

# Action Report

## Medical Board of California

July 1994 Vol. 50  
A Quarterly Publication

IN THIS  
ISSUE

CMA, CPIL Ally To Kill Board's Enforcement Division 2

Board Promotes Focus on Primary Care, Resource Distribution, Language Skills 3

A Statement by the MBC: Prescribing Controlled Substances For Pain 4-5

Medical Quality in California and How it is Maintained 6-7

Accusations of Sexual Misconduct or Harassment Against Physicians 8-9

Attention L.A. Physicians: DEA Drug Disposal Alert 10

Infection Control is Not "Just for Nurses" 11

New Physician Reporting Responsibilities 12-13

Lay Midwife Regulations Focus on Physician "Supervision" 14

Disciplinary Actions 15-19

INSERT:  
PROSTATE  
CANCER

Information about prostate cancer reprinted from the National Cancer Institute. Copies of this free insert are available from the Medical Board. Ordering information is on the back page of the insert.

### Medical Board of California Meeting Dates/Locations 1994

July 28-29	Los Angeles
November 3-4	San Diego
<b>1995</b>	
February 2-4	San Francisco
May 11-12	Sacramento
July 28-29	San Diego
November 2-3	Los Angeles

## License Fee Reduction Results From CMA Lawsuit

The Board ordered a two-year \$25 fee reduction to begin this fall (after appropriate regulations are adopted and legal notice given). The reduction is a direct result of a successful lawsuit by the California Medical Association challenging the transfer of special funds to the General Fund in the 1992 fiscal year. The Board supported the suit with declarations and affidavits showing the fiscal and management impacts of the transfers.

In search of funds to ease the budget shortfall in the General Fund, legislators ordered percentage transfers from all special funds that year. The CMA challenged that such transfers violated both the very reason for such funds to be established and paid for by targeted classes and the constitutional provisions which hold special funds as inviolate.

Superior Court Judge Kenneth G. Peterson of San Francisco agreed and ordered those amounts which had been transferred returned to all the state's special funds with interest. For the Medical Board this amounts to \$2.491 million (\$2.566 million less \$75,000 for the CMA's attorneys' fees).

The Medical Board Reform Act, SB 916 (Presley) of last year, contained a provision which mandates that should the CMA win its lawsuit, the amount refunded to the Board must be returned to the fee payers.

The State Department of Finance, which did not favor such transfers in the first place, declined to appeal the judge's ruling and announced that it would return the funds during the current fiscal year which ends June 30.

After reviewing several options, the Board decided to reduce fees over two years so that every physician who renews would benefit, inasmuch as licenses are renewed in two-year cycles. Mathematically, this translates into a \$25 reduction for slightly fewer than 100,000 licensees.

## News Organizations Sue For Raw Data on Doctors

The San Jose Mercury News, The Sacramento Bee and The Los Angeles Times filed a potentially precedent-setting lawsuit demanding that the Medical Board, under the Public Records Act, provide them with computer discs or printouts of all raw data on physicians kept by the Board otherwise available to the public.

The suit was prompted by the Board's new information disclosure policy, but is based on current law. At its February meeting the Board refused to modify its disclosure policy to allow access to raw data files (public information only) on the grounds that the data would be used to compile lists of doctors, by disclosure category and by community, resulting in news stories that would exaggerate the impact on a geographic area of disciplined doctors.

The Board maintains that the Public Records Act requires that it provide public information to consumers from existing documents. The Act does not require that records be created to satisfy a request, and media requests for lists mean that such lists have to be created. Thus, the Board refused to provide raw data from which lists could be crafted. The Board argues that the data the news groups seek is so raw as to be contained in several computer programs, not easily assembled as the plaintiffs seek.

The news organizations argue that the use of public records is not to be pre-judged by a public agency providing the records; the Act, they say, does not allow interpretation. And, they say, the technical difficulties and cost in developing the information they ask for is not a legal issue; they are willing to pay for it.

The court's ruling will have ramifications throughout state government. So will an earlier suit by the California Medical Association, which attempts to enjoin the Board's entire disclosure policy and, particularly, the policy that discloses when a case has been sent to the Attorney General. Thus, the CMA is suing the Board, saying too much information is disclosed, and the state's largest newspapers are suing the Board, saying the Board doesn't disclose enough.

### 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.

## CMA, CPIL Ally To Kill Board's Enforcement Division

by  
*Bruce H. Hasenkamp, J.D.*  
*President of the Board*

Although we approach the summer recess of the 1994 Legislature with the Board's bills gliding through committees with negotiated approvals of our potential adversaries, storm clouds forming for 1995 can be seen in the distance.

As a licensing and consumer protection agency, we often hear from consumer groups who think we are not doing enough to discipline doctors and from physicians' organizations who think we are doing too much.

In fact we often are negotiating with the major groups representing consumers (the Center for Public Interest Law at the University of San Diego, for example) and physicians (the California Medical Association and others) on legislation. Rarely do these organizations see eye to eye.



*Bruce H. Hasenkamp, J.D.*

Last year, in marathon negotiating sessions, a careful agreement on SB 916 (the Omnibus Medical Board Reform Act) authored by Appropriations Committee Chairman Senator Robert Presley, colloquially known as "Presley II," was crafted by these groups along with Board staff.

The same groups are involved in "Presley II-A" (SB 1775) this year and have reached good faith agreement. SB 1775 is a bill that contains technical "clean-up" provisions, but which also provides for expedited suspension of physician licenses when a physician has been convicted of a felony crime. The suspension is subject to a hearing by the Board's Division of Medical Quality on relevance to medical practice.

There is also agreement, after years of effort, on AB 595 by Assemblywoman Jackie Speier, which provides for regulating out-of-hospital surgery settings. And the same entities agree to the Board's provisions to require managed care groups that want to use a "shot card" system for injections to develop a safe operations protocol. These provisions are a part of AB 3260 by Assemblywoman Julie Bornstein. Finally, this year all the parties cooperated in a technical corrections bill that was necessary to ensure our fee increase.

Just as there appears to be calm and cooperation, however, an unholy alliance may be being crafted by the staffs of CPIL and CMA. Rumors that such an alliance had been formed to promote legislation in 1995 to eliminate the Board's Division of Medical Quality began to emerge before the Board's May meeting. Staff of both organizations confirmed the alliance and said initially they wanted such a change this year.

The CPIL and the CMA are ancient antagonists. Why, then, this unholy alliance?

For years the CPIL has wanted to streamline the Board's disciplinary process, which, at a maximum of due process, has five steps after investigation — a hearing before an administrative law judge, an automatic review by the Division of Medical Quality and appeals in the courts — superior, court of appeals and Supreme Court. CPIL's Director Robert Fellmeth maintains that this is more due process than a convicted murderer gets. Fellmeth also charges that the DMQ, with its majority of appointed physicians, is "...the fox guarding the chicken coop."

In the past the CMA has protected the DMQ and the physician majority, arguing that the quality of care cases judged by the DMQ are far too complicated to rely only on public members to understand. It appears that CMA, if the staff view prevails with the CMA leadership, will abandon its traditional view, opting instead for a system with better qualified, trained and tested medical experts to advise administrative law and court judges.

While the Board agrees with the goal of a vastly improved system of medical expertise (see articles on the work of our own Task Force on Medical Quality Review), I suspect my colleagues will not approve of such radical surgery. The DMQ, recently revitalized as part of last year's SB 916, has hit a new stride that is the cause of admiration by other state medical boards.

One of our Board members suggests that the CMA has changed its view because the new DMQ is proving more effective than is comfortable for a group (the CMA) that represents half the state's physicians. The DMQ is, after all, approving more disciplines as consumer access to the Board has become more user friendly and as the Board has changed to emphasize enforcement and a new information disclosure policy, against which the CMA has sued.

Certainly the combined political clout of the CPIL and the CMA, with the news media likely to sit out such a procedural battle, augers for approval of the elimination of the DMQ by the Legislature. But would a re-elected Governor Pete Wilson or a newly elected Governor Brown sign away his/her own Board? Stay tuned — and not just to the weather.

# Board Promotes Focus on Primary Care, Resource Distribution, Language Skills

by

*Robert del Junco, M.D.*

*Vice President of the Medical Board and Chairman, Task Force on Health Policy and Resources*

*At its May meeting the Medical Board approved the following memorandum:*

To: Joanne Kozberg, Secretary  
State & Consumer Services Agency

Sandra Smoley, Secretary  
Health & Welfare Agency

Via: C. Lance Barnett, Ph.D.  
Interim Director, Department of  
Consumer Affairs

Kim Belshe, Director  
Department of Health Services

David Werdegar, M.D., Director  
Office of Statewide Health  
Planning & Development

From: Robert del Junco, M.D., Chairman  
Task Force on Health Policy &  
Resources, Medical Board of CA

Subj: Governor's Summit on Health Resources



*Robert del Junco, M.D.*

incentives for health care professionals to serve in underserved areas. Nor are there incentives for health care providers to learn languages so that they are better able (and willing) to communicate with patients in those same areas.

In addition, there are new legislative proposals, driven by the current emphasis on primary care, that can provide the right policy, but will be impotent for lack of funding. Yet, at the same time, a case can be made that federal scholarship and loan funds are misdirected and that California could lead the nation by developing an initiative that would rely on redirecting

federal funds leveraged by matching money from the state.

The Task Force on Health Policy & Resources of the Medical Board of California strongly recommends the convening of a one-day "Summit on Health Resources" to focus on urgent issues relating to primary care, the geographic distribution of physicians and allied health professionals and the language abilities of health care providers in our state of growing diversity.

With the visible commitment of Governor Wilson to preventative care, beginning with his inaugural address, it is time to highlight the state's health resources needs and to develop an action plan to address those needs — even in a time of restrained budgets.

Health care reform proposals, among other trends, tend to reflect natural changes in medical school and allied health training and pressures on costs, including the rapid growth in new medical technologies. But reform proposals do little to direct a ready supply of health care professionals to the places where they are in greatest need, particularly providing primary (preventative) care and in the languages which now predominate our diverse society.

Laws at both the state and federal levels contain the concepts that come from ideas generated after years of experience with scholarship and loan programs, yet funds are misdirected or not available to provide appropriate

At the same time, we, as state officials, must be active and prudent in maintaining appropriate qualifications, testing and verification standards for those who would offer themselves as physicians and allied health professionals who provide primary and prenatal care in California. While seeking to insure that California has the right providers in the right places with the right skills, we must also insure that they are men and women of the highest quality and motivation.

Whatever recommendations may result from such a "Summit", it is clear that the discourse will provide an assimilation of ideas from knowledgeable experts which, in turn, can be evaluated and devised as a Governor's Initiative on Health Resources for California. The visibility of such a "Summit", with the Governor's active participation, will serve notice that together we intend to anticipate the needs of Californians everywhere and that we intend to provide for them within the limits of budget constraints.

The Task Force is willing to commit the time of its members and funds from the Medical Board to the "Summit on Health Resources". We are certain that the recommendations of the Summit will put California in a leadership role throughout the nation on an issue which commands increasing attention by the media and the public. We ask that you endorse this request and, on our behalf, ask the Governor to call us to action.

# A Statement by the Medical Board:

*On May 6 the Medical Board formally adopted the following statement on  
"Prescribing Controlled Substances For Pain Management."  
It is the first formal statement of its kind in the nation made by a licensing board.*

*This statement was adopted after a year of testimony at hearings held by the Board's Task Force on Appropriate Prescribing and a day-long "Summit," sponsored by Governor Wilson, involving scores of experts from around the country.*

*At the Board's July 28-29 meeting the members will consider formal adoption of a set of guidelines based on this policy statement. The guidelines, once adopted, will be published in the October Action Report and other publications read by physicians.*

## INTRODUCTION

The 1993 report of the Medical Board to the Governor signalled a new beginning in the history of medical regulation in California. An important part of this initiative is implementation of the recommendations made by the Board's Task Force on Appropriate Prescribing, chaired by Jacquelin Trestrail, M.D.

The Task Force was established to look into "malprescribing," one of the fastest growing categories of physician discipline. The Board continues to be concerned that controlled substances are subject to abuse by individuals who seek them for their mood altering and other psychological effects, rather than for legitimate medical purposes.

The Board is also concerned about effective pain management and the appropriate medical use of controlled substances. During the Task Force's public meetings, the members heard testimony that some physicians avoid prescribing controlled substances, including the "triplicate" drugs, for patients with intractable pain for fear of discipline by the Board. The Task Force recommended that the Board take a pro-active approach to emphasize to all California physicians that it supports prescribing of opioid analgesics (narcotics) and other controlled substances when medically indicated for the treatment of pain, including intractable pain. After careful review of this matter, the Board concurs with the following statement.

This statement is consistent with good medical practice, protection of public health and consumer interests, with international treaties, federal and California law, including the California Intractable Pain Treatment Act.

## THE PAIN PROBLEM

The Board recognizes that pain, whether due to trauma, surgery, cancer and other diseases, is often undertreated.

Minorities, women, children, the elderly and people with HIV/AIDS are at particular risk for under treatment of their pain. Unrelieved pain has a harsh and sometimes disastrous impact on the quality of life of people and their families.

While some progress is being made to improve pain and symptom management, the Board is concerned that a number of factors continue to interfere with effective pain management. These include the low priority of pain management in our health care system, incomplete integration of current knowledge into medical education and clinical practice, lack of knowledge among consumers about pain management, exaggerated fears of opioid side effects and addiction, and fear of legal consequences when controlled substances are used.

## PAIN MANAGEMENT SHOULD BE A HIGH PRIORITY IN CALIFORNIA

Principles of quality medical practice dictate that citizens of California who suffer from pain should be able to obtain the relief that is currently available. The Board believes that the appropriate application of current knowledge and treatments would greatly improve the quality of life for many California citizens, and could also reduce the morbidity and the costs that are associated with uncontrolled pain.

In addition to making this statement, the Board will take a number of steps to help make effective pain management a reality in California. The Board has provided information to all state physicians about new clinical practice guidelines for pain management that have been prepared by a panel of experts supported by the Agency for Health Care Policy and Research. The Board also co-sponsored and participated in the March 18, 1994 Pain Management and Appropriate Prescribing Summit in conjunction with the Department of Consumer Affairs on removing impediments to appropriate prescribing of controlled substances for effective pain management. Further, the Board will develop guidelines to help physicians avoid investigation if they appropriately prescribe controlled substances for pain management.

# Prescribing Controlled Substances for Pain

## THE APPROPRIATE ROLE OF OPIOID ANALGESICS

There are numerous drug and non-drug treatments that are used for the management of pain and other symptoms. The proper treatment of any patient's pain depends upon a careful diagnosis of the etiology of the pain, selection of appropriate and cost-effective treatments, and ongoing evaluation of the results of treatment. Opioid analgesics and other controlled substances are useful for the treatment of pain, and are considered the cornerstone of treatment of acute pain due to trauma, surgery and chronic pain due to progressive diseases such as cancer. Large doses may be necessary to control pain if it is severe. Extended therapy may be necessary if the pain is chronic.

The Board recognizes that opioid analgesics can also be useful in the treatment of patients with intractable non-malignant pain especially where efforts to remove the cause of pain or to treat it with other modalities have failed. The pain of such patients may have a number of different etiologies and may require several treatment modalities. In addition, the extent to which pain is associated with physical and psychosocial impairment varies greatly. Therefore, the selection of a patient for a trial of opioid therapy should be based upon a careful assessment of the pain as well as the disability experienced by the patient. Continuation of opioid therapy should be based on the physician's evaluation of the results of treatment, including the degree of pain relief, changes in physical and psychological functioning, and appropriate utilization of health care resources. Physicians should not hesitate to obtain consultation from legitimate practitioners who specialize in pain management.

The Board recommends that physicians pay particular attention to those patients who misuse their prescriptions, particularly when the patient or family have a history of substance abuse that could complicate pain management. The management of pain in such patients requires extra care and monitoring, as well as consultation with medical specialists whose area of expertise is substance abuse or pain management.

The Board believes that addiction should be placed into proper perspective. Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a behavioral syndrome characterized by psychological dependence and aberrant drug-related behaviors. Addicts compulsively use drugs for non-medical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts or habitues merely because they are being treated with opioids.

## PAIN MANAGEMENT, CONTROLLED SUBSTANCES AND THE LAW

The laws and regulations of the federal government and the State of California impose special requirements for the prescribing of controlled substances, including requirements as to the form of the prescription document, so as to prevent harm to the public health that is caused when prescription drugs are diverted to non-medical uses. For example, it is illegal to prescribe controlled substances solely to maintain narcotic addiction. However, federal and California law clearly recognize that it is a legitimate medical practice for physicians to prescribe controlled substances for the treatment of pain, including intractable pain.

The Medical Board will work with the Drug Enforcement Administration, the Bureau of Narcotic Enforcement, the Office of the Attorney General, the Board of Pharmacy and its own investigators in an attempt to develop policy and guidelines based on the physician's diagnosis and treatment program rather than amounts of drugs prescribed.

Concerns about regulatory scrutiny should not make physicians who follow appropriate guidelines reluctant to prescribe or administer controlled substances, including Schedule II drugs, for patients with a legitimate medical need for them. A physician is not subject to Board action when prescribing in the regular course of his or her profession to one under the physician's treatment for a pathology or condition and where the prescription is issued after a good faith examination and where there is medical indication for the drug. Good faith prescribing requires an equally good faith history, physical examination and documentation.

The Medical Board may identify a pattern of controlled substance use that merits further examination. A private, courteous and professional inquiry can usually determine whether the physician is in good faith appropriately prescribing for patients, or whether an investigation is necessary. The Board will judge the validity of prescribing based on the physician's diagnosis and treatment of the patient and whether the drugs prescribed by the physician are appropriate for that condition, and will not act on the basis of predetermined numerical limits on dosages or length of drug therapy.

The Board hopes to replace practitioners' perception of inappropriate regulatory scrutiny with recognition of the Board's commitment to enhance the quality of life of patients by improving pain management while, at the same time, preventing the diversion and abuse of controlled substances.

# Medical Quality in California and How it is Maintained

by

*Alan E. Shumacher, M.D.*

*Secretary of the Medical Board and its Division of Medical Quality  
Former Chairman, San Diego County Medical Society's Professional Conduct Committee*

No one should dispute that the assurance of quality medical care is a goal shared by individual physicians, physician groups, professional organizations, and the Medical Board of California.

Like the levels of a pyramid, each must be broadly supportive of the levels above if the structure is to remain stable. Each level, however, differs from the others in form and function.

The base of this pyramid must be the broadest and most solid level. In the case of medical quality, this level is called peer review. It is no more and no less than each of us as individual physicians in offices, clinics, and hospitals carrying out our responsibilities to the patient and to each other. As the weak link defines the chain, the seemingly less skilled or less "polished" physician may define his or her peer group. Each physician knows that peers watch over one's shoulder — and each is the better for this reciprocal oversight. Here is the strength of this basic level. It can have, however, a weakness as well. Few of us relish the task of speaking frankly yet constructively to a colleague who has drawn the disapproval or concern of those peers; and fewer still do this task well. Too often it remains undone.

The second level is that of local medical society mediation. Complaints from patients, families or other physicians are reviewed by a committee of the local medical society after

evaluating the physician's response to the allegations. These complaints usually deal with fees, treatment, conduct, communication (or the lack of it), or record transmittal.

After review, both parties are advised of the committee's suggestions for resolution of the dispute. The key word here — as was true at the level of peer review — is **suggestions** — for these committees have no ability to compel any actions. This level and the base level rely on peer pressure and voluntary compliance. Therein lies its strength — most of us seek the approval given by our colleagues. The counterbalancing weakness lies in the fact that most local medical societies deal only with complaints involving member physicians, leaving a large gap in organized medicine's ability to be

responsive to public complaints and to identify potential problem physicians.

The upper level — which should be and is in fact the smallest — is that which represents the state. The Medical Board of California is mandated by law to protect the public and enforce the Medical Practice Act. The law also limits the Board's authority to intervene only in those cases which may represent violations of this act. Its role in the assurance of quality begins with its Division of Licensing and a critical appraisal of the credentials of those applying for a medical license in California. The Division of Medical Quality is largely concerned with the investigation of

(Cont. on p. 7)



*Alan E. Shumacher, M.D.*

## Medical Quality Recommendations Due to Board at July Meeting

The Medical Board will receive the final report from its Task Force on Medical Quality Review at its July 28-29 meeting in Los Angeles. The Task Force will conclude its work after almost a year of study, recommendations by staff and numerous hearings.

It is expected that the Task Force recommendations will address a statewide system of minimum qualifications for medical counsel and the use of experts. In addition, the Task Force recommendations may include a system for training of consultants and experts as well as a method for evaluating performance as an expert.

Also, the Task Force has heard testimony on special procedures for consideration of "quality of care" cases as contrasted to criminal, fraud, malprescribing and sexual misconduct cases. Testimony has appeared unanimous suggesting that in such cases a standardized means be established by which investigators, deputy attorneys general and medical experts meet before the case proceeds to "accusation".

The Task Force received results of four studies relating to the use and effectiveness of medical experts on June 1. At a June 15 hearing the Task Force crafted tentative recommendations. In July the Task Force will hold a public hearing after which it will finalize its report.

## Medical Quality in California (Cont. from p. 6)

complaints, their adjudication, and the enforcement of penalties meted out to offenders. These penalties range from citation-and-fine through public letter of reprimand all the way to outright revocation of license. Specially trained Board investigators may work with law enforcement personnel from local state, or federal agencies in cases involving allegations of fraud, sexual misconduct, or certain drug violations, and in many instances these cases come to criminal prosecution by other authorities prior to any administrative action by the Board. In addition to this mandated priority given to public protection, the Board maintains a confidential diversion program for physicians with substance or alcohol abuse problems in an attempt to aid these individuals in their rehabilitative efforts and to allow them to resume productive practice when they are successful. The Board is also making a major increase in its commitment to preventive education, especially with respect to the appropriate prescribing of scheduled substances.

---

***“Each of us is diminished  
as a physician and  
an individual when  
a colleague goes astray.”***

---

The Medical Board has jurisdiction over every physician with a California license. Unlike the other two levels described, its decisions have the force of law. It is, if you will, the stick applied to those few for whom the carrot of the other levels did not maintain medical quality. Just how few? In FY 92-93 433 cases involving physicians were referred to the Attorney General out of 102,891 physician licensees both in and out of California — a rate of 0.4%. In this same period 6,730 complaints involving physicians were received.

At the apex of this pyramid is quality. Balanced precariously on the structure of the levels beneath, its fall is detrimental to the public and to the medical profession. Each of us is diminished as a physician and an individual when a colleague goes astray.

The pyramid is not perfect. It can be improved at each level. At the level of peer review, groups and hospital departments should increase their efforts to identify, educate, and monitor “weak links” rather than pass them on to be someone else's problem. At the level of the local medical society, attempts should be made to expand the role of mediation to nonmembers (my experience shows that most are willing to cooperate) and to take all necessary steps to assure the impartiality of the mediation process. At the level of the Medical Board, a process is already in place to

## Board to Consider Next Phase of “Study on Priorities”

After six months of reviewing the actual disciplinary cases of the past three years, Schubert & Associates, a health care consulting firm in Sacramento, presented to the February meeting of the Board a retrospective study which profiled disciplinary “risks”. This resulted in a “risk assessment worksheet” which could act as a management guide to investigators in prioritizing caseloads as well as explain to physician audiences the manner in which the Board’s enforcement staff works.

At its May meeting the Board had been set to approve Phase II of the study (a one-year prospective application of the “worksheet” to test the “risk” model on new cases as they come in and can be tracked). The Board delayed Phase II, however, instead ordering the model to be reconfigured. Several groups had protested that the model might contain a bias against international medical graduates.

While the study clearly debunked the old bromide that international medical graduates are disciplined disproportionately, graduates of medical schools in specific countries did show up as statistically disproportionate in some of the study’s 13 specific categories of discipline. The countries listed are all over the globe and are not concentrated. Also, it should be noted that this data comes only from a listing of the school from which the licensee graduated; the Board has no data on citizenship, race or national origin.

Still, the Board asked that the model be reconstructed after eliminating the school of graduation to determine if the difference in the model is significant. If it is not significant, the medical school of graduation will be eliminated in the prospective part of the study. If it is significant, it will remain as part of the model, but clearly labeled as the “school of graduation”, not “foreign medical graduate”.

The Board will make a decision on the prospective part of the study at its July 29 meeting.

evaluate and improve the Board's responsiveness, fairness, and quality of its decisions.

Some communication—to the extent permitted by law and by reason—among all levels keeps the quality pyramid strong and balanced. In the final analysis, however, it is the actions of each physician toward patients and as a participant in the system that determine quality. The right mechanism is in place. It is up to each of us collectively and as individuals to make it work.

# Accusations of Sexual Misconduct...

by

*J. Kent Garman, M.D.*

*President of the medical staff at Sequoia Hospital, Redwood City, CA  
Member, San Mateo County Medical Association's Board of Directors*

San Mateo County newspapers have recently publicized two criminal cases against physicians alleging sexual battery. Both physicians have lost patients and the respect of some of their colleagues. Without speculating on the degree of guilt or innocence in either case, it is fair to say that these two physicians will never enjoy their previous standing in the community after having these cases aired publicly in court. Since the Medical Board of California (MBC) may have a higher standard of ethics than the legal standard of the court, it is even possible that they will ultimately face Medical Board disciplinary measures.

Also, it is possible that civil suits may award the alleged victims large settlements. There are also other accusations in this county which could ultimately proceed to criminal accusations.

Over the previous several months, articles on sexual misconduct have appeared in the San Mateo County, Santa Clara County, and Kern County Medical Associations' Bulletins. Also, articles appear monthly in trade and consumer magazines. In addition, 10 years

ago, the term sexual harassment was rarely heard and certainly not understood. It is obvious that times have changed and physicians had better quickly learn the rights and wrongs of sexual misconduct or face possible accusations. While issues of sexual misconduct are clearly MBC's purview, issues of sexual harassment are more likely to be a cause of civil action.



*J. Kent Garman, M.D.*

Sexual misconduct can be defined as unwelcome behavior of a sexual nature which can take several courses. First, asking for sexual favors in exchange for some job-related benefits is clearly illegal and unethical. Second, creating a hostile work environment because of some conduct or harassment of a sexual nature is also illegal and unethical, although harder to prove. In both cases, the test is whether the victim felt the acts were unwanted. A federal court adopted a "reasonable woman" standard in 1991 in determining what constituted sexual harassment.

The fact remains that many men (and perhaps women) do not understand what constitutes sexual misconduct. This

## Bibliography

Bates, Carolyn. *Sex in the Therapy Hour: A Case of Professional Incest*. Guilford Press, New York, 1989

Black, Beryl. *Coping with Sexual Harassment*. Rosen Publications Group, New York, 1989

Childers-Hermann, Judy. *Awareness of Sexual Harassment: First Step Toward Prevention*. *Critical Care Nurse*: pg. 101-103, Feb. 1993

Edelwich, Jerry. *Sexual Dilemmas for the Helping Professional*. Brunner/Mazel, New York, 1991

Gabbard, Glen O. *Sexual Exploitation in Professional Relationships*. American Psychological Association, Washington, D.C., 1989

Johnson, Sandra H. *Judicial Review of Disciplinary Action for Sexual Misconduct in the Practice of Medicine*. *JAMA*: 270:13, pg. 1596-1600, 1993

Kapla, William J. *Avoiding Sexual Overture Accusations*. *Bulletin of the San Mateo County Medical Association*: pg 4, Feb. 1994

LaFranchise, Paul A. *How Can Doctors Avoid Sexual Harassment Complaints?* *Bulletin of the Kern County Medical Association*: pg. 18-19, Jan. 1994

Lippman, Helen. *Sexual Harassment: An Updated Picture*. *RN*: pg. 61-66, Feb. 1993

McNeil, Douglas E. *Sexual Abuse by Physicians: A Real and Perceived Problem*. *Bulletin of the Santa Clara County Medical Association*: pg. 7, Jan.-Feb. 1994

Pope, Kenneth S. *Sexual Feelings in Psychotherapy: Explorations for Therapists and Therapists-in-Training*. American Psychological Association, Washington, D.C., 1993

Rutter, Peter. *Sex in the Forbidden Zone: When Men in Power—Therapists, Doctors, Clergy, Teachers, and Others—Betray Womens' Trust*. Jeremy P. Tarcher, Inc., Los Angeles, 1989

Slade, Margot. *Sexual Harassment: Stories from the Field*. *New York Times*: Section 4, pg. 1, Mar. 27, 1994



# ...or Harassment Against Physicians

is a new age, where previously condoned male behaviors toward women are no longer considered acceptable. We must all learn to become more sensitive to the feelings of the opposite sex.

However, what we are seeing is even more subtle. Physicians (usually male) are increasingly being accused by patients (usually female) of improper conduct during physical examinations. In most cases, a chaperon was not present and the physician vehemently denies the accusation. These accusations can stem from poor physician-to-patient communication regarding the procedure or examination, misunderstandings by the patient of intent, or anger toward the physician for some reason.

Also, some physicians do actually abuse patients under the guise of medical care. The problem of medical staffs and the courts is to sort out the real episodes of abuse from the false accusations. Unfortunately (or perhaps fortunately, depending on which side of the accusation you are on) the burden of proof in the civil court system seems to have shifted to the accused to prove innocence. It often boils down to which of two individuals you believe, based on past history and credibility. Often multiple accusations are made against one physician when other patients and associates hear of the accusation. In other cases, multiple complaints are reported without any prompting. In either event, multiple accusations are much harder to defend since they seem to point to a pattern of misbehavior.

Physicians must be held to a higher standard than others, simply because of the very private nature of the doctor-patient relationship. There is a "zero-tolerance" policy as

far as the courts in California, the MBC, and the AMA are concerned. Any intimate or sexual relationship between a physician and a patient is illegal and unethical. There are no exceptions to this policy, nor should there be, even in the

case of mutual consent. According to the AMA policy, if an intimate relationship develops, physicians are expected to terminate the professional relationship at the least, although even this may not protect against allegations of unethical behavior if a physician "uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship."

The fact remains that some patients may find your behavior as a physician improper and may proceed to accuse you of sexual misconduct. Some women are much less tolerant of male physicians and may carefully examine your behavior during physical exams. Even if you are "squeaky clean" as far as you are concerned, the bottom line is that it is your word against the patient's when there is no witness present. Therefore, unfortunately, some defensive behavior by you is probably necessary to avoid future problems. I advise physicians to take certain steps to avoid these problems.

Therefore, consider the five measures listed here to create a circumspect environment

during physical examinations.

Although it is impossible to guard against all possibilities, the measures suggested should make it very unlikely that you will be accused of sexual misconduct by a patient.

## The Garman Guidelines

*"Waiting for your first accusation before taking some of these simple steps is foolhardy."*

1. Allow patients to disrobe and dress in private and offer cover gowns and appropriate drapes. (Yes, some physicians do not practice these simple steps.)
2. Have one of your office staff in the room whenever possible, especially during breast and pelvic exams. (I have talked to many physicians who feel this is silly and an added burden on their office staff. However, many women are very offended if these exams are done without another person in attendance. It would be reasonable to have your office nurse ask your patient if she would prefer to have an attendant in the room.)
3. Improve your communication with the patient about the reasons for and methods of examinations. (If you feel a breast examination for axillary lymphadenopathy is necessary for a hand infection, tell the patient why you are doing it.)
4. Avoid any flirtatious behavior toward patients. (Since you are perceived as a "power" figure, the patient may be hesitant to complain directly to you about jokes or other "innocent" behavior.)
5. Ask someone else to review your office procedures regarding physical exams with a view toward avoiding any risky procedures or making necessary changes. (One series of complaints was dealt with by asking the physician's female office staff to review and change standard examination procedures to avoid future problems.)

## Attention L.A. Physicians: DEA Drug Disposal Alert

Effective June 1, 1994 the Drug Enforcement Administration (DEA), Los Angeles Division, will no longer accept outdated or unwanted controlled substances for destruction, except under unusual or extenuating circumstances. Alternatives available to physicians for destroying controlled substances are:

- DEA may have previously authorized you in writing to conduct your own destructions. Those authorizations will remain in effect until rescinded, revoked, or procedures are changed.

- Controlled substances may be personally delivered to an Environmental Protection Agency (EPA) approved incinerator. DEA must be notified 14 days in advance of the proposed site. Two responsible individuals from your firm must accompany the controlled substances to the disposal site and actually witness their being rendered irretrievable. All required DEA Forms-41 (Registrants Inventory of Drugs Surrendered) must be completed and forwarded to the attention of the Drug Enforcement Administration, Los Angeles Division, Diversion Control Group, 255 East Temple Street, Suite 2000, Los Angeles, CA 90012.

- Controlled substances may be sent to a DEA registered disposal firm for destruction. The firms listed in the box to the right are currently registered by DEA for disposal of controlled substances.

If unusual or extenuating circumstances should arise concerning the destruction of unwanted or out-of-date controlled substances, contact the DEA Diversion Control Group within your area for instructions.

### DO NOT SEND THE CONTROLLED SUBSTANCES TO DEA.

Controlled substances received by the DEA office in Los Angeles or Riverside, without prior DEA approval, will not be accepted and will be returned to the sender. Regardless of the procedures followed, all federal, state and local requirements for the handling of controlled substances and for waste disposal must be followed.

If you have any questions, please contact the Los Angeles Division, Diversion Control Group at (213) 894-4016 or the Riverside Resident Office, Diversion Control Group at (909) 276-6001.

### Firms Registered by DEA for Disposal of Controlled Substances

BFI Pharmaceutical Services  
801 North Blacklawn Road  
Conveyers, GA 30207  
(800) 777-6565

3CI-Complete Compliance Corp.  
201 San Augustine  
Center, TX 75935  
(409) 598-4650

RX Returns, Inc.  
RR#1, Box 53  
Tollgate Road  
Palm, PA 18070  
(215) 679-9481

Reverse Distribution Services, Ltd.  
4100 Fleetwood Road  
Fort Worth, TX 76155  
(817) 868-5300

Capital Returns, Inc.  
9600 W. Flagg Avenue  
Milwaukee, WI 53225  
(414) 527-9912

EXP Pharmaceutical  
Waste Management  
2416 Radley Court, Suite 9  
Hayward, CA 94545  
(510) 887-5750

## Oversight Audits Underway

The State Auditor is expected to begin an audit of the Health Quality Enforcement Section of the Office of the Attorney General — the Board's prosecuting attorneys. The audit was ordered as part of SB 916 last year, the Omnibus Medical Board Reform Act, known as "Presley II" after the author, Senator Robert Presley, D-Riverside, Chairman of the Senate Committee on Appropriations.

The audit is to evaluate the case load, performance and billing of the HQES. Recent data comparing case loads from November 1993 to May 1994 show that the HQES has experienced case referral increases, yet managed to reduce the length of time it takes to process cases. The Auditor's staff will take six months or more to complete the audit and will report early next year.

In addition, other routine audits are in progress. At the Board's request, the State Department of Finance is auditing the enforcement program. This is a service provided by the Department as an aid in evaluating the cost-benefit of personnel, capital and operations.

Another Board oversight agency, the Department of Consumer Affairs, is auditing the Board's "evidence" funds, which are used to pay for the cost of obtaining evidence in disciplinary cases. DCA routinely audits these funds in all the consumer boards and commissions of the state.

# Infection Control is Not "Just for Nurses"

by

*Frances Taylor, M.D., M.P.H.*

*Director, Bureau of Epidemiology and Disease,  
City and County of San Francisco, Department of Public Health*

The December 24, 1993 issue of Morbidity and Mortality Weekly Report (MMWR), the weekly report from the Centers for Disease Control and Prevention (CDC), describes instances where a physician in the District of Columbia and another in Pennsylvania injected vaccine with used needles and syringes as a part of campaigns to administer influenza vaccine. In the first instance multiple doses were loaded into a single syringe and a single dose was injected into one patient after another with only an alcohol wipe to the common needle between injections. In the second case a clean needle and syringe was used to draw up and inject influenza vaccine. This contaminated needle and syringe was used to enter and draw up pneumococcal vaccine from a multi-dose vial and inject the same patient, thus contaminating the multi-dose vial repeatedly.

Each of these incidents involved a situation where many injections were given in a short span of time so that it was perhaps faster, more convenient or less expensive to use the procedures described. Each circumstance was sufficiently public that it seems unlikely that either physician understood that his/her actions were contrary to recommended practice.

Past experience shows that used needles and contaminated multidose vials can transmit infectious agents and that use of a contaminated needle or syringe to enter a multidose vial can contaminate it. In addition, perfectly healthy appearing individuals can harbor infectious agents capable of transmission to others. Proper infection control practices are imperative for patient safety. CDC has published the following infection control principles which should be adhered to by all who administer injections, not only nursing staff.



*Frances Taylor, M.D., M.P.H.*

- A needle or syringe that previously has been used to inoculate a patient is considered contaminated and should not be used to aspirate medication or vaccine from a multidose vial if any of the contents of the vial will later be administered to another patient.

- All hypodermic needles, as well as the lumens of syringes used to administer parenteral substances, should be sterile. Needles and syringes manufactured for single use only should be discarded and not reprocessed or reused on a different patient because the reprocessing method may not sterilize the internal surfaces and/or may alter the device's integrity.

Reusable needles and syringes should be cleaned and then sterilized by standard heat-based sterilization methods (e.g., steam autoclave or dry-air oven) between uses. Reprocessing of reusable needles and syringes by use of liquid chemical germicides cannot guarantee sterility and is not recommended.

Used needles should never be recapped or otherwise manipulated using both hands or any other technique that involves directing the point of a needle toward any part of the body. Either a one handed "scoop" technique or a mechanical device designed for holding the needle sheath should be used if recapping is necessary. Used needles and syringes should be disposed of in puncture-resistant containers located as close as practical to where the needles and syringes are used.

Recently, a physician on television gave an influenza vaccine to two talk show hosts. The second recipient was inadvertently injected with the used, empty needle and syringe. This would not have occurred had the practice banning recapping of needles and the recommendation that used needles and syringes be immediately discarded in a puncture proof container been followed.

## New Physician and Patient HIV Pamphlets Available

The U.S. Public Health Service's Agency for Health Care Policy and Research has developed four publications on early HIV infection.

The *Clinical Practice Guideline*, intended for practitioners, is a manual of selected protocols for the evaluation and management of the initial stage of infection caused by HIV. The *Quick Reference Guide for Clinicians*, also intended for the practitioner, is a brief summary of and companion volume to the *Clinical Practice Guideline*. It

provides highlights of the guideline and presents the tables and algorithms. The consumer guides, *Understanding HIV* and *HIV and Your Child*, are both published in English and Spanish, and provide information to help patients work in partnership with their health care providers.

These publications are available free of charge by writing to AHCPR HIV Guideline, CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849, or by calling (800) 342-AIDS.

## Physician Alert:

# New Physician Reporting Responsibilities...

by

*Derry Knight, J.D.*

*Deputy Director, Legal Affairs, Department of Consumer Affairs*

A new law (AB 1652) went into effect on January 1, 1994 which requires any health practitioner, including physicians, employed in any health facility, clinic or physician's office to report to law enforcement a wound or injury inflicted by a deadly weapon and to report any injury that the health practitioner knows or reasonably suspects resulted from assaultive or abusive conduct.

Penal Code section 11160 requires that any health practitioner employed in a health facility, clinic or physician's office must make a report if the practitioner has knowledge of, or observes, in his or her professional capacity within his or her scope of employment, a patient whom he or she knows or reasonably suspects is suffering from:

- Any wound or other injury inflicted by the patient's own act or inflicted by another by means of a deadly weapon;
- Any wound or physical injury resulting from assaultive or abusive conduct.

Whether to report may be a difficult decision if a person is not sure that he or she "knows or reasonably suspects" a patient is the victim of assaultive or abusive conduct. Section 11162.5 defines "reasonably suspects" to mean:

"...that it is objectively reasonable for a person to entertain a suspicion, based on facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect."

In other words, use your common sense, training, and experience.

An oral "report by telephone shall be made immediately or as soon as practically possible." Following the initial telephone contact with authorities, a "written report shall be prepared and sent to a local law enforcement agency within two working days...." The written report must include, but is not limited to:

- the name of the injured person, if known;
- the injured person's whereabouts;
- a description of the character and extent of the person's injuries; and
- the identity of anyone the injured person alleges is responsible for the injuries or for the assaultive or abusive conduct.

Section 11161(b) **recommends**, but does not require, that every physician who has under his or her care a victim of

assaultive or abusive conduct, also include the following information in the written report.

- Any comments by the injured person regarding past domestic violence, or the name of anyone suspected of inflicting the abuse;
- A map of the injured person's body showing the injuries;
- A copy of the law enforcement reporting form.

Subdivision (c) of section 11161 further **recommends** that the physician refer a person suffering from domestic violence to local domestic violence services.

Section 11163.2(b) requires that these reports be kept confidential by health facilities, practitioners, and law enforcement agencies. Thus, disclosure liability is always possible if this confidentiality is breached. However, section 11161.9 provides that physicians will be immune from any civil or criminal liability that might otherwise result from complying with the reporting requirement.

Immunity from liability is also granted to any physician who provides law enforcement or an adult protective services agency access to a victim of abuse. And no employee required to report shall be disciplined or harassed by his or her employer for doing so. Further liability protection is provided in section 11163.2 which eliminates the physician-patient and psychotherapist privilege in any court proceeding or administrative hearing that involves information required to be reported.

However, immunity from liability does not eliminate the possibility that suit might be brought against those required to report, pursuant to other laws. Consequently, section 11163(b)(1) allows any physician who is sued for complying with the reporting requirement to present a claim to the State Board of Control for reasonable attorney's fees incurred in the defense, provided the action is dismissed or the defense prevails.

Finally, section 11162 provides that a violation of this law is a misdemeanor, punishable by up to six months in county jail, or a maximum fine of \$1,000, or both. Although it is not specified in the code, a person convicted under this law for a failure to report could possibly be exposed to civil liability as a result of the death or further injury of the abuse victim at the hands of the abuser.

### **"Health Facility" and "Clinic" Defined**

"Health facility" is defined by Penal Code section 11162.5, and begins with a broad general definition that encompasses

## ...When You “Know or Reasonably Suspect”

any facility, where patients stay 24 hours or more, that is involved in any stage of diagnosis, care, or treatment of human physical or mental illness, including convalescence, rehabilitation, and pregnancy. The section then enumerates the following specific types of health facilities:

- “General acute care hospital” that provides 24-hour inpatient care including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. This category includes a “rural general acute care hospital” that does not provide surgery and anesthesia services;
- “Acute psychiatric hospital” that provides 24-hour inpatient care including medical, nursing, rehabilitative, pharmacy, and dietary services for mentally disordered, incompetent, or other patients referred to in Division 5 (§5000 et seq., Community Mental Health Services) or Division 6 (§6000 et seq., Voluntary Admissions) of the Welfare and Institutions Code;
- “Skilled nursing facility” that provides patients skilled nursing care on an extended basis;
- “Intermediate care facility/developmentally disabled habilitative” with a capacity of four to 15 beds, that provides 24-hour personal care, habilitation, developmental and supportive services to 15 or fewer developmentally disabled persons who require intermittent nursing care, but not continuous skilled nursing care;
- “Special hospital” that provides inpatient or outpatient care in dentistry or maternity;
- “Intermediate care facility/developmentally disabled” that provides 24-hour personal care, habilitation, developmental and supportive services to developmentally disabled clients who require intermittent skilled nursing;
- “Intermediate care facility/developmentally disabled—nursing” with a capacity of four to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who require intermittent, but not continuous, skilled nursing;
- “Congregate living health facility” that is a residential home with a capacity of no more than six beds (or no more than 59 beds if operated by a city or county) that provides inpatient care;
- “Correctional treatment center” operated by the Department of Corrections, the Department of the Youth Authority, or a county or city law enforcement agency that provides inpatient health services;
- “Nursing facility” certified to participate as a medicaid

### “Assaultive or abusive conduct”

“Assaultive or abusive conduct” specifically includes the following crimes or attempts to commit these crimes:

- |   |  |
|---|--|
| • murder;   | • assault with a stun gun or taser;                  |
| • manslaughter;   | • assault with a deadly weapon;                      |
| • mayhem;   | • rape;  |
| • aggravated mayhem;  | • spousal rape;                                      |
| • torture;  | • procuring any female to have sex with another man; |
| • assault with intent to commit mayhem, rape, sodomy, or oral copulation;                       | • child abuse or endangerment;                       |
| • administering controlled substances or anesthetic to aid in commission of a felony;           | • abuse of spouse or cohabitant;                     |
| • battery;  | • sodomy;  |
| • sexual battery;   | • lewd and lascivious acts with a child;             |
| • incest;   | • oral copulation;                                   |
| • throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure; | • genital or anal penetration by a foreign object ;  |
|   | • elder abuse  |

care provider under Title XIX of the federal Social Security Act.

“Clinic” is limited by section 11162.5 to include those specified in sections 1204 and 1204.3 of the Health and Safety Code:

- A primary care “community clinic” operated by a tax-exempt nonprofit corporation that utilizes a sliding fee scale based on the patient’s ability to pay;
- A primary care “free clinic” operated by a tax-exempt nonprofit corporation that does not charge patients directly;
- A “surgical clinic” that is not part of a hospital and provides ambulatory surgical care for patients who stay less than 24 hours;
- A “chronic dialysis clinic” that provides less than 24-hour care for patients with renal disease;
- A “rehabilitation clinic” that provides medical services and physical rehabilitation services for patients who stay less than 24 hours; and
- An “alternative birth center” that is not part of a hospital and provides perinatal services and delivery care to pregnant women who stay less than 24 hours.

# Lay Midwife Regulations Focus on Physician "Supervision"

by

*Thomas Joas, M.D.*

*Member, Medical Board of California, Division of Licensing, and Chair, Midwifery Licensing Committee*

The knotty problem of what, if anything, constitutes physician "supervision" of lay "direct-entry", midwives is the major focus of the Board's committee to develop regulations which will carry out new law providing for midwife licensing.

The author of the new law, SB 350 (1993), which became law this year, is Senator Lucy Killea (I-San Diego). Senator Killea had championed the cause of lay midwives by bills authorizing licensing for several years. In 1993, through extensive negotiations with the California Medical Association, she developed provisions that provided guarantees on training, examination and clinical verification.



*Thomas Joas, M.D.*

would ask Senator Killea if she would amend her bill to include supervision. She resisted such amendments; thus, the issue was "punted" to the Medical Board to be resolved as a part of the regulatory process.

The committee has heard hours of public testimony. Committee members have visited birthing centers and interviewed lay midwives. The committee has resolved the "easy" parts of the regulations (e.g., training requirements, application forms, clinical verification, fees), but the committee has yet to find the magic answer to the question of "supervision". Several suggestions have been made in testimony:

Left unwritten in the law, but debated in testimony, was the question of physician "supervision" of licensees, particularly in the event of emergencies. Malpractice insurers testified that they would only offer insurance to lay midwives at extremely high premiums, if at all, unless they were supervised by a physician and there was a written agreement to bind the parties to the supervisory arrangement.

Midwifery groups argued that their training precludes the necessity for such supervision, much less a written agreement, and that requiring either supervision or a written document is a smoke screen by insurers for outright opposition to lay midwifery. In addition, they say such a requirement is a "Catch 22"; that is, if midwives must have physician supervision, but insurers or the Board require a written agreement, physicians will be reluctant to commit themselves. Thus, the very requirement for written agreements will result in little, or no, physician supervision. And no supervision would mean no licenses.

During several legislative hearings, invariably, a legislator

- Require strict supervision, but not a written agreement, meaning that part of evaluating any complaint that might be received would be to audit supervisory arrangements,
- Require supervision and a written agreement, but define "supervision" to be non-binding,
- Require each midwife/physician to develop a protocol providing for their own level of supervision so that patients can be protected and the parties can be held accountable by their own agreement, and
- Define "supervision" loosely, with or without a written agreement.

The committee will meet at least once more in July before completing its work in time for our report to be included in the material prepared for the Board prior to its regular quarterly meeting in July. The Board's Division of Licensing, which is charged with the responsibility to adopt regulations, will meet on July 28 at the Burbank Hilton Hotel — a meeting open to the public.

## **Dr. Michael Weisman Resigns Board Post**

One of the Medical Board's most active members, Michael Weisman, M.D., resigned in May. Appointed in 1991 by Governor Wilson, Dr. Weisman had served as President of the Division of Medical Quality in 1992-93, assisting in the development of major reforms reflected in SB 916, authored by Senator Robert Presley. In addition, Dr. Weisman was Chairman of the Board's Task Force on Medical Quality Review.

Dr. Weisman is Professor of Medicine at the University of California at San Diego Medical Center where he recently received added faculty responsibilities. Prior to his appointment to the Board, Dr. Weisman served as a medical expert for the Board and later chaired the Council of Medical Quality Review Committees.

## Disciplinary Actions: February 1, 1994 to April 30, 1994 Decisions: Physicians and Surgeons

### **ALFRED, JOSEPH T., M.D. (C-24472)**

#### **Los Angeles, CA**

B&P Code §2234 (e). Stipulated Decision. Unprofessional conduct by the commission of an act involving dishonesty or corruption. He induced an elderly patient to extend him a loan on which he failed to make restitution. Revoked, stayed, 7 years' probation on terms and conditions. March 25, 1994.

### **ARNAZZI, HECTOR H., M.D. (G-40005)**

#### **Torrance, CA**

B&P Code §2234 (b),(c). Gross negligence, repeated negligent acts in his care of patient. Revoked, stayed, 3 years' probation on terms and conditions, including 30 days' actual suspension. March 11, 1994.

### **BURTON, ROBERT CALVIN, M.D. (A-29533)**

#### **Boise, ID**

B&P Code, §2234, 2305. Default Decision. Based upon discipline by Idaho Board of Medicine. California: Revoked. March 7, 1994.

### **COUSENS, GABRIEL, M.D (G-21874)**

#### **Petaluma, CA**

B&P Code §725. Stipulated Decision. Excessive prescribing. Revoked, stayed, 3 years' probation on terms and conditions. February 25, 1994.

### **DISTLER, EDWARD, M.D. (C-14345)**

#### **San Diego, CA**

B&P Code §2234 (b),(c),(d). Stipulated Decision. Gross negligence, repeated negligent acts and incompetence associated with patient record keeping. Public reprimand. February 28, 1994.

### **BARNETT, GEORGE, M.D. (C-11197)**

#### **Chicago, IL**

B&P Code §2234, 2305. Disciplined by Illinois Department of Registration and Education for dispensing controlled substance without medical examination or indication. Revoked, stayed, indefinite probation. California: License revoked. April 15, 1994.

### **BROADBENT, DAVID H., M.D. (G-29387)**

#### **Provo, UT**

B&P Code §2305. Disciplined by Utah Division of Occupational and Professional Licensing for poor medical judgment, inadequate medical history obtained or documented, on 2 liposuction patients. 2 years' probation, 1 stayed. California: License suspended, stayed, 2 years' probation on terms and conditions. April 13, 1994.

### **COMACHO-PARILLA, LUIS GUILLERMO, M.D.**

#### **(A-25151) Cochubemba, Bolivia**

B&P Code §2234 (e). Default Decision. Dishonesty in receiving payment from both patient and Medicare for surgical procedure; did not reimburse patient. Revoked. March 16, 1994.

### **FREEMAN, DAVID C., M.D. (C-022763)**

#### **North Hollywood, CA**

B&P Code §2234 (b), (d), (e). Stipulated Decision. Gross negligence, incompetence, and dishonesty in arriving at unsupported diagnoses and unconventional and unnecessary therapies in the care of 1 patient. Revoked, stayed, 5 years' probation on terms and conditions including 30 days' actual suspension. March 25, 1994.

(Cont. on p. 16)

## 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. 15)

### **FINE, JOEL, M.D. (A-42331)**

#### **Watertown, NY**

B&P Code §2234 (b), (c), (d). Gross negligence, repeated negligent acts and incompetence in administering anesthesia to a patient during elective outpatient surgery. Default Decision. Revoked. March 25, 1994.

### **GERMANN, TIMOTHY D., M.D. (A-16963)**

#### **Mission Hills, CA**

B&P Code §2239 (a), 2236 (a), 2234 (e). 2 convictions for driving under the influence of alcohol and dishonesty in informing the court on matters concerning the first conviction at the time of the second alcohol-related conviction. Revoked, stayed, 5 years' probation on terms and conditions with 30 days' actual suspension. April 1, 1994.

### **GROSSMAN, ROY, M.D. (G-34317)**

#### **Chico, CA**

B&P Code §2234 (b), (c), (d). Stipulated Decision. Failure to properly treat a heart attack patient, and failure to diagnose a cancerous mass. Revoked, stayed, 3 years' probation on terms and conditions, with 180 days' actual suspension. April 1, 1994.

### **HINES, WIRT ANDERSON, M.D. (G-20362)**

#### **Salt Lake City, UT**

B&P Code §2234 and 2305. Violated probation of prior discipline. Disciplined by the Utah board for unprofessional conduct. California: Default Decision. Revoked. February 14, 1994.

### **HUMPHREY, GARY BERTRAND, M.D. (A-038340)**

#### **Inglewood, CA**

B&P Code §2234 (b), (c), (d), 2238, 2242 (a). Gross negligence, repeated negligent acts, incompetence and prescribing dangerous drugs without prior exam and for other than legitimate purposes to a number of patients. Conviction of the crime (misdemeanor) of possessing paraphernalia used to inject or inhale a controlled substance. Revoked. February 27, 1994.

### **HYSNI, LOUIS F., M.D. (A-43336)**

#### **San Diego, CA**

B&P Code §2305. U.S. Navy terminated appointment and clinical privileges because of an impaired medical condition due to multiple sclerosis, inadequate clinical knowledge and skills, limited recall of old information, inappropriate statements and episodes of behavior that were disruptive to patient care. Revoked. April 22, 1994.

### **JOHNSON, THOMAS H., M.D. (C-42447)**

#### **Los Angeles, CA**

B&P Code §2305. Disciplined by the Minnesota Board for prescribing and administering abusable drugs for reasons other than therapeutic purposes. California: Revoked. March 16, 1994.

### **KROHN, HARRY LEON, M.D. (A-23194)**

#### **Long Beach, CA**

B&P Code §2234, 2238 and H&S Code §11171. Self use of Dilaudid, prescribing without medical examination or reason, and conviction of unlawful distribution of controlled substances.

Revoked, stayed, 7 years' probation on terms and conditions. April 7, 1994.

### **KURTZ, LEONARD D., M.D. (G-2341)**

#### **Farmingdale, NY**

B&P Code §2234, 2305. Relinquished Florida license after fraudulently representing completion of required continuing medical education on application for license renewal. California: Default Decision. Revoked. April 7, 1994.

### **LAFONT, HAROLD L., M.D. (A-19546)**

#### **Capitola, CA**

B&P Code §2234, 2236 (a), (b), (c), 490, 493. Convicted of sexual battery against a patient. Stipulated Decision. Revoked. April 12, 1994.

### **NYGREN, ROBERT C., M.D. (D-4961)**

#### **Lompoc, CA**

B&P Code §490, 2236(a). Stipulated Decision. Our action based on 2 convictions for drunk driving. Revoked, stayed, 5 years' probation on terms and conditions. April 7, 1994.

### **PARKISON, GARY ALAN, M.D. (A-49604)**

#### **Concord, CA**

B&P Code §2305. Disciplined by Oklahoma Medical Board for excessive prescribing and prescribing of controlled substances or narcotic drugs without medical need. California: Revoked, stayed, 3 years' probation on terms and conditions, including shall not prescribe controlled substances except for inpatients in a hospital or hospice. April 23, 1994.

### **PREECE, HOWARD G., M.D. (A-14734)**

#### **Monterey, CA**

B&P Code §2234 (b). Engaged in sexual intercourse with a patient. Revoked, stayed, prior condition, 7 years' probation on terms and conditions. April 30, 1994.

### **PRESLEY, PHYLLIS L., M.D. (A-11433)**

#### **Pasadena, CA**

B&P Code §2234 (b), (c), (d). Stipulated Decision. Mismanagement of 2 obstetrical cases. Revoked, stayed, 5 years' probation on terms and conditions, including passage of an oral clinical examination prior to resuming practice of obstetrics, and monitoring of obstetrical practice for 2 years. February 5, 1994.

### **REIDER, ARTHUR E., M.D. (G-12734)**

#### **Waban, Massachusetts**

B&P Code §2305. Stipulated Decision. Disciplined by Massachusetts for practicing while ability was impaired by mental instability. Sexual relations with a single patient. Revoked, stayed, 5 years' probation on terms and conditions. March 14, 1994.

### **ROMERO, JUSUSA NAVARRO, M.D. (A-34299)**

#### **Downey, CA**

B&P Code §2234 (e), 2236 (a), 2305, 2261. Stipulated Decision. Our action based on Medicaid fraud occurring in Louisiana as well as action taken by Ohio for lack of timely submission of documentation of CME compliance. Revoked, stayed, 5 years' probation on terms and conditions. February 7, 1994.

(Cont. on p. 17)



## **Disciplinary Actions (Cont. from p. 16)**

### **ROTH, ARTHUR, M.D. (C-10300)**

**San Jose, CA**

B&P Code §2234 (b), (d). Stipulated Decision. Failure to report suspected child abuse. Public reprimand. March 31, 1994.

### **RUBEL, PRESTON H., M.D. (G-50600)**

**Los Angeles, CA**

B&P Code §2239 (a), 2238, 2237 (a). Our action based on conviction of a crime for self use of drugs. Default Decision. Revoked. February 7, 1994.

### **SAINTHILL, GEORGE E., M.D. (G-56454)**

**New York, NY**

B&P Code §2234 (e), 2262. Dishonesty and fraud in the alteration of medical records. California: Revoked. February 25, 1994.

### **SHEPARD, DENNIS D., M.D. (G-9890)**

**Santa Maria, CA**

B&P Code §2261, 2234(e). Knowingly made and signed a certificate related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts. Suspended for 90 days, stayed, 3 years' probation on terms and conditions. April 22, 1994.

### **SMITH, KENNETH C., M.D. (G-3472)**

**South Lake Tahoe, CA**

B&P Code §2242 (a), 2261. Stipulated Decision. Prescribing without a good faith exam and medical indication, creating false medical records. Revoked, stayed, unlimited probation on terms and conditions. March 7, 1994.

### **SMITH, WILLIAM F., M.D. (C-18251)**

**Oakland, CA**

B&P Code §725. Stipulated Decision. Repeated excessive prescribing of drugs. Revoked, stayed, 7 years' probation on terms and conditions including 1 year actual suspension. April 13, 1994.

### **STEPHENSON, THOMAS R., M.D. (G-8862)**

**Los Angeles, CA**

B&P Code §2234 (a), (b), (c), (e), (f), 2261. Gross negligence, repeated negligent acts, creating false medical records, dishonesty, violating insurance requirements, false and misleading advertising in the care and treatment of plastic surgery patients. Revoked, stayed, prior condition, 10 years' probation on terms and conditions, including 120 days' actual suspension. April 11, 1994.

### **SWANSON, CRAIG E., M.D. (A-41844)**

**Wofford Heights, CA**

B&P Code §2234 (b), (d). Stipulated Decision. Gross negligence, incompetence, unprofessional conduct in the care and treatment of patients. Revoked, stayed, 5 years' probation on terms and conditions. March 30, 1994.

### **THOR, DANIEL E., M.D. (G-10241)**

**Vacaville, CA**

B&P Code §2236, 2239. Stipulated Decision. Our action based on a conviction for drunk driving. Revoked, stayed, 5 years' probation on terms and conditions. March 30, 1994.

### **URNS, JOHN EHRMAN, M.D. (G-44402)**

**Pleasanton, CA**

B&P Code §2234 (a), (b), (c), (d), (e). Stipulated Decision. Gross negligence, incompetence, repeated negligent acts, dishonesty, resulting from the lack of supervision of his physician assistants. Revoked, stayed, 3 years' probation on terms and conditions. February 7, 1994.

### **WOLPER, JACK, M.D. (G-13910)**

**Quincy, MA**

B&P Code §2234, 2305. Disciplined by Commonwealth of Massachusetts Board of Registration in Medicine.

Unprofessional conduct. California: Revoked. May 6, 1994.

### **ZIPORYN, MARVIN C., M.D. (C-18920)**

**Chicago, IL**

B&P §2305. Disciplined by Illinois Department of Professional Regulation. California: Default Decision. Revoked. February 7, 1994.

## **ACUPUNCTURE**

### **KIM, MOO BAE, C.A. (AC-2743)**

**Rowland Heights, CA**

B&P Code §123, 125, 496, 4955. Unprofessional conduct. Securing an acupuncture license by fraud or deceit. Default Decision. Revoked. April 18, 1994.

### **PARK, CHANG HA, C.A. (AC-1546)**

**Buchun, South Korea**

B&P Code §123, 125, 496, 4955. Unprofessional conduct. Securing an acupuncture license by fraud or deceit. Default Decision. Revoked. April 20, 1994.

### **UNTERMAN, BERNARD, C.A. (AC-2967)**

**Santa Barbara, CA**

B&P Code §4955. Stipulated Decision. Unprofessional conduct. Revoked, stayed, 5 years' probation on terms and conditions. February 14, 1994.

### **YUK, DON JIN, C.A. (AC-3175)**

**Los Angeles, CA**

B&P Code §123, 125, 496, 4955. Unprofessional conduct. Securing an acupuncture license by fraud or deceit. Default Decision. Revoked. April 18, 1994.

## **HEARING AID DISPENSERS**

### **ILLE, JOHN MICHAEL, H.A.D. (HA-1714)**

**Palo Alto, CA**

B&P Code §651 (b) (1) (5), 3401 (g) (i). Stipulated Decision. Fraudulent advertising and misrepresentation in the fitting or selling of hearing aids. Revoked, stayed, 3 years' probation with terms and conditions. March 25, 1994.

### **WALKER, LORETTA L., H.A.D. (HA-1922)**

**Grover City, CA**

B&P Code §3401 (b), 3365 (f). Gross negligence and selling hearing aid devices without a written warranty. 60 days' suspension, stayed, 1 year probation with terms and conditions. March 25, 1994.

**(Cont. on p. 18)**

## Disciplinary Actions (Cont. from p. 17)

### PHYSICIAN ASSISTANTS

**DILLON, JOHN R., P.A. (PA-12045)**

**Vallejo, CA**

B&P Code §3531. Our action based on a conviction for attempted manslaughter. Revoked. April 19, 1994.

**LYNCH, CHRIS, P.A. (PA-12072)**

**Victorville, CA**

B&P Code §2305. Our action based on the Air Force's revocation of license for indecent assault upon female patients during physical exams. Revoked, stayed, 5 years' probation on terms and conditions. March 7, 1994.

### PHYSICAL THERAPISTS

**CROSBY, CARL LENNOX (PT-5968)**

**Los Angeles, CA**

B&P Code §2660 (d), (f), (g). Conviction of possession of cocaine, multiple violations of probation. Habitual intemperance, cocaine addiction. License revoked. February 10, 1994.

**DAVE, CHARU (PT-7968)**

**Fremont, CA**

B&P Code §810, 2660 (l). Convicted on a plea of nolo contendere for insurance fraud. Revoked, stayed, 5 years' probation on terms and conditions including 90 days' actual suspension. April 8, 1994.

**JOHNSON, LEROY DUANE (PT-6244)**

**Montebello, CA**

B&P Code §2660 (i), (k), (l). Aiding and abetting unlicensed practice of physical therapy. Revoked, stayed, 3 years' probation on terms and conditions, including 90 days' actual suspension. February 23, 1994.

### DOCTORS OF PODIATRIC MEDICINE

**GAROFALO, FRANK J., D.P.M. (E-1174)**

**Canoga Park, CA**

B&P Code §2228, 2234, 2261, 2497.5. Stipulated Decision. Failed to comply with probationary terms of prior discipline, committed act of dishonesty in falsifying application for reappointment to hospital medical staff. Revoked, stayed, 2 additional years' probation on terms and conditions. February 18, 1994.

**LAMPELL, HARVEY J., D.P.M. (E-1494)**

**Fullerton, CA**

B&P Code §2239, 2234 (a). Stipulated Decision. Unprofessional conduct in administering controlled substances to himself. Revoked, stayed, 5 years' probation on terms and conditions. April 22, 1994.

### PSYCHOLOGISTS

**GEIGER, KATHLEEN., Ph.D. (PSY 7988)**

**MARTINEZ, CA**

B&P Code §2960 (a). Default Decision. Conviction of a crime. Revoked. February 24, 1994.

**BERLIN, STEPHEN., Ph.D. (PSY 6121)**

**PACIFIC GROVE, CA**

B&P Code §2960 (k), (i). Stipulated Decision. Improper supervision of psychological assistant. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' suspension. March 9, 1994.

**BEAUDOIN, JOHN, Ph.D. (PSY 13842)**

**PACIFIC GROVE, CA**

B&P Code §2913 (e),(f), 2960 (c),(i),(p). Stipulated Decision. Misrepresentation, practiced beyond the scope of education, training and experience. Probationary license issued, then license is revoked, stayed, 5 years' probation on terms and conditions. (Suspended practice until psychological evaluation is passed and has 90 days to take the psychological evaluation.) March 9, 1994.

**SPIEGEL, DONALD E., Ph.D. (PSY 1741)**

**STUDIO CITY, CA**

B&P Code §490, 2960 (a). Stipulated Decision. 3 prior convictions involving petty theft and lewd conduct. 60 days' suspension, stayed, 3 years' probation on terms and conditions. March 23, 1994.

**RICHARDSON, ROBERT, Ph.D. (PSY 7287)**

**FRESNO, CA**

B&P Code §2960 (j). Stipulated Decision. Gross negligence in performance of court-ordered evaluation. Must pass oral license exam in January 1995. If he passes exam, accusation will be withdrawn. If exam is failed: revoked, stayed, 3 years' probation on terms and conditions. April 2, 1994.

**MAKSIMCZYK, WALTER J., Ph.D. (PSY 2435)**

**HUNTINGTON BEACH, CA**

B&P Code §2960 (h), (j). Stipulated Decision. Gross negligence and breach of confidentiality. Revoked, stayed, 3 years' probation on terms and conditions. April 4, 1994.

**SMITH, DANIEL S., Ph.D. (PSY 5778)**

**CLAREMONT, CA**

B&P Code §2960 (i). Stipulated Decision. Unprofessional conduct. Revoked, stayed, 5 years' probation on terms and conditions. April 11, 1994.

### PSYCHOLOGICAL ASSISTANTS

**VENNERS-SISSONS, ANGELA, Ph.D. (PSB 7858)**

**LAKWOOD, CA**

B&P Code §2960 (a),(d),(i),(k),(n). Stipulated Decision. Convicted for Medi-Cal fraud on April 4, 1990. Revoked, stayed, 5 years' probation on terms and conditions. 30 days' suspension commencing on the 180th day from the effective date. March 22, 1994.

### RESPIRATORY CARE PRACTITIONERS

**ARISMAN, David Wayne (RCP 8502)**

**Harbor City, CA**

B&P Code §490, 3750(d), 3752.6. Felony convictions for burglary, attempted murder, attempted rape and assault with a

(Cont. on p. 19)

## Disciplinary Actions (Cont. from p. 18)

deadly and dangerous weapon. Revoked. Default. March 3, 1994.

### **BOUILLERCE, Jeffrey G. (RCP 17047)**

**Livermore, CA**

B&P Code §3750(b),(j). Stipulated Decision. Procured license by fraud in concealing convictions in license application. 3-year probationary license. April 25, 1994.

### **CAVA, Jose L. (RCP 16921)**

**La Mirada, CA**

B&P Code §3750(d), 3750.5(b),(d). Conviction for receiving stolen property. Self abuse of controlled substances. 5-year probationary license granted. February 1, 1994.

### **HARMEL, Sarah M. (RCP 17057)**

**San Diego, CA**

B&P Code §3760, 3750(j). Stipulated Decision. Unlawful practice of respiratory care without obtaining a license. Fraudulently continued to work on expired work permit. 5-year probationary license. April 28, 1994.

### **JACKSON, Gerald D. (RCP 2014)**

**Oceanside, CA**

B&P Code §3750(d), 3750.5(a),(b),(c). Conviction for self-use of controlled substances. Revoked. Default. February 7, 1994.

### **JONES, Leroi Pierre (RCP 7912)**

**Inglewood, CA**

B&P Code §490, 3750(d). Felony conviction for residential burglary. Revoked. Default. February 7, 1994.

### **McGOWAN, Deanna (RCP 6813)**

**Concord, CA**

B&P Code §3750(d). Felony conviction for grand theft for fraudulently obtaining payment for services as in-home care provider from the State of California for services not rendered to the patient. Revoked. March 3, 1994.

### **MONTGOMERY, James (RCP 16997)**

**Santa Ana, CA**

B&P Code §3750(d). Convictions for crimes involving theft-related crime and soliciting of a lewd act. 5-year probationary license. March 17, 1994.

### **MOSER, Patrick D. (RCP 16637)**

**Federal Way, Washington**

Violated terms of probation of prior discipline. Revoked. Default. February 7, 1994.

### **REYES, Jerry N. (RCP 8236)**

**Eureka, CA**

B&P Code §3750(d),(f) 3750.5(b),(c). Convictions for alcohol-related offenses. Intoxicated while on duty is extreme departure from the standard of care and demonstrates gross negligence. Revoked. February 25, 1994.

### **STAPLER, Cassandra M. (RCP 9035)**

**Long Beach, CA**

B&P Code §490, 3750(d). Stipulated Decision. Convictions for

soliciting prostitution. Revoked, stayed, 5 years' probation. April 2, 1994.

### **TUCKER, Michael A. (RCP 3944)**

**Gardena, CA**

Violated terms of probation of prior discipline. Revoked. April 30, 1994.

### **UMBENHOWER, James T. (RCP 5984)**

**Redwood City, CA**

B&P Code §3755. Unprofessional conduct in failing to consult with M.D. prior to changing ventilator parameters. Made a false entry in patient's medical record. Revoked, stayed, 5 years' probation. March 19, 1994.

### **WORLEY, Anthony (RCP 5849)**

**Rancho Cucamonga, CA**

B&P Code §3750.5, 3750(d). Stipulated Decision. Conviction for inflicting corporal punishment on spouse. Revoked, stayed, 3 years' probation, including 5 days' actual suspension. April 18, 1994.

## LICENSE SURRENDER

### PHYSICIANS

#### **BECK, JOHN J., M.D. (C-9335)**

**Los Altos, CA**

February 2, 1994.

#### **CARLSEN, ERNEST N., M.D. (G-19415)**

**Grand Terrace, CA**

February 1, 1994.

#### **CLOSSON, WILLIAM, M.D. (A-10597)**

**San Jose, CA**

February 13, 1994.

#### **DAVIS, FRANKLIN B., M.D. (C-19121)**

**Denair, CA**

April 18, 1994.

#### **HYMEL, BERNARD H., M.D. (A-52697)**

**San Jose, CA**

March 31, 1994.

#### **KING, WILLIAM F., M.D. (C-28048)**

**Lyons, CA**

February 5, 1994.

#### **LOFTUS, WILLIAM ANDREW, M.D. (G-49091)**

**Harrisburg, PA**

February 5, 1994.

### PSYCHOLOGIST

#### **VIDOS, MARIA, Ph.D. (PSY 7557)**

**Sacramento, CA**

April 21, 1994.

**Business and  
Professions Code  
Section 2021(b)  
requires  
physicians to  
inform the  
Medical Board of  
any address  
change.**

94 75176

**MEDICAL BOARD OF CALIFORNIA**

Bruce H. Hasenkamp, J.D., President  
Robert del Junco, M.D., Vice President  
Alan E. Shumacher, M.D., Secretary

**Division of Licensing**

Robert del Junco, M.D., President  
B. Camille Williams, M.D., Vice President  
Ray Mallel, Secretary  
Bruce Hasenkamp, J.D.  
Stewart Hsieh, J.D.  
Thomas A. Joas, M.D.  
C. Fredrick Milkie, M.D.

**Division of Medical Quality**

Karen L. McElliott, President  
Alan E. Shumacher, M.D., Secretary  
Clarence Avery, M.D.  
Theresa Claassen  
Lawrence D. Dorr, M.D.  
Anabel Anderson Imbert, M.D.  
Ira Lubell, M.D.  
Mike Mirahmadi, M.D.  
Gayle W. Nathanson  
Jacquelin Trestrail, M.D.  
Cathryne Bennett-Warner

Dixon Arnett, Executive Director

**TOLL FREE COMPLAINT LINE:**

**1-800-MED-BD-CA (1-800-633-2322)**

(Non-complaint calls to this number cannot be transferred.)

**Physicians and Surgeons:**

Applications and Examinations	(916) 263-2499
Complaints	(800) 633-2322
Continuing Education	(916) 263-2360
Health Facility Discipline Reports	(916) 263-2382
Fictitious Name Permits	(916) 263-2382
License Renewals	(916) 263-2382
Verification of Licensure	(916) 263-2382

**General Information**

**(916) 263-2466**

**Allied Health Professions:**

Complaints	(800) 633-2322
Acupuncture	(916) 263-2680
Audiology	(916) 263-2666
Hearing Aid Dispensers	(916) 263-2288
Physical Therapy	(916) 263-2550
Physician Assistant	(916) 263-2670
Podiatry	(916) 263-2647
Psychology	(916) 263-2699
Registered Dispensing Opticians	(916) 263-2634
Respiratory Care	(916) 263-2626
Speech Pathology	(916) 263-2666

**ACTION REPORT-JULY 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

July 1994

## Treatment of Prostate Cancer

Cancer of the prostate, a common form of cancer, is a disease in which cancer (malignant) cells are found in the prostate. The prostate is one of the male sex glands and is located just below the bladder (the organ that collects and empties urine) and in front of the rectum (the lower part of the intestine). The prostate is about the size of a walnut. It surrounds part of the urethra, the tube that carries urine from the bladder to the outside of the body. The prostate makes fluid that becomes part of the semen, the white fluid that contains sperm.

Cancer of the prostate is found mainly in older men. As you get older, your prostate may get bigger and block the urethra or bladder, which can cause you to have difficulty urinating or may interfere with sexual functions. This condition is called benign prostatic hyperplasia (BPH), and although it is not cancer, you may need surgery to correct it. The symptoms of BPH or of other problems in the prostate may be similar to symptoms for prostate cancer.

Like most cancers, the chance for cure for cancer of the prostate is greatest when the cancer is diagnosed and treated when it is small (at an early stage). You should see a doctor if you have any of the following: weak or interrupted flow of urine, urinating often (especially at night), difficulty urinating, pain or burning when you urinate, blood in the urine, or nagging pain in the back, hips, or pelvis. Often there are no symptoms of early cancer of the prostate. To examine you, usually your doctor will insert a gloved finger into the rectum (a rectal exam) to feel for lumps in the prostate. A special test called an ultrasound, which uses sound waves to make a picture of your bladder, may also be done.

If your doctor feels anything that is not normal, he or she may need to take cells from your prostate and look at them under a microscope. Your doctor will usually do this by putting a needle into the prostate to remove some cells. To get to your prostate, your doctor may put the needle through the rectum or through the space between the scrotum and the anus (the perineum). This is called a fine needle aspiration or a needle biopsy.

Your chance of recovery (prognosis) and choice of treatment depend on the stage of your cancer (whether it is just in the prostate or has spread to other places in the body) and your general state of health.

### Stages of cancer of the prostate

Once cancer of the prostate has been found (diagnosed), more tests will be done to find out if cancer cells have spread from the prostate to tissues around it or to other parts of the body. This is called "staging." Your doctor needs to know the stage of your disease to plan treatment. The following stages are used for cancer of the prostate:

**Stage A**—Prostate cancer at this stage cannot be felt and causes no symptoms. The cancer is only in the prostate and usually is found accidentally when surgery is done for other reasons, such as for BPH.

**Stage A1**—Cancer cells are found in only one area of the prostate.

**Stage A2**—Cancer cells are found in many areas of the prostate.

**Stage B**—The tumor can be felt in the prostate during a rectal exam, but the cancer cells are found only in the prostate gland.

**Stage C**—Cancer cells have spread outside the covering (capsule) of the prostate to tissues around the prostate. The glands that produce semen (the seminal vesicles) may have cancer in them.

**Stage D**—Cancer cells have spread (metastasized) to lymph nodes or to organs and tissues far away from the prostate.

**Stage D1**—Cancer cells have spread to lymph nodes near the prostate. (Lymph nodes are small, bean-shaped structures that are found throughout the body. They produce and store infection-fighting cells.)

*This information is provided to assist physicians to comply with the spirit of the new law requiring the posting of a notice that information on prostate cancer treatment options is available to patients. It is a verbatim republication of the most current (1/29/94) information provided by the National Cancer Institute of the United States Public Health Service.*

### 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.

**Stage D2**— Cancer cells have spread to lymph nodes far from the prostate or to other parts of the body, such as the bone, liver, or lungs.

**Recurrent**—Recurrent disease means that the cancer has come back (recurred) after it has been treated. It may come back in the prostate or in another part of the body.

### How cancer of the prostate is treated

There are treatments for all patients with cancer of the prostate. Three kinds of treatment are commonly used:

- surgery (taking out the cancer)
- radiation therapy (using high-dose x-rays or other high-energy rays to kill cancer cells)
- hormone therapy (using hormones to stop cancer cells from growing).

Surgery is a common treatment for cancer of the prostate. Your doctor may take out the cancer using one of the following operations:

**Radical prostatectomy** removes the prostate and some of the tissue around it. Your doctor may do the surgery by cutting into the space between the scrotum and the anus (the perineum) in an operation called a perineal prostatectomy or by cutting into the lower abdomen in an operation called a retropubic or by cutting into the lower abdomen in an operation called a retropubic prostatectomy. Radical prostatectomy is done only if the cancer has not spread outside the prostate. Often before the prostatectomy is done, your doctor will do surgery to take out lymph nodes in the pelvis to see if they contain cancer. This is called a pelvic lymph node dissection. If the lymph nodes contain cancer, usually your doctor will not do a prostatectomy, and may or may not recommend other therapy at this time. Impotence can occur in men treated with surgery.

**Transurethral resection** cuts cancer from the prostate using a tool with a small wire loop on the end that is put into the prostate through the urethra. This operation is sometimes done to relieve symptoms caused by the tumor before other treatment or in men who cannot have a radical prostatectomy because of age or other illness.

**Cryosurgery** is a type of surgery that kills the cancer by freezing it.

**Radiation therapy** uses high-energy x-rays to kill cancer cells and shrink tumors. Radiation may come from a machine outside the body (external radiation therapy) or from putting materials that produce radiation (radioisotopes) through thin plastic tubes in the area where the cancer cells are found (internal radiation therapy). Impotence may occur in men treated with radiation therapy.

**Hormone therapy** uses hormones to stop cancer cells from growing. Hormone therapy for prostate cancer can take several forms. Male hormones (especially testosterone) can help prostate

cancer grow. To stop the cancer from growing, female hormones or drugs that decrease the amount of male hormones made may be given. Sometimes an operation to remove the testicles (orchiectomy) is done to stop the testicles from making testosterone. This treatment is usually used in men with advanced prostate cancer. Growth of breast tissue is a common side effect of therapy with female hormones (estrogens); hot flashes can occur after orchiectomy and other hormone therapies.

**Chemotherapy** uses drugs to kill cancer cells. Chemotherapy may be taken by pill, or it may be put into the body by a needle in the vein or muscle. Chemotherapy is called a systemic treatment because the drug enters the bloodstream, travels through the body, and can kill cancer cells outside the prostate. To date, chemotherapy has not had significant value in treating prostate cancer, but clinical trials are in progress to find more effective drugs.

### Treatment by stage

Treatment of cancer of the prostate depends on the stage of your disease, your age, and your overall condition. If you do not have any symptoms, your doctor may follow you closely without any treatment if you are older, if you have another more serious illness, or if your tumor cells appear only slightly abnormal.

You may receive treatment that is considered standard based on its effectiveness in a number of patients in past studies, or you may choose to go into a clinical trial. Not all patients are cured with standard therapy and some standard treatments may have more side effects than are desired. For these reasons, clinical trials are designed to find better ways to treat cancer patients and are based on the most up-to-date information. Clinical trials are going on in most parts of the country for most stages of cancer of the prostate. If you want more information, call the Cancer Information Service at **1-800-4-CANCER (1-800-422-6237)**.

### Treatment by cell type

**Stage A prostate cancer**—Your treatment depends on whether you have stage A1 or stage A2 prostate cancer.

If you have stage A1 cancer and you are older, your doctor may follow you closely without any treatment. Your doctor may choose this option for you because your cancer is not causing any symptoms or other problems and may be growing slowly. If you are younger, you may have surgery to remove the prostate and the tissue around it (radical prostatectomy) or external radiation therapy.

If you have stage A2 cancer, your treatment may be one of the following:

1. External radiation therapy.
2. Surgery to remove the prostate and the tissue around it (radical prostatectomy), with or without new techniques to preserve the nerves necessary for an erection as well as



preventing leakage of urine from the bladder (nerve sparing technique). Usually some of the lymph nodes in the pelvis are also removed (pelvic lymph node dissection). Radiation therapy may be given after surgery in some cases.

3. A clinical trial of internal radiation therapy, often in addition to pelvic lymph node dissection.
4. If you are older or have another more serious illness, your doctor may follow you closely without treatment.
5. A clinical trial of cryosurgery.
6. A clinical trial of external radiation therapy using new techniques to protect your normal tissues from radiation.

**Stage B prostate cancer**—Your treatment may be one of the following:

1. Surgery to remove the prostate and the tissue around it (radical prostatectomy), with or without techniques to preserve the nerves necessary for an erection as well as preventing leakage of urine from the bladder (nerve sparing technique). Usually some of the lymph nodes in the pelvis are also removed (pelvic lymph node dissection). Radiation therapy may be given following surgery.
2. External radiation therapy. Clinical trials are testing new types of radiation.
3. A clinical trial of internal radiation therapy, often in addition to pelvic lymph node dissection.
4. If you are older or have another more serious illness, your doctor may follow you closely without treatment. Your doctor may choose this option for you because your cancer is not causing any symptoms or other problems for you because your cancer is not causing any symptoms or other problems and may be growing slowly.
5. A clinical trial of external radiation therapy using new techniques to protect your normal tissues from the radiation.
6. A clinical trial of cryosurgery.

**Stage C prostate cancer**—Your treatment may be one of the following:

1. External radiation therapy. Clinical trials are testing new types of radiation.
2. Surgery to remove the prostate and the tissue around it (radical prostatectomy). Usually some of the lymph nodes in the pelvis are also removed (pelvic lymph node dissection). Radiation therapy may be given following surgery.
3. If you are older or have another more serious illness, your doctor may follow you closely without treatment. Your doctor may choose this option for you because your cancer is not causing any symptoms or other problems and may be growing slowly.
4. A clinical trial of internal radiation therapy, often in addition to pelvic lymph node dissection.

If you are unable to have surgery or radiation therapy, your doctor may give you treatments to relieve symptoms such as problems urinating. In this case, your treatment may be one of the following:

1. Radiation therapy to relieve symptoms.
2. Surgery to cut the cancer from the prostate using a tool with a small wire loop on the end that is put into the prostate through the urethra (transurethral resection).
3. Hormone therapy.

**Stage D prostate cancer**—Your treatment depends on whether you have stage D1 or D2 prostate cancer.

If you have stage D1 cancer, your treatment may be one of the following:

1. External radiation therapy. Clinical trials are testing new forms of radiation. Hormone therapy may be given in addition to radiation.

2. Clinical trials of surgery to remove the prostate and the tissue around it (radical prostatectomy) and surgery to remove the testicles (orchiectomy).

3. If you are older or have another more serious illness, your doctor may follow you closely without treatment. Your doctor may choose this option for you because your cancer is not causing any symptoms or other problems and may be growing slowly.

4. A clinical trial of hormone therapy.

**ADDITIONAL INFORMATION  
CALL 1-800-4-CANCER**

There are many other places you can get material about cancer treatment and services to help you. You can check the social services office at your hospital for local and national agencies that help with your finances, getting to and from treatment, care at home, and dealing with your problems. The American Cancer Society, for example, has many free services. Their local offices are listed in the white pages of the telephone book.

You can also write to the National Cancer Institute at this address:

**National Cancer Institute  
Building 31, Room 10A24  
9000 Rockville Pike  
Bethesda, MD 20892**

If you have stage D2 disease, your treatment may be one of the following:

1. Hormone therapy.
2. External beam radiation therapy to relieve symptoms.
3. Surgery to cut the cancer from the prostate using a tool with a small wire loop on the end that is put into the prostate through the urethra (transurethral resection) to relieve symptoms.
4. Your doctor may follow you closely and wait until you develop symptoms before giving you treatment.
5. Clinical trials of chemotherapy, radiation therapy, or surgery.

**Recurrent prostate cancer**

Your treatment depends on many things, including what treatment you had before. If you had surgery to remove the prostate (prostatectomy) and the cancer comes back in only a small area, you may receive radiation therapy. If the disease has spread to other parts of the body, you will probably receive hormone therapy. Radiation therapy may be given to relieve symptoms, such as bone pain. You may also choose to take part in a clinical trial of chemotherapy.

### What is PDQ?

PDQ is a computer system that gives up-to-date information on cancer treatment. It is a service of the National Cancer Institute (NCI) for people with cancer and their families, and for doctors, nurses, and other health care professionals.

PDQ tells about the current treatments for most cancers. The information in PDQ is reviewed each month by cancer experts. It is updated when there is new information. The patient information in PDQ also tells about warning signs and how the cancer is found. PDQ also lists information about research on new treatments (clinical trials), doctors who treat cancer, and hospitals with cancer programs.

### How to use PDQ

You can use PDQ to learn more about current treatment for your kind of cancer. Bring this material from PDQ with you when you see your doctor. You can talk with your doctor, who knows you and has the facts about your disease, about which treatment would be best for you. Before you start your treatment, you might also want to seek a second opinion from a doctor who treats cancer.

Before you start treatment, you also may want to think about taking part in a clinical trial. A clinical trial is a study that uses new treatments to care for patients. Each study is based on past studies and what has been learned in the laboratory. Each trial answers certain scientific questions in order to find new and better ways to help cancer patients. During clinical trials, more and more information is collected about new treatments, their

risks, and how well they do or do not work. If clinical trials show that the new treatment is better than the treatment currently being used, the new treatment may become the "standard" treatment. Listings of clinical trials are a part of PDQ. Many cancer doctors who take part in clinical trials are listed in PDQ.

If you want to know more about cancer and how it is treated, or if you wish to learn about clinical trials for your kind of cancer, you can call the National Cancer Institute's Cancer Information Service. The number is 1-800-4-CANCER (1-800-422-6237). The call is free and a trained counselor will talk with you and answer your questions.

PDQ may change when there is new information. Check with the Cancer Information Service to be sure that you have the most up-to-date information.

Additional copies of this reproduction are available free of charge by writing:

**Treatment of Prostate Cancer  
Yolanda Gonsolis  
Medical Board of California  
1426 Howe Avenue, Suite 54  
Sacramento, CA 95825**

or

**Fax your request to (916) 263-2479**

(Please specify number of copies and provide your return address.)

U.S.  
Postage  
Here