meeting, and architecture. The Enforcement Committee needs a precise definition of "landscape architect" so it can tell when an unlicensed individual is violating the law. Enforcement Committee member Reed Dillingham drafted two versions of proposed revisions to section 5615 which are much shorter and illustrate the types of activities in which landscape architects engage.

CCASLA representative Dick Ratliff cautioned the Board to proceed with care on revising the statutory definition. Department of Consumer Affairs legal counsel Don Chang agreed, noting that such a proposal might raise excessive scrutiny of the profession and the Board by engineers, architects, and the legislature. However, several Board members stated that the current definition is so vague as to be unenforceable, and urged that the project continue. BLA took no action on either version drafted by Dillingham, and will discuss this issue further at future meetings.

**PELA and Possible Reciprocity with Other States:** At its November 19 meeting, BLA discussed whether to accept an invitation from Michigan's Board of Landscape Architects to make a presentation at a future Michigan board meeting on the PELA; the Michigan board is interested in accepting the PELA for license reciprocity purposes. Rather than paying for someone to attend the Michigan board meeting, the Board approved a motion instructing staff and HRStrategies, the Board's exam vendor, to respond to other state board requests for information about the PELA and to encourage reciprocity wherever possible.

**LEGISLATION**

**Future Legislation.** Along with possible sponsorship of a bill revising the definition of "landscape architect" (see above), BLA is expected to sponsor several legislative proposals during 1994. Last July, BLA approved proposed legislative changes to (1) require landscape architects to use 20% recyclable materials for their design plans, (2) amend Business and Professions Code section 5650 to require six years of education and/or experience in landscape architecture, and (3) increase the fee for filing a motion directing legal counsel to draft the language of a proposed policy establishing a fee for candidates who wish to review their PELA exam. The Board also agreed not to distribute its old PELA exams to review course providers, but to provide them with the candidate's handbook instead.

Finally, the Board elected its officers for 1994. Larry Chimbote was elected to another term as Board President, and Marian Marum was elected Board Vice-President.

**FUTURE MEETINGS**

May 6 in Sacramento.
August 5 in Sacramento.
November 4 in Sacramento.

**MEDICAL BOARD OF CALIFORNIA**

**Executive Director:** Dixon Arnett
(916) 263-2389
Toll-Free Complaint Number: 1-800-MED-BD-CA

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 non-physicians appointed to four-year terms, is currently divided into three autonomous divisions: Licensing, Medical Quality, and Allied Health Professions.

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

The functions of the individual divisions are as follows:

MBC's Division of Licensing (DOL) is responsible for issuing regular and probationary licenses and certificates under the Board's jurisdiction; administering the Board's continuing medical education program; and administering physician and surgeon examinations for some license applicants.

In response to complaints from the public and reports from health care facilities, the Division of Medical Quality (DMQ) reviews the quality of medical practice carried out by physicians and surgeons. This responsibility includes enforcement of the disciplinary and criminal provisions of the Medical Practice Act. It also includes the suspension, revocation, or limitation of licenses after the conclusion of disciplinary actions.

Until July 1, 1994, the Division of Allied Health Professions (DAHP) directly regulates five non-physician health occupations and oversees the activities of eight other examined committees and boards which license podiatrists and non-physician certificate holders under the jurisdiction of the Board. The following allied health professions are subject to the oversight of DAHP: acupuncturists, audiologists, hearing aid dispensers, medical assistants, physical therapists, physical therapist assistants, physician assistants, podiatrists, psychologists, psychological assistants, registered dispensing opticians, research psychoanalysts, speech pathologists, and respiratory care practitioners. Pursuant to the provisions of SB 916 (Presley) (Chapter 1267, Statutes of 1993), DAHP will cease to exist on July 1, 1994, and its members will be transferred to DMQ. [13:4 CRLR 55, 60]

MBC's divisions meet together approximately four times per year. Individual divisions and subcommittees also hold additional separate meetings as the need arises.

Three new gubernatorial appointees were sworn in at the Board's November
would resort to litigation without warning pressed anger and dismay that in open session, Board members ex-

ed. In December, the Governor appointed Cathryn Bennett Warner, one of his for-

r staff members, to replace Barbara Stemple, who resigned from DAHP. Until recently, Warner served as Director of the Northern California Office of the Govern-

or in San Francisco.

**MAJOR PROJECTS**

**Implementation of Public Disclosure Policy Followed by Trade Association Lawsuit.** On October 1, MBC finally im-

plemented the long-awaited public disclosure policy it approved last summer. After reconfiguring its computer system and training its telephone staff, the Board fi-

nally began to disclose several new cate-

gories of information about physician conduct to inquiring consumers, including felony convictions, medical malpractice judgments in excess of $30,000, and prior disciplinary actions against physi-

icians to inquiring consumers. However, the court preliminarily enjoined MBC from disclosing completed investigations at point of referral to the Attorney General's Office; under the court order, these cases may not be disclosed until the accusation is filed.

At this writing, the parties are engaged in discovery and briefing in anticipation of another oral argument on CMA's re-

quest for permanent injunction. (See LIT-

IGATION for a detailed description of this case.)

**Annual Report Indicates MBC En-

forcement Output Down in 1992-93.** MBC recently published its enforcement statistics for fiscal year 1992-93. Despite (or perhaps due to) the unusual public focus on the Board's enforcement pro-

gram resulting from the forced resignation of former MBC Executive Director Ken Wagstaff in November 1992, the release of the California Highway Patrol audit in January 1993, the March 1993 Medical Summit, and the pendency of SB 916 (Pre-

sley) throughout the spring and summer, the Board's disciplinary output actually decreased from fiscal year 1991-92 in several key areas. [13:1 CRLR 46]

For example, the total number of MBC disciplinary actions was 149 in 1992-93 (down from 162 in 1991-92), although the number of disciplinary actions for negligence/incompetence increased from 23 in 1991-92 to 57 in 1992-93, and the num-


The annual report also indicates that the time lag for case processing by MBC increased during 1992-93. On the aver-

age, cases languished for 104 days in the Board's Central Complaint Intake and

Control Unit (CCICU) before being as-

signed for formal investigation (up from an average of 72 days in 1991-92); they then spent an average of 90 days under formal investigation before being dis-

missed or forwarded to the Attorney General's Health Quality Enforcement Section (HQES) for disciplinary filing (up slightly from 89 days in 1991-92). The average time spent from MBC's receipt of a complaint to disposition (either by way of dismissal or referral to HQES) thus totalled 194 days, which exceeds the 180-

day statutory goal in Business and Profes-

sions Code section 2319. On top of 194 days at the Medical Board, the report indi-

cates that fully investigated cases then sit in HQES for an average of 282 addi-
tional days (up from 253 days in 1991–

92)—over 9.4 months—before the ac-

cusation is actually filed and the disciplinary proceeding begins. This statistic under-

scores the need for additional staffing of HQES, as argued in CMA v. Arnott (see LITIGATION).

Thus, MBC's overall enforcement per-

formance is down, and pales in compar-

ison to external reports of physician in-

competence and misconduct received by the Board. During 1992-93, MBC re-

ceived a total of 842 reports of medical malpractice judgments or settlements in excess of $30,000; and the hospital privi-

leges of 175 physicians were revoked, sus-

pended, or restricted for medical cause or reason.

While 149 total disciplinary actions in 1992-93 appears unacceptable in light of these statistics, the Board's performance improved markedly in one key area: In 1992-93, MBC filed 476 accusations, as compared with 270 in 1991-92. This num-

ber appears to reflect extra effort on the part of MBC investigators to clear away the historical backlog of cases pending at the Board, and clearly indicates height-

ened HQES output in spite of its severe understaffing. Hopefully, the increase in filed accusations means that the Board's overall 1992-93 statistical performance is an aberration, and that MBC's 1992-93 figures will reflect enforcement activity at a level consistent with actual physician incompetence and misconduct.

**Board Prepares for Implementation of "Presley II."** At its November meeting, the Board and staff discussed preparations which are under way for the implementa-

Specifically, the Board noted that DAHP's five members would join DMQ on January 1. Thus, DMQ will expand from seven to twelve members on the effective date of the bill, and will immediately split into two panels of six members each for purposes of reviewing individual discipline cases. Each panel will consist of four physicians and two public members, and the membership of the panels must be rotated annually. As SB 916 does not officially abolish DAHP until July 1, 1994, DAHP members will serve "double duty" until that date.

Board members discussed several issues related to the new two-panel DMQ. First, existing DMQ members suggested that they be split between the two panels to assist former DAHP members in adjusting to their new responsibilities. MBC Executive Director Dixon Arnett stated that staff would suggest such a mixture, but noted his belief that assignment of DMQ members to a particular panel is the prerogative of the Governor. At this writing, it unclear whether the Governor will appoint DMQ members to a particular panel or whether the DMQ President will carry out that task, as appears to be contemplated by SB 916 in its amendment to Business and Professions Code section 2230. The Division also discussed the procedure in case there is a 3-3 tie on the even-numbered panels; one suggestion was to send such cases to the other panel for review. Although this is a possibility, it may well defeat the purpose and intent of creating two panels, which is to expedite DMQ's review of individual disciplinary cases.

MBC to Increase Licensing Fees. Although some question remains about whether SB 916 (Presley) authorizes it to do so (13:4 CRLR 55-56), at its November 4 meeting DOL adopted emergency amendments to sections 1351.5 and 1352, Title 16 of theCCR, which increase MBC's biennial initial and renewal licensing fees from $500 to $600; in other words, MBC's licensing fees will increase to $300 per year effective January 1, 1994. The fee increase is needed primarily to enhance the staffing of the Health Quality Enforcement Section in the Attorney General's Office. On December 3, the Office of Administrative Law (OAL) approved the emergency regulatory action, which is now valid for 120 days. On December 17, OAL published notice of its intent to permanently adopt the fee increases, and scheduled a February 3 public hearing on the matter.

Citation and Fine Regulations. At its November 4 meeting, DMQ adopted a scaled-back version of sections 1364.10-.14, Title 16 of theCCR, its proposed citation and fine regulations. The proposed rules, which were the subject of an initial public hearing on September 13, were modified in response to comments made by CMA. [13:4 CRLR 58; 13:2 & 3 CRLR 79-80]

The modified rules list 56 sections of the Business and Professions Code, the violation of which may warrant a citation and/or fine. This list of violations, which are primarily technical in nature, was pared back from that proposed in September in response to CMA criticism that citation and fine treatment is inappropriate for "quality of care" issues because citations and fine decisions are made by non-physician MBC enforcement staff as opposed to DMQ members.

While the rules delegate citation and fine authority to six board officials, only the Enforcement Chief and Deputy Enforcement Chief will issue citations and fines during the first year of the program. After this probationary period, MBC will review the program and consider whether to extend such authority to each of the three area supervisors and the DOL Program Manager. The rules permit the issuance of a citation which includes an order of abatement; the citation may also include a fine ranging from $100 to $2,500. A cited licensee may challenge any citation by requesting, in writing, an informal conference with the issuing official within ten days of service or receipt of the citation. Upon receipt of such a request, the issuing official must hold the informal conference within thirty days; the licensee is permitted to have legal counsel present at the conference. At the conclusion of the conference, the official may affirm, modify, or dismiss the citation and any fine levied or abatement order issued. The decision of the official must state the reasons for the findings and be served upon the respondent in writing within ten days of the informal conference.

A licensee's request for an informal conference does not waive his/her right to a formal hearing before an administrative law judge, at which the licensee or his/her legal counsel may challenge the citation. A request for a formal hearing must be made in writing to the Board within thirty days of the date of the issuance of the citation.

The citation and fine sanction is a matter of public record, such that it will be disclosed to an inquiring consumer under the Board's new public disclosure policy. However, it will not be reported to the National Practitioner Data Bank because DMQ does not deliberate or vote on it. Because the version of the citation and fine regulations approved by DMQ on November 4 differed from the originally-proposed version, DMQ released the modified language for an additional 15-day comment period which ended on December 3. The regulations await review and approval by OAL.

Diversion Task Force. At its November 4 meeting, DMQ heard a report from Diversion Task Force member Dr. Alan E. Shumacher on the state of the Diversion Program, recommendations for improvement of the Program, and the need for the Task Force's continuing existence. Under Business and Professions Code section 2340, the Diversion Program attempts to identify and rehabilitate physicians who are impaired due to substance abuse or mental illness. MBC created the Task Force after the March 1993 Medical Summit and in response to harsh criticism of the Diversion Program by the California Highway Patrol in its January 1993 audit. [13:2 & 3 CRLR 78-80]

Dr. Shumacher explained that the Task Force believes that the Diversion Program should remain within the Medical Board, and that CMA's Liaison Committee to the Diversion Program should have a greater role in overseeing the program. Specifically, the Task Force recommended that the CMA Liaison Committee assist in developing an annual performance evaluation of Diversion Program group facilitators (GF), individuals who conduct Program-required group counseling sessions of diversioners across the state; refine the guidelines for selection of new GFs when the need arises; and develop a list of psychiatric consultants for use by MBC's six regional Diversion Evaluation Committees.

The Liaison Committee will also assist DMQ in addressing a nagging unresolved issue which presents potential liability problems for the Medical Board—whether the Diversion Program is therapeutic or primarily monitoring in nature. [13:2 & 3 CRLR 80] Diversion Program documents reviewed by the Task Force indicate that GFs are expected to provide "recovery-oriented psychotherapy which focuses on the use of 12-step programs" in the required group sessions. The therapeutic nature of the sessions may prove problematical for DMQ, as not all GFs are licensed therapists and it is unclear whether the Diversion Program's job description for GFs even requires licensure. The Liaison Committee suggested further study of this issue as a top priority, and recommended that DMQ consult with the Attorney General's Office to determine Board and facilitator liability for authorizing unlicensed therapy in the Diversion Program.
Following a review of several other Task Force recommendations, Dr. Shumacher stated his belief that the Task Force has completed its review of the effectiveness of the Diversion Program, and that its responsibilities should be passed to the CMA Liaison Committee. DMQ President Dr. Michael Weisman agreed that the Task Force has completed its duties, but recommended that DMQ assign two members to the CMA Liaison Committee to supervise and facilitate further discussion concerning the Program.

Before DMQ voted on whether to sunset the Task Force, Enforcement Chief John Lancara expressed concern that the therapy-vs.-monitoring issue is unresolved, and asked DMQ to formally refer the matter to the Attorney General's Office. Center for Public Interest Law intern Scott Vincent echoed Lancara's concerns, and also reminded DMQ that it had agreed to look into the issue of GF compensation and possible conflicts that may arise when GFs are paid directly by Program participants. Dr. Weisman directed staff to review the issue and place it on the agenda for the Division's February meeting. DMQ member Karen McElliott's motion to dissolve the Task Force, with the stipulation that the issues of facilitator payment and Board liability for unlicensed practice be considered at the February meeting, passed unanimously.

Use of Medical Consultants and Experts. On November 4, MBC's Task Force on Medical Quality Resources held a special meeting to hear a presentation by representatives of the Florida Department of Professional Regulation (FDPR). The Task Force is exploring alternatives to MBC's current practice of hiring full-time "medical consultants"—physician employees who work out of MBC's regional offices—to review and assist in the analysis of medical records gathered by DMQ investigators in cases where quality of care is at issue. Instead of using employee physicians like MBC's medical consultants to review quality-of-care complaints and investigations, FDPR uses a group of 164 volunteer physicians to review these cases, which it says saves the Florida Board of Medicine $240,000 during 1992. FDPR claims that its Medical Advisory Committee has not only saved money but also improved the quality of review and expedited the process.

MBC's Task Force is charged with re-examining MBC's entire system of medical review of disciplinary cases, including contract/volunteer medical consultants used at the complaint and investigative levels; the qualifications and role of current full-time medical consultants now working from each of the Board's twelve regional offices; and the role of volunteers (both physician and non-physician) located geographically at the community level to provide counseling, community outreach, and other duties representing the Board. This last function is intended to replace MBC's Medical Quality Review Committees, which were abolished in SB 916 (Presley).

At this writing, the Task Force is scheduled to hold two more hearings (on January 10 and February 3) before presenting a report to DMQ at its February 4 meeting.

MBC Rulemaking. The following is a status update on rulemaking proceedings undertaken by MBC's divisions over the past few months and reported in detail in previous issues of the Reporter.

- **SB 2036 Rule Rejected.** On October 19, OAL rejected MBC's adoption of new section 1363.5, Title 16 of the CCR, to implement SB 2036 (McCordquade) (Chapter 1660, Statutes of 1990). The new regulation attempts to define the terms "specialty board" and "specialty or subspecialty area of medicine," and establish standards for and three methods by which private specialty boards may qualify for DOL approval such that their members may advertise that they are "board certified" in California. OAL found that the rulemaking file on the proposed regulation failed to satisfy the necessity and consistency standards of Government Code section 11349.1; specifically, OAL found that MBC failed to include sufficient information on the "equivalency" criteria for approval of emerging specialty boards, and information on timeframes for application processing under the Permit Reform Act. The Board plans to correct these deficiencies and resubmit the rulemaking file on new section 1363.5 to OAL as soon as possible.

- **DOL Rulemaking.** Following a public hearing at its November 4 meeting, DOL adopted three proposed regulatory changes. First, DOL amended section 1301, Title 16 of the CCR, to authorize the referral of licensing cases to the Division's Application Review Committee or its Special Programs Committee at the request of the applicant, a Division member, or the DOL Program Manager. DOL also amended section 1321 to delete an inaccurate reference to "hospitals," and added new section 1335 to establish a fee which DOL will collect from specialty boards or associations applying for approval under the Board's new SB 2036 regulations (see above).
AB 929 (Horcher), as introduced March 1, would provide that if the trier of fact at a private peer review proceeding determines that the person who filed the complaint against the physician knowingly made a false accusation, the complainant of MBC licensee may seek civil remedies against his/her accuser. [A. Jud]

AB 720 (Horcher), as introduced February 24, would prohibit any person other than a licensed physician, podiatrist, or dentist from applying laser radiation to any person for therapeutic purposes; any person who violates this provision would be guilty of a misdemeanor. [A. Health]

AB 437 (Hart), as amended April 26, would partially authorize, notwithstanding existing provisions of law, supervision of a physical therapy aide by a physical therapist and would authorize a physician to supervise a physical therapy aide who is employed by the physician and who is authorized to provide services by specified provisions of law. [S. B&P]

AB 595 (Speier), as amended August 25, would prohibit, on and after January 1, 1996, any physician 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, as defined, approved by DOL; prohibit an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient surgical setting, as defined, unless the setting is one of those enumerated settings; require DOL to adopt standards for accreditation in accordance with prescribed criteria; require DOL to adopt standards for approval of accreditation agencies to perform accreditation of outpatient surgical settings; and permit DOL or an accreditation agency to inspect outpatient surgical settings accredited by an accreditation agency. [S. H&HS]

AB 140 (Kopp), as amended May 5, would establish that providers of medical care are not liable for the release of a patient's non-medical information unless the patient had made a prior written request to the contrary. [S. B&P]

AB 1291 (Speier), as amended July 2, would provide that it is a misdemeanor for a physician to refer persons for certain diagnostic tests and ancillary services, if the physician has a financial interest with the person or in the entity that receives the referral. This provision would apply only to a referral of a person for whom all or part of the costs of the referral are paid pursuant to Medi-Cal, the Public Employees' Retirement Law, or the Public Employees' Medical and Hospital Care Act. [S. B&P]

AB 1125 (Calderon), as amended May 19, would require the Department of Consumer Affairs to conduct a prescribed study of costs for clinical laboratory tests and to report the results to the legislature on or before May 1, 1994. [S. B&P]

AB 1294 (Lee), as introduced March 3, would repeal provisions of law which require that a certificate be obtained prior to engaging in the practice of midwifery. Instead, this bill would enact the Licensed Midwifery Practice Act of 1993, establishing within DAHP a Licensed Midwifery Examining Committee, which would issue licenses to all applicants who meet certain requirements promulgated by the Committee. The bill would also authorize the Committee to adopt regulations to carry out the Act, and require that a physician be consulted in the event of any significant deviation from normal. [A. Health]

AB 1689 (Statham), as amended April 20, would provide a tax credit of $5,000 for a taxpayer who is a qualified health care practitioner with a practice that is certified by the Office of Statewide Health Planning and Development to consist of at least 60% underserved rural patients. [A. Revs/Tax]

AB 1446 (Margolin), as introduced March 3, would require an applicant for a reciprocity MBC license to provide on the application a statement as to whether the employment or practice of the applicant has been suspended or terminated, or whether the applicant has resigned or taken a leave of absence from employment or practice, due to certain medical disciplinary investigations, causes, or reasons. [S. B&P]

AB 993 (Kelley), as introduced March 5, would state the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the creation of new categories of health care professionals who were not required to be licensed on or before January 1, 1994, or revises the scope of practice of an existing category of health professional, be supported by expert data, facts, and studies, including prescribed information. [S. B&P]

AB 1392 (Speier), as amended July 1, would require MBC, along with every other agency within DCA, to notify the Department whenever any complaint has gone thirty days without any investigative action, and authorize the DCA Director to review any complaint filed with MBC. [S. B&P]

AB 1907 (Knight), as amended April 21, would—under specified circumstances—exempt a physician who, in good faith and without compensation, renders voluntary medical services at a privately operated shelter from liability for any injury or death caused by an act or omission of the physician when the act or omission does not constitute gross negligence, recklessness, or willful misconduct. [A. Jud]

AB 2036 (Munjoy), as introduced March 5, would authorize MBC to issue an emergency order suspending a license, but only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions that violate the Medical Practice Act, and that the continued practice by the licensee pursuant to his/her license will endanger the public health, safety, or welfare. This bill would require a hearing to be conducted before an emergency suspension order is issued, unless it appears from the facts shown by affidavit that serious injury would result to a patient or to the public before the matter can be heard on notice. [A. Health]

AB 2214 (Lee), as introduced March 5, would require any physician who sells, closes, or transfers his/her medical practice to notify each patient in writing, and require that each patient be given an opportunity to determine where his/her records shall be directed. [A. Health]

AB 2156 (Polanco), as amended May 25, would require reports filed with MBC by professional liability insurers to state whether the settlement or arbitration award has been reported to the federal National Practitioner Data Bank. [S. Inactive File]

AB 1807 (Bromshvag), as amended September 8, would increase the initial and renewal license fee required to be paid by physicians; authorize MBC to charge a fee for oral examinations; and revise educational, examination, and experiential requirements for licensure as a physician. [A. Inactive File]

AB 2241 (Murray), as amended September 10, and SB 1166 (Watson), as amended September 10, would each create the Naturopathic Physicians' Practice Act and establish the Naturopathic Physicians' Examining Committee within DAHP. [A. Health, S. B&P]

LITIGATION

On November 2, over a month after MBC implemented its new public disclosure policy, CMA filed California Medical Association v. Dixon Arnett, et al., No. 376275 (Sacramento County Superior Court). [See MAJOR PROJECTS; 13:4 CCLR 1, 56–57; 13:2 & 3 CCLR 79–81]
Seeking a court order to stop MBC from disclosing information to inquiring consumers on physician felony convictions, malpractice judgments over $30,000, prior discipline, and fully investigated cases which have been forwarded to the Attorney General for disciplinary action, CMA’s complaint made two primary arguments. First, CMA argued that the Board is not permitted to disclose any of this information until it adopts regulations governing the disclosure under the Administrative Procedure Act (APA); CMA asserted that the Board’s failure to follow the APA rulemaking process renders the new policy, in its entirety, an invalid “underground regulation.”

Second, CMA challenged the Board’s disclosure of completed investigations which have been referred to the Attorney General’s Office prior to the filing of an accusation. The association argued that disclosure of these completed investigations violates physicians’ due process rights and their right to privacy under the California Constitution. In this regard, CMA complained that completed MBC investigations usually sit at the Attorney General’s Office for over nine months before an accusation is actually filed; under its new policy, MBC will disclose the fact that an investigation has been completed and charges will be sought during this time period. CMA asserted that this is unfair for two reasons: (1) in 2–3% of the cases, the AG may decline to file charges against the physician; and (2) during the nine-month time period, the physician allegedly has no ability to compel the AG to file the accusation so he/she can defend him/herself, and no ability to stop the Board from telling consumers that it has investigated the physician’s misconduct and intends to seek discipline.

In its complaint, CMA seeks preliminary and permanent injunctive relief, declaratory judgment, and payment of its attorneys’ fees by the Board under Code of Civil Procedure section 1021.5, California’s “private attorney general” statute reserved for prevailing parties whose litigation confers a public benefit on a substantial population.

On November 17, MBC filed a response to CMA’s complaint, arguing that its public disclosure policy is fully authorized by the Public Records Act (PRA), Government Code section 6250 et seq. The Board noted that information about felony convictions, malpractice judgments, and prior professional discipline is already a matter of public record and contended that it is fully authorized to disclose this information; further, the PRA does not permit CMA to pursue an action to prevent disclosure of public information. As to its disclosure of completed investigations which have been forwarded to the Attorney General’s Office, MBC argued that while the PRA permits an agency to withhold this information under the “investigatory files” exemption in Government Code section 6254(f), it does not preclude an agency from waiving that exemption if certain conditions are present. MBC argued that its public disclosure policy, which permits the disclosure of narrowly-tailored information about fully completed investigations, balances the competing interests between consumer protection and the privacy interests of the physician.

As to CMA’s APA claim, the Board argued that its public disclosure policy does not “interpret or make specific” the statutes administered by MBC; thus, no rulemaking is required. In the alternative, the Board argued that its disclosure of information to inquiring consumers falls within the “internal management” exception to the rulemaking requirements of the APA.

The Board also rejected CMA’s constitutional claims. MBC called CMA’s due process claim “singularly unpersuasive,” arguing that its disclosure of truthful information to inquiring consumers in no way deprives physicians of their vested right to practice medicine. As to the privacy issue, the Board noted that one’s privacy rights under the California Constitution are not absolute; they must be balanced against the fundamental rights sought to be protected in the Public Records Act. Quoting City of Santa Rosa v. Press Democrat, 187 Cal. App. 3d 3d 1315 (1987), MBC argued that “[i]n enacting the [Public Records Act], the Legislature, through mindful of the right to privacy, unequivocally declared that ‘access to information concerning the conduct of the people’s business is a fundamental and necessary right of every person in this state’....Thus, the provisions of the [Public Records Act] represent the Legislature’s balancing of the narrower privacy interests of individuals with the public’s fundamental right to know about the conduct of the public business.”

As to CMA’s complaint about the length of time that fully investigated cases wait at the Attorney General’s Office before an accusation is filed, the Board countered that “[t]his ‘issue’ is really nothing more than a red herring. Even after a formal Accusation has been filed, physicians cannot present their case until the start of the administrative hearing (actually the start of the physician’s case-in-chief) which may not commence for months after the initial filing of charges. Disclosure of narrowly-tailored information regarding fully investigated complaints of unprofessional conduct referred to the Attorney General’s Office thus affects no real change in a physician’s ability to challenge or defend against the allegations.”

Also on November 17, the Center for Public Interest Law (CPIL) filed an amicus curiae brief on behalf of the Board. Leaving the legal argument to the Board’s attorneys, CPIL instead addressed the public interests which—it contends—support validation of the Board’s new disclosure policy. Preliminarily, CPIL noted that under Business and Professions Code section 2229(a) and (c), the highest priority of MBC’s enforcement program is public protection; thus, when issues of physician privacy are pitted against consumer protection, the scales must tip in favor of the consumer.

CPIL also argued that the Board’s previous public disclosure policy was affirmatively misleading and provided deceptive information to the very consumers whom the Board is statutorily obligated to protect. Under the old policy, for example, Board personnel would tell an inquiring consumer that a physician’s record was “clean” in spite of their actual knowledge that the physician has two medical malpractice judgments in excess of $500,000, several criminal convictions (including driving under the influence), and is the subject of five completed MBC investigations which have been forwarded to the Attorney General’s Office for disciplinary action. Under the Board’s new policy, all of this information is disclosed to the consumer. According to CPIL, “[t]his lawsuit is not about the Medical Board’s disclosure of ‘inaccurate, misleading, and inconclusive information’ about physicians, as CMA has stated; that’s what the Medical Board has been doing for the past twenty years under its previous public disclosure policy—and that’s what its new public disclosure policy attempts to correct.

As to CMA’s complaint about the length of time between conclusion of an investigation and the filing of the accusation, CPIL argued that this situation is both CMA’s fault and within CMA’s power to correct. CPIL contended that one of the reasons it takes the Attorney General’s Office so long to process cases is because the Health Quality Enforcement Section (HQES), the unit of attorneys which handles physician discipline cases, is severely understaffed; HQES’ staffing is funded entirely with physician licensing fees; and CMA has consistently opposed the level
Thus, Judge Robie temporarily enjoined Sacramento County Superior Court. California Optometric Association challenged the General's Office; under the court order, the court denied CMA's request for preliminary injunction as to all the challenged categories of information except completed investigations which have been forwarded to the Attorney General's Office. Judge Robie noted that MBC is authorized to seek interim suspension of the license of a physician who is deemed to be dangerous, and found that "[p]ublic disclosure of disciplinary actions and other claims, the court denied CMA's request for preliminary injunction as to all the challenged categories of information except completed investigations which have been forwarded to the Attorney General's Office. Judge Robie noted that MBC is authorized to seek interim suspension of the license of a physician who is deemed to be dangerous, and found that "[p]ublic disclosure of disciplinary actions and completed investigations are appropriate fee increase which will permit adequate staffing of HQES.

Following a November 24 hearing on CMA's motion for preliminary injunction, Sacramento County Superior Court Judge Ronald B. Robie released his decision on December 2. Judge Robie flatly rejected CMA's APA argument, ruling that the Public Records Act authorizes disclosure of public information and that "it is not necessary for a state agency to adopt regulations to implement this law." As to CMA's other claims, the court denied CMA's request for preliminary injunction as to all the challenged categories of information except completed investigations which have been forwarded to the Attorney General's Office. Judge Robie noted that MBC is authorized to seek interim suspension of the license of a physician who is deemed to be dangerous, and found that "[p]ublic disclosure of disciplinary actions and other claims, the court denied CMA's request for preliminary injunction as to all the challenged categories of information except completed investigations which have been forwarded to the Attorney General's Office. Judge Robie noted that MBC is authorized to seek interim suspension of the license of a physician who is deemed to be dangerous, and found that "[p]ublic disclosure of disciplinary actions and completed investigations are appropriate fee increase which will permit adequate staffing of HQES.

At this writing, the parties are engaged in discovery and briefing in anticipation of another oral argument on CMA's request for permanent injunction. On October 8, the Sacramento County Superior Court heard oral argument in California Medical Association v. Hayes, No. 374372, CMA's challenge to the legislature's 1993 transfer of $2.7 million in pharmacy licensing fees to the Medical Board to the general fund. At its November meeting, DAHP directors approved, and DOL approved, a four-step follow-up to the Task Force's work: (1) a one-hour seminar to take place during the lunch hour of DOL's February 3 meeting; (2) DOL establishment of new prescribing guidelines (which have not been updated since 1985); (3) dissemination of Drug and Narcotic Codes to physicians upon request; and (4) staff research on the possible development of a continuing medical education course on appropriate prescribing techniques. At its November meeting, DAHP discussed whether to permit an out-of-state mail order firm which sells contact lenses to California residents to be registered as
a dispensing optician under Business and Professions Code section 2550. Although the Registered Dispensing Optician (RDO) Law does not expressly require registrants to be California residents or to have a California address as a condition of registration, DAHP has historically imposed such a requirement. Among other things, DAHP staff recommended that several out-of-state dispensers be given a "temporary authorization" until it determines whether an in-state business address is required. Attorneys for the California Association of Dispensing Opticians (CADO) urged that out-of-state dispensers are not eligible for registration under section 2550 because they do not engage in the fitting and prescribing of prescription lenses and frames to the eye and face of the customer. The Division agreed with CADO, and reaffirmed its interpretation that RDOs must have a permanent California business address.

Also in November, DAHP discussed MBC’s new responsibilities under SB 350 (Killea) (Chapter 1280, Statutes of 1993), which requires the Board to establish a certification program for lay midwives. [13:4 CRLR 61] The Division voted to recommend that DOL create a three-member committee to assist DAHP Program Manager Tony Arjil in implementing the bill. Finally, in November, the full Board and its three divisions elected officers for 1994. Public member Bruce Hasenkamp was elected Board President; Robert del Junco, MD, was chosen as Board Vice-President; and Alan Shumacher, MD, was selected Board Secretary. DOL elected Dr. del Junco as President, Camille Williams, MD, as Vice-President, and public member Ray Mallei as Secretary. DAHP chose Mike Mirahmadi, MD, as President and public member Stewart Hsieh as Vice-President and Secretary for its last six months of existence. DMQ President Michael Weissman, MD, will remain in office until the Division’s February meeting, as the Division’s vote for President resulted in a 3–3 tie between public member Karen McElliott and Clarence Avery, MD.

FUTURE MEETINGS
May 5–6 in Sacramento.
July 28–29 in Los Angeles.
November 3–4 in San Diego.

ACUPUNCTURE COMMITTEE
Executive Officer: Sherry Mehl
(916) 263-2680

The Acupuncture Committee (AC) was created in July 1982 by the legislature as an autonomous body; it had previously been an advisory committee to the Division of Allied Health Professions (DAHP) of the Medical Board of California. AC still functions under the jurisdiction and supervision of DAHP.

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

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

At its November 17 meeting, AC welcomed new public member Shawn Steel, appointed by Governor Wilson to replace former Committee member Janie Emerson. Steel, an attorney from the Los Angeles area, has a special interest in health care and alternative health care options. Also on November 17, AC public member Kathie Klass announced her resignation from the Committee effective at the end of the day. Klass is relocating to Washington, D.C.

MAJOR PROJECTS
AC Still Filing Disciplinary Charges Against Acupuncturists in 1988 Examination-for-Sale Scandal. On October 14, AC announced its filing of disciplinary charges against 27 more acupuncturists for their involvement in the 1988 Chae Woo Lew examination-for-sale scandal. [10:2 & 3 CRLR 103; 9:4 CRLR 65; 9:2 CRLR 64] This brings the number of acupuncturists facing AC disciplinary action in connection with the scandal to 55. Discipline has already been imposed on nine licensees.

The conspiracy, which was uncovered by the Los Angeles District Attorney’s Office in late 1988, involved an estimated 150–175 acupuncturists who paid then-AC member Chae Woo Lew an estimated $500,000 to $1.5 million in return for a copy of AC’s licensing exam or favorable grading on the exam. AC says its main objective is to retest individuals involved in the conspiracy to ensure that all licensed acupuncturists meet the state’s standards.

AC Rulemaking Update. Following is a status update on several AC rulemaking packages discussed in detail in previous issues of the Reporter:

- At this writing, an extensive rulemaking package adopted by AC at its February and May 1993 meetings is at the Office of Administrative Law (OAL) awaiting approval. The package includes amendments to existing sections 1399.417 (grounds for application abandonment), 1399.441 (languages in which AC’s exam will be administered), 1399.443 (passing score on AC’s exam), 1399.480 (acceptability of continuing education courses related to business management and medical ethics), and 1399.485 (completion of additional CE by inactive licensees seeking to reactivate their licenses), and the adoption of new sections 1399.444 (licenses expired for more than five years), 1399.460 (establishment of a license renewal system based upon licensee birthdate), 1399.486 (required curriculum for additional CE under Business and Professions Code section 4945.5), and 1399.487 (four hours of CE per year in business management and medical ethics). [13:4 CRLR 63; 12:2 & 3 CRLR 86; 13:1 CRLR 50–51]

- AC’s August 4 amendments to sections 1399.413 (applications for examinations must be received by AC 120 days prior to the exam), 1399.424(c) (application of training and experience obtained by a trainee prior to 1980 toward tutorial program credit), 1399.425(e) (requirements for approval of an acupuncture tutorial), 1399.445 (appeals of practical exam results), and 1399.450 (acupuncturists must provide a bathroom in their offices), and its adoption of new sections 1399.463 and 1399.464 to implement its authority to issue a citation to an individual for violation of the agency’s enabling act, and to provide a mechanism whereby a cited individual may appeal the issuance of a citation, still await review and approval by DAHP and OAL. [13:4 CRLR 63; 12:2 & 3 CRLR 86–87]

The one-year deadline in Government Code section 11346.4 passed on AC’s proposed amendments to sections 1399.436 and 1399.439. The amendments to section 1399.436 would have established the extent to which coursework completed at non-AC-approved institutions may be accepted as transfer credits for purposes of AC licensure; the amendments to section 1399.439 would have required AC-approved acupuncture schools to submit to
AC noted that it has asked the Legislative Counsel's Office for a formal opinion on the drugless herb issue; AC adopted Chang's opinion as a non-binding legal reference but agreed to further research the drugless herb issue.

AC Adopts HIV Guidelines. Also at its November meeting, AC again reviewed the Department of Health Services' (DHS) Guidelines for Preventing the Transmission of Bloodborne Pathogens in Health Care Settings. [13:4 CRLR 64; 12:3 CRLR 62-83] AC and other agencies regulating the health care professions must adopt DHS' Guidelines or an equivalent set of guidelines; under existing law, a knowing failure to follow them by an acupuncturist, without good cause, is grounds for disciplinary action. AC adopted DHS' Guidelines as Committee policy.

Committee to Reconsider Mission Statement. At its November meeting, AC decided to revisit the mission statement and set of Committee goals it adopted in August. Of particular concern is the mission statement, which includes as part of AC's mission the promotion of oriental medicine; any "promotion" role appears inconsistent with AC's mandate set forth in Business and Professions Code section 4926. [13:1 CRLR 50] At this writing, AC is scheduled to reconsider its mission statement and goals at its February meeting.

LEGISLATION

Future Legislation. At its November meeting, AC discussed its desire for a name change to the "Board of Acupuncture." Last May, AC decided to seek legislation separating it from the Medical Board in light of SB 916 (Presley) (Chapter 1267, Statutes of 1993), which abolishes MBC's Division of Allied Health Professions (under whose jurisdiction AC functions) effective July 1. [13:4 CRLR 64] AC noted that separation from MBC and a name change may need to be accomplished in a bill other than DCA's omnibus bill (AB 1807), as both proposals are surely to generate opposition from the California Medical Association.

AB 1807 (Bronshvag), as amended September 8, would provide that if, upon investigation, AC has probable cause to believe a person is advertising in a telephone directory with respect to the offer of acupuncture services incorporating specified terms, including the terms "oriental herbalist" or "certified herbalist," is guilty of a misdemeanor; this bill would delete those terms from section 4935.

Existing law requires a person who practices acupuncture to possess a license; this bill would provide that this requirement not be construed to prevent those engaged in a course or tutorial program in acupuncture from administering acupuncture treatment as part of the education program. This bill would also revise the qualifications required of an acupuncturist who may be approved to supervise an acupuncturist trainee; revise the fees relating to licensing of acupuncturists; and reduce the time within which an acupuncturist may renew his/her expired license from five to three years. [A. Inactive File]

RECENT MEETINGS

At the Committee's November meeting, AC Chair David Chen discussed a trip he and Executive Officer (EO) Sherry Mehl recently took to China and Taiwan. Approximately 20% of the applicants who sit for AC's licensing exam are foreign. AC has had a recurring problem with foreign applicants submitting forged documents from schools and training facilities in Asian countries. In an effort to alleviate the problem, Chen and Mehl traveled to China to meet with the Public Health Ministry and representatives of acupuncture training facilities to develop a system to ensure the authenticity of the documents, review facilities, and check for areas in which the state would require additional training. AC was able to work out a system with the Chinese officials whereby AC will fax to the Health Ministry and to the schools any documents received by AC from a Chinese licensure applicant; the Health Ministry and the school would then verify the authenticity of the document. The Committee believes this type of verification system is necessary to protect the consumers of California. AC's meetings with Taiwanese officials were not as productive as the meetings in China. There was some confusion regarding AC's offi-
REGULATORY AGENCY ACTION

The Committee encourages public comment. The Committee also reviews qualifications of applicants for hearing aid dispenser's license. The Committee continues to contract out for examination services. It has been administered by an outside firm, AC decided it is best to continue to contract out for examination services.

FUTURE MEETINGS
May 10–11 in Sacramento.
August 23–24 in San Diego.
November 1–2 in San Francisco.

HEARING AID DISPENSERS EXAMINING COMMITTEE
Executive Officer: 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 is authorized to issue licenses and adopt regulations pursuant to, and hear and prosecute cases involving violations of, the law relating to hearing aid dispensing. HADEC has the authority to issue citations and fines to licensees who have engaged in misconduct. Currently, HADEC recommends proposed regulations to the Medical Board’s Division of Allied Health Professions (DAHP), which may adopt them; HADEC’s regulations are codified in Division 13.3, Title 16 of the California Code of Regulations (CCR).

The Committee consists of seven members, including four public members. One public member must be a 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.

Governor Wilson recently appointed hearing aid dispenser Marilyn Havens of Paradise to the Committee. Havens, who was sworn in at HADEC’s November 12 meeting, replaces Byron Burton, who left the Committee in December 1992.

MAJOR PROJECTS

Legislative Oversight Hearing. On November 10, HADEC and the Speech-Language Pathology and Audiology Examining Committee (SPAEC) presented testimony to the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions, chaired by Senator Dan McCorquodale, on several issues related to the possible restructuring of the committee. Specifically, the Subcommittee requested comments on (1) whether hearing aid dispensers, speech-language pathologists, and audiologists should be deregulated and both committees abolished; (2) whether the two committees should be merged; and (3) whether either or both committees should be transformed into bureaus which lack a multi-member policymaking board and operate under the direct control of the Director of the Department of Consumer Affairs (DCA). The future of both HADEC and SPAEC is already clouded by the enactment of SB 916 (Presley) (Chapter 1267, Statutes of 1993), which—effective July 1, 1994—abolishes DAHP, under whose jurisdiction both HADEC and SPAEC operate. [13:4 CRLR 65–66]

HADEC Chair Keld Humluth and Executive Officer Elizabeth Ware represented the Committee at the November 10 hearing. Much of the Subcommittee's attention was focused on the enforcement records of the two committees. In 1992–93, HADEC received 417 complaints, dealt with 250 of them on an informal basis and 124 on a formal basis (through the citation and fine process), filed five accusations, and revoked four licenses; HADEC spent 65% of its budget on enforcement. During the same year, SPAEC received 27 complaints, dealt with 14 of them on an informal basis, filed one accusation, and revoked one license; SPAEC spent 25.5% of its budget on enforcement.

An issue addressed by the Subcommittee included the small number of staff members employed by each committee (SPAEC has three employees and HADEC has 3.2 positions); the widely varying licensing fees charged by the two committees (HADEC charges hearing aid dispensers $280 in annual licensing fees, while SPAEC’s fees are $37.50 annually for speech-language pathologists and audiologists); the fact that many complaints received by each committee derive from licensees of the other committee alleging deceptive advertising practices; and the fact that almost 50% of HADEC’s licensees are cross-licensed by SPAEC and/or another occupational licensing agency.

At the conclusion of the testimony, the consensus of the Subcommittee appeared to be that the committees should be merged; at this writing, no legislation has yet been introduced to accomplish the merger.

At its November 12 meeting, HADEC discussed the Subcommittee hearing and a list of possible merger options which had been prepared by Executive Officer Ware. These options include complete merger of the two committees with each program maintaining separate funds; complete merger of the committees including a combination of their funds; merging the audiologist licensing program with HADEC, leaving speech-language pathologists separate; and retention of HADEC in its present form. DCA legal counsel Greg Gorges indicated that the issues of administrative merger, duality of licensure, and allocation of license fees and budgets will be of primary concern in merger discussions.

Committee member James McCartney, Ph.D., proposed that the merger matter be referred to HADEC’s Examination and Continuing Education Subcommittee to gather pertinent information, discuss anticipated problems, and develop and evaluate specific options and proposals to be presented at the Committee's January 28 meeting. This motion carried unanimously.

Executive Officer Ware stated that she would contact the Senate Subcommittee and inform its staff that HADEC is looking at the merger, developing a proposal, and will forward a copy of the options discussed at the November meeting.

HADEC Moves Closer to Implementation of Electronic Examinations. At its
July 1993 meeting, the Committee approved electronic administration of its written examination and directed staff to request proposals from companies for this service. [13:4 CRLR 65] Since that time, HADEC received two bids on the contract from Assessment Systems, Inc. (ASI) and National Credential Clearinghouse. At its November 12 meeting, HADEC authorized its Examination and Continuing Education Subcommittee to proceed with the selection of the lowest qualified bidder and award the contract to enable implementation by April 1, 1994.

The bidders were required to meet a set of minimum standards in order to be considered for the contract. These standards were formulated by the Committee with the assistance of DCA's Central Testing Unit. The standards included a minimum number of statewide locations, availability of test results onsite, and adequate on-site security. From those bidders meeting these minimum requirements, the company with the lowest bid would be selected. The bidding was opened on November 15. Following the bidding period, HADEC determined that only ASI met the minimum standards; thus, ASI was chosen to implement HADEC's electronic testing program.

When the program is implemented, HADEC's written test will be available electronically at various locations throughout the state every day of the week. Potential exam takers will be able to call ASI's toll-free 800 number to be advised as to the nearest examination site and the times during the day when the test will be administered. Results of the test will be available onsite, and exam security will be preserved. ASI currently operates five testing sites throughout the state and has plans to expand that number in the near future. At this writing, HADEC's last non-electronic written exam is scheduled for February 7; after that date, all written exams will be administered electronically.

Examination Update. At the Committee's November 12 meeting, Dr. McCartney reported that the total pass rate on HADEC's November 6 practical examination was 74%; this is 7% lower than the national rate reported on a recent meeting between the HADEC and the Hearing Aid Dispenser Examining and Continuing Education Committee. This reduction, respectively.

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she had received a petition for rulemaking dated November 4 from hearing aid dispenser Robert Hughes. The petition requested that HADEC adopt a regulation removing itself from the process of conducting license examinations. Hughes argued that HADEC should employ an outside entity to conduct the license examinations to avoid a possible conflict of interest. Further, Hughes accused HADEC of "systematically failing" on the state licensing exam individuals whom he and his wife supervise as trainees at their hearing aid business. Section 1399.119, Title 16 of the CCR, specifies that if a trainee-applicant fails HADEC's license examination, the supervising dispenser is required to be physically present at all fittings and sales made by the trainee-applicant, and Hughes contended that the combination of HADEC's "systematic failure" of his employees and its enforcement of section 1399.119 has "effectively destroyed" his business, which depends on the provision of in-home service by his salespeople. Hughes also mentioned the April 1992 regulatory determination by the Office of Administrative Law (OAL), which concluded that some of HADEC's license examination rules and policies were regulations within the meaning of the Administrative Procedure Act (APA), and must therefore be adopted pursuant to the APA rulemaking process. [12:4 CRLR 99; 12:2&3 CRLR 111].

Hughes alleged that HADEC has ignored the OAL determination and persists in subjecting licensure applicants to "underground" regulations.

On November 16, Ware responded to Hughes' petition, reminding him that, under Business and Professions Code section 3328, HADEC is not authorized to adopt regulations on its own. Rather, HADEC may make recommendations to DAHP, which is charged with adopting regulations for HADEC. Ware stated that HADEC would not recommend Hughes' requested changes to DAHP. In response to Hughes' allegations that HADEC "systematically failed" his employees on the licensing examination, Ware stated that of the 13 individuals who trained under Mr. Hughes' supervision, only three took the licensing examination and two of them failed. The third passed the examination after going to work under a new supervisor. Ware also explained that HADEC has already taken steps to contract with an outside agency for electronic administration of its written examination (see MAJOR PROJECTS), and is currently revising its practical examination.

On November 20, Hughes sent HADEC another letter, petitioning HADEC to repeal sections 1399.116, 1399.118, and 1399.119, Title 16 of the CCR. Hughes asserted that these regulations have a serious adverse economic impact on small business because they limit a small business' ability to hire, train, and retain new employees. Hughes also claimed that the regulations are unduly restrictive because they have prevented many qualified people from being gainfully employed in the hearing aid industry in California, artificially limit entry into the occupation, and limit competition.

On November 22, Hughes sent HADEC another letter, this time petitioning HADEC to repeal sections 1399.135-.139, Title 16 of the CCR, the Committee's citation and fine regulations. [11:3 CRLR 91; 10:4 CRLR 87–88]. Hughes contended that during testimony before the Senate Subcommittee (see MAJOR PROJECTS), HADEC representatives stated that the Committee has been using its citation and fine regulations as a tool to "mediate" consumer complaints against hearing aid dispensers to force a monetary refund to consumers complaining under the Song-Beverly Consumer Warranty Act. Hughes cited an unspecified Legislative Counsel's opinion which he says takes the position that consumers have no right to demand a refund in lieu of allowing a hearing aid dispenser to adjust or replace a defective device. Hughes also questioned HADEC's authority to enforce the provisions of the Song-Beverly Consumer Warranty Act, and argued that HADEC is imposing discipline and fines without proper due process. Hughes again accused HADEC of repeatedly violating the APA both in adopting "underground regulations" and in assessing citations and fines.

Executive Officer Ware responded to Hughes' November 20 and 22 petitions with one of her own, dated November 24. Ware stated that Hughes' requests would be discussed at HADEC's January 28 public meeting, noted that she had circulated Hughes' petitions to all Committee members, and again reminded Hughes that HADEC is not authorized to adopt regulatory changes. She informed Hughes that any recommendations the Committee elects to make would be presented to DAHP at its February meeting.

Hughes responded to HADEC's denial of his November 4 petition with a letter dated November 26, in which he accused HADEC of attempting to discredit him by misrepresenting facts and disputing the facts presented in his petition. Hughes insisted that a review of HADEC's records by "unbiased individuals" would reveal that "everyone of the new salespeople who worked for [Hughes'] University Hearing Aid Center were failed on their first exam since 1987, and even before then." Hughes repeated his previous allegations, and then cites examples of specific individuals who failed HADEC's licensing exam. He accused HADEC of, among other things, changing the answers on one trainee-applicant's written exam, including questions on its written examination that are inappropriate, and providing a copy of the questions and answers on HADEC examinations to a competitor. Hughes concluded that HADEC's denial of his petition was inadequate and inappropriate.

On December 13, Hughes and his wife, hearing aid dispenser Mary Hughes, sent yet another letter to HADEC, this time requesting a hearing under Government Code section 11500 et seq. The Hugheses alleged that they have filed 22 separate petitions with various DCA agencies, including HADEC and DCA itself, concerning "underground regulations" and other improper activities allegedly engaged in by HADEC. The Hugheses contend that none of those petitions were responded to as required by Government Code section 11347. The Hugheses thus requested a hearing before an administrative law judge, seeking relief from "arbitrary and capricious actions on the part of HADEC." Further, the Hugheses stated that they intend to file a civil rights action seeking damages from the State of California under 42 U.S.C. section 1983 for actions by state officials under color of law which violate constitutional due process and equal protection provisions. They will also seek damages from various state officials in their individual capacities under 42 U.S.C. section 1983 for actions under color of law which exceeded their authority.

At this writing, HADEC is scheduled to discuss the Hughes matter at its January 28 meeting.

**FUTURE MEETINGS**

April 8 in Sacramento.
July 15 in Sacramento.
November 18 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 approximately 14,200 physical therapists and 2,300 physical therapist assistants.
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’s Division of Allied Health Professions (DAHP).

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 electromyography.

PTEC also approves physical therapy schools. An exam applicant must have graduated from a Committee-approved school before being permitted to take the license 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.

The Committee is currently functioning with five members—three public members and two PT members. Public member Louis Garcia was recently appointed by the Senate Rules Committee and took his seat on the Committee at its October 7 meeting. Governor Wilson must appoint the remaining PT member.

**MAJOR PROJECTS**

**Supervision Requirements/PTA Licensure Requirements.** Following discussion at its October 7 meeting, PTEC renoticed two rulemaking packages on November 26—one pertaining to PTs’ supervision and use of PTAs and physical therapist aides (proposed amendments to sections 1398.44 and 1399, and the adoption of 1399.1, Division 13, Title 16 of the CCR), and the other regarding PTA licensure standards (proposed amendments to section 1398.47). The Committee has been working on these two packages for the past few years. [13:2 & 3 CRLR 89; 13:1 CRLR 53]

First, PTEC seeks to revise section 1398.44 to clarify supervision requirements and protocols which PTs and PTAs must follow in all treatment settings, and to enable the Committee to better determine compliance. Under the existing supervision regulations, determining compliance is problematical because the PT’s evaluation of the patient and delegation of tasks to the PTA need not be documented in the patient’s record.

Thus, PTEC’s proposed revisions to section 1398.44 would establish two standards for PT supervision of PTAs—one for inpatient/outpatient facilities and another for the home care setting. In the inpatient/outpatient facility setting, the supervising physical therapist (SPT) must be present in the same facility with the PTA at least 50% of any work week or portion thereof the PTA is on duty; additionally, the SPT must be readily available to the PTA at all other times. The SPT must initially evaluate each patient prior to the provision of physical therapy treatment by the PTA, and document the evaluation in the patient’s record. Based on the evaluation, the SPT must formulate and document in each patient’s record a treatment program, and determine which elements thereof may be delegated to the PTA. The SPT must periodically reevaluate the patient and document the reevaluation in the patient’s record. At least every other week (or more often if necessary), the SPT must assess the patient, document the assessment in the patient’s record, and indicate the patient’s progress toward the treatment goals.

In the home care setting, the SPT must follow all the protocols established above for the inpatient/outpatient setting, with the exception of the every-other-week assessment. Additionally, the proposed revisions would require the SPT and the PTA to make a joint visit and provide treatment jointly prior to the PTA providing care without the SPT present. Also, the SPT must provide treatment every other week on every patient being seen by the PTA for the purpose of reevaluating the patient’s progress. The SPT must be readily available to the PTA via telephone at all times for advice, assistance, and instruction. Each week, the SPT and the PTA shall conduct a case conference on all patients.

The proposed revisions to section 1398.44 would eliminate an existing provision which permits PTEC to waive the 50% supervision requirement. Although this provision has met with opposition from the California Chapter of the American Physical Therapy Association (CCAPTA), PTEC contends that its small staff is unable to handle the large number of waiver requests that have been submitted to the Committee. [13:2 & 3 CRLR 89; 12:2 & 3 CRLR 114]

CCAPTA also objects to the Committee’s proposal to set separate supervision standards for the home care setting, and insists that waivers of the 50% supervision requirement must be afforded in the home care setting. CCAPTA encourages PTEC to set standards for the granting of waivers such that the waiver process will not be so burdensome to Committee staff.

Section 1399 pertains to PTs’ supervision of physical therapy aides, unlicensed individuals who may be utilized by a PT to perform both patient-related tasks and non-patient-related tasks. Under the proposed amendments to section 1399, the PT must evaluate every patient and document that evaluation in the patient’s record prior to the initiation of care by an aide. The PT must also formulate a written treatment program in which specific patient-related tasks are assigned to an aide. The SPT must provide “continuous and immediate supervision” of the aide, which requires the SPT to be in the same facility and in immediate proximity to the location where the aide is performing patient-related tasks. When patient-related tasks are performed by an aide, the SPT shall at some point during the same treatment day provide direct service to the patient, and so document in the patient’s record. The SPT must countersign and date all entries in the patient’s record on the same day as patient-related tasks are performed by an aide. New section 13991 would restrict a PT to supervising not more than one aide at any one time performing patient-related tasks.

Section 1398.47 currently describes numerous combinations of training and experience which PTEC believes are equivalent to its educational requirement for PTAs. The amendments to this section would require a significant portion of any qualifying experience to have been performed under the direct and immediate supervision of a PT in an acute care inpatient facility. [13:2 & 3 CRLR 89]

At this writing, PTEC is scheduled to hold a public hearing on these proposed regulatory changes on January 14 in Burbank.

**ENMG and KEMG Certification Regulations.** Responding to an ongoing controversy surrounding its existing electromyography (ENMG) and kinesiological electromyography (KEMG) certification regulations, PTEC has published proposed amendments to sections 1398.61 through 1399.67, Division 13; Title 16 of the CCR, the certification requirements for the two specialties. At this writing, PTEC plans to hold a public hearing on this regulatory proposal at its January meeting.

PTEC currently administers one examination in KEMG and a separate examination in ENMG, and has always interpreted section 1399.65(a) to require an applicant for ENMG to first pass the KEMG exam and then take and pass the ENMG exam. Concerns about the lack of necessity for making KEMG certification a prerequisite to ENMG certification prompted the Committee to undertake research to establish a clearer distinction between the certification requirements for each specialty. [13:4
LEGISLATION

AB 1807 (Bronshvag). Existing law requires PTEC to approve a PTA applicant who is otherwise qualified and receives a grade of 75% on the required examination. As amended September 8, this bill would require PTEC to approve a PTA applicant who is otherwise qualified if he/she receives a passing grade on the examination.

Existing law sets fees for the initial PT license and renewal of a PT license at $80, unless a lower fee is set by PTEC. Due to PTEC’s increased enforcement activity, this bill would increase the fee to $100, unless a lower fee is set by PTEC, and require PTEC to submit a report to the legislature whenever it increases any fee, specifying the justification for the increase and the percentage of the increase to be used for enforcement purposes. [A. Inactive File]

SB 437 (Hart), as amended April 26, would authorize, notwithstanding existing provisions of law, a physician to supervise a physical therapy aide who is employed by the physician and who is authorized to provide services by specified provisions of law. [S. B&P]

PTEC opposes SB 437. Unlike PTs and PTAs, aides have no formal training or licensure requirements. PTs must comply with PTEC’s supervision regulations in supervising aides, but SB 437 does not apply those supervision requirements to physicians who would be supervising physical therapy aides. If SB 437 is enacted, PTEC believes insurance companies will be billed by physicians for physical therapy treatment which is unskilled and inadequately supervised; in many cases, PTEC believes that patients will require treatment from a PT in addition to the treatment provided by an aide who works for a physician.

RECENT MEETINGS

At its October 7 meeting, PTEC elected officers for 1994. PT member Carl Anderson was reelected Chair, and public member June Koefelda was elected Vice-Chair.

PTEC is preparing for its imminent separation from the Medical Board; SB 916 (Presley) (Chapter 1267, Statutes of 1993) abolishes MBC’s Division of Allied Health Professions effective July 1. Executive Officer Steve Hartzell noted that PTEC is submitting two budget change

REGULATORY AGENCY ACTION

At its August meeting, PTEC established a task force consisting of two experts, one certified in ENMG and the other certified in KEMG, to assist in drafting revisions to the certification regulations to better reflect the training an individual needs to practice each of the specialties. The proposed amendments seek to establish ENMG and KEMG as two distinct specialties with separate certification requirements and examinations.

The rulemaking proposal consists of a series of amendments:

- Existing regulations do not specify that a PT who is certified to perform ENMG evaluations may not perform KEMG without additional authorization from the Committee; thus, proposed new subsection (c) of section 1399.61 states that no PT certified to perform ENMG shall perform KEMG without additional authorization from the Committee as indicated on his/her certification.

- Existing section 1399.63 sets forth the requirements for KEMG, including “ten clock hours” of training in tissue penetration. PTEC’s proposed amendments to section 1399.63 would delete the reference to “ten clock hours” in subsection (b); the requirement is redundant because subsections 1399.63(d)(1) and (2) also list the number of “clock hours” necessary for certification.

- Subsection (d) of section 1399.63 would be amended to clarify that KEMG certification requires completion of not less than 200 clock hours in KEMG under the supervision of a PT certified in KEMG or a physician qualified to perform KEMG, and documentation of completion of 50 KEMG examinations. The purpose of this revision is to separate the training and experience requirements for KEMG and ENMG.

- PTEC’s proposed amendments to section 1399.64, which sets forth the requirements for ENMG authorization, would delete any requirement of KEMG training for the ENMG authorization.

- Existing section 1399.65 provides that all ENMG applicants shall take and pass an examination in KEMG. The proposal would amend section 1399.65 to specify that (1) all PTs applying for certification to perform KEMG shall take and pass the KEMG examination referred to in section 1399.66 which will be administered by PTEC; and (2) all PTs applying for certification to perform ENMG shall take and pass the ENMG examination referred to in section 1399.67 which will be administered by PTEC. This proposal would create a separate and independent examination for each specialty.

- Section 1399.66 currently sets forth the subjects which must be tested on the KEMG examination; this proposal would amend section 1399.66 by deleting subjects under the basic science category and adding a subject to the examination related to the practical application of KEMG.

- Section 1399.67 currently sets forth the subjects which must be tested on the ENMG examination. This proposal would amend section 1399.67 by adding subjects to the basic science, clinical science, and practical application categories.

Consistent Standards for Credential Evaluation Services Reports. Responding to concerns about a lack of consistency among the reports obtained from credential evaluation services on foreign-trained PTs, PTEC has proposed draft regulatory language to ensure consistent credential evaluations from all the approved credential evaluation services used by the Committee. PTEC discussed the regulatory package at its October 7 meeting, noticed its proposed amendment to section 1398.25(c) on November 26, and—at this writing—plans to hold a public hearing on the regulatory proposal at its January meeting.

PTEC requires foreign-trained licensure applicants to submit documentation of their education to a credential evaluation service for review and report to the Committee. Currently, three evaluation services are approved to provide this service; however, there are no specific criteria as to what must be included in the report. Therefore, the evaluations vary according to which service completes the evaluation.

The proposed regulatory amendment adds new subsection 1398.25(c), which provides that the report submitted to PTEC by the service must be based on a review of an original copy of the applicant’s credentials and must document (1) the equivalent professional degree the applicant would have received from an accredited PT education program located in the United States, and (2) whether completion of the applicant’s PT education and training entitled the applicant to fully practice as a PT in the country where the education and training was completed.

Proposed Legislation on Education Standards for PTs and PTAs. At its October meeting, PTEC reviewed the latest draft of proposed legislative changes to statutes setting forth the education standards for licensure as a PT or PTA; the new draft incorporated amendments made at the August meeting. After making some minor technical corrections to the draft legislation, PTEC approved the amended language. Executive Officer Steve Hartzell suggested that the proposal could possibly be included in the Department of Consumer Affairs’ (DCA) omnibus bill, AB 1807 (Bronshvag) (see below).

PTEC’s proposed amendments to section 1399.64 and 1399.66 provide that (1) all PTs applying for certification to perform ENMG shall take and pass the KEMG examination referred to in section 1399.66 which will be administered by PTEC; and (2) all PTs applying for certification to perform ENMG shall take and pass the ENMG examination referred to in section 1399.67 which will be administered by PTEC. This proposal would create a separate and independent examination for each specialty.
proposals for 1994-95: one which transfers PTEC's funding of its investigative functions from the Medical Board to DCA's Division of Investigation, and another which transfers funding for complaint processing from the Medical Board to PTEC staff. CCAPTA expressed support for both budget change proposals, and the Committee has discussed both proposals in the past with no opposition. Hartzell stated he plans to meet with the Department of Finance to further discuss these issues.

The Committee also considered whether to create an inactive license status for licensees who live outside California. PTEC was approached by concerned licensees who live outside the state but still receive notices for tax returns from the Franchise Tax Board. After being briefed on research by DCA legal counsel Greg Gorges, the Committee charged staff with preparing an application form and information on inactive license status for licensees who live outside California.

**FUTURE MEETINGS**

April 29 in Sacramento.

**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 licenses individuals as PAs, allowing them to perform certain medical procedures under a physician's supervision, including drawing blood, giving injections, ordering routine diagnostic tests, performing pelvic examinations, and assisting in surgery. PAEC's objective is to ensure the public that the 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 regulations are codified in Division 13.8, Title 16 of the California Code of Regulations (CCR).

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

**MAJOR PROJECTS**

Fee Reduction for Supervising Physicians. At its October 22 meeting, PAEC discussed a proposal to reduce the fees it charges physicians who wish to supervise PAs. Under existing section 1399.553, Title 16 of the CCR, PAEC charges physicians a $50 application fee, a $75 initial approval fee, and a $150 biennial renewal fee. According to PAEC staff, the Committee is adhering to its budget and has a strong reserve fund; thus, staff recommended that the Committee reduce these fees to a $25 application fee, $75 for approval, and $100 for biennial approval. Fees set at this level will permit PAEC to maintain a reserve fund of about eight months' worth of operating expenses. The Committee agreed that staff should initiate rulemaking to accomplish this change.

On December 3, PAEC published notice of its intent to revise section 1399.553 to reduce the fees. At this writing, the Committee is scheduled to hold a public hearing on the regulatory change at its January 21 meeting in San Diego.

Citation and Fine Program. Also on October 22, PAEC discussed whether to implement its citation and fine authority under Business and Professions Code section 125.9. Most other Department of Consumer Affairs (DCA) boards, including the Medical Board, have adopted regulations creating a system of citations and fines to sanction minor violations of statute or regulations which may not merit the filing of an accusation but should not be ignored. The regulatory programs created by other DCA boards permit a cited and/or fined licensee to appeal the sanction to the board's executive officer (EO); if the EO upholds the sanction, the licensee may request a full-blown evidentiary hearing under the Administrative Procedure Act to protest the sanction. PAEC decided to refer the matter to an ad hoc subcommittee of its Budget and Executive Committee, which will consider the proposal and report back to PAEC at a future meeting.

Infection Control Guidelines. On October 22, PAEC again reviewed and accepted the Department of Health Services' (DHS) Guidelines for Preventing the Transmission of Bloodborne Pathogens in Health Care Settings (13 CCR 68; 13 CCR 82-83). The Committee plans to issue notices to all PAs informing them of the Guidelines and of the fact that knowing failure to follow them could result in disciplinary action. PAEC also plans to adopt an internal policy to guide its internal monitoring of PAs' compliance with the Guidelines.

**LEGISLATION**

AB 1392 (Speier), as amended July 1, would require PAEC to notify DCA whenever any complaint has gone thirty days without any investigative action, and authorize the DCA Director to review any complaint filed with PAEC. [S. B&P]

AB 1807 (Bronshvag), as amended September 8, would require PAEC licensees to notify PAEC of any change of address within thirty days after such change; authorize PAEC to establish an inactive license category; and make minor clean-up changes to the Physician Assistant Practice Act. [A. Inactive File]

AB 2157 (Polanco). Existing law limits the amounts of the various fees PAEC determines will be paid by a physician who seeks approval to supervise a PA; the existing limit for an application fee for a PA supervisor is $50 and the existing limit for an approval fee is $250 to be charged upon approval of an application to supervise a PA. As introduced March 5, this bill would raise the application fee limit for a PA supervisor to $100, and raise the limit of an approval fee for a PA supervisor to $350. [A. Health]

SB 993 (Kelley), as introduced March 5, would state the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the creation of new categories of health professionals who were not required to be licensed on or before January 1, 1994, or revises the scope of practice of an existing category of health professional, be supported by expert data, facts, and studies, including prescribed information, and be presented to all legislative committees of the legislature that hear that legislation prior to its enactment. [S. B&P]

AB 2350 (Escutia), as introduced March 5, would require the California Medical Assistance Commission to consider the extent to which a hospital maximizes the delivery of preventive health care services to pregnant women.
tioners, and PAs, and the demonstrated willingness of a hospital, or university medical school with which the hospital is affiliated, to actively support the recruitment and training of primary care physicians, primary care nurse practitioners, and PAs at that hospital site. [A. Health]

■ RECENT MEETINGS

At its October meeting, PAEC discussed its future responsibilities under AB 1065 (Campbell) (Chapter 1042, Statutes of 1993), which requires the Office of Statewide Health Planning and Development to coordinate the establishment of an international medical graduate (IMG) PA training program, with the goal of licensing and placing as many IMG PAs in medically underserved areas as possible in order to provide greater access to care for the growing population of medically indigent. [13:4 CRLR 68] Although the bill stated the legislature’s intent to create the program, it allocated no funding, and the program can begin only when a source of funding has been identified and allocated. At this point, no funding from specified federal sources has been identified. Until funding is secured and the Office establishes the program, PAEC sees no need to adopt regulations or standards for the licensure of IMG PAs. PAEC plans to liaison with the IMG program once it becomes funded.

PAEC also discussed ways to develop more contact with various PA training programs. Since 50% of new PA licensees come from the five programs in California, members felt that PAEC should offer to speak at these institutions. Topics could include California PA licensure requirements, legal requirements for practice, and problem areas addressed by the Committee.

PAEC staff member Jennifer Barnhart reviewed the Committee’s enforcement statistics. As of September 30, 11 complaints against PAs were being reviewed by the Medical Board’s Central Complaint and Investigation Control Unit; 36 complaints were under active investigation; and 11 cases were pending at the Attorney General’s Office awaiting the filing of an accusation. Fifteen filed accusations against PAs were pending at some point in the adjudication stage; the Committee has revoked one license in fiscal year 1993–94; and 11 PAs are on probation.

Also in October, staff noted that two publications are being prepared for distribution. PAEC’s licensee newsletter is being drafted, and will contain an article on the Clinton administration’s national health care proposal with an emphasis on the role of PAs. Staff is also preparing another publication containing factual information on the Committee.

Finally, the Committee elected PA Nancy Safinick as PAEC Chair and public member Ruth Ann Kahlert as Vice-Chair.

■ FUTURE MEETINGS

April 15 in San Francisco.
July 29 in Los Angeles.
October 7 in Sacramento.

BOARD OF PODIATRIC MEDICINE
Executive Officer: James Rathlesberger
(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 Professionals Code section 2460 et seq. BPM’s regulations appear in Division 13.9, Title 16 of the California Code of Regulations (CCR). The Board licenses doctors of podiatric medicine (DPMs), administers two licensing examinations per year, approves colleges of podiatric medicine, and enforces professional standards by initiating investigations and disciplining its licensees, as well as administering its own diversion program for DPMs. The Board consists of four licensed podiatrists and two public members.

■ MAJOR PROJECTS

Report on General Medical and Surgical Components of Podiatric Residency Training. At its November 5 meeting, BPM heard and discussed a report on the medical and surgical components of podiatric residency training in California; the report was prepared by Franklin J. Medio, Ph.D., and Thomas L. Nelson, M.D., whose services were retained by the Board earlier this year. [13:2 & 3 CRLR 92–93] Dr. Medio and Dr. Nelson presented their report to a three-member committee of the Medical Board of California at a hearing on November 4, and subsequently presented it to BPM on November 5.

In preparing their report, Dr. Medio and Dr. Nelson visited podiatric residency programs located at colleges of podiatric medicine, teaching hospitals, university-affiliated hospitals, and community-based hospitals located primarily in California. The consultants surveyed four types of existing podiatric residency programs: (1) the 12-month rotating podiatric residency; (2) the 12-month podiatric orthopedic residency; (3) the 12-month podiatric surgical residency; and (4) the 24-month podiatric surgical residency. The purpose of the study was to examine the current training programs and offer recommendations to strengthen them for podiatric residents in general medical and surgical specialties, including subspecialties.

The report concluded that the current training programs do a good job of training residents given the available resources. The consultants found that, particularly in the large teaching hospitals, first-year podiatric residents quickly begin to function in a manner similar to first-year medical residents, and that podiatric and medical residents are supervised in an identical manner by attending physicians. The report also made several recommendations, including the following: (1) ideally, all first-year podiatric residents should serve a significant portion of their general medical and surgical training in large teaching hospitals and academic health centers where space for podiatric residents is currently quite limited; (2) all first-year podiatric residents should have an emergency room rotation; (3) podiatric residents should receive increased training in pediatrics, women’s health, neurology, and psychiatry/behavioral science; (4) stipends for podiatric residents should be increased; and (5) BPM and MBC should encourage the development of mechanisms that will ensure comparability in content and quality of training among all podiatric residency programs in California.

After hearing the recommendations, BPM agreed that implementation of these recommendations would hinge on continued dialogue among BPM, MBC, the University of California medical schools, and other medical teaching centers.

BPM Enforcement. On November 12, BPM revoked the license of Newport Beach podiatrist Craig Lowe. Lowe was charged with billing insurance companies for unnecessary treatments and misdiagnosing problems in patients he treated in the 1980s; the case involved complaints from nine different patients.

■ LEGISLATION

Future Legislation. At its November 5 meeting, BPM affirmed its intent to sponsor 1994 legislation stating that, effective January 1, 1996, it will approve only those entry-level podiatric medical residencies that include surgical training. [13:4 CRLR 69–70] BPM also plans to pursue legislation to resolve its structural status with regard to the Medical Board; effective July 1, SB 916 (Presley) (Chapter 1267, Statutes of 1993) abolishes MBC’s Division of Allied Health Profes-
sions, under whose jurisdiction BPM currently operates. [13:4 70-71]

However, it decided to hold off on sponsoring a bill stating the legislature's intent that podiatric medical residents should have access to participation in training rotations in medical teaching centers that are affiliated with approved medical schools and receive state compensation or funding. BPM tabled this measure in favor of continued dialogue with MBC, the University of California medical schools, and other medical teaching centers. [13:1 CRLR 55] Also on November 5, BPM decided to move fully research a draft legislative proposal requiring additional training in ethics for podiatric medical residents.

AB 1807 (Bronshvag), as amended September 8, would revise the terms that may be used by DPMs for fictitious name permits, and reduce the amount of time within which a DPM may renew his/her expired license from five to three years. [A. Inactive File]

AB 2214 (Lee), as introduced March 5, would require any podiatrist who sells, closes, or transfers his/her practice to notify each patient in writing of the sale, closure, or transfer, and require that each patient be given an opportunity to determine where his/her records shall be directed before the licensee transfers or otherwise disposes of those records. [A. Health]

AB 720 (Horchera), as introduced February 22, would prohibit any person other than a licensed physician, podiatrist, or dentist from applying laser radiation, as defined, to any person for therapeutic purposes, and would require that any person who violates this provision is guilty of a misdemeanor. [A. Health]

AB 635 (Cortese). The Knox-Keene Health Care Service Plan Act of 1974 prohibits health care service plans that offer podiatry services as a specific podiatric service solely on the basis that they are podiatrists. As introduced February 22, this bill would instead prohibit a plan that offers podiatry services within the benefits of a plan that relate to foot care from refusing to give reasonable consideration to affiliation with podiatrists for the provision of podiatry services solely on the basis that they are podiatrists. The bill would also require a plan to consider, as prescribed, a request for affiliation by a podiatrist in relation to services offered by the plan. [A. Health]

**RECENT MEETINGS**


The Board also reviewed updates on its probation and diversion programs. Currently, 22 podiatrists are participating in the diversion program; five have successfully completed the program. The licenses of 23 podiatrists are currently on probation.

Also in November, the Board voted to rescind two conflicting scope of practice policies on the use of the laser on the lower leg by DPMs and on sclerotherapy performed by DPMs. The Board rescinded the policies because the scope of practice of DPMs is defined by law; no Board interpretation is necessary, and any attempted interpretation might be seen as underground rulemaking.

**FUTURE MEETINGS**

May 6 in San Francisco.

**BOARD OF PSYCHOLOGY**

*Executive Officer: Thomas O'Connor (916) 263-2699*

The Board of Psychology (BOP) (formerly the "Psychology Examining Committee") is the state regulatory agency for psychologists under Business and Professions Code section 2900 et seq. Under the general oversight of the Medical Board's Division of Allied Health Professions (DAHP), 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 handles 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. Currently, Louis Jenkins, Judith Fabian, Linda Lee, Frank Powell, and Bruce Ebert are BOP's psychologist members, and Philip Schlessinger and Linda Lucks are its public members. One BOP public member position is vacant.

**MAJOR PROJECTS**

Continuing Education Regulations. At its November 13 meeting, BOP held a public hearing on its proposal to adopt new Article 10 (commencing with section 1397.60), Division 13.1, Title 16 of the CCR, to implement SB 774 (Boatwright) (Chapter 260, Statutes of 1992). SB 774 added section 2915 to the Business and Professions Code, which requires psychologists, effective January 1, 1996, to satisfy continuing education (CE) requirements prior to license renewal.

Among other things, proposed Article 10 would require each licensed psychologist to submit with his/her application for license renewal proof satisfactory to the Board that he/she has completed the required CE hours, which may be satisfied by lectures, conferences, seminars, and workshops; under the proposed regulations considered on November 13, correspondence courses, independent study, and home study programs are not acceptable for CE credit. If requested by the Board, licensees must verify completion of CE courses by producing verification of attendance certificates; a false or material misrepresentation by a licensee on a CE verification form is grounds for disciplinary action. Article 10 also sets forth grounds for exemption from the CE requirement; provides that the California Psychological Association (CPA) is approved as a CE accreditation agency; and sets forth criteria for BOP approval as a CE accreditation agency and as a CE provider. [13:4 CRLR 71]

At the hearing, BOP received numerous comments from psychologists and their trade associations. Several witnesses objected to the fact that CPA was named as an accreditation agency in the proposed regulations; Board members agreed that the identification of CPA in the rules is unnecessary and noted that other organizations might qualify as accreditation agencies. Others noted that the proposed rules make no mention of "reasonable accommodations" for disabled licensees, and argued that the Board should accept a reasonable number of correspondence course and/or home study units toward the CE requirement.

Witnesses also expressed concerns that licensees who are not clinicians and/or who are engaged in particular specialties will not be able to find CE courses which are suitable for their particular field; Board members responded that the CE requirement is designed to assist in maintaining generic competence and is not intended to focus on specialized areas.

Finally, many witnesses objected to the proposed course approval fee of $150,
arguing that the fee should be imposed per course and not per course offering, or that it should be scaled based upon attendance.

Following the hearing, Board Chair Bruce Ebert directed staff to compile, review, and incorporate as appropriate all the public comments into the proposed regulatory package, and return with a modified proposal at the Board’s January meeting.

**BOP Reviewed by Senate Subcommittee.** On November 10, BOP and the Board of Behavioral Science Examiners presented testimony to the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions, chaired by Senator Dan McCorkquode, on several issues related to the possible restructuring of the boards. Specifically, the Subcommittee requested comments on (1) whether psychologists, marriage counselors, social workers, and educational psychologists should be deregulated and both boards abolished; (2) whether the two boards should be merged; and (3) whether either or both boards should be transformed into bureaus which lack a multi-member policymaking board and operate under the direct control of the Director of the Department of Consumer Affairs (DCA).

BOP Chair Bruce Ebert and Executive Officer Tom O’Connor represented the Board at the hearing; both rejected the notion of deregulation and questioned the advisability of merger with BBSE. Ebert stated that psychologists are more like the physician and psychiatrists regulated by the Medical Board than marriage counselors regulated by BBSE, in that psychiatrists and psychologists deal with psychopathology, a severe form of mental illness. Both acknowledged that certain BOP/BBSE enforcement functions could possibly be consolidated to prevent duplication of effort by the two boards (see agency report on BBSE for related discussion).

Senator McCorkquode closely examined the disciplinary decisions made by both BOP and BBSE, and expressed concern that practitioners found to have committed sexual misconduct with patients (either administratively or judicially) appear to have been treated differently; that is, some licenses were revoked outright (sometimes due to default) but others who had committed similar misconduct were allowed to keep their licenses and practice under a lengthy probationary period. Senator McCorkquode also questioned why the license of a practitioner who is found by the Board to have committed sexual misconduct with a patient or has been convicted of the crime of sexual misconduct with a patient is not immediately revoked. BOP and BBSE representatives explained that both boards must afford accused licensees—even those who have been convicted of the crime of sexual misconduct—full procedural due process, and noted that the presence of mitigating and aggravating circumstances in each individual case may explain what appears to be inconsistent treatment for similar offenses.

At this writing, no legislative proposals have been introduced as a result of the hearing.

**Board Suspends Full Implementation of New Public Disclosure Policy.** On December 9, BOP suspended the full implementation of its new public disclosure policy due to Sacramento County Superior Court Judge Ronald B. Robie’s December 2 issuance of a preliminary injunction in *California Medical Association v. Arnett*.

In March 1993, BOP became the first occupational licensing agency to liberalize its public disclosure policy when it decided to reveal to inquiring consumers the fact that it has completed a complaint investigation against a licensee and forwarded the case to the Attorney General’s Office for the filing of formal charges. [13:2&3 CRLR 94] Prior to the adoption of this policy, BOP declined to disclose its completed investigations until after formal charges had actually been filed—which, due to a backlog in the AG’s Office, might be nine months to one year after the investigation had been completed and the case forwarded to the AG. Because of the delay in the AG’s Office and possible harm to consumers from incompetent, impaired, or unethical psychologists, BOP decided the public would be better served with earlier factual information as to whether it has completed an investigation of a licensee and intends to pursue disciplinary action.

After the Medical Board of California (MBC) revised its public disclosure policy to include a similar rule in May 1993, it was sued by the California Medical Association. CMA sought a preliminary injunction invalidating MBC’s entire policy (which also included disclosure of felony convictions, medical malpractice judgments in excess of $30,000, and prior discipline in other states). In his December 2 opinion, Judge Robie denied CMA’s motion to all the challenged categories of information except completed investigations which have been forwarded to the AG’s Office (see agency report on MBC for complete discussion of this case).

Because section 2920 of the Business and Professions Code currently states that BOP is part of MBC, and because MBC has been enjoined from releasing pre-acquittal information on its completed investigations, BOP reluctantly decided to discontinue releasing similar information on its licensees until CMA v. Arnett is resolved.

**BOP Plans to Increase Renewal Fees.** At its November meeting, BOP agreed to initiate the rulemaking process to increase its biennial renewal fees from $400 to $500, pursuant to Business and Professions Code section 2987. BOP needs the additional revenue to finance its enforcement function. At this writing, the Board plans to commence the rulemaking process to amend section 1392, Title 16 of the CCR, in February.

**LEGISLATION**

**AB 1807 (Bronshvag).** Existing law provides for the administration of the Psychology Licensing Law by BOP and DAHP; as amended September 8, this bill would repeal DAHP’s authority to administer the law effective July 1, 1994. This bill would also revise requirements regarding publication of notices of the regular meetings of BOP, and authorize BOP to reduce any of prescribed fees relating to licensing of psychologists as it deems administratively appropriate.

Existing law authorizes BOP to order the denial of an application for licensure, issue a license with terms and conditions, or order the suspension or revocation of a license for certain causes. This bill would rewrite these provisions and eliminate the use of a fictitious, false, or assumed name by a licensee, alone or in conjunction with a group or partnership, as described, from those causes.

This bill would also authorize BOP to issue a citation if, upon investigation, the Board has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services without being properly licensed, and to require the violator to cease the unlawful advertising. This bill would also reduce the time within which a psychologist may renew his/her expired license from five to three years, and would require that BOP maintain complaints or reports as long as it deems necessary. [A. Inactive File]

**RECENT MEETINGS**

At its November meeting, BOP approved a set of criteria to guide it in reviewing proposed disciplinary decisions submitted by administrative law judges (ALJs) who have presided over BOP disciplinary hearings. Noting that the ALJ has actually observed the witnesses and received the evidence, and stating that it
should exercise its authority to overrule or non-adopt an ALJ’s proposed decision judiciously, BOP agreed that it should overrule an ALJ’s proposed decision only when the record reflects clear abuse of discretion by the ALJ; the ALJ was clearly erroneous in applying the relevant standard of practice of psychologists for the issues in controversy; the ALJ was clearly erroneous in interpreting BOP’s enabling act and its regulations; the ALJ failed to apply current ethical guidelines and standards in the formulation of the decision; the ALJ failed to properly interpret and apply current ethical guidelines and standards to the specific facts of the case; the ALJ failed to understand the significance of the testimony of the respondent with respect to the likelihood of future danger to the public; or the ALJ made the correct conclusions of law and properly applied ethical standards and rules of conduct, but the punishment is substantially less than is appropriate to protect the public.

Further, BOP agreed that it should not overrule an ALJ when the following circumstances exist: where the ALJ’s decision is based upon an assessment of the credibility of the witness; where the law and ethical standards are interpreted correctly and the decision is based upon an evaluation of the testimony by live witnesses at a hearing; where BOP is simply unhappy with the result; where the costs of proceeding are extreme in comparison with the severity of the offense and the probability of success for the respondent is high; where BOP does not approve of the respondent’s practices but the prevailing standards at the time of the alleged violation did not prohibit such conduct; where other complaints have been submitted to the Board about the respondent but have not been fully processed; or where the Board’s decision would involve the necessity of having been present at the administrative hearing.

Also in November, BOP discussed a project proposed by Dr. Norman Hertz of DCA’s Central Testing Unit (CTU) to enhance the reliability and validity of BOP’s oral examination. CTU designed a ten-step process involving Board members, Board staff, and outside practitioners who will serve as subject matter experts; under the process, the Board’s oral exam will be evaluated in light of a comprehensive and updated occupational analysis and in light of the usual requirements for any examination—standardization, reliability of measurement, reliability of evaluation procedures, and job-relatedness. At this writing, the Board is expected to further discuss CTU’s proposal at its March meeting.

- **FUTURE MEETINGS**
  May 13–14 in San Francisco.
  August 26–27 in San Diego.
  November 4–5 in Sacramento.

**SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE**

**Executive Officer:** Carol Richards (916) 263-2666

The Speech-Language Pathology and Audiology Examining Committee (S PAEC) 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 jurisdiction and supervision of the Medical Board’s Division of Allied Health Professions (DAHP). The Committee administers examinations to and licenses speech-language pathologists and audiologists. It also registers speech-language pathology and audiology aides. SPAEC hears all matters assigned to it by the Division, 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 DAHP for final adoption.

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

At this writing, SPAEC has three vacancies (two audiologist positions and one public member position), all of which must be appointed by Governor Wilson.

- **MAJOR PROJECTS**

**Legislative Oversight Hearing.** On November 10, SPAEC and the Hearing Aid Dispensers Examining Committee (HADEC) presented testimony to the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions, chaired by Senator Dan McCorquodale, on several issues related to the possible restructuring of the committees. Specifically, the Subcommittee requested comments on (1) whether speech-language pathologists, audiologists, and hearing aid dispensers should be deregulated and both committees abolished; (2) whether the two committees should be merged; and (3) whether either or both committees should be transformed into bureaus which lack a multi-member policymaking board and operate under the direct control of the Director of the Department of Consumer Affairs (DCA). The future of both SPAEC and HADEC is already clouded by the enactment of SB 916 (Presley) (Chapter 1267, Statutes of 1993), which—effective July 1, 1994—abolishes DAHP, under whose jurisdiction both SPAEC and HADEC operate.

13:4 CRLR 74

SPAEChair Robert E. Hall and Executive Officer Carol Richards represented the Committee at the November 10 hearing. Much of the Subcommittee’s attention was focused on the enforcement records of the two committees. In 1992–93, SPAEC received 27 complaints, dealt with 14 of them on an informal basis, filed one accusation, and revoked one license; SPAEC spent 25.5% of its budget on enforcement. During the same year, HADEC received 417 complaints, dealt with 250 of them on an informal basis and 124 on a formal basis (through the citation and fine process), filed five accusations, and revoked four licenses; HADEC spent 65% of its budget on enforcement.

Other issues addressed by the Subcommittee included the small number of staff members employed by each committee (SPAEC has three employees and HADEC has 3.2 positions); the widely varying licensing fees charged by the two committees (while SPAEC’s fees are $37.50 annually for speech-language pathologists and audiologists, HADEC charges hearing aid dispensers $280 in annual licensing fees); the fact that many complaints received by each committee derive from licensees of the other committee alleging deceptive advertising practices; and the fact that almost 50% of HADEC’s licensees are cross-licensed by SPAEC and/or another occupational licensing agency.

At the conclusion of the testimony, the consensus of the Subcommittee appeared to be that the committees should be merged; at this writing, no legislation has yet been introduced to accomplish the merger.

**S P A E C Rulemaking Update.** The following is a status update on SPAEC rulemaking proceedings conducted in recent months and reported in detail in previous issues of the Reporter:

- **On December 8,** the Office of Administrative Law (OAL) approved the Committee’s amendments to section 1399.161(b), Title 16 of the CCR, which specifies that a maximum of 5% per week of hearing screening services provided by a speech-language pathologist licensure candidate completing his/her required professional
experience (RPE) shall be creditable toward the experience requirement, and section 1399.163(e), which requires RPE supervisors to conduct monthly evaluations of RPE applicants and retain written documentation of the evaluations signed by the supervisor and the licensure candidate. Additionally, OAL approved SPAEC's repeal of section 1399.180(c), which previously classified as unprofessional conduct "[d]iagnosing or treating individuals for speech-language or hearing disorders by mail or telephone unless the individual has been previously examined by the licensee and the diagnosis or treatment is related to such examination." [13:4 CRLR 73; 13:2&3 CRLR 96-97]

- On October 4, OAL approved SPAEC's amendments to section 1399.159(b), Title 16 of the CCR, which define the criteria which will be applied by SPAEC in deciding whether to grant a request for an exam waiver under Business and Professions Code section 2532(e). [13:4 CRLR 73-74; 13:2&3 CRLR 96]

Ad Hoc Committee to Investigate Invasive Procedures. At its October 8 meeting, SPAEC received a report from Dr. David Alessi of the Ad Hoc Committee which is investigating several invasive procedures which are not presently covered by statute, establishing the scope of practice of SPAEC licensees—specifically, endoscopy (both nasal and oral) for speech-language pathologists, and cerumen management for audiologists. [13:4 CRLR 74]

Dr. Alessi reported on a recent position paper produced by the Pennsylvania Academy of Otolaryngology which suggests that the practice of endoscopy by speech-language pathologists should be limited to specified settings wherein a team approach is used and a physician is involved; the position paper also suggests that speech-language pathologists who wish to perform endoscopy should receive special training and even certification.

DCA legal counsel Greg Gorges stated that SPAEC should consider two approaches, both of which would require legislative changes. First, SPAEC or another state body could administer a certification program which would certify speech-language pathologists to perform endoscopy after the completion of specialized training and experience; this option would require the preparation of an examination and would cost SPAEC a considerable amount of money which would have to be recouped through certification fees. The other option, which would require less Committee involvement, would simply permit speech-language pathologists to perform the procedure but only under the supervision of a physician in specified settings and upon a showing of certain qualifications.

SPAEC agreed to continue researching these issues, and will revisit the matter at a future meeting.

■ LEGISLATION

- AB 1807 (Bronshvag). As amended September 8, would require SPAEC licensees to notify the Committee of any change of address within thirty days and authorize SPAEC to establish by regulation a system for an inactive category of licensure. [A. Inactive File]

- SB 595 (Rogers). Existing law permits physicians and audiologists to certify that a person is deaf or hearing impaired for purposes of receiving specialized or supplemental telephone equipment from telephone corporations regulated by the Public Utilities Commission. As amended April 19, this bill would permit such certification to be made by a hearing aid dispenser if a physician has evaluated the hearing of the applicant. [S. E&P/]

- AB 1392 (Speier), as amended July 1, would require SPAEC to notify DCA whenever any complaint has gone thirty days without any investigatory action, and would require the DCA Director to determine when a backlog of complaints justifies the use of DCA staff to assist in complaint investigation. [S. B&P]

- SB 993 (Kelley), as introduced March 5, would state the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the creation of new categories of health professionals who were not required to be licensed on or before January 1, 1994, or revises the scope of practice of an existing category of health professional, be supported by expert data, facts, and studies, including prescribed information, and be presented to all legislative committees hearing the legislation prior to its enactment. [S. B&P]

■ RECENT MEETINGS

At its October 8 meeting, SPAEC discussed the possible effects of the North American Free Trade Agreement on its licensing practices. Legal counsel Greg Gorges explained that one of the goals of the agreement is to prevent barriers against foreign practitioners. He stressed that the agreement does not entitle every foreign practitioner to licensure; however, all occupational licensing agencies may need to scrutinize their licensing standards to ensure they do not include any artificial barriers to entry.

Also in October, the Committee discussed an ongoing problem with university training programs in speech-language pathology and audiology. According to SPAEC Chair Robert Hall, these programs are overenrolled by as much as 20%, despite recent funding cutbacks. He suggested that SPAEC work in the future to encourage development of more university programs. The Committee took no action on this issue.

■ FUTURE MEETINGS


BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

Executive Officer: Pamela Ramsey (916) 263-2685

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

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

BENHA currently has one public member vacancy, which must be filled by the Assembly Speaker.