ity for sections of a written examination other than the PELA will be entitled to receive credit for those passed sections provided the exam is administered prior to December 31, 1994 and the Board determines that the exam is equivalent in scope and subject matter to the written exam last given in California. The modified version of section 2615 retains the provision allowing candidates who are licensed as landscape architects in other states by having passed an exam substantially equivalent in scope and subject matter to the exam last given in California to be eligible for licensure upon passing the reciprocity portion of the PELA. Thus, candidates who begin the exam process by taking CLARB's exam after January 1, 1995 must either take the PELA in its entirety in order to be licensed in California, or become fully licensed in another state and apply to qualify for California licensure under section 2615 by taking the reciprocity section of the PELA only.

On April 8, the Board released these modifications to the regulatory proposal for an additional comment period ending on April 29. BLA approved the modified version of the regulatory changes at its May 6 meeting; at this writing, the rulemaking file is being prepared for submission to the Office of Administrative Law.

LEGISLATION

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 would impose an initial "sunset" date of July 1, 1997 for BLA; create a Joint Legislative Sunset Review Committee within the legislature, which would review BLA's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which BLA's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether BLA should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case BLA would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (*See* agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

SB 2038 (McCorquodale), as amended April 5, would have abolished BLA; the provision was a direct result of the November 1993 oversight hearing of the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions. *[14:1 CRLR 47–48; 13:4 CRLR 5]* At a May 9 hearing of the Senate Business and Professions Committee, representatives of BLA and the California Chapter of the American Society of Landscape Architects expressed support for SB 2036 (*see above*) and lobbied tenaciously against SB 2038, urging Senator McCorquodale to delete the abolition provision and allow the board to participate in the SB 2036 sunset process on an expedited basis. Senator McCorquodale agreed to delete the abolition provision in SB 2038 and amend SB 2036 to establish a sunset date of July 1, 1997 for BLA; that language appears in the May 18 version of the bills. *[S. Appr]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at page 49:

AB 1392 (Speier), as amended July 1, 1993, would—among other things—provide that BLA's executive officer is to be appointed by the Governor, subject to Senate confirmation, and that the Board's executive officer and employees are under the control of the Director of the Department of Consumer Affairs. *[S. B&P]*

AB 1807 (Bronshvag), as amended March 23, reduces the time within which a landscape architect may renew his/her expired license from five to three years. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

RECENT MEETINGS

The Board's scheduled February 4–5 meeting was cancelled and rescheduled to March 10–11.

At its March 11 meeting, BLA reconsidered the election of its 1994 officers conducted at its November 1993 meeting. *[14:1 CRLR 49]* The Board elected landscape architect Marian Marum as its 1994 President and Greg Burgener, a public member who is a landscape contractor, as its Vice-President.

Also in March, Executive Officer Jeanne Brode informed the Board that the landscape architect boards in three other states (Michigan, Florida, and Georgia) are interested in scheduling presentations on the PELA by BLA and HRStrategies representatives.

At BLA's May 6 meeting, public member Michal Moore was appointed to chair the Board's Enforcement Committee. One of his goals is to more precisely define the term "landscape architect" so the Board can better detect unlicensed practice. *[14:1 CRLR 48–49]* Moore also stated that he plans to revamp the Board's current disciplinary system from one which is "too complicated" to one which would be "more public, with swift enforcement to deter negligent behavior, without having to involve the Attorney General."

FUTURE MEETINGS

August 5 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 examining committees and boards which license podiatrists and non-physician certificate holders under the ju-

risdiction 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.

On January 1, 1994, the membership of DMQ and DOL was realigned in anticipation of the July 1 abolition of DAHP. As of January 1, DOL included physicians Robert del Junco, Thomas Joas, C. Fredrick Milkie, and B. Camille Williams, and public members Bruce Hasenkamp, Stewart Hsieh, and Ray Mallel. Expanded to twelve members by SB 916 (Presley), DMQ consisted of physicians Clarence Avery, Lawrence Dorr, Anabel Anderson Imbert, Ira Lubell, Mike Mirahmadi, Alan Shumacher, Jacquelin Trestrail, and Michael Weisman, and public members Theresa Claassen, Karen McElliott, Gayle Nathanson, and Cathryne Bennett Warner.

At its February meeting, DMQ elected public member Karen McElliott as its President and Dr. Michael Weisman as its Vice-President. *[14:1 CRLR 56]* Also, again pursuant to SB 916 (Presley), the Division was split into two panels for the purpose of reviewing and adopting decisions in individual discipline cases. DMQ members Lubell, Mirahmadi, Nathanson, Trestrail, Bennett Warner, and Weisman were named to Panel A (with Weisman as chair), and DMQ members Avery, Claassen, Dorr, Anderson Imbert, McElliott, and Shumacher were named to Panel B (with McElliott as chair).

Immediately prior to the Board's May meeting, former DMQ President Dr. Michael Weisman—who was serving as Chair of MBC's Task Force on Medical Quality Resources (*see below*), DMQ Vice-President, and Chair of DMQ's Panel A—resigned from the Board. At the full Board's May 6 meeting, MBC President Bruce Hasenkamp announced that Dr. Alan Shumacher would replace Dr. Weisman as chair of the Task Force on Medical Quality Resources. At DMQ's May 5 meeting, Division President Karen McElliott named Dr. Jacquelin Trestrail as the new chair of Panel A, moved Dr. Clarence Avery to Panel A and noted that Dr. Weisman's replacement would be assigned to Panel B, and announced that an election to replace Dr. Weisman as DMQ Vice-President would be held at the Division's July meeting.

MAJOR PROJECTS

Implementation of "Presley II." SB 916—Senator Robert Presley's second major physician discipline reform bill—became effective on January 1, and has changed the way MBC's discipline system operates in several key respects.

• ***ALJ Panel Appointed.*** Among many other things, SB 916 created a Medical Quality Hearing Panel (MQHP) in the Office of Administrative Hearings (OAH), the state's centralized office of administrative law judges (ALJs). The MQHP must consist of at least five ALJs and no more than 25% of all the ALJs in OAH; panel members will exclusively hear and be able to specialize in medical discipline cases. *[13:4 CRLR 54–55]*

On January 10, OAH Director Karl Engeman announced his selection of ALJs to staff the MQHP: Catherine Frink and Muriel Evens in Sacramento; Michael Cohn and Jonathan Lew in San Francisco; William Byrnes, Richard Ranger, Samuel Reyes, and Carolyn Magnuson in Los Angeles; and Joyce Wharton and Stephen Hjelt in San Diego.

• ***DMQ Expands and Splits into Two Panels.*** As introduced, SB 916 would have relieved DMQ of its statutory authority to review proposed ALJ decisions in individual disciplinary cases and made those ALJ decisions final for purposes of judicial review; SB 916 co-sponsor Center for Public Interest Law (CPIL) has urged this structural reform to what is now a five-step administrative disciplinary system for five years. *[9:2 CRLR 1]* In an effort to preserve DMQ's authority to make the final decision in individual disciplinary cases and expedite its review of ALJ proposed decisions, MBC convinced Senator Presley to instead abolish the Division of Allied Health Professions, move those five MBC member positions to DMQ (thus creating a twelve-member DMQ), and split DMQ into two panels (four physicians and two public members) for the purpose of reviewing ALJ decisions, on the theory that two panels could decide twice as many cases in the same amount of time as before. *[13:4 CRLR 55]* SB 916 also reduced the timeframe within which DMQ must act on a proposed ALJ decision (or it becomes final) from 100 days to 90 days.

The two panels were created as of January 1 (*see above*), and immediately began to review cases and—apparently—experience problems. At DMQ's May 5 meeting, confusion reigned over the number of panel members needed to conduct business, and the number of votes needed to revoke a license outright (as opposed to revoking a license, staying the revocation, and imposing lesser actual penalties). Prior law required five votes of the seven DMQ members to revoke a physician's license; SB 916 inadvertently failed to address the number of votes of the six-member panels needed to revoke a license outright. After a lengthy debate, DMQ voted 7–4 to support a provision in SB 1775 (Presley) (*see* LEGISLATION) changing the number of panel votes needed to revoke a license outright from five to four; until and unless this legislation passes, however, the DMQ panels were warned that it should obtain five votes to revoke a license outright. DMQ also agreed that at least four members of a panel must show up to constitute a quorum and conduct business; under current law, however, if only four panel members appear for a meeting, that panel may not revoke a license outright, but must wait until the next panel meeting and hope that five members show up. In the meantime, the accused physician whose license is being considered for revocation is presumably free to practice.

Also at DMQ's May 5 meeting, members spent over an hour complaining about the distribution of cases, the number of times they had to meet outside regular board meetings in order to decide cases within the 90-day deadline, and the location and timing of meetings. Several members argued that cases should be distributed to the panels by staff such that only one panel would be required to meet between Board meetings; staff expressed doubt this could be accomplished while simultaneously distributing the cases evenly between the panels and meeting the 90-day deadline for decision. Part of this problem is of DMQ's own creation. The Administrative Procedure Act provides that reviewing board members may vote either to "adopt" or "nonadopt" the proposed decision of the ALJ. Initial votes on individual cases are taken through the mail, pursuant to Government Code section 11526. A majority vote to adopt an ALJ decision will prevail over a minority vote to nonadopt. However, DMQ has invented a new mail vote category called "hold"—if a single member votes to "hold" a case, that case will be scheduled for discussion at the next panel meeting. The "hold" mechanism is delaying DMQ decisionmaking and resulting in the scheduling of an interim panel meeting for consideration of only one or two cases which

must be decided within the 90-day deadline.

Because of the absenteeism rate of panel members at interim meetings and the continuing need to come up with five votes to revoke a license, DMQ President Karen McElliott instructed staff to schedule these meetings at hotels or other facilities near major airports, and urged her colleagues to make attendance a top priority. Other Division members took offense at McElliott's remarks, noting that it is not easy for full-time professionals to clear their schedules for a meeting between (and in addition to) quarterly Board meetings. At the end of this long discussion, DMQ public member Gayle Nathanson acknowledged the Division's continuing attempt to make the two-panel system work, but warned her colleagues that "if we can't, the whole role and function of the Division needs to be reevaluated."

• ***Letter of Reprimand.*** SB 916 also added section 2233 to the Business and Professions Code, authorizing MBC to issue a new "public letter of reprimand" by stipulation or settlement with a physician after case investigation. At DMQ's May 5 meeting, DMQ Enforcement Chief John Lancara sought and received the Division's approval to publish new sections 1364.15–.17, Title 16 of the CCR, to implement the public letter of reprimand. The proposed regulations authorize specified DMQ officials to issue, following an investigation, a public letter of reprimand in lieu of filing or prosecuting a formal accusation for minor unprofessional conduct violations. The letter must describe the nature and facts of the violation and be served upon the licensee by certified mail. Prior to formal service of the reprimand, DMQ must notify the physician of its intent to issue the letter; within 30 days, the licensee must indicate to DMQ in writing whether he/she will accept the letter. If the physician accepts, the letter will be served and its issuance shall be disclosed to members of the public who inquire about that physician's record. If the physician refuses to accept, DMQ is free to file and prosecute an accusation or evaluate the propriety of other sanctions, such as a citation and fine. At this writing, DMQ has not yet published the regulatory language for the required 45-day public comment period.

MBC Task Force Undertakes Detailed Study of Medical Consultants and Experts. Since the March 1993 Medical Summit, MBC's Task Force on Medical Quality Resources has been examining and reevaluating the Board's entire system of providing review of medical quality issues in disciplinary cases, including (1) contract/volunteer medical consultants used at the complaint and investigative levels; (2) the role, duties, and qualifications of current full-time district medical consultants (DMCs) now working from each of the Board's twelve district offices; these employees review and assist in the analysis of medical records gathered by DMQ investigators in cases where quality of care is at issue, and are responsible for retaining and securing opinions from expert medical reviewers who will serve as expert witnesses at trial if necessary; (3) the role, duties, and qualifications of physicians who are used as expert medical reviewers and witnesses at evidentiary hearings; and (4) 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). *[14:1 CRLR 52; 13:4 CRLR 57–58; 13:2&3 CRLR 81–82]*

The Task Force's study has included a review of alternative mechanisms, including an all-"volunteer" system utilized by the Florida Department of Professional Regulation (FDPR). 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 saved 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.

Following the November 1993 presentation by FDPR, MBC Executive Director Dixon Arnett and Deputy Director Doug Laue prepared a proposal for consideration by the Task Force and full Board. By requiring that all medical consultants, reviewers, and expert witnesses be both board certified and in active practice, the Arnett/Laue proposal would effectively "eliminate...the current system of the Chief Medical Consultant and the [District] Medical Consultants as full-time employees of the Board." The proposal suggests replacement of these employees and their functions with three advisory layers of review:

• An "M.D. Informal Counsel" panel of physicians representing all specialties would be available to MBC's Central Complaint and Investigation Control Unit (CCICU) for "informal counsel" (no formal written opinion would be submitted) on cases before their referral to MBC district offices for formal investigation.

• Six "Quality of Care Advisory Panels," each consisting of three physicians, would be formed. Following CCICU's referral of cases to a district office for formal investigation, these panels would evaluate the medical issues only in quality of care and sexual abuse cases, and advise whether such cases should be closed or move forward. Based on DMQ's projection of 288 quality of care/sexual abuse cases per year, these panels would meet three times per year for two days each time and handle eight cases per day.

• Ten "Probable Cause Advisory Panels," each consisting of two physicians and one public member, would be formed. After investigation and provision of a formal written opinion by a paid medical expert, these panels (assisted by an advisor from the Attorney General's Office) would review all cases and determine whether there is probable cause to believe that a disciplinable act has occurred. If so, the case will proceed to the Attorney General's Office for the filing of formal charges; if not, the case will be returned to the DMQ Enforcement Chief for appropriate action and disposition. DMQ projects a 900-case workload annually; each of the ten panels would meet three times per year for two days each time, and handle fifteen cases per day.

The Arnett/Laue proposal also suggested the use of an outside medical quality consulting firm, under a contract awarded through the state's competitive bidding process, to recruit, retain, train, and manage the physician and public members of the new medical quality review system, with oversight by a DMQ subcommittee. The proposal states that the cost of MBC's current medical quality review system is $1,710,000 during 1993–94, and projects the total cost of the proposed "volunteer" system at $1,265,000 —in other words, MBC could purportedly save $445,000 per year by implementing the proposed system.

Following discussion of the Arnett/Laue proposal at its February meeting, MBC decided it did not yet have enough information and understanding of its current system upon which to base a decision to change or retain it. MBC President Bruce Hasenkamp instructed the Task Force and staff to undertake a four-part factfinding study in order to provide MBC members with detailed information on the functions, performance, and cost of the current system as opposed to alternatives. The four studies include the following:

• ***Desk Audit of DMCs.*** Independent management consultant Carl Bergstrom is conducting a "desk audit" consisting of personal interviews with each of the DMCs. Bergstrom's audit is intended to

identify the tasks performed by DMCs, the time committed to certain tasks, the qualifications of expert medical witnesses and consultants who are retained by the DMCs, and the method(s) by which the DMCs choose these experts. At the Board's May 6 meeting, Bergstrom reported that his audit was about three-fourths complete.

• ***HQES Survey***. Step two is a survey conducted by Assistant Attorney General Al Korobkin, chief of the Health Quality Enforcement Section (HQES) of the Attorney General's Office; created in SB 2375 (Presley) (Chapter 1597, Statutes of 1990), HQES is a unit of deputy attorneys general (DAG) who specialize in prosecuting medical discipline cases. The first part of Korobkin's survey, which was presented at the April 25 meeting of the Task Force, involved a random sample of discipline cases prosecuted between March 1993 and February 1994; these cases were reviewed to determine the percentage which had been withdrawn or subject to early stipulation due to problems with the expert witnesses obtained by the DMCs. According to Korobkin's survey, expert witness problems caused the compromise of seven of the 93 cases reviewed (7.5%). However, if the focus is narrowed to quality of care cases where expert testimony is crucial to HQES/MBC prosecutorial success, the percentage of cases in which expert witness problems caused early compromise or withdrawal jumps to approximately 15%.

The cases reviewed presented situations where withdrawals or stipulations occurred due to conflicting opinions among medical experts, experts who changed their opinions between the time the accusation was filed and the hearing, and the DMCs' inability to obtain experts willing to testify at a hearing. One of the cases reviewed involved a medical expert who had been retained to render an opinion in a case involving a certain specialty. After the expert had rendered an opinion which formed the basis for the accusation but before the hearing, the DAG prosecuting the case learned that the witness had been the subject of numerous medical malpractice claims in that specialty over the past three decades (including a claim which was settled for $1 million in 1992)—rendering that "expert" subject to easy disqualification by defense counsel. Prior to recommending a stipulated settlement, the DAG also learned that the physician had ceased practicing in that specialty several years prior to being retained as the expert witness in that case.

In addition to the random sample, Korobkin asked his DAGs to identify specific problems they had experienced with expert witnesses. The DAGs echoed the random sample results, citing cases of wavering or changing expert opinions, witnesses lacking knowledge in the relevant specialty or no longer practicing that specialty, and witnesses whose qualifications are weakened by the existence of malpractice claims or adverse peer review decisions. Specific and recurring problems cited by HQES' DAGs include the following: (1) the expert does not practice in the relevant specialty or have sufficient familiarity with the issues; (2) the expert's opinion is too brief, often consisting of only one page, and fails to provide sufficient analysis to justify his/her conclusions; (3) the expert has not practiced for years before being chosen as a witness, and is unfamiliar with new procedures and techniques; (4) some experts refuse to accept as true the facts in a case; for example, they refuse to find gross negligence because they doubt the patient's statement of what occurred, and thus render an opinion based on their perception of the patient's credibility rather than the conduct of the physician in a given set of facts; (5) some experts disregard the instruction letter from the DAG, fail to use language in their opinions which may be understood by non-physician attorneys in the development and prosecution of a case, and then refuse to spend time with the DAG in order to educate them prior to hearing; and (6) some experts render an opinion while simultaneously noting that some of the records necessary to reach the opinion rendered were not available, thus offering an opinion based upon conjecture.

Finally, Korobkin identified a few cases in which a completed investigation had been referred by DMQ to HQES for the filing of an accusation but had to be returned unfiled because of problems with the expert opinions used in investigating the case and reaching the decision to file. In this area, the most common problem is that the Board's expert opinions conflict with each other and thus will not support the filing of an accusation.

• ***Analysis of MBC's Use of Medical Experts***. Step three is a computer analysis of the Board's use of medical experts from July 1992 to March 1994. This analysis, which is being conducted by MBC Deputy Director Doug Laue, will evaluate MBC's use of medical experts by region and specialty. The analysis will identify the district office which retained the expert, the type of service rendered (*e.g.*, record review, report preparation, conference with DAG, medical examination of respondent, oral clinical examinations), date of service provided, time spent, and fees charged. As part of his study, Laue will also collect the resumes of all experts used during this time period and determine the percentage who are board certified in the specialty area in which they rendered expert testimony.

• ***Cost of Current System vs. Alternatives***. The fourth and final step is a breakdown comparison of the cost of the current system vs. the cost of recruiting, training, retaining, and providing support for a "volunteer" expert system like Florida's. Because this staff analysis is dependent upon completion of steps one through three, it will not commence until those steps are completed.

At this writing, the Task Force—now being chaired by Dr. Alan Shumacher due to the resignation of Dr. Michael Weisman from the Board (*see above*)—is scheduled to meet three times (June 1, June 20, and July 11) before the Board's July 29 meeting; the Task Force will receive the final reports on the four steps described above, and hopes to prepare its final report and recommendation by July 11 to enable public comment at both the July 11 and July 29 meetings.

Public Disclosure Policy Update. Under the Board's new public disclosure policy which became effective October 1, 1993, MBC's new Consumer Information Unit continues to provide inquiring consumers with information on felony convictions against physicians, medical malpractice judgments in excess of $30,000, prior discipline in California or other jurisdictions, and ongoing disciplinary proceedings in which accusations have been filed. *[14:1 CRLR 50; 13:4 CRLR 1, 56–57; 13:2&3 CRLR 79–81]* Between October 1, 1993 and April 15, 1994, the new Unit has responded to almost 2,000 calls which have required the use of newly-installed public disclosure screens on MBC's computers. MBC continues to comply with a Sacramento County Superior Court order temporarily enjoining the Board from also releasing information on completed MBC investigations which have been referred to the HQES for the preparation and filing of an accusation (*see* LITIGATION).

At its February meeting, the full Board entertained Public Records Act requests from the *San Jose Mercury News* and several other newspapers; these requests generally seek a list or computer tape of all public information available on all physicians licensed to practice in California. In a memorandum dated January 3, staff noted that the Board had previously voted not to release "lists" but to confine the release of information under its new public disclosure policy to oral or written requests from individuals about particular

physicians; under Board policy, the Consumer Information Unit may respond to questions regarding a maximum of three physicians per telephone call. *[13:4 CRLR 56–57]* However, staff noted that some of the information requested by the newspapers could be "easily compiled" and that MBC would not in fact be releasing a "list" of doctors who have suffered discipline or other problems which are a matter of public record; MBC would simply be disclosing all public information on all California physicians, from which a reporter could generate his or her own "list." Executive Director Dixon Arnett and staff recommended that MBC comply with the request of the newspapers, and that it consider making the public information it routinely collects available on public access computer databases.

The Board rejected Arnett's recommendation by a 3–1 ratio, preferring to retain its current three-physicians-per-call policy, and prompting the newspapers to carry out their threat to sue the Board to compel compliance with the Public Records Act (*see* LITIGATION).

Diversion Program Issues. At its May 5 meeting, DMQ reviewed a status report on a set of reforms to the procedures of its Diversion Program. Under Business and Professions Code section 2340, the purpose of the Diversion Program is to identify and confidentially rehabilitate physicians who are impaired due to substance abuse or mental illness. MBC created a task force to evaluate the Diversion Program after the March 1993 Medical Summit and in response to harsh criticism of the Program by the California Highway Patrol in its January 1993 audit.

Diversion Program Manager Chet Pelton reported that five key reforms recommended by the task force had been implemented to improve the accountability of Diversion Program "group facilitators" (GFs)—independent contractors who conduct group meetings of program participants. Specifically, the Diversion Program has refined the guidelines for selecting new GFs; specifically defined the types of records which must be kept by GFs; will annually evaluate the performance of its GFs beginning in August 1994; will submit an annual report to DMQ on the GFs; and is preparing a presentation on the Program to familiarize the Division with its purpose and procedures.

Center for Public Interest Law (CPIL) Supervising Attorney Julianne D'Angelo noted that two issues which DMQ promised to take up in May 1993 and again in November 1993 have yet to be addressed. *[14:1 CRLR 51–52; 13:2&3 CRLR 78–80]* Specifically, DMQ promised to look at the issue of diversioners' direct payment to the GFs, a mechanism identified by the CHP as an apparent—if not actual—conflict of interest. DMQ also agreed to request a formal Attorney General's opinion on whether the Diversion Program is therapeutic or primarily monitoring in nature; to the extent the program purports to provide therapy, its employment of unlicensed group facilitators to provide this therapy may expose it to liability and, at the very least, embarrassment for authorizing the unlicensed practice of therapy. MBC's task force was sunsetted in November 1993 on the condition that these two issues would be examined, but they have yet to be addressed. DMQ instructed the CMA Liaison Committee to the Diversion Program, which oversees the program now that the task force has been sunsetted, to take up these two issues.

The Division also heard extensive oral testimony on a potentially explosive issue raised by Dr. Gary Nye, chair of the CMA Liaison Committee. Dr. Nye complained about a "new policy" of DMQ Enforcement Chief John Lancara, under which Lancara allegedly refuses to permit an impaired physician to be formally admitted into the Diversion Program until DMQ investigators have completed a lengthy investigation of the physician's conduct. Dr. Nye argued that the new policy, which resulted from legal advice provided by the Attorney General's Office in response to an appellate court decision in *Kees v. Board of Medical Quality Assurance*, 7 Cal. App. 4th 1801 (1992), is precluding impaired physicians from participating in the Diversion Program and improperly subjecting them to disciplinary action for offenses designed by the legislature to be addressed through the Program rather than through the disciplinary process.

In *Kees*, a respondent physician challenged DMQ's accusation on grounds the Division was precluded from taking disciplinary action against him because he was participating in the Diversion Program. Citing Business and Professions Code section 2340 *et seq.* and cases interpreting those statutes, the court stated that "once a physician enters the...program..., the Board halts all action against the physician, whether it is investigatory or disciplinary." Because it found that Kees had neither been evaluated by a Diversion Evaluation Committee nor signed a formal contract of participation in the Diversion Program, the court held that Kees had never been "formally admitted" to the Program and the Division was free to take disciplinary action against him. *[12:4 CRLR 94]*

Noting that nothing in statute requires DMQ to afford complete prosecutorial or investigative immunity to physicians who have been formally admitted to the Diversion Program, the AG's Office disagrees with the statement of law in the *Kees* decision; nonetheless, the court has so found and the AG and MBC must work within that statement of law until and unless it is overruled by legislation. Thus, the AG advised Enforcement Chief Lancara not to formally admit any physician into the Diversion Program until DMQ has completed a full investigation of the physician's conduct and is positive that no violation of the Medical Practice Act (other than self-abuse of drugs or alcohol) has been committed.

Dr. Nye lodged a twofold complaint on this issue. First, he argued that DMQ's investigations are taking too long and are unnecessarily preventing impaired physicians from entering into a formal contractual agreement with the Diversion Program, the actual signing of which—according to Dr. Nye and other physicians involved in the Program—has therapeutic and disciplinary value in and of itself. Second, Dr. Nye asserted that Lancara is hesitant to formally admit physicians to the program even after the investigation is completed and self-abuse is the only violation of the Medical Practice Act found to have been committed by the physician. CMA argued that if the physician has committed only self-abuse (which is unprofessional conduct and grounds for discipline), the physician should be formally admitted into the program and all investigation and disciplinary action should cease, as the Diversion Program was created (according to CMA) to afford substance-abusing physicians with diversion "in lieu of" discipline for self-abuse.

Lancara, assisted by Supervising Deputy Attorney General Jana Tuton and HQES Chief Al Korobkin, responded that the Division absolutely must be able to aggressively and fully complete an investigation of any complaint or other report of misconduct before formally admitting a physician into the program; if it does not investigate, it will never know whether the physician has committed only self-abuse or has also violated other provisions of the Medical Practice Act. Even if the preliminary finding is that self-abuse is the only violation, Lancara noted that further questions must be asked. For example, many drug-abusing physicians obtain narcotics by writing fraudulent prescriptions or purchasing them on the street; both actions are disciplinable violations in addition to self-abuse. Lancara also noted that nothing prevents physicians from participating in the Program on an informal basis until the investigation is complete and formal admission is granted.

With regard to self-abuse-only cases, Lancara stated that over the past nine months he has granted three such physicians formal admission into the Diversion Program rather than referring them to HQES for disciplinary action. According to Lancara, "That may not have been the best decision and was accompanied by serious risk. DMQ needs to determine whether that's a risk we should be taking." Lancara noted that Business and Professions Code section 2229 states that public protection is the highest priority for MBC and the Division of Medical Quality; "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." Lancara concluded by saying he supports the Diversion Program, "but it needs to be balanced toward public protection."

DAG Tuton supported Lancara's position, and reminded DMQ that many of the physicians who attempt to participate in the Diversion Program have injured patients (or have come dangerously close) due to their substance abuse problem, know that complaints or reports of misconduct are forthcoming, and request admission into the program because they want immunity from disciplinary action. She stated that "the larger group of cases we see involve more than simple self-abuse." Tuton described several recent cases of physicians seeking admission to the program, including an anesthesiologist who passed out in the operating room between surgery due to drug abuse, and a physician who snorted cocaine in his office between patient visits. She stated that the Diversion Program is open to physicians who self-refer into the program before their practices and patients are affected; where patient protection has already been implicated, however, she urged the Division to keep its options open to protect the public. The only way to do this is to aggressively and fully investigate all physicians seeking entry into the program and carefully evaluate the facts before granting formal admission.

HQES Chief Korobkin echoed Tuton's advice, urging the Division to protect its discretion. In evaluating the facts of alleged self-abuse-only cases, he urged DMQ to distinguish those which present "a very strong potential for injury"—in those cases, he said, discipline is more appropriate to protect the public than diversion. According to Korobkin, "if there is high potential for future harm, referral to the AG is appropriate."

At the conclusion of the discussion, DMQ took no formal action on Dr. Nye's complaint. However, Dr. Ira Lubell moved that MBC co-sponsor a bill with CMA which clarifies or overturns the *Kees* statement, and which will "protect the public and protect the integrity of the Diversion Program simultaneously." Dr. Lubell's motion carried by a vote of 10–1.

Controversy Over Closed Sessions of DOL Committees Continues. At its February and May meetings, DOL continued to discuss the contention of the Center for Public Interest Law (CPIL) that the closed sessions of its Application Review Committee (ARC) and Special Programs Committee (SPC) violate the Bagley-Keene Open Meeting Act. The ARC reviews nonroutine applications for physician licensure, while the SPC reviews applications for approval of special training or faculty programs under Business and Professions Code sections 2111, 2112, 2113, 1324 and 1327.

Prior to each DOL meeting, the committees meet in closed session under Government Code section 11126(c), which states that "an advisory body of a state body which administers the licensing of persons engaged in business and professions" may meet in private to consider "matters...which the advisory body has found would constitute an unwarranted invasion of the privacy of an individual licensee or applicant if discussed in an open meeting...." CPIL contends that, pursuant to a 1988 written statement adopted by DOL as Division policy which defines the role of the ARC and SPC, neither committee is an "advisory body" authorized to meet in closed session under section 11126(c); under the 1988 statement, both committees make binding licensing decisions which are simply directed to staff and not reviewed or ratified by the full Division. *[8:2 CRLR 61]* On two occasions since the Division's adoption of the 1988 statement, CPIL has petitioned DOL to open the meetings of these committees to the public or restructure them so that their closed sessions are lawful. *[13:4 CRLR 59–60]*

In December 1993 correspondence on the issue, DCA legal counsel Greg Gorges again advised DOL that these committees may meet privately. Specifically, Gorges pointed to DOL's recent amendments to section 1301, Title 16 of the CCR; the amendments authorize DOL staff to refer applications to these committees, and state that "[m]embers appointed to the committees *may advise* the program manager on the disposition of the above-mentioned applications" (emphasis added). Gorges stated that this language "should put to rest any question of the advisory nature of these committees and their qualification to meet in closed session...."

At the Division's February meeting, DOL President Dr. Robert del Junco asked whether any member believed that ARC meetings should be held in public; Division members opined that ARC's discussion of applicant information in public would invade the privacy interests of the applicants, and agreed that the Division should follow legal counsel's advice. Dr. del Junco concurred as to the ARC, but questioned whether meetings of the SPC could be opened to the public, and directed staff to prepare a memorandum exploring the pros and cons of holding SPC meetings in public.

At its May 5 meeting, DOL reviewed a staff memorandum on the functions of the SPC dated April 14. In spite of the amendments to section 1301 (which became effective on April 8) and legal counsel Gorges' comment about the "advisory nature" of both committees, the memorandum stated that the Committee itself continues to approve or deny applications for approval of special training or faculty programs under Business and Professions Code sections 2111, 2112, 2113, 1324 and 1327. Staff stated that if the SPC's meetings were held in open session, the public would be better able to understand the Committee's review process and issues of concern to the members, and medical school representatives in the audience might be able to answer questions that arise regarding the content of an applicant's proposed program. However, staff also noted that "confidentiality of applicants' personal information would be lost, possibly inviting legal action by applicants; medical school representatives in the audience may experience embarrassment if their school's program requests are discussed negatively or denied in public; applicants who attend the meetings may experience embarrassment if their qualifications are discussed negatively or their program request is denied in public, and they may disrupt the meeting to contest the denial; [and] audience members may interrupt the members' discussions with extraneous questions and requests."

Instead of evaluating the legality of closed sessions, Drs. Milkie and Joas focused on applicants' privacy concerns, and alternatively opined that open meetings of the SPC would create too much work for staff. Public member Bruce Hasenkamp disagreed, stating that administrative convenience does not justify ignorance of the open meetings law. DOL reached no clear consensus on this issue; CPIL intends to pursue it in the future.

Implementation of Lay Midwife Certification Program. At its February meeting, DOL President Dr. Robert del Junco named Dr. Thomas Joas and Stewart Hsieh to the Midwifery Committee and

charged the Committee with assisting Division staff in implementing SB 350 (Killea) (Chapter 1280, Statutes of 1993), which requires MBC to establish a certification program for lay midwives. *[14:1 CRLR 56; 13:4 CRLR 61]*

Under SB 350, there are two pathways for an applicant to obtain licensure as a lay midwife: (1) graduation from an accredited three-year midwifery program, or (2) licensure in another state with equivalent standards. An applicant may be deemed to have "graduated" from an accredited program in two ways: (1) by actually completing a three-year program, or (2) by "challenging" the coursework through proficiency and practical examinations administered by DOL (and satisfaction of experience prerequisites for taking the "challenge" examinations, which the Division must establish by regulation).

The Midwifery Committee held public meetings on March 1, April 4, and May 4 to discuss the requirements of the statute. Among other things, the Committee learned that 18 other states administer lay midwife programs, but not all of them require licensing. The North American Registry of Midwives has prepared and had validated a written licensing examination which is used in a number of states; DOL staff researched that examination and alternatives used by other states and programs.

DOL is required to adopt numerous regulations to implement SB 350, some by July 1, 1994. At its March meeting, the Midwifery Committee approved an ambitious rulemaking schedule to accomplish this task. Toward this end, at its May 5 meeting DOL held a public hearing on its proposal to adopt sections 1379.1, 1379.2, 1379.3, and 1379.5, Title 16 of the CCR, which set forth general provisions related to the lay midwife certification program and establish license application ($300), renewal ($200), and delinquency ($50) fees to support the program. Following the hearing, DOL adopted the proposed regulations, which now await review and approval by the Office of Administrative Law (OAL).

In future rulemaking proceedings, DOL will adopt regulations which (among other things) specify the written examination used to test applicants, prescribe the type and extent of clinical experience which must be demonstrated before an applicant is permitted to "challenge" the coursework completion requirement, set forth the application form to be used in the certification process, and establish continuing education requirements.

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

• ***Licensing Fees Increase.*** Following a public hearing on February 3, DOL adopted permanent amendments to sections 1351.5 and 1352, Title 16 of the CCR, which increase MBC's biennial initial and renewal licensing fees from $500 to $600, retroactive to January 1, 1994. DOL had previously adopted the fee increases on an emergency basis in November 1993. *[14:1 CRLR 51]* The fee increase is needed primarily to enhance the staffing of the Health Quality Enforcement Section in the Attorney General's Office. OAL approved the permanent fee increase amendments on April 25. A portion of this increase in renewal fees will be "refunded" to physicians under the provisions of SB 916 and due to CMA's victory in *California Medical Association v. Hayes* (*see* LEGISLATION and LITIGATION).

• ***DMQ's Citation and Fine Regulations Approved.*** On March 24, OAL approved new sections 1364.10–.14, Title 16 of the CCR, DMQ's citation and fine regulations. The rules list 56 sections of the Business and Professions Code, the violation of which may warrant a citation by specified DMQ officials; a citation may include an order of abatement and/or 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 DMQ 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 again 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 inquiring consumers. However, it will not be reported to the National Practitioner Data Bank because DMQ does not deliberate or vote on it. *[14:1 CRLR 51; 13:4 CRLR 58]*

• ***SB 2036 Regulation Approved.*** On January 27, OAL finally approved MBC's adoption of new section 1363.5, Title 16 of the CCR, to implement SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990). The new regulation defines the terms "specialty board" and "specialty or subspecialty area of medicine," and establishes 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. *[14:1 CRLR 52; 13:1 CRLR 47; 12:4 CRLR 90–91]*

At its February 3 meeting, DOL President Dr. Robert del Junco appointed Dr. Fredrick Milkie and Ray Mallel to serve on a subcommittee to review applications for SB 2036 approval. Dr. Milkie suggested that DOL hire a recognized physician consultant to assist the subcommittee in evaluating applications from specialty and subspecialty boards. At DOL's May 5 meeting, Dr. Milkie reported that although several boards have requested application packets, staff had received only one completed application for SB 2036 certification. Also in May, the Division approved an invitation for bids from persons wishing to serve as the consultant; the consultant selection process is expected to take at least four months.

• ***DOL Rulemaking.*** On May 9, OAL approved DOL's addition of section 1354 to Title 16 of the CCR, which establishes a fee which DOL will collect from specialty boards or associations applying for approval under the Board's new SB 2036 regulations (*see above*). OAL also approved DOL's amendments to section 1301, Title 16 of the CCR, which 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, and specify that these committees act in an advisory capacity only to the DOL Program Manager (*see above*); and section 1321, which delete an inaccurate reference to "hospitals." *[14:1 CRLR 52; 13:4 CRLR 59]*

• ***DAHP Rulemaking.*** At its May 4 meeting, DAHP adopted its proposed amendment to section 1366.3, Title 16 of the CCR, which provides that a qualified medical assistant (MA) is one who is currently certified by the American Association of Medical Assistants (AAMA). DAHP's proposed amendment would include the American Association of Medical Technologists (AAMT) as a certifying body for qualified MAs who provide training to other MAs under the direction of a licensed physician. During the comment

period, the California Medical Assistants Association (CMAA) argued that the addition of AAMT was erroneous, and requested that CMAA be listed instead as a certifying body. DAHP member Stewart Hsieh researched CMAA's certification process and recommended that CMAA's request be denied, as its process was not equivalent to that of AAMA or AAMT; the Division concurred. At this writing, the amendment to section 1366.3 awaits review and approval by OAL.

LEGISLATION

"Fee Fix" Legislation. SB 916 (Presley) contained a provision authorizing a $100 increase in MBC's biennial licensing fee (*i.e.*, from $500 to $600 every other year). However, the bill specified that should the California Medical Association prevail in its constitutional challenge to the state's 1992–93 appropriation of physician licensing fees from MBC's special fund and should those transferred funds be returned, they must be refunded to MBC's licensees in the form of a lower fee increase. On February 22, CMA won its litigation, and the state declined to appeal (*see* LITIGATION). Thus, MBC must now return a total of $2,566,315 (minus $75,000, which the state Department of Finance ordered to be paid from the recouped funds to CMA as attorneys' fees) to its licensees. At its May 6 meeting, MBC agreed to sponsor legislation accomplishing two goals: (1) exempting MBC from similar transfer language included in the 1993–94 budget bill, which is now unconstitutional as to MBC; and (2) amend the SB 916 provision which requires return of all recouped funds to exclude the $75,000 in attorneys' fees. The Board also agreed to "refund" the remaining $2.491 million to its licensees in the form of a one-time $25 reduction in the $100 biennial increase; that is, physicians renewing their licenses between September 1, 1994 and August 31, 1996 would renew at a reduced fee level of $575. At this writing, the language needed to accomplish the so-called "fee fix" has not been incorporated into any existing legislation.

SB 1775 (Presley), as amended April 12, is sponsored by MBC and referred to as "Presley IIA," as it makes approximately thirty technical and clean-up changes to the provisions of SB 916 (Presley) and other sections of the Business and Professions Code. Among many other things, SB 1775 would empower DOL (rather than DMQ) to adopt regulations governing the Board's disclosure of information about physicians; expand the private peer review records which must be made available to the Medical Board after an adverse peer review decision is reported to the Board; revise the procedure for the suspension or revocation of a physician's license after that physician is convicted of a felony; revise the contents of the *Medical Discipline Report* required to be published by the Office of Administrative Hearings by SB 916; and change the name of the MBC committee created in SB 916 to the "Committee on Healing Arts Professions." This bill is expected to be amended considerably over the summer. *[S. B&P]*

SB 1958 (Presley). SB 916 (Presley) authorized DMQ or the Health Quality Enforcement Section to establish panels or lists of experts as necessary to assist them in investigating and prosecuting violations of the Medical Practice Act. As amended May 16, this bill would instead require the establishment of these panels or lists of Medical Board experts. This bill would impose minimum qualifications for a physician to serve as a Medical Board expert, and impose certain restrictions regarding the length of time a person may serve as a Medical Board expert. At its May 6 meeting, MBC voted to oppose this CMA-sponsored bill, as MBC is currently in the process of establishing standards and qualifications for its expert reviewers and witnesses (*see above*), and wishes to complete its ongoing factfinding investigation and set its own criteria. *[S. Appr]*

SB 1886 (Presley). Existing law requires MBC to provide for representation of any non-employee who is hired or under contract to provide expertise in evaluating the conduct of a licensee and who is named as a defendant in a civil action for defamation resulting from the opinion rendered, statements made, or testimony given by that person. Existing law provides that the Board shall not be liable for any judgment rendered against that person; and further provides that the Attorney General shall be utilized in those actions. As amended May 4, this bill would include persons retained under any other arrangement, paid or unpaid, to provide that expertise to MBC among those to whom the Board is required to provide representation; add malicious prosecution and any other civil cause of action to the actions that must be defended; instead provide that the Board shall be liable for any judgment rendered against the person, unless the judgment results from that person's willful misconduct; authorize MBC to indemnify the defendant for a punitive damages judgment, unless the judgment results from willful misconduct; require that the defendant be liable to the Board for the costs of defending an action alleging willful misconduct when the plaintiff prevails; and provide that the Attorney General shall be utilized in those actions. *[S. Floor]*

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 would impose an initial "sunset" date of July 1, 1999 for MBC; create a Joint Legislative Sunset Review Committee within the legislature, which would review MBC's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which MBC and its performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether MBC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case MBC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (*See* agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

AB 3497 (B. Friedman). Existing law sets forth the required clinical instruction for applicants for licensure as a physician and specifies the required minimum amounts of instruction. As introduced February 25, this bill would add four additional weeks of clinical instruction in family medicine to the instruction required to be completed by applicants, and specify that this added requirement applies only to applicants who matriculate on or after September 1, 1995. *[S. B&P]*

AB 3386 (Burton). Existing law authorizes the administration of injections and the performance of certain other tasks by medical assistants upon the specific authorization and supervision of a physician. As amended April 11, this bill would require that the formulary of medications that may be administered by medical assistants not include certain types of medications, including those excluded by MBC because of their potential for substantial harm to the patient. This bill would also authorize registered nurses to assign simple, routine tasks to medical assistants, and to supervise the performance of those tasks, under described circumstances. *[A. Health]*

AB 3765 (Campbell), as amended April 28, would require MBC, with the participation of the Acupuncture Committee, the California Medical Association, the California Naturopathic Association,

the Osteopathic Medical Board of California, and the state Board of Chiropractic Examiners, to study and report to the legislature by July 1, 1995, on the practice of naturopathy and the desirability of establishing a "Naturopathic Practitioners Registration Act." *[A. W&M]*

SB 1566 (Watson), as amended April 28, would establish the Naturopathic Title and Registration Act that would regulate the practice of naturopathy, as defined, and would regulate the use of titles indicating any special credentials, knowledge, expertise, competence, or ability in the field of naturopathy. *[S. B&P]*

SB 1642 (Craven). The Physician Assistant Practice Act authorizes a physician assistant (PA), to perform medical services set forth in regulations adopted by DAHP, when the services are rendered under the supervision of a licensed physician(s) approved by the Division or, in certain emergency circumstances, under the supervision of a licensed physician regardless of whether the PA's approved supervising physician is available to supervise the PA. As amended April 25, this bill would authorize a licensed physician approved to supervise a PA to delegate to a PA under his/her supervision, and in a manner determined by the supervising physician, the authority to administer or provide medication to a patient or transmit a prescription from the supervising physician to a person who may lawfully furnish the medication or medical device to the patient. It would require, prior to delegating prescription transmittal authority to a PA, the supervising licensed physician to adopt a written, practice-specific formulary and protocols that specify all criteria to be considered for use of a particular drug or device, and any contraindications for the drug or device. The bill would require any supervising physician's prescription that is transmitted by the PA to be based on either the physician's order for the particular patient or for a drug listed in the formulary. It would prohibit a PA from administering, providing, or transmitting a prescription for Schedule II through Schedule V controlled substances without an order from the supervising licensed physician. *[S. Floor]*

SB 1557 (Thompson). Existing law authorizes an individual of sound mind and eighteen or more years of age to execute a declaration governing the withholding or withdrawal of life sustaining treatment, and appoint an attorney in fact to make health care decisions for that individual in the event of his/her incapacity pursuant to a durable power of attorney for health care. Existing law provides that a health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action for relying on a health care decision made by an attorney in fact under a durable power of attorney for health care in described conditions. Existing law also authorizes a health care provider to presume that a durable power of attorney for health care or similar instrument is valid.

As amended April 6, this bill would require that health care providers who honor a request to forego resuscitative measures, as defined, when that action or decision is in accord with reasonable medical standards, not be subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, under certain circumstances. This bill would provide that, in the absence of knowledge to the contrary, a health care provider may presume that a request to forego resuscitative measures is valid. *[A. Jud]*

SB 1402 (Greene). The Intractable Pain Treatment Act authorizes a physician to prescribe or administer controlled substances to a person in the course of treatment of that person for a diagnosed condition causing intractable pain, as defined, and prohibits MBC from disciplining a physician for that prescribing or administering. However, this authorization does not apply to treatment of any person in a health facility, as defined. As amended April 18, this CMA-sponsored bill would delete this exception (thereby making the Act applicable to inpatients at licensed health facilities), and provide that nothing in the Act is to be construed to prohibit the governing body of a hospital from taking disciplinary actions against a physician pursuant to certain professional peer review procedures. *[A. Health]*

AB 3081 (Lee), as amended April 21, would require the physician of an obstetric patient to relate information to the patient, using a standardized written summary, about (among other things) the risks of and available preventive treatment for neonatal group B streptococcal infection; a violation of this requirement would constitute unprofessional conduct. AB 3081 would also require the state Department of Health Services to develop and periodically revise the standardized written summary to be provided to obstetric patients about neonatal group B streptococcal infection, and require MBC to make the standardized written summary available to physicians. *[A. Floor]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at pages 52–53:

AB 1807 (Bronshvag), as amended March 23, revises educational, examination, and experiential requirements for licensure as a physician. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

SB 1048 (Watson), as introduced March 5, 1993, would establish the Clean Needle and Syringe Exchange Pilot Project, and would authorize physicians, among others, to furnish hypodermic needles and syringes without a prescription or permit, as prescribed. *[A. Health]*

SB 437 (Hart), as amended May 4, would authorize a physician who practices physical therapy as part of his/her practice to utilize one unlicensed aide to perform patient-related tasks, as defined, at any given time to assist with aspects of physical therapy, as long as, when performing these functions, the aide is at all times under the orders, direction, and immediate supervision of the physician. This bill would further require, among other things, that the supervising physician be responsible at all times for the conduct of the aide, and be in the same facility as, and in proximity to, the location where the aide performs those tasks. *[A. Health]*

AB 595 (Speier), as amended April 11, would prohibit, on and after January 1, 1996, any physician from performing surgery in an outpatient setting, as defined, using specified anesthesia unless the setting is one of enumerated health care settings, including a setting accredited by an accreditation agency approved by DOL. This bill would prohibit an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient 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 settings; permit DOL or an accreditation agency to inspect outpatient settings accredited by an accreditation agency; authorize certain disciplinary actions to be taken with regard to outpatient settings and accreditation agencies that are out of compliance with the requirements of these provisions; and require DOL to establish fees for approval of accreditation agencies. *[S. Appr]*

AB 1291 (Speier), as amended July 2, 1993, 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 1446 (Margolin), as introduced March 3, 1993, 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 1392 (Speier), as amended July 1, 1993, 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 2156 (Polanco), as amended May 25, 1993, 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]*

SB 366 (Boatwright), as introduced February 19, 1993, would permit DMQ to investigate complaints from a member of MBC that a physician may be guilty of unprofessional conduct. *[A. Health]*

SB 140 (Kopp), as amended January 3, is no longer relevant to MBC.

The following bills died in committee: **SB 971 (Rosenthal)**, which would have generally prohibited a health facility that operates a postgraduate physician training program from allowing any resident physician in that program to work in excess of certain hour limits, and prohibited the facility from routinely relying on resident physicians to perform ancillary services; **AB 929 (Horcher)**, which would have provided 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 complained-of MBC licensee may seek civil remedies against his/her accuser; **AB 720 (Horcher)**, which would have prohibited any person other than a licensed physician, podiatrist, or dentist from applying laser radiation to any person for therapeutic purposes; **SB 1125 (Calderon)**, which would have required DCA to conduct a study of the costs of clinical laboratory tests and report the results to the legislature by May 1, 1994; **AB 1294 (Lee)**, which would have enacted the Licensed Midwifery Practice Act of 1993; **AB 1689 (Statham)**, which would have provided a tax credit for a qualified health care practitioner with a practice certified by the Office of Statewide Health Planning and Development to consist of at least 60% underserved rural patients; **SB 993 (Kelley)**, which would have stated 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; **AB 1907 (Knight)**, which would have—under specified circumstances—exempted 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; **AB 2036 (Mountjoy)**, which would have authorized 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; **AB 2214 (Lee)**, which would have required any physician who sells, closes, or transfers his/her medical practice to notify each patient in writing and required that each patient be given an opportunity to determine where his/her records shall be directed; and **AB 2241 (Murray)** and **SB 1166 (Watson)**, which would created the Naturopathic Physicians' Practice Act and established the Naturopathic Physicians' Examining Committee within DAHP.

LITIGATION

MBC continues to defend the validity of its new public disclosure policy in ***California Medical Association v. Dixon Arnett, et al.***, No. 376275 (Sacramento County Superior Court). Under the new policy effective October 1, 1993, the Board began to disclose several new categories of information about physician misconduct to inquiring consumers, including felony convictions, medical malpractice judgments in excess of $30,000, prior discipline (in California and in other states), and its own completed investigations once it has decided to pursue disciplinary action and referred the case to the Attorney General's Office. On November 2, CMA filed suit to block implementation of the policy in its entirety, arguing primarily that the policy invades constitutionally protected privacy rights of physicians. On December 2, the court issued an order which leaves intact the bulk of the Board's new policy, temporarily enjoining only the disclosure of 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. *[14:1 CRLR 50, 53–55; 13:4 CRLR 1, 56–57; 13:2&3 CRLR 79–81]*

On May 11, CMA filed an amended petition for writ of mandate in the matter. The amended pleading repeats all of CMA's original claims and contentions, and adds a new basis which allegedly restricts MBC from disclosing completed investigations prior to the filing of an accusation. Specifically, CMA now argues that the state Information Practices Act (IPA), Civil Code section 1798 *et seq.*, which governs state agencies' disclosure of "personal information" they collect on individuals, prevents MBC from releasing information on fully investigated cases which have been referred to the AG's Office. The IPA defines the term "personal information" to include "name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history." CMA maintains that the IPA prevents MBC from disclosing fully investigated cases in which an accusation has not been filed, and/or requires MBC to both notify the physician prior to the release of such information and permit the physician to include a notice that the information being released is disputed by the physician. CMA's amended petition also newly alleges that MBC is precluded from disclosing filed accusations where those charges are later withdrawn due to a stipulated settlement. At this writing, MBC is required to file responsive pleadings by June 28.

In a related matter, several newspapers challenge MBC's refusal to comply with their Public Records Act request in ***San Jose Mercury News, et al. v. Medical Board of California***, No. 377991 (filed May 3, 1994 in Sacramento County Superior Court). In this action, the San Jose Mercury News, McClatchy Newspapers, Inc., and the Times-Mirror Company challenge MBC's refusal to supply them with computer tapes containing basic licensing information and other public information which MBC agreed to release in its May 1993 public disclosure policy on all licensed physicians in California (*see* MAJOR PROJECTS). At this writing, the matter is set for a July 6 hearing.

On February 22, the Sacramento County Superior Court issued an order favorable to CMA in ***California Medical Association v. Hayes***, No. 374372, CMA's challenge to the legislature's 1993 Budget

Act transfer of $2.6 million in physician licensing fees from the Medical Board's Contingent Fund to the general fund. *[13:4 CRLR 62–63; 13:2&3 CRLR 85; 12:4 CRLR 1]* Ruling in favor of CMA on two separate constitutional grounds, the court granted CMA's petition and directed the state to return all Medical Board funds transferred under the unconstitutional provisions. First, the court found that the transfer of funds required by the Budget Act is a "special law" which violates the state constitution because it requires physicians to pay more in general taxes than other similarly situated persons. Second, the court held that because the Budget Act transfer language purports to amend the Medical Practice Act (which restricts the use of physician licensing fees for consumer protection activities by the Medical Board and expressly prohibits the transfer of those fees to the general fund), the Budget Act language violates the single subject rule of the state constitution. The Department of Finance (DOF) subsequently decided not to appeal the superior court's ruling and returned $2.6 million to the Medical Board; additionally, DOF agreed that CMA should be paid $75,000 in attorneys' fees and then specified—without consulting with MBC—that the $75,000 must be paid from the recouped amount instead of the general fund. Under the provisions of SB 916, the recouped amount must be returned to California physicians in the form of reduced licensing fees. At its May 6 meeting, MBC adopted a plan for returning the recouped amount to its licensees (*see* LEGISLATION for a discussion of the "fee fix" bill), and directed Executive Director Dixon Arnett to send a letter to the Governor and the Department of Finance expressing MBC's extreme dissatisfaction that DOF is requiring it to absorb in its budget the cost of litigation to which it was not a party but which was necessary to challenge a legislative provision which it opposed and over which it had no control.

On April 25, the Sacramento County Superior Court struck down a provision of DAHP's medical assistant regulations in ***Engineers and Scientists of California (ESC), et al. v. Division of Allied Health Professions***, No. 532588. In this consolidated action, ESC and the California Optometric Association (COA) challenge the validity of section 1366(b)(4), Title 16 of the CCR, which authorizes MAs to perform "automated visual field testing, tonometry, or other simple or automated ophthalmic testing" under certain conditions. *[13:4 CRLR 63, 79; 13:2&3 CRLR 85–86, 100]* The court did not reach the merits of ESC/COA's claim (that the regulations permit unlicensed MAs to engage in tasks reserved for licensed optometrists); however, the court found fault with DAHP's procedure in adopting the regulations. DAHP added the offensive sections at the final public hearing on the proposed rules and released them as a "nonsubstantive change" for a 15-day public comment period; the court found that the changes were substantive and should have been republished for a full 45-day public comment period. At this writing, DAHP has not indicated whether it will appeal the decision.

RECENT MEETINGS

At their February meetings, the Board and its Divisions thanked and honored Department of Consumer Affairs legal counsel Greg Gorges for his many years of assistance and advice to them. After a distinguished 18-year career, Gorges retired from state service in January. DCA staff counsel Anita Scuri has been named to replace Gorges as legal advisor to the Medical Board.

At its February and May meetings, DOL was updated on the implementation of four recommendations made by the Board's Appropriate Prescribing Task Force last November. To better educate physicians on appropriate prescribing and pain management techniques (especially for terminally ill patients), the Task Force recommended, and DOL approved, a four-step plan: (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.

In February, staff reported that the one-hour seminar was being postponed until after a multi-agency "Effective Pain Management Summit" scheduled for March 18. The Summit was organized by the State and Consumer Services Agency in direct response to Governor Wilson's October 1993 veto of AB 2155 (Polanco), which would have required a newly-created Ad Hoc Advisory Committee on Prescription Pain Management to report to the Governor and legislature on the various issues involving the treatment of pain.

In May, MBC member Dr. Jacqueline Trestrail reported that the Summit, which was co-sponsored by MBC, brought together 120 health care practitioners, public educators, representatives of professional schools, and participants from the state pharmacy, dental, and registered nursing boards and professional trade associations. Summit participants identified a number of impediments which inhibit delivery of proper pain management, including lack of knowledge about pain management and appropriate use of controlled substances on the part of patients and their caregivers, professionals, and government agencies; the low priority of pain management in health care systems; and unwarranted fears of addiction and side effects of opiates on the part of practitioners, the public, patients, and their caregivers. Summit participants also developed a set of recommended solutions to these problems, including the development of positive statements on pain management and the appropriate use of controlled substances by the medical, nursing, pharmacy, dental, podiatry, physician assistant, and osteopathic boards in California; replacement of the state-required triplicate prescription form for controlled substances with electronic monitoring of controlled substances prescriptions; elimination of the apparent prohibition on prescribing controlled substances to those with a history of drug abuse when treating pain; development of appropriate standards for evaluation and investigation of inappropriate prescribing which avoid interference with legitimate medical care; and promotion of ongoing communication among regulators and practitioners, including training of regulatory and law enforcement staff, investigators, and attorneys on pain management and appropriate prescribing.

In conjunction with the Summit, MBC staff and Task Force members worked with representatives of the Pain Research Group at the University of Wisconsin-Madison to fulfill another of the four Task Force goals—the development of a draft policy statement on pain management and controlled substance prescribing to replace the Board's 1985 guidelines. At its May meeting, MBC reviewed the draft policy, which was well-received at the Summit; the policy emphasizes the Board's support for the appropriate prescribing of opioid analgesics (narcotics) and other controlled substances when medically indicated for the treatment of pain—not overprescribing of narcotics. The Board unanimously approved both the policy and Dr. Trestrail's final report on the Summit.

In a related matter, ACR 34 (O'Connell) (Chapter 77, Resolutions of 1993) requires MBC to conduct a survey of California medical schools to determine whether medical students receive adequate training in, and whether physicians and surgeons understand, pain manage-

ment and palliative care techniques for the terminally ill; based upon the survey, MBC is required to make recommendations to the legislature on necessary modifications to the medical school curriculum required for California licensure. *[13:4 CRLR 61]* After two requests, MBC staff had received responses from six of California's eight medical schools by the May meeting. DOL member Dr. B. Camille Williams is reviewing the materials furnished by the responding medical schools.

At its May meeting, DOL increased its application processing fee from $373 to $442 per application. DOL's licensure application processing program is supported entirely by applicants for licensure; no physician licensing fees are used. The application fee has not been changed since 1990, and the increase was needed because DOL application processing staff salaries have increased since then.

At its February and May meetings, DAHP continued to discuss out-of-state mail order firms which sell contact lenses to California residents; DAHP regulates registered dispensing opticians (RDOs) under Business and Professions Code section 2550 and seeks to include out-of-state firms which dispense contact lenses to California residents under its jurisdictional umbrella. Last November, the Division instructed Program Manager Anthony Arjil to draft a regulation requiring RDO registrants to have a permanent California address. *[14:1 CRLR 55–56]* Following a flurry of correspondence from out-of-state firms, DCA legal counsel Greg Gorges advised DAHP at its February meeting that the RDO law does not authorize it to require out-of-state contact lens firms to adhere to any standards, including the maintenance of a California address; these firms are generally not required to be registered as RDOs, because they do not fit and adjust lenses in addition to selling them. At the request of in-state RDOs and optometrists, DAHP members then instructed staff to seek both legislation and regulatory changes which would authorize DAHP to require out-of-state contact lens dispensers to (1) maintain a California business address, (2) notify customers that they should be reevaluated by a physician or optometrist within 60 days of receiving their contact lenses, (3) provide a toll-free 800 number whereby customers with complaints or questions could contact them, and (4) provide a quarterly report to DAHP on the number and type of complaints received and their resolution.

Continuing this discussion at DAHP's May meeting, Program Manager Arjil reported that no other state currently regulates out-of-state opticianary firms. Arjil stated that the two types of complaints received by DAHP staff on out-of-state contact lens firms involve receipt of the wrong brand of lens and receipt of lenses that fit incorrectly; he noted that the out-of-state firms have satisfactorily addressed these complaints. Washington, D.C. attorney William Helvestine, representing a large out-of-state opticianary firm, opined that DAHP's attempt to regulate his firm through a California address requirement would place an undue burden on interstate commerce in violation of the U.S. Constitution. Nevertheless, DAHP approved draft regulatory changes which would amend section 1399.220, Division 13.5, Title 16 of the CCR, to require RDO registration applicants to furnish a California address on their application forms; and add section 1399.233 to require registered contact lens dispensers to ensure that a written statement is placed on each contact lens container which directs the person named in the prescription to return to the prescribing physician or optometrist for an evaluation. At this writing, these regulatory changes are tentatively scheduled for a public hearing by DOL on July 28 (as DAHP will no longer exist after July 1, 1994).

At its May 4 meeting (the last meeting of its existence), DAHP discussed the new Committee on Allied Health Professions which was created in SB 916 (Presley) to carry on some of DAHP's duties after its July 1 sunset. Although SB 916 abolished DAHP and created the new Committee in Business and Professions Code section 2015(b), it did not specify the Committee's function or responsibilities; staff's understanding is that the Committee is to "hear all non-physician issues or problems as they pertain to allied health professions,...[and] develop recommendations which the chairperson would present to the full Board for approval." At the request of several existing allied health licensing programs, DAHP agreed to recommend that the new Committee be renamed as the "Committee on Healing Arts Professions"; this name change has been incorporated into SB 1775 (Presley), which is currently pending in the Senate Business and Professions Committee (*see* LEGISLATION).

■ FUTURE MEETINGS

July 28–29 in Los Angeles.
November 3–4 in San Diego.

ACUPUNCTURE COMMITTEE

Executive Officer: Sherry Mehl
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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.

■ MAJOR PROJECTS

Continuing Education Regulations Set for Hearing. On May 13, AC published notice of its intent to hold a June 29 hearing on several proposed changes to its continuing education (CE) regulations in Division 13.7, Title 16 of the CCR. Specifically, AC proposes to repeal several of its existing CE regulations (sections 1399.480, 1399.481, 1399.483, and 1399.484) and replace them with a comprehensive set of new regulations which would clarify AC's CE program.

New section 1399.480 would establish definitions of terms used throughout AC's CE regulations. New section 1399.481 would establish criteria for CE providers. New section 1399.482 would provide for the issuance of CE provider numbers, identify the records which must be retained by CE providers, identify the information and documentation which must be provided to AC and course participants

upon conclusion of an approved CE course, and set forth other responsibilities pertaining to CE providers. New section 1399.483 would establish criteria for the course content of approved CE courses and for evaluation of the course by participants, and provide that independent and/or home study is not acceptable for CE credit. New section 1399.484 would specify the procedures and information to be submitted by providers requesting AC approval of their CE courses. New section 1399.485 would establish standards and criteria for instructors of approved CE courses. New section 1399.486 would establish advertising standards for approved CE courses. New section 1399.487 would specify the grounds upon which AC could withdraw or deny its approval of a CE provider, and set forth procedures by which a provider could appeal AC's withdrawal or denial. New section 1399.488 would specify the processing times for CE provider and course request applications, and establish minimum, median, and maximum processing times for both provider and course request applications.

Additionally, AC proposes to amend existing section 1399.482 and renumber it as section 1399.489; the section would clarify the information which licensees are required to retain regarding completed CE courses and provide that CE instructors may receive a maximum of two hours of CE credit per year for their teaching activities. AC seeks to amend existing section 1399.485 and renumber it as section 1399.489.1; the section pertains to licensees on "inactive" status who are exempt from CE requirements. The existing regulation provides that before a licensee may be placed back on "active" status, he or she must document completion of at least 30 hours of CE; AC proposes to amend the section to revise the title of the "active/inactive" form and establish a provision for the completion of CE when a license is inactive for less than two years. Finally, AC proposes to amend existing section 1399.487 and renumber it as section 1399.489.2. The existing section allows for the acceptance of courses in office management and medical ethics as approved CE courses; the amendment would change the term "office management" to "practice management."

AC to Establish Fee Regulation, Reduce Renewal Fee. Also on May 13, AC published notice of its intent to adopt section 1399.460, Title 16 of the CCR, which would codify AC's fees in regulation and reduce its annual license renewal fee from $325 to $200. AC states that the reduction would significantly decrease its annual revenue, but would not impact its operations. At this writing, AC is scheduled to hold a public hearing on this proposed regulatory change on June 29 in Burbank.

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

• On February 3, the Office of Administrative Law (OAL) approved in part and disapproved in part an extensive rulemaking package submitted by AC in late December 1993. Specifically, OAL approved AC's adoption of new sections 1399.444 (licenses expired for more than five years) and 1399.487 (four hours of CE per year in business management and medical ethics), and its amendments to sections 1399.443 (passing score on AC's exam) and 1399.480 (acceptability of continuing education (CE) courses related to business management and medical ethics). OAL rejected AC's adoption of sections 1399.460 (establishment of a new fee schedule and license renewal system based upon licensee birthdate) and 1399.486 (required curriculum for additional CE under Business and Professions Code section 4945.5), and its amendments to sections 1399.417 (grounds for application abandonment), 1399.441 (languages in which AC's exam will be administered), and 1399.485 (completion of additional CE by inactive licensees seeking to reactivate their licenses). *[14:1 CRLR 56; 13:4 CRLR 63; 12:2&3 CRLR 86]*

At this writing, AC has resubmitted its changes to sections 1399.441 and 1399.460 (and has also republished notice of its intent to adopt section 1399.460 in the event OAL rejects it again—*see above*); republished its proposed changes to section 1399.485 for a hearing on June 29 (*see above*); and does not intend to resubmit its changes to sections 1399.417 and 1399.486.

• On April 4, OAL approved AC's 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). AC withdrew new sections 1399.463 and 1399.464, which would implement its citation and fine authority, after they were disapproved by DAHP at its February meeting; AC plans to redraft and republish these regulations in the near future. *[14:1 CRLR 56; 13:4 CRLR 63; 13:2&3 CRLR 86–87]*

• On February 2, AC held a public hearing on proposed amendments to sections 1399.436 and 1399.439, Title 16 of the CCR. *[14:1 CRLR 56–57; 13:2&3 CRLR 86; 13:1 CRLR 51]*

The amendments to section 1399.436 would clarify the percentage of transfer credits which may be accepted by AC-approved training programs from AC-approved and non-AC-approved schools and colleges. Specifically, training programs may award up to 100% transfer credit for coursework and clinical instruction completed successfully at another acupuncture school or college which is approved by the Committee; up to 100% transfer credit for successfully completed courses in biology, chemistry, physics, psychology, anatomy, physiology, pathology, nutrition and vitamins, history of medicine, medical terminology, clinical science, clinical medicine, Western pharmacology, cardiopulmonary resuscitation, practice management, and ethics at a school which is approved under Education Code section 94310 or by an accrediting agency recognized by the U.S. Department of Education; and up to 50% transfer credit for courses completed successfully in traditional Oriental medicine, acupuncture anatomy and physiology, acupuncture techniques, acupressure, breathing techniques, traditional Oriental exercise, and traditional Oriental herbology at a school which is not approved by AC.

AC's amendments to section 1399.439 would require each approved acupuncture school to annually submit to AC a course catalog for that year with supplemental information detailing any courses added, deleted, or significantly changed from the previous year's curriculum; any changes in faculty, administration, or governing body; any major changes in the school facility; and a statement regarding the school's financial condition which enables AC to evaluate whether the school has sufficient resources to ensure the capability of the program for enrolled students. The amended regulation also provides that if AC determines an onsite visit is necessary, the school will be required to reimburse the Committee for direct costs incurred in conducting such review and evaluation.

AC approved these proposed amendments at its February 17 meeting; DAHP approved them later that day. AC submitted them to OAL on April 14, where they are pending at this writing.

Scope of Practice Opinion Generates Controversy, Legislation. The August 1993 opinion by Department of Consumer Affairs (DCA) legal counsel Don Chang on the scope of practice of acupuncturists under the Acupuncture Licensure Act ("the Act"), Business and Professions Code sec-

tion 4925 *et seq.*, has generated considerable controversy. In his opinion, Chang noted that acupuncture is but one area of the larger body of knowledge and philosophy of Oriental medicine, and opined that, in the Act, the legislature sought to govern only that aspect of Oriental medicine which deals with acupuncture. "Accordingly, an acupuncturist is authorized to practice only those procedures enumerated in [Business and Professions Code] sections 4927(e) and 4937 rather than the full range of procedures and treatments traditionally associated with Oriental medicine." Chang also concluded that acupuncturists may prescribe drugless substances and herbs only "as dietary supplements to promote health"; they may not be used to diagnose, cure, treat, mitigate, or prevent disease. *[14:1 CRLR 57]*

In its May newsletter, the California Acupuncture Association (CAA) called the opinion "restrictive legal argument" which "amounts to a thinly disguised attempt to limit acupuncture practice." CAA claimed that AC has used the scope of practice opinion as a guideline in "evaluat[ing] the need for investigations of acupuncturists who practice methods of traditional Oriental medicine which are not specifically enumerated within the Acupuncture Licensing Act [sic]." CAA argued that the DCA opinion "does not grant acupuncturists the right to practice Oriental medicine despite the fact that the law specifically states legislative intent to make Oriental medicine available to California citizens through this Act."

However, two bills aimed at overturning the DCA opinion have gone nowhere. AB 2494 (Conroy), a bill sponsored by the Acupuncture Association of America to expressly permit acupuncturists to prescribe herbs for medicinal purposes, was soundly defeated by the Assembly Health Committee on May 3. The California Medical Association (CMA) strongly opposed AB 2494, arguing that the scope of practice for acupuncturists excludes curing diseases of patients. And AB 2804 (Burton), which would have achieved official recognition of the traditional Chinese pharmacopoeia, died in committee (*see* LEGISLATION).

Rather than introducing new legislation, CAA believes that acupuncturists should fight for recognition that existing law already authorizes acupuncturists to utilize Oriental medicine techniques beyond those specifically enumerated in statute. According to CAA, "[t]he California Medical Association has stated that its goal is to limit scope of practice of other professions." Thus, CAA is preparing its own scope of practice document which is being reviewed by its attorneys, has requested a legal opinion from the Legislative Counsel's Office concerning the intent of the legislature in enacting the Acupuncture Licensure Act, and has urged AC to "carefully review these issues so that the Executive Director [sic] can carry out the policies of the Committee when making recommendations for case investigations."

LEGISLATION

AB 2494 (Conroy) and **AB 2804 (Burton)** were unsuccessful attempts to expand the scope of practice under the Acupuncture Licensure Act as it has been interpreted by DCA attorney Don Chang in DCA Legal Opinion No. 93-11 (Aug. 3, 1993) (*see* MAJOR PROJECTS). AB 2494, as amended April 20, would have authorized acupuncturists to suggest, recommend, or direct the use of herbs for medicinal purposes in addition to dietary purposes; this bill was rejected by the Assembly Health Committee on May 3. AB 2804, which would have added to the definition of the term "official compendium," for purposes of state and federal food and drug laws, the traditional Chinese pharmacopoeia; this bill died in the Assembly Health Committee.

AB 1807 (Bronshvag), as amended March 23, provides that if, upon investigation, AC has probable cause to believe a person is advertising in a telephone directory with respect to the offering or performance of acupuncture services without being properly licensed by AC, the Committee may issue a citation containing an order of correction which requires the violator to cease the unlawful advertising. If the unlicensed person to whom a citation and order of correction is issued fails to comply with the order of correction after that order is final, AC shall inform the Public Utilities Commission (PUC) of the violation, and the PUC shall require the telephone corporation furnishing services to that person to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.

Business and Professions Code section 4935 currently provides that an unlicensed person who holds himself/herself out as engaging in the practice of acupuncture by the use of any title or description of services incorporating specified terms, including the terms "oriental herbalist" or "certified herbalist," is guilty of a misdemeanor; this bill deletes those terms from section 4935.

Existing law requires a person who practices acupuncture to possess a license; this bill provides 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 also revises the qualifications required of an acupuncturist who may be approved to supervise an acupuncturist trainee; revises the fees relating to licensing of acupuncturists; and reduces the time within which an acupuncturist may renew his/her expired license from five to three years. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 would impose an initial "sunset" date of July 1, 1999 for AC; create a Joint Legislative Sunset Review Committee within the legislature, which would review AC's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which AC's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether AC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case AC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (*See* agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

SB 1279 (Torres). Existing law prohibits the imposition of monetary liability on the part of professional societies and members of peer review committees that review the quality of various professional health care services for acts performed within the scope of the functions of peer review, if that committee or member acts without malice, has made a reasonable effort to obtain the facts, and acts in reasonable belief his or her action is warranted. As amended March 8, this bill would extend this prohibition to peer review bodies, and members of peer review bodies, that review acupuncturists.

Existing law exempts from discovery as evidence the proceedings and records of peer review bodies. This bill would extend this exemption to the proceedings and records of acupuncturist review committees.

Existing law conditionally authorizes certain licensed health care professionals to own shares in various professional corporations. This bill would similarly autho-

rize certain licensed health care professionals to be shareholders in an acupuncture corporation. *[A. Jud]*

AB 3765 (Campbell), as amended April 28, would require the Medical Board of California, with the participation of AC, the California Medical Association, the California Naturopathic Association, the Osteopathic Medical Board of California, and the Board of Chiropractic Examiners, to study and report to the legislature by July 1, 1995, on the practice of naturopathy and the desirability of establishing a "Naturopathic Practitioners Registration Act." *[A. W&M]*

RECENT MEETINGS

At its February 2 meeting, AC thanked David Chen for his two years of service as Committee Chair and held an election to choose its 1994 Chair and Vice-Chair. On a nomination from Chen, the Committee selected public member Jane Barnett as its 1994 Chair; AC elected Margaret Filante, MD, to serve as Vice-Chair.

Also in February, AC adopted self-imposed ethics and conflict of interest guidelines to be observed by its members. The guidelines address topics such as attendance at social functions representing the Committee, acceptance of gifts, use of AC letterhead and appropriate responses to correspondence related to AC, and the use of AC calling cards. In part, the guidelines are intended to address issues concerning AC members who also sit on trade association boards. The guidelines were adopted as AC policy only.

At the same meeting, AC approved in concept a procedure whereby it will assign different Committee members to act as liaison to different trade associations. In addition, the Committee also formalized a policy regarding the appointment of non-Committee members to serve on task forces which assist AC and its subcommittees. Under AC's new policy, non-AC members who serve on task forces will not have voting privileges on any subcommittees, will serve strictly at the pleasure of the Committee Chair, and will not be permitted to sit at the head table with Committee members of the subcommittee.

AC also announced a stringent policy regarding public comment at its meetings. In an effort to make Committee meetings run more smoothly, AC's new policy—which was not voted on but simply announced—requires that public comment be submitted in writing ten days prior to a meeting; how an interested citizen is supposed to accomplish this feat—when AC is not even required to publish its meeting agenda until ten days prior to a meeting—is unclear. AC's new policy also stresses that it wishes to receive public comment at its subcommittee meetings rather than at full Committee meetings; to this end, an oral public comment period will be scheduled at the end of each subcommittee meeting.

Also in February, AC briefly discussed the possibility of sponsoring legislation requiring acupuncturists to disclose to clients whether they carry malpractice insurance. The Committee estimates that only 25–30% of licensed acupuncturists are currently insured for professional malpractice, and approximately 50 malpractice cases are pending against acupuncturists. AC will discuss this issue at a future meeting.

In May, AC published an updated version of the *Laws and Regulations Relating to the Practice of Acupuncture*, which includes all amendments to AC's enabling act and regulations through March 1994.

FUTURE MEETINGS

May 24–25 in Sacramento.
June 29 in Burbank.
August 23–24 in San Diego.
October 18–19 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 licensed physician and surgeon specializing in treatment of disorders of the ear and certified by the American Board of Otolaryngology. Another public member must be a licensed audiologist. Three members must be licensed hearing aid dispensers.

MAJOR PROJECTS

McCorquodale Legislation to Merge HADEC and SPAEC. On April 5, Senator Dan McCorquodale amended SB 2037 (McCorquodale) to include a provision merging HADEC with the Speech-Language Pathology and Audiology Examining Committee (SPAEC). The April 5 version of SB 2037 called for creation of a new "Speech-Language Pathology, Audiology, and Hearing Aid Dispensers Board" consisting of one speech-language pathologist, one audiologist, one hearing aid dispenser, and four public members. The bill is a direct outgrowth of last fall's oversight hearing by the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions, chaired by Senator McCorquodale. *[14:1 CRLR 58]*

At its April 8 meeting, HADEC members voted to support SB 2037 in concept but expressed concern about several issues, including the composition of the proposed board; among other things, HADEC directed Executive Officer Elizabeth Ware to request that two board positions be reserved for hearing aid dispensers instead of only one. At a hearing before the Business and Professions Committee on May 9, the Committee agreed to restructure the composition of the merged board to include two speech-language pathologists, two audiologists, two hearing aid dispensers, and four public members. One of the public members must be a licensed physician who is board-certified in otolaryngology. The Committee also agreed to make several other amendments requested by HADEC and SPAEC: (1) the effective date of the merger was extended from July 1, 1995 to January 1, 1996; (2) the Governor, Assembly Speaker, and Senate Rules Committee must give consideration to current HADEC and SPAEC members when appointing members of the merged board; (3) current HADEC and SPAEC staff should be given consideration when staffing the new board; and (4) the existing regulations of the two committees will remain in effect until the merged board adopts its own consolidated regulations. At the request of the California Medical Association, SB 2037 was also revised to clarify that the merged board remains under the jurisdiction of the Medical Board of California (MBC). These amendments appear in the May 18 version of SB 2037 (McCorquodale).

One issue which was raised but not resolved at the May 9 legislative hearing, and which remains unresolved at this writ-

ing, is the status of the two special funds of the separate committees. The issue is whether to merge the funds, which are financed by licensing fees, or keep them separate. Representatives of speech-language pathologist and audiologist trade associations noted that HADEC's licensing fee is much higher than SPAEC's licensing fee (because HADEC engages in considerably more enforcement activity); the trade association lobbyists argued that speech-language pathologists and audiologists should not be required to pay for enforcement activity against hearing aid dispensers. As amended May 18, the bill retains the separate funds of each program, requires that expenses which are directly related to each program's licensees be paid from that program's separate fund, calls for equal sharing of other expenses (*e.g.*, board member per diem and expenses, executive officer and personnel salaries, and board office overhead), and requires the board to keep records "that will reasonably ensure that funds expended in the administration of each licensing or registration category bear a reasonable relation to the revenue derived from each category." HADEC's Elizabeth Ware contends that this recordkeeping requirement will force the new board's executive officer to focus on accounting functions rather than enforcement activity, and intends to seek amendments to this provision of SB 2037.

Educational Requirements for Dispenser Licensure. On March 4, HADEC's Examination and Continuing Education Subcommittee met to discuss the proposed adoption of educational requirements for entry into the hearing aid dispenser profession. *[14:1 CRLR 59]* At the meeting, the Subcommittee agreed to recommend that HADEC establish the following educational requirements for hearing aid dispenser licensure applicants: a high school diploma or its equivalent; some experience and training beyond high school, including a field placement in a hearing aid dispenser's office as practical training; and, for those applicants whose native language is not English, a showing of an acceptable level of English language proficiency prior to taking the written examination.

In addition, the Subcommittee agreed to the following components in concept: (1) applicants who have passed the written examination may take the practical examination, but may not be licensed until they have successfully completed the proposed field placement requirement or equivalent experience as a practicing dispenser in another state or country; and (2) applicants who fail the practical examination may complete a second field placement, but applicants who fail the practical examination twice will not be permitted a second extension of the field placement permit and will be required to complete additional training prior to being permitted to register for another examination.

The Subcommittee also discussed two other components of the education proposal, and agreed they would require extensive discussion at future meetings. These components include successful completion of 60 units of experience and training beyond high school (the equivalent of an associate of arts degree—which no other state or Canadian province requires for licensure as a hearing aid dispenser); and the elimination of the existing trainee-applicant licensing program and substitution of a six-month field placement permit granted by HADEC to applicants who are qualified to begin field placement.

HADEC discussed the Subcommittee's recommendations at its April 8 meeting. The Committee agreed in concept with most of the recommendations but did not formally approve any of them. Instead, HADEC directed the Subcommittee to finalize the educational requirements package at its next meeting and then present the entire package to HADEC for approval at a future meeting.

Enforcement Report. At HADEC's April 8 meeting, Committee member Deborah Kelly reported on HADEC's enforcement statistics. Thus far during fiscal year 1993–94, HADEC has issued 60 citations without fines and nine citations with fines. Also during 1993–94, HADEC has revoked three licenses, issued one conditional license, and accepted one voluntary surrender. A total of 209 enforcement cases are pending: 63 are being reviewed by a consumer services representative at the Medical Board's Central Complaint and Investigation Control Unit; 66 are under formal investigation; two are being reviewed by an expert consultant; 60 investigations have been forwarded to the Executive Officer; and 18 fully investigated cases are pending at the Attorney General's Office, with accusations filed in 11 of those cases.

Licensing Report. At HADEC's April 8 meeting, Licensing Coordinator Yvonne Crawford reported on the Committee's licensing statistics. Between November 5, 1993 and March 31, 1994, 47 temporary licenses were issued, bringing the total number of temporary licenses to 79. During that same time frame, 46 permanent licenses were issued. As of April 1, HADEC's cumulative license figures include 1,510 current licenses, 666 delinquent licenses, and 37 revoked licenses.

LEGISLATION

SB 2037 (McCorquodale), as amended May 18, would (among other things) merge HADEC and SPAEC into a single board under the jurisdiction of MBC (*see* MAJOR PROJECTS). *[S. Appr]*

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within the Department of Consumer Affairs (DCA), requiring each to be comprehensively reviewed every four years. In the event that SB 2037 (*see above*) is not enacted, SB 2036 would impose an initial "sunset" date of July 1, 1999 on HADEC; create a Joint Legislative Sunset Review Committee within the legislature, which would review HADEC's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which HADEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether HADEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case HADEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (*See* agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at page 59:

AB 1807 (Bronshvag), as amended March 23, authorizes HADEC to establish by regulation a system for an inactive category of licensure; repeals Business and Professions Code section 3365(g), which requires dispensers to state on receipts and contracts that any examination made by them must not be regarded as medical or professional advice; reduces the time within which a dispenser may renew his/her expired license from five to three years; and requires applicants, as a condition of licensure as a hearing aid dispenser, to be at least 18 years of age and to possess a high school diploma or its equivalent. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

AB 1392 (Speier), as amended July 12, 1993, would require DCA boards and committees, including HADEC, to notify DCA whenever any complaint has gone thirty days without any investigative action, and require DCA to determine when a backlog of complaints justifies use of DCA staff to assist in complaint investigation. *[S. B&P]*

SB 595 (Rogers). Under existing law, the Public Utilities Commission implements programs whereby specialized or supplemental telephone communications equipment may be provided to individuals who are certified as deaf or hearing impaired by a licensed physician or audiologist. As amended April 19, 1993, this bill would have also permitted that certification to be made by a hearing aid dispenser if a physician has evaluated the hearing impaired individual's hearing. This bill died in committee.

RECENT MEETINGS

At HADEC's January 28 meeting, the Committee discussed and approved responses to numerous accusations and requests made by hearing aid dispenser Robert Hughes over the past several months. *[14:1 CRLR 59–60]* These responses were conveyed to Hughes in a letter from Executive Officer Ware dated February 3, 1994.

First, HADEC denied Hughes' November 20, 1993 petition in which he asked the Committee to repeal sections 1399.116, 1399.118, and 1399.119, Title 16 of the CCR, which pertain to trainee supervision. In her letter, Ware explained that the denial was based on the Committee's role as a consumer protection agency and that direct licensee supervision of any trainee who has failed the dispenser's examination is necessary because that person has demonstrated that he or she lacks the minimum competence required to become a hearing aid dispenser.

The Committee also denied Hughes' November 22 request to repeal sections 1399.135–.139, Title 16 of the CCR, the Committee's citation and fine regulations. Ware cited the proven effectiveness of the current citation and fine program as the reason for the denial. Ware also noted a December 1 letter from Senator Dan Boatwright, Chair of the Senate Business and Professions Committee, in which the Senator stated that he "totally disagrees" with Hughes' petition to repeal the citation and fine regulations.

Ware also responded to allegations contained in Hughes' letter dated November 26. Hughes accused the Committee of intentionally failing his trainees on its licensing exam and attempting to discredit him by misrepresenting facts. Ware responded that 80% of the trainees who worked at Hughes' business and were supervised by Hughes (and Hughes' employees Mary Hughes, Milford Joe Hughes, and Ann Hughes Baca) did not even take HADEC's licensing examination; thus, Ware stated that it is inappropriate for Hughes to allege that his trainees have been "systematically failed" on the examination. Ware enclosed trainee data detailing these statistics.

Ware informed HADEC that DCA legal counsel Greg Gorges had responded to Mr. Hughes' December 13 letter. In that letter, Hughes requested a hearing under Government Code section 11500 *et seq.*; contended that his petitions requesting HADEC's repeal of "underground regulations" had not been responded to properly; requested a hearing before an administrative law judge; and stated that he intended to file a civil rights action seeking damages from the State of California under 42 U.S.C. section 1983.

In his letter dated December 28, Gorges responded by informing Hughes that it is "oxymoronic" to request repeal of an "underground regulation" because, by definition, an "underground regulation" is a standard of general application that has not been adopted as a regulation; a state agency cannot repeal something it has never adopted. To contest an "underground regulation," Gorges stated that it is more appropriate to request a regulatory determination from the Office of Administrative Law. Gorges further explained that the Committee itself does not have the power to adopt, amend, or repeal regulations; this authority is vested in the Medical Board's Division of Allied Health Professions. Gorges stated that Government Code section 11347 does not require that Hughes be provided a hearing on his request to repeal a regulation, "underground" or otherwise. Finally, Gorges stated that he was at a loss to determine how Hughes had been damaged or discriminated against under federal civil rights law.

Hughes sent yet another letter to the Committee on January 7. In this letter, Hughes again contended that HADEC has adopted and implemented a variety of "underground regulations," including policies precluding a trainee-applicant from being issued a trainee license to sell and fit hearing aids until the trainee's supervisor has properly completed a supervision application and it has been approved; requiring a $55 fee to be paid for fingerprinting of applicants; requiring use of HADEC's "Application to Supervise a Trainee" (75A-HAD-5, Rev. 10/92); and requiring the information on the "Application to Supervise a Trainee" to be typed or handwritten directly on the application form. The last accusation stems from HADEC's December 1993 denial of an "Application to Supervise a Trainee" submitted by Mary Hughes because the information contained on the form was photocopied from a previous form and then stapled onto the current form.

In a letter dated January 11, Ware responded to each of these allegations. First, she stated that existing law clearly requires trainees to be licensed as such before they may fit and sell hearing aids in California. Second, Ware explained that the Committee is authorized to charge fingerprinting fees as part of the application process under section 11105 of the Penal Code. Third, Ware maintained that HADEC's use of the "Application to Supervise a Trainee" form is permissible without a regulation, because the Committee is not required to adopt regulations in order to implement every statute which grants it authority. Finally, Ware stated that the information provided in the "Application to Supervise a Trainee" form may not simply be stapled onto the form from photocopies of answers used on an earlier supervision application form. The form is intended to elicit information assuring the Committee that the supervisor has formulated an adequate supervisory plan to meet the needs of the individual trainee-applicant.

At its January 28 meeting, HADEC announced that DCA legal counsel Greg Gorges had recently retired after 18 years of state service. Committee Chair Keld Helmuth noted that Gorges, who was not in attendance at the meeting, will be presented with a Distinguished Service Citation on behalf of the Committee. Anita Scuri will now serve as HADEC's legal counsel.

At HADEC's April 8 meeting, Committee member Dr. James McCartney reported that HADEC's written examination has been converted to electronic form and is being successfully administered at five testing sites by Assessment Systems, Inc., HADEC's exam vendor. *[14:1 CRLR 58–59]*

FUTURE MEETINGS

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. 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 electroneuromyography.

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

Governor Wilson recently appointed Valerie Sinkus as a new PT member of the Committee. Sinkus, who is from Whittier, took her seat on the Committee at its April 29 meeting in Sacramento.

MAJOR PROJECTS

Supervision Requirements/PTA Licensure Standards. After nearly three years of debate, PTEC has finally taken action on two pending rulemaking packages—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 section 1399.1, Division 13.2, Title 16 of the CCR), and the other regarding PTA licensure standards (proposed amendments to section 1398.47). Following a public hearing at its January meeting, PTEC adopted the proposed language regarding PTA licensure standards and requirements for PTs' supervision of physical therapy aides, but decided to not proceed with the regulatory proposal stiffening its requirements for PTs' supervision of PTAs (the proposed amendments to 1398.44). *[14:1 CRLR 61; 13:4 CRLR 67; 13:2&3 CRLR 89]*

PTEC's proposed amendments to its requirements for PT supervision of PTAs—which the Committee ended up temporarily abandoning—had a dual purpose. PTEC sought both to clarify the supervision requirements and protocols which PTs and PTAs must follow in all practice settings, and enable the Committee to better determine compliance. The revisions would have established two standards for PT supervision of PTAs—one for inpatient/outpatient facilities and another for the home care setting. At the public hearing in January, the proposed home care setting standards met with strong opposition from many individual PTs. In the home care setting, the proposed revisions would have required the supervising PT (SPT) and the PTA to make a joint visit and provide treatment jointly prior to the PTA providing care without the SPT present. Several home care providers alleged that these requirements would undermine their ability to compete with services provided by HMOs. Many suggested that the initial joint visit requirement could be limited to certain situations without jeopardizing the health and well-being of the patient. Apparently in agreement with this criticism, the Committee stated that it would attempt to further patient protection while avoiding unnecessary costs in redrafting its PTA supervision requirements.

Second, the PTA supervision proposal would have eliminated a provision which permits PTEC to waive an existing requirement that the SPT be present in the same facility with the PTA at least 50% of any work week or portion thereof the PTA is on duty. The proposed elimination of PTEC's ability to waive the 50% supervision requirement has been the most controversial part of the rulemaking package and led to a standoff between PTEC and the California Chapter of the American Physical Therapy Association (CCAPTA). While PTEC contends that elimination of the waiver program is necessary because its small staff is unable to handle the large number of waiver requests submitted, CCAPTA (as well as many individual PTs who use PTAs in home care practice) contends that elimination of the waiver system would be overly burdensome, and that the 50% supervision requirement is unnecessary in the home care setting. CCAPTA, which has been vocally objecting to elimination of the waiver of the 50% supervision requirement since PTEC originally made the proposal, was joined by several individual PTs at the January hearing. These PTs alleged that elimination of the waiver process would substantially hinder their ability to compete. CCAPTA argued that PTEC should retain the waiver for the home care setting and set standards for waiver requests so the process is not so burdensome for staff.

In the wake of this strong opposition, PTEC decided not to adopt the amendments to section 1398.44 as proposed. The changes suggested at the January hearing will be incorporated into a new draft proposal to be republished and discussed at future meetings. At this writing, PTEC hopes to hold a public hearing on the new draft at its August meeting.

PTEC did, however, adopt new standards governing PTs' supervision of physical therapy aides (proposed amendments to section 1399 and the addition of section 1399.1). Physical therapy aides are unlicensed individuals who may be utilized by a PT to perform both patient-related tasks and non-patient-related tasks. The amendments to section 1399 outline supervision protocols for physical therapy aides designed to assure adequate supervision and enhance the documentation of tasks in a manner that will assist in enforcement investigations. The protocols required by section 1399 include a mandatory evaluation of the patient by the SPT prior to the initiation of care by the aide, as well as a written treatment program in which specific patient-related tasks are assigned to the aide. At the public hearing at PTEC's January meeting, some PTs complained that these requirements are unnecessary in many situations and will result in an increase in the cost of care to the consumer. One PT noted that the protocols in section 1399 would have to be followed even when the treatment assigned to the aide is as minor as applying a hot pack or cold pack. Despite these objections, PTEC made only minor changes to language of section 1399 and adopted it subject to an additional 15-day comment period which ended on May 4.

New section 1399.1 would restrict a PT to supervising not more than one aide who is performing a patient-related task at any one time. This one-to-one ratio is not a new requirement but rather a clarification of existing law, Business and Professions Code section 2630, which states that a PT may use "an" aide to assist him/her in the practice of physical therapy. The Committee has always interpreted "an" aide to mean one aide. Although several PTs objected to section 1399.1, claiming that the requirement unfairly restricts their ability to practice, PTEC adopted the proposal and emphasized that it does not change existing law but merely clarifies the supervision requirement for physical therapy aides.

At this writing, the proposed amendments to section 1399 and new section 1399.1 have been forwarded to the Department of Consumer Affairs (DCA) for review but have not yet been approved. Once they are approved by DCA, they will be forwarded to the Office of Administrative Law (OAL) for review and approval.

Also at its January meeting, PTEC held a public hearing and adopted proposed amendments to section 1398.47 which describe numerous combinations of training and experience which PTEC believes are equivalent to its education requirements for PTAs. The amendments also specify that for applicants who file an application for PTA approval after June 30, 1996, a

significant portion of any qualifying work experience must be gained under the immediate supervision of a licensed PT in an acute care inpatient facility. *[14:1 CRLR 61; 13:2&3 CRLR 89]* No objections to this proposal were voiced at the public hearing. The Committee made minor modifications to the language of the proposal, and released it for an additional 15-day comment period on May 26. At this writing, the rulemaking file has yet to be forwarded to DCA and OAL for review.

ENMG and KEMG Certification Regulations. Following a public hearing at its January meeting, PTEC adopted regulatory amendments to sections 1399.61 through 1399.67, its requirements for specialty certifications in electroneuromyography (ENMG) and kinesiological electromyography (KEMG). 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 pass the ENMG exam. The rulemaking proposal adopted by PTEC follows a year of research and consists of a series of amendments designed to establish ENMG and KEMG as two distinct specialties with separate certification requirements and examinations. *[14:1 CRLR 61–62]*

At the January hearing, Arnold Tripp, an expert in the field, explained to the Committee that when the KEMG/ENMG certification regulations were originally adopted, KEMG was a last-minute add-on to the regulatory scheme; Tripp questioned whether the original certification scheme was correct to begin with. He emphasized that over the past year, it has become clearly apparent that the specialties are diverse, separate, and require different training. He concluded that the exams should therefore be separate and distinct to reflect the different skills and training necessary to practice each specialty.

Although the Committee's action to separate the certification requirements and examinations for the two specialties was met mostly with support, the California Medical Association (CMA) voiced opposition to the proposal. CMA complained neither the current regulations nor the proposed amendments include the requirement that a PT obtain authorization from a physician prior to performing tissue penetration procedures, as specified in Business and Professions Code section 2620.5. DCA legal counsel Dan Buntjer explained that restating the requirement that a PT obtain authorization is not necessary, and that such an addition may actually cause PTEC's proposal to be rejected by OAL as violative of the nonduplication standard in Government Code section 11349(f). CMA also voiced opposition to the fact that the rulemaking proposal retains existing language in section 1399.63(d)(1) which states that physicians who practice KEMG must be approved by PTEC. Buntjer replied by explaining that this approval requirement has existed in PTEC's regulations for many years, and that the new rulemaking proposal does not seek to change existing regulations in this respect.

At this writing, the proposed amendments to the ENMG and KEMG certification requirements and examinations have been forwarded to DCA for review but have not yet been approved. Once approved by DCA, they will be forwarded to OAL.

Consistent Standards for Credential Evaluation Services Reports. Following a public hearing at its January meeting, PTEC adopted proposed regulatory language providing for consistent credential evaluations from all the approved credential evaluation services used by the Committee in reviewing applications from foreign-trained PTs. *[14:1 CRLR 62]*

The proposed regulatory amendment adds subsection (c) to section 1398.25, and provides that reports submitted to PTEC by credential evaluation services must be based on a review of the original copies 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. At this writing, the proposed amendments to section 1398.25(c) have been forwarded to DCA but have not yet been approved. Once approved by DCA, they will be forwarded to OAL.

At its April 29 meeting, PTEC revisited the issue of consistent credential evaluations. One credential evaluation service suggested that more reliable evaluations could be obtained by having the evaluation service write directly to the candidate's school rather than having the candidate forward his/her transcript personally. Committee staff has requested comments from the other approved credential evaluation services on this issue. In discussing the new proposal, members of the Committee raised other issues about weaknesses in the current evaluation system, such as the lack of information regarding whether the candidate was actually practicing in the country in which he or she was educated. At this writing, PTEC plans to discuss these issues further at its August meeting.

Proposed Legislation on Education Standards for PTs and PTAs. PTEC's proposed changes to the statutes setting forth educational standards for licensure as a PT or a PTA, which were approved by the Committee in October 1993 *[14:1 CRLR 62]*, have been included in AB 2836 (Snyder) (*see* LEGISLATION).

LEGISLATION

AB 2836 (Snyder), as amended May 4, would require PTEC to adopt regulations setting forth standards and requirements regarding PTs' supervision of PTAs and physical therapy aides, and authorize a PT to utilize the services of one aide. This bill would specify that the maximum number of PTAs that may be supervised by a PT is two, and eliminate PTEC's authority to waive this maximum limitation.

This PTEC-sponsored bill would also revise the educational requirements and the standards for licensure as a PT and for approval as a PTA. For example, instead of 1,400 hours of coursework in specified content areas, this bill would require PT licensure applicants to complete a curriculum, including academic coursework and a clinical internship in physical therapy, as referenced in criteria of the Commission on Accreditation of Physical Therapy Education of the American Physical Therapy Association. This bill would also revise the requirements for practice while an applicant for licensure is a "physical therapist license applicant" or while an applicant for approval is a "physical therapist assistant applicant."

Existing law authorizes an applicant for licensure who fails to pass the examination to, in certain circumstances, be reexamined three times before paying an additional reexamination fee. This bill would instead require applicants who fail the examination and seek to be reexamined to pay the reexamination fee.

Existing law requires PTEC to approve certain schools of physical therapy and schools for physical therapist assistants in accordance with specified standards. This bill would revise the standards for approval of PT and PTA education programs. *[A. Floor]*

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 would impose an initial "sunset" date of July 1, 1999 for PTEC; create a Joint Legislative Sunset Review Committee within the legislature, which

would review PTEC's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which PTEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether PTEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case PTEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (See agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at page 62:

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 March 23, this bill requires 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 increases the fee to $100, unless a lower fee is set by PTEC, and requires 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. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

SB 437 (Hart), as amended May 4, would authorize a physician who practices physical therapy as part of his/her practice to utilize one unlicensed aide to perform patient-related tasks, as defined, at any given time to assist with aspects of physical therapy, as long as, when performing these functions, the aide is at all times under the orders, direction, and immediate supervision of the physician. This bill would further require, among other things, that the supervising physician be responsible at all times for the conduct of the aide, and be in the same facility as, and in proximity to, the location where the aide performs those tasks. This bill would also expressly limit PTs to the use of one aide to perform patient-related tasks at any given time. *[A. Health]*

RECENT MEETINGS

At its January meeting, the Committee charged staff with preparing a regulatory proposal to raise the fee for PT and PTA licensure examinations to compensate for increases in the cost of administering the examinations. Although the exact amount of the fee increase has not yet been determined, staff expects that the fees will be raised from the current rate of $80 to approximately $220.

At its April meeting, PTEC discussed transferring its complaint processing and investigation responsibilities from the Medical Board of California (MBC) to DCA's Division of Investigation (DOI). PTEC has noticed that MBC tends to focus its efforts on cases involving physicians. *[11:1 CRLR 73–74]* Hoping to improve the level of regulation of California PTs, PTEC plans to handle its own complaint intake and complaint mediation, and transfer investigative responsibilities to DOI as of July 1. Any cases in process with MBC will remain there until they are completed.

On April 30, PTEC held a strategic planning session intended to update its mission statement and objectives. The Committee tentatively plans to hold another strategic planning session on the same issues in conjunction with its August meeting.

FUTURE MEETINGS

August 5 in Sacramento.
October 13 in Santa Clara.

PHYSICIAN ASSISTANT EXAMINING COMMITTEE

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

PAEC licenses individuals as PAs, allowing them to perform certain medical procedures under a physician's supervision, including drawing blood, giving injections, ordering routine diagnostic tests, performing pelvic examinations, and assisting in surgery. PAEC's objective is to ensure the public that the 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).

On April 11, Governor Wilson appointed Caroline Lytle, MD, to fill a vacant position on the Committee. Dr. Lytle, a pediatrician at the University of Southern California who specializes in child abuse, directs the outpatient clinic, directs the pediatric residency program, and co-directs USC's PA training program.

MAJOR PROJECTS

Fee Reduction for Supervising Physicians. Following a public hearing at its January 21 meeting, PAEC adopted proposed amendments to section 1399.553, Division 13.8, Title 16 of the CCR; effective July 1, the revisions reduce PAEC's supervising physician (SP) fees to a $25 application fee, a $75 approval fee, and a $100 biennial renewal fee. *[14:1 CRLR 63]* PAEC slightly modified the language of the proposed changes to clarify exactly when the fee reductions will take effect, and released the modified text for an additional 15-day public comment period which ended on February 15. On April 22, the changes were filed with the Office of Administrative Law for review and approval, where they are pending at this writing.

Citation and Fine Regulations. At its January and April meetings, PAEC again considered whether to implement its authority under Business and Professions Code section 125.9 by adopting citation and fine regulations. *[14:1 CRLR 63]* At the April meeting, PAEC's Enforcement Subcommittee presented a report recommending that the Committee implement a citation and fine program, noting that such a system would provide PAEC with another tool to discipline PAs for offenses which are relatively minor but which should not be ignored. The Subcommittee also noted that a cite and fine program would save money, because minor viola-

tions could be sanctioned without use of the Attorney General's Office and the Office of Administrative Hearings. Department of Consumer Affairs (DCA) legal counsel Anita Scuri, who advises PAEC, commented that citations and fines are a matter of public record and will be dislosed to consumers who inquire about the record of cited PAs.

The Subcommittee also noted that it had studied the citation and fine regulations recently adopted by the Medical Board *[14:1 CRLR 51]*, and recommended the same "laundry list" approach. That is, MBC's regulations set forth a long list of specific statutory and regulatory provisions, the violation of which is grounds for a citation and/or fine. PAEC approved the Subcommittee's approach and directed staff to prepare draft citation and fine regulations, develop a range of appropriate fines, and present the issue to the Committee at its July meeting.

LEGISLATION

SB 1642 (Craven), sponsored by the California Academy of Physician Assistants, originally included language allowing SPs to delegate authority to PAs to prescribe or dispense drugs and devices to patients under the care of the SP, and cited the following reasons (among others) for this proposed expansion of the scope of PA practice: (1) the documented quality and safety of PA services; (2) the call for expansion of funding for PA services, as recommended by Dr. Molly Coye when she was director of the Department of Health Services and by the Clinton administration's health care plan; (3) the fact that most other states allow PAs prescriptive authority; (4) federal regulations which allow the issuance of registration numbers to PAs by the Drug Enforcement Agency in states where PAs hold prescriptive privileges; (6) extensive training in PA programs regarding prescriptive practices; and (7) the safety and efficacy of PA prescribing, as demonstrated by a 1981–83 pilot program of the Office of Statewide Health Planning and Development (OSHPD). As expected, the California Medical Association registered strong concerns about the original version of the bill.

As amended April 25, SB 1642 would authorize a SP approved to supervise a PA to delegate to a PA under his/her supervision, in a manner determined by the SP, the authority to administer or provide medication to a patient or transmit a prescription from the SP to a person who may lawfully furnish the medication or medical device to the patient. It would require, prior to delegating prescription transmittal authority to a PA, the SP to adopt a written, practice-specific, formulary and protocols that specify all criteria to be considered for use of a particular drug or device, and any contraindications for the drug or device.

The bill would require any SP's prescription that is transmitted by the PA to be based on either the physician's order for the particular patient or for a drug listed in the formulary. It would prohibit a PA from administering, providing, or transmitting a prescription, for Schedule II through Schedule V controlled substances without an order from the SP.

The bill would impose other requirements regarding the content of the prescription transmittal order and specify that, when transmitting a prescription, the PA is acting on behalf of and as an agent for the SP. *[S. Floor]*

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 would impose an initial "sunset" date of July 1, 1999 for PAEC; create a Joint Legislative Sunset Review Committee within the legislature, which would review PAEC's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which PAEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether PAEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case PAEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (*See* agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at pages 63–64:

AB 1807 (Bronshvag), as amended March 23, requires PAEC licensees to notify PAEC of any change of address within thirty days after such change; authorizes PAEC to establish an inactive license category; and makes minor clean-up changes to the Physician Assistant Practice Act related to physician assistant corporations. It also requires PAEC to consider including training regarding the characteristics and method of assessment and treatment of AIDS in continuing education and training requirements for its licensees. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

AB 1392 (Speier), as amended July 1, 1993, would require PAEC to notify DCA whenever any complaint has gone thirty days without investigative action, and authorize the DCA Director to review any complaint filed with PAEC. *[S. B&P]*

The following bills died in committee: **AB 2157 (Polanco)**, which would have raised the application fee limit for a PA supervisor to $100, and raised the approval fee limit for a PA supervisor to $350; **SB 993 (Kelley)**, which would have stated 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; and **AB 2350 (Escutia)**, which would have required the California Medical Assistance Commission to consider the extent to which a hospital maximizes the delivery of preventive health care services to pregnant mothers and children by appropriately utilizing primary care physicians, primary care nurse practitioners, 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.

RECENT MEETINGS

At its January meeting, PAEC discussed recent problems it has experienced in obtaining information about licensure applicants, particularly PAs from other states who wish to be licensed in California. Committee members suggested additions to PAEC's license application form (including questions designed to elicit information on voluntary surrender of a license, privileges, or appointments—which frequently occurs to thwart an imminent public disciplinary action) and the possibility of requiring "letters of good standing" from other state PA boards and background checks with the Federation of State Medical Boards (FSMB) and the National Practitioner Data Bank (NPDB). PAEC Enforcement Coordinator Glenn Mitchell reported that while FSMB collects information on PA disciplinary actions, the NPDB does not (although federal regulations are currently being prepared which would require enhanced reporting to the NPDB by states of disciplinary actions taken against health care practitioners, including PAs). The Committee

instructed staff to continue researching this issue and to prepare draft amendments to PAEC's license application form for review at the Committee's July meeting.

Virginia Fowkes, director of the PA and nurse practitioner training programs at Stanford, attended PAEC's January meeting to discuss PA training issues. Among other things, Fowkes noted that Stanford, in conjunction with other PA training programs and OSHPD, is compiling preliminary data in response to AB 1065 (Campbell) (Chapter 1042, Statutes of 1993), regarding the licensure of international medical graduates (IMGs) as PAs. *[14:1 CRLR 64; 13:4 CRLR 68; 13:2&3 CRLR 90–91]* The purpose of Stanford's effort is to assess the eligibility of IMGs for licensure as PAs, the level of clinical skills of IMGs, and the need for improving IMGs' skills. Stanford hopes the data it collects will influence entrance requirements, reduce barriers to entry, and help IMGs to enter the PA profession. Stanford will present its data to PAEC once the study is completed.

At its April 15 meeting, PA reviewed, updated, and adopted its goals and objectives for 1994. The Committee's goals include the following: (1) to ensure consumer protection and promote fair competition by improving licensing, educational, and enforcement services; (2) to improve internal and external communication to better inform and involve staff, PAs, physicians, others involved in the health care delivery system, and the public; (3) to improve operating procedures, upgrade equipment, and educate Committee members and staff to contain costs, expedite work flow, and increase the quantity and quality of products and services delivered; and (4) ultimately, to have PAs exclusively support the cost of operating PAEC.

To achieve these goals, the Committee intends to: (1) process all applications in a timely, unbiased, and efficient manner and broaden the evaluative process by obtaining information regarding disciplinary action in other states; (2) respond to all complaints against PAs and SPs in a prompt and appropriate manner; (3) provide accurate and timely responses to requests for information; (4) monitor, evaluate, and revise as necessary all aspects of PAEC operation to optimize fidelity and efficiency; (5) provide alcohol and drug diversion programs for selected PAs; (6) continue to lower all SP fees; (7) continue to investigate how to increase utilization of PAs by physicians; (8) develop some educational guidelines for use by SPs and encourage SPs to provide continuing education to PAs; (9) proactively keep in contact with all PA educational programs regarding California licensing requirements and related matters; (10) monitor actively all PA educational programs for continuing accreditation purposes; and (11) develop programs to educate PAs and SPs about their individual legal requirements and responsibilities.

At the April meeting, PAEC member Steve Johnson reported on the March 18 "Effective Pain Management Summit" cosponsored by the Medical Board. The Summit brought together 120 health care practitioners, public educators, and representatives of professional schools, state health care regulatory agencies, and professional trade associations. Summit participants identified a number of barriers which inhibit delivery of proper pain management and attempted to develop a set of solutions to the problems identified (*see* agency report on MBC for related discussion). In addition, MBC prepared a draft policy statement on pain management and controlled substance prescribing to replace its 1985 guidelines. The policy, which was reviewed and approved by MBC at its May meeting, emphasizes the Board's support for the appropriate prescribing of opioid analgesics (narcotics) and other controlled substances when medically indicated for the treatment of pain—not overprescribing of narcotics. PAEC plans to disseminate both the Summit findings and recommendations and MBC's new policy to its licensees.

FUTURE MEETINGS

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 Professions Code section 2460 *et seq.* BPM's regulations appear in Division 13.9, Title 16 of the California Code of Regulations (CCR).

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

At this writing, BPM is functioning with only five members; one public member position is vacant. As the appointing authority for the vacant position is the Senate Rules Committee, BPM Executive Officer Jim Rathlesberger wrote new Senate President pro Tempore Bill Lockyer in February, urging him to expedite the appointment of a public member with no professional, financial, or personal ties to BPM licensees.

MAJOR PROJECTS

Board Amends Citation and Fine Regulations. At its May 6 meeting, BPM held a public hearing on its proposed amendments to section 1399.698, Division 13.9, Title 16 of the CCR, BPM's citation and fine regulation. The existing regulation permits the Board's Executive Officer to issue citations for specified violations of the Business and Professions Code, the Health and Safety Code, and the California Code of Regulations, and sets forth two ranges of fines (from $100–$1,000, and from $1,100–$2,500) which may be assessed for the violation of specified sections. BPM's proposed regulatory changes add specific sections of law currently excluded from the regulations, and provide greater latitude in determining the exact amount of the fine to be imposed. The changes extend BPM's cite and fine authority to all appropriate sections of law and conform to the citation and fine program recently adopted by MBC. *[14:1 CRLR 51]*

Following the public hearing, BPM adopted the proposed regulatory changes with minor modifications. At this writing, the modified version of the regulatory language is being prepared for an additional 15-day public comment period; thereafter, the rulemaking file will be forwarded to the Department of Consumer Affairs (DCA) and the Office of Administrative Law for review and approval.

BPM to Separate from MBC? The imminent abolition of the Medical Board's Division of Allied Health Professions, under whose jurisdiction BPM technically operates, raises questions about the future status of BPM and presents BPM with a possible opportunity to separate from the Medical Board—a move BPM appeared to want several years ago. *[12:2&3 CRLR 121; 12:1 CRLR 84; 10:4 CRLR 91]*

Effective July 1, SB 916 (Presley) (Chapter 1267, Statutes of 1993) abolishes DAHP, from whom BPM has consistently sought independence on grounds that DPMs are not "allied health professionals"; for

years, BPM has urged either a name change for DAHP or separation from the Medical Board. In DAHP's place, SB 916 created a "Committee on Allied Health Professions" but did not delegate any particular authority to the new Committee, and MBC is still in the process of evaluating the best role for the Committee as it relates to the so-called allied health licensing programs (AHLPs), including BPM. While other AHLPs are seeking complete separation from the Medical Board and status as independent boards within DCA, BPM has made no formal decision on its future status. Staff believes that, eventually, MDs and DPMs should be regulated jointly by a single board consisting of MDs, DPMs, and public members; thus, staff has urged a name change for the Committee and wishes to begin a dialogue with Medical Board members about merging the two boards and their functions. BPM has suggested changing the Committee's name to "Committee on Other Healing Arts Professions" or "Committee on Other Health Professions"; SB 1775 (Presley), now pending in the legislature, would change the name to "Committee on Healing Arts Professions" (*see* LEGISLATION). The California Podiatric Medical Association (CPMA), however, may be leaning toward separation from the Medical Board. Discussion of this issue will continue at future BPM meetings.

Liaison Committee to Monitor Podiatric Medical Education and Training. BPM recently facilitated the creation of the California Liaison Committee for Podiatric Medical Education and Training (CLC) to further and promote the recommendations made in the so-called "Nelson/Medio Report" on the medical and surgical components of podiatric medical residencies in California. Among other things, the Nelson/Medio Report, which was commissioned by BPM and the Medical Board's Non-M.D. Postgraduate Training Committee, recommended that first-year podiatric residents should serve a significant portion of their medical and surgical training in large teaching hospitals and academic health centers (which coincides with the new standardized "PGY-1" concept being espoused by the Council on Podiatric Medical Education (CPME)—the development of uniform entry-level podiatric medical residencies which include some surgical training), and that all first-year podiatric residents should have an emergency room rotation. *[14:1 CRLR 64; 13:4 CRLR 69–70; 13:2&3 CRLR 92–93]*

The CLC is chaired by Franklin J. Medio, Ph.D., co-author of the Nelson-Medio Report, and includes five DPMs who represent various groups involved in training podiatric students and residents throughout California. The responsibilities of the CLC are to advise BPM, CPMA, and the colleges of podiatric medicine and liaison between them; liaison with the University of California and other medical schools, the California Medical Association's Education Committee, and other representatives of the medical community; liaison with the CPME regarding PGY-1 and other programs; organize programs and conferences for podiatric medical residency directors; obtain funding to support all CLC activities; and propose additional members and duties as appropriate.

During the spring, the CLC organized some significant activities, including a February 22 meeting with high-ranking representatives with the University of California to discuss opportunities for podiatric medical residents in residencies at UC teaching hospitals, and a March 12–13 conference of podiatric medical residency directors in which directors of 33 of the state's 41 programs participated. BPM views these two efforts as successful first steps toward CLC's overall goal of promoting the continued development of quality podiatric medical education and residency training in California.

LEGISLATION

Future Legislation. At this writing, BPM has been unable to secure a legislative author for its proposal requiring, as of January 1, 1996, that all approved entry-level podiatric medical residencies include surgical training. *[14:1 CRLR 64; 13:4 CRLR 69–70]* Executive Officer Jim Rathlesberger will continue to work with the staff of Senator Presley's office in hopes of amending the desired language into SB 1775 (Presley) (*see below*).

SB 1775 (Presley), as amended April 12, would change the name of MBC's Committee on Allied Health Professions, created in SB 916 (Presley) to take over some of the functions of the abolished Division of Allied Health Professions, to "Committee on Healing Arts Professions" (*see* MAJOR PROJECTS).

Under existing law, the use of a fictitious, false, or assumed name by a podiatrist, solely or in a partnership or corporation, without a fictitious name permit issued by BPM constitutes unprofessional conduct. This bill would repeal the provision making the use of the fictitious name unprofessional conduct, and instead make violation of the permit requirement a public offense punishable as either a misdemeanor or a felony. This bill would further require that the permit be posted; that a permit be obtained for each principal office of a medical group, clinic, or corporation; that the application for a permit be signed under penalty of perjury; and that the Board be notified within ten days of changes of staff, ownership, or physical address. This MBC-sponsored bill is expected to be amended considerably over the summer (*see* agency report on MBC for related discussion). *[S. B&P]*

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 would impose an initial "sunset" date of July 1, 1999 for BPM; create a Joint Legislative Sunset Review Committee within the legislature, which would review BPM's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which BPM's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether BPM should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case BPM would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (See agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

AB 1339 (Bronshvag), as amended May 9, would specify that, to the extent permitted by federal law, for purposes of services provided under the Medi-Cal program, DPMs shall receive the same reasonable consideration for participation and inclusion in, and reimbursement for services provided under, the program, to the same extent as any other specialty provider. *[S. Floor]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at page 65:

AB 1807 (Bronshvag), as amended March 23, revises the terms that may be used by DPMs for fictitious name permits, and reduces the amount of time within which a DPM may renew his/her expired license from five to three years. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

The following bills died in committee: **AB 2214 (Lee)**, which would have required any podiatrist who sells, closes, or transfers his/her practice to notify each patient in writing of the sale, closure, or transfer, and required 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; **AB 720 (Horcher)**, which would have prohibited any person other than a licensed physician, podiatrist, or dentist from applying laser radiation to any person for therapeutic purposes; and **AB 635 (Cortese)**, which would have prohibited a health care service 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.

RECENT MEETINGS

On January 24, BPM held a full-day discussion session of its enforcement process and the changes to that process which have been occasioned by SB 916 (Presley) and SB 2375 (Presley) (Chapter 1159, Statutes of 1990). Representatives from the Attorney General's Office, the Office of Administrative Hearings, and the Medical Board were on hand to explain and discuss their role in the process and answer questions.

On January 25, BPM approved the Department of Health Services' (DHS) Guidelines for Preventing the Transmission of Bloodborne Pathogens in Health Care Settings. *[13:2&3 CRLR 82–83]* BPM and other agencies regulating the health care professions must adopt DHS' guidelines or an equivalent set of guidelines; under existing law, knowing failure to follow them by a DPM, without good cause, is grounds for disciplinary action.

At its May 6 meeting, BPM reviewed statistics on its diversion program for substance-abusing licensees. Currently, eight podiatrists are participating in the program. A total of 24 licensees have participated to date; of those, six have successfully completed the program and three have been terminated from the program.

FUTURE MEETINGS

November 4 in Los Angeles.
February 10 in Sacramento.
May 5 in San Francisco.

BOARD OF PSYCHOLOGY

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

The Board of Psychology (BOP) is the state regulatory agency for psychologists under Business and Professions Code section 2900 *et seq.* Under the general oversight of the Medical Board'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 takes disciplinary action against licensees by suspension or revocation. BOP's regulations are located in Division 13.1, Title 16 of the California Code of Regulations (CCR).

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

MAJOR PROJECTS

Continuing Education Regulations. At its March 19 meeting, BOP held another 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. *[14:1 CRLR 65–66; 13:4 CRLR 71]*

BOP's regulations have been modified to address some of the concerns registered by licensees at its public hearings on the CE rules. The April 15 version of the proposed regulations, which was approved by BOP at its March meeting subject to an additional 15-day comment period ending on May 1, 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. Correspondence courses, independent study, and home study programs are not acceptable for CE credit, except for qualified individuals with a disability who apply to and receive approval from the Board. Effective January 1, 1997, BOP licensees must take a seven-hour CE course in the detection and treatment of alcohol and other chemical substance dependency; CE credit shall be granted for taking such a course only once during any two renewal periods. Licensees are encouraged to take CE courses in spousal or partner abuse assessment, detection, and intervention; geriatric pharmacology; and the characteristics and methods of assessment and treatment of AIDS.

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, criteria for CE accreditation agencies which may be approved by the Board, and requirements for approved CE course providers (whose courses must be approved by a BOP-recognized accreditation agency). The rules also establish fees which providers and licensees must pay to accreditation agencies.

At this writing, these regulations await review and approval by the Office of Administrative Law.

BOP Cancels Proposed Renewal Fee Increase. At its May meeting, BOP agreed to cancel the plan it adopted last November to increase its biennial renewal fee from $400 to $500. *[14:1 CRLR 66]* Although BOP needs additional revenue to finance its enforcement function, it will be refunded a total of $237,096 which was illegally transferred from its special fund to the state general fund through language in recent budget bills. *[12:4 CRLR 1]* On February 22, the Sacramento County Superior Court invalidated the required transfers as to the Medical Board in *California Medical Association v. Hayes*, No. 374372, ruling that they are unconstitutional on two separate grounds. (*See* agency report on MBC for details on this lawsuit.) Although the *Hayes* case was applicable only to the Medical Board, the state Department of Finance agreed not to appeal the decision and to cancel the fund transfers applicable to other special fund agencies as well.

LEGISLATION

SB 2039 (McCorquodale), as amended April 5, would require BOP and the Board of Behavioral Science Examiners to revoke the license of any psychotherapist who is found to have engaged in any act of sexual abuse, sexual relations with a patient, or sexual misconduct that is substantially related to the qualifications, functions, or duties of a psychotherapist. BOP supports this bill. *[A. Health]*

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within the Department of Consumer Affairs (DCA), requiring each to be comprehensively reviewed every four years. SB 2036 would impose an initial "sunset" date of July 1, 1999 for BOP; create a Joint Legislative Sunset Review Committee within the legislature, which would review BOP's performance approximately one year prior to its sunset date; and spec-

ify 11 categories of criteria under which BOP's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether BOP should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case BOP would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. (*See* agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

SB 1775 (Presley). Existing law regulates patient access to medical records and requires that patients of health care providers, as defined, be entitled to inspect their medical records and to obtain copies of those records in accordance with certain procedures. Existing law provides that willful violation of these requirements by a health care provider is either unprofessional conduct or an infraction for certain health care providers. As amended April 12, this bill would include psychologists within the definition of health care provider for these purposes, and provide that a willful violation of the requirements by a psychologist is unprofessional conduct. *[S. B&P]*

AB 2659 (Morrow). Existing law sets forth the psychotherapist-patient privilege, under which the patient has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between the patient and the psychotherapist; defines "psychotherapist" for purposes of this privilege; and provides that a professional person rendering mental health treatment has the psychotherapist-patient privilege in situations in which a minor has requested and received mental health treatment or counseling, as specified. As amended May 9, this bill would repeal the latter special provision and clarify that the minor who has requested and received mental health treatment or counseling is the sole holder of the psychotherapist-patient privilege. *[S. Jud]*

AB 1807 (Bronshvag), as amended March 23, revises requirements regarding publication of notices of the regular meetings of BOP, and authorizes 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 revises these provisions and eliminates 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 also authorizes 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 also reduces the time within which a psychologist may renew his/her expired license from five to three years, and require that BOP maintain complaints or reports as long as it deems necessary. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

RECENT MEETINGS

At its May meeting, BOP reviewed two recent legal opinions on issues related to the regulation of psychology. In Opinion No. 93-706 (Dec. 10, 1993), the state Attorney General's Office concluded that the phrase "same work setting" as used in section 1387, Title 16 of the CCR, requires the supervisor of a registered psychologist who is seeking licensure to render professional services a minimum of one-half time at the same physical location where the registered psychologist is obtaining experience. *[13:2&3 CRLR 94–95]* On April 15, DCA Supervising Counsel Dan Buntjer issued an opinion finding that psychological counseling services provided by a psychologist to a minor pursuant Civil Code section 34.10(a) must be by a psychologist who has a contract with the state or a county under the Bronzan-McCorquodale Act (formerly the Short-Doyle Act).

Also in May, BOP reviewed its latest enforcement statistics. From July 1, 1993 to May 1, 1994, the Board received 466 complaints, opened 152 investigations, and forwarded 53 cases to the Attorney General's Office for disciplinary action and/or to the district attorney's office for criminal action. During that same time period, the Board filed 34 accusations and made a total of 39 disciplinary decisions (including the revocation of 12 licenses). Of the 39 disciplinary decisions, ten were for sexual misconduct, eight were for gross negligence or incompetence, and four were due to a criminal conviction.

FUTURE MEETINGS

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 (SPAEC) consists of nine members: three speech-language pathologists, three audiologists and three public members (one of whom is a physician). SPAEC currently functions under the 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.

SPAEC 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).

Governor Wilson recently appointed two new members to the Committee. Marilyn Dailey of San Diego joined SPAEC as a public member, and Margaret Devane of Castro Valley is the newest audiologist member. At this writing, SPAEC still has one audiologist vacancy which must be filled by the Governor.

MAJOR PROJECTS

McCorquodale Legislation to Merge SPAEC and HADEC. On April 5, Senator Dan McCorquodale amended SB 2037 (McCorquodale) to include a provision merging SPAEC with the Hearing Aid Dispensers Examining Committee (HADEC). The April 5 version of SB 2037 called for creation of a new "Speech-Language Pathology, Audiology, and Hearing Aid Dispensers Board" consisting of one speech-language pathologist, one audiologist, one hearing aid dispenser, and four public members. The bill is a direct outgrowth of last fall's oversight hearing by the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions, chaired by Senator McCorquodale. *[14:1 CRLR 67]*

At its March 17 meeting, SPAEC members voted to support SB 2037 in concept

but expressed concern about several issues, including the composition of the proposed board; among other things, SPAEC directed Executive Officer Carol Richards to request that two board positions be reserved for speech-language pathologists and two for audiologists, instead of only one each. At a hearing before the Business and Professions Committee on May 9, the Committee agreed to restructure the composition of the merged board to include two speech-language pathologists, two audiologists, two hearing aid dispensers, and four public members. One of the public members must be a licensed physician who is board-certified in otolaryngology. The Committee also agreed to make several other amendments requested by SPAEC and HADEC: (1) the effective date of the merger was extended from July 1, 1995 to January 1, 1996; (2) the Governor, Assembly Speaker, and Senate Rules Committee must give consideration to current SPAEC and HADEC members when appointing members of the merged board; (3) current SPAEC and HADEC staff should be given consideration when staffing the new board; and (4) the existing regulations of the two committees will remain in effect until the merged board adopts its own consolidated regulations. At the request of the California Medical Association, SB 2037 was also revised to clarify that the merged board remains under the jurisdiction of the Medical Board of California (MBC). These amendments appear in the May 18 version of SB 2037 (McCorquodale).

One issue which was raised but not resolved at the May 9 legislative hearing, and which remains unresolved at this writing, is the status of the two special funds of the separate committees. The issue is whether to merge the funds, which are financed by licensing fees, or keep them separate. Representatives of speech-language pathologist and audiologist trade associations noted that HADEC's licensing fee is much higher than SPAEC's licensing fee (because HADEC engages in considerably more enforcement activity); the trade association lobbyists argued that speech-language pathologists and audiologists should not be required to pay for enforcement activity against hearing aid dispensers. As amended May 18, the bill retains the separate funds of each program, requires that expenses which are directly related to each program's licensees be paid from that program's separate fund, calls for equal sharing of other expenses (*e.g.*, board member per diem and expenses, executive officer and personnel salaries, and board office overhead), and requires the board to keep records "that will reasonably ensure that funds expended in the administration of each licensing or registration category bear a reasonable relation to the revenue derived from each category." HADEC Executive Officer Elizabeth Ware contends that this recordkeeping requirement will force the new board's executive officer to focus on accounting functions rather than enforcement activity, and intends to seek amendments to this provision of SB 2037.

Ad Hoc Committee to Investigate Invasive Procedures. At its January 7 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 statutes establishing the scope of practice of SPAEC licensees—specifically, endoscopy (both nasal and oral) for speech-language pathologists, and cerumen management (ear wax removal) for audiologists. *[14:1 CRLR 68; 13:4 CRLR 74]*

Following meetings with representatives of the American Academy of Otolaryngology (AAO) and the American Speech-Language Hearing Association (ASHA), Dr. Alessi reported that the Ad Hoc Committee's research has focused only on the use of fiberoptic endoscopes and rigid stroboscopes by speech-language pathologists; little progress has been made on the issue of cerumen management by audiologists. The Ad Hoc Committee is working on a position paper on the issue of how speech-language pathology might interact in areas involving endoscopy. Department of Consumer Affairs (DCA) legal counsel Kelly Salter reminded the Committee that the positions of AAO, ASHA, and other professional academies and trade associations on scope of practice issues have no impact on California law, and that the Business and Professions Code must be amended to clearly permit scope of practice expansion in any area.

SPAEC agreed that the Ad Hoc Committee should continue researching these issues, and will revisit the matter at a future meeting.

LEGISLATION

SB 2037 (McCorquodale), as amended May 18, would (among other things) merge SPAEC and HADEC into a single board under the jurisdiction of MBC (*see* MAJOR PROJECTS). *[S. Appr]*

SB 2036 (McCorquodale), as amended May 18, would create a "sunset" review process for occupational licensing agencies within DCA, requiring each to be comprehensively reviewed every four years. In the event that SB 2037 *(see above)* is not enacted, SB 2036 would impose an initial "sunset" date of July 1, 1999 on SPAEC; create a Joint Legislative Sunset Review Committee within the legislature, which would review SPAEC's performance approximately one year prior to its sunset date; and specify 11 categories of criteria under which SPAEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee would make recommendations to the legislature on whether SPAEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case SPAEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. *(See* agency report on DCA for related discussion of the "sunset" concept.) *[S. Appr]*

SB 2101 (McCorquodale), as amended April 4, would state that no provision of the Speech-Language Pathologists and Audiologists Licensing Act may be construed as restricting or preventing the practice of speech-language pathology or audiology by personnel holding the appropriate credential from the Commission on Teacher Credentialing as long as the practice is conducted within the confines of or under the jurisdiction of a public preschool by which they are employed. *[A. Health]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at page 68:

AB 1807 (Bronshvag), as amended March 23, requires SPAEC licensees to notify the Committee of any change of address within thirty days, and authorizes SPAEC to establish by regulation a system for an inactive category of licensure. This bill was signed by the Governor on March 30 (Chapter 26, Statutes of 1994).

AB 1392 (Speier), as amended July 1, 1993, would require SPAEC to notify DCA whenever any complaint has gone thirty days without investigative 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]*

The following bills died in committee: **SB 595 (Rogers)**, which would have permitted a hearing aid dispenser 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; and **SB 993 (Kelley)**, which would have stated the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the cre-

ation 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.

RECENT MEETINGS

At its January 7 meeting, SPAEC once again considered whether to require its licensees to complete continuing education (CE) coursework as a condition to license renewal. *[13:1 CRLR 57; 12:2&3 CRLR 126]* DCA representative Jackie Bradford explained that to implement a CE program, SPAEC would need authorizing legislation and supporting regulations. Once the program is in effect, monitoring CE offerings and the qualifications of CE providers requires great expense in terms of time and money. DCA legal counsel Bob Miller suggested that SPAEC approach related professional associations about pursuing legislative authorization. The Committee took no action on this issue.

Also at the January 7 meeting, Executive Officer Carol Richards suggested that the Committee waive its prior approval requirement for speech-language pathologist applicants who have gained their required professional experience (RPE) in the public preschool setting, a setting which is not currently exempt from licensure under Business and Professions Code section 2530.5 but which is proposed for exemption in SB 2101 (McCorquodale) (*see* LEGISLATION). Federal regulations require public preschools to provide speech therapy to preschool-age children, and many licensure applicants are gaining their RPE in this setting without obtaining prior approval by SPAEC; these applicants apparently believe that public preschool is an exempt setting under section 2530.5. After discussion at both its January and March meetings, SPAEC agreed to waive prior approval requirement for applicants who have completed sufficient RPE in public preschool settings.

Also in January, the Committee addressed the use in speech-language pathology or audiology advertisements of an unrelated degree, such as a Ph.D. in health care management, from a nonaccredited institution. DCA legal counsel Bob Miller stated that so long as an advertisement is truthful and not misleading, it must be permitted. At SPAEC's March 17 meeting, counsel Kelly Salter clarified the issue by presenting a DCA memorandum which states that advertisements must be clear as to the area of the degree if it is unrelated to the services being advertised, and there is no law preventing advertisement of a degree from an unaccredited institution.

At its January meeting, SPAEC re-elected Robert Hall as its Chair and Dr. Gail Hubbard as Vice-Chair for 1994.

FUTURE MEETINGS

July 22 in Irvine.
October 28 in San Francisco.

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.

On January 14, BENHA welcomed new public member Jack Fenton, who was recently appointed to the Board by Assembly Speaker Willie Brown.

MAJOR PROJECTS

BENHA Continues Focus on Disciplinary Process. At its March meeting, the Board continued the examination of its disciplinary process it began in October 1993. The process by which BENHA tracks complaints against and disciplines NHAs is entangled with, and to a certain extent dependent upon, the process by which the Department of Health Services (DHS) receives, investigates, and prosecutes complaints against skilled nursing facilities. *[14:1 CRLR 69]*

Among other things, the Board considered several suggestions for legislative changes made by the Attorney General's Office, which prosecutes enforcement cases against NHAs on behalf of the Board. First, the AG's Office has recommended that BENHA seek a change to Business and Professions Code section 3928(a), which requires the AG to file and serve an accusation to revoke or suspend a NHA's license within twelve months of DHS' issuance of a temporary suspension order, service of an accusation to revoke the facility's license, or final decertification of the facility from the Medi-Cal or Medicare program. BENHA and the AG's Office are dependent on DHS for providing records and other evidence needed to prosecute an enforcement case. However, the information required by and the burdens of proof imposed upon BENHA and DHS are not identical; the mission of DHS is to regulate facilities, not NHAs. In addition to the problem of insufficient information, the AG's Office frequently does not receive DHS' package of information until well into the twelve-month period. Thus, BENHA agreed to seek legislation lengthening the time period within which the AG's Office may file an accusation against a NHA's license. At this writing, the Board is seeking to insert this amendment into SB 2101 (McCorquodale), the Department of Consumer Affairs' (DCA) 1994 omnibus bill (*see* LEGISLATION).

At the same meeting, the Board agreed to work with both DHS and the AG's Office in preparing guidelines as to what information BENHA needs in order to pursue a disciplinary action. DHS has tentatively agreed to consider gathering that information at the same time it gathers the documentation from the facility that it needs to pursue its own disciplinary actions. Determination of the information needed to prepare a case against a NHA would also enable DHS to ascertain whether that information is already being collected, and whether DHS has the staffing and resources to assist in retrieving any additional information required.