RECENT MEETINGS
At its February 3 meeting in Burbank, the Board ratified a 3% salary increase for Executive Officer Jeanne Brode, retroactive to January 1, 1995. BLA also elected Sandra Gonzalez-Fiorenza as Board President; in anticipation of the arrival of two new members, the Board tabled the election of a Vice-President.

Also at the February 3 meeting, the Board voted to award full accreditation to UCLA Extension’s School of Landscape Architecture. The Board is currently evaluating the University of California at Berkeley’s Extension Program for Landscape Architecture.

At BLA’s May 12 meeting, Board President Sandra Gonzalez-Fiorenza announced that the Enforcement Committee had finalized the legal definition of a landscape architect for presentation at the Board’s July meeting; Gonzalez-Fiorenza confirmed that exemptions would be clearly defined under scope of practice, which will give the Board the “teeth” to pursue unlicensed activity.

FUTURE MEETINGS
July 14 in Irvine.
October 20 in Burbank.
December 8 in Sacramento.

CRITICAL REGULATORY LAW REPORTER
Volume 15, Number 2 & 3
Spring/Summer 1995

At its February 3 meeting, the Board adopted its proposed amendments to sections 2620, 2621, and 2649, Title 16 of the CCR, regarding licensing requirements and fees. BLA’s proposed amendments to section 2620 concern the amount and type of training, experience, and educational credits that qualify a person to sit for its landscape architect examination; the proposed changes to section 2621 would provide that a candidate will forfeit his/her examination fee if he/she fails to appear for the scheduled examination, unless he/she makes a showing of good cause within 90 days prior to the scheduled examination; and the proposed changes to section 2649 would increase the application fee for the examination from $325 to $425.

At this writing, DCA’s Legislative Unit is currently reviewing the rulemaking package, with the exception of the amendment to section 2649(a), which BLA severed from the package when CC/ASLA failed to submit a letter of support for the examination fee increase in a timely fashion.

The Medical Board of California (MBC) is an administrative agency within the state Department of Consumer Affairs (DCA). The Board, which consists of twelve physicians and seven public members appointed to four-year terms, 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 13 district offices throughout California.

The purposes of MBC and its divisions are to protect the consumer from incompetent, grossly negligent, unlicensed, 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. Assisted by the Board’s Committee on Affiliated Healing Arts Professions (CAHAP), DOL also oversees the regulation of dispensing opticians, lay midwives, research psychoanalysts, and medical assistants.

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. This responsibility includes enforcement of the disciplinary and criminal provisions of the Medical Practice Act. In this regard, DMQ 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 violators, and prosecutes the charges at an evidentiary hearing before an administrative law judge (ALJ). 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 of applicants.

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 also oversees 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.

MAJOR PROJECTS
Public Disclosure Regulations Clarified, Approved, Then Amended in Attempt to Settle Lawsuit. At its February 3 meeting, DMQ attempted to clarify the action it took after a November 1994 public hearing on proposed section 1354.5, Title 16 of the CCR, which would codify the Medical Board’s new public disclosure policy in regulation. The Board adopted its new policy in May 1993, and it became effective on October 1, 1993. State law requires MBC to adopt public disclosure regulations by July 1; however, the precise language of the regulations has been complicated by litigation filed by the California Medical Association (CMA) to invalidate the May 1993 policy (see LITIGATION). [15:1 CRLR 66; 14:1 CRLR 50; 13:4 CRLR 1, 56–57]

Under section 1354.5 as originally published, MBC planned to disclose to
inquiring consumers the following information regarding any physician licensed in California:

(a) current status of the license, issuance and expiration date of the license, medical school of graduation, and date of graduation;

(b) whether a disciplinary case has been referred to the Attorney General's Office for the filing of an accusation, temporary restraining order, or interim suspension order and, if so, the nature of the allegation and an appropriate disclaimer;

(c) any public document filed against the physician, including but not limited to accusations, decisions, temporary restraining orders, interim suspension orders, citations, and public letters of reprimand;

(d) medical malpractice judgments in excess of $30,000 reported to the Board on or after January 1, 1993, including the amount of the judgment, the court of jurisdiction, the case number, a brief summary of the circumstances as provided by the insurance company, and an appropriate disclaimer;

(e) discipline imposed by another state or the federal government reported to the Board on or after January 1, 1993, including the discipline imposed, the date of the discipline, the state where the discipline was imposed, and an appropriate disclaimer;

(f) California felony convictions reported to the Board on or after January 1, 1993, including the nature of the conviction, the date of conviction, the sentence (if known), the court of jurisdiction, and an appropriate disclaimer; and

(g) information regarding accusations filed and withdrawn.

At the November 1994 hearing, Center for Public Interest Law (CPL) Supervising Attorney Julie D'Angelo testified in support of the proposed regulations, but requested three amendments to enhance consumer protection. She suggested that (1) DMQ backlog felony convictions, medical malpractice judgments, and prior discipline dating from January 1991 (instead of 1993); (2) DMQ disclose all criminal convictions (not just felonies); and (3) DMQ disclose medical malpractice settlements in excess of $30,000 when a physician has settled more than two cases. [15:1 CRLR 67] DMQ rejected (2) and (3) above, but a transcript of the hearing indicates that DMQ agreed to disclose both medical malpractice judgments in excess of $30,000 and felony convictions dating back to 1991 (instead of 1993). However, the modified language of section 1354.5 released by MBC staff for a 15-day comment period indicated that medical malpractice judgments, felony convictions, and other-state discipline would be disclosed back to 1991.

At its February 3 meeting, DMQ discussed the issue and instructed staff to release another modified version of the regulations—this time, felony convictions and other-state discipline will be disclosed back to 1991; medical malpractice judgments in excess of $30,000 reported in 1993 or later will be disclosed, in spite of the fact that DMQ has been gathering this information by statute since January 1991. The full Board ratified DMQ's decision at its February 4 meeting.

Also at the November 4 hearing, DMQ decided to delete subsection (g) above, and to modify subsection (c) above to indicate that accusations which have been filed and later withdrawn shall be retained in the Board's files for a period of one year after the accusation was withdrawn. These amendments were not changed in February.

Following the February meeting, staff released the modified language for a comment period which ended on March 4. Thereafter, DMQ prepared the rulemaking file on the proposed public disclosure regulations and submitted it to the Office of Administrative Law (OAL) on April 18.

While the file was at OAL pending approval, the attorneys litigating California Medical Association v. Medical Board of California, CMA's case challenging the constitutionality of the Board's public disclosure policy, reached a tentative settlement in the case which called for amendments to the Board's policy regarding disclosure of fully investigated cases forwarded to the Attorney General's Office.

The draft settlement agreement, which was presented to the full Board at a closed session on May 12, obliged the Board to amend subsection (b) above to permit disclosure of limited information (specifically, only the name and statutory bases of the charges against the physician) about a fully investigated case, following referral to the Attorney General's Office but prior to the filing of an accusation, only in so-called "priority" cases which have been "accepted" by the Attorney General's Office. "Priority cases" include the following types of allegations: (1) cases alleging sexual misconduct with two or more patients; (2) cases alleging repeated acts of clearly excessive prescribing, dispensing, or furnishing of controlled substances; (3) cases alleging fraud involving five or more patients being treated under the workers' compensation law; (4) cases alleging drug or alcohol abuse by a physician and involving death or serious bodily injury to a patient; (5) cases alleging such an extreme departure from the standard of care and involving death or serious bodily injury to a patient that the physician presents a danger to the public; (6) cases alleging gross negligence and involving death or serious bodily injury to two or more patients; (7) cases alleging incompetence and involving death or serious bodily injury to a patient; or (8) cases in which the Attorney General's Office has decided to seek an interim suspension order or temporary restraining order to halt a physician's practice pending the conclusion of the disciplinary matter. The term "accepted" means that the Attorney General's Office has determined that no further investigation is necessary, that no referrals for non-prosecutorial action (such as referral to the Diversion Program) are to be made, and that an accusation will be filed.

The draft settlement agreement included other terms and conditions sought by CMA. For example, CMA demanded that the Board amend subsection (c) of its public disclosure regulations to specify that, if a filed accusation has been withdrawn for any reason, DMQ must offer the respondent physician a choice of (1) continued disclosure of both the accusation and the withdrawal, (2) disclosure of both the accusation and the withdrawal for a specified period of time, followed by termination of disclosure, or (3) immediate termination of disclosure. CMA also inserted an "enforcement rights" paragraph into the settlement enabling it to enjoin any "material breach" of the settlement agreement; for example, if in the future the Medical Board decides that it is in the public interest to amend its public disclosure regulations inconsistent with the language agreed to in the settlement agreement, the Board—by signing the draft settlement agreement—would be stipulating to an immediate preliminary injunction against the amended regulations. In other words, CMA would be given veto power over the Board's public disclosure regulations.

At its May 12 closed session, the Board approved most provisions of the draft settlement agreement. For example, it agreed to amend subsections (b) and (c) of its public disclosure regulations as described above. However, MBC expressly rejected the "enforcement rights" provision and instructed staff to return to the negotiating table to finalize the settlement. At this writing, MBC is expected to amend its public disclosure policy at its July meeting, and to formally amend its public disclosure regulations thereafter; it is unknown whether CMA will accept the settlement agreement absent the "enforcement rights" paragraph.

Federation Statistics Reveal MBC's Delay in Processing Disciplinary Cases. In its April Action Report newsletter, MBC revealed the results of a 1993 "self-
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examination" conducted by MBC and 38 other state medical boards based on a 300-question document known as the Self Assessment Instrument (SAI). The SAI was developed by a nationwide committee of board members and executives, under the guidance of the Federation of State Medical Boards. A consultant hired by the Federation compiled the results of SAIs completed by 39 state medical boards, and released them in late 1994.

MBC stands out as the largest board, with the largest number of licensees (over 100,000 active licenses), the largest number of staff (260, as compared with an average of 25), and the largest number of complaints received (over 9,000 annually, compared with an average of 850). However, MBC had the largest number of complaints per licensee (122.5 complaints per 1,000 licensees, more than twice the average of other states), took longer than any other state to process serious disciplinary cases [15:1 CRLR 62], and has one of the lowest ratios of formal disciplinary actions per number of licensees (3.46 formal disciplinary actions per 1,000 licensees).

Although MBC’s Diversion Program for substance-abusing physicians has extremely low participation in comparison to statistical estimates of the extent of the problem (200–240 participants in comparison to the 7,000–10,000 California physicians estimated to have a drug or alcohol problem [15:1 CRLR 63–64]), that participation rate is average compared to the other 38 states.

Also in the April Action Report, Board President Robert del Junco, MD, and Vice President Alan Shumacher, MD, announced a ten-point plan to address the deficiencies identified by the SAI. The plan includes the following goals: reduction of the time from complaint to adjudication by one-third over the next two years; adoption of a policy to prioritize cases for more efficient handling; evaluation of an increase in enforcement staff, funded by enhanced recovery of investigative costs from disciplined licensees (see below); and expedition of the time it takes DMQ to review a proposed disciplinary decision from the current 90 days to 30 days.

State Auditor Recommends Increased Cost Recovery Efforts. In March, the State Auditor released the results of an audit required by SB 916 (Presley) (Chapter 1267, Statutes of 1993). Under the statute, the Auditor was to perform an audit of MBC’s enforcement system by March 1, 1995, including an accounting of moneys spent by MBC on prosecutors from the Health Quality Enforcement Section (HQES) of the Attorney General’s Office and administrative law judges (ALJs) from the Office of Administrative Hearings (OAH); the statute also states that “[t]his review shall include an evaluation of the Attorney General’s Office in its performance of these services.” [13:4 CRLR 54–56] As a result of its review, BSA reached the following conclusions:

• MBC is not maximizing its efforts to recover the costs of its enforcement and disciplinary system. Effective January 1, 1993, Business and Professions Code section 125.3 gave MBC the authority to request ALJs to direct physicians found to have violated the Medical Practice Act to reimburse the Board for its reasonable costs of investigation and enforcement of their respective cases up to dates of their hearings; in addition, MBC is not precluded from recovering costs incurred for investigation and enforcement of cases resolved through stipulated settlements. During fiscal year 1993–94, MBC spent more than $25 million on enforcement and disciplinary efforts; of those costs, BSA determined that MBC could have attempted to recover more than $6.3 million. However, MBC recovered only $94,053 of its costs for that period.

• Prior to January 1, 1995, HQES and MBC had no way of knowing whether the Board was paying for necessary and reasonable services actually rendered by HQES on its behalf, because neither MBC nor HQES maintained a system to identify the type of activities HQES performed for MBC. Effective January 1, 1995, the Attorney General’s Office finally enhanced its Legal Time Reporting System in order to comply with SB 2038 (McCorquodale) (Chapter 1273, Statutes of 1994), which requires the AG to provide itemized statements of services rendered to agencies to which it provides legal representation. [14:4 CRLR 21]

• Finally, the Department of General Services’ OAH, whose ALJs preside over physician discipline hearings, overcharged MBC for services provided by hearing reporters and failed to reimburse the Board for the costs of some transcripts. As a result, BSA estimates that OAH owes MBC approximately $283,000. In addition, BSA determined that OAH also owes MBC an undetermined amount for the cost of transcripts and copies of transcripts ordered by third parties for appealed cases from January 1, 1991 through June 30, 1994.

BSA made the following recommendation to ensure that MBC maximizes its recovery of costs:

• MBC should be more aggressive in recovering disciplinary costs through stipulated settlements and as part of proposed disciplinary decisions rendered by ALJs.

• MBC should include in its recovery the costs of prosecuting cases, administering psychiatric examinations, and a portion of the administrative costs of its Diversion Program for substance-abusing physicians that represents the number of participants ordered to participate in the program as an alternative to other disciplinary action. The Board disagreed with BSA regarding recovery of costs from the diversion program; according to MBC, these costs should be evaluated on a case-by-case basis depending on a physician’s ability to pay.

• Finally, MBC should seek a change in the Business and Professions Code to allow the recovery of disciplinary costs incurred once the administrative hearing process begins.

BSA also recommended that the Attorney General require supervisors in each HQES office to review the number of hours and types of tasks for which attorneys and legal assistants are charging to assure MBC that the hours charged are reasonable and necessary. Also, MBC should develop its own procedure for reviewing invoices received from the Attorney General’s Office.

To avoid overcharging MBC in the future and to compensate the Board for past overcharges, BSA recommended that OAH compute the future hours worked by private court reporters in tenths of hours; recompute all hours worked by private court reporters since January 1993 using tenths of hours and reimburse MBC for the amount of the overcharges; reintegrate the practice of quarterly reimbursement of MBC for the amounts collected for transcripts ordered by third parties; review invoices received for transcripts ordered by third parties not involving appealed cases that were received from January 1, 1993 through January 31, 1995, and reimburse MBC for the total amount collected on its behalf; and review invoices received for transcripts of appealed cases ordered by third parties that were received from January 1, 1991 through June 30, 1994, and reimburse MBC for the amount OAH failed to collect from third parties as required by law.

Board Rejects Proposed Fee Increase to Add Investigators, Decrease Case Processing Delay. In spite of the goals set forth in Dr. del Junco’s ten-point plan to remedy the deficiencies identified in the Federation’s statistics (see above), the full Board at its May meeting rejected a proposed license fee increase which would be dedicated to increasing the number of DMQ investigative staff and decreasing the time it takes the Board to process serious physician discipline cases.

This is not a new problem for MBC. Prior to the release of the Federation’s statistics, this deficiency was brought to
the attention of the Board at its October 1994 retreat by DMQ Enforcement Chief John Lancara, who noted the recent significant increase in the number of complaints received and investigations conducted without any increase in DMQ investigative staff, and expressed the need for at least eight new investigator positions. Also at the October 1994 retreat, CPIL Supervising Attorney Julie D’Angelo displayed statistics indicating that it still takes the Board an average of 1,217 days (or 3.3 years) from receipt of a complaint containing serious patient harm allegations to final DMQ decision (specifically, 170 days at DMQ’s Central Complaint and Investigation Control Unit (CCICU), 285 days in investigations, 74 days with a medical expert in quality of care cases, at least 100 days at HQES prior to the filing of the accusation, 378 days at HQES after the filing of the accusation, 120 days with the OAH ALJ after submission, and 90 days for DMQ review of the ALJ’s proposed decision). Further, these figures do not include the time required for judicial review of DMQ’s decision where the disciplined physician appeals. D’Angelo argued that these case aging statistics have not changed significantly from the Board’s performance in 1989, and urged the Board to increase physician licensing fees to at least $400 per year to properly resource its enforcement program. [15:1 CRLR 61-62]

In a detailed May 2 memo to the Board, DMQ Enforcement Chief Lancara reiterated his position that “Medical Board field investigation staffing is inadequate.” He documented numerous non-staffing actions which he has taken to eliminate the lengthy case processing delay, but argued that “serious problems still exist which cannot be remedied without additional staffing resources.” Lancara noted that over the past two fiscal years, there has been a 23% increase in MBC complaint volume, with no commensurate increase in field sworn investigative staffing. Further, the complexity of the cases has increased, due in part to better screening out of marginal cases by CCICU. Experienced and trained investigators handling excessive caseloads become dissatisfied with the backlog and leave for other agencies, resulting in a chronic 10% vacancy rate in DMQ investigator positions—thus adding to the overall delay in case processing. These and several legal impediments led Lancara to request a license fee increase which would be dedicated to additional investigator positions.

Following Lancara’s presentation, the Board rejected any suggestion of a fee increase, and told Lancara to finance the needed positions with enhanced cost recovery, as suggested by the State Auditor (see above).

**Implementation of Medical Quality Task Force Report.** Following extensive debate at its July 1994 meeting, the Medical Board adopted a proposal of its Task Force on Medical Quality Review which accomplishes two long-time goals of the Board: (1) It establishes minimum qualifications for physicians who review quality of care disciplinary cases and provide expert testimony at disciplinary hearings, and those who will serve on volunteer “peer review panels” to assist DMQ in certain activities on the local level; and (2) it overhauls the Board’s system of providing in-house medical review of disciplinary investigations by its employee district medical consultants (DMCs) and its employment of a single, full-time Chief Medical Consultant. [15:1 CRLR 61-63; 14:2 & 3 CRLR 65-66]

At DMQ’s May 11 meeting, Committee on Medical Quality Chair Alan Shumacher, MD, noted that the target date for implementation of the new expert reviewer system is July 1 and reported on the steps recently taken to implement the Board’s decision. Dr. Shumacher noted that, as of May 8, over 1,000 physicians had responded to MBC solicitations for volunteers to become medical experts and peer review panel members.

First, DMQ reviewed an initial list of 218 individuals who meet the requirements adopted by the Board in its July 1994 decision. Those requirements include verifiable active practice, a “clean” license (defined as no prior discipline, no current accusation pending, and no complaints “closed with merit”), board certification in one of the 24 specialty boards certified by the American Board of Medical Specialties or equivalent qualifications, and a minimum of five years of post-residency experience in that specialty. DMQ approval means that these physicians are eligible to begin the training process and become expert reviewers for DMQ upon completion of training and signing an appointment agreement. Several physician members of DMQ expressed concern that none of the 218 individuals on the initial list are physicians whom they would consider experts in the specialty listed, and some began to question the criteria being used to select the appointees. In response, staff agreed to make an effort to market the program in a way that will reach and attract top physicians and surgeons.

DMQ also approved the training program assembled by the Committee on Medical Quality. The training will consist of a six-hour, “home-based” training program consisting of course materials in a reference binder for the expert reviewers. The answer sheet for the open-book examination will be collected at a two-hour in-person training session that will take place in MBC district offices and serve as the completion of the eight-hour training program. MBC district office supervisors, DMCs, and deputies attorney general (DAGs) will lead the two-hour session, which will consist of short presentations on the roles and responsibilities of experts, investigators, DMCs, and DAGs.

In order to make the transition even more smooth, DMQ approved an exception process during the implementation phase of the program. The Division approved a procedure through which a DMC may select an approved but untrained expert reviewer if the expert pool is low. When the reviewer pools expand to full size, MBC staff will cease using this exception. A second and even more temporary procedure will allow the use of applicants approved by the Committee but neither approved by DMQ nor trained as expert reviewers; this procedure will end in December 1995.

Also in May, DMQ rejected, by a 4-5 margin, a Committee recommendation to allow non-active status physicians to serve on peer review panels. The recommendation proposed to allow inactive physicians to provide counseling to local physicians, assist in probation monitoring, and provide public outreach. However, most DMQ members refused to remove the active practice requirement, stating that active practice status is a central element of the new program.

**Implementation of AB 595 (Speier): The Accreditation of Outpatient Surgery Settings.** At its May meeting, DOL held a public hearing on its proposal to adopt new Article 3.5 (sections 1313.2-1313.6). Title 16 of the CCR, to implement AB 595 (Speier) (Chapter 1276, Statutes of 1994). Commencing July 1, 1996, AB 595 prohibits physicians from performing surgery in an outpatient setting using specified anesthesia unless the setting is one of enumerated health care settings, including a setting accredited by an accreditation agency, unless that accreditation agency is approved by DOL; the bill requires DOL to adopt standards for the approval of accreditation agencies to perform accreditation of outpatient settings. [14:4 CRLR 69]

Currently, three agencies in California accredit outpatient settings: the Accreditation Association for Ambulatory Health Care, the Joint Commission on Accreditation of Health Care Organizations, and the American Association for the Accredita-
tion of Ambulatory Surgery Facilities. These agencies must now be approved by DOL under new Article 3.5. New section 1313.2 defines the terms "accredited" and "accreditation agency"; new section 1313.3 sets forth processing times for applications for DOL approval filed by accreditation agencies; new section 1313.4 requires accreditation agencies to meet the standards set forth in Health and Safety Code sections 1248.4 and 1248.15, and requires agencies to forward to DOL a copy of any certificates of accreditation issued within fourteen calendar days of issuance; new section 1313.5 addresses renewal of DOL approval; and new section 1313.6 sets forth the fees which DOL will charge.—2,000 for temporary approval as an accreditation agency, $5,000 for approval as an accreditation agency, and a renewal fee calculated at $100 per outpatient setting accredited or reaccredited during the three years immediately preceding the filing of the renewal application.

Following the public hearing, DOL adopted the proposed regulations subject to several modifications proposed by CMA and an additional 15-day comment period ending on June 3. Thereafter, staff will prepare the rulemaking file for submission to OAL.

Implementation of Lay Midwife Licensure Program. DOL is in the process of completing its implementation of SB 350 (Killea) (Chapter 1280, Statutes of 1993), which requires the Medical Board to establish a licensure program for lay midwives. [15:1 CRLR 64–65; 14:4 CRLR 66–67; 14:2&3 CRLR 68–69]

Under SB 350, there are two ways to obtain licensure as a lay midwife: (1) graduation from an accredited three-year midwifery program and successful completion of a comprehensive licensing examination, or (2) completion of an educational program in another state with equivalent standards, as determined by MBC, and licensure in that state. At its May 11 meeting, DOL declared that the standards of the midwifery educational program at Miami-Dade Community College in Florida are equivalent to California’s standards, such that midwives who complete that program may become licensed in California. Thus, DOL has now approved two educational programs under SB 350—those at Miami-Dade Community College and the Seattle School of Midwifery. California has no approved educational program.

Under the Killea bill, an applicant may be deemed to have "graduated" from an accredited program in two ways: (1) by actually completing a three-year program, or (2) through a "challenge" process whereby an approved midwifery program permits students to obtain credit by examination for previous midwifery education and clinical experience. Under Business and Professions Code section 2513, the challenge mechanism is tied to an approved midwifery education program, and its proficiency and practical examinations must be approved by DOL. At its May 11 meeting, DOL approved the "challenge" mechanisms proposed by Miami-Dade Community College and the Seattle School of Midwifery for California lay midwives.

SB 350 also requires DOL to adopt a series of regulations to implement the statute. The following is a status update on various DOL rulemaking proceedings related to the lay midwife licensure program:

- On April 26, OAL approved DOL’s adoption of new sections 1379.1, 1379.2, 1379.3, and 1379.5, Title 16 of the CCR; these rules set forth general provisions related to the lay midwife licensure program and establish license application ($300), biennial renewal ($200), and delinquency ($50) fees to support the program. [15:1 CRLR 65; 14:4 CRLR 67; 14:2&3 CRLR 69]
- In late May, DOL released a revised version of section 1379.10 (Application for Licensure as a Midwife) [14:4 CRLR 67] after withdrawing it from OAL, which recommended that the language be revised to incorporate by reference the actual application form for licensure as a lay midwife. Thereafter, DOL resubmitted section 1379.10 to OAL, where it is pending at this writing.
- Following a July 1994 hearing, DOL adopted a modified version of sections 1379.15, which would establish the minimum hours of clinical experience required for lay midwife licensure. The modified language of section 1379.15 would require the following minimum number of clinical experiences to be verified: 20 new antepartum visits, 75 return antepartum visits, 20 labor management experiences, 20 deliveries, 40 prenatal visits within the first five days after birth, 20 newborn assessments, and 40 postpartum/family planning/gynecology visits. Section 1379.15 also requires persons who apply for license as a midwife on or before December 31, 1997 to have obtained all of the verified clinical experiences within ten years immediately preceding the date of the application; persons who apply for license as a midwife on or after January 1, 1998 must have obtained at least 50% of the verified clinical experiences within five years immediately preceding the date of the application. [15:1 CRLR 65; 14:4 CRLR 67] At this writing, DOL has not yet submitted the rulemaking file on section 1379.15 to OAL for review and approval.
- At its November 1994 meeting, DOL approved the modified version of section 1379.20, which implements Business and Professions Code section 2508 by requiring midwives who do not carry liability insurance for the practice of midwifery to disclose that fact to clients not later than the time when the client relationship is established. The disclosure, whether verbal or written, must be noted and dated by the midwife in each client’s file. [15:1 CRLR 65] However, at this writing, DOL has not yet submitted the rulemaking file on section 1379.20 to OAL for review and approval.
- At its November 1994 meeting, DOL held a public hearing on proposed sections 1379.11 and 1379.21, Title 16 of the CCR. Following the hearing, DOL adopted section 1379.11, which sets forth the processing times for applications for licensure as a lay midwife, without change.
- In response to comments by District IX of the American College of Obstetricians and Gynecologists (ACOG), DOL modified the language of section 1379.21, which would establish guidelines for physician supervision of midwives. Based on ACOG’s comments, DOL modified section 1379.21 to provide that the supervising physician and the licensed midwife must (a) communicate the care of pregnant women and newborns and in accordance with the guidelines described in (b) and (c); (b) require periodic review and evaluation of the physician and the midwife; and (c) require periodic review and evaluation of the midwife’s practice and their outcomes. The modified language also requires the supervising physician to retain in his/her files a copy of any practice guidelines which the physician has approved for a period of at least five years after termination of a supervisory relationship with a midwife.

The Division released the modified language of section 1379.21 for a 15-day comment period in December 1994 [15:1 CRLR 65]; however, at this writing, DOL has not yet submitted the rulemaking file on sections 1379.11 and 1379.21 to OAL for review and approval.
- At its February 3 meeting, DOL held a public hearing on its proposed adoption of new section 1379.22, which would re-
quire physicians who supervise licensed lay midwives to have hospital privileges in obstetrics and to be “located in reasonable proximity, in geography or time, to the client whose care the physician will assume should complications arise.”[15:1 CRLR 65] Following the hearing, the Division adopted the proposal. At this writing, the rulemaking file on the proposed section has not yet been submitted to OAL.

Other MBC Rulemaking. The following is a status update on other rulemaking proceedings by MBC’s divisions reported in detail in previous issues of the Reporter:  

• Performance of Ophthalmic Tasks by Medical Assistants. On February 3, DOL held a public hearing on a controversial proposal to amend section 1366, Title 16 of the CCR, which defines the technical supportive services which may be performed by unlicensed medical assistants (MAs), to permit MAs to “perform ophthalmic testing not requiring interpretation in order to obtain test results, including (for example) but not limited to, the operation of automated objective ophthalmic testing equipment, color vision and depth perception.” As published, the language precludes MAs from performing “subjective refractions or any other procedure requiring the exercise of any judgment or interpretation of the data obtained on the part of the operator.”[15:1 CRLR 65–66] Following numerous comments, DOL tabled the proposal and postponed a decision until its May meeting.

On March 17, DOL republished its proposed amendments for a public hearing on May 11. This time, DOL proposed to amend section 1366 to permit MAs to perform ophthalmic testing which does not require interpretation in order to obtain test results. The proposed amendments would also delete existing subsection 1366(d) (which prohibits MAs from practicing optometry) as duplicative of existing law, and add a specific reference to Business and Professions Code section 2069 (which prohibits MAs from administering any local anesthetic agents). (In the meantime, DOL is sponsoring AB 1471 [Friedman] to repeal this prohibition; see LEGISLATION.) Following the May 11 hearing, DOL adopted the proposed changes; at this writing, staff is preparing the rulemaking file for submission to OAL.

• Performance of Physical Therapy by Medical Assistants. Also on May 11, DOL held a public hearing on another proposed change to its MA regulations—this time, the Division proposed to repeal subsection 1366(e), which states that “[n]othing in these regulations shall be construed to authorize a medical assistant to practice physical therapy.” According to DOL’s notice of proposed rulemaking, the Division seeks to repeal the subsection because the prohibition on the unlicensed practice of physical therapy is already contained in section 2630 of the Business and Professions Code. However, comments at the public hearing revealed that the actual impetus for the proposed regulatory change is a turf battle between physicians and physical therapists over who may practice physical therapy. Physical therapists contend that only a licensed physical therapist may perform physical therapy and supervise a physical therapy assistant; however, physicians contend that they are fully authorized to perform tasks classified as “physical therapy” and to supervised licensed and unlicensed personnel in the performance of those tasks.

Following the hearing, DOL adopted the proposed repeal of section 1366(e), thus indirectly authorizing physicians who supervise MAs to train and supervise them in the performance of physical therapy tasks. At this writing, staff is preparing the rulemaking file for submission to OAL.

• Public Letter of Reprimand. On March 2, OAL approved DMQ’s adoption of new sections 1364.20 and 1364.21, Title 16 of the CCR, which implement its “public letter of reprimand” authority in Business and Professions Code section 2233. The regulations authorize specified DMQ officials to issue, following an investigation, a public letter of reprimand in lieu of filing or prosecuting a formal accusation for minor unprofessional conduct violations. The letter must describe the nature and facts of the violation and be served upon the licensee by certified mail. Prior to formal service of the reprimand, DMQ must notify the physician of its intent to issue the letter; within 30 days, the licensee must indicate to DMQ in writing whether he/she will accept the letter. If the physician accepts, the letter will be served and its issuance shall be disclosed to members of the public who inquire about that physician’s record. If the physician refuses to accept, DMQ is free to file and prosecute an accusation or evaluate the propriety of other sanctions, such as a citation and fine.[14:4 CRLR 67; 14:2&3 CRLR 65]

• Contact Lens Notices. On May 17, OAL approved DOL’s adoption of new section 1399.233, Title 16 of the CCR, which requires registered contact lens dispensers to ensure that a written statement is enclosed with each contact lens container which directs the person named in the contact lens prescription to return to the prescribing physician or optometrist for an evaluation.[14:2&3 CRLR 74; 14:1 CRLR 55–56]

Quality of Care in a Managed Care Environment. Recently, the Board created a Committee on the Quality of Care in a Managed Care Environment, chaired by DMQ member Carole Hurvitz, MD. The Committee held an informational session on April 18 in Los Angeles, at which Dr. Hurvitz identified delayed care and denied care as system problems within the managed care environment. The Committee reviewed CMA’s managed care handbook, which gives advice to physicians about contracts with managed care organizations, malpractice liabilities, medical records, utilization review denials, and appeals of denials on behalf of patients. The Committee further formulated its mission statement: “The Medical Board of California has a mandate to develop standards under which managed care organizations are operated and a duty to protect the consumer in the managed care environment.”

At its May 12 meeting, the full Board discussed its realistic expectations concerning its role in managed care. Public member Ray Mallett stated that MBC is limited to licensing and regulating physicians, and noted that managed care organizations are regulated by the Department of Corporations (DOC). The Board resolved to work closely with DOC and the Department of Insurance to deal with quality of care issues that go beyond individual physicians.

Telemedicine. At its May meeting, the Board discussed the emerging phenomenon of “telemedicine”—the use of broadband communications technology to transmit and receive medical images (such as radiological or pathological images) and from remote locations. It also includes the transmission of physician-to-patient images, sound, and diagnostic readings. The forecasted benefits of telemedicine are better access to health care for populations with limited access under current delivery systems, more rapid access to specialized care, lower patient care cost, better quality control, and continuing “hands on” medical training of remote primary care practitioners.

However, telemedicine presents legal and practical issues. The primary legal issue appears to be individual state physician licensing laws which impede physicians from practicing in other states (either personally or via telemedicine); the apparent solution—federal or national licensure of physicians—is slowly emerging but is being questioned and challenged by
vidual state licensing boards (and the Federation of State Medical Boards) whose existence may be threatened by national licensure. Other legal issues which must be resolved concern medical records confidentiality and malpractice liability (due to telemedicine use or lack of use).

A major practical impediment to telemedicine is the initial cost of implementation. Although telemedicine applications may save money in transportation costs in the long run and aid in rural physician education, the issue boils down to who will pay for the transmission and equipment costs. Insurance reimbursement is a critical unresolved issue.

The Board decided to sponsor a conference on the various issues presented by telemedicine in the fall; at this writing, the conference is scheduled for September 28–29 in Sacramento.

REGULATORY AGENCY ACTION

LEGISLATION

SB 609 (Rosenthal) is DMQ’s omnibus bill containing many legislative changes relating to the Medical Board’s physician discipline system. [15:1 CRLR 67] As amended April 6, SB 609 would (among other things) make the following changes:

- Amend Business and Professions Code section 125.9 to increase the maximum fine which may be assessed by DMQ for fraudulent billing to $2,500 per violation or count (instead of $2,500 per inspection or investigation);
- Add new provisions requiring a physician to report to MBC the conviction of any felony or the bringing of an indictment or information charging a felony against him/her; requiring a defendant physician to report in writing to the court clerk that he/she is a licensed physician; and requiring prosecutors to notify court clerks that a defendant is a licensed physician;
- Require malpractice insurers to send a complete report to MBC regarding judgments against a physician in excess of $30,000 within certain time limits, and require insurers to provide copies of certain records and documents with the required report subject to reasonable costs to be paid by MBC;
- Require the Board to provide legal representation to key lay witnesses, such as cooperating ex-office employees of an accused physician or patients complaining of sexual misconduct, who become defendants in retaliatory lawsuits filed by the accused physician and intended to intimidate the witness;
- Authorize civil penalties to be assessed against health care facilities for failure to provide requested medical records to MBC under certain circumstances; and
- Include counties and other public entities within those employers of physicians which must report malpractice judgments and settlements or arbitration awards to MBC. [A. Health]

SB 609 fails to include one important legislative change approved by MBC at its November 1994 meeting: an amendment to section 805 to permit the Board to disclose certain adverse peer review actions reported by health care facilities to MBC. [15:1 CRLR 59–61] Neither Senator Rosen- thal nor any other legislator desired to tackle that amendment this year.

AB 1471 (Friedman) is DMQ’s omnibus bill containing many legislative changes relating to the Medical Board’s licensing program. [15:1 CRLR 67] As amended April 18, AB 1471 would (among other things) make the following changes:

- Require MBC to charge each applicant who is required to take the oral examination as a condition of licensure a fee equal to the amount necessary to recover the actual cost of that exam;
- Authorize DOL to prepare and mail to every licensee a questionnaire containing any questions necessary to establish that the licensee is in compliance with its licensing provisions;
- Provide that nothing in Business and Professions Code section 2069 authorizes the administration of local anesthetic agents, except topical anesthetic agents, by a medical assistant (see MAJOR PROJECTS);
- Revise the requirements and procedures in section 2111 under which foreign physicians engaged in postgraduate training in an approved medical school may be granted permission to engage in the limited practice of medicine; and
- Eliminate obsolete references to the Division of Allied Health Professions, which was abolished in SB 916 (Presley) (Chapter 1267, Statutes of 1993). [A. Floor]

AB 1471 does not include DOL’s proposal to increase the Board’s postgraduate training requirement for full physician licensure for graduates of unapproved medical schools from one year to two years. DOL has been trying to make this change for at least five years. [15:1 CRLR 65; 12:1 CRLR 72; 10:2A3 CRLR 99] Neither Assemblymember Friedman nor any other legislator agreed to carry that legislation.

AB 1974 (Friedman). Business and Professions Code section 805 requires the chief of the medical staff or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic to file a report with MBC in certain situations, including, but not limited to, when a physician has been denied staff privileges or membership, or had his/her membership, staff privileges, or employment terminated, revoked, or restricted, for a medical disciplinary cause or reason. As amended May 15, this bill would require DMQ to investigate the underlying circumstances of any report received pursuant to those provisions within thirty days.

Existing law provides for the establishment by DMQ of Diversion Evaluation Committees (DECs), and specifies the duties of those committees. This bill would require peer review bodies that review physicians to report certain information regarding investigations of physicians who may be suffering from a disabling mental or physical condition, within fifteen days of initiating an investigation, to MBC’s Diversion Program for referral to the appropriate DEC. This bill would require the DEC to monitor the peer review body’s investigation and to notify DMQ’s chief of enforcement of the investigation in certain circumstances. [A. Appr]

SB 779 (Lewis), as amended April 17, is an MBC-sponsored bill to legislatively repeal judicial language in Kees v. Board of Medical Quality Assurance, 7 Cal. App. 4th 1801 (1992), [15:1 CRLR 63–64] The Kees decision states that physicians formally admitted into MBC’s Diversion Program for substance-abusing licensees are immune from any MBC prosecution or investigation. This bill would clarify that immunity will be granted only for violations of the Medical Practice Act which are based primarily on the self-administration of drugs or alcohol under Business and Professions Code section 2239, or the illegal possession, prescription, or non-violent procurement of drugs for self-administration, and which do not involve actual harm to the public or his/her patients. This bill would also establish additional procedures relating to participation in the Diversion Program and the further investigation and discipline of a physician who is in the Program. [A. Health]

AB 281 (Kuehl), as amended April 25, would change the composition of MBC by requiring that it consist in majority of public members. It would prohibit any public member appointed to the Board from having any financial interest in the medical profession, and would require at least two of the nonpublic board members to be persons who serve a substantial number of low-income patients in their practice of medicine. [A. Floor]

SB 454 (Russell), as amended April 18, is a CMA-sponsored bill which would
require every health care service plan (HCSP) to include in its contracts with physician providers a dispute resolution system under which providers may submit their grievances to the plan; existing law only requires HCSPs, which are regulated by the Department of Corporations (DOC), to maintain a grievance system under which enrollees/patients may submit a grievance to the plan.

SB 454 would also allow subscribers and enrollees, and their agents, to submit a grievance to DOC for review after either completing the grievance process or participating in the process for at least 60 days. If a case is determined by DOC to involve an imminent threat to the patient, the 60-day requirement will be waived. This bill also requires HCSPs to notify enrollees or subscribers of this right. Among other things, this bill would also allow a provider to join with, or otherwise assist, a subscriber in filing a complaint, including the grievance or complaint to DOC and to assist with DOC’s grievance process. [S. Appr]

AB 1147 (Friedman). Existing law prohibits the for-profit referral of a person to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition; the presumption of a for-profit referral is created when the person or organization making the referral imposes a fee or charge for the referral. As introduced February 23, this bill would specifically prohibit the for-profit referral of a person for diagnostic imaging services, as defined, and create the presumption of a for-profit referral when the person or organization making the referral imposes a fee or charge for the referral, including the making of any additional or mark-up charges to charges made by licensed health care professionals. [A. Appr]

SB 682 (Peace). Existing law requires MBC, the State Bar, and the Board of Chiropractic Examiners to each designate employees to investigate and report to the Department of Insurance’s Bureau of Fraudulent Claims any possible fraudulent activities relating to motor vehicle or disability insurance by licensees of the boards or the Bar. As introduced February 22, this bill would require, in addition, that those entities investigate and report any possible fraudulent activities relating to workers’ compensation. [A. Ins]

SB 890 (Leslie). Existing law authorizes DMQ to investigate the circumstances of practice of any physician where there have been any judgments, settlements, or arbitration awards requiring the physician or his/her liability insurer to pay damages of $30,000 or more. As introduced February 23, this bill would also authorize MBC to investigate the practice of any physician where his/her employer was required to pay those damages. [A. Health]

AB 1310 (Mazzoni) and AB 1080 (Martinez). Existing law authorizes an individual of sound mind and eighteen or more years of age to execute a declaration governing the withholding or withdrawal of life-sustaining treatment; existing law also authorizes an individual to appoint an attorney in fact to make health care decisions for that individual in the event of his/her incapacity pursuant to a durable power of attorney for health care. As introduced February 23, these bills would enact the Death with Dignity Act, which would authorize an adult who meets certain qualifications, and who has been determined by his/her attending physician to be suffering from a terminal disease, to make a request for medication for the purpose of ending his/her life in a humane and dignified manner. The bills would establish procedures for making these requests, and would further provide that no provision in a contract, will, or other agreement shall be valid to the extent it would affect whether a person may make or rescind a request for medication for the purpose of ending his/her life in a humane and dignified manner; prohibit the sale, procurement, or issuance of any life, health, or accident insurance or annuity policy, or the rate charged for any policy, from being conditioned upon or affected by the request; require that nothing in them be construed to authorize ending a patient’s life by lethal injection, mercy killing, or active euthanasia, and provide that action taken in accordance with the Act shall not constitute suicide or homicide; provide immunity from civil or criminal liability or professional disciplinary action for participating in good faith compliance with the Act; and provide that willful alteration or forgery of a request with certain intent, and coercion or exertion of undue influence on a patient to make a request, are felonies. [A. Jud; A. Jud]

SB 1119 (Watson), as amended May 15, would provide that if a licensed psychiatrist, psychologist, marriage, family, and child counselor, or clinical social worker is appointed as an expert witness by a court in a matter relating to child custody or child welfare, no court-directed activity by that person within the scope of that appointment may be the subject of any disciplinary investigation or action by his/her licensing body. This bill would provide that it shall not be construed to apply to willful acts of unprofessional conduct by an appointed expert witness. [S. Jud]

AB 596 (Knight). Existing law exempts a physician from civil damages as a result of certain acts or omissions of the physician who in good faith renders emergency care at the scene of an emergency, emergency ob-scterial services, emergency medical care at the request of another physician, or gives emergency instructions to paramedics. As introduced February 17, this bill would, in addition, exempt a physician, who in good faith and without compensation or consideration renders voluntary medical services at a privately operated shelter, as defined, from liability for any injury or death caused by an act or omission of the physician in rendering the medical services, as defined, when that act or omission does not constitute gross negligence, recklessness, or willful misconduct, and if certain conditions are met. [A. Jud]

AB 869 (Katz). The Medical Practice Act requires all applicants for a physician’s certification to take an examination, and requires DOL to keep the examination records on file for a period of at least two years. As introduced February 22, this bill would instead require DOL to keep the examination records on file for a period of at least three years. [A. Health]

AB 1107 (Campbell). Under existing law, the right to sell or furnish prescription lenses is limited exclusively to licensed physicians, optometrists, and registered dispensing opticians. As amended May 15, this bill would, notwithstanding that limitation, authorize a pharmacist to dis-pense replacement contact lenses, as defined in accordance with certain requirements. [A. Appr]

SB 497 (Maddy). AB 595 (Speier) (Chapter 1276, Statutes of 1994) prohibits an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient setting, as defined, unless the setting is one of certain enumerated settings including an outpatient setting that is accredited by an accreditation agency, as defined, that has been approved by DOL (see MAJOR PROJECTS). Under AB 595, DOL is required to ensure that accreditation agencies include prescribed standards for outpatient settings in their certification programs. Existing law authorizes outpatient settings that have multiple service locations to have all service sites surveyed or a sample of sites surveyed for purposes of accreditation. As amended March 30, this bill would clarify those provisions govern-ning accreditation of outpatient settings with multiple service locations.

This bill would, as an alternative to an outpatient setting obtaining accreditation by an accreditation agency, establish procedures for certification by DOL of an
outpatient setting that is operated by an integrated health care delivery system, as defined. The bill would establish certain certification requirements and would require DOL to develop a certification form designed to ascertain whether an outpatient setting meets these requirements. The bill would exempt outpatient settings that are certified by DOL in accordance with these procedures from the prohibition under existing law against operating, managing, conducting, or maintaining an outpatient setting. [A. Health]

SB 640 (Craven). Existing law provides for the examination and licensure of spectacle lens and contact lens dispensers, and prohibits a person from fitting or adjusting contact lenses without being registered or working under the direct responsibility and supervision of a registered contact lens dispenser who is present on the registered premises. As amended May 2, this bill would prohibit, commencing January 1, 1997, any person located outside of California from shipping, mailing, or delivering contact lenses to residents of California unless registered with DOL. [115:1 CRLR 68] The bill would require the nonresident contact lens seller to complete an application, pay prescribed licensure and renewal fees, and satisfy various conditions in order to obtain and maintain registration. The bill would provide that contact lenses may be dispensed only within one year of the date on the written prescription, and if the written prescription is unavailable to the seller, it would require the seller to directly communicate with the prescriber to confirm the prescription. The bill would also set forth circumstances under which registration may be denied, suspended, or revoked, and would establish procedures for renewal of registration. It would authorize DOL to adopt regulations necessary to administer these provisions. [A. Health]

AB 1864 (Morrow). The Physician Ownership and Referral Act of 1993 prohibits a licensee (defined to include physicians) from referring a person for certain health care services if the licensee has a financial interest, as defined, with the person, or entity, that receives the referral. Existing law exempts from this prohibition a licensee or a payer to the extent the licensee or payer is subject to similar prohibitions on referrals for health care services paid pursuant to the provisions governing workers' compensation. As amended May 4, this bill would make a clarifying change by revising this exemption to instead exempt referrals that are subject to the similar prohibitions on referrals for services covered pursuant to the law governing workers' compensation. Existing law also exempts from this referral prohibition referrals where there is no alternative provider, or referrals when the person referring has certain ownership interests in the entity to which the referral is being made. This bill would revise, clarify, and broaden these exemptions and would provide that the referral prohibition does not apply in certain instances involving pathological examination services, diagnostic radiology services, and radiation therapy. [S. B&P]

AB 1727 (Bustamante). Existing law requires MBC to maintain a central file that includes information about each of its licensees regarding any conviction of a crime that constitutes unprofessional conduct, any judgment or settlement of a claim that injury or death was proximately caused by the licensee's negligence, error, or omission, public complaints, and disciplinary information. As introduced February 24, this bill would require MBC to annually prepare and issue a report to inform the public of all awards of $50,000 or more based on judgments against a licensee for acts of medical malpractice. [A. Health]

SB 1166 (Mountjoy). The Therapeutic Abortion Act requires the Department of Health Services (DHS) to, by regulation, establish and maintain a system for the reporting of therapeutic abortions, as prescribed, and requires DHS to report to the legislature each even-numbered year its findings related to therapeutic abortions and their effects. As introduced February 24, this bill would repeal the above-described provisions, and instead would require a report of each abortion performed to be made to DHS on forms prescribed by it. The report, in the case of an abortion performed in a licensed facility, would be required to be completed by the general acute care hospital, clinic, or other licensed facility, signed by the physician who performed the abortion, and transmitted to DHS. The report would be required to be completed and signed by the physician in the case of an abortion not performed in a licensed facility. The bill also would require a representative sample of tissue removed at the time of abortion to be submitted to a board eligible or certified pathologist, who would be required to file a copy of the tissue report with DHS and provide a copy to the facility where the abortion was performed or induced. The bill would require DHS to prescribe a form on which pathologists would be required to report to DHS and to the physician any absence of pregnancy, live birth, or viability.

The bill would require DHS to prepare an annual statistical report for the legislature based on the data gathered pursuant to the above-described provisions and based upon required reports of maternal deaths, and would provide that any person who willfully discloses any information obtained from the reports, except as otherwise authorized by law, is guilty of a misdemeanor.

This bill would require every facility in which an abortion is performed during any quarter year to file with DHS a report regarding the total number of abortions performed. The bill would require DHS, by regulation, to require that all reports of maternal deaths occurring within the state arising from pregnancy, childbirth, or intentional abortion state the cause of death and other information related to the woman's pregnancy, as prescribed. The bill would require every physician who provides medical care or treatment to a woman who is in need of medical care because of a complication or complications resulting, in the good faith judgment of the physician, from having undergone an abortion or attempted abortion to prepare and file a report with DHS.

The bill would provide that any physician required to file a report, to keep any record, or supply any information, who willfully fails to do so is guilty of unprofessional conduct and his/her license to practice medicine and surgery is subject to suspension or revocation in accordance with procedures provided under the Medical Practice Act. The bill also would provide that any person who willfully delivers or discloses to DHS any report, record, or information known by him/her to be false is guilty of a misdemeanor. The bill would further provide for the suspension or revocation of a license of any person, organization, or facility who willfully violates any provision of the bill, as prescribed. [S. H&HS]

AB 235 (Burton), as introduced February 1, would provide that any licensed physician who knowingly files a false peer review action report with MBC pursuant to Business and Professions Code section 805 against another physician, and who is motivated from a desire to harm that physician in order to benefit economically, is guilty of unprofessional conduct. The bill would require, upon the receipt of a complaint by a physician that a report was filed under these circumstances, DMQ to request all records and documents relating to the peer review action from the health facility or clinic where the peer review action took place. It would require the health facility or clinic to provide the records and documents upon DMQ's request. [A. Health]
failed to notify MBC of reportable hospital peer review events under Business and Professions Code section 805, and that they are now impeding MBC's investigations of the accused physicians by failing to comply with administrative subpoenas for their peer review records. The hospitals assert that their records are privileged under Evidence Code section 1157, which protects peer review records from "discovery." MBC argues that the term "discovery" in section 1157 applies to civil malpractice litigation and not investigative subpoenas issued by the state agency responsible for protecting consumers from incompetent or impaired physicians. The cases illustrate MBC's growing concern about the failure and/or refusal of health care facilities to comply with section 805; the number of section 805 reports in 1993-94 is only half the number filed in 1987-88, despite legislative amendments which should have doubled the number of filings. [15:1 CRLR 59-60, 68; 14:4 CRLR 71]

At its May 11 meeting, DMQ heard oral arguments on reconsideration of its August 1994 adoption of Administrative Law Judge Milford A. Maron's controversial proposed decision regarding Dr. Leo Kenneally. Whereas ALJ Maron recommended, and DMQ originally approved, a one-year suspension of Kenneally's license and ten years' probation, HQES filed a motion for reconsideration requesting revocation of Kenneally's license. [15:1 CRLR 68; 14:4 CRLR 71-72] At oral argument, HQES argued for revocation due to two deaths and two hysterectomies that occurred following hemorrhages from abortions performed by Kenneally. The physician's attorney argued for a lesser sentence because of the low percentage of complications experienced by patients of Kenneally in comparison to his unusually high volume of abortions. The attorney contended that, statistically, Dr. Kenneally should have expected 1,000 hospitalizations instead of the ten which have actually occurred; Kenneally's lawyer also argued that the physician's patients had no complications from the 5,000 abortions he performed last year. At this writing, the Division is expected to reach a decision in the case in late May.

In Reisner v. Regents of the University of California, 31 Cal. App. 4th 1195 (Jan. 26, 1995), the Second District Court of Appeal held that a physician's failure to inform a patient that she had received AIDS-tainted blood supports a third party's claim against the physician and the hospital. The decision will allow a claim for negligence against Dr. Eric Fonklesrud and the UCLA Medical Center by a man who contracted the HIV virus from one of Dr. Fonklesrud's patients who subsequently suffered an AIDS-related death. The patient was 12-year-old Jennifer Lawson, who received blood contaminated with the HIV virus during a surgery at UCLA. Dr. Fonklesrud informed the donor of the contamination but never Lawson or her parents—despite her continuing treatment—for five years. About three years after the surgery, Lawson started an intimate relationship with Daniel Reisner. Two years later, Lawson was diagnosed with AIDS, and she died within a month. Reisner, now 20, subsequently learned that he has contracted AIDS. Reisner sued the defendants for negligence. In response, the defendants claimed they owed no duty to Reisner as a third party with whom they had no special relationship. The trial court found in favor of defendants.

The Second District reversed and remanded. The decision relied on Tarassof v. Regents of the University of California, which established the following rule of law: "When the avoidance of foreseeable harm to a third person requires a defendant to control the conduct of a person with whom the defendant has a special relationship (such as physician and patient) or to warn the person of the risks involved in certain conduct, the defendant's duty extends to a third person with whom the defendant does not have a special relationship." The Tarassof rule applies even to third persons who are unidentified. Writing for a unanimous panel and quoting from Tarassof, Justice Miriam A. Vogel stated that "the doctor's duty includes the duty to warn "others likely to apprise the victim of the danger...or to take whatever...steps are reasonably necessary under the circumstances.'" She stated that physicians are "the first line of defense against the spread of communicable disease."

The defense argued that an adverse decision would extend liability without limitation and would not contribute to the battle against AIDS. Judge Vogel responded that "the possibility of such an extension does not offend us, legally or morally...[W]e believe that a doctor who knows he is dealing with the 20th Century version of Typhoid Mary ought to have a very strong incentive to tell his patient what she ought to do and not do...to prevent the spread of her disease." On May 18, the California Supreme Court denied defendants' petition for review of the Second District's decision.
Treatment, an informative brochure on breast cancer published by the Department of Health Services with assistance from MBC. Physicians who detect breast lumps and recommend biopsies or other treatment are required to distribute this brochure to the patient. Bennett-Warner noted that, although the brochure had only been available for a few weeks, several other states had called to obtain copies to use as a prototype for their brochure.

At its February meeting, DOL announced the hiring of Neil Fippin as its new program manager; Fippin replaces Terri Ciau, who left on January 1 to become the manager of DCA's Technical Resources Team. Fippin has 25 years of experience in state service in a number of posts, including senior positions at DCA in administration and data processing.

Also at DOL's February 3 meeting, staff noted that applications for physician licensure had recently been received from graduates of three new foreign medical schools. The three schools are Instituto Tecnologico de Santo Domingo (INTEC), Universidad Eugenio Maria de Hostos (UNIREMHOS) in the Dominican Republic, and the University of Health Sciences, Antigua (UHSA). DOL staff sent its medical school questionnaire to the three schools to obtain the necessary information regarding whether its curriculum is acceptable to qualify its graduates for medical licensure in California. Staff reported that it received materials from INTEC which had not yet been fully reviewed; it received insufficient materials from UNIREMHOS; and UHSA indicated it does not intend to complete DOL's survey questionnaire, despite numerous requests from staff and the applicant who is a graduate of that institution. DOL instructed staff to request more information from UNIREMHOS and UHSA, and directed staff to warn both schools that failure to comply result in disapproval of the schools' curricula for purposes of California licensure.

At DOL's May 11 meeting, staff reported that it had received sufficient information from UNIREMHOS and that it generally appears to comply with California law. DOL approved a site visit to UNIREMHOS (and possibly INTEC) by Division President Ray Mallet. However, staff reported that UHSA has failed to comply with DOL's requests for information. As a result, DOL approved an order to show cause requiring the medical school to show cause why its curriculum should not be disapproved under Business and Professions Code sections 2101 and 2102. If UHSA fails to appear, DOL will issue an order of disapproval, which means that it will not accept coursework taken on or after the date of the order of disapproval and that it will not license any person who graduates from UHSA after the order of disapproval; the order of disapproval may also contain other conditions related to the acceptance of a degree or coursework from UHSA as DOL deems appropriate.

At its May 12 meeting, the full Board unanimously endorsed a three-year plan to upgrade its internal information management systems. Under this ambitious plan, the Board will (among other things) make public information on physicians available to consumers through the Internet, in order to reduce costs and increase the efficiency of responding to requests for information about physicians under its new public disclosure policy. [15:1 CRLR 62-63]

**FUTURE MEETINGS**


**ACUPUNCTURE COMMITTEE**

Executive Officer: Jeff Wallack (916) 263-2680

The Acupuncture Committee (AC) was created by the legislature in 1982. Pursuant to the Acupuncture Licensure Act, Business and Professions Code section 4925 et seq., the Committee issues licenses to qualified practitioners, establishes standards for the approval of schools and colleges which offer education and training in the practice of acupuncture, establishes standards for the approval of tutorial programs (an alternative training method), receives and investigates complaints against licensees, and takes appropriate enforcement action against the licenses of practitioners who have committed disciplinary violations. The Committee is authorized to adopt regulations, which appear in Division 13.7, Title 16 of the California Code of Regulations (CCR), and submit them for approval to the Division of Licensing (DOL) of the Medical Board of California (MBC).

AC consists of five acupuncturists, two physicians who have experience in acupuncture, and four public members, all of whom serve three-year terms. The Governor appoints the five acupuncturists, the two physicians, and two of the public members. All of the Governor's appointments are subject to Senate confirmation; and the five acupuncturists must represent a cross-section of the cultural backgrounds of licensed members of the acupuncturist profession. The Assembly Speaker and the Senate Rules Committee each appoint one public member.

After an interview process on April 11, AC announced its appointment of Jeff Wallack as its new Executive Officer. Wallack, a consultant from Sacramento and formerly a member of the Board of Accountancy and the Cemetery Board, succeeds Sherry Mehl, who left AC to become the new Executive Officer of the Board of Behavioral Science Examiners.

At this writing, AC is functioning with one physician member vacancy.

**MAJOR PROJECTS**

AC Adopts Citation and Fine Regulations. At its January 24 meeting, AC adopted proposed new sections 1399.463–468, Division 13.7, Title 16 of the CCR, to implement its citation and fine authority under Business and Professions Code sections 125.9 and 148. [15:1 CRLR 69]

New section 1399.463 would authorize AC's Executive Officer to issue a citation for violations of the Act or AC's regulations; the citation may contain an order of abatement and/or an administrative fine. Each citation (which must be served on the individual personally or by certified mail) must be in writing and must describe the nature and facts of the violation, including a reference to the statute or regulation alleged to have been violated. New section 1399.464 would specify certain circumstances in which a citation is inappropriate. New section 1399.465 would establish the range of fines (from $100 to $2,500) which may be imposed by the EO, and set forth seven factors which the EO must consider on a case-by-case basis in determining the amount of the fine. New section 1399.466 would allow extensions of time for compliance with orders of abatement upon a showing of good cause, and describe the consequences for failure to comply with an order of abatement. New section 1399.467 would authorize AC's EO to issue citations to unlicensed individuals who are providing services for which a license is required under the Act. Finally, new section 1399.468 would permit the cited individual to contest the issuance of a citation by requesting an informal conference with the EO; if the EO affirms the issuance of the citation after the informal conference, the cited individual may request a hearing before an administrative law judge under the Administrative Procedure Act.

DOL approved AC's citation and fine regulations on February 4, and the Department of Consumer Affairs (DCA) ap-
Continuing Education Regulations Approved. On April 3, OAL finally approved AC’s extensive overhaul of its continuing education (CE) regulations; the package repeals several of the Committee’s existing CE regulations (sections 1399.480, 1399.481, 1399.483, and 1399.484) and replaces them with new regulations which clarify AC’s CE program. [15:1 CRLR 69; 14:4 CRLR 74–75; 14:2&3 CRLR 74–75]

AC Approves Consumer Brochure on Acupuncture. At its January 24 meeting, AC approved the contents of a new brochure which is intended to educate consumers on acupuncture, the tasks and functions which may be performed by acupuncturists, AC’s licensure requirement and the qualifications needed for licensure, and the role of AC. In the making for several years, the brochure is the culmination of a lengthy process of drafting and review by AC, acupuncture schools, and trade associations. [15:1 CRLR 70; 14:4 CRLR 76; 13:4 CRLR 64] Although the contents have been approved, AC is still working on the format of the brochure. At this writing, it is unknown exactly when the brochure will be published.

LEGISLATION

AB 1002 (Burton). Existing law, until January 1, 1997, defines the term “physician” as including acupuncturists for purposes of treating injured employees entitled to workers’ compensation medical benefits. As amended March 30, this bill would delete the repeal date of January 1, 1997. [A. Ins]

AB 1003 (Burton). Existing law defines the term “physician” as including acupuncturists for purposes of treating injured employees entitled to workers’ compensation medical benefits, and prohibits construing this provision as authorizing acupuncturists to determine disability for purposes of workers’ compensation and disability benefits. As amended April 17, this bill would delete this prohibition, and instead provide that acupuncturists certified as Qualified Medical Evaluators may determine disability for purposes of workers’ compensation and for purposes of unemployment compensation disability insurance. [A. Ins]

RECENT MEETINGS

At its January 24 meeting, AC reelected Jane Barnett as Committee Chair and Margaret Filante, MD, as Committee Vice-Chair for 1995.

Also in January, AC again discussed the issue of malpractice insurance, noting that some occupational licensing boards require practitioners to disclose to consumers whether they carry insurance; however, no DCA board requires its licensees to carry it. Previously, the Committee has noted that only 25–30% of licensed acupuncturists carry malpractice insurance. [14:2&3 CRLR 77] AC took no action following this discussion.

At its January and April meetings, AC received written comments on a proposal to eliminate its tutorial program as a pathway to licensure. Under Business and Professions Code section 4938, a candidate for licensure may complete an AC-approved tutorial program instead of an AC-approved educational and training program; under section 4940, an AC-approved tutorial program must be supervised by an acupuncturist who has been licensed in California for at least five years and has at least ten years of experience as an acupuncturist. By its April meeting, AC had received five written comments and several oral comments, most of which favored elimination of the tutorial program. AC will consider these comments and this issue at future meetings.

In both January and April, AC again discussed its desires to become independent of the Medical Board and to change its name to “Board of Acupuncture” or “Acupuncture Board.” [15:1 CRLR 70; 14:4 CRLR 76; 14:1 CRLR 57] AC noted that DCA has declined to sponsor these measures as they are controversial and will surely engender the opposition of the California Medical Association. The Committee decided to reconsider these issues, and stressed the importance of support from acupuncture schools and practitioners.

FUTURE MEETINGS

August 1–2 in San Francisco.
October 24–25 in Sacramento.

HEARING AID DISPENSERS EXAMINING COMMITTEE

Executive Officer: M. Elizabeth Ware (916) 263-2288

Pursuant to Business and Professions Code section 3300 et seq., the Hearing Aid Dispensers Examining Committee (HADEC) prepares, approves, conducts, and grades examinations of applicants for a hearing aid dispenser’s license. The Committee also reviews qualifications of exam applicants and issues hearing aid dispenser licenses to qualified individuals. HADEC is authorized to take disciplinary action against its licensees for statutory and regulatory violations, and may issue citations and fines to licensees who have engaged in misconduct. HADEC functions under the jurisdiction of the Medical Board of California (MBC); it submits proposed regulatory changes to MBC for approval. HADEC’s regulations are codified in Division 13.3, Title 16 of the California Code of Regulations (CCR).

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

MAJOR PROJECTS

Measure to Require Enhanced Educational Requirements for Dispenser Licensure Dropped. On February 21, Senator Don Rogers introduced SB 563, which would have implemented HADEC’s longtime proposal to establish educational requirements for licensure as a hearing aid dispenser; currently, there is no minimum educational requirement for hearing aid dispenser licensure. [15:1 CRLR 71; 14:4 CRLR 76; 14:2&3 CRLR 78]

As introduced, SB 563 would have required applicants for hearing aid dispenser licensure to have a high school degree or the equivalent. Further, commencing on January 1, 1999, applicants would also be required to complete 300 hours of additional training at an approved educational institution and practical training in an approved hearing aid dispenser’s office in subjects designated by HADEC. The bill would also statutorily require HADEC licensees to complete nine hours of continuing education (CE) per year in certain prescribed subjects (HADEC’s regulations currently require six hours of CE per calendar year) [15:1 CRLR 71]; and provide that all temporary licenses are null and void on an after January 1, 1999, and repeal HADEC’s authority to issue temporary licenses.

However, as the legislative session wore on, SB 563 was amended several times. As of April 26, the provisions to require a high school diploma and other educational requirements were deleted from the bill; at this writing, the only provision left in the bill would require HADEC licensees to take nine CE hours per year (see Legislation).

Enforcement Report. At HADEC’s March 31 meeting, Committee member...
Deborah Kelly reported on HADEC's enforcement statistics. Thus far during fiscal year 1994–95 (from July 1 to March 15), HADEC has issued 34 citations without fines and 37 citations with fines. To date, HADEC has revoked seven licenses, issued two conditional licenses, placed three licenses on probation, and accepted one voluntary surrender. A total of 125 enforcement cases are pending: 38 are being reviewed by a consumer services representative (CSR) at the Medical Board's intake unit; 43 are under formal investigation; two are being reviewed by an expert consultant; 16 investigations have been forwarded to HADEC's executive officer; 16 fully investigated cases are pending at the Attorney General's Office awaiting the filing of an accusation; and the Attorney General has filed the accusation in ten additional cases.

Kelly also presented a "case aging report" compiled by the Medical Board on the lengthy enforcement process. The report outlines the average total number of days HADEC cases spend in each of the six stages of enforcement. The March 1 report indicates that complaints against HADEC licensees sit at the CSR stage for an average of 112 days, followed by a 298-day investigation period. Quality of care cases are usually submitted to an outside expert, which takes an average of 108 days. Completed investigations must be approved by HADEC's executive officer, which takes an average of 62 days. Once forwarded to the Attorney General's Office, cases sit for an average of 203 days before the formal accusation is filed, and then spend another 266 days at the AG's Office during the hearing and post-hearing decision-making process. Thus, it takes an average of 783 days—or 2.1 years—from the time a complaint is received until the filing of the accusation, and 2.9 years from receipt of complaint to final disciplinary decision. [15:1 CRLR 72]

**Licensing Report.** At HADEC's March 31 meeting, Licensing and Examination Coordinator Kathi Burns reported on the Committee's licensing statistics. Between November 15 and February 28, HADEC issued 29 temporary licenses, bringing the total number of temporary licenses to 75. During the same timeframe, 37 permanent licenses were issued. As of February 28, HADEC's cumulative licensing figures include 1,457 current licenses, 652 delinquent licenses, and 44 revoked licenses. Also during the same timeframe, 50 branch licenses were issued, bringing that cumulative total to 244 current licenses and 560 delinquent licenses.

**HADEC Studying the Elimination of Licensure Grace Period.** At its March meeting, HADEC charged its Legislation Subcommittee with drafting legislation that would change the current law allowing for a 30-day grace period prior to the charging of delinquency fees for licenses not renewed on a timely basis. Business and Professions Code section 3452 provides that "if the license is renewed more than 30 days after its expiration the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter." HADEC plans to seek a repeal of the 30-day grace period.

At this writing, the Subcommittee is scheduled to present the proposed legislative language to HADEC at its next meeting.

**LEGISLATION**

**SB 563 (Rogers),** as amended April 26, would require HADEC licensees to complete nine hours of continuing education per year in certain prescribed subjects. [S. Floor]

**LITIGATION**

At HADEC's March 31 meeting, Executive Officer Elizabeth Ware reported on recent success in the Committee's efforts to enforce California law against out-of-state mail order corporations. HADEC recently targeted two out-of-state corporations selling what HADEC alleges are hearing aids without a license from HADEC. The two corporations, Home Health Products (which sells the "MaxiSound Duo") and Telebrands, Inc. (which sells the "Whisper XL"), claimed their products were "amplification devices," not hearing aids, and were thus exempt from California law. After pressure from HADEC, Home Health Products ceased the sale of its product in California as of November 1, 1994. [15:1 CRLR 72] On January 31, Telebrands finally agreed to suspend all further shipments of its product to California, pending resolution of a petition the company has filed with the U.S. Food and Drug Administration.

HADEC has also instituted a campaign to educate consumers and warn them against purchasing any mail order or other advertised "amplification devices." HADEC contends that despite the fact that these devices are supposedly for those with normal hearing who just want to hear better, they still meet the legal definition of a hearing aid and those distributing such products in California must abide by the California Hearing Aid Dispensers Licensing Law.

Hughes v. State of California, et al., No. BS029050 (filed June 14, 1994 in Los Angeles County Superior Court), is still pending. [15:1 CRLR 72–73] At a hearing on April 7, Robert Hughes' motion to amend his complaint was granted. In his second amended complaint, Hughes continues to allege that several HADEC licensing and examination policies and advertising guidelines are in fact "regulations" which must be adopted by the Committee through the formal rulemaking process and approved by the Office of Administrative Law, and that the Committee's advertising guidelines and specified disciplinary policies are unconstitutional as violative of the first and fourteenth amendments.

**RECENT MEETINGS**

At HADEC's March 31 meeting, Committee staff reported that a total of 167 candidates took the computerized version of HADEC's written examination between April and January 1995; of these candidates, 100 passed for a pass rate of 59%. The next practical exams are scheduled for November 4.

At the March 31 meeting, the Subcommittee on Examination and Continuing Education reported that HADEC's temporary contract with Assessment Systems, Inc. (ASI) has been extended. ASI administers HADEC's written exam in electronic form. Following recent contract disagreements, ASI and HADEC reached a temporary agreement implemented for a period of 120 days (December 1, 1994–March 3, 1995). [15:1 CRLR 73; 14:4 CRLR 77] On March 21, Executive Officer Ware signed a new agreement with ASI, effective April 1–July 31. The current contract provides for two days of test administration per month and permits candidates to set exam appointments seven days in advance, allowing ASI to close an inactive testing center a week in advance. At the conclusion of the agreement, ASI and HADEC will have the opportunity to extend or amend the current terms.

The Subcommittee on Examination and Continuing Education also reported on the results of the 1994 CE Audit Report. As of December 31, 1994, 1,301 of HADEC's 1,516 individual licensees were in compliance with current CE requirements, for an 86% compliance rate.

Also at the March 31 meeting, Executive Officer Ware presented the results of staff's study of expired licenses that HADEC had requested at its last meeting. The purpose of the study was to determine if a significant number of individuals with expired licenses are still practicing hearing aid dispensing and to gather information that could assist in preventing such delinquency. After contacting every tenth person on the list of 550 delinquent hearing aid dispenser licensees, the survey group concluded that continued practice by delinquent licensees is not a significant
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problem; only two of 51 (approximately 4%) contacted were found to actually be practicing without a license.

At its March 31 meeting, the Committee discussed the interest shown by several other states in HADEC’s written licensing exam. The Committee voted affirmatively to accept the idea of royalty revenue that could potentially be earned from “selling” HADEC’s written exam to other states. The Examination and Continuing Education Subcommittee has been charged with working out the details of such transactions, with the state of Washington being the first recipient, Mississippi and Texas have shown similar interest.

FUTURE MEETINGS
August 4 in Sacramento.
November 17 in Sacramento.

PHYSICAL THERAPY EXAMINING COMMITTEE
Executive Officer: Steven Hartzell (916) 263-2550

The Physical Therapy Examining Committee (PTEC) is a six-member board responsible for examining, licensing, and disciplining 13,970 physical therapists and 2,840 physical therapist assistants. The Committee is comprised of three public and three physical therapist members. PTEC is authorized under Business and Professions Code section 2600 et seq.; the Committee’s regulations are codified in Division 13.2, Title 16 of the California Code of Regulations (CCR). The Committee currently functions under the general oversight of the Medical Board of California (MBC).

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

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

At this writing, PTEC is functioning with only five members; PTEC Vice-Chair John R. Matthews resigned from the Committee in February because the Attorney General’s Office has filed an accusation against his PT license due to sexual misbehavior. Matthews has denied the charges. Additionally, the terms of two public members expire at the end of June.

MAJOR PROJECTS

PTEC Tries Again on PTA Supervision Regulations. On November 29 and February 2, a PTEC task force met in an attempt to finally hammer out an agreement on amendments to section 1398.44, Division 13.2, Title 16 of the CCR, which is intended to define “adequate supervision” by a PT of a PTA. These amendments have been the source of conflict within the profession, especially between PTEC and the California Chapter of the American Physical Therapy Association (CCAPTA), the major PT trade association in California. [15:1 CRLR 73-74; 14:4 CRLR 77-78; 14:2 & 3 CRLR 80]

Among other things, existing section 1398.44 requires a supervising physical therapist (SPT) to be “present in the same physical therapy facility with the assistant at least 50% of any work week or portion thereof the assistant is on duty unless this requirement has been waived by the Committee.” Historically, PTEC’s small staff has been inundated with requests for waivers of the so-called “50% requirement,” such that it has sought to eliminate the waiver provision altogether and more clearly define precise supervisory requirements which will protect patients of PTs and PTAs. CCAPTA opposes elimination of the waiver provision, and has objected to previous versions of the amendments on grounds that they were too strict and would impose requirements which are overly burdensome and unnecessary to patient protection.

At its October 1994 meeting, PTEC considered a new version of the proposed amendments which would eliminate both the 50% actual presence requirement and the waiver procedure. The amendments would require the licensed SPT to be readily available in person or via electronic means to the PTA at all times for advice, assistance, and instruction. The SPT must initially evaluate each patient prior to the provision of physical therapy treatment by the PTA, and document the evaluation and the date of the next scheduled reevaluation in the patient’s record. Based on the evaluation and other information available to the PT, the SPT must formulate and record in each patient’s record a treatment program, and determine which elements thereof may be delegated to the PTA; the SPT must sign the treatment program. The SPT must reevaluate the patient as determined necessary in the initial evaluation, modify the treatment program as necessary, and document and sign each reevaluation in the patient’s record. At a hearing on these amendments, however, CCAPTA again objected—this time on grounds the language is too vague and effectively destroys the supervision requirement; CCAPTA argued that the proposal eliminates the requirement that a PT actually observe the work of a PTA, and again opposed deletion of the waiver process. PTEC decided to defer action and appoint a task force to reevaluate the supervision proposal, particularly the existing waiver process and problems associated with it.

At PTEC’s February meeting, the task force presented the Committee with proposed language which is substantially similar to the language considered in October 1994. However, the new language requires the SPT to communicate to the PTA, verbally or in writing, the treatment goals and plan prior to the initiation of treatment by the PTA. Further, the SPT must reevaluate the patient “as determined is necessary,” and must provide treatment to the patient during the reevaluation. The PTA must document in the patient’s record any change in the patient’s condition not consistent with planned progress or treatment goals; any such change necessitates a reevaluation by the SPT before further treatment. The SPT must review, cosign, and date all documentation by the PTA within seven days of the care being provided by the PTA. Every 30 calendar days of treatment, the SPT and PTA must conduct a verbal case conference on each patient, which must be documented in the patient’s record and cosigned by the SPT and PTA. At time of discharge, the SPT must document in the patient’s record, along with his/her signature, the patient’s response to treatment in the form of a discharge summary or reevaluation. The Committee approved this language for publication in the California Regulatory Notice Register and a May 16 public hearing.

At the public hearing, CCAPTA again objected to the language, arguing that it eliminates the requirement for onsite supervision of a PTA by the SPT. In its May newsletter calling on PTs to communicate their opposition to the proposed amendments to PTEC, CCAPTA clarified its more fundamental reason for its opposition to the proposed language: “If physical therapists are no longer needed to provide onsite supervision to PTAs, then other providers will most assuredly ask, ‘Why can’t we supervise PTAs? Wouldn’t we be the perfect medical professional to be allowed to employ physical therapist assistants in our offices?’”

At the May 16 hearing, PTEC Executive Officer Steve Hartzell took issue with the article in CCAPTA’s newsletter, stat-
ing that the proposed regulatory scheme preserves supervision of the PTA by the SPT and actually increases the direct involvement of the SPT in patient care by requiring treatment by the SPT when the PTA is providing care to a patient. Hartzell also noted that section 1398.44’s current requirements may be satisfied even though the SPT does not know the name of the PTA being supervised or the patient being treated; the lack of any documentation requirements makes it difficult for PTEC to determine whether proper supervision is being provided. Following the hearing, PTEC adopted the proposed language subject to a few minor modifications, and directed staff to release the modified version for an additional 15-day public comment period. At this writing, PTEC hopes to take a final vote on section 1398.44 at its August meeting.

**Performance of Physical Therapy by Medical Assistants.** On May 11, the Medical Board’s Division of Licensing (DOL) held a public hearing on a proposed amendment to its regulations which define the services which may be performed by unlicensed medical assistants (MAs) supervised by physicians. Specifically, the Division proposed to repeal subsection 1366(e), which states that “[n]othing in these regulations shall be construed to authorize a medical assistant to practice physical therapy.”

According to DOL’s notice of proposed rulemaking, the Division seeks to repeal the subsection because the prohibition on the unlicensed practice of physical therapy is already contained in section 2630 of the Business and Professions Code. However, comments at the public hearing revealed that the actual impetus for the proposed regulatory change is a turf battle between physicians and physical therapists over who may practice physical therapy. Physical therapists contend that only a licensed physical therapist may perform physical therapy and supervise physical therapy assistants and aides; in its written opposition to the proposed repeal of section 1366(e), PTEC stated that Business and Professions Code section 2630 applies only to the performance of physical therapy tasks by unlicensed physical therapy aides (not medical assistants), who must be supervised at all times by a licensed physical therapist (not a physician). However, physicians contend that they are fully authorized to perform tasks classified as “physical therapy” and to supervise licensed and unlicensed personnel in the performance of those tasks.

Following the hearing, DOL adopted the proposed repeal of section 1366(e), thus indirectly authorizing physicians who supervise MAs to train and supervise them in the performance of physical therapy tasks. At this writing, DOL staff is preparing the rulemaking file for submission to the Department of Consumer Affairs (DCA) and the Office of Administrative Law (OAL).

**PTEC Proposes to Require Reapplication for Licensure After One Year.** At its May meeting, the Committee held a public hearing on its proposal to adopt section 1398.21.1, Title 16 of the CCR, which would clarify that an application for licensure shall be deemed abandoned when an applicant fails to pass the examination within one year of the date of the original notice to appear for the exam. The applicant will then be required to file a new application for licensure and pay a new application fee, and to apply for reexamination and pay the reexamination fee.

Following the hearing, PTEC adopted the proposal with a few minor modifications, and directed staff to prepare the rulemaking file for submission to DCA and OAL.

**Personnel Identification Proposal Dropped.** At its May meeting, PTEC decided to drop its proposal to adopt new section 1398.11, Title 16 of the CCR, which would require PTs, PTA, applicants for PT and PTA licenses, and aides who provide PT services to wear an identification badge to indicate their title. [15:1 CRLR 74; 14:4 CRLR 78]

### RECENT MEETINGS

At its February meeting, PTEC voted to change its subcommittee structure. Instead of eight subcommittees consisting of two members each, PTEC will now have two subcommittees consisting of three members each. The Licensing Subcommittee will oversee staff’s review of applications for licensure based on foreign education and equivalency; monitor PTEC’s examination program; and review issues related to education programs. The Practice Issues Subcommittee will review and approve requests for supervision waivers (until section 1398.44 is amended; see above); review scope of practice questions; and determine the need to revise statutes and regulations. PTEC also appointed member Jerry Kaufman as enforcement liaison, which requires availability to Executive Officer Steve Hartzell for general issues related to the enforcement program.

### FUTURE MEETINGS


### PHYSICIAN ASSISTANT EXAMINING COMMITTEE

Executive Officer: Ray Dale (916) 263-2670

The legislature established the Physician Assistant Examining Committee (PAEC) in Business and Professions Code section 3500 et seq., in order to “establish a framework for development of a new category of health manpower—the physician assistant.” Citing public concern over the continuing shortage of primary health care providers and the “geographic mal-distribution of health care service,” the legislature created the physician assistant (PA) license category to “encourage the more effective utilization of the skills of physicians by enabling physicians to delegate health care tasks...” PAEC functions under the jurisdiction of the Medical Board of California (MBC); the Committee’s regulations are codified in Division 13.8, Title 16 of the California Code of Regulations (CCR).

PAEC licenses individuals as PAs, allowing them to perform certain medical procedures under a physician’s supervision, including drawing blood, giving injections, ordering routine diagnostic tests, performing pelvic examinations, and assisting in surgery. PAEC also establishes standards for and approves education and training programs for PAs, and makes recommendations to MBC concerning guidelines for physicians who apply to supervise PAs and the approval of such applications. PAEC keeps two registers—one consisting of approved supervising physicians (SPs) and one consisting of licensed PAs. PAEC’s objective is to assure the public that the incidence and impact of “unqualified, incompetent, fraudulent, negligent and deceptive licensees of the Committee or others who hold themselves out as PAs are reduced.”

PAEC’s nine members include one MBC member, a physician representative of a California medical school, an educator participating in an approved program for the training of PAs, one physician who is an approved supervising physician of PAs and who is not an MBC member, three PAs, and two public members. Committee members may serve a maximum of two four-year terms.

On March 1, Assembly Speaker Willie Brown appointed Juande Ragsdale-Blevins to the PAEC public member position formerly held by Ruth Ann Kahler, who resigned from the Committee earlier this year. Ragsdale-Blevins’ term expires on
January 1, 1997. PAEC still has one vacant position.

### MAJOR PROJECTS

**PAEC Schedules Public Hearing on Citation and Fine Regulations.** In late May, PAEC published notice of its intent to adopt regulations to implement its citation and fine authority as a means of more efficiently and effectively disciplining minor violations of its enabling act and regulations. [15:1 CRLR 75; 14:4 CRLR 80]

Proposed Article 6 (commencing with section 1399.570), Division 13.8, Title 16 of the CCR, would allow PAEC’s Executive Officer to levy citations and/or fines between $100 to $2,500 per infraction against licensed PAs and individuals who are engaging in the practice of a PA without a license. The regulations would specify the format for citations, the range of fines for a violation of specified provisions, the factors to be considered in assessing the amount of an administrative fine, the consequences of a failure to comply with the order, and the method by which citations may be contested. At this writing, PAEC plans to hold a public hearing on the proposed regulations at its July 21 meeting in Irvine.

### Confusion About SB 1642

**SB 1642.** SB 1642 (Craven) (Chapter 968, Statutes of 1994), which converts one of PAEC’s regulations to statute (Business and Professions Code section 3502.1), authorizes PAs to write and sign prescription “transmittal orders” when authorized to do so by their SPs. The bill also amended the Pharmacy Law to authorize licensed pharmacists to dispense drugs or devices based on a PA transmittal order. [15:1 CRLR 75–76; 14:4 CRLR 80]

However, considerable disagreement has erupted over whether the bill permits a PA to transmit orders for Schedule II drugs (including opiates and other narcotics). A March 9 memo from the Legislative Counsel’s Office to Senator Craven opines that SB 1642 authorizes a PA to transmit, upon a written transmittal order, and sign prescription “transmittal orders” which converts one of PAEC’s regulations (Craven) (Chapter 968, Statutes of 1994), into law.

At the Committee’s January meeting, the Board approved its strategic plan for the next five years, after making minor changes to a draft reviewed at its October 1994 meeting. [15:1 CRLR 75] The plan defines PAEC’s primary functions, lists its priorities for this five-year period, and articulates its mission and vision statements. PAEC voted to review the vision statement and strategic plan document in six months to decide if any additional changes are warranted.

In January, PAEC identified the following as its objectives for 1995: (1) work towards effective implementation of SB 1642 (see above); (2) create an SB 2036 Sunset Review Ad Hoc Subcommittee; and (3) increase communication with PA training programs, PA professional associations, and other state agencies.

Also at its January meeting, the Committee voted to adopt six new internal policies which establish protocols and procedures for Committee member absence and attendance at meetings, resignation, and term limits for elected officers; define the required quorum for deciding disciplinary cases, and outline the appropriate procedure for Committee members’ review of proposed stipulations; and establish standing subcommittees to facilitate ongoing responsibilities and tasks. Among other things, these internal policies require any Committee member who has two consecutive unexplained absences from PAEC meetings to submit a request for resignation; stipulate that an officer may serve only two consecutive terms in the same office; and define a quorum for deciding disciplinary cases as five votes, whether the votes are submitted at a meeting or by mail. These policies also establish the following standing subcommittees and define their responsibilities: Executive and Budget Subcommittee, Education Subcommittee, Legislation and Regulation Subcommittee, and Ad Hoc Subcommittees as required. By consensus, the Committee decided at its April meeting to abolish the Education Subcommittee and allocate its responsibilities to two new subcommittees, the Training Program Subcommittee and the Communication and Public Affairs Subcommittee. PAEC’s Ad Hoc Policy Subcommittee plans to submit further internal policy proposals at future meetings.

### LEGISLATION

**SB 641 (Craven).** Existing law authorizes a licensed pharmacist to dispense drugs upon a transmittal order of a physician assistant who has been delegated that authority by a physician. As introduced February 22, this bill would state the intent of the legislature to enact guidelines for pharmacists who accept Schedule II prescriptions from physician assistants in accordance with those provisions. [S. B&P]

**AB 753 (Morrow).** Existing law authorizes PAs to perform certain prescribed services under the supervision of a licensed physician provided that the PA is licensed by PAEC and the physician is approved to supervise the PA by MBC or the Osteopathic Medical Board of California. As amended April 26, this bill would also authorize a PA to perform these prescribed services while under the supervision of a licensed podiatrist, provided the podiatrist is approved by the Board of Podiatric Medicine (BPM) and the assistant is licensed by BPM as a podiatrist assistant. The bill would restrict a podiatrist to supervising no more than two podiatrist assistants and would require BPM to restrict podiatrist assistants within the scope of practice of podiatric medicine. It would also require BPM to restrict podiatrist assistants to practicing only within the scope of podiatric medicine. [A. Floor]

### RECENT MEETINGS

At the Committee’s January meeting, PAEC Analyst Jennifer Barnhart announced the first successful completion by a PA of PAEC’s diversion program for substance-abusing licensees, and reminded the Committee of its mandate to review diversion program participant files. [15:1 CRLR 76]

For the past two years, PAEC has contracted with Occupational Health Services, Inc., to administer its substance abuse program. Under Business and Professions Code section 3534.9, PAEC is authorized to hire a consultant to evaluate the competency of the services provided by the diversion program, but the Committee itself is required to review the files of diversion program participants on a biennial basis. At its April meeting, the Committee agreed that its members have sufficient chemical dependency expertise to adequately perform the required review of the diversion program files, and established an Ad Hoc Subcommittee for Diversion Program Re-
view. In so deciding, the Committee opted not to pursue a legislative change that would grant it authority to delegate review of the participant files to an outside consulting group. PAEC appointed Committee members Stephan Morey and Nancy Safinick to comprise the Ad Hoc Subcommittee. As of PAEC’s April meeting, six files from the diversion program were awaiting review. The Ad Hoc Subcommittee plans to review three of the six before the July meeting. There are currently no firm criteria in place by which to review these files.

At the Committee’s April meeting, PAEC Analyst and Enforcement Coordinator Glenn Mitchell reported enforcement statistics for the period of July 1, 1994 through March 17, 1995. He noted a slight increase in all areas of enforcement over last year’s statistics. As of March 17, seven complaints were being processed by the Medical Board’s Central Complaint and Investigation Control Unit, 59 complaints were under active investigation, 13 cases were pending at the Attorney General’s Office, and two cases were pending charges at district attorney’s offices. Thus far in fiscal year 1994–95, PAEC has disciplined one licensee by revoking his license and has placed four licensees on probation.

At its April meeting, PAEC discussed a proposed revision of its PA application form and voted to add one question regarding current physical and psychiatric conditions and substance abuse problems which might impair a PA’s ability to practice with reasonable skill and safety. The Committee tailored the language of its question very closely to language suggested by Department of Consumer Affairs legal counsel in order to fully comply with the Americans with Disabilities Act (ADA).

The advice given regarding compliance with the ADA is seemingly pertinent to PAEC’s previous discussions about modifying its SP application [15:1 CRLR 76]; those proposed changes were not discussed at the April meeting.

Also at its April meeting, the Committee approved draft revisions to its sample “Delegation of Services Agreement Between Supervising Physician and Physician Assistant” and “Supervising Physician’s Responsibility for Supervision of a Physician Assistant” documents in order to fully comply with the Americans with Disabilities Act (ADA).

In so deciding, the Committee opted not to pursue a legislative change that would grant it authority to delegate review of the participant files to an outside consulting group. PAEC appointed Committee members Stephan Morey and Nancy Safinick to comprise the Ad Hoc Subcommittee. As of PAEC’s April meeting, six files from the diversion program were awaiting review. The Ad Hoc Subcommittee plans to review three of the six before the July meeting. There are currently no firm criteria in place by which to review these files.

At the Committee’s April meeting, PAEC Analyst and Enforcement Coordinator Glenn Mitchell reported enforcement statistics for the period of July 1, 1994 through March 17, 1995. He noted a slight increase in all areas of enforcement over last year’s statistics. As of March 17, seven complaints were being processed by the Medical Board’s Central Complaint and Investigation Control Unit, 59 complaints were under active investigation, 13 cases were pending at the Attorney General’s Office, and two cases were pending charges at district attorney’s offices. Thus far in fiscal year 1994–95, PAEC has disciplined one licensee by revoking his license and has placed four licensees on probation.

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The advice given regarding compliance with the ADA is seemingly pertinent to PAEC’s previous discussions about modifying its SP application [15:1 CRLR 76]; those proposed changes were not discussed at the April meeting.

PAEC has stated its goal of eventually eliminating all SP fees and supporting the SP program from PA licensing fees. [15:1 CRLR 75; 14:4 CRLR 79] At its April meeting, Committee member Stephan Morey presented information regarding the SP fees charged by approximately forty other state agencies regulating PAs. Only eight states require any SP fee at all, and of those, the application fees range from $10–$200, as compared to PAEC’s $25 application fee and $75 approval fee. Morey also found that only two states require an SP renewal fee. PAEC charges a $100 biennial renewal fee for SPs. The Committee voted to send a letter to state agencies regulating PAs across the country to request further information regarding their funding sources and demographics of their PA populations.

PAEC continues to wrestle with the publication of its licensee newsletter. [15:1 CRLR 76] At its January meeting, the Board decided to cancel Issue #6 because the information was no longer current, and voted to change the format of the newsletter to a more informal “bulletin” or “flier” style. The focus of the new newsletter will be on legislative and regulatory changes pertinent to PA practice and on clarifying the role of PAEC in the PA community. At its April meeting, the Committee agreed to publish the newsletter quarterly, and agreed that the newsletter should continue to be used as an enforcement tool in which names of disciplined PAs are published. PAEC’s last newsletter was published a year and half ago. At this writing, the Communications and Public Affairs Subcommittee is scheduled to present the final draft of Issue #7 at PAEC’s July meeting.

**FUTURE MEETINGS**

July 21 in Irvine.
October 20 in Sacramento.

**BOARD OF PODIATRIC MEDICINE**

**Executive Officer:**

James Rathsieberger
(916) 263-2647

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

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

On February 27, the Senate Rules Committee appointed former Senator Robert Presley to fill a BPM public member position which has been vacant since Karen McElliot was transferred to the Medical Board two years ago. During his distinguished 20-year legislative career, Senator Presley focused significant attention on improving the professional discipline systems for attorneys and physicians; with regard to physicians, he authored three so-called “Presley Bills” which have overhauled many aspects of the MBC/BPM enforcement system—SB 2375 (Presley) (Chapter 1597, Statutes of 1990) [10:4 CRLR 84], SB 916 (Presley) (Chapter 1267, Statutes of 1993) [13:4 CRLR 54–56, 60], and SB 1775 (Presley) (Chapter 1206, Statutes of 1994) [14:4 CRLR 68]. Senator Presley has also been a leader in anti-crime, environmental, government efficiency, and children’s services legislation. His current term will expire on June 1, but he is expected to be reappointed for a full four-year term.

**MAJOR PROJECTS**

BPM to Voluntarily Sunset and Merge with MBC? At its May 5 meeting, the Board discussed a proposal to voluntarily “sunset” on its currently scheduled sunset date of July 1, 1999 [14:4 CRLR 81–82] and to merge with the Medical Board on that date. Representatives of the California Podiatric Medical Association and some Board members testified in opposition to the proposal, but Executive Officer James Rathsieberger argued that the proposal is a good one because a merger would assist DPMs in gaining respect and equal recognition within the medical community. Rathsieberger testified that as long as DPMs are regulated by a separate board (which is actually a committee of the Medical Board) with different certification requirements and different procedures, they will be regarded by the medical community and by consumers as “different” and “suspect.”

Following discussion, the Board tentatively agreed to draft legislation which would continue the existence of the Board beyond 1999 but also require a formal, independent study of a possible merger with the Medical Board; BPM members also stressed that sunset of the Board and a merger with MBC would be appropriate only when podiatric medicine is fully accepted as an approved medical specialty.
The Board will discuss the details of this proposal at future meetings.

**Podiatric Medical Education and Training Regulations.** At its January 24 meeting, BPM held a public hearing on its proposal to amend several regulations to standardize podiatric medical education and training [15:1 CRLR 777]:

- Existing section 1399.662 requires all applicants for a podiatric medical license to complete a medical curriculum at a school or college of podiatric medicine approved by the Board, and requires BPM to approve all colleges of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association. BPM will seek to amend section 1399.662 to permit it to approve a CPME-accredited college, thus preserving its discretion to reject curricula which provide insufficient podiatric medical education and training.

- Existing section 1399.666 requires that "equivalent training," for purposes of Business and Professions Code section 2483, be undertaken through those educational programs approved by the CPME; the Board proposes to amend section 1399.666 to further specify that such training must meet all requirements of the Business and Professions Code.

- Section 1399.667 currently specifies that hospitals approved to provide post-graduate training to podiatric medical residents must meet minimum requirements set by the CPME; BPM proposes to further specify that hospitals must have designated a Director of Medical Education, provide emergency medical training through emergency room rotations and exposure to medical research, measure and evaluate the progress of participants and program effectiveness, and reasonably conform with general requirements of the AMA's Accreditation Council for Graduate Medical Education.

Following the public hearing, the Board adopted the proposed regulations, with several modifications to section 1399.662. Specifically, BPM added subsection (b) to section 1399.662, which expressly states that "[n]othing contained in this section shall prevent the Board from disapproving any college of podiatric medicine which would otherwise be approved under subsection (a)," if it does not meet the requirements of the Business and Professions Code, including section 2483, and any regulations BPM may adopt.

Staff released the modified language for a 15-day public comment period on February 24; at this writing, the proposed amendments have not yet been submitted to the Office of Administrative Law (OAL) for review and approval.

**Continuing Podiatric Medical Education Regulation Amended.** Also at its January meeting, BPM held a public hearing on proposed amendments to section 1399.670, which currently provides for approval of some continuing medical education (CME) courses by BPM based upon prior approval by various organizations, including medical associations and educational institutions. BPM's proposed amendments to section 1399.670 would expressly state that all CME courses accepted by the Board in fulfillment of license renewal requirements must be scientific courses relating directly to patient care. All other types of courses, although they have previously qualified for CME credit, would no longer satisfy license renewal requirements. Following the hearing, the Board approved the proposed amendments, which were subsequently approved by OAL on May 2.

**Public Disclosure Regulations.** At its November 1994 meeting, BPM adopted a revised section 1399.700, Title 16 of the CCR, which would establish BPM's public disclosure policy in regulation [14:4 CCR 81: 13:26:3 CRLR 92].

Under section 1399.700 as approved, BPM will disclose the following information regarding any DPM licensed in California: current status of the license, issuance and expiration date of the license, podiatric medical school of graduation, and date of graduation; whether a disciplinary case has been referred to the Attorney General's Office for the filing of an accusation, temporary restraining order, or interim suspension order and, if so, the nature of the allegation and an appropriate disclaimer; any public document filed against the podiatrist, including but not limited to accusations, decisions, temporary restraining orders, interim suspension orders, citations, and public letters of reprimand; medical malpractice judgments in excess of $30,000 reported to the Board on or after January 1, 1993, including the amount of the judgment, the court of jurisdiction, the case number, a brief summary of the circumstances as provided by the insurance company, and an appropriate disclaimer; discipline imposed by another state or the federal government reported to the Board on or after January 1, 1993, including the discipline imposed, the date of the discipline, the state where the discipline was imposed, and an appropriate disclaimer; California felony convictions reported to the Board on or after January 1, 1993, including the nature of the conviction, the date of conviction, the sentence (if known), the court of jurisdiction, and an appropriate disclaimer; and information regarding accusations filed and withdrawn. The language of proposed section 1399.700 mirrors that of proposed section 1354.5, Division 13, Title 16 of the CCR, the Medical Board's proposed public disclosure regulations.

On April 20, BPM submitted the proposed regulatory changes to OAL, where they are pending at this writing. Because the Medical Board agreed to amend its public disclosure regulations at its May meeting (see agency report on MBC for details), BPM may further amend section 1399.700.

**Prohibited Referrals.** On May 11, BPM published a fact sheet alerting DPMs to several important sections of the Business and Professions Code applicable to referrals.

Under section 650, the offer, delivery, receipt, or acceptance by a DPM of any rebate, refund, commission, preference, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients or customers to any person, is unlawful; the section also outlines certain limited circumstances under which it is not unlawful for a DPM to refer a patient to a laboratory, pharmacy, clinic, or health care facility in which the DPM has an ownership interest. Section 650.01 states that, notwithstanding section 650, it is unlawful for a DPM to refer a patient for laboratory, diagnostic nuclear medicine, radiation, oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the DPM or his/her immediate family has a financial interest therein. Finally, section 654.2 states that it is unlawful to charge, bill, or otherwise solicit payment from a patient on behalf of, or refer a patient to, an organization in which a DPM, or his/her immediate family, has a significant beneficial interest, unless the DPM discloses in writing to the patient that there is such an interest and advises the patient that he/she may choose any organization.

BPM's fact sheet also lists numerous sections of the Business and Professions Code (including many provisions of the Medical Practice Act) which are fully applicable to DPMs.

**Legislation**

SB 609 (Rosenthal) is the Medical Board's omnibus enforcement bill containing many legislative changes relating to MBC's physician discipline system, many of which would apply to DPMs and BPM (see agency report on MBC for details). In addition, SB 609 would authorize physicians and podiatrists to conduct their professional practices in a partnership of...
AB 1471 (Friedman), as amended April 18, would require BPM to charge each applicant who is required to take the oral examination as a condition of licensure a fee equal to the amount necessary to recover the actual cost of that exam. [A. Floor]

AB 753 (Morrow). The Medical Practice Act provides for the licensure of podiatrists and physicians and defines their scopes of practice. Existing law authorizes a physician assistant (PA) to perform certain prescribed services under the supervision of a licensed physician, provided that the PA is licensed by the Physician Assistant Examining Committee (MBC) or the Osteopathic Medical Board of California. As amended April 26, this bill would also authorize a PA to perform these prescribed services while under the supervision of a licensed podiatrist, provided the podiatrist is approved by BPM and the assistant is licensed by BPM as a podiatrist assistant. The bill would restrict a podiatrist to supervising no more than two podiatrist assistants and would require BPM to restrict podiatrists to supervising podiatrist assistants within the scope of practice of podiatric medicine. It would also require BPM to restrict podiatrist assistants to practicing only within the scope of podiatric medicine. [A. Floor]

RECENT MEETINGS
At its May 5 meeting, BPM elected Elaine Davis, DPM, as Board President, as outgoing President Joanne Watson’s term expired.

FUTURE MEETINGS
November 3 in Los Angeles.
March 11, 1996 in Sacramento.
May 3, 1996 in San Francisco.

BOARD OF PSYCHOLOGY
Executive Officer:
Thomas O’Connor
(916) 263-2699

The Board of Psychology (BOP) is the state regulatory agency for psychologists under Business and Professions Code section 2900 et seq. Under the general oversight of the Medical Board of California (MBC), BOP sets standards for education and experience required for licensing, administers licensing examinations, issues licenses, promulgates rules of professional conduct, regulates the use of psychological assistants, investigates consumer complaints, and takes disciplinary action against licensees by suspension or revocation. BOP’s regulations are located in Division 13.1, Title 16 of the California Code of Regulations (CCR).

BOP is composed of eight members—five psychologists and three public members. Each member of the Board is appointed for a term of four years, and no member may serve for more than two consecutive terms.

MAJOR PROJECTS
Psychology Community Complains About Continuing Education Regulations. SB 774 (Boatwright) (Chapter 260, Statutes of 1992) requires psychologists, effective January 1, 1995, to complete continuing education (CE) requirements as a condition of license renewal. For the past eighteen months, the Board has struggled to adopt CE regulations; they were finally approved by the Office of Administrative Law (OAL) on December 29, 1994. [15:1 CRLR 77-78; 14:4 CRLR 82; 14:2 & 3 CRLR 86]

At the Board’s March meeting, staff reported that numerous psychologists have applied for a waiver of the CE requirements for a variety of reasons. To handle the deluge of waiver requests, BOP created a subcommittee to review the requests, develop a policy on how to handle them, and present its recommendations to the Board at each meeting.

Also at BOP’s March meeting, Peggy Duder from the California Psychological Association (CPA)—which has been designated by the Board as an “accreditation agency” for purposes of evaluating and approving the content of CE courses under section 1397.64, Title 16 of the CCR—reported on CPA’s progress in reviewing and approving CE courses and providers. Both providers and courses are reviewed by five teams of licensed psychologists; if one team recommends denial of approval, that recommendation is reviewed by another team. By March 16, CPA had received over 500 applications for provider approval; it had approved 95 providers and was processing another 35 applications. It had received 375 applications for course approval. CPA reported that six to eight weeks elapse from receipt of a completed application to written notification of content review results.

CPA is currently the only entity which has been approved as an “accreditation agency” by the Board. This situation, coupled with the six- to eight-week delay in course approval, has upset numerous psychologists who have complained to the Board. The time lag has forced many CE providers to cancel courses because they were not approved on time. Additionally, several psychologists have complained that, under the Board’s regulations, courses accredited by the American Psychological Association (APA) do not qualify toward California’s CE requirement unless they are taken out of state. This regulatory provision has been challenged by many as being overly protective of CPA and discriminatory against California providers who are approved by APA but not CPA; additionally, some public officials have complained that the Board’s regulations are forcing psychologists to take CE courses out of state rather than in California. CPA Executive Director Michael Haley addressed some of these issues at the Board’s May 20 meeting; BOP asked Haley to investigate these matters further and report back at its August meeting. In addition, BOP staff plans to present proposed changes to the Board’s CE regulations at the August meeting.

Board Amends Examination Regulations. At its March meeting, BOP held a public hearing on its proposed amendments to sections 1388, 1388.5, 1389, and 1390, Title 16 of the CCR, which would alter its examination structure and limit a licensure candidate’s ability to appeal the results of the Board’s oral examination. [15:1 CRLR 78] The Board considered the following proposed changes:

• An amendment to section 1388 would specify that administrative action may be taken against any licensure applicant found cheating during the licensing exam.

• The Board proposed to repeal language in section 1388.5(b) which provides that an applicant who fails to obtain a grade of 75 in the oral exam will be given reasons in writing why the failing score was issued, and insert language which instead provides that any applicant who sits for the oral exam will be provided with oral exam feedback.

• Currently, section 1388.5(c) requires BOP to keep an electronic recording of each oral exam for at least two years following the date of the exam; the Board proposed to shorten the time period to one year to conform to the language of Business and Professions Code section 2945.

• Section 1389(a) currently provides that all requests for reconsideration of a failed oral exam must be submitted in writing to BOP within 60 days following notification of failure. The Board proposed to reduce the period for filing a request for reconsideration to 30 days from the date of notification of failure, and provide that requests for reconsideration must be based on procedural errors during the administration of the exam; requests for reconsideration challenging the
content of the oral exam or the appropriateness of a response will not be considered.

- The Board proposed to repeal section 1389(b), which currently provides that a failed oral exam will be reconsidered by BOP if the applicant receives a grade of 72.1 or greater, and authorizes BOP to reconsider an exam with a grade of less than 72.5.

- Section 1389(d) currently provides that there shall be no reconsideration of the grade received on "an objective written examination." This proposal would delete the language "an objective written examination" and insert "the written licensing examination administered by the Board."

- The Board also proposed to repeal section 1390(b), which currently authorizes an examinee to inspect his/her oral exam rating sheet or the recording of his/her oral exam within one year following the exam.

- Finally, BOP proposed to amend section 1390(c), which currently provides that no inspection is allowed of the written exam administered by the Board, to state that no inspection of the oral exam administered by the Board is allowed either.

Following public comment by several witnesses, the Board adopted the proposed regulations but with several modifications. Specifically, BOP deleted the proposed addition to section 1389(a) which would have expressly stated that a request for reconsideration challenging the content of the oral exam or the appropriateness of a response will not be considered. Also, the Board declined to repeal section 1390(b), and instead amended it to permit inspection only of the electronic recording of an oral exam within a period of one year; accordingly, the Board also declined to adopt the proposed amendment to section 1390(c).

Board staff released the modified language of the proposed regulatory changes for an additional 15-day comment period ending on April 20; at this writing, the rulemaking file on the proposed regulatory changes awaits review and approval by the Department of Consumer Affairs (DCA) and OAL.

Fee Increase Approved. At its November 1994 meeting, BOP approved staff's request to increase the Board's initial licensing fee and biennial renewal fee to $475 effective July 1, 1995. The primary reason for the fee hike is to cover increased enforcement costs. [15:1 CRLR 78; 14:4 CRLR 82] At this writing, staff is in the process of preparing the notice of proposed rulemaking, and the Board hopes to hold a public hearing on the regulatory proposals at its August meeting.

LEGISLATION

SB 1119 (Watson), as amended May 15, would provide that if a licensed psychiatrist, psychologist, marriage, family, and child counselor, or clinical social worker is appointed as an expert witness by a court in a matter relating to child custody or child welfare, no court-directed activity by that person within the scope of that appointment may be the subject of any disciplinary investigation or action by his/her licensing body. This bill would provide that it shall not be construed to apply to willful acts of unprofessional conduct by an appointed expert witness. [S. Jud]

SB 777 (Polanco), as amended May 2, is CPA's bill to authorize psychologists with special training to prescribe drugs. [14:4 CRLR 82] This bill would require BOP to establish and administer a certification program to grant licensed psychologists prescriptive authority, as defined, and to develop procedures for that certification with the advice of the state Department of Health Services and the Board of Pharmacy; require each applicant for certification to satisfy certain educational and training requirements; and delete the existing exclusion of the prescribing of drugs by certified psychologists from the practice of psychology. [S. B&P]

AB 1586 (House), as introduced February 24, would expand the class of persons required to be licensed in order to practice psychology by repealing Business and Professions Code section 2910, which currently exempts from the Psychology Licensing Law persons who are salaried employees of accredited or approved academic institutions, public schools, or governmental agencies. [A. Health]

AB 944 (Gallegos). Under existing law, the rules of a health facility may enable the appointment of clinical psychologists on the terms and conditions that the facility may establish. As introduced February 22, this bill would instead require the rules of a health facility to include provisions for the use of the facility by, and staff privileges for, duly licensed clinical psychologists. The bill would provide that medical staff status in health facilities with respect to the practice of psychology shall include the right to practice full clinical privileges for holders of a M.D. degree or a doctorate degree in psychology within the scope of licensure. This bill would require a health facility to establish a staff to regulate the admission, conduct, suspension or termination of the staff appointment of clinical psychologists. [A. Health]

LITIGATION

In Opinion No. 94-1007 (May 11, 1995), Attorney General Dan Lungren found that a clinical psychologist who is a member of the medical staff of a health facility may, subject to the rules of the facility and in order to protect the patient from injury to self or others, order temporary restraint (but not seclusion) in an intermediate care facility for the developmentally disabled and in an intermediate care facility for the developmentally disabled-rehabilitative, and both restraint and seclusion in a psychiatric health facility.

The opinion comes in response to a request by Senator Dan Boatwright, and to the California Medical Association's petition requesting that the Department of Health Services (DHS) amend sections 73627, 77103, and 76867, Title 22 of the CCR, to remove provisions which currently authorize clinical psychologists to order restraints and/or seclusion in these facilities. [15:1 CRLR 78; 14:4 CRLR 83] CMA primarily complained that the use of restraints and/or seclusion does not fall within the practice of psychology as described in Business and Professions Code section 2903. The Attorney General rejected CMA's position, and found that the issue turns on whether DHS may, under the statutory scheme, adopt regulations authorizing and limiting the imposition of restraint and seclusion by anyone within a health facility, and not merely to members of the medical staff, in order to protect the patient from injury to him/herself or others. Viewing the matter in this light, and noting that clinical psychologists may serve as members of the medical staff of a health facility, the AG found that DHS is authorized by Health and Safety Code section 1275 et seq. to adopt standards in connection with these health care facilities, and that the challenged sections of DHS' regulations are valid.

RECENT MEETINGS

At BOP's March 18 meeting in San Francisco, staff presented—and the Board approved—criterias for selecting experts to review disciplinary cases. Under the new policy, therapists seeking to serve as BOP experts must (1) submit a current curriculum vitae which documents training, education, and experience; (2) complete a questionnaire to identify area(s) of expertise; (3) have a valid license issued at least three years prior to application; (4) have no past or present enforcement action (de-
BOP invited several proponents of the MBTI to the May meeting to give their opinion on the test’s significance. These representatives claimed that the MBTI is not a test designed to diagnose mental disorders, but is rather an instrument which measures personal preferences or style. For this reason, the instrument is most often used in counseling and advising persons on career choices. As stated in its instruction manual and supporting materials, the MBTI was not designed to measure pathology or psychological dysfunction; as such, the MBTI proponents recommended that the Board not limit its use to licensed psychologists. BOP decided not to take an official position on the MBTI at this time, but directed staff to further investigate this issue by speaking with representatives of other state boards which have previously dealt with this issue. At this writing, Board staff hopes to present more information at BOP’s November meeting.

Also in May, the Board reviewed its enforcement statistics for the first ten months of the 1994–95 fiscal year. From July 1 to May 1, BOP received 478 complaints, opened 135 investigations, and forwarded 46 cases to the Attorney General’s Office for disciplinary action and/or to a district attorney’s office for criminal action. During that same time period, the Board filed 20 accusations and made a total of 42 disciplinary decisions (including the revocation of ten licenses). Of the 42 disciplinary decisions, 16 were for sexual misconduct, eight were for gross negligence/incompetence, and seven were for criminal conviction.

Finally, at its May meeting, BOP re-elected Bruce Ebert, Ph.D., J.D., as Board Chair, Judith Janaro Fabian, Ph.D., as Vice-Chair, and Philip J. Schlessinger, Ph.D., as Secretary.

FUTURE MEETINGS
August 16–17 in San Diego.
November 17–18 in Sacramento.
March 8–9, 1996 in Sacramento.
May 17–18, 1996 in Los Angeles.
August 16–17, 1996 in San Francisco.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE
Executive Officer: Carol Richards (916) 263-2666

The Speech-Language Pathology and Audiology Examining Committee (SPAEC) consists of nine members: three speech-language pathologists, three audiologists and three public members (one of whom is a physician). SPAEC currently functions under the supervision of the Medical Board of California (MBC).

The Committee administers examinations and licenses speech-language pathologists and audiologists, and registers speech-language pathology and audiology aides. SPAEC hears disciplinary matters assigned to it by the Medical Board, including but not limited to any contested case or any petition for reinstatement, restoration, or modification of probation. Decisions of the Committee are forwarded to MBC for final adoption.

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

Recently, SPAEC member Jacquelyn Graham, a speech-language pathologist, resigned from the Committee. At this writing, Governor Wilson has yet to name her replacement.

MAJOR PROJECTS
Committee Adopts Updated Mission Statement. In light of the 1994 passage of SB 2036 (McCorquodale), Executive Officer Carol Richards noted at SPAEC’s October 1994 meeting that a revision of the Committee’s current mission statement might be in order. SB 2036, the “sunset bill,” calls for mandatory review and potential abolition of a number of licensing boards within the Department of Consumer Affairs (DCA), including SPAEC. [14:4 CRLR 83] The Committee decided to circulate a draft of the updated mission statement and associated goals for member approval and/or suggested provisions for inclusion. [15:1 CRLR 79]

At its January 20 meeting, the Committee adopted a new mission statement emphasizing its commitment to “maintaining legislative and regulatory guidelines which promote a scope of professional practice responsive to the demands of dynamic professions and improvements in technology.” The statement also accen-
tuates the maintenance of high standards for licensure in order to assure high-quality consumer services, as well as the importance of aggressively pursuing all consumer complaints regarding licensees.

Occupational Analyses in Full Swing.
Also at its January meeting, SPAEC discussed the occupational analyses of the speech-language pathology and audiology professions being conducted by DCA’s
Office of Examination Resources (OER). [15:1 CRLR 79; 14:4 CRLR 84-85] The purpose of the project is to define the practices of speech-language pathology and audiology in terms of actual job responsibilities and the knowledge, skills, and abilities necessary to perform those responsibilities. This information will be gathered through a survey of current practitioners. According to SPAEC staff, such a survey has never been conducted, either on a national or local level. The Committee hopes that the availability of this information will assist in the revision of the current California exam or, alternatively, enable SPAEC to furnish information to the American Speech-Language Hearing Association (ASHA) for use in updating the national exam.

OER Manager Dr. Norman Hertz appeared before the Committee to provide a brief overview of the project, including its anticipated cost. The total expenditure for one complete program analysis, including printing and postage costs of pre- and post-survey mailings, was estimated at $16,500. Since audiology and speech-language pathology are two separate "programs," this cost would be multiplied by two.

OER's Dr. Roberta Chinn, who provided the actual project plan and who will conduct the analysis, also appeared before the Committee. Dr. Chinn explained the process and indicated that her primary function is the gathering of information and weighing of its importance in relation to the actual practice of licensees. A final report will be produced at the completion of the project and presented to the Committee for interpretation.

Although SPAEC licensure is not mandated for public school personnel who provide speech-language pathology and/or audiology services, this setting will be included in the analysis pursuant to a request of the Committee.

**Extended Practice Issues.** At its April meeting, SPAEC continued its ongoing discussion of several procedures which are not presently covered by statutes establishing the scope of practice of SPAEC licensees [15:1 CRLR 79; 14:2 & 3 CRLR 88; 14:1 CRLR 68], this time focusing on the practice of strobovideolaryngoscopy—a laryngeal imaging procedure which is utilized in the field of otolaryngology (the branch of medicine dealing with disorders of the ear, nose, and throat) as a diagnostic procedure.

Currently, physicians are the only professionals authorized to administer this procedure. However, members of the Committee have previously indicated that there are limited circumstances where the offering of strobovideoendoscopic procedures by speech-language pathologists is appropriate and should be legalized when an individual has demonstrated the appropriate preparation and competence. In this regard, SPAEC noted that a draft position paper on the use of strobovideolaryngoscopy by speech-language pathologists has been submitted to ASHA and the American Academy of Otolaryngology, both of which have been working on this issue for several months. The draft position paper, which states that speech-language pathologists with experience in voice disorders and with specialized training in strobovideolaryngoscopy should be permitted to use this tool in an interdisciplinary setting, is scheduled for publication in ASHA's journal for comment later this year.

SPAEC legal counsel again noted that the actions of private trade or professional associations are irrelevant to the scope of practice of speech-language pathologists and audiologists in California, and that expansions in the scope of practice—especially where accompanied by additional educational, training, and/or supervised professional experience requirements—must be authorized by the legislature. The Committee discussed the possibility of administering a specialty certification program for specific types of extended practices; for example, the Board of Registered Nursing offers specialty certification programs to its registered nurse licensees who have secured additional education and training and seek to be certified as a nurse practitioner or certified nurse-midwife. This option, which must be legislatively authorized, would permit SPAEC licensees to demonstrate their competence to engage in extended practice.

**Provision of Services in Private Schools.** At its January and April meetings, the Committee discussed an apparent conflict in the interpretation of SPAEC's licensure statutes in the Business and Professions Code and the Department of Education's (DOE) regulations governing the provision of speech-language pathology and audiology services in public schools and in private schools which are under contract to public schools.

As noted above, Business and Professions Code section 2530.5 exempts from SPAEC's licensing requirement public school personnel who provide speech-language pathology in audiology services, so long as they hold the appropriate credential from the Commission on Teacher Credentialing (CTC) and meet other specified requirements. Individuals who perform the same services in a private school must be licensed by SPAEC. Recently, the Committee was approached by a speech-language pathologist candidate who advised Committee staff that she intended to apply for licensure and was gaining her required professional experience (RPE) in a private school; however, she had never registered with SPAEC or filed her RPE plan with SPAEC for approval, pursuant to Business and Professions Code section 2532.2. Executive Officer Richards informed the applicant that she was engaging in the unlicensed practice of speech-language pathology. However, the candidate explained that her private school employer was mandated to provide the services in question, and had entered into a contract to provide those services with the county department of education. The candidate informed Richards that her school principal and the county considered her private school employer to be a public school for this purpose, as it is providing state-mandated services. Inasmuch as the candidate was providing services in an "exempt setting," the department of education had advised her that her credential was sufficient.

Richards believes that DOE's interpretation of its regulations directly conflicts with SPAEC's licensing statutes. At SPAEC's April meeting, Richards noted that private schools handle the provision of speech-language pathology and audiology services in a number of ways: (1) they contract with SPAEC licensees for provision of the services; (2) they directly employ a SPAEC licensee; (3) some have an agreement with public schools whereby the children receive the services through the public schools; (4) some employ properly credentialed but unlicensed personnel to provide the services; or (5) some employ less than qualified, unlicensed personnel to provide the services. According to Richards, the first three scenarios comply with the letter of the law, the fourth—while not legal under the Business and Professions Code—"has some potential," while the last one "definitely does not."

SPAEC agreed to form a subcommittee to gather information on this issue, including information on CTC's speech-language pathology and audiology credential requirements.

**Use of Speech-Language Pathology and Audiology Aides.** At its April meeting, SPAEC discussed its response to a letter from O.T. Kenworthy, Ph.D., Commissioner on Professional Practice of the California Speech-Language-Hearing Association (CSHA), which asked the Committee to clarify its policy on the use of support personnel by licensees. [12:4 CRLR 110; 12:1 CRLR 86-87; 11:4 CRLR 101] Dr. Kenworthy noted the increased use of less expensive aides as opposed to licensees in the managed care environment.

In response to specific questions by Dr. Kenworthy, and citing to Business and
REGULATORY AGENCY ACTION

Professions Code section 2530.6 and sections 1399.170-177, Title 16 of the CCR, SPAEC clarified as follows:

- Aides may not carry out language therapy programs, as aides are not required to complete any educational requirements. To date, aides have not been approved to perform brief evaluations or screenings, nor to provide information to parents or patients regarding the findings or outcomes.
- There are no minimal training requirements for aides. Each individual supervisor should determine what type of training would best suit the proposed duties of a particular aide.
- The supervisor must be physically present while the aide is assisting with the provision of services. SPAEC interprets section 1399.172(c), Title 16 of the CCR, to require 100% supervision of the aide by the supervisor, unless SPAEC has approved an alternative plan outlining the specific duties of the aide and the percent of supervision proposed.
- With regard to billing for the services of aides, SPAEC stated that it has no jurisdiction over billing practices (except to the extent they constitute fraud by a licensee or unlicensed practice). While this issue might be of interest to Medi-Cal or other payors, SPAEC’s attorneys have consistently advised that billing is not within its jurisdiction.
- With regard to the corporate status of the employer, SPAEC stated that it has no jurisdiction over billing practices (except to the extent they constitute fraud by a licensee or unlicensed practice). While this issue might be of interest to Medi-Cal or other payors, SPAEC’s attorneys have consistently advised that billing is not within its jurisdiction.

Employment of a Speech-Language Pathologist or Audiologist by a General Law Corporation. At SPAEC’s meeting, DCA legal counsel Kelly Salter presented an updated legal memorandum on (1) whether speech-language pathologists and audiologists may be employed by general law corporations or other business entities, and (2) whether speech-language pathologists and audiologists may be employed by individuals who are unlicensed or licensed in a different profession. [13:4 CRLR 74]

Traditionally, California law has prohibited the employment of health care professionals by unlicensed or differently licensed individuals or businesses. However, this ban has been relaxed in recent years. Based on her analysis, Salter concluded that there is no express language in the statutes which would prohibit SPAEC from interpreting the law to permit the employment of speech-language pathologists or audiologists by general law corporations or other business entities, should it so choose, provided that the employment agreement, whatever its form, does not involve referrals for consideration, and does not advertise or imply the licensure of unlicensed persons or impute the licensure of one type of professional to another type of professional. Salter noted that SPAEC’s historical prohibition against individual non-licensed employees of speech-language pathologists and audiologists is backed both by legal opinions of DCA and the Attorney General’s Office and by the “substantial risk that an individual non-licensed employer will exercise supervision and control over the practice of a professional employee,” and stated that “this policy should probably continue.”

The Committee decided to solicit members’ views in writing, and placed this issue on its July agenda.

Future Rulemaking. At its January and April meetings, SPAEC continued its discussion of two future rulemaking proposals. The first regulatory change would require that SPAEC’s waiver of the licensure requirement for aides, as long as SPAEC has approved an alternative plan outlining the specific duties of the aide and the percent of supervision proposed.

- With regard to billing for the services of aides, SPAEC stated that it has no jurisdiction over billing practices (except to the extent they constitute fraud by a licensee or unlicensed practice). While this issue might be of interest to Medi-Cal or other payors, SPAEC’s attorneys have consistently advised that billing is not within its jurisdiction.
- With regard to the corporate status of the employer, SPAEC stated that it has no jurisdiction over billing practices (except to the extent they constitute fraud by a licensee or unlicensed practice). While this issue might be of interest to Medi-Cal or other payors, SPAEC’s attorneys have consistently advised that billing is not within its jurisdiction.

Legislation

SB 563 (Rogers), as amended April 26, would increase the continuing education requirement for hearing aid dispensers licensed by the Hearing Aid Dispensers Examining Committee (HADEC) from six to nine hours per calendar year. This bill would affect a large number of SPAEC licensees, as 50% of SPAEC’s licensee population dispense hearing aids as part of their practice and are cross-licensed by HADEC. [S. Floor]

Recent Meetings

At its January 20 meeting, the Committee discussed a request by the International Association of Laryngectomees (IAL) for temporary waiver of the licensure requirement for professional-faculty attendees of IAL’s annual meeting in San Francisco in July 1995. Legal counsel advised that SPAEC’s statutes do not authorize it to grant such an exemption, and that such an action could subject the Committee and/or members to liability should a mishap occur. As an alternative to temporary waiver of the licensure requirement, the Committee agreed to advise IAL that participants in the annual meeting could apply for temporary licenses under Business and Professions Code section 2532.2(d) authorizing ASHA-approved or other-state-licensed professionals to practice in California for up to 150 days.

Also at its January 20 meeting, the Committee elected audiologist Stephen Sinclair as its chair for 1995. Dr. David Alessi was elected as the new Vice-Chair for 1995.

At SPAEC’s April meeting, staff presented a revised version of SPAEC’s Student Manual for Licensure in the Speech-Language Pathology and Audiology. The manual contains information on California licensure requirements, including academic coursework standards, clinical practice criteria, and RPE, as well as the licensure process in general.

Future Meetings

July 21 in southern California.

Board of Nursing Home Administrators

Executive Officer: Kim Smith (916) 263-2685

Pursuant to Business and Professions Code section 3901 et seq., the Board of Nursing Home Administrators (BNHA),