

Action Report

Medical Board of California

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| IN THIS ISSUE | Consolidating Our Gains | 2 |
| | Task Force Hearings on Quality of Medical Review | 3 |
| Injured Workers and the Treating Physician: The New Law | 4 | |
| Specialty Board Regulations are Approved | 5 | |
| Pain Management | 6-7 | |
| Regulatory Agencies Ombudsmen | 8 | |
| Tuberculosis: Physician Responsibilities | 9 | |
| Committee Hearings to Implement Midwifery Program | 10 | |
| Disciplinary Actions | 11 | |

INSERT: BREAST CANCER

"Breast Cancer: Understanding Treatment Options"
Copies of this free insert are available from the Medical Board. Ordering information is on the back page of the insert.

IN APPRECIATION

The Medical Board of California acknowledges with respect and pride the hours of voluntary service rendered by its licensees to the citizens of Los Angeles following the Northridge earthquake of January 17, 1994.

1994
Medical Board of California
Meeting Dates/Locations
May 5-6 Sacramento
July 28-29 Los Angeles
November 3-4 San Diego

Working "Smart"

The Medical Board's Enforcement Priorities

A recent retrospective study of the Medical Board's disciplinary files of the past three years has provided the statistical basis for a detailed priority system of handling complaints, investigations and disciplinary actions in the future.

The study by Schubert & Associates, a medical quality review consulting firm headquartered in Sacramento, was previewed for the Board at its February meeting; the final report was delivered on March 1.

These and other indicators — a "snapshot" of recent files — are intended to be applied to complaints and investigations prospectively for the next year. The Board will evaluate the study and decide on prospective application of the study's "severity index" and "complaint profile" at its May meeting.

Schubert & Associates reviewed current priority systems in three other states and used 732 cases with disciplinary action and 303 cases which were closed from the California files in addition to consulting other sources such as the National Practitioner Data Bank and the specialty directories of the 24 ABMS boards.

Data elements analyzed included basic licensing information, sources of complaints, levels of harm to patients/complainants, disposition categories, licensure methods, specialties (self-identified), specialty certification, malpractice information, prior complaints/disciplines, reports from hospital peer reviews and out-of-State disciplinary actions.

Depending on the category of complaint, significant data elements included age, referral source, levels of harm, specialties, Board certification (or lack thereof), levels of insurance awards and prior disciplines. Perhaps the most significant data element was the disciplinary outcome (e.g. probation or revocation/suspension). Other elements which were factors but not so significant were gender, IMG/country of graduation, licensure method and prior complaints/discipline.

Professor of Statistics Doraiswamy Ramachandran of California State University, Sacramento, took the raw data and developed a "Risk Ranking System" of four groups by testing the design from a sample of cases against the full data base of 1,034 cases. Multiple discriminant analysis was used to identify which variables were key modifiers. From this a scoring scheme was developed.

Scores were assigned to the 732 disciplinary cases from 10.00 to 80.00. The mean score was 23.01

with a standard deviation of 10.74. Of the 89 cases that fell into the high risk group, 85.4% went on to revocation/suspension. Of the 240 cases that fell into the low risk group, only 25.9% went on to revocation/suspension. As an added cross-test, the same scoring model was applied to the 304 cases that were closed. Only 3.0% of those fell into the "high risk group".

"Thus," the study concludes, "the scoring scheme and the resultant risk grouping will assist investigative staff in expediting their decision-making by prioritizing the cases they have to pursue vigorously."

SOME OF THE MAJOR STATISTICAL FINDINGS ARE:

- In the most egregious categories of discipline, including criminal charges, the overwhelming majority of respondent physicians are not Board-certified.
- In sexual misconduct cases, it is the younger and older age groups that are disciplined more than the middle age group.
- Overall, the proportion of complaints involving international medical graduates as well as the proportion of actual disciplines involved, is consistent with their proportion among all California licensees.

THE MISSION OF THE MEDICAL BOARD OF CALIFORNIA

The mission of the Medical Board of California is to protect consumers through proper licensing of physicians and surgeons and certain allied health professions and through the vigorous, objective enforcement of the Medical Practice Act.

CONSOLIDATING OUR GAINS

by

Bruce Hasenkamp, J.D.
President of the Board

In 1991 it was SB 2375, otherwise known as Presley I (after the author, State Senator Robert Presley, D-Riverside). In 1993, after a year of turmoil in the media and unprecedented reforms voted by the Board, it was SB 916, the Medical Board Omnibus Reform Act, known as Presley II.

Now the Board is attempting to consolidate its position by asking the Legislature to enact SB 1775 — a refinement to last year's high water mark in Medical Board legislation. At the February meeting the Board approved "Presley II-A," a bill to further define responsibilities for providing records in malpractice cases, to add strength to sanctions for fraud and to make some important, but technical, changes in the administration of the law.

805 Disclosure

In addition the Board voted to reintroduce legislation which would provide for disclosure to the public, upon inquiry, certain reports to the Board of adverse peer review actions by hospital staffs (known as "805 Reports" after Section 805 of the Business & Professions Code that requires these reports be filed by hospitals to the Board). This provision was originally in last year's SB 916 but was amended out of the bill by the Senate Committee on Business & Professions after lobbying by the California Medical Association.

The CMA contended that disclosure of 805 reports would have a "chilling effect" on peer review actions by local hospitals. The Board contends that such a prediction assumes less intensity at local self-discipline than the CMA is willing to credit. The Board also insists that consumers/patients have the right to know, particularly when an errant physician has challenged a charge by his peers and been overruled — not by the Board but by his/her own peers.

"Shot Card" Legislation

In addition the Board voted to sponsor legislation that would specify new definitions of a "facility license" and "prescriptions" to cover omissions in the law that arose after an investigation by the Board of Pharmacy and the Medical Board into the so-called "shot card" practices at the Sacramento facilities of the Permanente Medical Group.

Permanente initiated an easier way to get routine injections, like flu shots, some years ago at several of its satellite

facilities. Over time the system, called "shot cards," evolved into use for those seeking relief from pain.

Last year a patient, Michelle Todd, who had sought treatment for migraine headaches, won a malpractice settlement with Permanente on the grounds that she had become addicted to

drugs because there was no central control to record the use of multiple Permanente facilities by patients and no requirement that patients using "shot cards" be seen on a regular basis by a physician. Todd's case was reported in the Sacramento media and on "NBC Nightly News." The suit was settled, without admission of wrongdoing by either side, for more than \$130,000.

Permanente made several promises to fix what was wrong with their good-idea-gone-bad. To date the promises have been kept. Now, for example, Sacramentans can go to only one Permanente facility where injections are given, and Permanente's computers containing prescription records are to be centralized.

But, Medical Board investigators found, even had they wanted to sanction Permanente, they wouldn't be able to, because out-posted "shot card" clinics were not defined in the law as places requiring separate licensing. Similarly the use of "shot cards" is not defined as a "prescription." Lack of definition means lack of enforcement. Thus, at the suggestion of experts in the Attorney General's Office, the Board acted. The Board's recommendations will be carried in a separate bill by Assemblywoman Julie Bornstein (D-Palm Desert).

Provisions of Presley II-A

Presley II-A (SB 1775) will tighten provisions in current law relating to reporting of malpractice settlements. Often managed care organizations and large medical centers will attempt to attract physicians to their staffs by indemnifying them against malpractice. Not only will they cover premiums, they will insure that part of any settlement is an agreement to remove the name of the defendant physician from the settlement record. Thus, the settlement goes against the institution, not the physician.

As a result of such a settlement, the malpractice insurer, under current law, does not have to report the settlement to the Board because, technically, no physician was named. Presley II-A (SB1775) will close that loophole.



Bruce Hasenkamp, J.D.

(Cont. on p. 3)

TASK FORCE HEARINGS ON QUALITY OF MEDICAL REVIEW

After four public hearings/meetings and hours of testimony, the Medical Board's Task Force on Medical Quality Review has ordered three more reports to be ready by May.

The February 2 Task Force hearing focused on the staff presentation of revised recommendations (to reflect testimony at the earlier hearings), the use of expert witnesses, and the role of the Board's current full-time, civil service medical consultant system.

Staff recommendations continued to reflect elements of a system adopted in Florida which provides for two types of panels to review cases — "Quality of Care" panels (composed of physicians) and "Probable Cause" panels (composed of a majority of physicians but including public members). The purpose of the panels is to serve as a focal point for the "presentation" of each case where, as appropriate, the investigative staff and the deputies attorney general (who act as the Board's lawyers) meet with medical advisors to evaluate the merits of each case.

Panels are not empowered to make decisions, thus no change in law would be necessary to adopt this system. The goal of the panels is to insure the quality of each case, particularly quality of care cases, and to provide more timely oversight. Medical "experts" would be used as they are now except that they would agree in advance of taking a case that they will see the case through to the courts if necessary and testify as expert witnesses.

The staff recommendation also includes requiring that any medical counsellor, be he/she a consultant or expert, paid or volunteer, must be Board-certified (or the equivalent in accord with the Board's new regulations governing medical

advertising) and be in active practice at least a fixed percentage of the time (to be determined by the Board's Division of Medical Quality).

In addition, the recommendations provide that each respondent's case will be reviewed by a consultant/expert who is the same specialty, where indicated, (using the 24 ABMS boards or the equivalent) but who practices in a geographic area different from the respondent so as to avoid any appearance of conflict.

“... each respondent's case will be reviewed by a consultant/expert who is the same specialty, where indicated ... but who practices in a geographic area different from the respondent so as to avoid any appearance of conflict.”

The staff recommendation to turn to consultants in active practice has caused particular controversy. Under the proposal, the present system of full-time, civil service consultants would give way to part-time counsellors/experts with different qualifications.

The Task Force received a progress report on March 23. The final reports are due by May 1. The reports are:

- A "desk audit" by an outside consultant expert in personnel studies to evaluate the tasks currently assigned to the Board's Chief Medical Consultant and the regional medical consultants, particularly with respect to the recruitment, retention and training of medical "experts",
- A study by the Health Quality Enforcement Section of the Office of the Attorney General to evaluate the performance of the Board's experts with particular attention to evaluating cases, if any, that were not pursued because the medical expert was a factor, and
- A staff analysis, including budget data, of various options of using "volunteer" physicians (some may be paid per diem and hourly rates) in roles as panelists, part-time consultants and/or medical experts.

CONSOLIDATING OUR GAINS (Cont. from p. 2)

Presley II-A will also provide that any physician who is convicted of a felony or pleads guilty or nolo contendere to a felony will lose his/her license automatically. Under present law a person judged guilty of murder and serving a life sentence (this is a real example featured on "60 Minutes") cannot have his/her license taken away until all appeals are exhausted. The Administrative Procedure Act does not consider them "convicted" until that time — which, of course, can take years.

While such a circumstance may not seem much of a threat inasmuch as the physician is in prison, consider other cases, such as one now in the news in southern California. It is the case of a physician convicted of possession for sale of a large quantity of narcotics. Because the physician has his case on appeal, we cannot conclude administrative action against his license. Under current law, he can continue to practice medicine. Presley II-A will remedy such situations. Finally, several provisions to tighten laws relating to fraud are included.

Injured Workers and the Treating Physician: The New Law

by Linda Rudolph M.D., M.P.H.

Medical Director, Division of Workers' Compensation,
California Department of Industrial Relations

"The treating physician knows the patient best. By using the treating physician's knowledge and expertise, we can help injured workers get through the system more quickly, and gain significant cost savings. Expanding the role of the treating physician in the workers' compensation system is one of the most important elements of the recent workers' compensation reform."

Governor Pete Wilson

Last fall, the California workers' compensation laws were changed in ways that may greatly affect your patients. Each year in California, over 450,000 workers suffer disabling on-the-job injuries. The primary role of the treating physician caring for these injured workers remains the same: helping the worker to recover with as little residual disability as possible and return to work. But as of January 1, 1994, the treating physician is also expected to play a significant and active role in the medical-legal process that determines the type and amount of benefits your patients will receive through the workers' compensation system.

Many physicians will find these new responsibilities challenging. This column attempts to provide an initial framework to help the treating physician understand the new requirements, and alert them to the availability of information resources.

The workers' compensation system is a complex medically driven legal system. Medical information, provided by physicians, controls key decisions about whether an injured worker is eligible for workers' compensation benefits.

Workers' Compensation Benefits

- all medical treatment that is reasonably required to cure or relieve the effects of a work-related injury or illness;
- temporary disability payments equal to about 2/3 of estimated wage loss;
- permanent disability payments for workers who suffer permanent impairment (including pain), loss of capacity, or restrictions which reduce the ability to compete for jobs in the labor market;
- future medical awards, for any treatment that may be required in the future as a result of the work injury;
- vocational rehabilitation, for "qualified injured workers" who cannot continue in their occupation but can be retrained for other employment; and
- death benefits for surviving dependents.

In workers' compensation, an injured worker files a claim to obtain benefits. Claims are handled by self-insured employers, or by workers' compensation insurance carriers

on behalf of employers. If all parties agree about the work-relatedness of the injury/illness, the nature of necessary medical treatment, and the length and extent of disability, the worker receives benefits and the case is closed. But in cases where any of these issues are disputed, the physician plays a key role in the dispute resolution process.

Under the old system, forensic medical specialists provided most of the medical information used to resolve disputes between insurers/employers and injured workers. But for injuries occurring after January 1, 1994, the new law requires the treating physician "to render opinions on medical issues needed to determine eligibility for compensation" benefits.

Questions for the Treating Physician

- Is the injury work related? Are the patient's work conditions or exposures reasonably likely to have contributed to the injury or illness?
- Can the patient return to work? If not, is modified work a possibility? The treating physician must provide very specific information about what the patient cannot do.
- Is the patient "permanent and stationary"? Has the injured worker reached maximum medical improvement, or been stationary for a reasonable length of time? If so, and the patient has not returned to the pre-injury level of function, the patient is permanent and stationary. At this point, temporary disability payments will end.
- What is the extent of permanent disability? The treating physician is now required to perform the initial disability examination, which evaluates the patient's subjective symptoms, physical findings, work restrictions, and loss of pre-injury capacity. Subjective factors of disability must be described thoroughly, properly using terms which have distinct legal meaning in the w.c. system. Work restrictions must be defined carefully and completely, including not only which aspects of the patient's old job cannot be done, but also those limitations which could affect a patient's ability to get any other job. Loss of pre-injury capacity must be assessed on the basis of what the individual patient could do, on and off the job, before the injury.
- Did the patient have a pre-existing disability? In some cases, if a worker had a disability before the current injury,

(Cont. on p. 15)

SPECIALTY BOARD REGULATIONS ARE APPROVED

by C. Fredrick Milkie, M.D., Member, Division of Licensing

1992 President of the Board

After almost four years since SB 2036 (McCorquodale) was passed, the Medical Board of California will begin accepting applications from specialty boards.

The law was enacted for the purpose of restricting physicians from advertising that they are "board certified" unless they were certified by an approved, bonafide specialty board. Author Senator Dan McCorquodale was concerned that members of counterfeit boards, that were only established for the purpose of advertising and not for any kind of training or genuine certification, were misleading the public by advertising they were "board certified."

Originally, the bill prohibited advertising as board certified unless the board was approved by the American Board of Medical Specialties (ABMS). After much negotiation, the law was amended to include two alternatives to define legitimate specialty boards; either the board has met requirements "equivalent" to ABMS and has been approved by the Medical Board of California or a complete curriculum in the specialty is approved by the Accreditation Council for Graduate Medical Education (ACGME).

The law itself did not specifically articulate a definition of "equivalent," leaving it up to the Medical Board to define it in regulation. It is important to note that the Board members and their staff at the time of its passage did not seek this legislation, and had voiced their concerns to the author that this would be an extremely arduous task.

The regulatory process has indeed been arduous, and the Board members involved have diligently worked to establish regulations that would be fair. It is no secret that there are genuine turf battles between specialty boards, and the Board members patiently listened to all of the public comment, taking all arguments into account.

The Board formed a subcommittee to look into the ABMS certification standards, and develop language for regulations that would protect the public from misleading advertising.

The Division held a number of public hearings, all well attended by those who would like the regulations to either include their board, or exclude others. Never have turf battles between specialties been more aptly demonstrated in public view. Some ABMS boards would have liked to exclude all other boards, and other boards, some genuine, and some not, were intent on having regulations that would include them.

Defining "equivalent" for the purpose of complying with SB 2036 was difficult. If defined as identical, as many of the ABMS boards would have had it defined, and not merely as equal value, then only ABMS boards would be approved. The law, however, did not restrict advertising to only ABMS boards; it could have, but it did not. Therefore, the law left open the possibility of approving some boards that are not ABMS approved.

It has been a long journey. In February, the Office of Administrative Law finally approved the Board's regulations to implement the law.

SUMMARY OF SB 2036 REGULATIONS

If a specialty board is not ABMS approved or there is no postgraduate training program accredited by ACGME, the regulations require:

- the primary purpose must be for certification in a medical specialty or subspecialty.
- must be a nonprofit corporation or association and have at least 100 members in at least one-third of the states.
- articles of incorporation, constitution, or charter and bylaws must meet specified minimum standards.
- must set standards for evaluating those certified to ensure they possess sufficient knowledge and skill to provide competent care in their specialty.
- 80% of the board's revenue must be from certification, examination, and membership fees and investment income.
- certified physicians must have a valid license to practice medicine from a jurisdiction in the United States.
- applicants must have satisfactorily completed a postgraduate training program accredited by the ACGME that includes identifiable training in the specialty, with the following

- exceptions: 1) Where training is other than ACGME accredited, the board must set training standards that include identifiable training in the specialty (the Medical Board's Division of Licensing must find this training to be equivalent in scope, content and duration) or: 2) In lieu of the postgraduate training, require a minimum of six years of full-time teaching or practice and at least 300 hours of continuing medical education in the specialty.
- must show that one or more postgraduate training programs exist providing identifiable training in the specialty.
- must require a written or oral examination which tests applicants' knowledge and skills in the specialty. The examination must be a minimum of 16 hours.
- must issue certificates to those physicians who meet their requirements.
- must assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training, and have a mechanism for assisting accrediting agencies in the evaluation of training programs.

CLINICAL PRACTICE GUIDELINES: CANCER PAIN MANAGEMENT

Pain control remains a significant problem for cancer patients despite evidence that most cancer pain can be managed effectively.

The Federal Agency for Health Care Policy and Research (AHCPR) released Clinical Practice Guidelines in March 1994. The Guideline presents strategies for managing general and specific cancer pain syndromes. It also addresses cancer pain management in children, the elderly, HIV/AIDS patients, and substance abusers. In addition to the *Clinical Practice Guideline for the Management of Cancer Pain*, there is a "Quick Reference Guide" in summary form for practitioners. Consumer education booklets are available for both adults and children with cancer and pain.

Single copies and limited bulk supplies of each publication are available free of charge, and can be ordered by calling the National Cancer Institute's Cancer Information Service at 1-800-4CANCER.

The implementation of current knowledge about pain management would greatly improve the quality of life for many California citizens. The Medical Board recognizes that the AHCPR Clinical Practice Guidelines and consumer information provide a solid and rational approach to pain management and encourages practitioners and patients to obtain and use these materials.



Photo by Rick Wallinder

CLINICAL PRACTICE GUIDELINES: ACUTE PAIN MANAGEMENT

Unrelieved pain is a problem for about half of all postoperative patients. The result is unnecessary discomfort, longer recovery periods and greater use of scarce resources.

The Federal Agency for Health Care Policy and Research (AHCPR) has published a series of Acute Pain Management Guidelines for clinicians and patients: 1) *Clinical Practice Guideline for Acute Pain Management: Operative or Medical Procedures and Trauma*; 2) *Quick Reference Guide for Acute Pain Management in Adults: Operative Procedures*; 3) *Quick Reference Guide for Acute Pain Management in Infants, Children, and Adolescents: Operative and Medical Procedures*; and 4) *Pain Control After Surgery, A Patient's Guide*. These

booklets may be obtained by calling the AHCPR at 1-800-358-9295.

The AHCPR was established in 1989 to improve the quality, appropriateness, and effectiveness of health care; it pursues this mission through the development and dissemination of clinical practice guidelines and consumer information, and by sponsoring patient outcome research.

Clinical practice guidelines are developed by private-sector panels of physicians, nurses, pharmacists, psychologists and consumers under the Agency's sponsorship. The guidelines are the result of a thorough examination of the research literature, peer review, and field testing. The Medical Board encourages you to use these resources.

SUMMIT ON EFFECTIVE PAIN MANAGEMENT: REMOVING THE IMPEDIMENTS TO APPROPRIATE PRESCRIBING

The Wilson Administration sponsored the "Summit on Effective Pain Management: Removing the Impediments to Appropriate Prescribing" on March 18, 1994 in Los Angeles. The Medical Board cosponsored the Summit.

The State of California recognizes that effective pain management, including the use of controlled substances, is essential to the health and welfare of its citizens. While prevention of prescription drug-related fraud and abuse is a priority, the state seeks to ensure that no law, regulation, policy or practice interferes with the availability of controlled substances to patients for legitimate medical purposes.

The purpose of the Summit was to identify the barriers to effective pain management (both real and perceived) in order to achieve a positive and consistent regulatory environment. The Summit was devoted to effective pain management and removing barriers to appropriate prescribing; issues pertaining specifically to improving the state's response to drug diversion are being addressed by other groups.

The Summit began with speaker Richard Payne, M.D., (Chief of Pain and Symptom Management, Department of Neuro-oncology, University of Texas M.D. Anderson Cancer Center, Houston; Co-Chair, Cancer Pain Guideline Panel of the U.S. Agency for Health Care Policy and Research (AHCPR); and member, AHCPR Acute Pain

Management Guideline Panel) who explained the significant advances in pain management in the last 15 to 20 years, the extent to which pain is under-treated in the U.S., and how the under treatment of pain affects patients, families and the health care system. He also spoke on the relationship of unrelieved pain to the growing interest in assisted dying, the appropriate role of opioids and other controlled substances in the treatment of acute cancer and non-cancer pain. He talked about addiction/drug dependence when opioids are used to manage pain, and what the barriers to pain management are, in particular those relating to the regulation of professional practice and controlled substances.

Other issues discussed at the Summit included: the consumer perspective on pain management; the impact of the triplicate prescription program; laws and regulations of other controlled substances; regulatory and law enforcement policy and procedures; timely availability of opioids in different care settings; knowledge and attitudes of patients and the public; and knowledge and attitudes of licensed health care professionals.

Betty A. Ferrell, R.N., Ph.D., FAAN, (Research Scientist, Nursing Research and Education Program, City of Hope National Medical Center; member of the AHCPR Acute Pain Management Guideline Panel and the Clinical Guideline Panel for Management of Cancer Related Pain) gave a presentation about the crucial need for pain management.

CONTROLLED SUBSTANCES ACT

The Drug Enforcement Administration (DEA) provides copies of their *Physician's Manual* to assist in understanding the provisions of the Controlled Substances Act and the regulations. The booklet will answer questions you may encounter in your practice and will give guidance on complying with the regulations.

The sixth edition of the *Physician's Manual* is available from your local DEA Office. For your reference, the telephone numbers of the various DEA Offices are provided below:

| | |
|--------------------|----------------|
| Fresno area | (209) 487-5402 |
| Los Angeles area | (213) 894-4016 |
| Riverside area | (909) 276-6001 |
| Sacramento area | (916) 978-4949 |
| San Diego area | (619) 585-4236 |
| San Francisco area | (415) 556-3325 |

Finally, the Summit participants discussed the recommendations, which were grouped into four areas:

- 1) board policy and disciplinary practice,
- 2) regulation and legislation,
- 3) consumer and professional education, and
- 4) other recommendations.

The audience provided comments which were read to the Summit participants.

A written record of the Summit proceedings is available by written request to Lowayne Shieh, Chief of Consumer Services, Department of Consumer Affairs, 400 R Street, Sacramento, CA 95814.

A draft copy of the Medical Board's policy statement and guidelines on appropriate prescribing were presented as part of the materials for the Summit. The draft documents will be discussed at the Board's May 6, 1994 meeting in Sacramento and, if acceptable to the members, will be adopted and then distributed to physicians and surgeons in the next "Action Report".

REGULATORY AGENCIES OMBUDSMEN — QUALITY OF CARE DEMONSTRATION PROJECT

by Tom Heerhartz,

former Assistant Executive Director of the Medical Board,
Regional Administrator for Health Services, Department of Corrections

Representatives of nine State regulatory agencies, seven local Ombudsmen Coordinator/Managers and staff in the Office of the State Long-Term Care Ombudsman have just concluded a 12 month Demonstration Project that challenged them to develop strategies to improve the effectiveness with which Ombudsmen complaints are referred to appropriate state regulatory agency(ies) and the efficiency with which these regulatory agencies handle the complaints.

The State Long-Term Care Ombudsman Program, located in the California Department of Aging, has the responsibility of advocating for residents in skilled nursing facilities, intermediate care facilities, adult day health care centers, adult residential facilities, and residential care facilities for the elderly.

Approximately 1,000 sub-state Ombudsmen work under the supervision of 35 Ombudsmen Coordinator/Managers in providing advocacy services to more than 150,000 residents living in over 7,000 facilities. An average of 47,000 complaints are investigated annually. These complaints are received when Ombudsmen visit long-term care facilities or through the statewide toll free CRISISline (1-800-231-4024). Almost 90% of the complaints are resolved by the Ombudsmen at the local level. Approximately 7,000 complaints are referred annually to local agencies and State licensing agencies (facility and health personnel) because they are very complex or require investigation by agencies that have legal/jurisdictional responsibility to handle situations that place residents at risk.

The Demonstration Project Committee successfully developed a *Long-Term Care Ombudsman Resource Manual* to inform Ombudsmen about the various state regulatory agencies involved in the care of residents in long-term care settings. These agencies include health personnel licensing boards, facility licensing programs, and the Bureau of Medi-Cal Fraud, Attorney General's Office in the Department of Justice.

The health personnel licensing boards involved in the Demonstration Project were the: Medical Board of California, Board of Registered Nursing, Physician Assistant Examining Committee, Board of Vocational Nurse and Psychiatric Technician Examiners, Board of Examiners of Nursing Home

Administrators, and Board of Pharmacy. The facility licensing programs were the Licensing and Certification Program located in the Department of Health Services and the Community Care Licensing Division in the Department of Social Services.

A special complaint form was also developed to facilitate sharing of important information between Ombudsmen and the regulatory agencies. This form, called the *Complaint From Long-Term Care Ombudsman*, identifies the various agencies receiving the same complaint and will help them coordinate their investigative activities. This increase in efficiency can potentially result in cost savings.

For more information about this Demonstration Project, contact Linda Scott in the Office of the State Long-Term Care Ombudsman, California Department of Aging, 1600 K Street, Sacramento, CA 95814, at (916) 323-6681.



Tom Heerhartz

Physician Alert:

REPORT HEALTH EFFECTS OF PESTICIDES PROMPTLY

Help California maintain our leadership in pesticide safety and stay in compliance with Health and Safety Code section 2950 by phoning in notification. Every reported case of pesticide poisoning in California is investigated by county agricultural commissioners — even when the pesticide involved is on chlorine bleach for controlling microbes. The results of these investigations are compiled in annual reports available from the Worker Health and Safety Branch of the Cal/EPA Department of Pesticide Regulation, 1020 N Street, Sacramento, CA 95814. PLEASE HELP make reporting complete and accurate by notifying your local health officer any time you see such a case.

Your county agricultural commissioner has a list of the telephone numbers designated by the health officers of each jurisdiction to receive these notifications.

— CAL EPA

TUBERCULOSIS: PHYSICIAN RESPONSIBILITIES IN RESPONDING TO THE NEW EPIDEMIC OF AN ANCIENT DISEASE

by Hildy Meyers, M.D., M.P.H.

Epidemiologist, Orange County Health Care Agency

The likelihood that a physician in California will see a patient with tuberculosis (TB) is increasing. TB has been rising in the United States since the mid-1980s. In California, TB cases increased 54% from 1985 to 1992 to a rate of 17.2 cases of TB per 100,000 population, the third highest rate in the United States. Drug-resistant TB has become a serious problem in some areas. Early diagnosis (including a sputum smear for acid-fast bacilli (AFB) and culture and sensitivities), immediate reporting to the local health department, and appropriate treatment of TB are critical to interrupting continued transmission of TB.

In response to the resurgence of TB, changes in the legal reporting requirements concerning suspected and confirmed cases of TB by physicians have been made, effective January 1, 1994. The law requires physicians and other health care providers to report promptly to the local health officer when there is a reasonable suspicion of active TB, before discharge from a hospital or penal institution, and when a person ceases treatment for TB. When reporting a case of TB, you must include an individual treatment plan and pertinent clinical and laboratory information, including drug susceptibility results when they become available.

It is crucial to involve the local health department, by reporting and consultation, to prevent the spread of TB. The department will perform contact investigations, provide instructions on isolation with enforcement measures, follow-up TB patients, assist with directly observed therapy and provide data on the incidence of TB and drug susceptibility patterns in your county. All of this depends on physicians fulfilling their legal responsibilities in reporting known or suspected TB cases.

A recent outbreak of TB in a high school in Orange County illustrates the need for rapid diagnosis with sputum smears for AFB, prompt reporting, culture results with drug sensitivities, and appropriate treatment.

Following reports of several cases of TB with a similar drug-resistance pattern at one high school, an investigation by multiple agencies found 13 outbreak-related cases. The following factors contributed to this large outbreak: The index case had been symptomatic with an illness consistent with TB since January 1991 but was not diagnosed with TB until February 1992. This failure to diagnose TB resulted in

prolonged exposure of contacts in the household, in the school, and elsewhere in the community.



Hildy Meyers, M.D., M.P.H.

Failure to promptly report the index case to the local health department resulted in inadequate isolation and delayed the contact investigation, further contributing to the spread of TB. The practice of using bronchoscopy to establish the diagnosis without also doing sputum smears for AFB impeded the assessment of infectiousness of several cases. Treatment of cases without obtaining cultures and drug sensitivities prevented earlier recognition of the outbreak strain. Inadequate drug regimens resulted in prolonged infectiousness. Lack of follow-up sputum smears after the

institution of treatment resulted in an unknown period of communicability and an inability to assess early treatment response. **Failure to obtain follow-up cultures during the course of therapy to demonstrate successful eradication of organisms may have resulted in inadequate treatment.**

Physicians must maintain a high level of suspicion for TB. TB should be suspected whenever a patient presents with symptoms consistent with TB: unusual fatigue for more than two weeks, unintentional weight loss, persistent cough for more than two weeks, blood-streaked sputum, fever associated with cough for more than one week, night sweats.

Persons at higher risk for TB include: foreign-born persons from areas of high TB prevalence (e.g. Asia, Africa, Latin America, eastern Europe), close contacts of infectious cases, persons with HIV infection, medically underserved low-income populations, persons with medical risk factors known to increase the risk of disease, alcoholics and injection-drug users, prison inmates, etc.

Single-drug treatment is **NEVER** indicated for known or suspected TB disease. Because susceptibilities are usually not known when treatment is initiated and because of the possibility of drug-resistant TB, initial therapy with four drugs is recommended.* In patients who may not be compliant with their medications, directly observed therapy is indicated.

Your local health department can provide additional information and recommendations, including new TB treatment guidelines.

* MMWR 1993; 42(No. RR-7);1-8.

COMMITTEE HEARINGS TO IMPLEMENT MIDWIFERY PROGRAM

On February 3, 1994 the Division of Licensing was given an update on the progress made in implementing the Licensed Midwifery Act (SB 350, Killea, Chapter 1280, Statutes of 1993). Doug Laue, Assistant Executive Director, provided the division with a summary of staff's analysis of the bill:

- there are two pathways/methods to qualify for licensure: 1) graduation from a three-year accredited program, or 2) licensure in another state with equivalent standards;
- there are two ways to graduate from an accredited program: 1) complete the three-year program, or 2) pass the proficiency and practical challenge examinations;
- the Board must adopt licensing fees;
- the Board must adopt the written examination required for licensure by July 1;
- the Board must determine and approve out-of-state programs that meet California standards;
- the Board must approve clinical and educational experiences required for the challenge provisions; and
- the Board must determine continuing education requirements.

Laue presented an aggressive plan to implement the provisions of the bill. This plan calls for the division to hear

various regulations (fees, definitions, standards, etc.) at each of its remaining 1994 meetings. In addition, the division must review and approve the application form and adopt those items listed above.

To accomplish this task in the time frames proposed, Board staff recommended that the division establish a two-member committee to work with staff in the development of the program.

The division voted to establish a Midwifery Committee to oversee the implementation of the program. Board members Stewart Hsieh, J.D. and Thomas Joas, M.D. were appointed to the committee. The California Medical Association, Senator Killea's office and representatives from the midwifery community agreed to assist the committee.

The committee held its first meeting on March 1. Topics discussed included: draft regulations on fees and definitions of terms; a survey and matrix to be used to determine if other states' programs meet equivalency requirements; the proposed application package; programs offered by educational institutions; and testing firms that may offer a licensing examination for California. The next meeting is scheduled for April 4 in San Francisco.

Those seeking additional information or who wish to be placed on the interested parties mailing list may write to: Tony Arjil, Program Manager, Medical Board of California, Division of Allied Health, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.

ACCOLADES!



At the Board's February 4 meeting, 1993 Board President Jacquelin Trestrail, M.D. was presented with a gavel that read: "A huge gavel...for a year of huge achievement."



Photos by Rick Wallinder

Where would the world be without its cadre of veteran employees? Such a person is Billie Harris, who retired March 1 after 18 years as the Medical Board's Executive Secretary. In that span of time she worked for six Directors.

DISCIPLINARY ACTIONS: NOVEMBER 1, 1993 TO JANUARY 31, 1994

DECISIONS-PHYSICIANS AND SURGEONS

AGUILAR, DOLORES, M.D. (A-22762) Los Angeles, CA
2234 (b) B&P Code—Gross negligence in obstetrical care and management of existing pregnancy. Unwilling to be on probation. Revoked. December 17, 1993.

ALTIG, DONALD, M.D. (A-20838) Huntington Beach, CA
2234(b) B&P Code—Stipulated decision. Gross negligence in anesthesiology practice, failed to adequately oxygenate and ventilate the patient post-arrest. Revoked, stayed, 3 years' probation on terms and conditions. November 21, 1993.

BARBIERI, JOAN, M.D. (A-38423) Anahelm, CA
2305, 2234 (a) B&P Code—Disciplined by Rhode Island Board for aberrations from good medical practice. Also, made false statement in D.E.A. renewal application concealing the above discipline. Revoked, stayed, 5 years' probation on terms and conditions. January 5, 1994.

BOLLENGIER, WILLIAM E., M.D. (G-20991) Vincennes, IN
2234 (b),(c) B&P Code—Gross negligence in failing to perform re-exploratory surgery to rule out cardiac tamponade. Also, repeated negligent acts in cardiothoracic practice. Revoked, stayed, 3 years' probation on terms and conditions. November 14, 1993.

BURGARD, JAMES K., M.D. (C-34368) Aptos, CA
2234 (b), (e), (d), 2236 B&P Code—Stipulated Decision. Convictions for driving under the influence of alcohol. Also, gross negligence, repeated negligent acts and incompetence in OB/GYN practice. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. January 28, 1994.

CHARLES, JAMES D., M.D. (A-12799) Redding, CA
725, 2242 B&P Code—Prescribing controlled drugs excessively and without good faith prior examination and medical indication therefor. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. December 20, 1993.

DALLMAN, JAMES, M.D. (G-53600) Waynesville, MO
2305 B&P Code—Disciplined by U.S. Army for wrongful distribution of controlled substance prescriptions. California: Revoked. Default. November 26, 1993.

FOSTER, KENNETH W., M.D. (G-42475) Holdenville, OK
2234 (e), 2261, 2305 B&P Code—Violated probation of prior discipline. False statements in applications. Disciplined by Louisiana Board for false application. California: Revoked. Default. November 26, 1993.

GARCIA, FRANCISCO, M.D. (A-30484) Reedley, CA
2234(b) B&P Code—Stipulated Decision. Gross negligence in failing to come to the hospital to see and assess his 83 year-old patient within two hours after receiving a phone call from the hospital concerning the patient's condition. Revoked, stayed, 5 years' probation on terms and conditions. November 26, 1993.

GARDUNO, LEONARDO, M.D. (A-33758) Irvine, CA
2234 (e), 2261 B&P Code—Stipulated Decision. Dishonesty in making false statements in hospital application. Revoked, stayed, 5 years' probation on terms and conditions. November 26, 1993.

GERTZ, EDWARD W., M.D. (G-26476) Paradise Valley, AZ
2305 B&P Code—Disciplined by Arizona Board. California: Revoked. Default. November 26, 1993.

(Cont. on p. 12)

EXPLANATION OF DISCIPLINARY LANGUAGE

1. "Revoked"—The license is canceled, voided, annulled, rescinded. The right to practice is ended.

2. "Revoked - Default"—After valid service of the Accusation (formal charges), the licensee fails to file the required response or fails to appear at the hearing. The license is forfeited through inaction.

3. "Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' suspension"—"Stayed" means the revocation is postponed, put off. Professional practice may continue so long as the licensee complies with specified probationary terms and conditions, which, in this example, includes 60 days' actual suspension from practice. Violation of probation may result in the revocation that was postponed.

4. "Suspension from practice"—The licensee is benched and prohibited from practicing for a specific period of time.

5. "Temporary Restraining Order"—A TRO is issued by a Superior Court Judge to halt practice immediately. When issued by an Administrative Law Judge, it is called an ISO (Interim Suspension Order).

6. "Probationary Terms and Conditions"—Examples: Complete a clinical training program. Take educational courses in specified subjects. Take a course in Ethics. Pass an oral clinical exam. Abstain from alcohol and drugs. Undergo psychotherapy or medical treatment. Surrender your DEA drug permit. Provide free services to a community facility.

7. "Gross negligence"—An extreme deviation from the standard of practice.

8. "Incompetence"—Lack of knowledge or skills in discharging professional obligations.

9. "Stipulated Decision"—A form of plea bargaining. The case is negotiated and settled prior to trial.

10. "Voluntary Surrender"—Resignation under a cloud. While charges are pending, the licensee turns in the license—subject to acceptance by the relevant Board.

11. "Probationary License"—A conditional license issued to an applicant on probationary terms and conditions. This is done when good cause exists for denial of the license application.

12. "Effective date of Decision"—Example: "January 8, 1994" at the bottom of the summary means the date the disciplinary decision goes into operation.

13. "Judicial Review recently completed"—The disciplinary decision was challenged through the court system—Superior Court, maybe Court of Appeal, maybe State Supreme Court—and the discipline was upheld. This notation explains, for example, why a case effective "June 10, 1990" is finally being reported for the first time four years later in 1994.

DISCIPLINARY ACTIONS (Cont. from p. 11)

GRINBERG, MICHAEL, M.D. (G-35143) San Diego, CA
2236 B&P Code—Conviction for soliciting murder. Revoked.
January 21, 1994.

GUTSTEIN, ROBERT A., M.D. (G-15434) Agoura Hills, CA
490, 2236 B&P Code—Conviction for securities fraud, wire fraud
and conspiracy. Revoked, stayed, 5 years' probation on terms and
conditions. December 17, 1993.

KLVANA, MILOS, M.D. (A-29719) San Luis Obispo, CA
490, 2236, 2234 (a),(b),(c) B&P Code—Convictions for second
degree murder in connection with the deaths of nine infants in home
deliveries. Among other failings, repeatedly administered Pitocin
improperly. Insurance fraud. Prior discipline. Revoked. January 15,
1994.

LEIVA, DANIEL B., M.D. (A-16211) Cupertino, CA
Violated probationary conditions of prior discipline. Revoked.
Default. January 22, 1994.

LINDEN, ZENA, M.D. (G-4971) Los Gatos, CA
Violated probationary conditions of prior discipline. Revoked.
Default. December 4, 1993.

LOCKE, ROBYNNE M., M.D. (G-57529) Modesto, CA
2234 (b),(c) B&P Code—Gross negligence and repeated negligent
acts in anesthesiology practice. Revoked, stayed, 5 years' probation
on terms and conditions. January 7, 1994.

LOFTHOUSE, WILLIAM E., M.D. (G-5864) San Mateo, CA
2234 (b) B&P Code—Stipulated Decision. Gross negligence in
dispensing Anafranil to a patient taking Nardil, resulting in an
adverse drug interaction and death. Revoked, stayed, 5 years'
probation on terms and conditions, including 45 days' actual
suspension. January 5, 1994.

LONERGAN, TAD E., M.D. (A-19156) Glendale, CA
2237 B&P Code—Conviction of three counts of prescribing
controlled substances to person not under treatment for pathology
or condition. Revoked, stayed, 5 years' probation on terms and
conditions. January 1, 1994.

MAHAYNI, AHMAD, M.D. (A-36427) San Clemente, CA
2305 B&P Code—Stipulated Decision. Disciplined by Florida
Board based on revocation of military clinical privileges.
California: Revoked, stayed, 5 years' probation on terms and
conditions. January 21, 1994.

McBAY, MICHAEL, M.D. (G-63748) Hollywood, CA
2238, 2239 (a), 2354 B&P Code—Self use of controlled substances.
Failed to complete diversion treatment program. Revoked, stayed, 5
years' probation on terms and conditions, including 60 days' actual
suspension. November 19, 1993.

McMILLAN, LEMMON, M.D. (C-34897) Venice, CA
2234 (b),(c),(d) B&P Code—Stipulated Decision. Gross negligence,
repeated negligent acts, and incompetence in obstetrical practice. 30
days' suspension, stayed, 3 years' probation on terms and
conditions. January 21, 1994.

MESSER, SIDNEY, M.D. (C-6210) Los Angeles, CA
725, 2242, 2234 (b),(c),(d) B&P Code—Treated patient over the

years with a variety of drugs, vitamins and therapy under medical
diagnosis not supported by lab findings, radiologic evaluations, or
objective clinical evidence. Excessive treatment, gross negligence,
repeated negligence, incompetence. Revoked. December 4, 1993.

MOTLAGH, FRANK, M.D. (A-33135) San Diego, CA
2234 (c) B&P Code—Stipulated Decision. Repeated negligent acts
in leaving a chest retractor blade in the body after a lobectomy, and
failing to review the radiologist's material carefully. Revoked,
stayed, 5 years' probation on terms and conditions. November 19,
1993.

RANESES, JOVENCIO L., M.D. (C-37687) Anaheim Hills, CA
490, 725, 2234 (b),(c) B&P Code—Conviction for prescribing
Dilaudid not for legitimate medical purposes. Excessive and
indiscriminate prescribing of the narcotic Dilaudid for his Dilaudid
treatment program demonstrates incompetence and gross
negligence. Revoked, stayed, 8 years' probation on terms and
conditions, including 60 days' actual suspension. December 15,
1993.

ROSS, GAIL, M.D. (A-31936) Downey, CA
2234(c) B&P Code—Stipulated Decision. Repeated negligent acts
in psychiatric practice in failing to make timely hospital visits and
failing to make timely entries in hospital charts. Revoked, stayed, 5
years' probation on terms and conditions, including 30 days' actual
suspension. November 29, 1993.

SAAL, BRUCE MARSHALL, M.D. (C-35248) Los Gatos, CA
2234(b) B&P Code—Gross negligence in dermatology practice.
One year suspension, stayed, 3 years' probation on terms and
conditions. October 15, 1993.

SAINZ, GILBERT, M.D. (C-31264) Sacramento, CA
725 B&P Code—Sexual relations with a patient. Revoked, stayed, 7
years' probation on terms and conditions. December 31, 1993.

SANDLER, MAURICE, M.D. (G-22522) San Pablo, CA
495, 2227 B&P Code—Stipulated Decision. Inadequate and
incomplete diagnosis and examination of urology patient
complaining of blood in urine. Public Reprimand. January 4, 1994.

TAMPOYA, POTENCIANO, M.D. (C-38085) Glendale, CA
725, 2234(b),(c),(d),(e), 2236, 2262 B&P Code—Stipulated
Decision. Conviction for 9 counts of violating statutes regulating
controlled substances. Excessive and indiscriminate prescribing to
abusers and addicts. False document. Revoked, stayed, 5 years'
probation on terms and conditions, including actual suspension until
criminal probation is terminated. January 28, 1994.

TAY, ALFRED BENG, M.D. (A-25394) Anaheim, CA
2234(b),(c),(d) B&P Code—Gross negligence, repeated negligence
and incompetence in the management of 6 pregnancies before,
during or after delivery of infants. Revoked, stayed, 10 years'
probation on terms and conditions. December 31, 1993.

VANGSGARD, GERALD E., M.D. (A-22092) Carmel, CA
2234(e), 2236 B&P Code—Stipulated Decision. Conviction for
multiple fraudulent Medi-Cal claims for payment. Revoked, stayed,
8 years' probation on terms, including 2 years' actual suspension.
January 27, 1994.

(Cont. on p. 13)

DISCIPLINARY ACTIONS (Cont. from p. 12)

WARIN, ADUL, M.D. (A-30044) Upland, CA
2234(b) B&P Code—Gross negligence in the care and surgery of two patients. Revoked. Default. November 22, 1993.

WARREN, M. CHARLES, M.D. (G-31571) Riverside, CA
2234, 2236 B&P Code—Conviction for trespass, related to lewd conduct in a public park restroom. Revoked, 3 years' probation on terms and conditions. January 1, 1994.

WEINTRAUB, JOSEPH, M.D. (C-33123) Santa Cruz, CA
2234, 2236, 2242 B&P Code—Stipulated Decision. Conviction for prescribing Codeine, a controlled substance, for a person not under his treatment for a pathology or condition. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. January 28, 1994.

WILLIAMS, SAM JR., M.D. (C-24782) San Diego, CA
2237, 2242 B&P Code—Stipulated Decision. Conviction for prescribing controlled substances (Fastin, Prelu-2, Tylenol with Codeine) without legitimate medical purpose. Revoked, stayed, 10 years' probation on terms and conditions, including 30 days' actual suspension. November 19, 1993.

ZAKRZEWSKI, TADEUSZ, M.D. (A-25638) Phoenix, AZ
2305 B&P Code—Disciplined by Arizona for excessive diagnostic procedures with no scientific or medical justification; for charging excessive fees, and for fraud. California: Revoked. Default. November 18, 1993.

ZANE, JOHN, M.D. (C-20382) Palm Springs, CA
2234(b),(d),(e), 2242 B&P Code—Diagnosis and injections of a secret formula (nutritional therapy) claimed to cure serious illnesses at a cost of \$36,000 for 24 shots, without taking a history, without doing a good faith physical exam, without establishing medical indication for the shots, without maintaining medical records, constitutes gross negligence, incompetence and dishonesty. Prior discipline. Revoked. January 17, 1994.

CORRECTION

In the last "Action Report", the description of the offense in the JOHN DIN, M.D. case was incorrectly summarized. Here is the corrected summary:

DIN, JOHN, M.D. (A-18979) Sacramento, CA
2234(b) B&P Code—Stipulated Decision. Gross negligence in the performance of gynecological examination. Revoked, stayed, 7 years' probation on terms and conditions, including 60 days' actual suspension. October 1, 1993.

ACUPUNCTURISTS

KIM, SOO BONG, C.A. (AC-1292) Norwalk, CA
4935, 4955(f) B&P Code—Stipulated Decision. Allowed his unlicensed son to practice acupuncture at his clinic. Revoked, stayed, 5 years' probation on terms and conditions. November 29, 1993.

LEE, THOMAS GIN-SING (AC-2254) Glendale, CA
490, 4955(d) B&P Code—Stipulated Decision. Conviction for Medi-Cal fraud. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. October 25, 1993.

HEARING AID DISPENSERS

CANNEDY, RONALD, H.A.D. (HA-1807) Petaluma, CA
651, 3401(i) B&P Code—Stipulated Decision. Misleading advertising. Revoked, stayed, 3 years' probation on terms and conditions. December 20, 1993.

LATTA, DONALD, H.A.D. (HA-2748) San Diego, CA
490, 3401(d) B&P Code—Conviction for trespass, related to taking \$106 shoes from department store without paying. Revoked. Default. December 20, 1993.

RUIZ, MIGUEL ANGEL, H.A.D. (HA-2446) Sun City, CA
3401(g) B&P Code—Fraud or misrepresentation in the fitting and selling of hearing aids. Revoked. Default. December 20, 1993.

PHYSICAL THERAPISTS

BLACK, JAMES LEROY, P.T.A. (AT-3319) San Jacinto, CA
2660(d) B&P Code—Stipulated Decision. Conviction for attempted burglary in 1985. Conditional PT license issued on 3 years' probation on terms and conditions. December 15, 1993.

CASTRO, CIPRIANO, R.P.T. (PT-6752) Alta Loma, CA
490, 2660(d) B&P Code—Conviction for lewd acts upon a child. Revoked, stayed, 10 years' probation on terms and conditions. December 31, 1993.

PARAMORE, SANDRA D., R.P.T. (PT-6649) Los Angeles, CA
490, 2660(d), 2261 B&P Code—Stipulated conviction for transportation and sale of PCP (Phencyclidine). Revoked, stayed, 3 years' probation on terms and conditions, including 60 days' actual suspension. December 3, 1993.

STRAFACI, THOMAS FRANK, P.T.A. (AT-346) Covina, CA
581, 582, 2630, B&P Code—Stipulated Decision. Physical Therapy Assistant criminally convicted of holding himself out as a Registered Physical Therapist. His PT Assistant license is revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. November 28, 1993.

THOMAS, DAVID KEITH, R.P.T. (PT-12236) Folsom, CA
726, 22660(h)(1) B&P Code—Stipulated Decision. Sexual misconduct during physical therapy. Stipulated order for monitoring and admonishment. January 28, 1994.

PHYSICIAN ASSISTANTS

GLAZIER, FREDERICK M., P.A. (PA-12159) Prunedale, CA
3527(a), 4149 B&P Code—Stipulated Decision. Unlawful possession of hypodermic needle and syringe. Revoked, stayed, 3 years' probation on terms and conditions. January 7, 1994.

LAHEY, JOHN JEROME, P.A. (PA-11366) Laguna Niguel, CA
3529, 3527(a), 2262, 2234(e)—Stipulated Decision. PA impersonating a physician, particularly for improperly prescribing drugs for ailing wife. Making false documents. Revoked, stayed, 3 years' probation on terms and conditions. January 10, 1994.

SANDOVAL, PATRICIA, P.A. (PA-10669) Alameda, CA
490, 3531 B&P Code—Stipulated Decision. Conviction for Medi-Cal fraud and prescription forgery. Revoked, stayed, 3 years' probation on terms and conditions. January 7, 1994.

(Cont. on p. 14)

PODIATRISTS

AMBROSINO, JOHN A., D.P.M. (E-2827) Concord, CA
2261, 2239, 2242, 2238 B&P Code—Stipulated Decision. Self abuse of Demerol. Violated laws regulating controlled substances. Diverted Demerol intended for patients. Revoked, stayed, 6 years' probation on terms and conditions. January 21, 1994.

LOWE, CRAIG, D.P.M. (E-1997) Newport Beach, CA
2234(b),(c),(d),(e) B&P Code—Gross negligence, incompetence, and repeated negligent acts in the care and treatment of podiatry patients. Also, dishonest billings. Revoked. November 12, 1993.

SANDERS, RAYMOND, D.P.M. (E-2426) Sacramento, CA
2234(c)(d) B&P Code—Incompetence and repeated negligent acts for repeated failure to remove the boney structures required for the arthroplasty and for his failure to remove the existing bone fragment in the fifth right toe. Revoked, stayed, 5 years' probation on terms and conditions. December 18, 1993.

REGISTERED DISPENSING OPTICIAN

S & S OPTIKS, RDO (D-3080) Inglewood, CA
2556 B&P Code—Stipulated Decision. Unlawfully sharing office space with an eyecare practitioner, and advertising the furnishing of optometric services. Citation of \$1,000. November 26, 1993.

PSYCHOLOGISTS

CAMPION, JOHN N., Ph.D. (PSY 2414) Stockton, CA
2960 (b) (o) (j) B&P Code—Default Decision. Self abuse of alcohol and Vicodin. Making phone calls to patient to solicit sexual acts. Revoked. November 24, 1993.

HUTCHINSON, GRANT L., Ph.D. (PSY 4023) Sacramento, CA
2690 (j) (n) B&P Code—Stipulated Decision. Gross negligence in preparing a deficient child custody report for the court. Revoked, stayed, 5 years' probation on terms and conditions. November 12, 1993.

JENSEN, J. ALAN., Ph.D. (PSY 10799) Malibu, CA
2960 (h) (j) (n) (p) B&P Code—Default Decision. Gross negligence, breach of professional confidences. Dishonest acts, and operated outside his field of experience in practicing "sports medicine" and physical therapy. Revoked. December 22, 1993.

LOUDEN, KENNETH., Ph.D. (PSY 4490) Rosemead, CA
2960 (i) (k) (n) B&P Code—Default Decision. Sexual misconduct. Revoked. January 7, 1994.

VINCENT, GEORGE K., Ph.D. (PSY 9615) Merced, CA
2960 (j) B&P Code—Stipulated Decision. Gross negligence in failing to keep therapeutic distance by engaging in social activities with patient which constitutes an inappropriate dual relationship. Revoked, stayed, 3 years' probation on terms and conditions. January 5, 1994.

RESPIRATORY CARE PRACTITIONERS

THOMAS, BILLY R. (RCP 5493) Los Angeles, CA
3750, 3750.5(g),(c), 3732, 3752.5 B&P Code—Conviction for felony drunk driving with bodily injury. Suspension 90 days', stayed, 3 years' probation on terms and conditions, including 5 days' actual suspension. November 15, 1993.

MILLER, DAVID W. (RCP 15296) Roseburg, OR
3750.5 B&P Code—Self abuse of cocaine and morphine. Revoked. November 20, 1993.

SWITZER, MICHAEL A. (RCP 10187) La Puente, CA
3750.5 (b),(c),(d) B&P Code—Stipulated Decision. Convictions for alcohol-related offenses. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. December 22, 1993.

GLENNON, PAUL K. (RCP 4891) San Francisco, CA
3750(d), 3750.5(b),(c), 3752.5 B&P Code—Felony conviction for assault with a deadly weapon likely to produce great bodily injury. Conviction for driving under the influence of alcohol. Revoked, stayed, 5 years' probation on terms and conditions. December 30, 1993.

ZWICKER, MARY LEE (RCP 11614) Paradise, CA
3760, 3761, 3750(j) B&P Code—Stipulated Decision. Altered the expiration date on her pocket license for presentation to her employer so she could continue to practice while unlicensed. Revoked, stayed, 3 years' probation on terms and conditions, including 12 days' actual suspension. January 6, 1994.

RAMIREZ, MITCHELL D. (RCP 9695) Sylmar, CA
490, 3750(d), 3752.2, 3750.5 B&P Code—Stipulated Decision. Conviction of willful infliction of corporeal injury on a spouse. Intemperate use of alcohol. Revoked, stayed, 5 years' probation on terms and conditions. January 9, 1994.

LOYA, ARTHUR R. (RCP 9778) Canoga Park, CA
490, 3750(d), 3750.5 (b),(c),(d) B&P Code—Conviction for sale of rock cocaine. Self abuse of controlled substances. Conviction for writing bad check with intent to defraud. Revoked. Default. January 17, 1994.

CAPOSINO, CHARLES J. (RCP 12612) Azusa, CA
490, 3750 B&P Code—Stipulated Decision. Conviction for battery on a parking ticket officer. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. January 17, 1994.

THOMAS, JUDITH N. (RCP 11551) San Diego, CA
3750(d) 3750.5(a),(b) B&P Code—Conviction of reckless driving with alcohol or drugs in her system. Revoked, stayed, 5 years' probation on terms and conditions. January 21, 1994.

DONLEY, DALE G. (RCP 10180) Upper Lake, CA
3750(b),(d), 3750.5(b) B&P Code—Conviction for burglary for breaking into a hospital drug supply and stealing syringes and 10 vials of Versed, a schedule IV controlled substance. Self abuse of drug. Fraud in procuring license. Revoked. Default. January 24, 1994.

(Cont. on p. 15)

DISCIPLINARY ACTIONS (Cont. from p. 14)

VLASAK, JAMES R. (RCP 13048) Rancho Santa Margarita, CA
Agency issued license by mistake. License suspended indefinitely until training and licensing requirements are satisfied. October 20, 1993.

MUFTI, SYED A. (RCP 8000) Moreno Valley, CA
3750 (d), 3752.5 B&P Code—Stipulated Decision. Conviction for striking and fracturing the nose of his live-in girlfriend during an argument. Revoked, stayed. 5 years' probation on terms and conditions. October 17, 1993.

VOLUNTARY SURRENDERS

PHYSICIANS AND SURGEONS

MALONEY, CALVIN G., M.D. (A-14910) National City, CA
December 31, 1993

MOLDE, DONALD ALLEN, M.D. (G-17276) Reno, NV
November 28, 1993

YEN, WILLIAM T., M.D. (A-25454) Bakersfield, CA
October 10, 1993

ZEILENGA, DONALD W., M.D. (G-20408) Longview, WA
January 29, 1994

PSYCHOLOGISTS

HORN, CHARLES H., Ph.D. (PSY 4148) Irvine, CA
November 1, 1993

LUDWIG, STUART, Ph.D. (PSY 6939) Del Mar, CA
December 20, 1993

RESPIRATORY CARE PRACTITIONER

RUSTAD, RALPH (RCP 10390) Eugene, OR
December 23, 1993

Injured Workers and the Treating Physician: The New Law

(Cont. from p. 4)

permanent disability benefits may be reduced, or "apportioned". Apportionment is a complex legal concept.

- Will the patient require any continuing or future medical care as a result of the injury?
- Is the patient medically-eligible for vocational rehabilitation benefits? Is the worker medically able to perform some work, but unlikely to be able to continue in the prior occupation?

The treating physician is required to supply medical information through written reports, for which they are reimbursed through fee schedules of the Division of Workers' Compensation. (In some cases, the treating physician may designate another physician to prepare a comprehensive report.) Physicians' reports serve as expert opinion on medical issues, and are used as evidence when workers' compensation judges rule on disputes.

The treating physician's report will be rebuttably presumed to be correct. Thus, it is critical that your reports be complete, accurate, and carefully written. Words have very specific meanings in the workers' compensation system. **The way that you as a physician use certain words or concepts can open, or close, doors to the various benefits an injured worker may need. Your patient's life will be tremendously affected by the reports you provide.** Failure to provide complete reports in a timely manner can cause delays in your patient's benefits. Incomplete or late reporting may also affect the payment you receive.

Treating Physicians' Reports

- Doctor's First Report of Occupational Injury and Illness must be sent to the w.c. insurer or self-insured employer within 5 days after the initial examination. Physicians chosen by an injured worker must notify the employer within 3 days of initiating treatment.
- Treatment Plan: the employee-selected physician must file a treatment plan with the insurer/employer within 7 days of the first exam, including the planned course, scope, frequency, and duration of treatment.
- Progress Reports: periodic reports filed at intervals not exceeding 45 days or 12 visits.
- Initial Disability Evaluation: prepared when the patient is "permanent and stationary", this report covers all medical issues used to determine the worker's permanent disability and future medical awards.

The workers' compensation system is very complex. **In order to better serve your patients, treating physicians who care for injured workers can learn more about the system.** A detailed "Physicians' Guide to Medical Practice in the California Workers' Compensation System" is available from the Industrial Medical Council. The Guide explains the concepts and terminology of workers' compensation, and provides thorough information about requirements, reporting, and billing in the system. Send \$25 to: IMC, P.O. Box 8888, South San Francisco, CA 94128-8888. You can also call the IMC (415-737-2767) or the Division of Workers' Compensation (800-736-7401) for more information.

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Dixon Arnett, Executive Director

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ACTION REPORT-APRIL 1994

The Action Report is a quarterly publication of the Medical Board of California. For information or comments about its contents, please contact:
Candis Cohen, Editor, (916) 263-2389.

For additional copies of this report, please fax your company name, address, telephone number, and contact person to: Yolanda Gonsolis, Medical Board Support Services Unit, at (916) 263-2479, or mail your request to her at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.

Medical Board of California

1426 Howe Avenue, Suite 54, Sacramento, CA 95825 (916) 263-2389

April 1994

Breast Cancer Understanding Treatment Options

As recently as a decade ago, most doctors considered removal of the breast the only treatment for breast cancer. The most common procedure was a radical **mastectomy***, the removal of the entire breast, the chest muscles under the breast, and the underarm lymph nodes. Breast cancer treatment almost always caused women serious physical and emotional trauma. Many women feared the treatment as much as the disease.

Today, radical mastectomies are rarely done. There has been much progress in the early identification and treatment of breast cancer. Beginning with the time a breast lump is found, women have a number of treatment options. As developments occur, doctors are continuing to learn about the advantages and disadvantages of these different treatments. Because of the different stages at which breast cancer is diagnosed, there is no one treatment that is best for all women

**Boldface words are defined in the glossary on page vi.*

If you discover a lump in your breast or if your doctor suspects you have breast cancer, now is the time to learn about the various treatments available, as well as their risks and benefits. This booklet will help you get started.



The options available to you will depend on a number of factors, including the type of tumor, the extent of the disease at the time of diagnosis, your age, and your medical history. But your personal feelings about the treatment, your self-image, and your lifestyle will also

be important considerations in your doctor's assessment and recommendations. You and your doctor should discuss these treatment methods and how they apply to your situation.

Right now, you may be asking yourself, "Why me?" Cancer has suddenly intruded on your life and threatened your health and well-being. You don't

This information is provided to assist physicians to comply with the spirit of the new law requiring the posting of a notice that such information is available to patients. It is a verbatim republication of the most current brochure provided by the National Cancer Institute of the United States Public Health Service.

A new brochure, prepared by the Cancer Control Branch of the California Department of Health Services, in conjunction with both physician and public advisory groups, is being developed and will be distributed by the Medical Board by January 1995, in accordance with SB 112, authored by Senator David Roberti (Chapter 657, Statutes of 1993).

MISSION STATEMENT OF THE MEDICAL BOARD OF CALIFORNIA

The mission of the Medical Board of California is to protect consumers through proper licensing of physicians and surgeons and certain allied health professions and through the vigorous, objective enforcement of the Medical Practice Act.

have to lose control of your personal health, however. You can continue to take care of yourself by working in partnership with the health care professionals responsible for your treatment and safe recovery. By becoming informed, asking questions, and participating in treatment decisions, you can have a positive influence on your own well-being.

BIOPSY: LEARNING IF YOU HAVE BREAST CANCER

If you have noticed a lump or other change in your breast, your doctor may recommend several tests to determine if you have cancer. After taking your medical history and performing a manual breast exam, your doctor may recommend a breast x-ray or mammogram. If the lump is suspected to be a cyst, your doctor may use a needle to drain fluid from the lump. Another test is a **biopsy**, in which tissue is removed and examined under a microscope by a pathologist. Part or all of the lump is removed under local or general **anesthesia**. Biopsy is the only certain way to diagnose breast cancer.

During the biopsy procedure, the surgeon removes the suspicious tissue and sends it to the pathology department to be analyzed. The pathologist will examine the tissue to see if it is **benign or malignant**. If it is malignant, the pathologist will try to identify the type of cancer cells present, how fast they reproduce, if the blood vessels or lymph system contains cancer cells, and if the cancer's growth is affected by hormones. All of this information allows your doctor to determine the best treatment for you. There are two ways that a pathologist prepares the tissue for examination—a "frozen section," which is a quick procedure that takes about 30 minutes, and a "permanent section," which takes a day or two. The frozen section is a quick way of determining whether or not cancer is present. The permanent section is the most accurate method.

THE FROZEN SECTION

The frozen section is done while the patient is in the operating room; the surgeon does not continue the operation until the pathologist reports the results from the frozen section.

In the frozen section, the pathologist cuts thin slices of the tissue and fast-freezes them to be able to look



quickly at the tissue. The disadvantage of the frozen section is that the freezing process distorts the cells and the method is not always accurate.

THE PERMANENT SECTION

The permanent section takes longer than a frozen section—usually a day or two. In this process, the tissue is treated by a series of chemical solutions that give a high quality slide. The advantage of this process is that it is more accurate and allows the pathologist to make a more correct diagnosis. Permanent sections are always performed, even if a frozen section is done too.

If your lump is cancer, estrogen and progesterone receptor assay tests may be performed. These tests will determine if hormone treatment may benefit you.

Other diagnostic procedures may be performed including special blood tests, additional x-rays, radioisotope scans, and/or computerized body scans.

There are two basic options for having a biopsy: the one-step and the two-step procedures.

In this procedure, biopsy, diagnosis of cancer, and breast removal are completed in a single operation. With this procedure, you and your doctor must agree before surgery that your breast will be removed if the lump is cancerous. Your doctor will explain the full details of a mastectomy (surgical removal of the breast) before biopsy—even though the lump may not be cancerous. In the past, the one-step procedure was thought to be the best way to treat breast cancer. However, studies have shown that treatment can safely follow a biopsy by a week or two—even if the lump is cancerous.

This method involves biopsy on one day; then, if the lump is cancerous, the treatment takes place within a couple of weeks. In many cases, the biopsy can be done on an outpatient basis, and it may be possible to perform the biopsy under local, rather than general, anesthesia. The short time between biopsy and treatment (which will not reduce the chances for success) allows time to examine the permanent section slides, to perform additional tests to determine the extent of the disease, to discuss treatment options, to gain another medical opinion, to make home and work arrangements, and to prepare emotionally for the treatment.

If you are going to have a biopsy, discuss these procedures with your doctor. The two of you can decide which option is best for you. Additional information about biopsy can be found in *Breast Biopsy: What You Should Know*, another National Cancer Institute booklet.

BREAST SURGERY

Mastectomy is the medical term for surgical removal of the breast. It refers to a number of different operations, ranging from those that remove the breast, chest muscles, and underarm **lymph nodes**, to those that remove only the breast. Other kinds of surgery remove only the breast lump.

The different types of breast surgery are described below. Based on the size and location of the lump, your doctor will recommend the type of surgery that offers you the best chance of successful treatment.

Most medical and surgical procedures carry some risk. The risk may be small or serious, frequent or rare. Because there is such a wide range of potential risks and benefits from the various treatments for the different stages and kinds of breast cancer, you should discuss with your doctor the particular benefits and risks of the treatment methods suitable for you.

RADICAL MASTECTOMY

This type of surgery removes the breast, the chest muscles, all of the underarm lymph nodes, and some additional fat and skin. It is also called a “Halsted radical” (after the surgeon who developed the procedure). A radical mastectomy was the standard treatment for breast cancer for more than 70 years and is still used today for some women.

- *Advantages*—Cancer can be completely removed if it has not spread beyond the breast or nearby tissue. Examination of the lymph nodes provides information that is important in planning future treatment.

- *Disadvantages*—Removes the entire breast and chest muscles, and leaves a long scar and a hollow chest area. May cause **lymphedema** (swelling of the arm), some loss of muscle power in the arm, restricted shoulder motion, and some numbness and discomfort. Breast reconstruction is also more difficult.

MODIFIED RADICAL MASTECTOMY

This procedure removes the breast, the underarm lymph nodes, and the lining over the chest muscles. Sometimes the smaller of the two chest muscles is also removed. This procedure is also called “total mastectomy with axillary (or underarm) dissection” and today is the most common treatment of early stage breast cancer.

- *Advantages*—Keeps the chest muscle and the muscle strength of the arm. Swelling is less likely, and when it occurs it is milder than the swelling that can occur after a radical mastectomy. Leaves a better appearance than the radical. Survival rates are the same as for the radical mastectomy when cancer is treated in its early stages. Breast reconstruction is easier and can be planned before surgery.

• *Disadvantages*—The breast is removed. In some cases, there may be swelling of the arm because of the removal of the lymph nodes.

TOTAL OR SIMPLE MASTECTOMY

This type of surgery removes only the breast. Sometimes a few of the underarm lymph nodes closest to the breast are removed to see if the cancer has spread beyond the breast. It may be followed by radiation therapy.

• *Advantages*—Chest muscles are not removed and arm strength is not diminished. Most or all of the underarm lymph nodes remain, so the risk of swelling of the arm is greatly reduced. Breast reconstruction is easier.

• *Disadvantages*—The breast is removed. If cancer has spread to the underarm lymph nodes, it may remain undiscovered.

PARTIAL OR SEGMENTAL MASTECTOMY

This procedure removes the tumor plus a wedge of normal tissue surrounding it, including some skin and the lining of the chest muscle below the tumor. It is followed by radiation therapy. Many surgeons also remove some or all of the underarm lymph nodes to check for possible spread of cancer.

• *Advantages*—If a woman is large-breasted, most of the breast is preserved. There is little possibility of loss of muscle strength or arm swelling.

• *Disadvantages*—If a woman has small- or medium-sized breasts, this procedure will noticeably change the breast's shape. There is a possibility of arm swelling.

LUMPECTOMY

Lumpectomy removes only the breast lump and is followed by radiation therapy. Many surgeons also remove and test some of the underarm lymph nodes for possible spread of cancer.

• *Advantages*—The breast is not removed.

• *Disadvantages*—Small-breasted women with large lumps may have a significant change in breast shape. Scar tissue from the treatment may make it more difficult to examine the breast later. There is a possibility of arm swelling.

For more information, contact the National Cancer Institute for a copy of *Mastectomy: A Treatment for Breast Cancer*.

A WORD ABOUT BREAST RECONSTRUCTION

As you consider mastectomy as a treatment option, you should be aware of breast reconstruction, a way to recreate the breast's shape after a natural breast has been removed. This procedure is gaining in popularity, although many women are still unaware of it.

Today, almost any woman who has had a mastectomy can have her breast reconstructed. Successful reconstruction is no longer hampered by radiation-damaged, thin, or tight skin, or the absence of chest muscles.

Reconstruction is not for everyone, however. And it may not be right for you. After mastectomy, many women prefer to wear artificial breast forms inside their brassieres.

Both a general surgeon and a plastic surgeon may help you decide whether to have breast reconstruction. If possible, you should discuss breast reconstruction before your surgery because the position of the incision may affect the reconstruction procedure. However, many women consider the option of reconstruction only after surgery.

For more information on breast reconstruction, contact the National Cancer Institute for a copy of *Breast Reconstruction: A Matter of Choice*.

RADIATION THERAPY

Radiation therapy as primary treatment is a promising technique for women who have early stage breast cancer. This procedure allows a woman to keep her breast and involves lumpectomy followed by radiation (x-ray) treatment.

Once a biopsy has been done and breast cancer has been diagnosed, radiation treatment usually involves the following steps:

- Surgery to remove some or all of the underarm lymph nodes to see if the cancer has spread beyond the breast;
- External radiation therapy to the breast and surrounding area; and
- “Booster” radiation therapy to the biopsy site.

For external radiation therapy, a machine beams x-rays to the breast and possibly the underarm lymph nodes. The usual schedule for radiation therapy is 5 days a week for about 5 weeks. In some instances, a “booster” or concentrated dose of radiation may be given to the area where the cancer was located. This can be done with an electron beam or internally with an implant of radioactive materials.

If you are having radiation therapy as primary treatment for early stage breast cancer, it should be done by a qualified, board-certified radiation therapist who is experienced in this form of treatment.

• *Advantages*—The breast is not removed. Lumpectomy with radiation therapy as a primary treatment for breast cancer currently appears to be as effective as mastectomy for treating early stage breast cancer. Because this is a new treatment procedure, researchers are continuing to collect information on long-term results. Usually there is not much deformity of surrounding tissues. This skin usually regains a normal appearance after treatment is completed.

• *Disadvantages*—A full course of treatment requires short daily visits to the hospital as an outpatient for about 5 weeks, as well as hospitalization for a few days if implant radiation therapy is used. Treatment may produce a skin reaction like a sunburn, and may cause tiredness. Itching or peeling of the skin may also occur. Radiation therapy can sometimes cause a temporary decrease in white blood cell count, which may increase the risk of infection.

For detailed information about radiation therapy, contact the National Cancer Institute for a copy of *Radiation Therapy: A Treatment for Early Stage Breast Cancer*.

ADJUVANT THERAPY

Recent studies have shown that women with early stage breast cancer may benefit from adjuvant (additional) therapy following primary treatment (mastectomy or lumpectomy with radiation therapy). These studies indicate that many breast cancer patients whose underarm lymph nodes show no sign of cancer (known as node negative) may benefit from **chemotherapy** or hormonal therapy after primary treatment. (These findings do not apply to women with preinvasive or *in situ* breast cancer.)

Until now, women whose underarm lymph nodes were free of cancer usually received no additional therapy because they have a relatively good chance of surviving the disease after primary treatment. But scientists know that cancer may return in about 30 percent of these women. Adjuvant therapy may prevent or delay the return of cancer.

Based on these findings, the National Cancer Institute has alerted doctors to consider using adjuvant therapy for their node negative breast cancer patients. Although there is strong evidence of the benefits of adjuvant therapy, there also are certain risks and expenses. Therefore, each woman should discuss her treatment options with her doctor.

THE BREAST CANCER TREATMENT TEAM

During your treatment you are likely to meet several health professionals who will perform the various tests and treatments your doctor recommends. It may be difficult at first to talk with them about your illness and your feelings about treatment. But each of them can offer information to help you feel more at ease. By talking with the professionals who care for you, you will come to understand more about cancer and its treatment and be better able to cope.

INFORMED CONSENT: WHEN SURGERY IS RECOMMENDED

When surgery is recommended, most health care facilities require patients to sign a form stating their willingness to permit diagnosis and medical treatment. This certifies that you understand what procedures will be done and that you have consented to have them performed.

Before consenting to any course of treatment, ask your doctor for information on:

- The recommended procedure;
- Its purpose;
- Risks and side effects associated with it;
- Likely consequences with and without treatment;
- Other available alternatives; and
- Advantages and disadvantages of one treatment over another.

You are likely to discover that your anxiety over treatment decreases as your understanding of breast cancer and its treatment increases.

These are some of the specialists you may meet or hear about:

- **Anesthesiologist**—A doctor who administers drugs or gases to put you to sleep before surgery.
- **Clinical nurse specialist**—A nurse with special knowledge in a particular area, such as postoperative care or radiation therapy.
- **Medical oncologist**—A doctor who administers anticancer drugs or chemotherapy.
- **Pathologist**—A doctor who examines tissue removed by biopsy to see if the tissue is cancerous.
- **Personal physician**—Your doctor, who will be responsible for coordinating your treatment and working with you to ensure that treatment is satisfactory. Your personal physician may be a surgeon, radiation oncologist, medical oncologist, or family physician.
- **Physical therapist**—A specialist who helps in rehabilitation after surgery by using exercise, heat, light, and massage.

Glossary

Anesthesia: loss of feeling or sensation resulting from the administration of drugs or gases.

Benign: not cancerous.

Biopsy: removal of a sample of tissue to see if cancer cells are present.

Chemotherapy: treatment with drugs to destroy cancer cells. Most often used to supplement surgery or radiation therapy.

Lymph nodes: part of the lymph system that removes wastes from body tissue and carries the fluids that help the body fight infection. Lymph nodes in the underarm are those most likely to be invaded by cancer cells and are therefore often removed during breast cancer surgery.

Lymphedema: swelling in the patient's arm caused by excess fluid that collects when the lymph nodes and vessels are removed during surgery or damaged by x-ray. The patient's arm and hand become more prone to infection.

Malignant: cancerous.

Mastectomy: surgical removal of the breast.

Pectoral muscles: muscles that overlay the chest wall and help to support the breasts.

- **Plastic surgeon**—A doctor who specializes in rehabilitative and cosmetic surgery. Plastic surgeons perform breast reconstruction.
- **Radiation oncologist**—A doctor who supervises radiation therapy.
- **Radiation technologist**—A specially trained technician who helps the radiation oncologist give external radiation treatments.
- **Surgeon**—A doctor who performs surgery, such as biopsy and mastectomy.

Other NCI Breast Cancer Patient Education Booklets

For free copies of other booklets in the Breast Cancer Patient Education Series, call the Cancer Information Service or write to the Office of Cancer Communications, National Cancer Institute, Building 31, Room 10A24, Bethesda, MD 20892.

Breast Exams: What You Should Know; Questions and Answers About Breast Lumps

Breast Biopsy: What You Should Know

Mastectomy: A Treatment for Breast Cancer

Radiation Therapy: A Treatment for Early Stage Breast Cancer

Adjuvant Therapy: Facts for Women With Breast Cancer

Breast Reconstruction: A Matter of Choice

After Breast Cancer: A Guide to Followup Care

When Cancer Recurs: Meeting the Challenge Again

Advanced Cancer: Living Each Day

Making Decisions About Treatment

Important decisions are always hard to make, particularly when they concern your health. However, there are a number of things you can do to make decisions about breast cancer treatment easier. One is gathering information. You can:

- **Talk with your doctor.** There are a number of treatments that may be used for breast cancer. To make sure you will be comfortable with your decision to have a particular treatment, you may want to get another medical opinion.

- **Gather additional information from published reports.** Many articles and books have been written about breast cancer for patients and professionals. There is also much information available about cancer in general. Some recommended reading materials are listed at the back of this booklet. Others are available at local libraries and may be available through local offices of the American Cancer Society.

- **Call the Cancer Information Service (CIS).** This program, sponsored by the National Cancer Institute, is available to answer questions about cancer from the public, cancer patients and their families, and health professionals. Call this toll-free number and you will automatically be connected to the CIS office serving your area:

1-800-4-CANCER

Spanish-speaking CIS staff members are also available.

- **Ask your doctor to consult PDQ.** The National Cancer Institute has developed PDQ (Physician Data Query), a computerized database designed to give doctors quick and easy access to the latest treatment information for most types of cancer; descriptions of clinical trials that are open for patient entry; and names of organizations and physicians involved in cancer care. To access PDQ, a doctor may use an office computer with a telephone hookup and a PDQ access code or the services of a medical library with online searching capability. Cancer Information Service offices provide free PDQ searches and can tell doctors how to get regular access. Patients may ask their doctor to use PDQ or may call 1-800-4-CANCER themselves.

Some of the other things you might want to do before making a final decision about various treatments are:

- **Discuss them with friends or relatives.** Although you and your doctor are in the best position to evaluate treatment options, it sometimes helps to discuss your feelings with others whose judgment you respect. Often, close friends and relatives can provide insights that can help your own thinking.

- **Talk with other women who have had breast cancer:** Many women who have been treated for breast cancer are willing to share their experiences. Your local American Cancer Society (ACS) office may be able to direct you to such women through its Reach to Recovery program. This program, which works through volunteers who have had breast cancer, helps women meet the physical, emotional, and cosmetic needs of their disease and its treatment. Some ACS offices have volunteer visitors who have had a mastectomy, breast reconstruction, radiation, or chemotherapy. Sometimes they are able to meet with women before surgery. Contact your local ACS office for more information.

Remember that you have time to consider options. Except in rare cases, breast cancer patients do not need to be rushed to the hospital for treatment as soon as the disease is diagnosed. Most women have time to learn more about available options, make arrangements at medical facilities where treatments will be given, and organize home and work lives before beginning treatment. A long delay, however, is not advisable because it may interfere with the success of your treatment.



This information, presented as an "Insert" to the Action Report, is intended for physicians to distribute to patients who have, or may have, breast cancer. Additional copies of this brochure are available in bundles of 25 FREE of charge by writing:

Breast Cancer Treatment Options

Yolanda Gonsolis

Medical Board of California

1426 Howe Avenue, Suite 54

Sacramento, CA 95825

or

Fax your request to (916) 263-2479

(Please specify # of bundles and provide your return address.)

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