MEDICAL BOARD OF CALIFORNIA

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> *Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.*
>
> — Business and Professions Code § 2000.1

The Medical Board of California (MBC) is a consumer protection agency within the state Department of Consumer Affairs (DCA). The 15-member Board consists of eight physicians and seven public members. MBC members are appointed by the Governor (who appoints all eight 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 assisted by several standing committees and ad hoc task forces.

The purposes of MBC 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*.; provide public-record information about physicians to the public via its website and individual requests; 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 is responsible for ensuring that all physicians licensed in California have adequate medical education and training. In this regard, the Board issues regular and probationary licenses and certificates under its jurisdiction, administers a continuing medical education program, and

administers physician and surgeon examinations to some license applicants. MBC also oversees the regulation of licensed midwives; polysomnographic technologists, technicians, and trainees; research psychoanalysts; and medical assistants.

In response to complaints from the public and reports from health care facilities and other mandated reporters, MBC reviews the quality of medical practice carried out by physicians and surgeons. In this regard, MBC's responsibilities include enforcement of the disciplinary, administrative, criminal, and civil provisions of the Medical Practice Act. MBC's enforcement staff receives and evaluates complaints and reports of misconduct and negligence against physicians. If there is reason to suspect a violation of the Medical Practice Act, an investigator from DCA's Health Quality Investigation Unit (HQIU), together with a deputy attorney general (DAG) from the Health Quality Enforcement Section (HQE) in the Attorney General's Office, will investigate the allegations and may file charges against alleged violators. Barring a stipulated settlement, the HQE DAG will prosecute 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 (OAH). Following the hearing, a seven-member panel of MBC reviews the ALJ's proposed decision and takes final disciplinary action to revoke, suspend, or restrict the license, or impose other appropriate administrative action.

MBC meets approximately four times per year; its committees and task forces hold additional separate meetings as the need arises.

At this writing, the Board has three vacancies—one physician member and two public members—all of which must be filled by Governor Brown.

MAJOR PROJECTS

MBC Releases 2016–17 Annual Report

In October 2017, MBC released its 2016–2017 Annual Report, which reveals an increase in the number of disciplinary actions taken and a decrease in initial complaint processing time, but an increase in investigative cycle times for both sworn and non-sworn investigators as compared to their 2015-2016 performance.

In 2016-2017, MBC received 9,619 complaints and opened 1,465 investigations (as compared to 8,679 and 1,654, respectively, in 2015–2016). It forwarded 425 completed investigations cases to HQE—considerably higher than 345 in the year prior. HQE filed 314 accusations—compared to 299 in 2015–2016. In 2016–2017, the Board took a total of 466 disciplinary actions (an increase of 78 actions over the prior year), including 57 revocations, 111 license surrenders, 7 probations with suspension, 190 probations, and 86 public reprimands. Additionally, the Board issued 137 citations and fines (up from 55 in 2015–2016); it obtained 36 interim suspension orders and 68 other suspension orders.

MBC's Annual Report also indicates the average time it takes to process complaints at the various stages of processing. During 2016-17, it took the Board's Central Complaint Unit (CCU) an average of 123 days to process complaints before forwarding them for investigation (down from 146 days in 2015–2016); it took an average of 467 days for HQIU sworn investigators to investigate cases, and an average of 258 days for non-sworn investigators in MBC's Complaint Investigation Office to investigate cases (up from 426 and 124, respectively, in 2015–2016). HQE prosecutors took an average of 77 days to file an accusation (down from 93 in 2015–2016). Other stages of the legal process, after the charges are filed, took an average of 455 days (similar to 453 in 2015–2016).

Although the improved performance of CCU in processing complaints and HQE in filing accusations is encouraging, the increase in investigative case cycle time (and the continued high vacancy rate in HQIU investigative positions—see below) is sure to be a topic of discussion at upcoming meetings. Further, MBC's enforcement output still pales in comparison to the number of external complaints and reports of physician incompetence and misconduct received by the Board. In 2016–2017, the Board received 640 reports of medical malpractice judgments or settlements; 12 autopsy reports from coroners indicating that the cause of death was physician gross negligence or incompetence; 96 reports that physicians had been charged with or convicted of crimes; and 99 reports of adverse peer review action taken against physicians by hospitals or health care facilities.

Attorney General's Annual Report on Accusation Matters Received and Adjudicated

On January 1, 2018, the Office of the Attorney General (AG) released its first Annual Report on Accusations Prosecuted for Department of Consumer Affairs Client Agencies as required under Business and Professions Code section 312.2, which became effective on January 1, 2016 and required the first report to be filed January 1, 2018. The report is based on information from fiscal year 2016–2017. The Annual Report provides a baseline concerning accusation matters referred and adjudicated accusations for each DCA client agency of the Licensing Section and Health Quality Enforcement Section of the Attorney General's Office.

In general, section 312.2 requires the AG's Office to document the number of accusation matters referred to it by each DCA client agency, including information on the number of those matters rejected for filing, returned for further investigation, and the number of accusations actually filed, withdrawn, and adjudicated. Section 312.2 also requires the AG's Office to

document the average number of days from receipt of an accusation referral to the filing of the accusation, and other case cycle times depending on the outcome of the AG's review and handling of the matter.

The report on MBC starts by noting that MBC has six licensing categories; as such, the AG's data is not confined to MBC's physician discipline process. According to the Annual Report, in 2016–2017 MBC referred 412 accusation matters to HQE, which handles most physician discipline matters using vertical enforcement as required by Government Code section 12529.6 (see below). HQE rejected eight of the 412 accusation matters; requested further investigation in 16 cases; and received further investigation in 31 cases. Ultimately, HQE filed 384 accusations in MBC matters, withdrew four accusations, and adjudicated 433 matters. The average number of days that elapsed between receipt of the matter and the filing of the accusation was 86. The average number of days to prepare an accusation in matters that were re-referred to HQE following further investigation was 192. The average number of days between accusation filing and sending a stipulated settlement to MBC was 300. The average number of days from the filing of the accusation and HQE's request for a hearing date was 129. The average number of days from HQE's receipt of a hearing date to the commencement of the hearing was 182.

HQIU Vacancy Rate and Investigation Timelines

As MBC's 2016–2017 Annual Report documented, the average cycle time for investigations by sworn investigators in HQIU rose from 426 days in 2015-2016 to 467 days in 2016-2017. This is not a new problem at MBC *[23:1 CRLR 43]*; many blame the high vacancy rate among HQIU investigators, which stood at 38% as of MBC's July 2017 meeting.

At MBC's October 2017 meeting, HQIU Deputy Chief Kathleen Nicholls reported that the vacancy rate for HQIU investigators stood at 35%—27 of 77 investigator positions were vacant.

However, she noted that an enhanced recruiting and advertising program paid off: 35 sworn candidates were undergoing background checks, and HQIU offered eight of those individuals conditional jobs and were awaiting final clearance. In addition, she announced that HQIU created 17 limited-term, non-sworn investigator positions to assist with the caseload; these individuals handle some of the less complex matters, and HQIU hopes this mechanism will enable it to identify and develop future sworn candidates for the Unit.

At MBC's January 2018 meeting, Nicholls and Supervising Investigator Andrew Hegelein, who oversees the northern California HQIU field offices in Sacramento, Concord, San Jose, and Fresno, reported that seven sworn investigators started with HQIU earlier that month. Hegelein stated that with the newly hired staff, HQIU has 23 vacancies (30%), with 25 candidates in the background check phase of the hiring process. Additionally, 19 limited-term investigators are working in HQIU to assist with workload. The closed case average for December 2017 was 530 days (1.45 years), but Hegelein stated that as HQIU becomes fully staffed the closed case average number will reduce; the goal is to have every case investigated in a year or less. Hegelein explained that HQIU sworn staff have a high percentage of complex overprescribing cases (as of December 2017, 30% of all sworn investigator cases involved allegations of overprescribing), which take longer to investigate. These cases tend to be more complex because they involve multiple patients and in some cases multiple undercover operations.

While HQIU still has a number of positions to fill, the numbers presented during the October and January meetings are encouraging and show an improvement from previous meetings.

Vertical Enforcement Update

At MBC's October 2017 meeting, Executive Director Kimberly Kirchmeyer reminded Board members that Governor Brown attached a "signing message" to his approval of SB 798

(Hill) (Chapter 775, Statutes of 2017), MBC's sunset extension bill. The Governor's message indicated that during MBC's 2017 sunset review, two issues require further review, including MBC's use of "vertical enforcement" (VE), which is required for most physician discipline cases by Government Code section 12529.6. *[23:1 CRLR 37]* Under VE, once a complaint survives CCU screening and is referred for formal investigation, an HQIU investigator and an HQE prosecutor are jointly assigned to handle the matter, and the investigation proceeds under the direction of the prosecutor. VE simply requires investigators and prosecutors to work collaboratively together from the beginning of a formal investigation, which is especially important when, as in quality of care cases, the legal and factual issues are complex. Early versions of SB 798 would have repealed the VE statute; but the bill's author was persuaded to remove the repeal language and instead place a one-year sunset date (January 1, 2019) on the VE statute. Kirchmeyer noted that the Governor's Office intends to convene meetings between his staff and the Attorney General's Office; no details of those meetings have been made public.

Also at MBC's October meeting, Senior Assistant Attorney General Gloria Castro, who heads HQE, addressed the value of hands-on Board member activity to foster understanding of the VE program. Castro specifically wanted the Board to understand the value that is added to enforcement cases through VE joint investigations, as well as the burdens that are placed on staff to perform this important function on the Board's behalf. Castro noted she has been meeting with HQIU Deputy Chief Kathleen Nicholls on a monthly basis, and as needed, collaborating and troubleshooting issues. Finally, Castro emphasized that Attorney General Xavier Becerra has a keen interest in protecting patients and enhancing the quality of health care in California.

At the January 2018 meeting of MBC's Enforcement Committee, Supervising Deputy Attorney General Matthew Davis and HQIU's Andrew Hegelein gave an informative presentation

on the VE process and the role and duties of each team member, including HQIU investigators (and their supervisors) and medical consultants (who are based at 13 district offices throughout the state), HQE prosecutors (and their supervisors) (who are based at six field offices across the state), expert witness(es), and MBC's enforcement chief and executive director. The presentation featured the "three Cs" that underlie VE: cooperation, consultation, and communication. They stated that cases are assigned to investigators based on their experience level, and to deputies attorney general (DAGs) based on rank; the potential for patient harm in each case is frequently reevaluated to determine whether the incoming evidence reveals a need for urgent action (such as a petition for an interim suspension order or "ISO"). Davis and Hegelein explained that the need for collaboration between investigators and DAGs is not only confined to routine disciplinary matters but may also be needed in ancillary matters, such as subpoenas for medical records, Penal Code section 23 bail hearings where a physician has been arrested and incarcerated, Business and Professions Code section 820 proceedings seeking a mental or physical examination of a physician, and ISO petitions and hearings. They noted that MBC's disciplinary matters are among the most complex cases at any DCA board, and that physicians' ability to hire high-powered defense counsel and multiple expert witnesses underlie the need for collaboration and communication by all team members at all levels of the VE process.

Disciplinary Demographics Task Force

At MBC's October 2017 meeting physician member Howard Krauss, MD, reported to the Board on the activities of the Disciplinary Demographics Task Force. The Task Force was created in January 2017 with the release by the California Research Bureau (CRB) of a report entitled Demographics of Disciplinary Action by the Medical Board of California (2003–2013). MBC commissioned the CRB report after receiving complaints from members of the African-American

physician community and a formal request from the Golden State Medical Association, which complained over the course of multiple meetings that African-American physicians were being targeted or "profiled" by MBC's enforcement program, and have been disproportionately disciplined by MBC in relation to their population within the overall physician community and in comparison to other ethnic groups. In January 2017, CRB released its report, which found that Latino and African-American physicians were both more likely to be the subject of complaints and more likely to see those complaints escalate to investigations; additionally, Latino physicians were also more likely to see those investigations result in disciplinary outcomes. Despite the limitations of the study, MBC decided to create the Task Force to explore "implicit bias" training for all parties to MBC disciplinary proceedings. *[23:1 CRLR 49]*

At the MBC's October meeting, Dr. Krauss stated that since its last meeting, the Board finalized a contract with a vendor to provide implicit bias training and held training sessions in both northern and southern California. Board members and staff from MBC, HQIU, and HQE were invited to attend the training sessions. Dr. Krauss noted that most of the individuals required to attend the training did so. Dr. Krauss further explained that the training provided specific information about the Board's enforcement process as well as walked attendees through case studies to identify potential areas of implicit bias. Dr. Krauss stated that the Task Force recommends the training be repeated every two years.

Additionally, Dr. Krauss said the Task Force identified certain information that should be removed from the complaint, investigation, and prosecution process. Specifically, the Board should redact any information that could identify the medical school that the licensee attended or the location of postgraduate training. On September 25, 2017, MBC Executive Director Kirchmeyer sent a memo to HQIU and HQE regarding the policy change. Additionally,

Kirchmeyer spoke with the presiding judge of the Office of Administrative Hearings and will provide a written request asking that this information not be included in a proposed decision.

Physician Health and Wellness Program

At MBC's October 2017 meeting, Executive Director Kirchmeyer and staff counsel Kerrie Webb discussed draft regulations for the physician health and wellness program established under SB 1177 (Galgiani) (Chapter 591, Statutes of 2016). Sponsored by the California Medical Association (CMA), SB 1177 authorizes the Board to create and establish a "physician and surgeon health and wellness program" (PHP) to provide early identification of, and appropriate interventions to support, a physician in his/her rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety while maintaining the integrity of the medical profession. SB 1177 requires MBC to contract with a third-party vendor to administer the PHP, and it expressly requires the program to comply with the Uniform Standards developed by DCA pursuant to SB 1441 (Ridley-Thomas) (Chapter 548, Statutes of 2008). The contract between the Board and the outside entity must require the entity to provide MBC with detailed data and statistics sufficient to enable the Board to meaningfully oversee the program; further, and consistent with the Uniform Standards, the program must submit to periodic audits and inspections. *[23:1 CRLR 53]*

The draft regulations set forth detailed requirements for the vendor and require the vendor to adhere to the Uniform Standards, which are largely incorporated into the draft regulations. One provision of the regulations specifies that if the vendor imposes a practice restriction on a participant in the program, the vendor must notify MBC of that restriction and MBC will post it on the participant's profile on its website. Another provision requires the vendor to compile and submit to MBC, no less than quarterly, a long list of de-identified information about program

participation.

Yvonne Choong, representing CMA, expressed concern that the regulations do not sufficiently differentiate between individuals that have self-referred into the program and individuals who have been ordered by the Board to participate in the program as a condition of probation. CMA is concerned that restrictions imposed by the vendor will be posted on MBC's website; CMA believes that only the Board has the ability to place restrictions on a licensee that can be publicly disclosed, thus the practice restrictions placed on participants by the vendor should not be posted on the Board's website. Julianne D'Angelo Fellmeth of the Center for Public Interest Law (CPIL) responded by reminding the Board that SB 1177 (sponsored by CMA) specifically states that any program created under the bill must comply with the Uniform Standards, which do not differentiate between self-referrals and Board-ordered participants. She strongly recommended that the vendor be required to report timeframes for various significant events, such as the length of time it takes the vendor to detect a relapse and remove a participant from practice.

Executive Director Kirchmeyer explained that the Brown administration recently revised the rulemaking process. Now, agencies must submit draft regulations (including the notice, initial statement of reasons, fiscal impact, and text) to DCA for review and approval prior to submitting them to the Office of Administrative Law (OAL) for publication. Additionally, once DCA approves draft regulations, they must be submitted to and approved by the Business, Consumer Services, and Housing Agency. Once approved, the package will be filed with OAL and set for hearing. Kirchmeyer noted this process is anticipated to take about six months, so MBC will not be able to publish the draft regulations, conduct a 45-day comment period, and hold a public hearing until approximately October 2018.

Noting that suggested changes and/or additions to the draft regulations can be made during

the public comment period, the Board unanimously authorized staff to move forward with the regulatory process without making changes to the language of the draft regulations.

Cannabis for Medical Purposes

At MBC's October 2017 meeting, the Board discussed a draft document called *Guidelines for the Recommendation of Cannabis for Medical Purposes.* SB 643 (McGuire) (Chapter 713, Statutes of 2015) requires the Board to consult with the California Marijuana Research Program to develop guidelines for the appropriate administration and use of cannabis for medical purposes and, based upon this requirement, the Board established the Marijuana Task Force consisting of Howard Krauss, MD, and Kristina Lawson, JD.

The draft guidelines released by the Board are intended to provide physicians with guidance as they recommend cannabis for medical purposes, but are not regulations and "are not intended to mandate the standard of care." The guidelines clarify that any cannabis recommendation must be made within a physician-patient relationship by the patient's treating physician and on the basis of an "appropriate prior examination." The guidelines also encourage physician-patient discussion of the risks and benefits of the use of cannabis, and they include a "treatment agreement" that would facilitate such dialogue. Ms. Lawson noted that there is no requirement that physicians use the guidelines and, if a physician is brought before the Board for disciplinary reasons, the experts will look to whether the actions of the physician deviated from the standard of care in the community, not whether he/she deviated from the guidelines.

Ultimately, the Board unanimously approved the draft guidelines but deferred action on the "treatment agreement."

Detection of Overprescribing Physicians: CURES 2.0

On April 2, 2018, the Department of Justice (DOJ) certified the Controlled Substance Utilization Review and Evaluation System CURES 2.0 as ready to be used on a statewide basis. Under SB 482 (Lara) (Chapter 708, Statutes of 2016), all prescribers (with fairly significant exceptions) are required to consult CURES before issuing a prescription for Schedule II, III, or IV controlled substances to a patient for the first time (and at least once every four months thereafter if the substance remains part of the treatment of the patient). Under SB 482, the CURES consultation requirement becomes effective six months after DOJ certifies that the CURES database is ready for statewide use. Thus, beginning October 2, 2018, all prescribers are required to consult CURES as required by SB 482 (Lara). *[23:1 CRLR 45]*

MBC Rulemaking

On October 19, 2017, OAL approved MBC's amendments to sections 1364.10, 1364.11, 1364.13, and 1364.15, Title 16 of the CCR, to add licensed midwives and polysomnographic technologists, technicians, and trainees as licensees/registrants to whom the Board may issue citations with orders of abatement and fines when these allied health care professionals violate statutes or regulations referenced in section 1364.11. The Board originally noticed its proposed amendments in September 2016. These regulatory changes became effective on January 1, 2018.

LEGISLATION

SB 1448 (Hill), as amended April 9, 2018, would require physicians and licensees of several other health care boards to disclose to patients the fact that their license is on probation.

As to MBC, new Business and Professions Code section 2228.1 would require physicians—on and after July 1, 2019—to provide a probation disclosure to a patient, or the

patient's guardian, before the patient's first visit; the physician must obtain a signed disclosure from the patient. The disclosure must include the licensee's probation status, the length of probation and the probation end date, and all practice restrictions placed on the licensee by MBC, as well as MBC's telephone number and an explanation of how the patient can find further information on the licensee's probation status online. A physician whose license is on probation is exempt from the disclosure requirement if (1) the patient is unconscious or otherwise unable to comprehend the disclosure and sign a copy of it; (2) the visit occurs in an emergency room or urgent care facility, or the visit is unscheduled; (3) the physician who will be treating the patient is not known to the patient until immediately prior to the start of the visit; or (4) the physician does not have a direct treatment relationship with the patient.

New section 2228.1 would also require MBC to provide the following information in plain view on a probationer's profile page on its Internet website: (1) for probation pursuant to a stipulated settlement, the causes alleged in the accusation, along with a designation identifying those causes which the licensee has admitted; (2) for probation imposed by an adjudicated decision of the Board, the causes for probation stated in the final order; (3) for a licensee granted a probationary license, the causes by which the probationary license was imposed; (4) the length of the probation and end date; and (5) all practice restrictions imposed by the Board.

The language of SB 1448 is similar to language included in previous versions of MBC's 2017 sunset review bill, SB 798 (Hill) (Chapter 775, Statutes of 2017), but that language was removed prior to the bill's passage. However, SB 798 required patient notification only in specified types of cases, where SB 1448 would require notification by all physicians on probation.

SB 1448 would make California the first state to require doctors to notify their patients if their license is on probation. The author notes that hospitals and malpractice insurers are already

notified when a doctor's license is placed on probation, but patients are "left in the dark." According to a 2016 survey by *Consumer Reports*, 82% of Americans favor the idea of doctors having to tell patients they are on probation, and why. *[S. BP&ED]*

AB 2487 (McCarty), as introduced February 14, 2018, would amend section 2082 of the Business and Professions Code to require the Board's physician and surgeon application for licensure to require proof of completion of a course on the treatment and management of opiate-dependent patients that meets the requirements of the federal Comprehensive Addiction Recovery Act of 2016 (CARA); the course required for licensure must include at least eight hours of instruction in buprenorphine treatment of opioid use disorders. AB 2487 would also add new Business and Professions Code section 2190.6, which would require licensed physicians to complete a continuing medical education (CME) course on the treatment and management of opiate-dependent patients, unless the physician meets the requirements of a "qualifying physician" set forth in CARA; the CME course must include eight hours of instruction in buprenorphine treatment of opioid use disorders. *[A. Appr]*

SB 1109 (Bates), as amended April 4, 2018, would amend Business and Professions Code sections 2190.5, 2191, and 2196.2 to require an existing mandatory CME course for physicians licensed on or after January 1, 2019 to include the subject of the risks of addiction associated with the use of Schedule II drugs. SB 1109 would require the Board—in determining its CME requirements—to give its highest priority to considering a course in the risks of addiction associated with the use of Schedule II drugs, and would require the Board to periodically develop and disseminate information and educational material on the risks of addiction associated with the use of Schedule II drugs to physicians and general acute care hospitals. Finally, SB 1109 would state the intent of the Legislature to codify MBC's "Guidelines for Prescribing Controlled

Substances for Pain," as it relates to patient counseling, consent, and pain management agreements, and to ensure that health care providers and young athletes receive necessary education on this topic. *[S. BP&ED]*

AB 2741 (Burke), as amended April 2, 2018, would add Article 10.8 (commencing with section 745) to the Business and Professions Code, to prohibit a prescriber from prescribing more than a five-day supply of opioid medication to a minor unless the prescription is for a specified use. Additionally, AB 2741 would require the prescriber to take steps, such as discussing opioid risks and obtaining written consent, before prescribing opioid medication to a minor. AB 2741 would specifically impact MBC by requiring it to create—by January 1, 2020—a standardized consent form to be used when obtaining written consent. *[A. Health]*

AB 2760 (Wood), as amended April 3, 2018, would add Article 10.7 (commencing with section 740) to the Business and Professions Code, to require a prescriber to co-prescribe naloxone hydrochloride for patients taking opioid medication when certain conditions are present, and to provide education on overdose prevention to those patients and their households. The purpose of AB 2760, as stated by the author, is to help stem the rising number of drug overdose deaths in California by co-prescribing naloxone for patients at high risk of overdose. Naloxone is used in opioid overdoses to counteract life-threating depression of the central nervous system and respiratory system, allowing an overdosing person to breathe normally. *[A. Health]*

AB 2783 (O'Donnell), as amended April 11, 2018, would amend sections 11055 and 11056 of the Health and Safety Code, to reclassify specified hydrocodone combination products as Schedule II controlled substances. Existing law classifies specified compounds, including some hydrocodone compounds, as Schedule III controlled substances. According to the author of

AB 2783, the bill seeks to reconcile discrepancies between federal and state controlled substance schedules, which will make it less confusing for prescribers and dispensers. *[A. PubSafe]*

AB 1998 (Rodriguez), as amended April 11, 2018, would add section 11153.1 to the Health and Safety Code, to require—by June 1, 2019—that every health care practitioner authorized to prescribe Schedule II or III opioids adopt a safe prescribing protocol. AB 1998 would require that the protocol be a written document promoting the appropriate and optimal selection, dosage, and duration of opioid prescriptions for patients, with the goal of reducing the misuse of opioids. This bill does not mandate the standard of care in law, but it does require physicians to have a protocol for prescribing opioids. *[A. Health]*

AB 182 (Waldron), a two-year bill amended May 26, 2017, would add Article 5 (commencing with section 11774) to the Health and Safety Code, to require the California Department of Health to develop, coordinate, implement, and oversee a public awareness campaign, called the Heroin and Opioid Public Education (HOPE) Program, to combat the growing heroin and opioid epidemic. This bill would sunset the HOPE Program on January 1, 2023. MBC believes this bill will increase awareness and provide education to help prevent heroin use and opioid medication abuse, ultimately furthering the Board's mission of consumer protection. Thus, the Board supports AB 182. *[S. Appr]*

AB 1751 (Low), as introduced January 3, 2018, would amend section 11165 of the Health and Safety Code to allow the Department of Justice (DOJ) to enter into an agreement with an entity operating an interstate data sharing platform for the purpose of participating in interjurisdictional information sharing between prescription drug monitoring programs (PDMP) across state lines. Additionally, AB 1751 would require any agreement entered into by DOJ to comply with patient privacy and data security standards required for direct access to its CURES database, California's

PDMP. At its January 2018 meeting, the Board noted that CURES is a very important enforcement tool and an effective aid for physicians to use to prevent doctor-shopping by drug-seeking patients. The Board voted unanimously to support the bill. *[A. PubSafe]*

AB 1752 (Low), as amended April 5, 2018, would amend sections 11165 and 11165.1 of the Health and Safety Code to require that Schedule V controlled substances be added to the CURES database. Schedule V drugs are considered by the U.S. Drug Enforcement Administration to have "lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics." Importantly, the bill would also reduce the timeframe within which pharmacists and other dispensers must report the prescription of controlled substances to CURES from seven days to one working day. AB 1752 will not add Schedule V drugs to the section of law that requires physicians to check the CURES database. Therefore, adding Schedule V drugs to CURES will primarily impact dispensers, not prescribers. AB 1752 is sponsored by the Board of Pharmacy. *[A. PubSafe]*

AB 1753 (Low), as introduced January 3, 2018, would amend sections 11161.5, 11162.1, and 11165 of the Health and Safety Code to require DOJ—beginning January 1, 2020—to limit the number of approved security printers for controlled substance prescription pads to three. Additionally, AB 1753 would require prescription forms for controlled substance prescriptions to have a uniquely serialized number, enabling law enforcement to identify the circulation of prescriptions written on lost or stolen pads and ensuring that serialized pads are linked to CURES. *[A. PubSafe]*

AB 2086 (Gallagher), as amended April 3, 2018, would amend section 11165 of the Health and Safety Code, to allow a prescriber to access the CURES database for a list of patients for

whom that prescriber is listed as a prescriber. According to the author, physicians currently can only pull up individual patients to check that patient's prescription history in CURES. *[A. Appr]*

AB 1996 (Lackey), as amended April 5, 2018, would amend Business and Professions Code section 2525.1 to require MBC to consult with the California Cannabis Research Program on developing and adopting medical guidelines for the appropriate administration and use of medicinal cannabis. *[A. B&P]*

AB 1002 (Cooley), a two-year bill amended July 18, 2017, would amend section 2525.1 of the Business and Professions Code; as it relates to MBC, the bill is substantially similar to AB 1996 (Lackey) (see above) in that it would require MBC to consult with the California Cannabis Research Program on developing and adopting medical guidelines for the appropriate administration and use of medicinal cannabis. *[S. Appr]*

AB 710 (Wood), as amended April 2, 2018, is an urgency bill that would make legislative findings that "both children and adults with epilepsy are in desperate need of new treatment options and that CBD [cannabidiol] has shown potential as an effective treatment option. If federal laws prohibiting the prescription of medications composed of CBD are repealed or if an exception from the general prohibition is enacted permitting the prescription of drugs composed of CBD, patients should have rapid access to this treatment option." AB 710 would add section 26002 to the Business and Professions Code and add section 11150.2 to the Health and Safety Code to allow a physician, pharmacist, or other authorized healing arts licensee acting within their scope of practice to prescribe, furnish, or dispense cannabidiol if it is excluded from Schedule I of the federal Controlled Substances Act or if a product composed of cannabidiol is approved by the U.S. Food and Drug Administration (FDA). *[S. Rules]*

AB 1791 (Waldron and Gipson), as amended April 2, 2018, would add section 2191.4 to the Business and Professions Code, to require MBC—in determining its CME requirements—to consider including a course in integrating HIV/AIDS pre-exposure prophylaxis and post-exposure prophylaxis medication maintenance and counseling in primary care settings. Under existing law, physicians must complete at least 50 hours of approved CME during each two-year license renewal cycle. The Board has historically opposed bills mandating specified CME courses, but because this bill would not require a physician to take a particular CME course, Board staff suggested the Board take a neutral position on the bill. *[A. Appr]*

SB 944 (Hertzberg), as amended March 21, 2018, would amend section 1797.272 of and add Chapter 13 (commencing with section 1800) to the Health and Safety Code to create the Community Paramedicine Act of 2018, and would authorize a local emergency medical services (EMS) agency to develop a community paramedicine program to provide specified services with the approval of the state Emergency Medical Services Authority (EMSA). Under existing law, a paramedic is limited to providing care in emergency situations, during ambulance transport, and while working in a small or rural hospital. In 2014, 13 community paramedicine pilot projects began testing six concepts, and this bill would allow five of the original six concepts to continue. Specifically, SB 944 would allow community paramedic services to consist of the following program specialties: (1) providing short-term post-discharge follow-up for persons recently discharged from the hospital; (2) providing directly observed case management services to frequent EMS users; (3) providing directly observed therapy for tuberculosis, where the paramedic dispensed medications and observed patients taking them to assure effective treatment; (4) providing hospice services to treat patients in their homes; and (5) providing patients with transport to an alternate destination facility (such as a behavioral health facility or a sobering center). SB

944 would also establish a Community Paramedicine Oversight Committee (Oversight Committee) within EMSA to advise EMSA on, and approve minimum medical protocols for, the community paramedicine program specialties described above; and would require EMSA to develop, in consultation with the Oversight Committee, regulations that establish minimum standards for the development of a community paramedicine program. *[S. Health]*

AB 1795 (Gipson), as amended April 2, 2018, would amend and enact numerous provisions in the Health and Safety Code to authorize a local EMS agency to submit a plan to transport specified patients who meet triage criteria to a behavioral health facility or a sobering center in lieu of an acute care hospital. AB 1795 would authorize a city, county, or city and county to designate, and contract with, a sobering center to receive patients, and would establish sobering center standards. The author of this bill states that hospital emergency departments are not well equipped to serve patients who have mental health care needs or who are inebriated because these individuals require specialized care and access to supportive services. The author believes this bill will ensure that paramedics have the option to direct a person to a mental health urgent care or sobering center to receive appropriate care. *[A. Health]*

AB 2311 (Arambula), as introduced February 13, 2018, would amend section 2066.5 of Business and Professions Code to permanently authorize a clinical instruction program for certain international medical graduates (IMGs) at the David Geffen School of Medicine of the University of California at Los Angeles as part of an existing preresidency training program. Each participant in the program must graduate from a medical school recognized by MBC at the time of their selection. Section 2066.5 of the Business and Professions Code originally established this program as a pilot program in 2006. Since the passage of AB 1533 (Mitchell) (Chapter 109, Statutes of 2012), IMG participants have been providing hands-on clinical care. A December 2017, evaluation

of the program found that it helped match 112 IMGs into California family medicine residency programs and found that 87% of program alumni continue to work in underserved communities. *[A. Appr]*

AB 2539 (Mathis), as amended April 5, 2018, would revise several sections of the Health and Safety Code that establish the Steven M. Thompson Physician Corps Loan Repayment Program, which is funded in part by physician licensing fees, makes awards to physicians who agree to practice for three years in a medically underserved areas, and is administered by the Health Professions Education Foundation within the Office of Statewide Health Planning and Development (OSHPD). For new awardees between January 1, 2019 and January 1, 2021, the bill would modify the term "practice setting" to include clinics and physicians' offices in rural areas with at least 30% of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program; clinics and offices in non-rural areas must have 50% of patients in one of these categories. The bill would define the term "rural area" as a medical service study area with a population density of fewer than 250 persons per square mile and no population center in excess of 50,000 within the area, as determined by OSHPD. The author states that the purpose of this bill is "to give rural areas a greater chance to obtain the benefits of the Steven M. Thompson Loan Repayment Program, and as such to incentivize quality health care throughout disadvantaged regions." *[A. Appr]*

AB 2904 (Carrillo), as amended March 23, 2018, would amend section 2290.5 of the Business and Professions Code, to require a health care provider to document the consent of a patient to use telehealth (defined as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the

patient is at the originating site and the health care provider is at a distant site") in either printed or electronic form. *[A. Health]*

AB 505 (Caballero), as amended March 27, 2018, would add section 2227.1 to the Business and Professions Code to prohibit MBC from entering into any stipulation for disciplinary action if the stipulation places the licensee on probation for accusations of specific acts, including a felony conviction involving harm to patient safety or health; drug or alcohol abuse directly resulting in harm to patient safety or health; or sexual act with or sexual exploitation of a patient. This bill is sponsored by CMA, and is opposed by MBC. *[S. BP&ED]*

AB 2461 (Flora and Obernolte), as introduced February 14, 2018, would amend section 11105.2 of the Penal Code, to require DOJ to continually update authorized entities—including MBC—with information regarding new arrests and convictions of licensees who have their fingerprints on file with DOJ or the FBI. *[A. Appr]*

AB 2483 (Voepel), as amended April 9, 2018, is the latest legislative attempt to respond to the U.S. Supreme Court's 2015 decision in *North Carolina State Board of Dental Examiners v. FTC*, in which the Court held that a state regulatory board controlled by "active market participants" (licensees of that board) is not entitled to state action immunity from federal antitrust scrutiny for an anticompetitive act unless the act or decision is subject to "active state supervision" by a person or entity that is not controlled by licensees. This bill would require a public entity to pay for a judgment or settlement for treble damages antitrust awards against a member of any DCA regulatory board for an act or omission within the scope of his/her official capacity as a member of the regulatory board. As such, the state would simply indemnify any board member for antitrust liability for anticompetitive acts, rather than reconstituting boards to a non-licensee majority or establishing an "active state supervision" mechanism. *[A. Appr]*

AB 2682 (Burke), as introduced February 15, 2018, would amend section 2746.5 of the Business and Professions Code, to authorize a certified nurse-midwife to practice in a variety of settings without supervision by a physician, subject to certain situations requiring consultation or comanagement with, or referral or transfer to a physician. AB 2682 is co-sponsored by the California Nurse-Midwives Association, which states that "this bill will improve health outcomes for women and babies, increase access to high quality women's health care, and permit women to choose for themselves their preferred reproductive health providers." *[A. B&P]*

AB 2789 (Wood), as amended April 3, 2018, would add section 688 to the Business and Professions Code to require, by January 1, 2020, health care practitioners authorized to issue prescriptions have the capability to electronically transmit prescriptions and require pharmacies to have the capability to receive the electronic transmissions. By January 1, 2021, AB 2789 would require health care practitioners authorized to issue prescriptions to electronically transmit prescriptions, unless certain exemptions are met. The author of AB 2789 stated that in a study conducted at Johns Hopkins Medication Outpatient Pharmacy, 89% of handwritten prescriptions failed to meet best practice guidelines or were missing information that would have been prompted through an electronic prescription system. The Board's primary mission is consumer protection and the growing opioid abuse epidemic is a matter of concern for the Board. Board staff states that moving towards electronic prescriptions would help eliminate fraudulent prescriptions, but is concerned about physicians' access to technology. *[A. Appr]*

AB 2968 (Levine), as amended March 23, 2018, would amend section 337 of the Business and Professions Code, which requires DCA to develop an informational brochure for victims of psychotherapist-patient sexual contact and their advocates in consultation with the Office of Criminal Justice Planning and the Office of the Attorney General. AB 2968 revises the contents

of the brochure and provides that DCA may develop a revised brochure without consulting with the Office of Criminal Justice Planning and the Office of the Attorney General. The bill also amends section 728 to require that the brochure must be provided to each individual contacting MBC, the Osteopathic Medical Board of California, the Board of Psychology, or the Board of Behavioral Sciences regarding a complaint involving psychotherapist-client sexual behavior and sexual contact. *[A. B&P]*

SB 1163 (Galgiani), as amended April 3, 2018, would amend section 27521 of the Government Code to require a postmortem examination or autopsy on an unidentified body or human remains to be completed by an attending physician or the chief medical examiner who is a board-certified forensic pathologist. Existing law allows a postmortem examination or autopsy on an unidentified body to be conducted at the discretion of a coroner, medical examiner, or other agency of a coroner. Additionally, SB 1163 would require agencies tasked with specified exhumations to perform the exhumation under the direction of a board-certified forensic pathologist. *[S. PubSafe]*

SB 1238 (Roth), as amended April 9, 2018, would add section 123106 to the Health and Safety Code, to require health care providers to provide a statement to a patient at the time the initial patient medical record is created that sets forth the patient's rights to inspect and copy his/her medical records, and the retention period for the records. Additionally, SB 1238 would require a health care provider to notify a patient at his/her last known address at least 60 days before the provider destroys patient records and, if requested, the health care provider must provide the patient with his/her medical records that the provider plans to destroy. When providing the records to a patient, the provider may charge the patient for the actual cost of copying, mailing, or shipping of the patient's records. The Board receives many inquiries from consumer regarding medical

records and where to find them if their physician retires, moves away, or dies. Currently, no law requires a physician to notify patients before destroying their medical records or of the medical records retention schedule. Board staff believes requiring this notification will help consumers gain access to their medical records before they are destroyed. This will help ensure that their future physicians are well informed of their medical history. *[S. Jud]*

SB 1336 (Morrell), as amended April 2, 2018, would amend sections 443.19 and 443.22 of the Health and Safety Code, to require the annual End of Life Option Act report created by the Department of Public Health to include additional information regarding the area of practice of the physician who wrote the prescription for an aid-in-dying drug, the motivating reasons behind the patient's decision to request the aid-in-dying drug, and the number of patients who received a mental health assessment prior to receiving the aid-in-dying drug. Under amended section 443.22, MBC would need to update its existing forms to ensure that DPH is able to collect information in compliance with this bill. *[S. Health]*

SB 1495 (Hernandez), as amended April 10, 2018, would make noncontroversial changes to numerous sections of law pertaining to health care. Of import, the bill would clarify language in SB 512 (Hernandez) (Chapter 428, Statutes of 2017) which required health care practitioners to notify patients if they are providing stem cell therapies that have not been approved by the FDA. *[23:1 CRLR 65]* The intent of SB 512 was to curb abuses by "stem cell clinics" that were using unproven therapies. SB 1495 would specify that the stem cell therapies that require notice do not include therapies meeting the criteria of the sections 1271.10 and 1271.15, Title 21 of the Code of Federal Regulations, which are those that do not require FDA premarket review or clearance, but are still regulated by the FDA, or those that qualify for a specified exception. This bill would

ensure the notice requirement of SB 512 only applies to non-FDA approved, experimental therapies. *[S. Health]*

AB 2138 (Chiu and Low), as amended April 2, 2018, would amend various sections of the Business and Professions Code relating to professional licensure applicants with criminal records. Of note, the bill would limit the circumstances under which DCA boards may deny professional licensure to individuals who have previously been convicted of crimes; require DCA boards to develop criteria for determining whether a crime is directly and adversely related to the qualifications, functions, or duties of the business or profession a board regulates; develop procedures when requesting or taking disciplinary action based on an applicant's criminal history; and require boards to annually report specified de-identified information relating to Board action pertaining to applicants with criminal convictions, including the number of licensees who were affected, whether they provided evidence of rehabilitation or mitigation; whether they appealed; the final disposition; and the voluntarily provided information on race or gender of any applicant.

The bill is sponsored by a coalition of criminal justice advocacy groups who note that California has among the highest recidivism rates in the nation, and one of the root causes of the high recidivism is the inability of prior offenders to secure gainful employment upon reentry. According to the authors, "[a]ll too often, qualified people are denied occupational licenses or have licenses revoked or suspended on the basis of prior arrests or convictions, many of which are old, unrelated to the job, or have been judicially dismissed. Alleviating barriers to occupational licensing is just one way California can reduce recidivism and provide economic opportunity to all its residents." [*A. B&P*]

AB 2193 (Maienschein), as introduced February 12, 2018, would add section 685 to the Business and Professions Code, to require health care practitioners who treat or attend a mother or

child, or both, to screen the mother for maternal mental health conditions at least once during pregnancy and once during the postpartum period, unless the health care practitioner has received confirmation from a treating psychiatrist that she will remain under the treating psychiatrist's care during pregnancy and the postpartum period, as applicable. The health care practitioner shall, in a manner consistent with applicable federal privacy law, report the findings of that screening to the mother's primary care physician if the health care practitioner is not the mother's primary care physician. According to the author, one in five women will be affected by a maternal mental health disorder during pregnancy or within the first year of giving birth and no state or federal law regulates or mandates screening for maternal mental health disorders. AB 2193 would set the standard of care in statute. The bill would also amend the Insurance Code and the Health and Safety Code to require health insurers and health plans to cover the cost of the mental health screening. *[A. Health]*

AB 1790 (Salas and Fong), as amended April 3, 2018, would add sections 1233.6 and 1257.4 to the Health and Safety Code, to require primary health clinics and general acute care hospitals to develop, adopt, and implement policies regarding Coccidioidomycosis infections, commonly known as "Valley Fever," by January 1, 2020. Valley Fever is a lung infection caused by a fungus that lives in the soil. There are about 10,000 cases reported each year, mostly in California and bordering states. Valley Fever can be misdiagnosed because its symptoms are similar to those of other illnesses. According to the bill's authors, diagnosing and treating Valley Fever early and accurately can mean life or death for a patient. *[A. B&P]*

AB 2943 (Low), as amended March 23, 2018, would amend sections 1761 and 1770 of the Civil Code, to make sexual orientation change efforts an unlawful business practice under the state's Consumer Legal Remedies Act. The bill defines "sexual orientation change efforts" to mean

any practice that seeks to change an individual's sexual orientation. The bill would ban both the practice of sexual orientation change efforts and the advertising of such efforts. California banned sexual orientation change efforts for minors in 2012, when SB 1172 (Lieu) (Chapter 835, Statutes of 2012) became law, the first such law in the nation. Specifically, SB 1172—which has been upheld in multiple federal court challenges—prohibits a mental health provider, including physicians specializing in psychiatry, from conducting any sexual orientation change efforts involving an individual under the age of 18. *[A. Jud]*

AB 1659 (Low), as amended January 3, 2018, would amend sections 701, 702, and 703 of the Business and Professions Code, to prohibit an individual with an inactive license from representing that he/she has an active license. Additionally, amended section 703 would allow DCA boards to charge a licensee on inactive status a lower licensing fee. The author states that because inactive licensees do not receive the same benefits as active licensees, it is reasonable to charge a lower fee. An inactive license does not allow a person to practice, but does allow him/her to convert to an active license if desired. *[S. Rules]*

AB 1368 (Calderon), a two-year bill amended June 29, 2017, would add sections 124037 and 125186 to the Health and Safety Code, and add section 14133.91 to the Welfare and Institution Code, to authorize the Department of Health Care Services (DHCS) to allow a physician assistant (PA) or nurse practitioner (NP) to sign any authorization form required by DHCS for services. This bill would only allow PAs or NPs to sign off on authorization forms if their physician supervisor or standardized protocols have designated them to do so. This may prevent delays in access to care for patients and will not compromise consumer protection. *[S. Appr]*

LITIGATION

On March 5, 2018 in ***Selvidge v. Tang,*** 20 Cal. App. 5th 1279 (2018), the Third District Court of Appeal reversed the trial court's decision and held that plaintiff Selvidge took adequate steps to achieve actual notice of her intent to sue defendant Tang for medical malpractice by mailing her notice of intent to Tang's address of record on MBC's website.

On November 4, 2013, Vincent Selvidge died of a heart attack. After his death, his surviving wife and children ("Selvidge") sought to sue Sullyvan W. Tang ("Tang"), a physician who treated Mr. Selvidge, for medical malpractice. Selvidge filed her medical malpractice lawsuit on January 28, 2015, which is 85 days after the one-year statute of limitations to bring a medical malpractice claim expired. However, Selvidge claimed she was entitled to tolling of the statute of limitations period under Code of Civil Procedure (CCP) section 364 because she had provided Tang with notice of her intention to sue him for medical malpractice on October 24, 2014. Tolling the date would mean the statute of limitations would not expire until February 2, 2015, making her lawsuit timely. The legal assistant to Selvidge's attorney sent a letter informing Tang of her intent to file an action, but Tang claimed to never have received the letter. The legal assistant mailed the letter to the address of record that Tang provided to MBC and which was listed on MBC's website; that address was not Tang's residence but an address he used for billing purposes. The legal assistant declared that the letter was not returned as undeliverable, but she did not send the letter by certified mail or prepare proof of service.

The issue presented to the court was whether mailing a notice of intent to file an action to a physician's address of record with MBC, short of complying with CCP section 1013(a), provides adequate notification of a potential medical malpractice suit under the Medical Injury Compensation Reform Act (MICRA). The trial court granted Tang's motion for summary

judgment, finding that Tang did not have actual notice of Selvidge's intention to file an action because Selvidge did not comply with the mailing provision of section 1013(a). Selvidge appealed.

The Third District reversed the trial court's decision, relying heavily on its earlier decision in *Jones v. Catholic Healthcare West*, 147 Cal.App.4th 300 (2007):

> In *Jones*, the plaintiff communicated with the defendant through fax on multiple occasions and knew the defendant received documents transmitted to him via fax. Before the statute of limitations expired, the plaintiff faxed a notice of intent to the defendant but without first complying with the provisions set forth in section 1013. The defendant did actually receive the notice, yet moved for summary judgment arguing the plaintiff was required to effectuate service pursuant to section 1013. This court rejected that argument noting that the test under the Act was whether the plaintiff "took adequate steps to achieve actual notice." It then analyzed whether plaintiff's conduct met the notice requirement of the Act and ruled that "[o]nce [the plaintiff] determined that [the defendant] would actually receive the notice of intent to sue if transmitted by fax, there was no need for [the plaintiff] to comply with . . . section 1013 . . . ."

Selvidge, 20 Cal. App. 5th at 1284 [internal citations omitted]

The court found that the applicable test for whether proper notice was given under MICRA is "whether the plaintiff took adequate steps to achieve actual notice." While the court noted that one way to ensure adequate steps were taken to achieve actual notice is to follow the requirements of section 1013, it found that is not the only way, and notice was sufficient when sent directly from Selvidge to Tang at the address of record that he himself provided to MBC. The Third District cited to *Derderian v. Dietrick*, 56 Cal. App. 4th 892 (1997), for the proposition that any doubt as to where to mail a notice of intent "'may be resolved by resorting to the public record of the Medical Board of California . . . where physicians' current addresses are maintained in accordance with the law regulating medical doctors.'"

Thus, the appellate court found that because Selvidge mailed her notice of intent to file an action to the address Tang provided to MBC, she took adequate steps to achieve actual notice.

Accordingly, the statute of limitations to file a medical malpractice action was tolled for 90 days and Selvidge's suit filed on January 28, 2015 was timely. Dr. Tang has petitioned the California Supreme Court for review and/or depublication of the Third District's decision.

On January 8 in ***Medical Board of California v. Superior Court***, 19 Cal. App. 5th 1 (2018), the First District Court of Appeal held that Business and Professions Code section 492, which authorizes healing arts boards to take disciplinary action based on evidence in arrest records, trumps Penal Code section 1004.1, an earlier-enacted statute precluding such boards from taking disciplinary action based on information in arrest records if the defendant successfully completes a drug treatment program.

Police arrested Dr. Brandon Erdle ("Erdle"), the real party in interest, in September 2013 for possession of cocaine. Erdle entered, and successfully completed in January 2016, drug treatment under a deferred entry of judgment program authorized by Penal Code section 1000 *et seq*. In November 2014, after learning of Erdle's arrest, MBC interviewed him regarding the circumstances surrounding his arrest. During the interview, the MBC investigator referenced the police arrest report. On April 17, 2015, after the interview but before Erdle completed the drug treatment program, MBC filed an accusation against Erdle, alleging that his possession of cocaine was a violation of numerous drug laws and unprofessional conduct pursuant to Business and Professions Code sections 2227, 2234, and 2238.

At an August 2016 administrative hearing, Erdle argued that MBC could not discipline him because its action was based on information obtained from the police arrest report, which (he contended) is prohibited under Penal Code section 1000.4. Penal Code section 1000.4(a) generally provides that "[a] record pertaining to an arrest resulting in successful completion of a pretrial diversion program shall not, without the defendant's consent, be used in any way that could result

in the denial of any employment, benefit, license, or certificate . . . ." MBC countered by citing to Business and Professions Code section 492, a later-enacted statute stating: "Notwithstanding any other provision of law, successful completion of any diversion program under the Penal Code shall not prohibit any agency established under Division 2 (commencing with Section 500) of this code . . . from taking disciplinary action against a licensee or from denying a license for professional misconduct, notwithstanding that evidence of that misconduct may be recorded in a record pertaining to an arrest."

Following the conclusion of the evidentiary hearing, the ALJ first concluded that "section 492 permits discipline for underlying conduct even if the facts on which the agency relies are contained in an arrest report or other record pertaining to the arrest." However, the ALJ also determined, based on section 1000.4, that records pertaining to the arrest should not be introduced as evidence at the hearing, and that any portion of the Erdle's prior interview with MBC that directly referenced arrest records would be excluded. Instead, the ALJ required the allegations in the accusation be proven by other means, including through the direct testimony of the arresting officer. The ALJ determined that the officer would not be allowed to refresh his recollection with any arrest documents during the hearing, but did allow the officer to testify regardless of whether he refreshed his recollection with the police report prior to the hearing. At the close of the hearing, the ALJ found a cause for discipline did exist, that Erdle's license should be "public[ly] reproved," and that any subsequent reinstatement of his license should be on a probationary basis.

In October 2016, Erdle filed a petition for writ of administrative mandate in the Superior Court for the City and County of San Francisco, seeking to set aside the decision of the ALJ because, among other reasons, the ALJ improperly allowed into evidence information that should have been excluded pursuant to section 1000.4 by allowing the arresting officer to testify after he refreshed his recollection with the arrest report immediately before the evidentiary hearing. The

trial court granted Erdle's petition, holding that the ALJ violated section 1000.4 in admitting the police officer's testimony, stating:

> There is nothing in the record to indicate that the officer had a clear recollection of his arrest of [the doctor] independent of the arrest report. An officer can testify at a medical board hearing and that testimony can be the basis for discipline. But the officer cannot read the arrest report immediately prior to the hearing to refresh his recollection and then subsequently parrot that report. Such a process violates [section 1000.4].

In response to the superior court's holding, MBC filed a petition for extraordinary writ in the First District Court of Appeal, challenging the trial court's decision and requesting a stay. On May 5, 2017, the court issued a stay of the trial court proceedings pending further order. Applying basic principles of statutory interpretation, the appellate court held the ALJ did not err in admitting the testimony of the police officer in this case. Section 1000.4(a) provides that "[a] record pertaining to an arrest resulting in successful completion of a pretrial diversion program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate." However, a more recent and more specific statute, Business and Professions Code section 492, expressly states that "[n]otwithstanding any other provision of law, successful completion of any diversion program under the Penal Code . . . shall not prohibit any agency established under Division 2 (commencing with Section 500) of this code . . . from taking disciplinary action against a licensee or from denying a license for professional misconduct, notwithstanding that evidence of that misconduct may be recorded in a record pertaining to an arrest." The court found that the plain language of section 492 provides a blanket exemption from the restrictions on the use of arrest records contained in section 1000.4 for licensing decisions made by the healing arts agencies referenced in section 492, such as MBC. Thus, section 492 is an exception to the more general statute, section 1000.4.

On March 28, 2018, the California Supreme Court denied Dr. Erdle's petition to review the First District's decision.

RECENT MEETINGS

At its January 2018 meeting, MBC heard a presentation from Norlyn Asprec, Executive Director of the Health Professions Education Foundation (HPEF), a 501(c)(3) nonprofit organization housed within the Office of Statewide Health Planning and Development. HPEF administers six scholarship and seven educational loan repayment programs available to health professional students and graduates who are willing to provide medical and mental health services in underserved areas of California. Of import, HPEF administers the Steven M. Thompson Physician Corps Loan Repayment Program, which is funded in part by physician licensing fees and makes grants of up to $105,000 to physicians who agree to practice in medically underserved areas of the state for a three-year period. In past years, state law required two MBC members to serve on the HPEF board. That statute sunsetted but was resurrected in SB 798 (Hill) (Chapter 775, Statutes of 2017) with its amendment of Health and Safety Code section 128335. The Board appointed public members Katrina Lawson and Brenda Sutton-Wills to the HPEF board.

Also at MBC's January 2018 meeting, Executive Director Kirchmeyer introduced Carlos Villatoro as the Board's new Public Information Manager. Mr. Villatoro came to the Board in November 2017 from the California National Primate Research Center at University of California at Davis. Kirchmeyer also congratulated April Alameda, who became MBC's Chief of Licensing in December 2017. Ms. Alameda was promoted from Staff Services Manager II of the Board's licensing program, a position that she has held since March 2016. Prior to her role at MBC, Ms. Alameda was with the Department of Consumer Affairs.