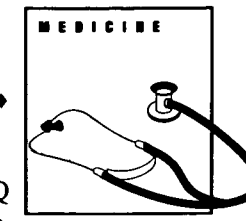
Medical Board of California



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The Medical Board of California (MBC) is a consumer protection agency within the state Department of Consumer Affairs (DCA). The 19-member Board consists of twelve physicians and seven public members. MBC members are appointed by the Governor (who appoints all twelve physicians and five public members), the Speaker of the Assembly (one public member), and the Senate Rules Committee (one public member). Members serve a four-year term and may be reappointed to a second term. The Board is divided into two autonomous divisions: the Division of Licensing and the Division of Medical Quality. The Board and its divisions are assisted by several standing committees, ad hoc task forces, and a staff of 250 who work from 12 district offices located throughout California.

The purposes of MBC and its divisions are to protect consumers from incompetent, grossly negligent, unlicensed, impaired, or unethical practitioners; enforce the provisions of the Medical Practice Act, Business and Professions Code section 2000 *et seq.*; and 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).

MBC's Division of Licensing (DOL), composed of four physicians and three public members, is responsible for ensuring that all physicians licensed in California have adequate medical education and training. DOL issues regular and probationary licenses and certificates under the Board's jurisdiction, administers the Board's continuing medical education program, and administers physician and surgeon examinations for some license applicants. DOL also oversees the regulation of medical assistants, registered dispensing opticians, research psychoanalysts, and lay midwives.

The statutory authority and effective functioning of both divisions of the Medical Board are jeopardized due to the ongoing failure of Governor Gray Davis to fill eight vacancies on the nineteen-member Board.

In response to complaints from the public and reports from health care facilities, the Division of Medical Quality (DMQ)—composed of eight physicians and four public members—reviews the quality of medical practice carried out by physicians and surgeons. DMQ's responsibilities include enforcement of the disciplinary, administrative, criminal, and civil provisions of the Medical Practice Act. DMQ's enforcement staff receives and evaluates complaints and reports of misconduct and negligence against physicians, investigates them where there is reason to suspect a violation of the Medical Practice Act, files charges against alleged violators, and prosecutes the charges at an evidentiary hearing before an administrative law judge (ALJ) from the special Medical Quality Hearing Panel within the Office of Administrative Hearings. In enforcement actions, DMQ is represented by legal counsel from the Health Quality Enforcement Section (HQES) of the Attorney General's Office. Created in 1991, HQES is a unit of deputy attorneys general who specialize in medical discipline cases. Following the hearing, DMQ reviews the ALJ's proposed decision and takes final disciplinary action to revoke, suspend, or restrict the license, or impose other appropriate administrative action. For purposes of reviewing individual disciplinary cases, DMQ is divided into two six-member panels (Panel A and Panel B), each consisting of four physicians and two public members. DMQ is also responsible for overseeing the Board's Diversion Program for physicians impaired by alcohol or drug abuse.

MBC meets approximately four times per year. Its divisions meet in conjunction with and occasionally between the Board's quarterly meetings; its committees and task forces hold additional separate meetings as the need arises.

At its July 31 meeting, MBC welcomed two new public members appointed by the legislature. On June 11, the Senate Rules Committee appointed James Bolton, Ph.D., to replace Michael Sidley on DOL. Dr. Bolton is a retired professor of education and is currently a marriage, family and child counselor. On June 10, Assembly Speaker Antonio Villaraigosa appointed Rudy Bermudez to replace DMQ member Dan Livingston. Bermudez is a parole agent with the California Department of Corrections. He oversees the Inglewood Cornell Corrections Re-entry Facility Program, and manages inmate services such as medical care, rehabilitation, and release programs for adult offenders. Bermudez has served as a member of the Norwalk-La Mirada Unified School District since 1991.

MAJOR PROJECTS

Governor's Failure to Appoint Members Threatens Board's Authority

At this writing, the statutory authority and effective functioning of both divisions of the Medical Board are jeopardized due to the ongoing failure of Governor Gray Davis to fill eight vacancies on the nineteen-member Board.

Effective July 31, the statutory terms and grace periods of three members of the Division of Licensing expired, leaving DOL without a quorum and unable to conduct business. The seven-member Division is down to three members: physician Thomas Joas and public members Bruce Hasenkamp

and James Bolton. All of DOL's vacancies—three physicians and one public member—must be appointed by Governor Davis.

DOL's problem began in early 1999, when the terms of Thomas Heider, MD, and public member Stewart Hsieh were cancelled by incoming Governor Davis. Heider had been appointed and Hsieh reappointed by former Governor Wilson in 1998. However, their appointments must be confirmed by the Senate, which did not schedule confirmation hearings on either appointee during 1998. Thus, Governor Davis cancelled their appointments upon taking office in early 1999, and has not yet filled either of them. *[16:2 CRLR 39–40]* To make matters worse, the terms of DOL physician members Bernard (Bud) Alpert and Raja Toke expired effective July 31—leaving the Division with only three members and legally incapable of conducting business. It can meet as a committee, but it cannot take action on matters requiring a formal vote because it needs, by statute, four members duly appointed and present in order to "take action." As of October 31, the Governor has yet to fill any of the four DOL vacancies.

The status of the twelve-member Division of Medical Quality is also threatened by the Governor's failure to promptly fill Board vacancies. In January 1999, DMQ lost Robert del Junco, MD, and public member Phil Pace when Governor Davis cancelled their reappointments upon taking office. On July 31, the terms of DMQ physician members Carole Hurvitz and Jack Bruner expired—leaving DMQ with only eight members; Governor Davis is responsible for filling all four DMQ vacancies.

Although DMQ as a whole is able to conduct business, the "panel" structure it utilizes to review proposed disciplinary decisions has been disrupted. To manage the heavy workload inherent in its disciplinary function, DMQ is split into two six-member panels; each six-member panel hears and decides one-half of the pending disciplinary cases, and four votes are statutorily required to revoke a license. With only eight members, DMQ is unable to split into two four-member panels because of the four-vote requirement. Instead, it has created one six-member panel which is now handling the Board's full physician discipline caseload—double the normal workload.

Board President Karen McElliott expressed extreme frustration over CMA's refusal to meet on a regular basis and to withdraw any of its fourteen demands.

And on June 1, 2000, the Board will lose six more members, including several of its most experienced members. Unless the Governor makes new appointments, there will only be five members on the 19-member Medical Board. Neither division will have a quorum.

At the full Board's July 31 meeting, MBC President Karen McElliott expressed concern about the future of the Board, and urged the Governor's Office to expedite its review and appointment of new Board members so MBC does not lose its ability to protect the public or experience a huge influx of new members at once.

MBC Fee Increase Negotiations Stall

Frustration boiled over at DMQ's July 30 meeting as members discussed the fate of their latest attempt to secure a licensing fee increase to support more Board investigators. For the past several years, MBC has sought a legislative fee hike to increase the number of DMQ investigators and lessen their heavy caseloads *[15:4 CRLR 85]*, but the California Medical Association (CMA) has blocked every attempt. In 1998, Senator Richard Polanco dropped a fee increase provision from SB 1930 (Polanco) after CMA announced its opposition. *[16:1 CRLR 47–48]* In 1999, the Board sponsored AB 265 (Davis), which would increase biennial license renewal fees for physicians from $600 to $690. CMA countered with its sponsorship of SB 1045 (Murray), which would grant the Board an unspecified fee increase in exchange for a laundry list of 14 changes to the Medical Practice Act, some of which sparked intense opposition. When the two sides were unable to reach any agreement and the matter threatened to explode in the legislature in April 1999, Attorney General Bill Lockyer intervened and offered to serve as a "mediator" to facilitate a resolution. *[16:2 CRLR 24–25]*

Since then, a working group of representatives from MBC, CMA, the AG's Office, and several legislative committees has been meeting occasionally in an attempt to narrow the number of issues on the table. However, the meetings have not gone well, and DMQ members lashed out at CMA lobbyist Bob McElderry at the Division's July 30 meeting. Board President Karen McElliott expressed extreme frustration over CMA's refusal to meet on a regular basis and to withdraw any of its fourteen demands; she demanded that CMA identify issues that are true priorities so the Board can deal with them. "Apparently, this is not a priority issue for you, yet—at the same time—you are holding up a needed fee bill," according to McElliott. Division member Alan Shumacher, MD, echoed McElliott's concerns, and accused CMA of stalling and dragging its feet. According to Shumacher, "It's getting to the point where I am embarrassed to be a CMA member." McElderry protested that the busy legislative session (including "issues of importance to physicians," such as managed care regulation, prevention of expanded scopes of practice for non-physician health care providers, and maintenance of the $250,000 cap on noneconomic damages in medical malpractice lawsuits) had left the trade association with no time to negotiate the fee bills. McElliott noted that CMA is arguing over $45 per year, a "reasonable increase" in light of the fact that MBC renewal fees have not increased since 1994.

One of the issues CMA is attempting to address in SB 1045 is its allegation that the AG's Office—in order to avoid having to prove "gross negligence" under Business and Professions Code section 2234(b)—segments a "single event"

or "single course" of merely negligent treatment into a series of "repeated negligent acts," which is also a basis for discipline under Business and Professions Code section 2234(c). For example, CMA believes that it is inappropriate to charge "repeated negligent acts" for a single misdiagnosis and subsequent erroneous treatment based on the misdiagnosis, and—to bolster its claim—cites approximately 20 recent cases in which it says that has been done. MBC and the AG's Office counter that its formulation of charges is based upon the expert testimony of a physician, not on its own whims or priorities. Further, it is not inappropriate or unethical to plead alternative grounds for discipline, because a prosecutor does not know what the evidence will prove until trial. However, CMA is insistent that multiple charges are unfair to the respondent and wasteful of the Board's limited resources.

For its part, MBC asserts that CMA's dispute over "repeated negligent acts" and several other issues raised in SB 1045 (including CMA's desire to eliminate cost recovery under Business and Professions Code section 125.3, establish priorities for investigations and prosecutions, require MBC's Executive Director to demand detailed documentation of work in cases which consume more than 200 hours of investigative and prosecutor time, and impose substantial new documentation requirements on the AG's Office) have to do with CMA's perceived problems with the Attorney General's Office; MBC resents the idea that its fee increase is being held hostage over issues outside its control. At the full Board's July 31 meeting, Executive Director Ron Joseph noted the need for a fee increase to stabilize the Board's reserve fund, supplement its investigative staff and lessen their individual caseloads, and also address emerging issues that threaten public safety and require additional resources—including the practice of medicine and sale of dangerous drugs over the Internet (see below), and the disturbing increase in the number of unlicensed "backroom" clinics that are providing medical services without physician supervision in low-income communities.

Meanwhile, consumer groups expressed frustration that they have not been included in the negotiations. Kathryn Dresslar, Senior Policy Advocate for the Center for Public Interest Law (CPIL), voiced concern that any compromise emerging from the secret negotiations might be at consumers' expense because no consumer representatives have been invited to the private talks. She urged the negotiators to expedite their discussions and to include consumer representation, because "every day that an investigation drags on because of inadequate staffing of the Board is another day a potentially dangerous and incompetent physician continues to practice—and health consumers are left at risk. Consumers do not have another year to waste, accommodating the petty micromanagement of the regulator by the regulated industry—we have waited five years already. An increase to pay for additional investigators is overdue, and should not be postponed another year."

At this writing, the parties are still attempting to negotiate a solution to the issues raised, but no action is expected until the legislature reconvenes in January 2000.

MBC Releases 1998–99 Enforcement Statistics and DIDO Update

In October, MBC released its *1998–99 Annual Report*, which reveals continued processing of enforcement cases at a level comparable to its 1997–98 performance *[16:1 CRLR 46–47]*, and somewhat decreased case processing time. However, other statistics in the *Annual Report* again reflect inadequate MBC disciplinary activity compared with the level of physician negligence and incompetence detected by others.

In 1998–99, MBC received 10,751 complaints and opened 2,139 investigations against physicians. It referred 618 cases to HQES, which filed 392 accusations. The Board took a total of 359 disciplinary actions, including 48 revocations, 77 license surrenders, 12 probations with suspension, 110 probations, and 45 public reprimands. Additionally, the Board issued 332 citations and fines, and obtained 33 interim suspension orders (ISO) or temporary restraining orders (TRO), which suspend a particularly dangerous physician's license pending conclusion of the disciplinary process.

MBC's *Annual Report* also indicates that the average time spent by a complaint at the various processing stages of MBC's enforcement system decreased somewhat during 1998–99, particularly at the investigative stage. On the average, cases remained for 53 days in the Board's Central Complaint and Investigation Control Unit (CCICU) before being forwarded to a MBC district office for investigation (down from 56 days in 1997–98 and 64 days in 1996–97); they then spent an average of 243 days under investigation before being dismissed or forwarded to HQES for accusation filing (down from 313 days in 1997–98 and 336 days in 1996–97). The average time period from complaint receipt to disposition (which should be 180 days under Business and Professions Code section 2319) was 296 days (compared to 369 days in 1997–98 and 400 days in 1996–97). Fully investigated cases then spent 83 days in HQES (down from 110 days in 1997–98 and 134 days in 1996-97) prior to accusation filing.

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The improvement in investigation time may be due to the full implementation of the "Deputy in District Office" (DIDO) program, which implements Government Code section 12529(b)'s requirement that HQES assign deputy attorneys general (DAGs) to work onsite with MBC investigators "to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." The statute, which was enacted in 1990

[10:4 CRLR 79, 84], also requires HQES to ensure that an HQES DAG is "frequently available on location at each of the working offices at the major investigation centers of the board, to provide consultation and related services and engage in case review with the board's investigative, medical advisory, and intake staff."

At the urging of DMQ, HQES created the DIDO program on January 1, 1997; under the program, an HQES DAG physically works in Medical Board district offices one or two days per week to permit onsite prosecutor guidance of investigations. In addition to being available to MBC investigators for legal advice, the DIDO DAGs (1) review all new incoming cases, especially to determine whether the Board should seek an ISO or TRO; (2) at an early stage, become involved in subpoena enforcement to assist investigators in obtaining requested medical records; (3) review all completed investigations before their referral to HQES, to ensure that all investigative "loose ends" are tied up and that the matter is ready for pleading; (4) review all cases proposed for closure at the district office level; and (5) draft initial pleadings in investigations being transmitted from district offices to HQES for accusation filing.

The original hope was that the DIDO program would assist in cutting the time which fully investigated cases sit in HQES after transmittal by MBC and prior to the filing of the accusation from 134 days in 1996-97 to about 90 days. However, the results have been more dramatic. As reported by HQES Chief Al Korobkin at DMQ's July 30 meeting, between January 1, 1997 and July 1, 1999, 710 cases were referred to HQES from DIDO DAGs. Of those, accusations had been filed in 675 cases by July 1, and the average number of days from receipt of the case by HQES to accusation filing was only 28.62 days.

The DIDO program is important because the filing of the accusation is a critical point in the process from a consumer protection standpoint—at that point, the case becomes a matter of public record and will be disclosed to an inquiring consumer. Prior to that point, MBC call handlers are not permitted to disclose the fact of a completed investigation, no matter how many are undertaken against a physician, the nature of the charges, or how close HQES is to filing the case. Thus, expediting the filing of the accusation—which the DIDO program is facilitating—provides enhanced consumer protection; further, MBC investigators' immediate access to HQES prosecutors via the DIDO program may be contributing to the overall decrease in MBC's investigation time.

While DMQ's enforcement output is greatly improved over prior years, it still pales in comparison to the number of external complaints and reports of physician incompetence and misconduct received by the Board.

While DMQ's enforcement output is greatly improved over prior years, it still pales in comparison to the number of external complaints and reports of physician incompetence and misconduct received by the Board. In 1998–99, DMQ received 1,356 reports of medical malpractice judgments or settlements in excess of $30,000; 26 reports from coroners indicating that the cause of death was physician gross negligence or incompetence; 21 reports that physicians had been charged with or convicted of crimes; and 82 "section 805" reports of adverse peer review action taken against physicians by hospitals or health care facilities. This last number is of particular concern—it is one-third the number of peer review actions reported in 1987-88, indicating significant underreporting by hospitals and health care facilities. Although peer review actions were underreported, almost 11,000 physicians were the subject of consumer complaints and a total of 1,485 licensees were reported to DMQ for incompetence or misconduct in 1998–99, compared with only 359 disciplinary actions by MBC. In a related matter, Washington, D.C.-based Public Citizen released its annual rankings of the enforcement output of state medical boards in May 1999. Based upon number of serious disciplinary actions per 1,000 doctors, California ranked 27th in the nation in 1998. Although this is an improvement over its 42nd-place showing in 1992, MBC's recent enforcement figures reflect a continuing performance problem in an area where incompetence, negligence, impairment, or misconduct can result in irreparable harm to patients.

Diversion Program Task Force Update

DMQ's Diversion Program Task Force continues its probe into the functions and operations of MBC's Diversion Program for substance-abusing physicians. The Diversion Program is a nondisciplinary track for physicians who are abusing drugs or alcohol. Participants are required to sign a contract with the Program and adhere to all the terms and conditions in the contract, which include group meeting attendance, random urine testing, abstinence from drug/alcohol use, and workplace monitoring. In exchange for compliance, participants are permitted to rehabilitate in absolute confidentiality from both MBC's Enforcement Program and public knowledge, and are immune from disciplinary action for self-abuse of drugs or alcohol (which is otherwise a disciplinable offense).

Since November 1997, the structure, functioning, and secrecy of the Diversion Program have been the subject of criticism by the Center for Public Interest Law. CPIL cites Business and Professions Code section 2229, which provides that "protection of the public shall be the highest priority for the Division of Medical Quality....Where rehabilitation and protection are inconsistent, protection shall be paramount." However, CPIL contends that DMQ, which is statutorily charged with administering the Program, has failed to properly oversee it and has essentially abdicated that responsibility to CMA's Liaison Committee to the Diversion Program (see below). Significantly, CPIL charges that DMQ has misinterpreted the statutes creating the Diversion Program and improperly permitted members of the Program's Diversion Evaluation

Committees (DECs)—regional committees of private parties appointed by the Division—to make decisions that only government officials should make. The Center further contends that because of the secrecy that shrouds the Program, the lack of any substantive standards to guide Program decisionmaking, and the Program's own failure to comply with state law requiring comprehensive reporting about its decisions and its cost, "it is impossible for anyone to determine whether the Diversion Program protects the public from the state's most dangerous physicians. Yet that is exactly what the Legislature has demanded of the Medical Board in Business and Professions Code sections 2229 and 2340." DMQ created the Task Force in February 1998 to investigate CPIL's concerns and determine whether the Diversion Program provides the public protection demanded by law; the Task Force held a daylong hearing to take testimony from interested members of the public in January 1999. *[16:2 CRLR 27; 16:1 CRLR 1, 52]*

CPIL charges that DMQ has misinterpreted the statutes creating the Diversion Program and improperly permitted members of the Program's Diversion Evaluation Committees (DECs)—regional committees of private parties appointed by the Division—to make decisions that only government officials should make.

DMQ, the Task Force, and Diversion Program staff have been involved in a number of activities over the past several months, including the following:

◆ ***New Acting Program Manager Named.*** At DMQ's May 7 meeting, Janis Thibault was introduced as Acting Diversion Program Manager. Thibault previously worked as one of the Program's five case managers; she replaces Chet Pelton, the Program's longtime manager who retired during the summer of 1998.

◆ ***DMQ Considers Recommendations of Liaison Committee.*** At its May meeting, DMQ discussed a January 1999 letter from CMA's Liaison Committee to the Diversion Program. The Liaison Committee (LC) was created in 1982, just after the Diversion Program was enacted; it meets quarterly in private and consists of representatives of CMA, the California Society of Addiction Medicine, the DECs, and DMQ. Although the LC was intended to be an "information sharing forum" about issues related to the functioning of the Diversion Program, CPIL charges that former management of the Diversion Program simply implemented recommendations of the LC without submitting them to DMQ for review and approval. In its letter, the LC made several recommendations. *[16:2 CRLR 29]* DMQ discussed the recommendations, the input of program staff and CPIL, and made the following decisions:

• The LC recommended that DMQ hire a physician to serve as a Diversion Program medical review officer for a twelve-month trial period to perform an independent urine test evaluation in situations where a Program participant may be unjustly accused of relapse or wrongfully directed to an inpatient facility based on a false positive urine test. Noting that the Diversion Program already costs $800,000 per year, DMQ did not support the LC's recommendation due to scarce resources.

• The LC suggested that DMQ permit the acceptance of physicians with emotional disorders or mental illness into the Diversion Program, educate its enforcement personnel to recognize symptoms of mental illness in order to make referrals to the Diversion Program when they suspect mental illness, and require each DEC to have at least one member who is a psychiatrist experienced in the treatment of alcohol/drug addiction and dual diagnosis. On this point, DMQ recognized that Business and Professions Code section 2340 intends that the Diversion Program apply to physicians with "mental or physical illness" as well as those afflicted with addictive disorders, and stated that physicians who are diagnosed with both mental illness and addiction may be admitted into the Program. However, as currently structured, the Diversion Program is not suited to handling physicians with mental illness alone. Finally, DMQ reiterated a prior policy that physicians with sexual addictions should not be referred to the Diversion Program. *[12:2&3 CRLR 101]*

• The LC requested that DMQ provide it with the Diversion Program Manual to enable it to carry out its activities in conformity with the Manual. CPIL supported this request, noting that in the past it has requested and received excerpts from the Manual under the Public Records Act. However, staff argued that the Manual is an incomplete, not-recently-updated "work in progress," and noted its intent to convert many of the provisions of the Manual into formally adopted regulations (such that those provisions will be subject to notice and public comment). DMQ instructed staff, as a "low-priority item," to go through the Manual and see whether certain portions of it can be disclosed to the LC.

• The LC asked DMQ to require at least one of its members to attend and participate in Liaison Committee meetings. Staff and CPIL responded that LC members should attend and actively participate in DMQ meetings instead. DMQ agreed, but Division President Ira Lubell offered to attend the next two meetings of the LC.

• The LC suggested that the chairs of the DECs should serve two-year staggered terms. Neither DMQ nor CPIL objected, although CPIL noted its contention that the DECs should be overhauled and stripped of their current decisionmaking activity (which CPIL believes is unauthorized under current law).

• Finally, the LC recommended that DMQ allow a Diversion Program participant to be excused from regular participation in group meetings when his/her recovery has progressed to a point where public safety is no longer a concern (in the clinical judgment of the DEC members). CPIL noted that this is an area of conflict among the DECs—some DECs permit participants to "wean off" the Program by foregoing group meeting attendance during the last months of participation,

and some do not. According to CPIL, this is an example of unauthorized decisionmaking by the DECs and the Diversion Program—decisionmaking that should be made by DMQ. Enforcement Chief Lancara indicated strong hesitation about the LC's suggestion, noting that the national trend is toward monitoring substance-abusing physicians for longer periods (*e.g.*, five to seven years) rather than shorter periods (the Diversion Program statute, Business and Professions Code section 2350(g), requires only two years of monitoring). DMQ took no action on the LC's recommendation and referred it to the Diversion Program Task Force.

◆ ***Diversion Program to Commence Rulemaking.*** At DMQ's July 30 meeting, Enforcement Chief Lancara proposed to circulate draft language of new section 1357.9, Title 16 of the CCR, to implement SB 2239 (Committee on Business and Professions) (Chapter 878, Statutes of 1998), which requires Diversion Program participants to sign an agreement permitting use of their diversion records if they are terminated from the Program for reasons other than successful completion *[16:1 CRLR 57]*; thus, there is a need to specify in regulation the kinds of records which will be kept by the Program. Lancara will also seek to amend DMQ's criteria for termination from the Diversion Program, which are currently codified in section 1357.5, Title 16 of the CCR.

Under draft section 1357.9, the Program would retain all intake reports and case analyses, all agreements and amendments thereto, all correspondence with the Enforcement Program, all DEC letters regarding a participant, all file notes and lab and incident reports, and computerized records derived from any of the foregoing types of documents. Under the draft amendments to section 1357.5, a Diversion Evaluation Committee may terminate a physician's participation from the Program for any of the following reasons: (1) successful completion; (2) the physician has failed to comply with the diversion agreement he/she signed, including but not limited to failure to comply with the prescribed monitoring or treatment regimen, use of alcohol or other unauthorized drugs, or refusal to stop practice when directed to do so by a DEC; (3) any cause for denial of admission into the Program under section 1357.4; or (4) a DEC determines that the physician will not benefit from further participation in or has not substantially benefitted from participation in the Program, or that the physician's continued participation in the Program creates too great a risk to the public health, safety, or welfare.

CPIL's Julie D'Angelo Fellmeth commented on the proposals, noting that she has no objection to section 1357.9 or the proposed termination criteria in section 1357.5. However, she reiterated CPIL's position that section 1357.5, as written and as currently effective, is inconsistent with state law and may in fact conflict with federal antitrust law and the Constitution. According to Fellmeth, section 1357.5 authorizes the DECs to terminate participants from the Diversion Program for unsuccessful completion of the Program's requirements; however, nothing in Business and Professions Code sections 2352, 2018, 2350, 2351, or 2354 authorizes DECs to make that decision. Further, the "private party" nature of the DEC decisionmakers implicates federal antitrust law (because no statute authorizes such decisionmaking and no state official independently supervises it) and the Constitution (unlawful delegation of governmental decisionmaking authority to private parties).

Despite Fellmeth's comments, DMQ authorized Lancara to publish the rulemaking for public comment. On September 10, the Division published notice of its intent to adopt section 1357.9 and amend section 1357.5, Title 16 of the CCR; at this writing, a public hearing on these proposed changes is scheduled for November 5 in San Diego.

◆ ***1998 Annual Report of the Diversion Program.*** At DMQ's July 30 meeting, Acting Program Manager Janis Thibault unveiled the Program's *1998 Annual Report*, which notes the creation of the Task Force and its charge to investigate and improve the Program. The report also discusses the passage of SB 2239 (see above), which will enhance the ability of the Enforcement Program to receive and use the diversion records of physicians who do not successfully complete the Diversion Program.

The report also reveals some interesting statistics. As of December 31, 1998, 304 physicians were being monitored under the Diversion Program; only 239 of these physicians reside in California. Of the 304 participants, 59 suffer from alcohol abuse, 90 from other drug abuse, and 77 from both alcohol and drug abuse. The primary drugs of choice are alcohol (90 participants), the narcotics demerol, vicodin, and fentanyl (60), other narcotics (21), cocaine (16), and amphetamines (12). The participants' medical specialties are primarily anesthesiology (40 participants), family practice (38), internal medicine (32), psychiatry (24), and emergency medicine (16). According to the report, 921 instate participants have completed the program since 1980—629 successfully and 292 unsuccessfully. "Successful completion" means that a participant has completed at least two years of monitoring; the Program does not systematically track the status of participants after they are terminated. Of the 292 who unsuccessfully completed the program, the report indicated that three licenses were revoked, two were put on probation, eleven surrendered their licenses, 25 have died, and 47 have moved out of state; no information is provided on the status of the licenses of the other 204 physicians who failed to successfully complete the Diversion Program.

◆ ***Staff Awaiting National Study of Diversion Programs.*** At DMQ's July meeting, Enforcement Chief John Lancara noted that MBC Executive Director Ron Joseph had attended a March 1999 conference sponsored by the Washington, D.C.-based Citizen Advocacy Center (CAC), which is midway through a national study of the way various state licensing boards operate rehabilitation and monitoring programs for substance-abusing health care professionals, and intends to develop national model "best practice" standards for the operation of these programs. Joseph found the program excellent, and stated that CAC intends to produce a draft of its

standards by the end of 1999. Board staff hope to compare the Diversion Program's existing standards and make necessary changes thereto based on CAC's model standards.

♦ ***DEC Member Performance Evaluation.*** Also in July, Diversion Program staff noted that the attendance and performance of DEC members, who are appointed and reappointed by DMQ for four-year terms, are not monitored or evaluated in any comprehensive way. Acting Program Manager Thibault reported that staff keeps track of DEC members' attendance at quarterly meetings and their responses to requests for consultations; however, "there is no review regarding the quality of their input or work." DMQ instructed staff to design a performance evaluation form for review at the Division's November meeting.

Committee on Internet Prescribing

The Board's new Committee on Internet Prescribing, chaired by Bud Alpert, MD, met for the first time on July 29 in Los Angeles. To provide audience members with background information on the problem the Committee was created to address, Dr. Alpert explained that the issue of "telemedicine" (the practice of medicine, usually via advanced technology, across state lines or national boundaries) has presented vexing and unaddressed problems for state medical boards and their respective licensing and enforcement programs. The sudden emergence of the Internet, however, makes those problems seem pale in comparison. With the Internet comes the ability of doctors to practice medicine across state lines and patients to obtain access to medical care and prescription drugs from out-of-state or out of the country, with or without a prescription. This issue has recently exploded with the advent of so-called "lifestyle drugs," including Viagra (impotence), Propecia (hair loss), and Xenical (weight loss). According to Dr. Alpert, "pharmacies are shipping across state lines, physicians are writing prescriptions for people they've never met, patients are able to get access to prescription drugs for which they have no legitimate prescription, and some of these sites are not necessarily supervised or run by physicians who are licensed in any state."

According to Dr. Alpert, "pharmacies are shipping across state lines, physicians are writing prescriptions for people they've never met, patients are able to get access to prescription drugs for which they have no legitimate prescription, and some of these sites are not necessarily supervised or run by physicians who are licensed in any state."

According to Dr. Alpert and Board staff, no government agency at any level has any kind of handle on this problem. At the close of the 1998 legislative session, no state laws addressed Internet prescribing. Congress has sent a number of letters to federal agencies (including the Department of Justice, the Drug Enforcement Administration, the Food and Drug Administration, and the Federal Trade Commission) inquiring about their jurisdiction regarding this problem, what actions they have taken, and what actions they plan to take, but none of the answers have been satisfactory. Currently, there is no consensus on which federal agency—if any—has jurisdiction over which part of this problem. Further, the problem is compounded by the prospect of offshore sources of drugs, where no prescription is needed.

MBC Executive Director Ron Joseph conceded that the problem is a global one, and that it is futile to discuss anything other than what is achievable by a state medical board. Business and Professions Code section 2242 states that prescribing, dispensing, or furnishing prescription drugs without a "good faith examination" is unprofessional conduct; however, the term "good faith examination" is not defined in statute or regulation. Some physicians contend that asking three questions over the Internet satisfies the test; most disagree. Further, that statute is of little help when dealing with physicians from other countries which do not demand prescriptions.

The Committee distributed an inch of materials documenting efforts by other states to combat this problem. Some states have filed lawsuits against websites offering medical services or prescription drugs to their residents, and have succeeded in enjoining those practices and shutting down the websites (at least temporarily). The National Association of Boards of Pharmacy is taking steps to construct a certification program for websites that offer pharmaceuticals for sale. Other agencies and states are engaging in public education programs to alert consumers to the dangers of purchasing prescription drugs over the Internet (see agency article on BOARD OF PHARMACY for related discussion).

As a starting point, the Committee instructed staff to (1) focus on defining "good faith examination" under Business and Professions Code section 2242, and publish a policy statement on the issue in the Board's *Action Report* newsletter; (2) attempt to determine where a California patient is being "treated" if she, for example, logs on to a Florida site and purchases drugs; (3) consider widening the composition of the Committee to include representatives from the legislature, the Board of Pharmacy, the Attorney General's Office, and the U.S. Department of Justice; and (4) add a warning to the Board's website concerning the dangers of purchasing drugs over the Internet.

DMQ Rulemaking

The following is a description of rulemaking proposals published and considered by the Division of Medical Quality during recent months:

♦ ***Implementation of New Statute of Limitations.*** On May 27, the Office of Administrative Law (OAL) approved DMQ's permanent adoption of section 1356.2, Title 16 of the CCR, which implements AB 2719 (Gallegos) (Chapter 301, Statutes of 1998). AB 2719 requires MBC to file an accusation against a physician within three years after it "discovers" the alleged act or omission, or within seven years after

the alleged act or omission, which is the basis for disciplinary action—whichever occurs first.

New section 1356.2, which DMQ first adopted on an emergency basis at its November 1998 meeting, defines the term "discovers" to mean the date the Board receives a complaint or report describing the act or omission alleged as the grounds for disciplinary action, or the date the Board subsequently becomes aware of one or more acts or omissions, alleged as grounds for disciplinary action, that were not contained in the original complaint or report. "Complaint" means a written complaint from the public or a written report generated by Board staff that names a particular physician; "report" means any written report required to be filed with MBC under the Business and Professions Code. However, a report filed with MBC pursuant to Code of Civil Procedure section 364.1 does not suffice as a "report" which triggers the statute of limitations. Section 364.1 requires a medical malpractice plaintiff to send the defendant and MBC a notice announcing that an action will be filed 90 days prior to the filing of the lawsuit. According to MBC, a section 364.1 report does not contain sufficient information about the acts complained of to serve as a "report" and thus trigger the statute of limitations. *[16:2 CRLR 31–32; 16:1 CRLR 53]*

♦ ***DMQ Acceptance of Amicus Curiae Briefs in Disciplinary Matters.*** At its May 7 and July 30 meetings, DMQ discussed draft language of a regulation that would permit an outside party to file an *amicus curiae* ("friend of the court") brief in a MBC disciplinary case in limited circumstances. At DMQ's request, staff drafted the regulatory language followed an April 1999 meeting of an "*Amicus Curiae* Brief Subcommittee" appointed by DMQ to hammer out the issue after the Division itself split 5–5 on a December 1998 petition for rulemaking by the Union of American Physicians and Dentists' (UAPD) in which UAPD asked DMQ to adopt regulations permitting the filing of *amicus curiae* briefs in disciplinary matters. *[16:2 CRLR 32–33; 16:1 CRLR 54]*

Under staff's proposal, DMQ would adopt new section 1364.31, Title 16 of the CCR, which would permit a nonparty to file an *amicus curiae* brief in a MBC disciplinary matter at three points in the process: (1) when a DMQ panel has nonadopted a proposed decision submitted by an ALJ after an evidentiary decision, (2) when a DMQ panel has received a petition for reconsideration of a prior decision, and (3) when a DMQ has granted a petition for reconsideration of a prior decision. Under the draft language, the filing of an *amicus* brief regarding whether a panel should nonadopt a proposed decision is not permitted. A person who seeks to file an *amicus* brief must submit the proposed brief along with a one-page request to the Board's Executive Director specifying the points to be argued in the brief and indicating why additional argument on those points is necessary or would be helpful to the panel. Upon receiving the request, the Executive Director must immediately transmit it to the chair of the panel; the decision whether to grant the request will be made by the panel chair and one panel member designated by the chair. If the vote is not unanimous, the request is deemed denied. If the request is granted, the Executive Director must then transmit a copy of the brief to each panel member.

The proposed regulation also sets timeframes for two of the three situations in which an *amicus* brief may be filed. Where DMQ has nonadopted a proposed ALJ decision or has granted reconsideration of one of its own decisions, a request to file an *amicus* brief must be received no later than 45 days prior to the date on which oral argument is scheduled or the matter is to be considered by the panel if no oral argument has been requested. The draft language contains no deadline for filing a request after DMQ has received a petition for reconsideration; however, Government Code section 11521 requires DMQ to act within a very limited timeframe after receiving a petition for reconsideration, so prospective *amici* should be prepared to file quickly as well.

Following consideration of the draft language at its July meeting, DMQ approved it and instructed staff to publish it and schedule a public hearing. On September 10, staff published notice of DMQ's intent to adopt new section 1364.31, and scheduled it for public hearing at DMQ's November 5 meeting.

♦ ***Revisions to DMQ's Disciplinary Guidelines.*** At its May 7 meeting, DMQ held a public hearing on its proposal to amend section 1361, Title 16 of the CCR, which currently requires the Division—in reaching a decision in a disciplinary matter—to consider the 1995 version of its *Disciplinary Guidelines and Model Disciplinary Orders* ("disciplinary guidelines"), and incorporates those guidelines by reference. The disciplinary guidelines are intended to guide HQES prosecutors, ALJs, and the Division itself in assessing penalties for given violations of the Medical Practice Act and the Board's regulations, to ensure that licensees are treated consistently. DMQ made several changes to its disciplinary guidelines at its February 1999 meeting *[16:2 CRLR 33]*, and proposes to amend section 1361 to require consideration of the new 1999 version of its disciplinary guidelines. Following the hearing, the Division approved the amendment subject to a few modifications to the disciplinary guidelines. Staff released modified versions of the disciplinary guidelines for an additional 15-day comment period on June 7 and again on October 6; at this writing, staff is preparing the rulemaking file on the amendments for submission to DCA and OAL.

DOL Rulemaking

The following is a description of rulemaking proposals published and considered by the Division of Licensing during recent months:

♦ ***Postgraduate Training Exemption Period.*** Business and Professions Code section 2096 requires all applicants for licensure as a physician in California to have completed at least one year of approved postgraduate training (PGT), and sections 2065 (pertaining to U.S. and Canadian applicants) and 2066 (pertaining to graduates of other foreign medical schools) provide a maximum two-year exemption from the

licensure requirement during which an applicant may practice medicine in an approved PGT program while they complete the training required for licensure. If an applicant exhausts the exemption pursuant to sections 2065 or 2066 without having obtaining a license (*e.g.*, because the applicant has failed the licensing exam or completed a PGT program unsatisfactorily and without receiving credit for it), the applicant must cease clinical training until a license has been issued.

Occasionally, applicants who have completed part of their training requirement in another state or nation desire to transfer into a California training program. Historically, it has been DOL's position that the intent of sections 2065 and 2066 is that the maximum time permitted during which an applicant may train in California without a license is decreased by all the time spent in ACGME-approved training programs in the United States and Canada, including partial-year periods of training completed before the applicant withdrew or was terminated from the program, and training periods for which the applicant was denied credit. In the recent past, however, some applicants who were terminated from their training programs have taken the position that partial years of training completed, and periods of training completed in an unsatisfactory manner, should not be deducted from their maximum licensure exemption in sections 2065 and 2066. DOL believes that if it were to accept this argument, such individuals could transfer from program to program in California or from other states into California to continue training, possibly endangering patient safety, without exhausting their licensure exemption and would never be compelled to satisfy the licensing requirements by demonstrating their ability to practice with skill and safety to the public.

Because the statutes do not specifically describe the parameters of the limited exemption period, DOL published notice of its intent to adopt section 1320, Title 16 of the CCR, on June 11. New section 1320 would state that all approved PGT shall count toward the two-year exemption period provided in Business and Professions Code sections 2065 and 2066, including any training obtained within or outside of California, whether a full or partial year of training and regardless of whether the training was successfully completed. The Division held a public hearing on section 1320 at its July 30 meeting, and thereafter adopted the proposed section as published. At this writing, DOL staff is preparing the rulemaking file on section 1320 for submission to DCA and OAL.

AB 265 is sponsored by the Medical Board and would amend Business and Professions Code section 2435 to increase the biennial license renewal fee for physicians from $600 to $690. SB 1045 is CMA's competing fee bill which would revise the biennial license renewal fee for physicians to an unspecified amount, while imposing numerous conditions and requirements on the Medical Board.

◆ ***Postgraduate Training Requirement.*** The Medical Practice Act sets forth a number of different "pathways" whereby a graduate of a foreign (non-U.S. or Canadian) medical school may be licensed to practice medicine in California. Effective January 1, 1999, SB 1981 (Greene) (Chapter 736, Statutes of 1998) eliminates the oral examination as a requirement for foreign medical graduate (FMG) licensure in California. *[16:1 CRLR 57]* In lieu of the oral examination, some licensure pathways now allow a FMG applicant to complete a second year of approved PGT as one of the alternative methods to qualify for licensure.

Because DOL's existing regulations do not incorporate the provisions of SB 1981, DOL published notice on June 11 of its intent to amend section 1321, Title 16 of the CCR, to set parameters for completion of the two-year PGT pathway and make technical amendments for consistency and clarity purposes. Specifically, DOL seeks to amend section 1321(d), to provide that an applicant must have completed one continuous year of approved PGT in a single program in order to qualify for licensure as a physician. The one year may be interrupted in cases due to illness or hardship. With respect to an applicant who qualifies for licensure by completing at least two years of PGT, the second year must be one continuous year in a single program, which may be the same or a different program than the first year. The second year may be interrupted in cases due to illness or hardship.

At its July 30 meeting, DOL held a public hearing on its proposed amendments to section 1321. Following the hearing, the Division adopted the amendments as published; at this writing, staff is preparing the rulemaking file on section 1321 for submission to DCA and OAL.

LEGISLATION

AB 265 (Davis) and **SB 1045 (Murray)**, as introduced in February 1999, would increase biennial license fees for physicians. AB 265 is sponsored by the Medical Board and would amend Business and Professions Code section 2435 to increase the biennial license renewal fee for physicians from $600 to $690. SB 1045 is CMA's competing fee bill which would revise the biennial license renewal fee for physicians to an unspecified amount, while imposing numerous conditions and requirements on the Medical Board. Both bills were stalled in committee in 1999, and are the subject of private negotiations among MBC, CMA, and the Attorney General's Office (see MAJOR PROJECTS).

AB 271 (Gallegos), SB 450 (Speier), SB 836 (Figueroa), SB 835 (Figueroa), SB 837 (Figueroa), and **SB 595 (Speier)** have emerged from the work of the Board's Plastic and Cosmetic Surgery Committee *[16:2 CRLR 29–31]*, and enjoyed varying degrees of success during the first year of the 1999–2000 legislative session:

◆ ***AB 271 (Gallegos)***, as amended September 3, is a MBC-sponsored bill that enacts the Cosmetic and Outpatient Surgery Patient Protection Act. Generally, AB 271 requires

physicians to carry malpractice insurance to cover surgery performed outside acute care hospitals, requires minimum staffing levels for some outpatient procedures, and requires physicians to report to MBC any death or serious hospitalization of a patient resulting from certain procedures.

Specifically, AB 271 requires any physician who performs a scheduled medical procedure outside a general acute care hospital that results in the death or transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours, of any patient on whom that medical treatment was performed by the physician, or by a person acting under the physician's orders or supervision, to report that occurrence in writing to MBC California within 15 days after the occurrence. Failure to comply with this requirement constitutes unprofessional conduct.

The bill also provides that, on and after July 1, 2000, it is unprofessional conduct for a physician to perform procedures in any outpatient setting unless the setting has a minimum of two staff persons on the premises, one of whom is either a licensed physician or a licensed health care professional with current certification in advanced cardiac life support, as long as a patient is present who has not been discharged from supervised care. It further provides that it is unprofessional conduct for a physician to fail to provide "adequate security" by liability insurance or by participation in an interindemnity trust for claims by patients arising out of surgical procedures performed outside a general acute care hospital; MBC must determine what constitutes "adequate security."

Existing law provides for the accreditation of outpatient facilities by accreditation agencies approved by DOL, and requires outpatient facilities to submit an emergency plan to the accrediting agencies. This bill requires outpatient settings to post the certificate of accreditation in a location readily visible to patients and staff, and to post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff. It also requires outpatient settings to develop written discharge criteria, and states that transfer to an unlicensed setting of a patient who does not meet the discharge criteria constitutes unprofessional conduct. AB 271 further requires outpatient settings to have a minimum of two staff persons on the premises, one of whom shall be either a licensed physician or a licensed health care professional with current certification in advanced cardiac life support, as long as a patient is present who has not been discharged from supervised care. This bill was signed by the Governor on October 10 (Chapter 944, Statutes of 1999).

♦ ***SB 450 (Speier)***, as amended August 31, clarifies that when a physician uses the term "board certified" in any advertising, he/she must specify the full name of the approved specialty board that has issued the certification. SB 450 also (1) provides for the waiver of MBC's license fees for physicians who certify that the sole purpose for seeking renewal or restoration of licensure is voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation which provides medical services to indigent patients in medically underserved or critical-need population areas of the state; and (2) requires the Board to adopt extraction and postoperative care standards in regard to liposuction procedures performed by a physician outside a general acute care hospital, and further provides that a violation of these standards constitutes unprofessional conduct. This bill was signed by the Governor on October 5 (Chapter 631, Statutes of 1999).

♦ ***SB 836 (Figueroa)***, as amended August 30, revises and expands the prohibition against fraudulent advertising by health care professionals, including physicians. Intended to rid the marketplace of misleading advertising about cosmetic surgery, the bill specifies that use of a misleading image in advertising is unlawful; bars the use of photographs and images that do not accurately depict the results of the procedure being advertised, that have been altered from the actual image of the subject depicted, that do not clearly state that the image is a model, and that depict the results of a procedure or present "before" and "after" views without specifying what procedures were performed; and require "before" and "after" views to be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of the presentation, and to contain a statement that the same "before" and "after" results may not occur for all patients. SB 836 also bans scientific claims that cannot be substantiated by reliable, peer-reviewed scientific evidence; limits claims of professional superiority to circumstances that can be substantiated by objective scientific evidence; and limits use of testimonials or endorsements that are likely to mislead by virtue of a failure to disclose material facts. This bill was signed by the Governor on October 8 (Chapter 856, Statutes of 1999).

♦ ***SB 835 (Figueroa)***, as amended August 30, would have required physicians who perform cosmetic surgery, including physicians who practice oral and maxillofacial surgery, to provide MBC with information regarding their training, certification, and other specified qualifications, including an optional 200-word statement commenting on the information provided. The bill would have required the Board to post the information on the Internet; authorized physicians to annually update the information upon payment of a $25 fee; required the Board to conduct random audits of the information submitted (including the 200-word statement); authorized MBC to adopt regulations to further ensure compliance with these reporting provisions; and authorized the Board to prohibit a licensee from practicing cosmetic surgery if he/she fails to comply with the new reporting requirements.

SB 835 was vetoed by the Governor on October 10. In his veto message, Governor Davis noted that although the bill "attempted to address serious problems within the cosmetic surgery industry, the method by which it would do so is unduly burdensome on both the licensees and the Board and very costly. For example, the bill would allow physicians to include a 200-word essay commenting on information not contained in or required by other provisions of the bill. It is

not the appropriate role of state government to spend considerable resources reviewing such statements for truthfulness and content. In fact, such information could actually mislead the public. In addition, the bill does not provide adequate fees to accomplish the required tasks."

♦ ***SB 837 (Figueroa)***, as amended August 23, would provide that no physician may perform cosmetic surgery unless that surgery is performed in a licensed general acute care hospital specified in section 1250(a) of the Health and Safety Code or in an outpatient setting specified in section 1248.1 of the Health and Safety Code. The bill would add section 2098 to the Business and Professions Code, defining "cosmetic surgery" as "surgery that is performed to alter or reshape normal structures of the body solely in order to improve appearance," and set forth a list of procedures which are deemed to be "cosmetic surgery." The bill would authorize MBC to adopt regulations adding and/or deleting cosmetic surgery procedures from the statutory list, based on a determination of significant risk to the patient; and exempt surgeries for the removal of cysts, moles, or warts on the skin, the repair of simple lacerations, minor scar revisions, skin biopsies, and other procedures that pose similar risks from the definition of "cosmetic surgery." *[A. Appr]*

♦ ***SB 595 (Speier)***, as amended August 16, would require the Medical Board to clarify the definition of "outpatient settings" that are subject to accreditation and MBC regulation under AB 595 (Speier) (Chapter 1276, Statutes of 1994). AB 595 generally prohibits physicians from performing surgical procedures "where anesthesia...is used...in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes" in unaccredited outpatient settings. *[14:4 CRLR 69]* However, this threshold for mandatory accreditation has proven impossible to define or enforce. The medical community disagrees over the precise level of anesthesia which would place a patient "at risk for loss of the patient's life-preserving protective reflexes."

Thus, SB 595 would require MBC to redefine the current threshold for mandatory accreditation by November 1, 2000; if the Board fails to act, the current standard would be repealed and a new standard in the bill would take effect. Under the new standard, no physician could perform a procedure after November 1, 2000 in an outpatient setting using anesthesia, except local anesthesia, minor blocks, or minimal oral tranquilization. *[S. Appr]*

SB 1308 (Committee on Business and Professions), as amended September 2, is a DCA-sponsored omnibus bill that makes numerous technical and conforming changes to existing law governing its occupational licensing agencies. SB 1308, which was supported by MBC, makes a number of clean-up changes to the Medical Practice Act, Business and Professions Code section 2000 *et seq.*, including the following:

• It amends section 2085 to delete references to the National Board of Medical Examiners' (NBME) examination for graduates of a special medical school program. The NBME is no longer administered in the United States. The new test is the United States Medical Licensing Examination (USMLE).

• It repeals sections 2119 and 2178, which refer to the Federation Licensing Examination; this exam has become obsolete under the current USMLE examination system.

• It repeals section 2168.2(b) and deletes references in section 2113 which refer to oral examination requirements for foreign medical graduate licensure, which were repealed last year in SB 1981 (Greene) (Chapter 736, Statutes of 1998). *[16:1 CRLR 57]*

• It amends section 2107 to permit applicants for licensure who graduated from medical school after January 1, 1986 to apply unlimited postgraduate study to remedy deficiencies in medical school education and training. Previous law allowed applicants who graduated before January 1, 1986 to use unlimited postgraduate study to correct deficiencies but limited applicants who graduated after that date to 36 hours of credit.

• For purposes of DOL's midwifery licensing program, it revises section 2506's definition of "midwifery accrediting organization" from one that is recognized by the U.S. Department of Education to one that is approved by the Board, enabling MBC to approve other accrediting agencies.

• It amends sections 2512.5, 2513, and 2520, relating to examination requirements for midwife licensure. Existing law specifies that the examination must be the equivalent of the examination of the American College of Nurse Midwives and that the fee for the exam must not exceed $350. However, the currently approved exam now costs $400. These amendments would permit DOL to approve other examinations and would eliminate the reference to cost.

• It removes references in sections 2565(a), 2566(a), and 2566.1(b) to registration of dispensing opticians and spectacle and contact lens dispensers which expire less than one year from issuance, because the renewal period has changed to no less than one year.

AB 791 implements a December 1994 MBC recommendation to the legislature following its survey of medical schools to determine whether medical students are receiving adequate instruction in pain management and end-of-life issues.

SB 1308 was signed by the Governor on October 6 (Chapter 655, Statutes of 1999).

AB 791 (Thomson and Migden), as amended August 17, adds pain management and end-of-life care to the medical school curriculum required for licensure in California for persons entering medical school on or after June 1, 2000. AB 791 implements a December 1994 MBC recommendation to the legislature following its survey of medical schools to determine whether medical students are receiving adequate instruction in pain management and end-of-life issues. The bill also requires licensed health facilities, as a condition of licensure, to include pain as an item to be assessed at the same

time as vital signs are taken. AB 791, which was supported by MBC after Assemblymember Thomson made a personal presentation to the Board at its July 31 meeting, was signed by the Governor on September 15 (Chapter 403, Statutes of 1999).

AB 794 (Corbett), as amended August 16, clarifies the requirements for Board licensees whose patients' records are subpoenaed in civil litigation. Among other things, the bill expands the definition of "personal records" to include electronic data; conforms the time for production of documents under Code of Civil Procedure sections 1985.3 and 1985.6 to that in Code of Civil Procedure section 2020 (no earlier than 20 days after the issuance, or 15 days after the service, of the subpoena duces tecum, whichever is later); requires that when provided with advance notice of at least five business days, the witness must designate at least a six-hour block of time on a date certain for the deposition officer to copy records subject to the subpoena; adds a presumption that any objection to release of records is waived by a party when his/her attorney signs an authorization for the release; and raises the maximum amount the party serving the subpoena may be charged for clerical costs associated with making the records available, from $16 to $24 per person per hour, computed on the basis of $6 per quarter hour. Governor Davis signed AB 794 on September 21 (Chapter 444, Statutes of 1999).

AB 285 (Corbett), as amended September 8, pertains to in-state and out-of-state business entities engaged in the business of providing telephone medical advice services (advice services) to California consumers; these advice services are frequently provided by health plans licensed by the Department of Corporations under the Knox-Keene Health Care Service Plan Act. AB 285 requires, on and after January 1, 2000, any in-state or out-of-state advice service that provides medical advice to a patient at a California address to be registered with the Department of Consumer Affairs. In order to obtain and maintain registration, advice services must comply with the requirements established by the Department, which shall include: (a) ensuring that all staff who provide advice are appropriately licensed as a physician, dentist, dental hygienist, psychologist, marriage and family therapist, optometrist, chiropractor, or osteopath in the state within which they provide advice services, and are practicing within their respective scope of practice (however, registered nurses providing advice, both in-state and from an out-of-state location, must be licensed in California); (b) maintaining records of advice services, including records of complaints, provided to patients in California for a period of at least five years; and (c) complying with all directions and requests for information made by the Department. The bill also requires health plans and disability insurers that provide advice services to ensure that their advice service is registered pursuant to this bill, and to ensure that a physician is available on an on-call basis at all times the service is advertised to be available. This bill was signed by the Governor on September 27 (Chapter 535, Statutes of 1999).

AB 552 (Thompson), as introduced in February 1999, extends until January 1, 2002 the provisions of AB 745 (Thompson) (Chapter 505, Statutes of 1998), which permit licensed physicians to administer general anesthesia in dentists' offices upon inspection of the facility and the payment of a fee. *[16:1 CRLR 59]* AB 552 was signed by the Governor on July 26 (Chapter 177, Statutes of 1999).

AB 1558 (Wildman) and **SB 765 (Schiff)** are double-joined bills relating to the security of biological specimens collected by licensed health care professionals for testing in a clinical laboratory.

AB 1558, as amended August 23, requires a physician who collects biological specimens for clinical testing or examination to secure or ensure that his/her employees, agents, or contractors secure those specimens in a locked container when placed in a public location outside of the custodial control of the physician or his/her employees, agents, or contractors. As of July 1, 2000, MBC may impose a fine against a licensee not to exceed $1,000 for a violation of these provisions. These provisions, however, do not apply to biological specimens received by mail in compliance with applicable laws and regulations. The Governor signed AB 1558 on October 9 (Chapter 922, Statutes of 1999).

SB 765, as amended August 30, requires, commencing July 1, 2000, every licensed health care professional who collects human biological specimens for clinical testing or examination to secure those specimens in a specified manner. The bill also requires, on and after January 1, 2001, clinical laboratory employees, agents, and couriers who retrieve biological specimens located in a specified public place that are not secured in a locked container to notify the licensee by attaching a specified form to the container and to mail a copy of the form to the Department of Consumer Affairs. SB 765 was signed by the Governor on October 7 (Chapter 748, Statutes of 1999).

SB 97 (Burton), as amended June 8, prohibits a health care facility from retaliating or discriminating against an employee, patient, or other person who files a grievance or complaint with a licensing agency or who cooperates in any investigation or proceedings of a governmental entity related to the care, services, or conditions in the facility. The bill establishes a "rebuttable presumption" that any discriminatory treatment taken by a health facility is retaliatory if it occurs against a patient within 180 days of the filing a grievance or complaint or an employee within 120 days of such a filing. SB 97 establishes civil penalties and makes violations of its provisions punishable as a misdemeanor. This bill was signed by the Governor on July 22 (Chapter 155, Statutes of 1999).

AB 78 (Gallegos), SB 21 (Figueroa), AB 55 (Migden), AB 12 (Davis), SB 19 (Figueroa), AB 416 (Machado), and **SB 59 (Perata)** are part of a package of bills signed by Governor Davis intended to improve the regulation of managed care in California. These bills have special impact on physicians and/or their relationships with their patients; other bills related to managed care regulation are reported in our article

on the Health Plan Division of the Department of Corporations (see above):

♦ ***AB 78 (Gallegos)***, as amended September 8, transfers responsibility for administration and implementation of the Knox-Keene Health Care Service Plan Act of 1975, under which most managed care plans are regulated, from the Department of Corporations to a new Department of Managed Care (DMC) within the Business, Transportation and Housing Agency. The Department will be headed by a Director who is appointed by and serves at the pleasure of the Governor. The bill also establishes within DMC an Advisory Committee on Managed Care to assist and advise the DMC Director on various issues, and an Office of Patient Advocate to provide educational material to plan enrollees and to render advice and assistance to enrollees. This bill becomes effective on January 1, 2000, and become operative on the date that the Governor, by executive order, establishes the Department of Managed Care or July 1, 2000, whichever occurs first. AB 78 was signed by the Governor on September 27 (Chapter 525, Statutes of 1999).

♦ ***SB 21 (Figueroa)***, as amended September 8, provides that health care service plans and managed care entities, for services rendered on or after January 1, 2001, have a duty of ordinary care to provide medically appropriate health care service to their subscribers and enrollees where such health care service is a benefit provided under the plan, and makes such entities liable for any and all harm legally caused by the failure to exercise ordinary care in arranging for the provision of, or denial of, health care services when both of the following apply: (1) the failure to exercise ordinary care results in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee; and (2) the subscriber or enrollee suffers "substantial harm." The term "substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.

SB 21 also prohibits health care service plans and managed care entities from seeking indemnity from providers for their violation of their duty of ordinary care to arrange for the provision of medically necessary health care service to their subscribers and enrollees, and makes any provisions to the contrary in a contract with providers void and unenforceable. Further, any waiver by a subscriber or enrollee of the liability of the health plan is contrary to public policy and unenforceable. SB 21 also provides that a person may not maintain a cause of action against a health care service plan unless he/she has exhausted the procedures provided by any applicable independent medical review system or independent review system, with certain exceptions. Governor Davis signed SB 21 on September 27 (Chapter 536, Statutes of 1999).

AB 12 (Davis), as amended September 7, requires health plans and insurers to provide or authorize a second opinion upon request of a patient or a participating health professional treating a patient under five specified circumstances.

♦ ***AB 55 (Migden)***, as amended September 9, requires the new DMC to establish, commencing January 1, 2001, an independent medical review system (IMRS) for health plan enrollees to seek an independent review whenever health care services have been denied, delayed, or otherwise limited by a plan or one of its contracting providers based on a finding that the service is not medically necessary or appropriate; "coverage decisions" (*i.e.*, a finding that a service is included or excluded under the terms of a plan) are not reviewable by the IMRS. The DMC shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The independent reviews will be conducted by expert medical organizations independent of plans and certified by an accrediting organization, pursuant to conflict of interest provisions. The Department must adopt the determination of the independent review entity, which shall be binding on the plan. In cases where the enrollee's position prevails, the plan must either offer the enrollee the disputed health care service or reimburse the enrollee for care received if so directed by the Department. Under this bill, an enrollee would not pay any application or processing fee; the costs of the IMRS will be paid by an assessment on health plans. The bill establishes a similar IMRS in the Department of Insurance for review of similar decisions by disability insurers. AB 55 was signed by the Governor on September 27 (Chapter 533, Statutes of 1999).

♦ ***AB 12 (Davis)***, as amended September 7, requires health plans and insurers to provide or authorize a second opinion upon request of a patient or a participating health professional treating a patient under five specified circumstances. The second opinion must be provided by an "appropriately qualified health care professional," meaning a primary care physician or a specialist who is acting within his/her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. The bill also requires plans to authorize or deny the second opinion in an expeditious manner; requires plans and insurers to file timelines for responding to requests for second opinions by July 1, 2000, with the appropriate state agency; and requires that the timelines be made available to the public upon request. This bill was signed by the Governor on September 27 (Chapter 531, Statutes of 1999).

♦ ***SB 19 (Figueroa)***. Existing law, known as the Confidentiality of Medical Information Act, prohibits the disclosure of medical information by providers of health care, including certain health care service plans, except in specified circumstances. Unauthorized disclosure that results in economic loss or personal injury to a patient is a misdemeanor. SB 19 revises the definition of "providers of health care,"

and makes the prohibitions on disclosure of medical information applicable also to all health care service plans and contractors. The bill expressly prohibits (1) negligent disposal or destruction of medical information, and (2) the intentional sharing, sale, or use of medical information for any purpose not necessary to provide health care services to the patient, except as otherwise authorized. Violation of the Act is grounds for suspension or revocation of a health plan's license and creates a right of action to recover damages for any individual whose confidential information or records are negligently released; additionally, the bill provides for specified administrative and civil penalties. SB 19 also prohibits a provider of health care or a health plan and its contractors from requiring a patient, as a condition to receiving health care services, to sign an authorization, release, consent, or waiver permitting the disclosure of any medical information subject to confidentiality protections provided by law. SB 19 further requires all health plans, by July 1, 2001, to provide all patients with a written statement describing how the plan maintains the confidentiality of medical information. Governor Davis signed SB 19 on September 27 (Chapter 526, Statutes of 1999).

◆ ***AB 416 (Machado)***, as amended September 9, makes a number of legislative findings and declarations regarding the importance of maintaining confidentiality of information on patients undergoing mental health treatment. The bill adds section 56.104 to the Civil Code, which prohibits health care providers from releasing specified medical information created regarding an individual as a result of that person's participation in outpatient treatment with a psychotherapist, unless the person or entity requesting the information ("requester") submits a written request to both the patient and the health care provider. The written request must be signed by the requester, and must include (1) the specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses; (2) the length of time during which the requester will keep the information before destroying or disposing of it (a requester may extend that timeframe, provided that the requester notifies the provider of the extension and explains the specific reason for the extension, the intended use(s) of the information during the extended time, and the expected date of the destruction of the information); (3) a statement that the information will not be used for any purpose other than its intended use; and (4) a statement that the requester will destroy the information and all copies in the requester's possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified in section (2) above has expired. The bill also extends this prohibition to health care service plans and their contractors.

The bill also amends Civil Code section 56.35, to provide that a patient whose medical information has been used or disclosed in violation of Civil Code section 56.104 and who has sustained economic loss or personal injury therefrom may recover compensatory damages, punitive damages not to exceed $3,000, attorneys' fees not to exceed $1,000, and the costs of litigation. The Governor signed this bill on September 27 (Chapter 527, Statutes of 1999).

◆ ***SB 59 (Perata)***, as amended September 9, sets forth procedures and timeframes within which health plans must review treatment proposed by a physician. Specifically, the bill requires health plans to approve or deny requests by providers within five business days, except when the enrollee's condition is such that five days could be detrimental or jeopardize the enrollee's recovery, in which case decisions must be made within 72 hours. The bill requires a written response denying, delaying, or modifying treatment, which must describe the criteria used and clinical reasons for the decision and also provide information on how the enrollee may file a grievance. Further, the bill requires a health plan to disclose the process by which the plan, its contracting provider groups, or any entity with which the plan contracts for services uses to authorize, modify, or deny health care services to health care providers, enrollees, or to any other person or organization upon request.

Importantly, AB 59 makes a finding that "decisions about medical care should be made by physicians and other relevant health care professionals." The bill adds section 1367.01 to the Health and Safety Code, which expressly requires health plans to "employ or designate a medical director who holds an unrestricted license to practice medicine in this state" pursuant to the Medical Practice Act or the Osteopathic Act; if the plan is a specialized health care service plan, the plan must employ or designate a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, complies with the requirements of this bill. The Medical Board has been seeking enactment of a provision requiring appropriate California licensure for persons making medical necessity decisions for several years. Although MBC sponsored AB 58 (Davis) to accomplish its goal, that bill was vetoed (see below). However, SB 59 (Perata) includes the provision. The Governor signed SB 59 on September 27 (Chapter 539, Statutes of 1999).

Importantly, AB 59 makes a finding that "decisions about medical care should be made by physicians and other relevant health care professionals."

AB 58 (Davis). Early versions of this MBC-sponsored bill would have would added section 2042 to the Business and Professions Code to require any employee of a health care service plan licensed under the Knox-Keene Act of 1975 who is responsible for the final decision, or is responsible for

the process in which a final decision is made, regarding the medical necessity or medical appropriateness of any diagnosis, treatment, operation, or prescription to be a physician licensed by the Medical Board of California. As noted above, a similar provision was incorporated into SB 59 (Perata), which was signed by the Governor.

As amended September 9, AB 58 would have enacted the Leslie-Davis-Figueroa Medical Accountability Act of 1999, to require a chiropractor, dentist, osteopath, pharmacist, psychologist, optometrist, or podiatrist who makes a decision regarding medical necessity or appropriateness that denies, delays, or modifies, any health care service made by a healing arts licentiate acting within his/her scope of practice, to be licensed in California and acting within his/her scope of practice. The Governor vetoed AB 58 on October 6, noting that he had already signed SB 59, which requires an HMO's medical director to be licensed in California. He expressed concern that AB 58 would "preclude out-of-state experts from making determinations regarding medical necessity which will, in some cases, inhibit the best input on critical clinical questions....While the bill would allow a California physician to consult with an out-of-state physician, the final decision would have to be made by a California licensee. This effectively prohibits plans from employing top experts to make the decisions in very specialized cases."

SB 7 (Figueroa and Leslie), as amended May 28, and **SB 18 (Figueroa)**, as amended June 28, would also ensure that any person who makes a medical necessity or appropriateness decision that denies, significantly delays, terminates, or otherwise limits any diagnosis, treatment, operation, or prescription is appropriately licensed in California. As noted above, a similar provision was enacted in SB 59 (Perata). *[A. Health; A. Appr]*

SB 422 (Figueroa), as amended June 21, would require any communication by a health plan or its contracting medical groups and independent practice associations, indicating a denial or modification of a request for prior authorization for health care services to be communicated to the enrollee in writing, and to physicians or other health care providers, initially by telephone, and then in typewritten form. The bill would also require any written communication to a physician or other health care provider of a denial or modification of a request for prior authorization to include the name and telephone number of the health care professional responsible for the denial. *[A. Desk]*

AB 751 (Gallegos), as amended May 13, would provide that AB 2719 (Gallegos) (Chapter 301, Statutes of 1998) applies to all accusations that were pending on the effective date of that bill (August 17, 1998) and had not yet gone to administrative hearing. AB 2719 imposed a statute of limitations on the filing of accusations by the Medical Board; under that bill, MBC must file an accusation to revoke, suspend, limit, or condition the license of a physician or surgeon within three years after the Board discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission occurred, whichever occurs first. *[16:1 CRLR 49, 57] [A. Appr]*

SB 1305 (Figueroa), as amended August 31, would require MBC to study medical malpractice settlements and patterns of claims or actions for damages for death or personal injury, and prepare a report to the legislature no later than July 1, 2001. *[A. CPGE&ED]*

AB 1592 (Aroner), as amended May 13, would enact the Death with Dignity Act, and permit a terminally ill patient to request medication to end his/her life in a humane and dignified manner. Modeled after similar legislation in Oregon, this bill would authorize attending physicians to prescribe medication for the purpose of hastening death, provided certain procedural safeguards are followed. First, the patient must be terminally rather than chronically ill, as determined by at least two qualified physicians. Second, the patient must make an informed request both orally and in writing for medication, and must reiterate that request not less than 15 days after making the initial request. In addition, the bill would prohibit life, health, and accident insurance from being conditioned on such patient requests and would also prohibit active euthanasia and mercy killing. *[A. Inactive File]*

AB 1418 (Strom-Martin). SB 350 (Killea) (Chapter 1280, Statutes of 1993) added section 2505 *et seq.* to the Business and Professions Code, which authorizes DOL to license lay midwives operating under the supervision of a licensed physician and requires DOL to adopt regulations for the licensed midwife program. *[13:4 CRLR 61]* Implementation of the program, however, has proven difficult and licensed midwives complain that compliance with existing regulations is impossible due to the problem of finding physicians willing to serve as their supervisors. As introduced in February 1999, this bill would delete the requirement for physician supervision and instead require licensed midwives and physicians to have a collaborative relationship. The bill would also delete the existing midwife-to-physician ratio, modify the disclosures that are to be made to a client, and provide that a midwife's license may not be revoked or suspended for an incident or conduct occurring more than seven years earlier or prior to the initial issuance of the license, subject to specified exceptions. *[A. Health]*

AB 827 (Baldwin), as amended April 26, is an alternative medicine bill sponsored by the California Citizens for Health. AB 827 would authorize physicians to use "nonconventional methods" in the treatment of diseases, injuries, deformities, and other physical and mental conditions, and provide that the law governing the licensure and discipline of physicians shall not be construed to prevent the use of any system, methods, or mode of treating the sick or afflicted, whether conventional or nonconventional, for which the licensee has a reasonable expectation of efficacy. The term "nonconventional methods" means those health care methods of diagnosis, treatment, or intervention that are not acknowledged to be conventional, but that may be offered by some licensed physicians in addition to, or as an alternative to,

conventional medicine, and that provide a reasonable potential for therapeutic gain in a patient's medical condition not reasonably outweighed by the risk of those methods.

AB 827 would require all health care practitioners who choose to provide nonconventional treatment to a patient to provide to the patient information on the possible benefits and risks; the foreseeable outcomes; the provider's education, training, and experience in relation to the contemplated treatment; and any other truthful and nonmisleading information that the patient and his/her parent, guardian, or conservator, as appropriate, require in order to make an informed and understanding determination regarding whether to undertake or refuse the recommended nonconventional treatment. Under AB 827, such additional information includes the following: (1) a description of how the nonconventional treatment or remedy affects the body; (2) the existence of scientific literature that reports on or reviews the medical claims in relation to the treatment recommended; and (3) information regarding the degree of acceptance of the treatment by the medical community.

AB 827 would also provide that in the investigation of complaints involving issues of specialty clinical practice, investigators must consult experts who are of the same specialty of practice; in the investigation of complaints involving nonconventional clinical practice, investigators must consult experts who dedicate a significant portion of their practice to nonconventional health care and diagnosis. Finally, AB 827 would allow the use of any health care remedy, procedure, or treatment not generally accepted by the majority of the health care practice community, including dietary supplements and homeopathy, for the treatment of cancer. The Medical Board has not yet taken a position on this bill. *[A. Health]*

AB 215 (Soto), as amended September 10, no longer establishes deadlines for health plans to respond to physician requests that a patient be referred to a specialist *[16:2 CRLR 35]*; instead, it places a moratorium on the Department of Managed Care's authority to issue health plan licenses with waivers or limited licenses. This bill was signed by the Governor on September 27 (Chapter 530, Statutes of 1999).

AB 62 (Davis) was previously a medical records confidentiality bill similar to SB 19 (Figueroa) (see above); it has been amended and is no longer relevant to the Medical Board.

SB 1128 (Speier), as amended August 30, is no longer relevant to MBC.

LITIGATION

On May 10 in ***Krain v. Medical Board of California***, 71 Cal. App. 4th 1416 (1999), the First District Court of Appeal upheld the Medical Board's revocation of the license of Lawrence Krain, MD. MBC's revocation was based in part on Krain's guilty plea to a criminal charge of soliciting the subornation of perjury in violation of Penal Code section 653f(a). The crime is a "wobbler" (meaning it may be charged as either a felony or misdemeanor); Krain pled guilty to a felony count. Pursuant to its authority under Penal Code section 17(b)(3), the superior court later reduced the conviction to a misdemeanor. The court later permitted Krain to change his plea to not guilty, and subsequently dismissed the case under Penal Code section 1203.4(a). Krain argued that MBC is precluded from using his expunged guilty plea to a misdemeanor as a basis for discipline.

Business and Professions Code section 2236 provides that "[t]he conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct....A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred." Section 2236.1(d) provides in part: "Discipline may be ordered in accordance with Section 2227...when the time for appeal has elapsed, the judgment of conviction has been affirmed on appeal, or an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under section 1203.4 of the Penal Code allowing the person to withdraw his or her plea of guilty and to enter a plea of not guilty, setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment."

Krain first argued that subsection 2236.1(d) only permits the Board to discipline his license for a felony conviction. However, the court found that, while subsections 2236.1(a) and 2236.1(b) refer to felonies, subsection 2236.1(d) does not; therefore, the Board may rely on a misdemeanor conviction as a basis for discipline. Krain next challenged the Board's ability to use an expunged misdemeanor conviction in the absence of express statutory authority. The court had no trouble rejecting this argument, noting that "decisions of the California courts have 'consistently upheld denial of a license or the right to pursue a particular profession on the basis of an expunged conviction' and have done so without relying on statutory language expressly permitting consideration of expunged convictions....Permitting discipline on the basis of a plea of guilty—an admission of certain conduct—regardless of whether the plea is later set aside under Penal Code section 1203.4,...represents a focus on the physician's conduct, not the criminal consequences of that conduct."

Krain also contended that his conviction for solicitation of subornation of perjury is not "substantially related" to his qualifications as a physician, as required by section 2236. The court rejected that contention as well, noting that the crime to which Krain pled guilty involves dishonesty.

Krain also contended that his conviction for solicitation of subornation of perjury is not "substantially related" to his qualifications as a physician, as required by section 2236. The court rejected that contention as well, noting that the crime

to which Krain pled guilty involves dishonesty. Relying on *Windham v. Board of Medical Quality Assurance*, 104 Cal. App. 3d 461 (1980), the court held that "the intentional solicitation to commit a crime which has as its hallmark an act of dishonesty cannot be divorced from the obligation of utmost honesty and integrity to the patients whom the physician counsels, as well as numerous third party entities and payors who act on behalf of patients." Krain's petition for reconsideration was rejected on June 8.

The Fourth District Court of Appeal recently interpreted Probate Code section 4750(c), which broadly immunizes a health care provider from civil liability, criminal prosecution, and professional discipline when he/she refuses to withdraw health care necessary to keep a patient alive. In ***Duarte v. Chino Community Hospital***, 72 Cal. App. 4th 849 (June 3, 1999), the family of a comatose automobile accident victim sued the victim's treating physician and hospital after the physician refused to authorize removal of a respirator, unless the victim became brain dead or the family obtained a court order. The family had been informed that the victim was in a persistent vegetative state that was irreversible. Based on the victim's oral expression of her wishes in such a circumstance, the family asked the treating physician to remove the respirator that was keeping the victim alive; however, the physician refused. The family sued for negligence and intentional infliction of emotional distress, seeking money damages. The court refused to limit the immunity provision in section 4750(c) as requested by the Duartes, and applied it to bar damages in spite of the facts that no one in the family had been designated as attorney-in-fact and no one in the family had consented to the use of a respirator. The court further found that the immunity provision is not contrary to the Natural Death Act, Health and Safety Code section 7185, finding that the Natural Death Act merely permits adults to execute a declaration governing the withholding or withdrawal of life-sustaining treatment and does not deal with the issue of whether a physician is liable for damages for failing to comply with such a directive. The California Supreme Court denied the Duartes' petition for review on September 1.

Still pending before the California Supreme Court are several cases which will decide the constitutionality of Business and Professions Code section 2337, which was recently amended to require a physician to appeal a superior court decision affirming DMQ's discipline of a medical license by way of a petition for an extraordinary writ.

At DOL's July meeting, staff updated the Division on the progress of ***American Academy of Pain Management v. Joseph***, No. CV-96-02108-LKK (U.S.D.C., E.D. Cal.). In this matter, the American Academy of Pain Management (AAPM) challenges DOL's 1997 denial of its application for approval as a specialty board under Business and Professions Code section 651. DOL's denial prevents AAPM members from advertising themselves as "board certified" in California. AAPM argues that section 651 and the Division's regulations implementing it are unconstitutional, in that they impermissibly infringe on AAPM's commercial speech rights under the first amendment. In addition to challenging the statute on its merits, AAPM sought a preliminary injunction against DOL. The U.S. District Court for the Eastern District of California found "serious questions regarding whether plaintiffs' speech is protected by the First Amendment," and denied the motion in May 1997; the Ninth Circuit upheld the district court's ruling in September 1998, and the U.S. Supreme Court denied AAPM's petition for *certiorari* in March 1999. At this writing, the case is expected to go to trial on the merits on April 25, 2000.

Still pending before the California Supreme Court are several cases which will decide the constitutionality of Business and Professions Code section 2337, which was recently amended to require a physician to appeal a superior court decision affirming DMQ's discipline of a medical license by way of a petition for an extraordinary writ. Section 2337 was amended in a series of bills sponsored by the Center for Public Interest Law during the early 1990s, following its 1989 study indicating that a typical physician discipline case can take six to eight years—during which time most respondent physicians continue to practice with an unrestricted license. *[9:2 CRLR 1]* The extraordinary writ procedure permits the court to reject a nonmeritorious case after full briefing, but without the oral argument and written decision required by a direct appeal. In ***Leone v. Medical Board of California***, 57 Cal. App. 4th 1240 (1997), the Second District Court of Appeal held that section 2337 violates a physician's right to appellate review, which is guaranteed by the California constitution. However, the First District Court of Appeal in ***Landau v. Superior Court (Medical Board of California)***, 60 Cal. App. 4th 940 (1998), upheld the validity of the same statute, finding that appellate review by way of an extraordinary writ satisfies the constitutional guarantee. *[16:1 CRLR 59–60]* In early 1999, two other courts have joined the *Landau* camp. In unpublished decisions, the Fourth District Court of Appeal in ***Shahhal v. Medical Board of California***, No. D031407 (1999), and the Third District Court of Appeal in ***Driss v. Medical Board of California***, No. C029353 (1999), both found that section 2337 does not violate the California constitution. The Supreme Court has granted review in these cases and deferred further action pending a decision in *Leone* and *Landau*.

The California Supreme Court is also considering ***Potvin v. Metropolitan Life Insurance Co.***, 54 Cal. App. 4th 936 (1997), in which the Second District Court of Appeal affirmed a physician's right to procedural due process when being terminated by managed care providers and physician groups. In the case, the issue is whether an independent contractor physician is entitled to notice and opportunity to be heard before

his membership in a mutual insurer provider network may be terminated notwithstanding an at-will provision in the agreement. In April 1997, the Second District Court of Appeal held that a physician who was a participating member of a managed health care network provided by an insurance company had a common law right to fair procedure before the insurance company could terminate his membership. The court stated that membership in an association (including a hospital staff), once attained, is a valuable interest which cannot be arbitrarily withdrawn. Procedural fairness in the form of adequate notice of the charges brought against the individual and an opportunity to respond is an indispensable prerequisite for one's expulsion from membership, and "overrides a provision in the agreement between the two [parties] allowing termination without cause." The court based its decision on the premise that health plans control a physician's economic well-being by acting as gatekeepers between doctors and their patients. Metropolitan controlled substantial economic interests, as demonstrated by the number of physicians in its networks as well as the adverse effect on Potvin's practice following his "deselection."

RECENT MEETINGS

At its May meeting, the full Board elected public member Karen McElliott as MBC President for 1999–2000; Bud Alpert, MD, as Board Vice-President; and Jack Bruner, MD, as Board Secretary. Also in May, DOL elected Bud Alpert as its President; Tom Joas, MD, as Vice-President; and public member Bruce Hasenkamp as Secretary. At its May meeting, DMQ elected Ira Lubell, MD, as President; Carole Hurvitz, MD, as Vice-President; and Alan Shumacher, MD, as Secretary.

At DOL's May 7 meeting, public member Bruce Hasenkamp summarized a written report on the Division's recent site visit to inspect four medical schools in the Philippines. DOL last visited Philippine medical schools in 1987, and issued a detailed report concluding that the schools' medical education was not equivalent to that provided by medical schools in the United States. Because of the large number of graduates of Philippine medical schools applying for licensure in California and concerns about the education provided to these students, DOL authorized a January 12–22, 1999 site visit to four medical schools in Manila: the University of Santo Tomas, the University of the East, Far Eastern University, and the University of the Philippines. The objectives of the site visit were to evaluate the quality of the students being admitted; evaluate the quality of the education being provided as reflected in the quality and competency of the faculty, the curriculum provided the students, the methods of student evaluation, and the facilities available to support the educational program; where possible, compare the findings of the current visit with those documented in 1987 to determine what changes or improvements have been made; and gain a greater understanding of the process of medical education and student evaluation to facilitate interpretation of medical school transcripts when graduates of these medical schools apply for California licensure.

Overall, the site visit team was favorably impressed with the quality of the medical education being provided by the University of the Philippines and the University of the East, and stated that graduates of these schools meet the educational standards expected of applicants for medical licensure in California. At the University of Santo Tomas and Far Eastern University, the site visit team acknowledged some "areas within the educational process which were less than optimum and of which school officials are cognizant and endeavor to address within the limitations of the country and the institution"—but nonetheless concluded that both medical schools should continue to be recognized as acceptable for purposes of its graduates being eligible for medical licensure in California.

At DMQ's July 30 meeting, Enforcement Chief John Lancara reported on a site visit to the University of California at San Diego to visit the Physician Assessment and Clinical Education (PACE) program. On the site visit, Lancara was accompanied by MBC Executive Director Ron Joseph and DMQ members Kip Skidmore and Alan Shumacher, MD. UCSD and MBC collaborated to develop the PACE program to provide assessments of physicians' clinical skills and remediation education and training as part of a probation order. Based on an extensive initial assessment and the probation order, ALJ proposed decision, or stipulation, PACE medical staff design a clinical training program for each physician participant. Participants are evaluated on their knowledge, judgment, clinical skill, relationships with patients, care of actual patients, and ability to recognize medical expertise boundaries. *[16:1 CRLR 55–56]*

Several DMQ members commented on the PACE program. Public member Kip Skidmore noted that PACE is an impressive program that is going through "growing pains," and that PACE management has done a good job of convincing the UC system to let "wayward doctors" into its everyday life. Although Skidmore stated the assessment is well-done and includes both a clinical and psychometric assessment, there is no academic or "book learning" aspect to the PACE program. According to Skidmore, "if what the doctor needs to do is read all the latest studies or literature on a certain procedure, that part is missing from this program." Skidmore also expressed some concern with the clinical aspect of the program, in that there is no "hands-on" experience for the participating physician—he/she simply observes, due to serious liability issues and the insufficiency of patients to accommodate both PACE participants and the University's medical students. Skidmore also noted that there is no follow-up of PACE participants—"nothing to tell us here at DMQ whether the PACE program has helped the participants." Finally, Skidmore stated that DMQ should exercise more oversight over the program because "it has its limits—it can only handle so many physicians." DMQ physician member Alan Shumacher agreed with Skidmore, noting that "the weak point of the program is its assessment of how well it works for a given individual. They are aware of that problem, and we need to work with them to fix it." Shumacher also noted that

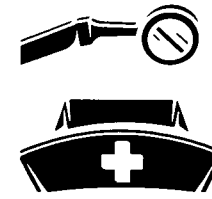
PACE is funded solely by the physicians who are referred to it and that this source of funding is inadequate; "the program needs more money, but I'm not sure where they should get that." Enforcement Chief Lancara expressed overall satisfaction with the program, but stated that he was disturbed to find that some defense attorneys of referred physicians had been in direct contact with PACE personnel, "trying to get them to change the doctors' probation orders to stipulations. I put an immediate stop to that."

FUTURE MEETINGS

- November 4–6, 1999 in San Diego.
- February 3–5, 2000 in Los Angeles.
- May 11–13, 2000 in Sacramento.
- July 27–29, 2000 in San Francisco.
- November 2–4, 2000 in San Diego.

Board of Registered Nursing

Executive Officer: Ruth Ann Terry ♦ (916) 322-3350 ♦ Internet: www.rn.ca.gov/



The Board of Registered Nursing (BRN) is a consumer protection agency within the state Department of Consumer Affairs (DCA). Pursuant to the Nursing Practice Act, Business and Professions Code section 2700 *et seq.*, BRN licenses registered nurses (RNs) and certifies nurse-midwives (CNMs), nurse practitioners (NPs), nurse anesthetists (NAs), public health nurses (PHNs), and clinical nurse specialists (CNSs). BRN also establishes accreditation requirements for California nursing schools and reviews nursing school criteria; receives and investigates complaints against its licensees; and takes disciplinary action as appropriate. BRN's regulations implementing the Nursing Practice Act are codified in Division 14, Title 16 of the California Code of Regulations (CCR).

The nine-member Board consists of three public members, three RNs actively engaged in patient care, one licensed RN administrator of a nursing service, one nurse educator, and one licensed physician. All serve four-year terms. The Board, which is currently staffed by 95 people, is financed by licensing fees and receives no allocation from the general fund.

The second terms of Board members Genevieve Deutsch, RN, and Judith Jonilonis, RN expired on June 1, 1999. Both were originally appointed in 1992 by then-Governor Pete Wilson. Because neither has been replaced by Governor Davis, both continue to serve as Board members during their "grace year" under Business and Professions Code section 105.5.

At its September 10 meeting, BRN approved an "advisory statement" setting forth the qualifications necessary in order for a RN to be certified as a clinical nurse specialist (CNS) by BRN.

MAJOR PROJECTS

Board Approves Advisory Statement on Certification of Clinical Nurse Specialists

At its September 10 meeting, BRN approved an "advisory statement" setting forth the qualifications necessary in order for a RN to be certified as a clinical nurse specialist (CNS) by BRN.

AB 90 (Cuneen) (Chapter 159, Statutes of 1997) added section 2838 *et seq.* to the Business and Professions Code, and authorized BRN to administer a new certification program for RNs holding themselves out CNSs. AB 90 implements the recommendations made in BRN's 1995 *Clinical Nurse Specialist Study Report* required by AB 518 (Woodruff) (Chapter 77, Statutes of 1993), in which BRN found that nurses in California were using the unregulated title "clinical nurse specialist" without fulfilling the role of a CNS. *[15:2&3 CRLR 98; 15:1 CRLR 92; 14:4 CRLR 97]* Under AB 90, effective July 1, 1998, any RN who holds him/herself out as a CNS must meet the Board's standards and be certified as a CNS. However, the Board has not yet adopted regulations to establish certification standards for RNs seeking to become certified as a CNS, although it planned to do so in 1999. *[16:2 CRLR 41]*

In the interim, BRN is receiving telephone calls on a daily basis about CNS certification. Thus, at its September meeting, BRN adopted an "advisory statement" regarding CNS certification qualifications which it has since posted on its website. The advisory statement notifies applicants for certification that BRN has accepted the standards of the National Association of Clinical Nurse Specialists' *Statement on CNS Practice and Education*, and the American Association of Colleges of Nursing's *Essentials of Master's Education for Advanced Practice*. In addition, the national organizations that have met BRN's CNS certification requirements and are equivalent to BRN's standards for CNS certification are the American Nurse Association-American Nurses Credentialing Center, the Oncology Nursing Certification Corporation, and the American Association of Critical Care Nurses.

According to the advisory statement, in order to be certified as a CNS in California, an applicant must have completed a minimum of 400 hours of clinical experience concurrently with master's-degree level coursework in five