



Department of Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

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UPDATED CONSENSUS AND RECOMMENDATIONS BY TASK FORCE ON AIDS

Concomitantly with the dramatic increase in the number of reported Acquired Immune Deficiency Syndrome (AIDS) cases in California, there also have been some misleading and unnecessarily alarming news media reports of the communicability of AIDS to the general population. In response to this problem, Mr. Peter Rank, Director of the State Department of Health Services, convened a group of experts on AIDS, community leaders and representatives of official and professional organizations to review available data on AIDS and to place the risk of AIDS in proper perspective.

AIDS Risks for the General Population

Since the first AIDS cases were diagnosed in 1979, virtually all cases have occurred in four identified AIDS risk groups: 1) homosexual or bisexual males, 2) IV drug abusers, 3) Haitians recently arrived in the United States, and 4) hemophiliacs.

If AIDS were highly contagious (e.g., if transmission were possible by mere skin contact, by the respiratory route or by fecal-oral spread) the number of cases in "other" groups in the general population without any of the known risk factors should have been increasing over the four-year period. This is not the case as there is no indication of AIDS spreading to the general population who have none of the risk factors of the identified high risk groups. For instance, family members other than sex partners of AIDS patients have not developed AIDS even though they have had close and prolonged household contact. Ambulance drivers, police and firemen who have offered emergency assistance to AIDS patients have also not developed AIDS.

Epidemiologic data suggest that AIDS is transmitted by modes similar to hepatitis B. Sexual contact with mucosal trauma and the inoculation of blood are the key risk factors in the overwhelming majority of cases. There is no evidence for respiratory or fecal-oral spread of AIDS. Although other diseases may be transmitted through saliva, there is no evidence that AIDS is transmitted by either saliva or sweat.

Despite the strong evidence that AIDS is not highly contagious and is not spreading to persons without identified risk factors, great anxiety persists in the general public, and even in some health professionals as to the communicability of AIDS.

Plainly put, AIDS appears to be spread only by direct sexual contact (most often homosexual) and by inoculation of blood from a person with AIDS

(as with intravenous drug abuse).

AIDS is not spread by any of the following:

1. Casual contact with an AIDS patient or a person possibly incubating AIDS.

This would include being in the same room, working in the same office, shaking hands, riding in a crowded bus, turning the same doorknob, sharing meals or communal cups, and sharing swimming pool, whirlpool or hot tub facilities.

2. Foodhandlers who might be AIDS carriers.

Like hepatitis B, AIDS is not spread by the foodborne route. Carriers of hepatitis B virus are not restricted from food handling occupations and neither should persons who might be in AIDS risk groups. If AIDS were transmitted by the foodborne route, there would be many cases not associated with sexual contact and blood exposure and the age and sex distribution of cases would show many more females and children.

3. Community cardiopulmonary resuscitation (CPR) classes.

Community CPR classes need not be modified since transmission of AIDS in such a setting would not be expected and is not considered a risk. However, all CPR classes should routinely adhere to the Centers for Disease Control (CDC) recommendations for the decontamination of cardiopulmonary resuscitation training manikins to minimize transmission risks of *known* infectious disease agents (CDC: Hepatitis Surveillance Report No. 42, Issued June 1978).

4. Mosquitoes or other blood-sucking insects.

Despite the evidence that AIDS occurs in IV drug abusers who share dirty needles and that AIDS

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has occurred in hemophiliacs who receive large amounts of blood-derived clotting concentrates, it is highly unlikely that mosquitoes would be effective in transmitting AIDS. There is no epidemiological evidence that mosquitoes can effectively transmit hepatitis B virus. Although large amounts of virus are present in the blood of hepatitis B carriers, experiments to transmit that virus by mosquito bite have not been successful.

Again, if AIDS were transmitted by mosquitoes or other blood-sucking insects, there would be many cases not associated with sexual contact and blood exposure, and the age and sex distribution of AIDS cases would show more females and children.

The immune deficiency of AIDS patients makes them extremely susceptible to infectious agents, and conversely, when infected, they may transmit known infectious agents to other immunocompromised patients. Epidemiological data indicates that whatever may be the etiologic agent of AIDS, it is transmitted primarily by sexual contact and possibly by blood or body fluids mixed with blood. Although other disease agents may be transmitted through saliva, there is no evidence that AIDS is transmitted by either saliva or sweat. Since the modes of transmission for hepatitis B and AIDS appear similar, the CDC has suggested that hepatitis B precautions be utilized in implementing infection control procedures for AIDS cases.

A. AIDS Inpatients:

The recommend precautions for handling hospitalized AIDS patients are designed to accomplish two objectives: (1) to prevent transmission of a possible AIDS agent from the patient to health care workers; and (2) to prevent transmission of known infectious disease agents to and from the AIDS patient.

1. Procedures for the protection of health care workers

- a. Strict isolation is not necessary for AIDS cases. Blood precautions are sufficient for the protection of health care staff. Gloves should be used when in contact with blood from an AIDS patient. Gowns are recommended for those who may have direct contact with blood of an AIDS patient.
- b. Specimens from AIDS patients should be appropriately designated so transport precautions, such as using an impervious bag or container, will be used. The code "H/A" has been used to label specimens that are obtained from either hepatitis or AIDS patients, both to be handled with hepatitis B precautions.
- c. Contaminated equipment should be sterilized as recommended by the CDC guidelines. Contaminated disposable items must be considered infectious waste and handled accordingly.
- d. Surfaces contaminated by blood or body fluids which may be contaminated by blood of an AIDS patient should be immediately cleaned with sodium hypochlorite or a similar disinfectant.
- e. Health care providers with a known specific exposure to blood of an AIDS patient, such as a needle stick or blood splash onto mucous membranes, should be reported to the hospital infection control officer for evaluation and follow-up.

2. Procedures for limiting the spread of opportunistic and known infectious agents

- a. If the AIDS patient has a respiratory infection and is coughing, respiratory precautions should be instituted to prevent transmission of known infections and opportunistic agents. Masks are not essential for all AIDS patients. They are recom-

mended if the patient is actively coughing, and particularly if infectious agents capable of transmission via aerosols have been identified.

- b. Patients who share a room with an AIDS patient should not have an impaired immune system because of the risk of being exposed to an opportunistic infection which may be harbored by the AIDS patient, nor should any patient sharing a room with an AIDS patient have an infectious disease which could be transmitted to the AIDS patient.

B. AIDS Outpatients:

These patients may use common waiting areas and bathroom facilities in hospitals or doctor's offices. Exposure to other immunocompromised patients should be avoided as much as possible as well as exposure to other patients with infectious diseases. Blood and tissue specimens should be handled as described above.

C. Non-symptomatic AIDS cases:

These patients may return to work if they are given a release by their physician to do so.

All AIDS cases should be informed of local support groups ready to assist them in the event of emotional, social, or economic problems.

Blood Transfusions, Blood Banks and AIDS Risks

Transfusion linked AIDS cases have been reported. However, direct evidence of transmission of AIDS via blood transfusion is lacking. Some of these patients had received blood or blood components from a donor who subsequently developed AIDS or from donors with AIDS risk factors.

However, after more than two years of national AIDS surveillance, the data show that the incidence of AIDS is very low in blood recipients. In terms of the number of units of blood transfused relative to the few cases of AIDS which may have been acquired via this route, the risk of AIDS from blood transfusions in California is exceedingly low. Nevertheless, blood banks in the State have instituted screening procedures to minimize any potential risk which may be present.

Since there is no specific predictive or diagnostic test for AIDS screening of blood donors, reliance must be placed on voluntary self-screening through the traditional medical history and physical examination (if indicated). In the absence of specific screening tests for an AIDS agent, several surrogate screening tests have been proposed and evaluations of some of the tests are in progress.

Screening of donors for AIDS risk through the usual blood bank medical history questionnaire (specific questions on previous diagnosis of AIDS, AIDS and pre-AIDS symptoms, sexual

intercourse with AIDS patients, homosexual or bisexual intercourse with multiple partners, recent entry to the U.S. from Haiti, past or present use of IV drugs, and sexual intercourse with any individual with increased risk for AIDS) began in early 1983 and is now practiced in all blood banks.

Conclusions and Recommendations:

1. Blood donors are not at risk of being exposed to AIDS. All blood banks use sterile disposable needles and equipment. There is no way AIDS could be transmitted through the act of blood donation.
2. Epidemiologic data suggest that AIDS may be transmitted by trans-
3. Patients scheduled for elective surgery should be encouraged to donate blood for their own use shortly before surgery.
4. Implementation of a blood bank policy of designated (directed) donations (family and private

fusion of blood or blood products. However, the incidence of such transmission by blood collected from volunteer donors is exceedingly low. Screening procedures (and donor information) instituted by all State Blood Banks as required by the federal Food and Drug Administration have reduced this risk further.

blood clubs) is not advisable. There is no scientific evidence that designated donations will be any safer than blood which is currently provided by blood banks in the State. A marked increase of designated donations will likely result in a serious disruption of the current blood banking system and could lead to serious errors in donor and patient identification.

5. Physicians should adhere strictly to medical indications for transfusions. Transfusions when medically indicated should not be withheld because of perceived risk of AIDS.
6. Educational efforts should continue to be directed at groups who are at risk for AIDS to defer blood and plasma donations.
7. Continued research should be encouraged to develop and evaluate the effectiveness of better donor screening procedures including laboratory tests, for identifying and excluding blood and plasma which may have an AIDS risk.
8. Efforts should be intensified to recruit new donors who are not in any of the documented risk groups for AIDS to enter voluntary blood donation programs.

GOVERNOR DEUKMEJIAN MAKES HIS FIRST BMQA APPOINTMENTS



DR. EUGENE J. ELLIS, of Los Angeles, has been appointed to the Division of Medical Quality, replacing Dr. Lawrence N. Hill. Dr. Ellis received his bachelor's degree and his M.D. degree from the University of Southern California. He also received a master's degree in physiology from the University of Minnesota. Dr. Ellis developed and directed the Cardiology Department at St. Vincent Medical Center, Los Angeles, from 1955-58 and from 1959-82 developed and directed the Department of Cardiology at the Hospital of the Good Samaritan, based in Los Angeles.



DR. GALAL S. GOUGH, of Montebello, has been appointed to the Division of Licensing, replacing Dr. Frederic Quevedo. Dr. Gough received his bachelor's degree from Wichita State University in 1959 and his M.D. degree from the California College of Medicine in 1963. He is an associate clinical professor for the University of Southern California School of Medicine, a position he has held for 13 years.



DR. RENDEL LEVONIAN, of Pico Rivera, has been appointed to the Division of Medical Quality, replacing Dr. Eugene Feldman. Dr. Levonian received his bachelor's degree in medicine in 1944 and his M.D. degree in 1948 from the American University of Beirut (Lebanon). He is a general surgeon, has practiced at Hollywood Presbyterian, Presbyterian Intercommunity, Beverly, Whittier Community, and Pico Rivera Community Hospitals, and is currently an administrator at Pico Rivera Community Hospital.



DR. JAMES MAGNALL, of Long Beach, has been appointed to the Division of Licensing, replacing Dr. William Gerber. Dr. Magnall received his D.O. degree from the Los Angeles College of Osteopathic Physicians and Surgeons in 1944 and his M.D. degree from the California College of Medicine in 1962. He has been a Long Beach area family practice physician for 37 years.

Medical Assistants— What They May and May Not Do

The Board receives many inquiries about the legal functions of Medical Assistants (M.A.s). The most common question is, "What can and cannot be done by a Medical Assistant?"

The law defines an M.A. as an unlicensed person who "performs basic administrative, clerical and technical supportive services . . ." for physicians or podiatrists. With appropriate training* and supervision, an M.A. may administer intramuscular, subcutaneous or intradermal injections, and may perform skin tests, venipuncture and

(Continued on Page 4)

* The regulations require 10 hours of training each for injections and venipuncture, covering:

- Pertinent anatomy and physiology
- Proper technique
- Post treatment and patient care
- Choice of equipment
- Hazards and complications
- California Medical Assistant laws

Each procedure must be demonstrated 10 times to the satisfaction of the physician giving the training before being performed without direct supervision. When the training is completed, the physician may certify in writing that the M.A. has been trained, and a copy of the certification retained in the personnel record. (Sections 1376-1377.1, Title 16, Admin. Code.)

AIDS IS NOW REPORTABLE IN CALIFORNIA

On March 23, 1983, the California Department of Health Services declared Acquired Immune Deficiency Syndrome (AIDS) cases to be a legally reportable condition in California, under California Administrative Code Title 17, Section 2503, which pertains to the reporting of the occurrence of unusual diseases.

The entire health care community should be apprised of this requirement to report cases to local health departments so that AIDS cases can be identified and a uniform, national case history report form can be completed. All completed case history report forms should be sent to the Infectious Disease Section, 2151 Berkeley Way, Berkeley, CA 94704 (415) 540-2566. Questionnaire blanks may be obtained from this same address.

MEDICAL ASSISTANTS

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skin punctures for blood. An M.A. may NOT administer anesthetics, do arterial punctures, start, superimpose, or discontinue I.V.'s.

Whenever a Medical Assistant performs one of the permitted procedures, the physician or podiatrist must be physically present on the premises, although it is not necessary to directly observe the procedure. In any case, the M.A. must have either a patient-specific order for each task, or a standing order which is noted in the patient chart. Under current law, such orders cannot be given by a registered nurse or a physician's assistant.

Because M.A.s are not licensed, and often have minimal training, it is not legal for them to perform what a physician considers "simple and routine" medical tasks, even if the supervising physician is present and observing. Some examples of UNLAWFUL tasks include: Inserting urinary catheters—changing dressings—removing sutures—lavaging ears—debriding and suturing lacerations—inserting or removing endoscopic instruments, and performing punch hair transplants. Included in the prohibition is the administering of physical therapy modalities such as hot packs, diathermy or exercise. If the task involves patient contact or counseling, it must be specifically permitted by the law, or it is illegal. The M.A. statutes are sections 2069, 2070, B&P Code.

California does not license or certify M.A.s, and does not require them to complete a formal training program. Any

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DISEASES ASSOCIATED WITH CELLULAR IMMUNE DEFICIENCY

The etiology of Acquired Immune Deficiency Syndrome (AIDS) has still not been identified. Whether some type of pre-existing immunologic deficiency in the host is necessary for the development of AIDS, or whether the postulated AIDS "agent" will lead to progressive immunologic deficiency in persons with "normal" intact immune systems is not known. Up to now, AIDS has been almost exclusively reported in patients who may have some depression of their immune systems by virtue of disease agents which can temporarily depress certain immune factors.

For the purposes of epidemiologic surveillance, the Center for Disease Control defines a case of "the Acquired Immune Deficiency Syndrome" (AIDS) as a person (adult or child) who has had a reliably diagnosed disease that is "at least moderately indicative of an underlying cellular immune deficiency, but who, at the same time, has had no known underlying cause of cellular immune deficiency nor any other cause of reduced resistance reported to be associated with that disease." These diseases are listed below:

A. Protozoal and Helminthic Infections:

1. Cryptosporidiosis, intestinal, causing diarrhea for over one month, (on histology or stool microscopy);
2. Pneumocystis carinii pneumonia, (on histology, or microscopy of a "touch" preparation or bronchial washings);
3. Strongyloidosis, causing pneumonia, central nervous system infection, or disseminated infection, (on histology);
4. Toxoplasmosis, causing pneumonia or central nervous system infection (on histology or

microscopy of a "touch" preparation).

B. Fungal Infections:

1. Aspergillosis, causing central nervous system or disseminated infection (on culture or histology);
2. Candidiasis, causing esophagitis (on histology, or microscopy of a "wet" preparation from the esophagus, or endoscopic findings of white plaques on an erythematous mucosal base);
3. Cryptococcosis, causing pulmonary, central nervous system, or disseminated infection (on culture, antigen detection, histology, or India ink preparation of CSF).

C. Bacterial Infections:

1. Atypical mycobacteriosis (species other than tuberculosis or lepra), causing disseminated infection (on culture).

D. Viral Infections:

1. Cytomegalovirus, causing pulmonary, gastrointestinal tract, or central nervous system infection (on histology);
2. Herpes simplex virus, causing chronic mucocutaneous infection with ulcers persisting more than 1 month, or pulmonary, gastrointestinal tract, or disseminated infection (on culture, histology, or cytology);
3. Progressive multifocal leukoencephalopathy (presumed to be caused by Papovavirus) (on histology).

E. Cancer:

1. Kaposi's sarcoma (on histology);
2. Lymphoma limited to the brain (on histology).

Breast Cancer Summaries Now Available in English and Spanish

The State of California's Publications Section has a new supply of the breast cancer brochure required by Senator Roberti's Senate Bill 1893 to be distributed by physicians to patients being treated for breast cancer.

Copies are now available in Spanish as well as English and may be purchased from:

State of California
Publications Section
P.O. Box 1015
North Highlands, CA 95660

at a cost of \$3.40 per 25. The publications are prepackaged in sets of 25 English or 25 Spanish and must be ordered accordingly.

BMQA ADOPTS NEW LICENSURE REVIEW PROCEDURE FOR FOREIGN MEDICAL GRADUATES

During the Spring of 1983, the staff of the Division of Licensing of the BMQA noted that there were numerous discrepancies in the applications for California medical licensure from graduates of CETEC medical school in Santo Domingo, Dominican Republic.

At its May meeting the Division reviewed the problem. Then, in an unusual move, the BMQA Division of Licensing officially decertified CETEC as an approved medical school.

However, in order to be fair with recent graduates of that school, the BMQA Division of Licensing appointed an eight-member task force (to include deans of California medical schools) to develop standards that could be "fairly applied to all foreign graduates (as well as recent CETEC graduates)."

The task force met on July 25, August 3, and August 10. Their work resulted in the formulation of requirements for foreign medical graduates other than the United States or Canadian medical schools. The U.S. and Canadian schools are approved by the Liaison Committee on Medical Education (LCME), and the Canadian Council on Medical Education (CCME).

Requirements of Foreign Graduates:

After carefully considering current practice in U.S. and Canadian medical schools, and current licensing laws and regulations, the following requirements were detailed:

(a) Each applicant for a physician's and surgeon's certificate shall show, by official transcript and other official evidence satisfactory to the Division of Licensing, that he or she has successfully completed courses and received the degree "M.D." or equivalent in an allopathic medical curriculum extending over a period of at least four academic years. The total number of all courses shall consist of a minimum of 4,000 hours and at least 80 percent of actual attendance shall be required. Documentation must be provided for all schools attended and in the case of an applicant attending more than one school, he or she must have attended the school granting the M.D. degree for at least one full academic year.

(b) The curriculum for all applicants shall provide for adequate instruction in the following:

Anatomy, including
embryology, histology, and
neuroanatomy
Anesthesia
Biochemistry

Child abuse detection and treatment
Dermatology
Geriatric medicine
Human sexuality
Medicine, including pediatrics
Neurology
Obstetrics and gynecology
Ophthalmology
Otolaryngology
Pathology, bacteriology, and immunology
Pharmacology
Physical medicine
Physiology
Preventive medicine
Psychiatry
Radiology, including radiation safety
Surgery, including orthopedic surgery
Therapeutics
Tropical medicine
Urology

(c) All clinical rotations, except for a maximum of 18 weeks designated by the school as electives, must:

- (1) be sponsored by the institution where the rotation takes place.
- (2) be certified as having been successfully completed by the applicant by both the individual instructor and the program director.
- (3) be conducted in an institution that:
 1. Is a formal part (primary hospital) of the medical school, or
 2. has formal affiliation with

an LCME/CCME approved medical school, or

3. has an approved residency program by the Accreditation Council on Graduate Medical Education (ACGME) in the clinical area for which credit is being sought.

The requirements are intended to conform as closely as possible to current practice in LCME/CCME approved medical schools and regulations. It is intended that an applicant's file be reviewed for compliance with these requirements without regard or prejudice for the medical school attended. These basic standards are the absolute minimum required to afford a measure of protection for the public.

The task force also made three recommendations to the BMQA Division of Licensing:

1. Specific, immediate review procedures are to be implemented by the staff for all applications from graduates from non-LCME/CCME approved medical schools.
2. The procedures used for reviewing files be uniformly applied to all foreign medical graduates.
3. The curriculum and training requirements for medicine (listed above) be adopted by the Division as the minimum and comparable standards for a medical education for licensure of foreign graduates.

On August 19, 1983, BMQA Division of Licensing adopted the task force's proposed requirements and recommendations as they apply to CETEC and other foreign medical school graduates.

MEDICAL ADVERTISING— IS IT LEGAL?

Traditionally, advertising by a physician has been looked upon by fellow physicians as odious and, at best, unethical. In fact, in prior years, the Medical Board enforced strict California statutes regulating and prohibiting various aspects of medical advertising.

Then, in 1977, the United States Supreme Court issued a historic decision reversing state discipline against an attorney for price advertising. The court ruled that professionals (to include physicians) are guaranteed the right of free speech, including commercial free speech (legalese for advertising). Furthermore, the states may not unduly stifle this constitutional right without showing a compelling state interest to be protected. The court said that false and misleading advertising, however, is always subject to restraint.

Following this decision, California and the other states moved to repeal most of their strict professional advertising statutes. Our new advertising statute is found in Section 651, Business and Professions Code. Even that new statute is constitutionally questionable in light of a more recent U.S. Supreme Court decision that struck down a Missouri statute that attempted to restrict professional advertising to a more "dignified" level.

Presently, the California legislature is considering numerous changes to the professional advertising laws to bring them into conformity with the recent U.S. Supreme Court opinion.

BMQA enforcement of advertising restrictions, other than false or misleading advertising, is generally in a holding pattern until the new laws are made known.

DISCIPLINARY ACTIONS

January 1, 1983-June 30, 1983

- Angio, Roger, M.D. (C-38052)—Los Angeles**
725, 2242(a), 2238 B&P Code, 11154 H&S Code
Prescribed controlled drugs excessively without a good faith prior examination and medical indication, and to persons not under his treatment for a pathology or condition. No appearance by respondent.
Revoked.
April 4, 1983
- Arsenault, William J., M.D. (A-21430)—Orange**
490, 2238, 2242, 2236 B&P Code
Violation of probation. Prescribed controlled drugs with no medical examination and no medical indication, and to persons not under his treatment for pathology or condition, resulting in a criminal conviction.
Prior discipline.
Revoked. Judicial Review recently completed.
September 20, 1982
- Bailey, Nicholas E., M.D. (AO-9376)—Loomis**
Stipulated decision. Surrender of license.
Accusation dismissed.
February 9, 1983
- Baker, Charles E., M.D. (A-19634)—Long Beach**
Stipulated decision. Surrender of license.
Accusation dismissed.
March 16, 1983
- Bare, Jack L., M.D. (A-27773)—Sloughhouse**
2234(c) B&P Code
Stipulated decision. Repeated similar negligent acts. Six month suspension, stayed, 3 years probation on terms and conditions.
June 8, 1983
- Bienenstock, Solomon, M.D. (C-38351)—Beverly Hills**
2242, 2234(b), 2239 B&P Code, 11154 H&S Code.
Stipulated decision. Conviction for prescribing controlled drugs to a person not under his treatment for a pathology or condition. Prescribing without a medical examination and without medical indication.
Revoked, stayed, 5 years probation on terms and conditions.
June 1, 1983
- Bosley, Larry Lee, M.D. (C-23493)—Beverly Hills**
651, 2271, 17500 B&P Code
Stipulated decision. Misleading advertising. Prior discipline.
One year suspension, stayed, 3 years probation on terms and conditions.
February 9, 1983
- Burgess, George Lang, M.D. (C-39944)—Los Angeles**
2242 B&P Code
Stipulated decision. Prescribed Preludin at weight clinic without medical examination and without medical indication.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
January 12, 1983
- Carter, Gilbert B., M.D. (C-34276)—Santa Cruz**
2234 B&P Code
Stipulated decision. Failed to comprehensively evaluate a minor child's state of severe malnutrition and failed to recognize the need for immediate rather than delayed hospitalization for that minor.
Revoked, stayed, 5 years probation on terms and conditions.
January 5, 1983
- Carter, William N., M.D. (C-23486)—Atwater**
2234(b) B&P Code
Stipulated decision. Gross negligence in management of diabetes.
Revoked, stayed, 5 years probation on terms and conditions.
April 20, 1983
- Chamberlain, Terranee, M.D. (C-28469)—Presidio of San Francisco**
2234(b), 2236 B&P Code
Stipulated decision. Sex relations with patient. Conviction for filing fraudulent claims.
Revoked, stayed, 7 years probation on terms and conditions, including one year actual suspension.
May 9, 1983
- Coffield, Kenneth J. M.D. (G-8267)—Vallejo**
2234(b)(c) B&P Code
Repeated similar negligent acts in the management of diabetes cases; one case involving gross negligence.
Revoked, stayed, 5 years probation on terms and conditions.
Judicial Review recently completed.
February 24, 1983
- DeMonterice, Anu, M.D. (G-14647)—Cotati**
2236, 2285 B&P Code
Stipulated decision. Federal conviction for filing false claim against U.S.; conspiracy; aiding and abetting mail fraud, Medi-Cal and CHAMPUS. Use of the fictitious name "Cotati Holistic Health Center" without a fictitious name permit.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
May 9, 1983
- Dummer, Jerome Martin, M.D. (A-10902)—Monroe, LA**
Stipulated surrender of license.
Accusation dismissed.
January 12, 1983
- Goodlin, Roger Neal, M.D. (A-32752)—San Gabriel**
2239, 2391.5 B&P Code
Stipulated decision. Several convictions involving the use of alcohol. Unlawful possession of Quaalude. Recent default decision for revocation set aside and replaced by this negotiated decision.
Revoked, stayed, 5 years probation on terms and conditions, including 120 days actual suspension.
February 16, 1983
- Goodman, Theodore A., M.D. (G-35973)—Sacramento**
2236, 2234(e) B&P Code
Stipulated decision. Conviction for unauthorized sale of government property. Sale to private lab of human organs, tissues and fluids removed during autopsies at VA hospital and other hospitals. Knowingly provided lab with list of fake names of decedents.
Revoked, stayed, 3 years probation on terms and conditions.
April 6, 1983
- Grant, Walter James, M.D. (C-15022)—Bakersfield**
490, 2236, 2234(e) B&P Code
Conviction for grand theft: False Medi-Cal claims for psychotherapeutic services.
Revoked, stayed, 5 years probation on terms and conditions.
March 7, 1983
- Heinemann, Herman Judd, M.D. (C-37067)—Hollister**
Failed to comply with probationary terms and conditions of prior disciplinary decision. No appearance by respondent.
Revoked.
June 9, 1983
- Hinds, Ramon K., M.D. (A-28478)—Bakersfield**
2234(d) B&P Code
Stipulated decision. Failed to carry out adequate diagnostic studies to determine patient's illnesses; then proceeded to subject patient to useless and inappropriate treatments.
Revoked, stayed, 3 years probation on terms and conditions.
February 24, 1983
- Karnopp, Irma Mae, M.D. (C-19066)—Santa Rosa**
725, 2242, 2238, 2234(b),(c),(d), 2240 B&P Code, 11154, 11156 H&S Code.
Prescribed controlled drugs excessively and without a good faith prior examination and medical indication to persons not under her treatment for a pathology or condition, and to persons who represent themselves as addicts or habitual users. Gross negligence, incompetence and repeated similar negligent acts in the care of patients. Under the influence of an unidentified substance while attending patient at the Emergency Room.
Revoked.
May 9, 1983
- Keenan, Barbara Jean, M.D. (C-32249)—Lone Pine**
2305, 2236 B&P Code
Arizona license suspended for conviction in Arizona for unlawful possession of Talwin—related to drug addiction problems of ex-husband. Respondent now in California.
Revoked, stayed, 5 years probation on terms and conditions.
February 11, 1983
- Kirkwood, Kenneth J., M.D. (G-39643)—San Bernardino**
2237, 2239 B&P Code; 11190 H&S Code
Stipulated decision. Conviction for unlawful dispensing and administration of Cocaine to numerous persons and for failing to maintain records of controlled drug transactions.
Revoked, stayed, 2 years probation on terms and conditions.
February 18, 1983
- Kotarac, John P., M.D. (A-16529)—Kernville**
2390, 2391.5 B&P Code; 11170, 11173, 11190 H&S Code
Stipulated decision. Self use of controlled drugs. Obtained schedule II drugs fraudulently. Failed to keep records of controlled drug transactions.
Revoked, stayed, 5 years probation on terms and conditions.
February 4, 1983
- Kushner, Paul J., M.D. (G-4817)—Long Beach**
2234(b) B&P Code
Stipulated decision. Gross negligence in the management of a cardiac and circulatory arrest in the operating room after surgery.
Revoked, stayed, 5 years probation on terms and conditions.
June 20, 1983
- Larson, Lorry James, M.D. (A-24981)—Westwood**
2234, 2238, 4390 B&P Code
Stipulated decision. Issued fictitious prescriptions for Percodan to a friend.
Revoked, stayed, 5 years probation on terms and conditions.
February 24, 1983
- LaValle, Peter L., M.D. (G-17435)—San Francisco**
490, 2234(e), 2236 B&P Code
Stipulated decision. Conviction for grand theft: Filed false claims for services not rendered.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
June 5, 1983
- Lilly, Terry E., Jr., M.D. (C-12769)—Irvine**
2261 B&P Code
Knowingly entered false progress notes on hospital chart.
30 days suspension, stayed, one year probation on terms and conditions.
February 24, 1983
- Low, Leslie Y., M.D. (A-12652)—Stockton**
Violated probationary conditions of a prior disciplinary decision.
Revoked.
March 30, 1983
- Ludlow, Lester A., M.D. (G-8762)—Orange**
2242, 2238 B&P Code
Stipulated decision. Prescribed dangerous drugs without a good faith prior examination and medical indication, and to persons not under his treatment for a pathology or condition.
Revoked, stayed, 5 years probation on terms and conditions.
January 20, 1983
- Marcum, John Douglas, M.D. (G-38741)—San Dimas**
2234(e), 2236 B&P Code
Stipulated decision. Federal conviction for soliciting kickbacks from clinical lab for Medi-Cal referrals.
Revoked, stayed, 5 years probation on terms and conditions.
April 7, 1983
- Marius, Fitzalbert, M.D. (A-16714)—Fresno**
2234(d)
Incompetence in post-operative care of OB patient following caesarean operation.
30 days suspension, stayed, one year probation on terms and conditions.
May 18, 1983

- Martin, Larry Albert, M.D. (A-30225)—San Diego**
2234(b)
Stipulated decision. Gross negligence involving foot surgery performed in the office.
Revoked, stayed, 5 years probation on terms and conditions.
May 9, 1983
- Nadell, Judith, M.D. (G-3329)—Mountain View**
Stipulated surrender of license. Therefore, probation under prior discipline is terminated.
January 28, 1983
- Neiger, Bruce, M.D. (G-26416)—Santa Cruz**
4390, 2238, 2262, 2261 B&P Code
Unlawfully altered a prescription from his dentist by increasing the number of tablets. Altered or modified a patient's chart to show that 20 and 50 Quaalude tablets were dispensed to the patient, which was untrue.
Revoked, stayed, 5 years probation on terms and conditions, including 120 days actual suspension.
June 6, 1983
- Neubert, James W., M.D. (C-32569)—Redding**
2238, 2239, 2240 B&P Code
Several occasions of self-administration of anesthetic gases at the hospital, causing him to be in a partial stupor and unfit to serve as the anesthesiologist for scheduled surgeries. No appearance by respondent.
Revoked.
June 30, 1983
- Noecker, Frances P., M.D. (A-14239)—Fall River Mills**
2234(d) B&P Code
Incompetency in her care of a pregnant patient and in her care of the new-born.
Revoked, stayed, 5 years probation on terms and conditions.
March 11, 1983
- Osibin, Willard S., M.D. (A-15955)—Templeton**
2234(d) B&P Code
Stipulated decision. Incompetence in the care of a pregnant patient.
Revoked, stayed, 5 years probation on terms and conditions.
January 17, 1983
- Pearson, Craig, M.D. (A-29117)—Carmichael**
725, 2234(b),(c),(d) 2242 B&P Code
Stipulated decision. Prescribed dangerous drugs excessively and without a good faith prior examination and medical indication and constituting gross negligence, incompetence, and repeated similar negligent acts.
Revoked, stayed, 7 years probation on terms and conditions.
March 11, 1983
- Presser, Harvey, M.D., (A-28716)—Encino**
725, 2234(b),(c),(d), 2242, 2248 B&P Code; 11154 H&S Code
Stipulated decision. Prescribed dangerous drugs excessively and without a good faith prior examination and medical indication; and to persons not under his treatment for a pathology or condition; and constituting gross negligence, incompetence, and repeated similar negligent acts.
Revoked, stayed, 10 years probation on terms and conditions, including one year actual suspension.
January 27, 1983
- Reeder, David D., M.D. (A-21356)—Klamath Falls, OR**
2305 B&P Code
Stipulated decision. Oregon license disciplined by Oregon for alcoholism.
Revoked.
May 5, 1983
- Reiner, Edwin, M.D. (A-12145)—Chula Vista**
2361(b),(c),(d) old B&P Code
Gross negligence, incompetence, and repeated similar negligent acts in OB-GYN practice.
Revoked, stayed, 10 years probation on terms and conditions, including 6 months actual suspension.
September 10, 1978
Judicial review recently completed April 1, 1983
- Riley, Robert M. Jr., M.D. (A-16498)—Placerville**
2242 B&P Code
Prescribed dangerous drugs without a good faith prior examination and medical indication. Prior discipline.
Revoked, stayed, 3 years probation on terms and conditions.
March 2, 1983
- Rubin, Harvey N., M.D. (C-19884)—San Diego**
725; 2234(b), 2242 B&P Code
Prescribed dangerous drugs excessively and without a good faith prior examination and medical indication, demonstrating gross negligence for the outrageous nature of overprescribing.
Revoked.
June 30, 1983
- Sandberg, Harry W., M.D. (A-15284)—Linden**
2234(c) B&P Code
Stipulated decision. Performed inadequate physical examinations for individuals seeking DMV licenses for school bus drivers.
Revoked, stayed, 5 years probation on terms and conditions.
February 28, 1983
- Sciaroni, Lloyd G., M.D. (A-28105)—Fresno**
2234(d) B&P Code
Stipulated decision. Respondent suffers from a mental condition which renders him incompetent to assume responsibility for patient care.
Revoked, stayed, 10 years probation on terms and conditions, with practice limited to doing insurance or employment physicals.
March 11, 1983
- Scouten, George Frederick, M.D. (A-27035)—Seal Beach**
Stipulated surrender of license for health reasons in lieu of compliance with terms and conditions of a prior disciplinary decision effective October 4, 1982.
January 28, 1983
- Shapiro, Richard, M.D. (A-23661)—El Cajon**
2234(a), 2264 B&P Code
Stipulated decision. Employed a person to work as a Physician's Assistant who was not a licensed PA.
Revoked, stayed, 3 years probation on terms and conditions.
February 28, 1983
- Simay, Douglas Alan, M.D. (G-34521)—San Diego**
2234(e), 2236 B&P Code
Stipulated decision. Federal conviction for mail fraud for receiving a check by mail from a clinical lab based upon false documentation. A false list of "donors" was provided the lab in connection with the sale of human organs, tissues and fluids removed during autopsies at various hospitals.
Revoked, stayed, 5 years probation on terms and conditions.
March 30, 1983
- Smith, Gerard, M.D. (G-16983)—Anaheim**
2238, 2242, 725 B&P Code
Stipulated decision. Prescribed controlled drugs excessively without a good faith prior examination and medical indication, and to persons not under his treatment for a pathology or condition.
Revoked, stayed, 5 years probation on terms and conditions including 60 days actual suspension.
February 11, 1983
- Spelman, Leslie P., M.D. (G-7675)—Chula Vista**
Violated probationary conditions of a prior disciplinary decision.
Revoked, stayed, 7 years probation on terms and conditions, including 6 months actual suspension.
Judicial Review recently completed.
November 18, 1982
- Stapleton, Michael Reid, M.D. (C-25366)—San Jose**
725, 2234(b),(c),(d), 2242 B&P Code
In numerous patient cases, provided treatment and care in a grossly negligent and incompetent manner, and prescribed drugs excessively and without medical indication.
Revoked.
April 15, 1983
- Sutherland, Ralph M., M.D. (A-27822)—Bakersfield**
2234(d) B&P Code
Stipulated decision. (Companion to Hinds case above.)
Failed to carry out adequate diagnostic studies to determine patient's illnesses; then proceeded to subject patient to useless and inappropriate treatments.
Revoked, stayed, 3 years probation on terms and conditions.
February 24, 1983
- Tokunaga, Masaharu, M.D. (A-15011)—Huntington Beach**
725, 2234(b),(d), 2242, 2238 B&P Code; 11154, 11157 H&S Code
Stipulated decision. Gross negligence; incompetence; excessive prescribing; prescribing controlled drugs without a medical exam, without medical indication, to persons not under his care for a pathology or condition; issuing prescriptions using false names.
Revoked.
January 11, 1983
- Vergara, Abelardo F., M.D. (C-37798)—Lomita**
2242, 2234(b), 2238 B&P Code; 11154 H&S Code
Stipulated Decision. Prescribed controlled drugs without a good faith prior examination and medical indication, and to persons not under his treatment for any pathology or condition.
Revoked, stayed, 5 years probation on terms and conditions, including 120 days actual suspension.
May 4, 1983
- Wagner, Kurt J., M.D. (G-5538)—Beverly Hills**
2236 B&P Code
Stipulated Decision. Conviction for receiving stolen property. (Art objects, statues, ivory objects, etc.)
Six month suspension, stayed, 3 years probation on terms and conditions.
June 6, 1983
- Wakefield, John C., M.D. (A-21840)—San Mateo**
Stipulated Decision. Failure to comply with probation. Extension of prior Decision.
June 30, 1983
- Williams, Aubrey D., M.D. (A-29106)—Hayward**
2297 B&P Code
Stipulated Decision. Mental problems involving alcohol.
Revoked, stayed, 10 years probation on terms and conditions.
January 27, 1983
- Wilson, Richard I., M.D. (A-29108)—Montclair**
2242, 2361.5, 725, 2234, 2238 B&P Code; 11154 H&S Code
Gross negligence, repeated negligent acts and incompetence in weight reduction practice. Multitude of cases of prescribing controlled drugs excessively without a good faith prior examination and without medical indication and to persons not under his treatment for a pathology or condition.
Revoked.
June 8, 1983
- Woo, Young Ok, M.D. (A-32793)—Mountain View aka Woo, Florence, M.D.**
2234(b),(c),(d) B&P Code
Gross negligence, incompetence, repeated similar negligent acts in obstetrical practice.
Revoked, stayed, 5 years probation on terms and conditions.
April 1, 1983
- Yates, James E., M.D. (A-16668)—Reno, Nevada**
2236 B&P Code
Conviction for filing false Medi-Cal claims.
Revoked, stayed, 5 years probation on terms and conditions.
April 1, 1983
- Zane, John J., M.D. (C-20382)—Anaheim**
2234(b),(d) B&P Code
Gross negligence and incompetence in the use of the Automated Immunostatus Differential test to detect cancer.
Revoked, stayed, 7 years probation on terms and conditions.
Judicial review recently completed.
February 3, 1983

NONNARCOTIC PAIN RELIEF MEDICATIONS REVIEWED AGAIN

Editor's Note: Our last issue of Action Reports provided misleading information on nonnarcotic pain medications. Several physicians correctly pointed out that the drugs Zomepirac (Zomax) and benoxaprofen (Oraflex) had been withdrawn from use. One of those physicians, Ronald L. Kaye, M.D. of Palo Alto, submitted the following updated, accurate information.

The choice of a therapeutic intervention for pain, one of man's most complex human experiences, is determined by the nature of the patient's problem, the resources available, the comparative risk of the treatment under consideration and the cost to the patient and society.

Nonnarcotic analgesics should be considered whenever possible to minimize the phenomena of tolerance, drug dependence, and addiction. Most nonnarcotic analgesics belong to the class of drugs currently known as nonsteroidal antiinflammatory drugs (NSAIDs). These drugs are not only antiinflammatory, but also antipyretic and analgetic. The nonnarcotic pain relief medications include salicylates, ibuprofen, naproxen, fenoprofen, and acetaminophen (acetaminophen is not an antiinflammatory drug, but it is an antipyretic and analgetic one).

The table below lists the chemical categories of these drugs so that the physician may recognize their chemical groupings and may more easily assess

future drugs of a particular group when they are released. These drugs relieve pain presumably by altering the chemical environment of the nociceptors and by various prostaglandin inhibition effects.

In the table, trade or brand names are followed by chemical names in parentheses. Starred drugs are currently approved for analgetic use. Drugs formerly released, but currently withdrawn from use, are in brackets. They are included for completeness and because of possible rerelease.

Side effects of these drugs may include gastrointestinal disorders (peptic ulcerations, diarrhea, bleeding), adverse hepatic effects, nephrotoxicity (oliguria, anuria, interstitial nephritis, nephrotic syndrome, acute papillary necrosis), blood dyscrasias (bleeding tendencies, agranulocytosis, aplastic anemia), central nervous system symptoms (headaches, tinnitus, eye abnormalities), and allergic reactions.

The nonacetylated salicylates, unlike aspirin, appear to have less gastrointestinal irritation, little effect on platelet activity and do not appear to cause liver function abnormalities, nephrotoxicity, or the syndrome of nasal polyps and asthma. Acetaminophen causes less gastrointestinal irritation, but may cause hepatotoxicity. Because of the potential side effects of these drugs, periodic laboratory and ophthalmologic monitoring is recommended.

BMQA PHYSICIANS' DIVERSION PROGRAM TO ANALYZE RESULTS

At its September meeting, the Division of Medical Quality of the BMQA directed the Program Manager of the Diversion Program for Physicians to carry out a study survey of the program's participants from January 1980 to July 31, 1983.

Although information concerning individual physicians enrolled in the program is strictly confidential, it will be possible to analyze general data. This data will focus on:

- 1) The pattern, type and length of time of a physician's illness.
- 2) The referral pathways of physicians seeking treatment.
- 3) The length of time that elapsed in obtaining treatment.
- 4) The failures, slips and successes of the participants in the Diversion Evaluation Committee's treatment plan.

From the inception of the program in January 1980 to July 31, 1983, the program received 302 physician referrals. Of these, 84 were referred by the BMQA as diversions from discipline and 218 contacted the program on their own without the Board's knowledge or coercion. The proposed survey will provide useful data in developing better understanding and treatment of the ill physician.

As of July 31, there were 125 active program participants. At that time, 34 physicians had successfully completed their treatment plan.

Participation in the Physicians' Diversion Program is voluntary. Anyone seeking help may phone Jerome Becker, Diversion Program Manager at the following numbers:

(916) 924-2561 (during office hours)
(916) 334-4669 (weeknights)
(415) 525-8682 (weekends)

CLASSIFICATION OF NSAIDs BY STRUCTURAL CLASS

ENOLIC ACIDS

OXICAMS	PYRAZOLES
Feldene (Piroxicam)	Butazolidin (phenylbutazone)
	Tandearil (oxyphenbutazone)

CARBOXYLIC ACIDS

SALICYLATES	ACETIC ACIDS	FENAMATES	PROPIONIC
*Aspirin, Easprin, Zorprin (acetylsalicylic acid)	Indocin (Indomethacin)	Meclomen (meclofenamate)	*Motrin, Rufen (ibuprofen)
*Disalcid (salsalate)	Clinoril (Sulindac)	Ponstel (mefenamic acid)	*Naprosyn (naproxen)
*Dolobid (diffunisal)	Tolectin (Tometin)		*Anaprox (naproxen sodium)
*Trilisate (choline magnesium trisalicylate)	*[Zomax (Zomepirac)]		[Oraflex (benoxaprofen)]
			*Nalfon (fenoprofen)

NEW CHANGES IN THE ENFORCEMENT PROVISIONS OF THE MEDICAL PRACTICE ACT

A number of changes in the enforcement provisions of the Medical Practice Act were made by a new bill signed into law by the Governor last August. Senate Bill 109 (Chapter 398) makes three changes, two of which will go into effect on January 1, 1984, and a third which will not be effective until 1985.

Effective January 1, 1984, judges will no longer have the ability to rule that notice of a malpractice award should not be reported to BMQA. Under SB 109, all awards or settlements over \$30,000 must be reported.

Also, effective next January 1, the law will make "repeated negligent acts" a violation of the Medical Practice Act. The effect of this is to eliminate legal hairsplitting over whether reported acts of negligence committed by a physician were "similar", a requirement specified under current law.

The final change gives the Division of Medical Quality new powers to deal with

negligence which is not "gross negligence" under the law, but which still is indicative of a possible problem with competency. As currently written, the Division would have the authority to require a physician to take a competency examination in cases where an investigation has found evidence of one or more violations. The evidence must be sufficient to establish "reasonable cause" to believe that a physician is incompetent, and a number of due process guarantees are written into the law.

This competency examination provision of SB 109 will not become effective until January 1, 1985. In the meantime, the Division of Medical Quality is directed to work with the California Medical Association and others in organized medicine to explore whether there are other better ways to deal with ordinary negligence. The Division is required to report its findings and recommendations to the Legislature by

March 1, 1984, so that it can act to modify the competency examination provisions, if need be, before they become effective. Meetings with representatives of organized medicine will begin in October and continue until the final report is prepared.

Under another new law effective January 1, 1984, the Board will be able to deny, suspend, revoke, or otherwise restrict a license on the ground that an applicant or licensee subverted, attempted to subvert, or in any way cheated on a licensing examination. Violation of examination security has been a serious and continuing problem. During the last two FLEX examinations administered in California, 48 examinees were ejected for various types of cheating, and a number of others suspected of copying had their tests subjected to statistical analysis, which confirmed that the suspect applicants had engaged in examination irregularities.

PHYSICIANS' AND PHARMACISTS' CORRESPONDING RESPONSIBILITIES IN PREVENTING PRESCRIPTION DRUG ABUSE

Appropriate prescribing depends upon open communication between the prescribing doctor and the dispensing pharmacist. When this communication is absent, prescription drug abuse and potential patient harm flourishes.

A combined task force of representatives from BMQA, California Medical Association, Board of Pharmacy, California Pharmacists Association, Bureau of Narcotic Enforcement, Drug Enforcement Agency and the Department of Health Services have drafted the corresponding responsibilities of physicians and pharmacists. Their recommendations will help prevent prescription drug abuse.

The BMQA has unanimously approved the task force's statement, and supports the implementation of its recommendations. In August the CMA Council also approved this statement.

BMQA approved statement by the Task Force on Prescription Drug Abuse:

Abuse of prescribed controlled substances is a problem of increasing magnitude, severity and concern in contemporary society. Since physicians prescribe and pharmacists dispense controlled substances, they each possess a very real potential for contributing to this drug abuse. Working cooperatively,

physicians and pharmacists possess a potential to curb the misuse, abuse and diversion of legitimate controlled substances.

Abuse potential determines how closely a drug's distribution is controlled by federal and state regulatory agencies. Even with this regulatory control, controlled substances are often obtained legally, but subsequently diverted to the illicit market, and pose a major problem for physicians, pharmacists and law enforcement agencies.

Traditionally, pharmacists have been the final professional link in the chain of drug distribution. In this position, they serve as the final safety check for the prescription drug consuming public and are mandated by statute and regulation to justify the safe, appropriate, and legal use of controlled substances.

Pharmacists are trained to be professionally competent, and have this legal responsibility to verify—often directly with the prescriber—not only the authenticity of the prescription, but that it has been issued for a valid medical reason. (Title 16, CAC Sec. 1761)

Therefore, while the physician has the responsibility for properly diagnosing a patient's condition and selecting the appropriate drug therapy, the pharmacist has the corresponding professional

and legal responsibility to authenticate the legality and safety of the prescription, especially in cases involving controlled substances. These authentications protect and thus benefit both prescribing physicians and dispensing pharmacists as well as the public at large.

Unfortunately, implementation of these authentication procedures may result in adversarial encounters between physicians and pharmacists. Physicians may resent pharmacists' apparent questioning of medical judgments and prescribing prerogatives. Similarly, pharmacists may resent physicians' apparent lack of cooperation in providing the prescription information necessary for authentication as required by law. Such adversarial relationships not only deter efforts to stem the growing abuse of legitimate controlled substances, but also exacerbates the problem. The task force believes that

these situations can and should be remedied at the community level by developing a functional day-to-day cooperation between practicing physicians and pharmacists.

The Task Force therefore recommends:

1. That physicians and pharmacists become fully aware of the laws and regulations governing the prescribing and dispensing of controlled substances.

2. That local medical societies and local pharmacists' associations establish standing liaison committees to address the matter of controlled substances abuse in their localities.

3. That these committees undertake such functions as:

a) Holding joint educational meetings on the appropriate use, as well

as misuse, of controlled substances.

b) Establishing a confidential peer review mechanism for physicians and pharmacists who find themselves in a position where the professional checks and balances are not functioning to prevent the inappropriate use of controlled substances.

c) Establishing formal lines of communication to federal and state regulatory agencies with the express purpose of identifying and correcting controlled substance misuse, abuse, or diversion.

The Task Force makes these recommendations with the firm conviction that the problem of controlled substance abuse can be best solved by physicians and pharmacists working cooperatively to exercise their corresponding legal and professional responsibilities.

**BMQA MEETINGS
SCHEDULED FOR 1984**

February 9 and 10—Anaheim
April 26 and 27—San Francisco
June 21 and 22—Sacramento
September 20 and 21—San Diego
November 15 and 16—Los Angeles

**WINTERS ELECTED
PRESIDENT OF DMQ**

At its September meeting in San Francisco, the Division of Medical Quality elected Ben Winters, Los Angeles, to serve as president. Mr. Winters is the first public member in the history of BMQA to be elected to this position.

BMQA RECOMMENDS CHANGE IN BASIC CPR TRAINING

Responding to the concerns of many doctors, the Division of Licensing of the BMQA at the September 22 meeting recommended a modification of the basic cardiopulmonary resuscitation (CPR) course required of all California physicians.

The Division of Licensing approved the deletion of mouth-to-mouth training on the practice manikin because of the possibility of a physician contracting a communicable disease.

With this modification, the Division reaffirmed its requirement that each physician at the time of license renewal shall certify that he or she possesses a current and valid certificate in basic cardiopulmonary resuscitation.

WAGSTAFF SELECTED NEW EXECUTIVE DIRECTOR OF BMQA

Kenneth Wagstaff was selected by the members of the Board of Medical Quality Assurance from among 225 candidates to be the new executive director. Wagstaff replaces Robert Rowland who resigned in May. The new director has been a deputy secretary for the Health and Welfare Agency and the director for the Department of Mental Health.

In addition, he has served as a consultant to the Assembly Health Committee where he supervised staff work on the legislation that created the Board of Medical Quality Assurance.

MEDICAL ASSISTANTS (Continued from Page 4)

licensed physician or podiatrist may train and certify a Medical Assistant. While there is a national certifying examination given by the American Association of Medical Assistants, the AAMA certificate is not required to prac-

tice in California.

Copies of the law and regulations outlining scope of practice and training requirements are available without charge from the Board. For additional information you may write or phone:

Division of Allied Health Professions
Board of Medical Quality Assurance
1430 Howe Avenue
Sacramento, CA 95825
(916) 924-2611

DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE
SACRAMENTO, CA 95825

Applications & Examinations (916) 920-6411
Continuing Education (916) 920-6353
Disciplinary Information (916) 920-6363
Fictitious Names (916) 920-6943
Verifications of Licenses (916) 920-6343
Allied Health Professions:
Acupuncture (916) 924-2642
Hearing Aid/Speech Pathology/Audiology
(916) 920-6377
Physical Therapy (916) 920-6373
Physician's Assistant (916) 924-2626
Podiatry (916) 920-6347
Psychology (916) 920-6383
Registered Dispensing Opticians
(916) 920-6336
Respiratory Therapy (916) 920-6336
Speech Pathology/Audiology
(916) 920-3388



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