 training programs," on grounds that they are inferior to ACGME-approved PGT programs, exploitative in that the training facility sometimes charges the FMG a significant amount of money (up to \$35,000) for the privilege of receiving the training, and unnecessary in that there are sufficient ACGME-accredited residencies in California to accommodate FMGs. (See CRLR Vol. 11, No. 1



(Winter 1991) p. 69; Vol. 10, No. 4 (Fall 1990) p. 83; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 100 for detailed background information.)

On July 17, Department of Consumer Affairs (DCA) Director Jim Conran notified DOL that he was returning the rulemaking file to DOL for submission to OAL, but without his signature. Specifically, Conran expressed concern about "the unanswered policy questions and the potential injury to the public health, safety and welfare which are implicit in this rulemaking file." Conran stated that the file "does not support the significant shift in policy that was adopted by the Division in the course of these rulemaking proceedings," and "does not reflect careful deliberation by the Division of the public health, safety and welfare issues that were raised by various sources during the public comment period."

DOL submitted the file to OAL without DCA's approval. On August 19, OAL rejected the proposed regulatory changes, on grounds the rulemaking file failed to comply with the necessity, authority, and clarity standards of Government Code section 11349.1; DOL failed to summarize and respond to all comments made during the public comment period; and the file failed to comply with the procedural requirements of the Administrative Procedure Act. While OAL noted numerous specific deficiencies in the rulemaking file, OAL stated in particular that during the course of the rulemaking proceeding, DOL shifted from a provision flatly prohibiting the training facility from charging an FMG for the training, to a provision permitting the facility to charge the FMG \$5,000 for the training, to a provision permitting the facility to charge the FMG \$6,000 for the training. OAL also targeted for rejection DOL's amendment to section 1325.5, which requires that a director of a section 1324 training program have an M.D. degree. OAL noted that DOL adopted this amendment over numerous objections that it violates Business and Professions Code section 2435, which prohibits discrimination against osteopaths, and found that DOL documented no necessity for the restriction. DOL plans to correct the deficiencies found by OAL and resubmit the rulemaking file for approval.

At its September meeting, DOL discussed a draft amendment to regulatory section 1327, which pertains to criteria for DOL's approval of clinical training programs for foreign medical students. Existing section 1327 requires hospitals in California to obtain DOL's approval before they provide clinical train-

ing to students who are matriculating in medical schools outside the United States and Canada. To receive DOL's approval, the hospital must submit a proposal to DOL's Special Programs Committee and undergo a site visit by one of the Committee members. The approval is valid for one year; hospitals must submit renewal requests if they wish to continue offering their program.

DOL staff has found that although the section 1327 approval process is not complicated, "it is cumbersome enough to discourage hospitals from complying when they plan to train only an occasional international student." Only five hospitals in California are currently approved under section 1327. Thus, staff proposed to amend section 1327 to exempt hospitals that have a major affiliation with a California medical school and facilities with ACGME-accredited PGT programs in the area that the student is seeking a clinical rotation from the requirement of submitting a proposal to DOL for approval. Hospitals with limited or no affiliation with a California medical school and those without ACGME-accredited training programs would still be required to obtain the section 1327 approval.

At its September meeting, the Division approved the draft regulatory changes; DOL was scheduled to hold a public hearing on the changes at its November 21 meeting.

**Additional Medical Instruction Required After Failed Examinations.** In April 1990, DOL adopted guidelines, under section 2185 of the Business and Professions Code, outlining the additional medical instruction which license applicants must complete after twice failing a written or oral examination. Data gathered by DOL staff during a one-year period indicate that examination passage rates improved after the additional instruction specified in the guidelines. DOL determined that the guidelines were effective and unanimously adopted them as permanent at its September meeting.

The guidelines include the following. After two failures of either an oral exam, the SPEX, or FLEX Component 2, four months of full-time PGT in the area of general medicine is required; after four failures, twelve months of full-time PGT is required; for each additional two failures, one additional year of PGT is required.

After two failures of FLEX Component 1, a one-month full-time FLEX/National Board review course is required; after four failures, a four-month full-time FLEX/National Board review course is required; for each additional

two failures, another four-month full-time FLEX/National Board review course is required. Also, if an applicant was enrolled in a general medicine PGT program in another state, training completed for the number of months specified above would be accepted in lieu of a review course.

**DCA Rejects Medical Assistant Regulations Again.** On August 9, the DCA Director rejected DAHP's proposed medical assistant (MA) regulations for the second time. The regulations, required by SB 645 (Royce) (Chapter 666, Statutes of 1988), are intended to define the technical supportive services which may be performed by an MA, set forth the training which must be provided to the MA by the supervising physician/podiatrist or in an approved community college/postsecondary institution, and set forth recordkeeping requirements regarding services provided by MAs. In December 1990, then-DCA Director Michael Kelley disapproved them because he believed they delegate too much responsibility and discretion to MAs; current DCA Director Jim Conran found that the proposed regulations leave too many unanswered questions which may pose a threat to public health, safety, and welfare. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 87; Vol. 10, No. 4 (Fall 1990) p. 82; and Vol. 10, No. 1 (Winter 1990) pp. 76-77 for extensive background information on DAHP's proposed regulations.)

Specifically, Conran expressed concern that the proposed regulations permit a supervising physician or podiatrist to delegate his/her duty to supervise an MA to others who hold only limited licenses (e.g., physician assistants or registered nurses). Several participants raised this issue; DAHP acknowledged that such delegation is permissible under the regulations and rejected its impropriety. Conran also criticized as unclear, vague, and overbroad the criterion that a permissible technical supportive service must be "a usual and customary part of the practice of the medical or podiatric office where the medical assistant is employed." Conran further objected to language in the proposed regulations which authorizes the supervising physician or podiatrist to use standing orders and written instructions to MAs, as opposed to direct, patient-specific instructions and supervision. Finally, Conran agreed with the criticism of the Board of Registered Nursing and the Physician Assistant Examining Committee, among others, that the proposed regulations provide no standardization of either the training



that is needed for MAs or how it is to be provided.

At its September 13 meeting, DAHP again addressed the proposed regulations. It had two options: attempt to override the DCA Director's rejection with a unanimous vote, or make further amendments to the regulations to meet his objections. DCA General Counsel Derry Knight was present at the meeting, and advised that DCA is willing to work with DAHP and compromise on the regulations if further amendments are filed. With this in mind, DAHP elected not to override the DCA veto and unanimously decided to attempt further amendments; a progress report was expected at the November meeting.

**MBC "Enforcement Matrix" Adopted.** At DAHP's September 13 meeting, MBC Assistant Executive Officer Tom Heerhartz and Lynn Thornton, chief of MBC's Central Complaint and Investigation Control Unit (CCICU), unveiled a new "enforcement matrix" which will be completed and distributed at each MBC meeting. The matrix displays key enforcement statistics of DMQ's physician discipline program and the enforcement programs of all the allied health licensing boards and committees; all DMQ and allied health program complaints are routed and tracked through the CCICU.

Staff distributed the first such matrix, with data current as of July 31, 1991. The matrix indicates that 2,259 complaints are pending in the CCICU against physicians and allied health professionals; 1,941 are currently under investigation; 359 charges have been filed by the Attorney General's Office; 393 cases await action by the AG's Office; and 452 cases are on probation. At the request of Dr. John Tsao and Dr. Jacquelin Trestrail, future matrices will include information on the age of these cases and the amount of time cases spend at each step of the process.

The inclusion of allied health program enforcement statistics in the matrix was suggested over the summer by Board of Podiatric Medicine Executive Officer Jim Rathlesberger. Although several EOs of other allied health programs initially opposed having their enforcement statistics publicly displayed in a matrix format and argued that the allied health programs are not "legally accountable" to DAHP, they were quite supportive of the idea at the September 13 meeting. Rathlesberger noted that the matrix would enable MBC and allied health program EOs to better evaluate the services they are receiving from CCICU, MBC investigators, and the AG's office; identify growing backlogs

at an early stage, and request additional staffing to alleviate them; and evaluate the performance of staff.

Thornton noted four major improvements as a result of the new tracking system. First, 1,400 fewer complaints were forwarded to the AG's office this year because CCICU was able to scrutinize them and weed out the less serious violations or nonviolations and concentrate on the worst offenses. Second, operational costs are down. Third, consumers are receiving faster response to their complaints and more detailed explanations about their disposition. Finally, the AG's office is receiving a more detailed description of complaints that are forwarded to that office.

**OMD v. DOM Revisited.** At its September meeting, DAHP once again took up the issue whether an acupuncturist may suffix his/her name with the accompanying title OMD (Oriental Medical Doctor) or must utilize the acronym DOM (Doctor of Oriental Medicine). In an opinion dated March 3, 1988, the Attorney General (AG) ruled that an acupuncturist may use OMD only if accompanied by an amendment describing the degree, such as "Acupuncturist," "Licensed Acupuncturist," or "Certified Acupuncturist." (See CRLR Vol. 9, No. 2 (Spring 1989) p. 63; Vol. 9, No. 1 (Winter 1989) p. 53; and Vol. 8, No. 3 (Summer 1988) p. 65 for background information.) In spite of the AG's opinion, many acupuncturists continue to use OMD without the necessary amendment.

DAHP public member Alfred Song suggested the possibility of legislation which would prohibit acupuncturists from using the term OMD and also void the AG's opinion. Pamela Lee, President of the California Acupuncture Association, was present at the September meeting; she argued that the OMD degree has been approved by the Department of Education, the AG's opinion indicates that its use is permissible, DAHP has no authority to change the degree, and there have been no complaints from the public regarding use of that acronym. DAHP members replied that they do not wish to change the degree; they merely want compliance with the AG's opinion. If acupuncturists choose not to comply, the Division will be forced to seek legislation forcing compliance.

After much discussion, DAHP and Ms. Lee agreed that acupuncturists should be informed of the AG's opinion and their duty to comply with it. As a result, DAHP decided to defer legislative action subject to voluntary compliance by the acupuncture profession; an

update on the status of the agreement was scheduled for presentation at DAHP's November meeting.

**Podiatric Diversion Program to be Administered by MBC.** At DAHP's September 13 meeting, Chet Pelton, Program Manager of MBC's diversion program for impaired physicians, addressed the Division on whether the diversion program of the Board of Podiatric Medicine (BPM) should or could be administered by the MBC diversion program. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 89 and 94 for background information.) Mr. Pelton informed DAHP that several factors should be considered: no policy, regulatory or legislative change would be required to enable MBC to administer BPM's diversion program; the MBC program currently operates a computerized tracking system which is the backbone of the program's monitoring system; it would require only 43 hours of programming and data entry before the system could be adjusted to accommodate BPM participants, while maintaining the separateness of the two programs; since five of the eight existing podiatric diversioners are already attending physician diversion programs, there would be little impact by shifting participants from one program to another; BPM would be assessed \$2,150 per participant per year for MBC to administer its program; and no additional staff would be required for the eight podiatrists or future projected participants.

Mr. Pelton also stated that there are virtually no private treatment programs that deal exclusively with impaired physicians. Based on Pelton's recommendation, DAHP unanimously approved MBC's assumption of the administrative functions of BPM's diversion program.

## LEGISLATION:

**SB 1070 (Thompson),** the Patient Protection Act of 1991, was signed by the Governor on October 14 (Chapter 1180, Statutes of 1991). This bill requires the Department of Health Services to promulgate guidelines and regulations to minimize the risk of transmission of blood-borne infectious diseases in the health care setting by January 1993. It further requires MBC, in addition to the Board of Dental Examiners, the Board of Registered Nursing, and the Board of Vocational Nurse and Psychiatric Technician Examiners, to ensure that its licentiates are informed of their responsibility to minimize the risk of transmission of blood-borne infectious diseases from health care provider to patient, from patient to patient,



and from patient to health care provider, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission. This bill amends the Medical Practice Act's definition of unprofessional conduct to include, except for good cause, a knowing failure to protect patients by failing to follow infection control guidelines and, thereby, risking the transmission of blood-borne infectious diseases.

**SB 101 (Hart)**, as amended June 19, establishes statewide guidelines on child support and enacts provisions relating to the enforcement of family support obligations. Among other things, it prohibits various professional licensing agencies, including MBC, from issuing or renewing a license to a person listed by the Department of Social Services as being in noncompliance with a support order or judgment issued by a court of this state. Instead, this bill requires MBC to issue a 120-day temporary license to such an applicant or licensee; if, upon the expiration of the temporary license, the applicant is in compliance with all court orders and judgments for support, MBC would be able to issue a regular license. SB 101 was signed by the Governor on July 2 (Chapter 110, Statutes of 1991).

At its September meeting, DOL members expressed surprise that SB 101 could have "slipped through" its legislative tracking system without their being informed of its pendency. They stated their opinion that family support issues are not appropriate for professional licensing agency interference or participation, and that implementation of the bill would cause extensive problems for the Division. For example, DOL does not have a temporary license category and will be forced to create one. Also, DOL members expressed their opinion that a 120-day period is too short to allow an applicant or licensee to cure any underpayments. DOL member Dr. Rider directed staff to look into the possibility of clean-up legislation to SB 101.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at pages 87-89:

**SB 1195 (Boatwright)**. As amended August 26, this bill provides, among other things, that the examination administered by DOL to applicants for physicians' certificates need not be practical in character; requires that these examinations be kept on file for at least two years; authorizes DOL to designate other equivalent written examinations; requires DOL to determine the passing score for the examination; requires applicants to pass an examina-

tion in basic sciences and clinical sciences, as determined by DOL; requires only that MBC and its divisions give notice of their meetings in accordance with the Bagley-Keene Open Meeting Act; permits DOL to modify or terminate terms of a probationary license upon petition from a physician; and permits DMQ to initiate disciplinary proceedings to revoke or suspend a probationary license for any cause that would subject a licensee to license revocation or suspension. This bill was signed by the Governor on October 13 (Chapter 983, Statutes of 1991).

**AB 1553 (Filante)**, as amended July 1, requires MBC's initial license fee and biennial renewal fee to be fixed at an amount not to exceed \$500, and reduces MBC's required Contingent Fund reserve to approximately two months' operating expenses. This bill was signed by the Governor on September 3 (Chapter 367, Statutes of 1991).

**SB 1258 (Torres)**, as amended May 30, prohibits health care providers from withholding patient records or summaries of patient records because of an unpaid bill for health care services. A health care provider who willfully withholds patient records or summaries of patient records because of an unpaid bill for health care services shall be subject to specified sanctions. This bill was signed by the Governor on October 13 (Chapter 920, Statutes of 1991).

**AB 1496 (Murray)**, as amended May 30, specifies a procedure by which a coroner may enforce a subpoena duces tecum for records of confidential communications of a decedent subject to the physician-patient privilege, when the records are sought by the coroner for specified purposes. This bill was signed by the Governor on October 14 (Chapter 1092, Statutes of 1991).

**AB 1084 (Filante)**, as amended April 10, is the California Medical Association's (CMA) controversial bill which would enable it to revive its Medical Practice Opinion Program in such a way as to immunize it—theoretically—from tort and antitrust liability. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 87; Vol. 11, No. 2 (Spring 1991) p. 81; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 99 for detailed background information on this issue.) This bill is pending in the Assembly Judiciary Committee.

**AB 1691 (Filante)**, as amended May 8, would require, on or after July 1, 1993, every health facility operating a PGT program to develop and adopt written policies governing the working conditions of resident physicians. AB 1691 was rejected by the Assembly on June

27; it is pending in the Assembly inactive file.

**AB 1199 (Speier)**, as amended May 30, would prohibit, on or after January 1, 1992, a health facility operating a PGT program from allowing any resident physician in that training program to work, either in clinical or didactic duty, in excess of certain prescribed hour limits. Among other things, the bill would also authorize a resident physician to work in excess of any specified hour limit whenever he/she is completing a surgical procedure or treating an acutely ill patient whose care may be compromised by the transfer of care to another physician. This bill is pending in the Assembly Ways and Means Committee.

**AB 2180 (Felando)**, as amended May 30, would amend SB 2036 (McCorquodale) (*see supra* MAJOR PROJECTS) by prohibiting a person certified by an organization other than a board from using the term "board certified" in reference to that certification. This bill is pending in the Business and Professions Committee.

**AB 569 (Hunter)**, as introduced February 15, would permit MBC to take action to implement SB 2036 (McCorquodale) on or after January 1, 1992. This bill is pending in the Senate Business and Professions Committee.

**SB 664 (Calderon)**, as introduced March 5, would prohibit physicians, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

**AB 992 (Brulte)**, as introduced March 4, would require medical experts testifying in medical malpractice actions against a physician to have substantial professional experience in the same medical specialty as the defendant. Under the bill, "substantial professional experience" would be determined by the custom and practice of the same or similar localities where the alleged negligence occurred. This bill is pending in the Assembly Judiciary Committee.

**SB 1119 (Presley)**. Existing law requires the district attorney, city attorney, or other prosecuting agency to notify MBC of any filings against a physician charging a felony, and the clerk of the court in which an MBC licensee is convicted of a crime is required to transmit a copy of the record of conviction to the Board. As amended April 30, this bill



## REGULATORY AGENCY ACTION

would expressly limit the transmittal duties of the clerk of the court to felony convictions. This bill is pending in the Assembly Health Committee.

**AB 14 (Margolin)**, which, as amended May 14, would enact the Health Insurance Act of 1991 for the purpose of ensuring basic health care coverage for all persons in California, is pending in the Senate Rules Committee.

**AB 190 (Bronzan)**, as amended September 3, would require a physician to give each patient a copy of the relevant standardized written summary describing the advantages, disadvantages, risks, possible side effects of, and the conditions for which the federal government has approved silicone implants and injections and collagen injections used in plastic, reconstructive, or similar surgery, before the physician performs the surgery. This bill is pending in the Senate Business and Professions Committee.

**AB 465 (Floyd)**. Existing law provides general civil immunity to persons who provide information to MBC or the Department of Justice indicating that an MBC licensee may be guilty of unprofessional conduct or impaired because of drug or alcohol abuse or mental illness. Existing law also sets forth special immunity provisions relating to certain activities of specified health care organizations. As introduced February 8, this bill would make the general immunity provisions inapplicable to the activities which are subject to the special immunity provisions. This bill is pending in the Senate Judiciary Committee.

**AB 112 (Kelley)**, as introduced December 4, would exempt a physician from liability for any negligent injury or death caused by an act or omission of the physician in rendering medical assistance, when the physician in good faith and without compensation or consideration renders voluntary medical assistance at a clinic or long-term health care facility. AB 112 is pending in the Assembly Judiciary Committee.

**AB 117 (Epple)**, as amended April 2, would exempt licensed health care providers from liability for any negligent injury or death caused by an act or omission of the health care provider in rendering the medical assistance, who in good faith and without compensation or consideration renders voluntary medical assistance at a shelter. This bill, which would sunset on January 1, 1997, is pending in the Assembly Judiciary Committee.

**AB 566 (Hunter)**, as amended July 11, would prohibit any person from practicing or offering to practice perfu-

sion for compensation received or expected to be received, or from holding himself/herself out as a perfusionist, unless at the time of doing so the person holds a valid, unexpired, unrevoked perfusionist license. This bill is pending in the Senate Business and Professions Committee.

**AB 704 (Speier)**, as amended July 11, would require DMQ, when undertaking a review of a physician's practice during any investigation pursuant to the Medical Practice Act, to ensure that the review is accomplished by peers of the subject physician. This bill is pending in the Senate Business and Professions Committee.

**AB 1183 (Speier)**, as introduced March 6, would require MBC to develop a California Indigent Obstetric Care Indemnification Program, requiring the program to provide prescribed state indemnification for malpractice claims against a physician who provides obstetric or gynecological care to patients at least 10% of whom are enrolled in Medi-Cal or other indigent care programs, and who has at least \$100,000 in malpractice coverage. This bill is pending in the Assembly Judiciary Committee.

**AB 2222 (Roybal-Allard)**, as introduced March 12, would provide that the reviewing of X-rays for the purpose of identifying breast cancer or related medical disorders without being certified as a radiologist qualified to identify breast cancer or related medical disorders by a member board or association of the American Board of Medical Specialties, or a board or association with equivalent requirements approved by MBC, constitutes unprofessional conduct. This bill is pending in the Assembly Health Committee.

**SB 1190 (Killea)**, as amended July 17, would enact the Licensed Midwifery Practice Act of 1991, establishing within DAHP a five-member Licensed Midwifery Examining Committee, which would be required to adopt reasonable rules and regulations to carry out the Act. This bill, which would also provide that a physician shall not be liable for independent acts of negligence by a licensed midwife, is pending in the Senate Appropriations Committee.

**AB 819 (Speier)** would provide that, effective July 1, 1992 and subject to specified exceptions, it is unlawful for specified licensed health professionals to refer a person to any laboratory, pharmacy, clinic, or health care facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest; the bill would also provide that disclosure of the owner-

ship or proprietary interest would not exempt the licensee from the prohibition. This bill is pending in the Assembly Health Committee.

### LITIGATION:

MBC and the Center for Public Interest Law (CPIL) have settled the attorneys' fee matter in *Le Bup Thi Dao v. Board of Medical Quality Assurance*. Although CPIL was awarded almost \$100,000 in fees and costs for its successful representation of 32 Vietnamese physicians seeking licensure by the Board, the Center agreed to accept \$68,000 in settlement of the matter. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 30 and 89, and Vol. 11, No. 1 (Winter 1991) pp. 24 and 70 for background information.)

In a case of first impression, *People v. Superior Court (Memorial Medical Center of Long Beach, Real Party in Interest)*, 91 D.A.R. 11852, No. B056780 (Sept. 24, 1991), the Second District Court of Appeal held that the records of disciplinary proceedings conducted by hospital peer review committees are subject to discovery in a criminal action.

The District Attorney of Los Angeles County sought to obtain a search warrant for documents at Memorial Medical Center of Long Beach (Memorial) regarding a physician, Dr. Larry Igor Borden. The DA asserted that the documents are relevant to a criminal investigation arising from two separate incidents. The first incident, occurring in 1984, resulted in the death of six-week-old infant during surgery for a hernia. The second incident, occurring in 1989, resulted in the death of a 68-year-old patient admitted to the hospital for coronary bypass surgery. Dr. Borden was the anesthesiologist during the surgeries; both patients died of lack of oxygen to the brain. According to the statements of two anesthesia experts, Dr. Borden's behavior during these surgeries constituted gross negligence. (*EDITOR'S NOTE:* Although these incidents occurred in 1984 and 1989, at the time the Second District rendered this opinion and at this writing, Dr. Borden retains an unrestricted license from MBC to practice medicine in California.)

In order to establish that Dr. Borden acted with criminal negligence or implied malice, the DA sought a search warrant compelling Memorial to produce the reports compiled by its peer review committees which reviewed Dr. Borden's involvement in the two incidents, as well as Memorial's credentials file on Dr. Borden. Memorial opposed





the issuance of the warrant, relying on Evidence Code section 1157, which protects the "proceedings" or "records of organized committees" of hospital medical staffs or peer review bodies from "discovery." Although section 1157 was apparently enacted to protect peer review records from civil discovery in medical malpractice actions, Memorial argued—and the trial court agreed—that section 1157 applies to criminal as well as civil actions.

The Second District disagreed and ordered the trial court to vacate its order. Although it found the language of section 1157 to be ambiguous, the court held that section 1157 does not apply to property sought under a properly issued warrant in a criminal action. The court failed to find any evidence in the history of the original bill creating section 1157 or its amendments to support the contention that the legislature intended the effect of section 1157 to be the same in criminal as well as civil cases. The court acknowledged that section 1157 represents a legislative choice between two competing policy goals: better health care through medical staff candor during peer review proceedings, at the cost of denying individual plaintiffs access to evidence of medical malpractice. However, the instant case presents a weighing of different interests. "Because the choice between providing immunity for peer review committee records and allowing criminal actions to go unpunished is different than the choice we think was made by the Legislature in enacting section 1157, we will not now presume to make that choice for them."

In *Szkorla v. Vecchione*, 231 Cal. App. 3d 1541 (June 17, 1991), the Fourth District Court of Appeal affirmed the decision of the San Diego County Superior Court that a battery verdict against a surgeon is not subject to a limit on damages.

Helen Szkorla sued Dr. Thomas Vecchione, a plastic surgeon, after he performed the third of three breast reduction surgeries on her in May 1982. The jury returned special verdicts against Dr. Vecchione on theories of professional negligence, lack of informed consent, and battery. The jury awarded Szkorla \$600,000 in general damages for pain and suffering and \$17,430 in special damages for the cost of future medical care. Dr. Vecchione appealed, contending, among other things, that Civil Code section 3333.2, one of the provisions of the Medical Injury Compensation Reform Act of 1975 (MICRA), limits general or noneconomic damages in any case

against a health care provider to \$250,000. On this point, Vecchione was joined in the appeal by several health care associations, including the California Medical Association, which filed amicus curiae briefs in support of Vecchione's position.

The Fourth District disagreed, citing *Waters v. Bourhis*, 40 Cal. 3d 424, 431-37 (1985), for the proposition that MICRA statutes apply only to actions "based upon [the provider's] alleged professional negligence. . . . In a non-MICRA action the plaintiff is not subject to (1) the \$250,000 limit on noneconomic damages (Civ. Code section 3333.2). . . ." The Fourth District noted that the *Waters* court held that in hybrid actions of this type, where both viable MICRA (*i.e.*, negligence) and non-MICRA (*e.g.*, battery) theories were pursued and recovery could have been based on the non-MICRA theory, MICRA limitations would not apply. The Fourth District further concluded that the legislature did not intend the damage cap of section 3333.2 to apply to cases involving battery.

On June 25, the Attorney General released *Opinion No. 90-926*, which rules that only a licensed physician may perform an abortion under California law. Penal Code section 274 imposes a criminal sanction for the performance of abortions except as provided in the Therapeutic Abortion Act of 1967, Health and Safety Code sections 25950 through 25958. The preamble of section 25951 of that Act states that "[a] holder of the physician's and surgeon's certificate . . . is authorized to perform an abortion or aid or assist or attempt an abortion" under certain circumstances. Although most of those circumstances have been invalidated as unconstitutional under *Roe v. Wade*, 410 U.S. 113 (1973), and its progeny, the preamble still exists. Because the various sections of the Act have been held by the California Supreme Court to be severable, the Attorney General opined that the preamble is valid. Regarding the authority of physician assistants to perform abortions, the Attorney General found that the legislature's broad grant of authority to physician assistants to perform any medical services set forth in regulations adopted by DAHP "when such services are rendered under the supervision of a licensed physician" (Business and Professions Code section 3502) does not supersede the specificity of the Therapeutic Abortion Act and Penal Code section 274. The AG thus concluded that physician assistants may not perform abortions in California.

#### RECENT MEETINGS:

At its September meeting, the Medical Board was introduced to Jim Conran, the new Director of the Department of Consumer Affairs. In his remarks to the Board, Conran emphasized his commitment to putting the word "consumer" back into the Department of Consumer Affairs. He maintained that all 38 agencies which fall under DCA's control must protect the public, while also being fair to business in maintaining a competitive marketplace. In closing, he emphasized to the Board that the most effective way to ensure public safety is through active and aggressive enforcement of licensing and competence standards.

Also in September, MBC discussed its progress in preparing and distributing a physician and surgeon questionnaire to ensure the collection of the data required by Division 2, Chapter 1.6 of the Business and Professions Code (Healing Arts Licentiates Information). This questionnaire will be mailed to all California physicians with their license renewal application packets. Any physician who fails to return a completed questionnaire will not be allowed to renew his/her license during the next renewal period until a substantially completed questionnaire is received. Physicians will be afforded every opportunity to comply with the questionnaire requirement before DOL is authorized to withhold the license renewal.

At its September meeting, DOL approved a modified decision of disapproval against the Universidad Tecnologica De Santiago (UTESA) School of Medicine. The modified decision will make the temporary order of disapproval dated October 11, 1984 permanent effective May 10, 1991. This modification would also allow graduates of the UTESA School of Medicine to apply to DOL for individual review of their undergraduate credentials if they matriculated and/or graduated from the medical school prior to August 27, 1985.

At DMQ's September meeting, Enforcement Program Chief Vern Leeper reported that staff is in the process of establishing new regional offices in Glendale, Novato, and Pleasant Hill. It is expected that staff will be increased in fiscal year 1992-93 by four consumer assistant technicians. This is in addition to the 24 new positions that were approved under the 1991-92 budget.

Also in September, MBC reported on its continuing efforts to revive the Physician Loan Incentive Program. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 85; Vol. 11, No. 1 (Winter 1991) p. 71; and Vol. 10, No. 4 (Fall 1990) p. 86 for



extensive background information.) Dr. Madison Richardson, chair of the Special Committee on Physician Loans For Underserved Areas, stated that the best way to provide focus for the needs of the program is to sponsor a conference. It is hoped this conference would accommodate all the necessary participants, including federal and state agencies, private organizations, hospitals, and others. Dr. Richardson thought the best way to construct an agenda for such a conference would be to meet informally with key resource persons (the Sierra Foundation, the Department of Health Services, insurance carriers, and others) in October; a timetable for the conference may be established after the informal discussions.

In closing, the Board discussed the May 1991 settlement agreement in the lawsuit filed by MBC, CMA, the American Physical Therapy Association, and the Physical Therapy Examining Committee against the Board of Chiropractic Examiners (BCE) over BCE's adoption of regulatory section 302, which sets forth the scope of chiropractic practice. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 182-83 for background information.) The parties agreed on new language of section 302 which prohibits chiropractors from rendering prenatal/postnatal care, obstetrical services, colonic irrigations, enemas, lithotripter use, and mammographies; in addition, thermography is restricted to diagnostic use. Chiropractors may perform the following with restrictions: manipulation of soft tissue is restricted to manipulation of muscle and connective tissue related to the spine or other joints which are in the process of being adjusted; ultrasound is restricted to diagnostic use for purposes of neuromuscular-skeletal diagnosis, and is entirely prohibited for use on a fetus. Chiropractors may not advertise that they practice physical therapy or use the term "physical therapy" in advertising.

#### FUTURE MEETINGS:

January 30-31 in San Diego.  
May 7-8 in Sacramento.  
August 6-7 in San Francisco.  
November 5-6 in Los Angeles.

#### ACUPUNCTURE COMMITTEE

*Executive Officer: Lynn Morris*  
(916) 924-2642

The Acupuncture Committee (AC) was created in July 1982 by the legislature as an autonomous body; it had previously been an advisory committee to

the Division of Allied Health Professions (DAHP) of the Medical Board of California.

Formerly the "Acupuncture Examining Committee," the name of the Committee was changed to "Acupuncture Committee" effective January 1, 1990 (Chapter 1249, Statutes of 1989). That statute further provides that on and after July 1, 1990, and until January 1, 1995, the examination of applicants for a license to practice acupuncture shall be administered by independent consultants, with technical assistance and advice from members of the Committee.

Pursuant to Business and Professions Code section 4925 *et seq.*, the Committee sets standards for acupuncture schools, monitors students in tutorial programs (an alternative training method), and handles complaints against schools and practitioners. The Committee is authorized to adopt regulations, which appear in Division 13.7, Title 16 of the California Code of Regulations (CCR). The Committee consists of four public members and five acupuncturists. The legislature has mandated that the acupuncturist members of the Committee must represent a cross-section of the cultural backgrounds of the licensed members of the profession.

#### MAJOR PROJECTS:

**AC Adopts Proposed Regulatory Changes.** After a public hearing on July 18, AC took action on proposed amendments to eleven sections and the addition of three new sections to its regulations in Division 13.7, Title 16 of the CCR.

AC amended section 1399.401 to correct AC's name and address; section 1399.403 to correct the names of AC and the Medical Board; section 1399.414(a) to reduce the period of time in which an applicant for registration as an acupuncturist has to request AC reconsideration of a rejected application; section 1399.418 to clarify that applicants who fail to appear for a scheduled examination must state their reason for failing to appear in writing, or their application will be deemed withdrawn; section 1399.436 to clarify that "four academic years" means eight semesters, twelve quarters, nine trimesters, or 36 months, and to specify that acupuncture schools must be approved by the Council for Private Postsecondary and Vocational Education (CPPVE) pursuant to Education Code section 94310; section 1399.443, subject to a minor modification, to require licensure applicants to pass the written examination before they are eligible to sit for the oral and practical examination; section

1399.422, regarding tutorials, to correct a grammatical error; section 1399.424(c) to delete a requirement that a tutorial trainee's experience and training must have occurred prior to January 1, 1980 in order to reduce the theoretical and clinical training components of their tutorial program; section 1399.425, subject to a minor modification, regarding AC's criteria for approval of tutorial programs; section 1399.427, regarding the duties of trainees in tutorial programs; and section 1399.430(d), regarding denial, suspension, or revocation of a supervisor's registration. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 90 for detailed background information on these amendments.)

AC adopted new section 1399.433, specifying AC's processing time periods for tutorial applications, in compliance with the Permit Reform Act of 1981; new section 1399.419, specifying AC's examination processing time periods, in compliance with the Permit Reform Act of 1981; and new section 1399.445, subject to a minor modification, which establishes an appeals process for applicants who fail the practical examination.

AC did not take action on proposed amendments to section 1399.439, deferring the suggested changes for further research and review. The proposed amendments would have required each approved school of acupuncture to submit annual reports to AC containing specified information. These schools would reimburse AC for any necessary onsite visits. Schools would have 30 days to notify AC of any changes to course schedules, policies, instructors, curricula, facilities, clinics, or programs.

On August 21, AC published its modified language of sections 1399.443, 1399.445, and 1399.425 for a 15-day comment period. Following that comment period, AC decided to revisit section 1399.425 at its October meeting, and submit the remainder of the proposed regulatory changes to DAHP for review and approval at its November 22 meeting.

**Implementation of SB 633.** Following a public hearing on July 18, AC adopted two proposed regulatory changes to implement SB 633 (Rosenthal) (Chapter 103, Statutes of 1990), which requires all acupuncturists licensed prior to 1988 to complete 40 hours of continuing education (CE) in six specified subject areas prior to January 1, 1993. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 90; Vol. 11, No. 2 (Spring 1991) p. 86; and Vol. 11, No. 1 (Winter 1991) pp. 71-72 for background information.)



Specifically, AC adopted new section 1399.486, which sets forth the curriculum which is to be covered in each of the specified subject areas. Acupuncturists required to comply with this section must take at least four hours of CE in each of the specified areas; the remaining 16 hours may be taken in any of the areas. AC also amended section 1399.481 to clarify that CE providers must submit specified course information and the curriculum vitae of instructors to AC at least 30 days before the first day of the scheduled course. In addition, one hour of CE instruction would equate to 50 minutes of classroom instruction.

DAHP was scheduled to review these proposed regulatory changes at its November 22 meeting.

**Senate Committee to hold Interim Hearing on Acupuncture.** The Senate Health and Human Services Committee was scheduled to hold a public hearing on the subject of acupuncture on October 7. The half-day hearing in Los Angeles was to be conducted by Senator Diane Watson, chair of the Senate committee, and was to provide a forum for discussion of the nature, development, and history of acupuncture.

## LEGISLATION:

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at pages 90-91:

**SB 1195 (Boatwright).** The Acupuncture Act requires that on or before September 1, 1990, or within five years of initial approval by the Committee, whichever is later, each acupuncture education/training program must be approved by the CPPVE under Education Code section 94310. As amended August 26, this bill instead requires that each program receive full institutional approval within three years of initial approval; requires, until January 1, 1996, each acupuncturist to complete fifteen hours of CE every year; and requires, until January 1, 1996, acupuncturist certificates to expire annually on the last day of the birth month of the licensee. This bill was signed by the Governor on October 13 (Chapter 983, Statutes of 1991).

**SB 664 (Calderon),** as introduced March 5, would prohibit acupuncturists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year

bill is pending in the Senate Business and Professions Committee.

**SB 417 (Royce),** as amended April 15, would (among other things) revise existing law regarding the licensure and regulation of acupuncturists to require a person to complete an education and training program approved by the appropriate governmental educational authority to award a professional degree in the field of traditional oriental medicine approved by the Committee. In the case of an applicant who has completed education and training in schools and colleges other than those approved by the Committee, this bill would require the applicant's educational training and clinical experience to be approved by the Committee as equivalent to the standards established pursuant to prescribed provisions through an examination administered by one or more qualified, independent consultants with expertise in the professional licensure field, which is based on educational program learning outcomes comparable to those of institutions approved under a certain provision. The bill would also add section 4938.2 to the Business and Professions Code, to require AC to contract with an independent consultant for the purposes of determining the equivalency of educational training and clinical experience. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 86 for background information.) This two-year bill is pending in the Senate Business and Professions Committee.

## RECENT MEETINGS:

At its July 18 meeting, AC approved the mission statement and name of its new Planning and Development Subcommittee. AC also voted to notify examinees appealing written exam scores that there are presently no grounds for such appeals. In addition, AC voted to hold scope of practice workshops for licensees. In response to a request from CE instructors to receive credit for teaching such courses, AC decided not to give CE credit to course instructors at this time. AC also directed staff to commence a rulemaking proceeding to incorporate ethics and office management as approved CE subjects.

Also in July, AC noted that the recent state budget cuts which are affecting most boards and commissions have also impacted AC's programs. The AC informational video and planned newsletter have been delayed due to the budget cuts. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 91 for background information.)

DAHP Program Manager Tony Arjil was present at the July meeting to in-

form AC about the development of an enforcement matrix to monitor and report MBC and allied health program enforcement activity. In addition, Karen McGagin, Special Assistant to the Director of the Department of Consumer Affairs (DCA), emphasized the Director's concern about keeping an open line of communication between DCA and AC.

At its August 21 meeting, AC reviewed submitted proposals for the tutorial and foreign school equivalency studies mandated by SB 633. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 91 for background information.) AC chose the bid submitted by Fox Systems, Inc., to perform the foreign school equivalency study. However, the request for proposals for the tutorial study has been published twice because no proposals have met the required criteria necessary for approval.

At a special September 19 meeting, AC chose National Credential Clearinghouse (NCC) to be its new exam consultant for 1992-93. Until 1995, AC is required to hire an independent consultant to prepare and administer its licensure examinations. Subsequently, the other bidders formally protested the award of the bid to NCC. Hoffman Research Associates, AC's former exam consultant, and Western Institute of Traditional Chinese Medicine both protested the selection. (Hoffman subsequently withdrew its protest.) The Department of General Services is scheduling proceedings to hear the parties and resolve the issue. This controversy may delay the administration of AC's next licensing examination, since the contract cannot be signed until the issue is resolved.

## FUTURE MEETINGS:

December 12 in Sacramento.

## HEARING AID DISPENSERS EXAMINING COMMITTEE

*Executive Officer: Elizabeth Ware (916) 920-6377*

Pursuant to Business and Professions Code section 3300 *et seq.*, the Medical Board of California's Hearing Aid Dispensers Examining Committee (HADEC) prepares, approves, conducts, and grades examinations of applicants for a hearing aid dispenser's license. The Committee also reviews qualifications of exam applicants, and is authorized to issue licenses and adopt regulations pursuant to, and hear and prosecute cases involving violations of, the law relating to hearing aid dispensing.



## REGULATORY AGENCY ACTION

HADEC has the authority to issue citations and fines to licensees who have engaged in misconduct. HADEC recommends proposed regulations to the Medical Board's Division of Allied Health Professions (DAHP), which may adopt them; HADEC's regulations are codified in Division 13.3, Title 16 of the California Code of Regulations (CCR).

The Committee consists of seven members, including four public members. One public member must be a licensed physician and surgeon specializing in treatment of disorders of the ear and certified by the American Board of Otolaryngology. Another public member must be a licensed audiologist. The other three members are licensed hearing aid dispensers.

### MAJOR PROJECTS:

**HADEC's Need for New Members.** As reported previously, HADEC is down to four members, and can conduct business only if all four show up at meetings. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 92 for background information.) The Committee did not have a quorum at its last meeting on June 15, and cancelled its scheduled September 14 meeting because of lack of a quorum. At its March meeting, HADEC had voted to send a letter to the Governor indicating that the Committee would not object to the appointment of a dispensing audiologist to sit on the Board in a slot reserved for a hearing aid dispenser. At that time, one HADEC member had asked Executive Officer Elizabeth Ware to delay sending the letter until further discussion; however, those present at the June meeting decided the letter should be sent as approved at the March meeting.

Jerry Desmond of the Hearing Aid Association of California (HAAC) commented at the June meeting that HAAC is opposed to the appointment of a dispensing audiologist in place of a dispenser.

**Update on SB 2375 (Presley).** At HADEC's June meeting, Assistant Attorney General Al Korobkin reported on the development of the new Health Quality Enforcement Section (HQES) created by SB 2375 (Presley), a 37-part bill enacted in 1990 which overhauls the Medical Board's discipline system. (See CRLR Vol. 11, No. 2 (Spring 1991) pp. 81-82; Vol. 11, No. 1 (Winter 1991) pp. 66-67; and Vol. 10, No. 4 (Fall 1990) pp. 79-80 for background information on SB 2375.) HQES is a special unit of deputy attorneys general which specializes in prosecuting MBC and allied health program disciplinary cases. Korobkin, who is chief of HQES, re-

ported that HQES is currently staffed by seven attorneys in San Diego, seven in Los Angeles, four in San Francisco, and four in Sacramento. Although HQES is presently laboring under a huge backlog of physician discipline cases, its attorneys provide onsite training to MBC investigators and consultants through monthly visits to MBC regional offices. If a case is investigated inadequately, it is returned to the investigator by a deputy attorney general, who informs the investigator of the additional evidence needed for prosecution. Through HQES, the AG's office is becoming involved with MBC/allied health program handling of all complaints, including the review of closed cases. Korobkin noted that more attorneys must be added to HQES (see *supra* agency report on MBC for related discussion).

**Consumer Pamphlet.** At the June meeting, staff announced that HADEC's new consumer brochure, *Everything You Always Wanted to Know About Hearing Aids*, is ready for print. Due to the Committee's tight budget, the pamphlet will be completed in the new fiscal year which began on July 1.

**Regulatory Determination Delayed.** On January 11 in the *California Regulatory Notice Register*, the Office of Administrative Law (OAL) published notice that Robert Hughes of Long Beach has requested a regulatory determination as to the "underground rulemaking" status of several policies and procedures of HADEC. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 91-92 for background information.) Although OAL was scheduled to issue its determination in March, at this writing it has not yet been released. According to OAL Director Marz Garcia, OAL has suffered a 50% budget cut and, as a result, will not be able to publish regulatory determinations until three to four years after a request is made. (See *infra* LITIGATION for related discussion.)

**Occupational Analysis Survey.** HADEC is in the process of conducting a validation study of its licensing examination in order to assess its effectiveness and to facilitate the possible creation of a new exam. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 92 for background information.) At the June meeting, HADEC's Examination and Educational Requirements Subcommittee reported that the survey is on schedule and that a questionnaire would be ready for mailing to all dispensers in September. Staff also noted that, as a result of a provision in the 1991-92 budget bill which strips most licensing boards of their reserve funds, HADEC could lose approximately \$60,000—the

amount needed to complete the occupational analysis survey.

### LEGISLATION:

**SB 664 (Calderon),** as introduced March 5, would prohibit hearing aid dispensers, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

### LITIGATION:

On July 15, the Los Angeles County Superior Court dismissed plaintiffs' second amended complaint in *Hughes v. State of California*, No. BC011688. In their complaint, Robert and Mary Hughes, both licensed hearing aid dispensers, alleged that HADEC applies "underground rules" in regulating the hearing aid industry and, particularly, in approving licensed hearing aid dispensers to train and supervise trainees. Specifically, plaintiffs alleged that HADEC applied underground rules to "unfairly, arbitrarily, and without cause" revoke its approval of plaintiffs to supervise hearing aid dispenser trainees, revoke the temporary licenses of plaintiffs' trainees, and withhold permanent licensure from plaintiffs' trainees, thus making it "impossible for plaintiffs to induce would-be trainees into their employ." Plaintiffs prayed for \$550,000 in damages and injunctive relief.

However, the court dismissed the complaint without leave to amend, citing—among other things—plaintiffs' lack of standing to sue and defendants' immunity from liability for failure to issue a license. In incorporating into its decision defendants' demurrer, the court also dismissed the complaint for failure to exhaust administrative remedies—*i.e.*, OAL review of the alleged "underground rules," which Hughes has attempted but been unable to secure due to OAL's severe budget cuts. (See *supra* MAJOR PROJECTS.) This action prompted Hughes to write a letter to Governor Wilson, warning him that the reductions to OAL's budget amount to a "de facto repeal of the Administrative Procedure Act."

### RECENT MEETINGS:

Elizabeth Ware's appointment as HADEC's permanent Executive Officer was announced at the June 15 meeting. Ware had been acting as Executive Officer during Peggy McNally's



leave of absence. McNally recently resigned, and Ware will serve as Executive Officer.

## FUTURE MEETINGS:

To be announced.

## PHYSICAL THERAPY EXAMINING COMMITTEE

*Executive Officer: Steven Hartzell (916) 920-6373*

The Physical Therapy Examining Committee (PTEC) is a six-member board responsible for examining, licensing, and disciplining approximately 11,400 physical therapists. The committee is comprised of three public and three physical therapist members. PTEC is authorized under Business and Professions Code section 2600 *et seq.*; the Committee's regulations are codified in Division 13.2, Title 16 of the California Code of Regulations (CCR).

Committee licensees presently fall into one of three categories: physical therapists (PTs), physical therapist assistants (PTAs), and physical therapists certified to practice kinesiological electromyography or electroneuro-myography.

PTEC also approves physical therapy schools. An exam applicant must have graduated from a Committee-approved school before being permitted to take the licensing exam. There is at least one school in each of the 50 states and Puerto Rico whose graduates are permitted to apply for licensure in California.

At this writing, no replacement has been appointed for public member Mary Ann Meyers, who resigned in November 1990. The Committee currently has two public members and three PT members.

## MAJOR PROJECTS:

**PTEC Newsletter.** At PTEC's June 7 meeting, Executive Officer Steve Hartzell announced a revised target date of October 1991 for publication of PTEC's first newsletter, pending approval by the Department of Consumer Affairs. The newsletter's audience will primarily be PT licentiates in California. The newsletter will provide information on the Committee, including the function and composition of PTEC, licensure information, and complaint/enforcement procedures. Initially, the newsletter will be published twice a year.

**Citation Program.** PTEC is currently developing a citation manual which will outline its procedures for

issuing citations to physicians who illegally supervise physical therapist assistants, physical therapy, or other unlicensed individuals performing physical therapy. Although the Medical Board is opposed to PTEC's issuance of citations to physicians, Steve Hartzell explained that the Committee is authorized to issue such citations under the Physical Therapy Practice Act. A physician's scope of practice does not include the supervision of physical therapy or the performance of duties which only a physical therapist is authorized to perform; therefore, a physician is considered to be an unlicensed person under the Act. Citations would be issued upon recommendation after an investigation.

### Medical Board Investigations.

PTEC is currently utilizing investigators from both the Medical Board's Division of Medical Quality (DMQ) and the Department of Consumer Affairs' (DCA) Division of Investigation (DOI) to investigate consumer complaints against PTEC licensees. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 73 for background information.) Steve Hartzell is still unsatisfied with DMQ's inability to track cases assigned to DOI through its Central Complaint and Investigation Control Unit (CCICU), and DMQ's backlog of investigations. In a recent interview, Hartzell commented that he will continue the use of DOI investigators, especially for cases which warrant their use due to timeliness or importance.

**Diversion Program.** During its August 23 meeting, the Committee discussed a draft request for proposals to administer PTEC's diversion program for substance-abusing licensees. The program was mandated by SB 2512 (McCorquodale) (Chapter 1087, Statutes of 1990). (See CRLR Vol. 11, No. 2 (Spring 1991) p. 88 and Vol. 10, No. 4 (Fall 1990) p. 88 for background information.) The funding for the program, which will begin on January 1, 1992, has been established. As there is only one bidder for the program, PTEC will submit the proposal as a sole source contract.

**Fee Increase To Be Delayed.** At the Committee's June meeting, Steve Hartzell noted that the legislature was considering a budget provision which would strip special-funded agencies—including PTEC—of much of their surplus reserve funds as of June 30, 1992, in an attempt to help reduce the \$14.3 billion state budget deficit. To minimize the revenue available for transfer to the general fund, Hartzell recommended that PTEC delay implementa-

tion of the license fee increases approved at its April meeting. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 92 and Vol. 11, No. 2 (Spring 1991) p. 88 for background information.) DCA legal counsel Greg Gorges suggested that PTEC modify the language of the proposed regulatory amendments to implement the fee increases as of July 1, 1992, and release the modified language for a 15-day public comment period. Thus, PTEC published the delayed implementation language between September 9 and September 25. Even if PTEC delays the fee increase, it will still have to turn over \$62,000 to the general fund due to the budget crisis.

## LEGISLATION:

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at page 93:

**SB 483 (Green),** as amended April 30, authorizes PTEC to create a cost recovery system; that is, in any order issued in resolution of a disciplinary proceeding before the Committee, PTEC may request the administrative law judge to direct any licensee found guilty of unprofessional conduct to pay to PTEC a sum not to exceed the actual and reasonable costs of the investigation and prosecution. This bill, which also increases fees applicable to the practice of physical therapy, was signed by the Governor on October 11 (Chapter 855, Statutes of 1991).

**SB 664 (Calderon),** as introduced March 5, would prohibit physical therapists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

**AB 819 (Speier).** Existing law provides that it is not unlawful for prescribed health professionals to refer a person to a laboratory, pharmacy, clinic, or health care facility solely because the licensee has a proprietary interest or co-ownership in the facility. As introduced February 27, this bill would, effective July 1, 1992, provide that, subject to specified exceptions, it is unlawful for these licensed health professionals to refer a person to any laboratory, pharmacy, clinic, or health care facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest; the bill would also provide that disclosure



# REGULATORY AGENCY ACTION

of the ownership or proprietary interest would not exempt the licensee from the prohibition. This two-year bill is pending in the Assembly Health Committee.

## RECENT MEETINGS:

At PTEC's June 7 meeting, Executive Officer Steven Hartzell commented on a letter received from Medical Board Executive Director Kenneth Wagstaff regarding MBC's decision to discontinue publication of disciplinary actions taken against applicants (statement of issues cases) and those who are not licensed. The cases were formerly reported in the *Hot Sheet* and *Action Report*, both Medical Board publications. Hartzell expressed his concern regarding this decision, stating he felt the result would be a reduced level of service to consumers. Due to various complaints from allied health program executive officers, including Hartzell, Wagstaff announced by memorandum on June 12 that statement of issues cases would continue to be published in the *Hot Sheet*, but not in the *Action Report*.

PTEC will continue to include on its 1991 agenda the issue of the practice of physical therapy through a general business corporation (as opposed to a professional corporation). (See CRLR Vol. 11, No. 1 (Winter 1991) pp. 74-75 for background information.) At PTEC's June 7 meeting, DCA legal counsel Greg Gorges announced that the issue would be addressed at an open forum to be held on October 17 in conjunction with the American Physical Therapy Association (APTA) convention in Los Angeles.

Also in June, Executive Officer Hartzell discussed a letter he received from the North Carolina Board of Physical Therapy Examiners regarding the discontinuation by Assessment Systems Incorporated (ASI) of overseas testing of physical therapists. Hartzell mentioned that several other states are also upset by ASI's decision. He suggested the Committee research the reasoning behind the decision. At its August 23 meeting, the Committee discussed the fact that the exam, which is currently owned by APTA, is being purchased by the Federation of State Boards of Physical Therapy. Although the purchase transaction will not be completed until January 1, 1993, Hartzell reported that APTA and FSBPT are currently working together in an attempt to administer the exam in London possibly in July 1992.

## FUTURE MEETINGS:

January 3 in San Diego.  
March 27 in San Francisco.

## PHYSICIAN ASSISTANT EXAMINING COMMITTEE

Executive Officer: Ray Dale  
(916) 924-2626

The legislature established the Physician Assistant Examining Committee (PAEC) in Business and Professions Code section 3500 *et seq.*, in order to "establish a framework for development of a new category of health manpower—the physician assistant." Citing public concern over the continuing shortage of primary health care providers and the "geographic maldistribution of health care service," the legislature created the physician assistant (PA) license category to "encourage the more effective utilization of the skills of physicians by enabling physicians to delegate health care tasks. . . ."

PAEC licenses individuals as PAs, allowing them to perform certain medical procedures under a physician's supervision, including drawing blood, giving injections, ordering routine diagnostic tests, performing pelvic examinations, and assisting in surgery. PAEC's objective is to ensure the public that the incidents and impact of "unqualified, incompetent, fraudulent, negligent and deceptive licensees of the Committee or others who hold themselves out as PAs [are] reduced." PAEC's regulations are codified in Division 13.8, Title 16 of the California Code of Regulations (CCR).

PAEC's nine members include one member of the Medical Board of California (MBC), a physician representative of a California medical school, an educator participating in an approved program for the training of PAs, one physician who is an approved supervising physician of PAs and who is not a member of any division of MBC, three PAs, and two public members.

## MAJOR PROJECTS:

**Scope of Practice Regulations Rejected For Third Time.** On September 19, the Office of Administrative Law (OAL) rejected for a third time PAEC's new regulations defining the permissible scope of practice of a physician assistant, adopted in response to Attorney General's Opinion 88-303 (Nov. 3, 1988). Specifically, PAEC is attempting to amend sections 1399.541, 1399.543, and 1399.545, Division 13.8, Title 16 of the CCR. The proposed regulatory changes would permit a PA's supervising physician (SP) to specify the type and limit of delegated medical services based on the SP's specialty or usual and customary scope of practice. They would also authorize PAs to ini-

tiate (or transmit an order to initiate) certain tests and procedures, and to provide necessary treatment in emergency or life-threatening situations. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 75; Vol. 10, No. 4 (Fall 1990) p. 90; and Vol. 10, No. 1 (Winter 1990) pp. 81-82 for background information.) Following two rejections, PAEC had resubmitted the rule changes to OAL on August 19.

In its September 19 ruling, OAL primarily found that the regulatory amendments fail to satisfy the clarity standard in Government Code section 11349.1 in two respects. First, proposed section 1399.541 contains nine subsections listing various medical services that a PA may perform under the supervision of a physician. One subsection, 1399.541(b), permits a PA to order or transmit several services "without the prior patient-specific order of the supervising physician." OAL questions whether this means that a prior patient-specific order is required in order for a PA to provide the services listed in the other eight subsections. Second, section 1399.541(c) permits a PA to perform certain procedures only if they are "consistent with the supervising physician's specialty, or usual and customary practice, and with the patient's health and condition." Again, OAL questions whether this limitation also applies to the services listed in the other eight subsections of section 1399.541.

OAL further found that PAEC failed to document in its rulemaking file the fact that the August 19 version of the regulatory changes had been submitted to the Director of the Department of Consumer Affairs (DCA) for review and approval, as required by Business and Professions Code section 313.1(a).

MBC's Division of Allied Health Professions (DAHP) was scheduled to discuss the possible resubmission of the PA scope of practice regulations at its November 22 meeting.

**Fee Increases Approved.** On June 13, OAL approved PAEC's changes to regulatory section 1399.553, which increase the approval fee for SPs from \$50 to \$100, and increase the biennial approval fee for SPs from \$100 to \$150. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 94; Vol. 11, No. 2 (Spring 1991) p. 89; and Vol. 11, No. 1 (Winter 1991) pp. 75-76 for background information.)

## LEGISLATION:

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at page 94:



**AB 535 (Clute)**, as introduced February 14, permits a PA acting under the patient-specific authority of his/her physician supervisor to administer a controlled substance to treat an addict for an addiction. This bill was signed by the Governor on July 26 (Chapter 176, Statutes of 1991).

**SB 1077 (Killea)**, as amended May 16, raises the limit of the initial license fee for PAs from \$100 to \$250 and the biennial renewal fee from \$150 to \$300; raises the limit of the approval fee for SPs from \$100 to \$250 and the biennial renewal fee from \$150 to \$300; establishes a fee for letters of endorsement, good standing, or verification of licensure or approval; requires that all Committee approvals for SPs expire at midnight on the last day of the birth month of the physician; and requires MBC to establish a cyclical renewal program for approvals. This bill also requires PAEC to submit a report to the legislature identifying the percentage of funds derived from any increase in fees permitted under this bill that are to be used for investigations or enforcement activities by PAEC and MBC. This bill was signed by the Governor on October 13 (Chapter 917, Statutes of 1991).

**SB 664 (Calderon)**, as introduced March 5, would prohibit physician assistants, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

## LITIGATION:

On June 25, the Attorney General released *Opinion No. 90-926*, which rules that only a licensed physician may perform an abortion under California law. Penal Code section 274 imposes a criminal sanction for the performance of abortions except as provided in the Therapeutic Abortion Act of 1967, Health and Safety Code sections 25950 through 25958. The preamble of section 25951 of that Act states that "[a] holder of the physician's and surgeon's certificate . . . is authorized to perform an abortion or aid or assist or attempt an abortion" under certain circumstances. Although most of those circumstances have been invalidated as unconstitutional under *Roe v. Wade*, 410 U.S. 113 (1973), and its progeny, the preamble still exists. Because the various sections of the Act have been held by the California Supreme Court to be severable,

the Attorney General opined that the preamble is valid. Regarding the authority of PAs to perform abortions, the Attorney General found that the legislature's broad grant of authority to physician assistants to perform any medical services set forth in regulations adopted by DAHP "when such services are rendered under the supervision of a licensed physician" (Business and Professions Code section 3502) does not supersede the specificity of the Therapeutic Abortion Act and Penal Code section 274. The AG thus concluded that PAs may not perform abortions in California.

## RECENT MEETINGS:

In his enforcement report at PAEC's July 26 meeting, Executive Officer Ray Dale noted that three PAs were disciplined during fiscal year 1990-91, and that four other accusations are pending at the Attorney General's office.

Staff member Jennifer Barnhart presented a status report on current licensing statistics. As of June 30, there were 4,648 approved supervising physicians and 2,061 licensed physician assistants.

Nancy Chavez, legislative assistant to Senator Lucy Killea, presented SB 1190 (Killea) for discussion at PAEC's July meeting. The bill would authorize the licensing of midwives to give necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period; conduct deliveries on his/her own responsibility; and provide immediate postpartum care of the newborn and primary reproductive health care to essentially healthy women during the interconceptual period. This care would include preventive measures, detection of abnormal conditions, procurement of a physician's assistance, and the provision of emergency measures in the absence of such assistance, as specified in regulations to be adopted by a new Licensed Midwifery Examining Committee to be established within DAHP. The purpose of Chavez' discussion was to gauge the level of PAEC's interest in administering the new licensing program until a new Licensed Midwifery Examining Committee can be established and self-supporting. PAEC members expressed a number of concerns about the proposal, but took no formal position on it at the July meeting.

Also in July, PAEC renewed its contract with Occupational Health Services, which currently administers PAEC's Diversion Program. The purpose of the program is to identify and rehabilitate PAs whose competence may be impaired due to substance abuse. (See CRLR Vol.

10, No. 4 (Fall 1990) p. 90 and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 107 for background information.) Three PAs participated in the program during fiscal year 1990-91; one of those cases is closed.

## FUTURE MEETINGS:

January 10 in San Diego.  
March 13 in San Francisco.  
May 8 in Palm Springs.

## BOARD OF PODIATRIC MEDICINE

*Executive Officer: James Rathlesberger*  
(916) 920-6347

The Board of Podiatric Medicine (BPM) of the Medical Board of California (MBC) regulates the practice of podiatry in California pursuant to Business and Professions Code section 2460 *et seq.* BPM's regulations appear in Division 13.9, Title 16 of the California Code of Regulations (CCR).

The Board licenses doctors of podiatric medicine (DPMs), administers two licensing examinations per year, approves colleges of podiatric medicine, and enforces professional standards by initiating investigations and disciplining its licensees, as well as administering its own diversion program for DPMs. The Board consists of four licensed podiatrists and two public members.

On May 15, Assembly Speaker Willie Brown appointed Theresa D. Taylor as BPM's new public member. Taylor is an attorney who previously served as a consultant to the Senate Judiciary Committee; she is currently a lobbyist whose primary client is the State Bar.

## MAJOR PROJECTS:

**Enforcement Update.** At BPM's June 14 meeting, Al Korobkin and Barry Ladendorf from the Attorney General's office updated the Board on the purpose and progress of the new Health Quality Enforcement Section (HQES). HQES was created by SB 2375 (Presley), a 37-part bill enacted in 1990 which overhauls the Medical Board's discipline system. (See CRLR Vol. 11, No. 2 (Spring 1991) pp. 81-82; Vol. 11, No. 1 (Winter 1991) pp. 66-67; and Vol. 10, No. 4 (Fall 1990) pp. 79-80 for background information on SB 2375.) HQES is a special unit of deputy attorneys general which specializes in prosecuting MBC and allied health program disciplinary cases. Korobkin, who is chief of HQES, reported that HQES is currently staffed by seven attorneys in San Diego, seven in Los Angeles, four in



## REGULATORY AGENCY ACTION

San Francisco, and four in Sacramento. Although HQES is presently laboring under a huge backlog of physician discipline cases, its attorneys provide onsite training to MBC investigators and consultants through monthly visits to MBC regional offices. If a case is investigated inadequately, it is returned to the investigator by a deputy attorney general who informs the investigator of the additional evidence needed for prosecution. Through HQES, the AG's office is becoming involved with MBC/allied health program handling of all complaints, including the review of closed cases. Korobkin noted that more attorneys must be added to HQES (see *supra* agency report on MBC for related discussion). At its June meeting and in correspondence thereafter, BPM affirmed its commitment to stronger discipline and to funding HQES at a level which will enable BPM to move swiftly and effectively.

**Advertisement of Specialty Board Certification.** At BPM's June meeting, the Board discussed a proposed revision to its June 1990 policy decision regarding podiatrist advertisement of specialty board certification. In its June 1990 policy statement, the Board decided that "it is inherently misleading for a podiatrist to advertise a specialty certification or other recognition of professional superiority unless that specialty certification or recognition is issued or awarded by a specialty board or other organization which is authorized or approved by an accrediting body which is recognized by the U.S. Department of Education."

In May 1991, the Board received a letter from the American Podiatric Medical Association's Council on Podiatric Medical Education (CPME), which explained while the Department of Education is authorized to recognize accrediting bodies (such as CPME), it is not authorized to recognize professional agencies that engage in the approval of specialty boards for particular areas of professional practice. Thus, BPM amended its policy statement to prohibit podiatrists from advertising specialty certifications or other recognitions unless they are issued or awarded by a specialty board or other organization which is authorized or approved by the CPME. Currently, the only boards recognized by CPME are the American Board of Podiatric Orthopedics, the American Board of Podiatric Public Health, and the American Board of Podiatric Surgery.

**Diversion Program.** At its September 13 meeting, the Medical Board agreed that its Diversion Program should

administer BPM's Diversion Program as well, in which eight podiatrists are currently participating. The purpose of a diversion program is to identify and rehabilitate licensees whose competence is impaired due to drug or alcohol abuse. (See *supra* agency report on MBC; see also CRLR Vol. 11, No. 3 (Summer 1991) pp. 93-94; Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 108; and Vol. 10, No. 1 (Winter 1990) p. 84 for background information.)

### LEGISLATION:

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at page 95:

**SB 1195 (Boatwright)**, as amended August 26, permits BPM to reduce its initial license fee by up to 50% for any applicant enrolled in an MBC-approved postgraduate training program or who has completed an MBC-approved postgraduate training program within six months prior to the payment of the initial license fee. This bill was signed by the Governor on October 13 (Chapter 983, Statutes of 1991).

**AB 1568 (Klehs)**, as amended September 5, proposed to make numerous changes to the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, to correct the unintended exclusion of DPMs from provisions which specifically mention physicians and surgeons. For example, this bill would have prohibited a hospital which contracts with an insurer, non-profit hospital service plan, or health care service plan from determining or conditioning medical staff membership or clinical privileges upon the basis of a podiatrist's participation or nonparticipation in the contract. AB 1568 was sponsored by the California Podiatric Medical Association; BPM took no position on the bill, affirming its mandate to protect the public and not the parochial interests of the podiatric community. This bill was vetoed by the Governor on October 14.

**SB 1004 (McCorquodale)**, as amended May 7, would prohibit health facilities from denying, restricting, or terminating a podiatrist's staff privileges on the basis of economic criteria unrelated to his/her clinical qualifications or professional responsibilities. This bill would define "economic criteria" as factors related to the economic impact on the health facility of a podiatrist's exercise of staff privileges in that facility, including but not limited to the revenue generated by the podiatrist, the number of Medi-Cal or Medicare patients treated by the podiatrist, and the severity of the patients' illnesses treated by the podia-

trist. This two-year bill is pending in the Senate Health and Human Services Committee.

**SB 664 (Calderon)**, as introduced March 5, would prohibit podiatrists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

**SB 1119 (Presley)**. Existing law requires the district attorney, city attorney, or other prosecuting agency to notify BPM of any filings against a licensee charging a felony, and the clerk of the court in which the licensee is convicted of a crime is required to transmit a copy of the record of conviction to the Board. As amended April 30, this bill would expressly limit the transmittal duties of the clerk of the court to felony convictions. This two-year bill is pending in the Assembly Health Committee.

**AB 465 (Floyd)**. Existing law provides general civil immunity to persons who provide information to MBC/BPM or the Department of Justice indicating that a licensee may be guilty of unprofessional conduct or impaired because of drug or alcohol abuse or mental illness. Existing law also sets forth special immunity provisions relating to the certain activities of specified health care organizations. As introduced February 8, this bill would make the general immunity provisions inapplicable to the activities which are subject to the special immunity provisions. This two-year bill is pending in the Senate Judiciary Committee.

### RECENT MEETINGS:

At BPM's June meeting, the Board was introduced to Karen McGagin, Special Assistant to the Director of the Department of Consumer Affairs. McGagin discussed the priorities of new DCA Director Jim Conran, and informed the Board that DCA hopes to provide formal orientation sessions for all board members of DCA agencies.

Also in June, public member Karen McElliott was elected BPM president for fiscal year 1991-92; podiatrist Michael Vega was selected vice-president.

### FUTURE MEETINGS:

March 6 in Sacramento.  
June 26 in San Francisco.  
September 25 in Los Angeles.





## BOARD OF PSYCHOLOGY

*Executive Officer: Thomas O'Connor  
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The Board of Psychology (BOP) (formerly the "Psychology Examining Committee") is the state regulatory agency for psychologists under Business and Professions Code section 2900 *et seq.* BOP sets standards for education and experience required for licensing, administers licensing examinations, issues licenses, promulgates rules of professional conduct, regulates the use of psychological assistants, investigates consumer complaints, and takes disciplinary action against licensees by suspension or revocation. BOP's regulations are located in Division 13.1, Title 16 of the California Code of Regulations (CCR). BOP is composed of eight members, three of whom are public members.

### MAJOR PROJECTS:

**BOP Rulemaking.** At its July and September meetings, BOP discussed two long-delayed rulemaking proceedings scheduled to commence in the near future. First, the Board must adopt regulations to implement AB 4016 (Filante) (Chapter 800, Statutes of 1988), which prohibits psychologists from practicing under a fictitious name unless that name is approved by BOP. BOP attempted to adopt regulations to establish a fictitious name program in 1989, but those proposed rules were rejected by the Office of Administrative Law in March 1990. (See CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 110; Vol. 10, No. 1 (Winter 1990) p. 85; and Vol. 9, No. 4 (Fall 1989) p. 70 for background information.) At this writing, BOP hopes to notice the proposed fictitious name regulations in time for a hearing on January 10 in Los Angeles.

BOP also hopes to finally amend section 1387, Division 13.1, Title 16 of the CCR, to further define the criteria for and responsibilities of a "qualified primary supervisor"; specify the length and type of required supervised professional experience; define acceptable group supervision; and delineate the responsibilities of supervisors and supervisees regarding the proper logging of experience to ensure accurate verification of supervised professional experience. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 96; Vol. 10, No. 4 (Fall 1990) p. 93; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 110 for background information.) At its July 27 meeting, BOP decided to add a provision to section 1387 prohibiting a licensee from supervising a former or cur-

rent patient. At this writing, BOP does not expect to notice these proposed regulatory changes until 1992.

### LEGISLATION:

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at pages 96-97:

**AB 1496 (Murray)**, as amended May 30, specifies a procedure by which a coroner could enforce a subpoena duces tecum for records of confidential communications of a decedent subject to the psychotherapist-patient privilege when sought by the coroner for specified purposes. This bill was signed by the Governor on October 14 (Chapter 1092, Statutes of 1991).

**SB 1004 (McCorquodale)**, as amended May 7, would prohibit health facilities from denying, restricting, or terminating a clinical psychologist's staff privileges on the basis of economic criteria unrelated to his/her clinical qualifications or professional responsibilities. This bill would define "economic criteria" as factors related to the economic impact on the health facility of the psychologist's exercise of staff privileges in that facility, including but not limited to the revenue generated by the psychologist, the number of Medical or Medicare patients treated by the psychologist, and the severity of the patients' illnesses treated by the psychologist. This two-year bill is pending in the Senate Health and Human Services Committee.

**AB 1106 (Felando)**, as introduced March 5, would create the Alcohol and Drug Counselor Examining Committee within the Board of Behavioral Science Examiners (BBSE), and require the Committee to adopt regulations to establish certification standards and requirements relating to education, training, and experience for persons who practice alcohol and drug abuse counseling, and to grant certificates to practice drug and alcohol abuse counseling to applicants who meet the requirements and standards established by BBSE. This two-year bill is pending in the Assembly Health Committee.

**SB 664 (Calderon)**, as introduced March 5, would prohibit psychologists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

**SB 774 (Boatwright)**, as amended July 3, would, commencing January 1, 1995, prohibit BOP from issuing any renewal license unless the applicant submits proof satisfactory to the Board that he/she has completed no less than 48 hours of approved continuing education (CE) in the preceding two years, and require each person renewing his/her license to practice psychology to submit proof satisfactory to the Board that, during the preceding two-year period, he/she has completed CE courses in or relevant to the field of psychology. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 78 for background information.) This two-year bill has passed both the Senate and the Assembly and is pending in the Senate inactive file.

At its July meeting, BOP voted to disapprove SB 774, and directed Executive Officer Tom O'Connor to communicate its concerns to Senator Boatwright. In an August 30 letter, O'Connor stressed that the Board opposes mandatory continuing education requirements in general, and disapproves of the specifics of SB 774 in particular. For example, SB 774 requires BOP to approve CE courses, thus creating a significant workload for Board staff, but does not expressly permit BOP to charge CE providers for review and approval of the courses. Further, the bill does not appear to permit BOP to exempt certain psychologists who do not diagnose and treat patients from the CE requirement. At BOP's September meeting, a representative from the California Psychological Association (CPA), which is sponsoring SB 774, stated that CPA will try to address BOP's concerns about the bill. BOP will appoint a Board member to work with CPA on bill language.

**SB 738 (Killea)**, as introduced March 6, would require BOP to establish required training or coursework in the area of domestic violence assessment, intervention, and reporting for all persons applying for an initial psychologist's license and the renewal of such a license. This two-year bill is pending in the Senate Business and Professions Committee.

### LITIGATION:

In *McGuigan v. California Board of Psychology*, No. 3 Civil C01084 (Third District Court of Appeal), respondent BOP recently filed its brief arguing that Dr. Frank McGuigan's petition for a writ of mandate requiring BOP to provide him with a statement of issues and an administrative hearing on its denial of his 1984 application for waiver of its license examination is moot because, subsequent to the filing of Dr.



## REGULATORY AGENCY ACTION

McGuigan's lawsuit in 1990, BOP finally granted him a statement of issues and an administrative hearing. (See CRLR Vol. 11, No. 2 (Spring 1991) pp. 92-93 and Vol. 10, No. 4 (Fall 1990) p. 94 for background information on this case.) McGuigan has argued that the Administrative Procedure Act and fundamental notions of procedural due process require BOP to afford him and other reciprocity applicants a hearing on its denial of exam waivers under Business and Professions Code section 2946. Although BOP contends that McGuigan supplied no evidence to support his contention that the circumstances of his case are likely to occur again, the Board itself entertained three such petitions for exam waivers at its July and September meetings. (See *infra* RECENT MEETINGS.) Oral argument was scheduled for November 18 in the Third District Court of Appeal.

### RECENT MEETINGS:

At its July 27 meeting in San Francisco, BOP voted to amend its existing Reasonable Accommodation Policy for handicapped examinees to add that all examinations, both written and oral, will be administered at examination sites which are handicapped accessible. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 97 for background information.)

Also in July, BOP appointed Executive Officer Tom O'Connor to a task force to determine how the legislative intent of AB 3314 (Harris) (Chapter 1005, Statutes of 1990) may be achieved. AB 3314 requires BOP to consider the adoption of CE requirements with respect to training in substance abuse detection and intervention. (See *supra* agency report on BBSE; see also CRLR Vol. 10, No. 4 (Fall 1990) p. 93 for background information.) Although BOP currently has no CE requirements, the Board discussed other creative ways of encouraging psychologists to comply with the spirit of AB 3314.

At its July and September meetings, BOP considered the petitions of three individuals for a waiver of the Board's licensing examination under section 2946 of the Business and Professions Code. Section 2946 permits BOP to waive the exam for psychologists licensed in other states if the requirements for obtaining a license in that state were substantially equivalent to BOP's requirements, or if the Board determines that the applicant has made a significant contribution to psychology and has had at least ten years of experience. BOP denied all three petitions.

At its September 28 meeting in San Diego, BOP discussed possible amend-

ments to section 820 of the Business and Professions Code, to permit BOP to require a compulsory psychological examination for licensure applicants who appear to be impaired due to mental illness or afflicted with a physical illness affecting competence. Current language allows for compulsory testing of licensees under such circumstances; however, nothing in existing law allows BOP to require an applicant to undergo a psychological examination. BBSE is considering similar legislation. This issue was scheduled for further discussion at the November meeting.

### FUTURE MEETINGS:

March 13-14 in San Diego.

July 24-25 in San Francisco.

### SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

*Executive Officer: Carol Richards*  
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The Medical Board of California's Speech-Language Pathology and Audiology Examining Committee (SPAEC) consists of nine members: three speech pathologists, three audiologists and three public members (one of whom is a physician).

The Committee registers speech pathology and audiology aides and examines applicants for licensure. The Committee hears all matters assigned to it by the Board, including, but not limited to, any contested case or any petition for reinstatement, restoration, or modification of probation. Decisions of the Committee are forwarded to the Board for final adoption.

SPAEC is authorized by the Speech Pathologists and Audiologists Licensure Act, Business and Professions Code section 2530 *et seq.*; its regulations are contained in Division 13.4, Title 16 of the California Code of Regulations (CCR).

At SPAEC's June meeting, David M. Alessi, M.D., was introduced as the Committee's newest member. Dr. Alessi is an otolaryngologist from Los Angeles.

### MAJOR PROJECTS:

**Mandatory Continuing Education.** At SPAEC's June 28 meeting, Committee members again discussed whether to impose a mandatory continuing education (MCE) requirement on its licensees. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 97; Vol. 11, No. 1 (Winter 1991) pp. 79-80; and Vol. 10, No. 4 (Fall 1990) p. 96 for background information.) The California Speech-

Language-Hearing Association recently decided to explore the issue of mandatory continuing education. Any legislative proposal to create an MCE requirement will likely have to be a joint effort by the professional groups and SPAEC. The Committee passed a resolution that continuing education should be mandatory for purposes of licensure renewal, and formed a subcommittee to conduct a survey of other states and the national program to determine how other programs are operated and at what cost.

At SPAEC's September 6 meeting, the MCE subcommittee reported its findings. Committee member Philip Reid offered preliminary recommendations, suggesting a minimum requirement of three continuing education units (CEUs) every two years, with sponsor approval by SPAEC. He stated that the program could not be implemented in less than two years, and that legislation would be required to make continuing education mandatory. The MCE subcommittee was directed to begin drafting a formal proposal to be discussed at SPAEC's November meeting.

### Required Professional Experience.

At its June 28 meeting, SPAEC considered whether the Committee should approve a required professional experience (RPE) plan for the purpose of enabling an individual who has already completed the experience requirements in another state to work while awaiting licensure in California. Business and Professions Code section 2530.5 exempts from the licensure requirement individuals who are completing their RPE under a plan approved by the Committee. However, an individual with prior experience would not be completing RPE under that provision. The Committee adopted a policy whereby no RPE plan will be approved by SPAEC for the purpose of exempting from the licensure law an applicant who has completed professional experience which qualifies for licensure.

**Treatment of Dysphagia.** SPAEC discussed swallowing disorders, known as dysphagia, at its September meeting. The Committee identified the importance of taking a stance on dysphagia because it is the only area of treatment in speech pathology which is potentially fatal to clients. Committee member and otolaryngologist David M. Alessi explained that treatment of dysphagia is not limited to speech pathologists, but it is part of the practice of speech pathology. Dr. Alessi was asked to write an article for a future SPAEC newsletter stressing the importance of developing standards for the treatment of dysphagia, and proposing



that all speech pathologists be required to take continuing education in this area prior to license renewal.

**Immittance Testing.** At SPAEC's June 28 meeting, Committee Chair Robert Hall explained that position statements on aural acoustic immittance measurements have been approved by the American Speech-Language-Hearing Association (ASHA), the California Speech-Language-Hearing Association (CSHA), and California Speech Pathologists and Audiologists in Private Practice (CALSPAPP). According to the CSHA statement, the aural acoustic immittance test battery has one purpose: to assess auditory function by indicating the physical and physiological status of the eardrum, middle ear, cochlea, seventh and eighth cranial nerves, and the auditory pathway in the brainstem. It is not a test of hearing, and should only be performed by professionally-trained audiologists (not hearing aid dispensers).

Dr. Dennis Arnst, present at the June meeting representing CALSPAPP and CSHA, stated that the terms "tympanometry," "impedance," and "immittance" have become used interchangeably, but are in fact different. Mr. Hall suggested the Committee take care to utilize the terms accurately, and noted that SPAEC and the Hearing Aid Dispenser Examining Committee (HADEC) adopted a joint statement in January 1990 to the effect that acoustic immittance testing for other than the purpose of fitting or selling hearing aids exceeds the scope of practice of a hearing aid dispenser. (See CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 111 for background information.)

**Speech Pathology Aides.** At its June 28 meeting, SPAEC continued its discussion regarding speech pathology aides and problems of supervision. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 97 and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 111 for background information.) The Committee decided to modify the aide application to clarify the licensee/supervisor's responsibilities. The question of multiple supervisors was also addressed. Discussion focused on who is ultimately responsible for services performed by the aide. SPAEC formed a subcommittee to research issues concerning aides.

## LEGISLATION:

**SB 664 (Calderon)**, as introduced March 5, would prohibit speech pathologists and audiologists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party

payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

## RECENT MEETINGS:

At its June meeting, the Committee discussed a proposal to establish a standing subcommittee between SPAEC and HADEC to deal with ongoing issues of mutual interest. One issue of concern involves alleged misrepresentations in advertising by hearing aid dispensers. SPAEC is pursuing remedies, but the committees are in dispute over their respective jurisdiction to monitor violations. Although HADEC has expressed interest in the proposal, creation of the subcommittee has been delayed indefinitely due to committee member vacancies on HADEC. At SPAEC's September 6 meeting, Committee member Gail Hubbard reported that HADEC has only one dispenser member. (See *supra* agency report on HADEC for related discussion.)

SPAEC is currently in the process of developing a manual for use by Medical Board investigative staff in pursuing violations of the speech-language pathology and audiology laws and regulations. The manual will attempt to define the services provided by licensees in layperson's terms. Committee member Gail Hubbard had completed a draft encompassing the practice of audiology as of the September 6 meeting. She requested assistance from the speech pathologists on the Committee to complete a draft encompassing that specialty. The manual will also be used in implementing SPAEC's citation and fine regulations. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 79; Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 111; and Vol. 10, No. 1 (Winter 1990) pp. 85-86 for background information.)

Also in September, SPAEC Executive Officer Carol Richards announced that she has asked legal counsel to draft language for possible inclusion in the Department of Consumer Affairs' 1992 omnibus bill to change SPAEC's licensure expiration date from December 31 of each odd-numbered year to a cyclical renewal system. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 97 for background information.)

## FUTURE MEETINGS:

January 24 in San Diego.  
April 16 in San Francisco.

## BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

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Pursuant to Business and Professions Code section 3901 *et seq.*, the Board of Examiners of Nursing Home Administrators (BENHA) develops, imposes, and enforces standards for individuals desiring to receive and maintain a license as a nursing home administrator (NHA). The Board may revoke or suspend a license after an administrative hearing on findings of gross negligence, incompetence relevant to performance in the trade, fraud or deception in applying for a license, treating any mental or physical condition without a license, or violation of any rules adopted by the Board. BENHA's regulations are codified in Division 31, Title 16 of the California Code of Regulations (CCR). Board committees include the Administrative, Disciplinary, and Education, Training and Examination Committees.

The Board consists of nine members. Four of the Board members must be actively engaged in the administration of nursing homes at the time of their appointment. Of these, two licensee members must be from proprietary nursing homes; two others must come from nonprofit, charitable nursing homes. Five Board members must represent the general public. One of the five public members is required to be actively engaged in the practice of medicine; a second public member must be an educator in health care administration. Seven of the nine members of the Board are appointed by the Governor. The Speaker of the Assembly and the Senate Rules Committee each appoint one member. A member may serve for no more than two consecutive terms.

## MAJOR PROJECTS:

### Nursing Home Reform Act Update.

As a result of the recent settlement between the federal Health Care Financing Administration (HCFA) and California's Department of Health Services (DHS) regarding California's implementation of the federal Nursing Home Reform Act passed by Congress in 1987, HCFA is responsible for circulating guidelines implementing the federal reforms and compiling and circulating changes submitted by California and other states. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 98 and Vol. 11, No. 2 (Spring 1991) pp. 94-95 for background information.) At BENHA's August 14 meeting, BENHA Executive Officer Ray Nikkel informed the Board