

# Action Report

## Medical Board of California

No. 53, April 1995

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## Call for Medical Experts Brings Gratifying Response

Over 400 physicians responded to last quarter's *Action Report* notice asking that California's physician community volunteer for duty—modestly paid—as medical experts. The notice was added on a back page of the January edition; the response was beyond staff expectations.

"Clearly, California's physicians are joining our vital effort to improve the Board's use of medical expertise in ensuring quality of care. The response is heartwarming and gratifying," said Board Vice President Alan Shumacher, M.D., who chaired the Board's Task Force on Medical Quality.

Dr. Shumacher added, "If we can get over 400 resumes from a small notice on page 14, what can we get from a front page appeal? We want a statewide computer system of over 2,000 experts, whose upgraded qualifications are on current file, so our choices of those who provide medical counsel on cases or who testify in court are second to none."

According to program coordinator Linda Whitney, well over 80% of those responding meet the new, improved statewide minimum standards set by the Board when it adopted the Task Force Report last July 29. The goal of the Board has been to **create a systematic, objective and efficient approach to the qualifications, appointment, training, oversight, evaluation and functions of the physicians who constitute the Board's medical resources.**

The first group of applicants will be selected in April and the first short 8-hour training course to complement the new program will be in May/June.

The new appointments will be effective July 1.

Medical experts are compensated at the rate of \$75/hour for time reviewing complaints or investigative files or in office conferences. For time providing expert testimony, the rate is \$100/hour. Actual travel expenses (with limits imposed by the state) are added.

Ms. Whitney: "This is not a full- or even part-time job. Experts may be called infrequently, but when they are, their role is essential. Experts are used for individual case review—in general in the geographic area where a complaint originated—in their area of specialty and preferably in their own part of the state, being careful to avoid any conflict of interest. We have

received CVs from physicians representing all 24 ABMS boards, but we still lack geographic, proportional representation of these specialties statewide. Our recruitment is going better than we dreamed, but we can always do better."

For more information or to send a CV, contact Linda Whitney, Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236, (916) 263-2677.

### New Minimum Qualifications:

- A current medical license in good standing,
- no prior discipline, no current accusation pending and no complaints "closed with merit,"
- board certification in one of the 24 ABMS boards or equivalent/superior qualifications in an "emerging" specialty or subspecialty,
- a minimum of 5 years' active practice in the area of specialty or subspecialty, and
- have an active practice (defined as at least 80 hours/month in direct patient care, clinical activity or teaching, at least 40 hours of which is in direct patient care) or have been non-active for no more than 2 years prior to appointment (2-year term, renewable)
- Peer review experience is recommended but not required.

### 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.

1995

Medical Board of California  
Meeting Dates/Locations  
May 11-12 Sacramento  
July 28-29 Los Angeles  
November 2-3 San Diego

## An Evaluation of MBC Policies/Operations: Successes, Improvements, Much More To Do

by

*Robert del Junco, M.D., President of the Board*

Our decision to publish the comparisons of our Board against other states (see this issue's insert) gave us pause, for the comparisons are not uniformly complimentary. Yes, there is much in the results of which we are proud, but there are improvements indicated as well.

The Self Assessment Instrument (SAI) was developed by the Federation of State Medical Boards. It was years in the making and took months to tabulate. The FSMB plans to repeat the effort every three years.

The SAI shows the California Board as first in sheer size in a large variety of categories, notably in numbers of licenses (almost 1/5 of all physicians in the U.S.) and, correspondingly, in numbers of complaints (now almost 10,000/year but will exceed 12,000 in the 94-95 fiscal year). We have the largest fees and the largest staff, yet our investigator and attorney caseloads are also the largest in the nation by all measurements. But the quality of our cases is the best. Appeals of Board decisions are the lowest in the nation; successful court appeals are also the lowest.

California takes longer to resolve cases from complaint to stipulation or judgment than any other state. Almost 60% of the time to judgment is in the courtroom (not under the control of the Board). Clearly, California's penchant for litigiousness means "justice delayed", hence, on occasion, "justice denied." Such a system serves no one well.

Based on the SAI results, Board Vice President Alan Shumacher and I have proposed a 10-point plan of action:

- (1) Reduce the overall time from complaint to adjudication by one-third in the next two years (since the SAI was first issued, we have already gained almost five months' time primarily from improvements at our Central Complaint Unit and medical expert review),
- (2) Formally adopt a policy, after completion of current studies and public hearings, of enforcement priorities,
- (3) Evaluate possible increase in investigative staff, the cost of which can be achieved by added revenues from cost recovery,
- (4) With the encouragement of a brand new report from the State Auditor, conduct an intensive review of billing charges to the Medical Board by the Health Quality Enforcement Section of the Attorney General's

Office (our prosecuting lawyers) and the Office of Administrative Hearings (administrative law judges),



*Robert del Junco, M.D.*

(5) Enforce current provisions of law requiring administrative law judge to meet legally prescribed time limits for decision-making and the filing of their proposed decisions,

(6) Set a goal that adopt/non-adopt decisions and stipulations of the Board's Division of Medical Quality will be within 30 days instead of the current 90 days allowed in law,

(7) Increase information/education to the public and to licensees,

(8) Establish a committee to consider testing as a condition of periodic relicensure (e.g., every 10 years or

fifth renewal) for knowledge of the Medical Practice Act (including Board regulations), medical jurisprudence and mandatory reporting laws,

(9) Keep the Board's Diversion Program strong and confidential, and

(10) Mandate orientation training for new Board members (now voluntary but all new members have attended in the last two years).

On other fronts, the Board has approved its 1995 legislative program—a further refinement of earlier reforms. The most notable inclusions are substantial increases in fines for repeated counts of fraud and a codification of the Kees Decision governing the delicate relationship between the Board's Diversion Program and protection of patients.

In 1995 most of the policy lawsuits pending will be resolved, including the California Medical Association's challenge to our information disclosure policies. There will be new (and renewed) legislative battles over "scope of practice" issues (see page 3). The Board will complete implementation of its new policies on the use of medical experts and consultants (see page 1). We will join in hosting a major summit on health resources and primary care and we will launch the work of our new Committee on Quality of Care in a Managed Care Environment.

But our highest priority for 1995 is to reduce the time it takes to evaluate, investigate, prosecute and adjudicate cases. This goal is vital for it goes to the core of our responsibility as a regulator and consumer protector.

# “Scope of Practice” Issues Crowd Legislative Agenda

by

*Candis Cohen*

*Assistant Director for Public Affairs, Medical Board of California*

It should come as no surprise that in 1994 the Legislature considered 19 bills designed to amend or create scopes of medical or allied health practices. The 1994 list is about average. “Scope of practice” issues have been around since the first Medical Practice Act and there seems to be no diminution of debate in sight.

Of the 19 bills, 12 failed passage or were vetoed by the Governor; seven were enacted. This continues a pattern that only about one-third of the proposed changes make it through the legislative process, but, surprisingly, some of the more controversial become law. For example, in 1994, after years of trying, Senator Lucy Killea (I-San Diego) succeeded in convincing her colleagues and the Governor that a new scope of practice—licensed lay midwifery—should be allowed. At the February meeting of the Board, the Division of Licensing adopted the first set of regulations to carry out the provisions of the new law—and, no sooner are the regulations adopted but Senator Killea is already sponsoring a new bill this year to modify her 1994 provisions relating to physician supervision.

“Scope of practice” issues, of course, are either the expression of concern over properly trained health care personnel providing adequate quality of care to California’s patients or they are economic turf battles, depending on the eye of the beholder. Most often they are both.

Last year one of the more hard-fought “scope of practice” issues was AB 2020, an aptly numbered bill sponsored by the California Optometric Association and authored by Assemblyman Phil Isenberg (D-Sacramento). This measure would have allowed optometrists to diagnose eye disease and to prescribe therapeutic pharmaceutical agents. AB 2020 was defeated by the Senate Committee on Business and Professions in late June, but it is a virtual certainty that the optometrists will keep trying. This is probably their association members’ most important issue.

At the same time, in all probability, no issue is more important to California’s ophthalmologists—but their effort is focused on the bill’s defeat. And no doubt they will rally again for a new battle when it comes up.

Optometrists argue that advances in technology and higher standards of training and practice now qualify them to

perform diagnoses and procedures reserved under current law to ophthalmologists. They suggest that the same, or better, level of services can be offered to patients/consumers at lower prices. Ophthalmologists argue that the training and standards are not the same, that the quality of care to patients would be put at great risk and that costs in the long run would not be saved because ophthalmologists would have to repair mistakes by lesser-skilled optometrists.

These are classic arguments in “scope of practice” issues. One group is on the outside looking in and the group on the inside is protecting its position. The group that wants in says it is qualified and that it is motivated by concern for the patient/consumer. The group that has the advantage of incumbency says it is better qualified and that quality of care

must not be sacrificed. Both sides generally finesse the obvious economic battle that rages underneath, for, in this case, the business lost by ophthalmologists if AB 2020 had passed would have been in the multi-millions. By the same token, optometrists would have gained that same business over time.

The Medical Board voted to side with the ophthalmologists to oppose AB 2020, convinced that the training and standards of practice were not equal and that the public safety was at risk—at least for now.

With obvious advances in medical technology and higher standards of practice, the push for more far-reaching changes in “scope of practice” will increase for physicians and allied health professions. In last year’s 19 bills, besides midwifery and optometry/ophthalmology, various proposals involved naturopathy (four bills), dietitians, medical assistants, medical physicists, nurse midwives, occupational therapists, perfusionists, physical therapists (two bills), physician assistants, doctors of podiatric medicine, respiratory care practitioners and registered dispensing opticians. If some groups seem to be missing from this list it is only because they sat out 1994.

Oral surgeons want to get closer to the nose through the upper palate only to be resisted by ENT physicians. Doctors of podiatric medicine want to go above the ankle only to be resisted by orthopedic surgeons. More allied health groups want to be able to prescribe drugs and want to shed or diminish the need for physician supervision. And on it goes.

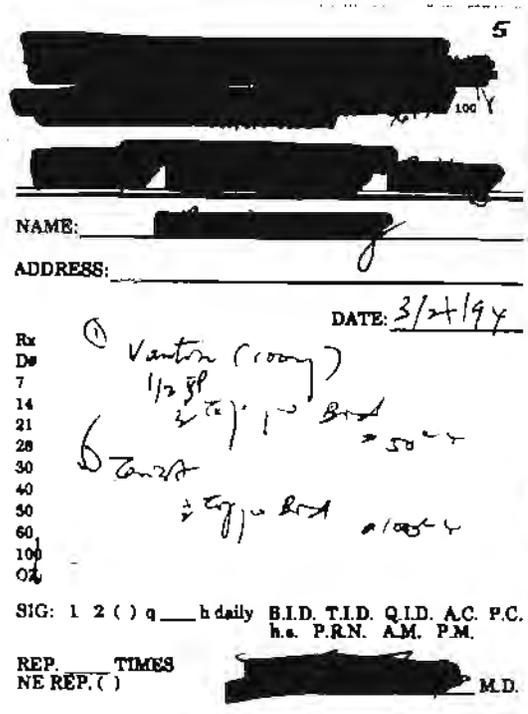
# Prescription Legibility: Potential Liability —

by  
Patricia Harris, Executive Director, Board of Pharmacy

Can you read this prescription? One pharmacist thought he could and filled the prescription incorrectly. Fortunately, the patient was not harmed; nevertheless, the board cited the pharmacist for the error because he filled an ambiguous and uncertain prescription.

"Can you read this prescription?" is not a brain teaser. The legibility of prescriptions is a serious problem that affects patient safety. The incidence of medication error is well established and the consequences are costly and far reaching. These errors harm patients and contribute to the increasing health care costs through time consuming pharmacist-physician contact, remedial medication therapy and malpractice suits. Physicians and pharmacists both have roles in assuring that medication prescribed by the physician is accurately and appropriately dispensed by the pharmacy to the patient. As many physicians will attest, many pharmacists are diligent in contacting physicians to ascertain the correct prescription information.

The American Medical Association recently published its Report to the Board of Trustees (dated 11-1-94) on the subject of medication errors in hospitals. While physicians, pharmacists, nurses and the health care system all contribute to medication errors, the AMA reports that physicians are mostly responsible for prescribing errors which are often caused by illegible handwriting, misspelling and the use of inappropriate abbreviations in written orders. In its recommendations, the AMA encourages physicians to minimize medication errors by writing legible prescription orders and physicians with poor handwriting to print or type medication orders if direct entry capabilities for computerized systems are unavailable.



## SOLUTIONS?

One important step is for physicians to write clear, legible and complete prescriptions. The legal requirements for a complete prescription are the patient's name, the name and quantity of the drug prescribed, and the directions for use. Although not

## CORRECTION:

### Financial Interest Disclosure — Outpatient Surgery Centers

In the January *Action Report*, under the article "Financial Interest Disclosure," (page 10) we implied that under Business and Professions Code section 650.01 it was unlawful and a misdemeanor for a physician to refer a patient to an "outpatient surgery center" in which the referring physician has a financial interest.

This is incorrect. Section 650.01 does not prohibit self-referrals to outpatient surgery centers. Outpatient surgery is not included in section 650.01 as one of the eight types of businesses barred from self-referrals (laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging).

Thus, physicians may refer patients to their own outpatient

surgery centers so long as they comply with the disclosure requirements of B&P Code section 654.2 (give the patient written notice of the physician's interest, including advice that the patient is free to go elsewhere for the same service).

The confusion is that under another statute enacted by the legislature (B&P Code section 2097), physicians must disclose financial interest in eight specified outside businesses. Here, "outpatient surgery" is a listed business that must be disclosed.

Conclusion: "Outpatient surgery" must be listed in the license renewal form as required by section 2097. But under B&P Code section 650.01, outpatient surgery is not listed as a prohibited service for self-referrals.

# A Consequence for Physicians and Pharmacists

legally required, writing the drug's purpose on the prescription (or desired therapeutic outcome) will reduce the chance of confusion and alert the pharmacist to seek clarification in ambiguous situations.

Another step is for pharmacists to provide oral consultation to the patient when the medication is dispensed. Consultation provides the pharmacist with an important opportunity to check the dispensed medication with the written prescription and reinforces the drug information already given to the patient by the physician.

Perhaps the most significant and preventative solution is to assure that the prescription is legibly prepared. Type the prescription, issue a computer-generated prescription, or use a preprinted prescription form on which the medication is checked-off from a preprinted list of dangerous drugs (note: only one drug may be checked-off per form and controlled drugs cannot be preprinted on such a form, since prescriptions for controlled substances must be in the handwriting of the prescriber). Additionally, current technology provides for computer-generated prescriptions. Reasonably priced software exists that can generate a printed prescription complete with patient information and such software is currently being used by health care practitioners. The benefits of this new technology far outweigh the implementation costs because a legible prescription will eliminate the time required to verify the information on the prescription and reduce medication errors and associated costs, thus improving patient care.

## ELECTRONIC TRANSMISSION

Physicians also have the option of electronically transmitting a prescription to the pharmacy. To keep pace with emerging technology, the Board of Pharmacy recently adopted regulations that allow for this safe and effective means of transmitting prescriptions. These regulations authorize the electronic transmission of prescriptions (except for schedule II drugs) from the physician directly to the pharmacy of the patient's choice. The prescription data is entered in the physician's computer system and is sent via network to the pharmacy for filling. The pharmacy then creates a computer-

generated prescription that is legible.

By publishing this article, the Board of Pharmacy and the Medical Board of California are addressing the issue of illegible prescriptions and are seeking the assistance of our licensees. Pharmacists are required to verify all unclear, ambiguous prescriptions by contacting the prescriber.



Patricia Harris

## PHYSICIAN LIABILITY

Moreover, while pharmacists have the legal obligation and professional responsibility to contact the prescriber to resolve uncertainties or ambiguities on the face of a prescription, situations arise where the pharmacist does not perceive an uncertainty and yet the incorrect medication is dispensed. Such was the instance with the prescription

at the beginning of this article. The prescription was written for Tavist and it was incorrectly filled with Zovirax. No patient injury occurred as a result of the prescription error; however, the eight month-old child still had his runny nose seven days later, necessitating a call to the physician and the

discovery of the error. At the time the prescription was presented to the pharmacy, the patient's mother expressed her concern that the prescription would be difficult to read. Unfortunately the concerns of the mother were never followed through, and now she wants the licenses of both the physician and pharmacist permanently revoked.

## UNPROFESSIONAL CONDUCT?

Prescription errors arising because a prescription is illegible are unconscionable and completely preventable. Both physicians and pharmacists have professional obligations to assure that poorly written prescriptions are not written or used to dispense medications to patients. Should it be unprofessional conduct for the physician who writes

an illegible prescription when it results in patient harm? It is unprofessional conduct for the pharmacist who erroneously fills it. The issue is patient safety.

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***“The legibility of prescriptions is a serious problem that affects patient safety. The incidence of medication error established and the consequences are costly and far reaching.”***

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# Supervising Physicians May Authorize...

by

*Robert E. Sachs, Physician Assistant-Certified  
Chairperson, Physician Assistant Examining Committee, Medical Board of California*

Recently enacted legislation permits a Board-approved supervising physician (SP) to delegate to a physician assistant, who works under the physician's supervision, authority to write a "transmittal order" for medications and medical devices. Senate Bill 1642 in part permits the supervising physician to specifically authorize physician assistants (PAs) to "transmit ... in writing ... a transmittal order," for a prescription from his or her supervising physician. The written "transmittal order" may then be given directly to any person who may lawfully furnish the medication or medical device, or to the physician's patient for delivery to a pharmacist.

Long established regulations of the Medical Board of California, and provisions of California Pharmacy Law, allow PAs to transmit a supervising physician's prescription electronically, orally, or "in writing on a patient's record," when authorized to do so by the SP. Now, after meeting

certain preconditions, SB 1642 lets SPs delegate additional authority to PAs to issue written transmittal orders for many, but not all, of the SP's prescriptions.

A supervising physician may authorize a PA to issue written transmittal orders only for drugs listed in the supervising physician's adopted, signed and dated protocols and formulary, or an order given by the supervising physician for a particular patient. A protocol, as required by the Physician Assistant Regulations, must specify all criteria for the use of a particular drug or device, and any contraindications for its selection. As under previous board regulations, the medical record of any patient cared for by a PA for whom the supervising physician's prescription was transmitted or carried out must be reviewed, countersigned, and dated by a SP within seven days.

Drugs listed in the protocol make up a formulary. They should only include drugs that are appropriate for use in the type of practice engaged in by the supervising physician. Protocols may incorporate by reference texts that contain the required information. However, if not all of the drugs in the text are appropriate for use in the supervising physician's practice, or if the PA is not authorized to order certain drugs or categories of drugs, a protocol that adopts a text should specify which parts are applicable and/or which parts are excluded from the protocol.

A transmittal order for drugs not listed in the supervising physician's protocols and formulary may only be issued by a PA based on an order from the supervising physician for the particular patient. Also, a physician assistant may not administer, provide or transmit a prescription for Schedule III through V controlled substances without an order by a supervising physician for a particular patient. The supervising physician's order may be verbal.

Additionally, the physician prescriber may not authorize a PA to issue any form of transmittal order for any Schedule II controlled substance. Federal and California laws do not permit anyone except a prescriber from writing an order for Schedule II controlled substances. PAs may not under any circumstance issue a written transmittal order for controlled substances in Schedule II.

Written transmittal orders issued per the requirements of SB 1642 must contain the printed name, address and phone number of the supervising physician. They must also contain the printed name, license number and signature of the physician assistant. Written transmittal orders should also contain the physician's license and DEA numbers.

## Physician Alert

### **Illegal Chinese Pesticide Threatens Toddlers**

The Department of Health Services' Pesticide Illness Surveillance Program reports that two young children have been hospitalized, in separate episodes, following ingestion of "Miraculous Insecticidal Chalk". The active ingredient of this product appears to be deltamethrin, a synthetic pyrethroid with predominantly neurologic toxicity and no specific antidote. Although pyrethroids are considered low toxicity compounds, recent evidence indicates that deltamethrin may be disproportionately toxic to immature organisms. Please counsel your patients to avoid this product, and any toxic substance that resembles something familiar.

If you suspect pesticide toxicity, you may consult:

- 1) the poison control center;
- 2) the county agricultural commissioner. Commissioners can accept pesticides and pesticide-contaminated clothing or equipment for appropriate analysis and disposal, provide information on pesticide characteristics, and provide the telephone number designated by
- 3) the local health officer, to whom such episodes are to be reported under Section 2950 of the Health and Safety Code;
- 4) the Department of Pesticide Regulation Senior Medical Coordinator Dr. Michael O'Malley, at (916) 445-4281.

# ...Assistants to Issue Written Transmittal Orders

The physician's signature is not required on written transmittal orders created by a PA. However, the PA must sign every written transmittal order he or she creates. Any of the physician's prescriptions transmitted by a PA is subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician's practice. As with all tasks delegated to a PA, the supervising physician may limit the PA's authority to issue oral, electronic or written transmittal orders.

Prescriptions based on written transmittal orders, as with all other forms of transmitted prescriptions, will be issued by a licensed pharmacist in the name of the prescribing supervising physician.

*(Note: The author's interpretations of SB 1642 are under review by the Board of Pharmacy. For further information contact the Board of Pharmacy directly.)*

## The complete text of SB 1642:

SB 1642 (Craven) Section 3502.1 is added to the Business and Professions Code, to read:

3502.1. (a) In addition to the services authorized in the regulations adopted by the board, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons approved by the board, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a transmittal order, a prescription from his or her supervising physician and surgeon to a person who may lawfully furnish the medication or medical device pursuant to subdivision (b) and (c).

(1) A supervising physician and surgeon who delegates prescription transmittal authority to a physician assistant may limit this authority by specifying the manner in which the physician assistant may transmit prescriptions.

(2) Each supervising physician and surgeon who delegates prescription transmittal authority shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. The drugs listed shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician

and surgeon. When transmitting an order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) The supervising physician and surgeon's

prescription for any patient cared for by the physician assistant that is transmitted by the physician assistant shall be based on either an order given by a supervising physician and surgeon for a particular patient, or on the protocols described in subdivision (a).

(1) A physician assistant shall not administer or provide a drug or transmit a prescription for a drug other than for a drug listed in the formulary without an order from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician

assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant may not administer, provide or transmit a prescription for Schedule II through Schedule V controlled substances without an order by a supervising physician and surgeon for the particular patient.

(3) Any prescription transmitted by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(c) A transmittal order issued pursuant to subdivision (a) shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. The requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name and license number of the physician assistant, and shall be signed by the physician assistant. When transmitting an order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(d) The medical record of any patient cared for by a physician assistant for whom the supervising physician and surgeon's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.



Robert E. Sachs

## Regulating Telemedicine Practitioners: Protection of Consumer to be Balanced by Concern for Provider

At the annual meeting of the Federation of State Medical Boards in mid-April, sessions on issues relating to telemedicine are prominent on the agenda. The FSMB Committee on Licensure-by-Endorsement will file a report, the last section of which states, in part:

"... telemedicine is expected to expand and flourish in the twenty-first century ... it is imperative that state medical boards develop a mechanism to regulate telemedicine providers ... (because of) the potential for abuse of telemedical technology for economic gain of the provider ... all state medical boards (should) develop a system to regulate the practice of telemedicine that will protect the public without being unduly burdensome to providers."

The technique most often discussed is a simple permit issued by a state medical board to telemedicine practitioners from other states that wish to advise on patients within that state's jurisdiction. The permit process would be, in effect, a registry.

The purpose of such a system is:

a) To recognize that what is now considered informal consultation among physicians and allied health professionals

is going to become big business facilitated by technology and reimbursed by insurers and the government, and

b) To establish a permit or registration system so that the permit can be withdrawn in the event there is a complaint that warrants disciplinary action, after which, if the practitioner continues to provide telemedical counsel, he/she would be practicing medicine without a license/permit/registration in that jurisdiction. Practicing medicine without a license carries heavy penalties, thus diminishing the incentives for errant providers to use the practice of telemedicine as a "cash cow."

The FSMB Committee contends that much of the paperwork for multiple permits for physicians whose licenses are current and in good standing can be done centrally as a service to member boards and providers. Enforcement would continue to be reserved to the states, which, acting on valid complaints, could shut down abusers and report such disciplinary actions throughout all the states.

Proposals along these lines will be discussed at the FSMB meeting as part of this committee report. Individual state legislatures could start considering legislation in late 1995 or early 1996.

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### A New Focus

## Quality of Care Issues in a Managed Care Environment

Chaired by Dr. Carole Hurvitz, a new committee of the Board will examine emerging issues concerning quality of patient care in today's fast-growing managed care environment.

Anecdotal examples of incidents concerning physician choices which may be affected by pressures to cut costs have now become the subject of feature stories in a number of newspapers and magazines. In voting to create the committee Board members Gayle Nathanson and Dr. Clarence Avery noted that anecdotal evidence seems to go beyond third-party payer review procedures and now, more important, involves management decisions in situations where physicians are employed.

"Vertical integration" appears to be the next major trend in managed care—that is, companies which own and operate their own hospital systems and clinics. Already that trend is more evident in California than elsewhere in the country and even more so in Northern California (where over one-

third of the population is covered by managed care) than in the rest of the state.

With government-paid or reimbursed programs now 58% the consumer of health care in the nation and with continuing pressures on public budgets, it is a certainty that cost-saving managed care will grow rapidly. As a consequence, more physicians and allied health professionals will be employed in contrast to today's proportions of independent partnerships, physician corporations and solo practitioners. Thus, with more physicians in the status of employee, management controls are more enforceable. The committee will explore how and why there may be conflicts in independent physician decision-making and management directives to cut costs.

In addition to Dr. Hurvitz, Board members appointed to the committee are Dr. Alan Shumacher, Gayle Nathanson, Phillip Pace, Dr. Anabel Anderson Imbert, Cathryne Bennett-Warner and Dr. Clarence Avery as an advisor.

# Governor Wilson Appoints New Director of Department of Consumer Affairs

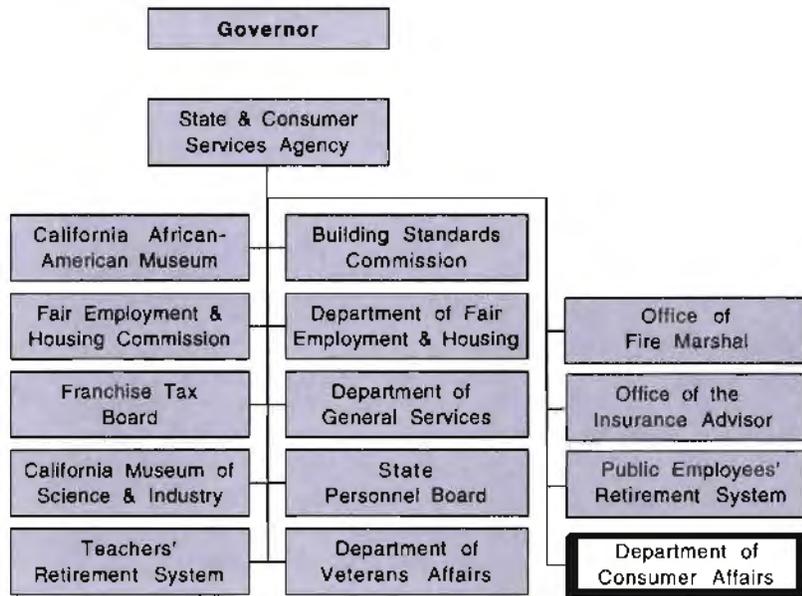
Last January, Governor Pete Wilson appointed Marjorie M. Berte as director of the Department of Consumer Affairs (DCA). Ms. Berte succeeds Jim Conran, who resigned last spring. Ms. Berte, of San Francisco, served since 1991 as director of the State Office of Insurance Advisor.

She has a background in consumer and insurance issues, and is experienced in both public policy and business management. She was a self-employed media relations consultant specializing in strategic planning and policy development from 1989 to 1991 and served as executive vice president for the Professional

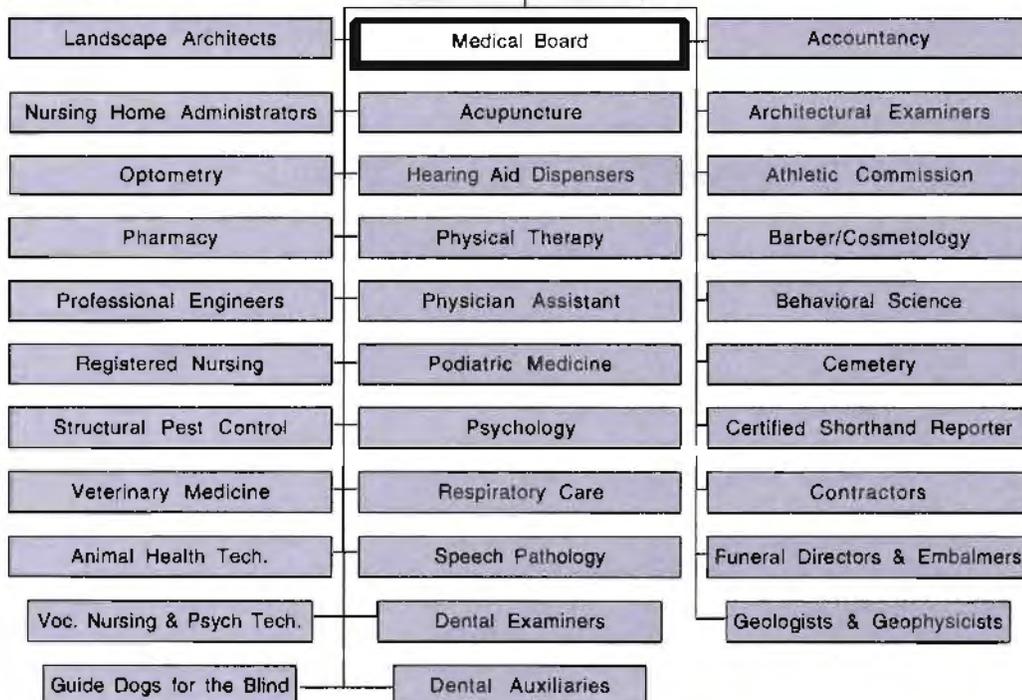
Insurance Agents of California, a non-profit trade association, from 1978 to 1988. Ms. Berte is a 1974 graduate of Stanford University, with a bachelor of arts degree in English.

The DCA is the primary state agency responsible for overseeing a fair and competitive marketplace in which consumers are protected. The department is responsible for the certification, registration, and licensing of approximately 2.5 million providers of goods and services in California.

Of DCA's 32 boards, bureaus, and programs, the Medical Board is one of the larger, with 103,000 licensed physicians.



Marjorie M. Berte



## Twelve Decades of Physician Regulation Told in Upcoming Book

by

*Linda A. McCready, Manager, Special Projects, Medical Board of California*

From its first meeting on June 29, 1876, the board responsible for licensing California physicians has encountered controversy. The legislation creating the first Board of Medical Examiners was repealed and reenacted several times in the first quarter century as various factions struggled for recognition.

California was a magnet for invalids from colder climes particularly after the railroads were built. They were followed by medical practitioners ranging from university trained specialists to self-appointed snake-oil peddlers, to dangerous butchers. Hampered by limited funds, weak laws and chronic understaffing, in the early years the board often could do little to stop the most egregious medical mischief.

The original Board of Medical Examiners consisted of five physicians appointed by the state medical society, who met in the society office in San Francisco. The only requirement for licensure was to show a board member a diploma or license and an affidavit confirming its authenticity. Applicants who had neither one could take an oral examination. Money was so limited—the original license fee was only \$5—that applicants could take the examination only at board meetings, which were held infrequently and only in San Francisco or Los Angeles.



*Linda A. McCready*

For much of the first century of physician regulation, the board focussed on trying to control diploma mills and other sources of fake credentials, and on snuffing out quackery. When written examinations were introduced by a 1901 law change, they were the target of vitriolic attacks. One examination actually led to a libel suit against two board members who accused a critic of being a former San Quentin inmate.

The present form of the Medical Board of California is the result of twelve decades of evolution in laws, regulatory practices, medical education, and most of all hard experience. Even as controversies arise from time to time, the board continually refines and reevaluates its processes, and strives to accomplish its mission of protecting the residents of California from bad medical practice.

In early April, the board will publish a book written by staff members Billie Harris and Linda A. McCready, which compiles the high points of the first twelve decades of its history. Copies may be ordered by sending a check for \$10 (to cover printing and postage), payable to MEDICAL BOARD OF CALIFORNIA to: Medical Board of California, Support Services Program, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236

## Department of Consumer Affairs Honors Medical Board Employees

The Department of Consumer Affairs recently honored three members of the Medical Board's Enforcement Program for their professional performance.

Kami Dudley, Associate Analyst, and Arlene Paganini, Staff Analyst, received the Sustained Superior Accomplishment Award. Renee Threadgill, Supervising Investigator I, received the Supervisory Performance Bonus Award.

The Sustained Superior Accomplishment Award was established to recognize those individuals who consistently demonstrate an outstanding level of expertise in the performance of their duties. This represents a \$250 bonus. Kami Dudley was nominated for her professional attitude and high performance. Her accomplishments include a major reorganization of the Central File Room, and

responsibility for the annual and agency statistical profile reporting. Arlene Paganini was recognized as a valuable resource to others for her willingness to perform extra work and provide guidance to other employees in the Board's Central Complaint and Investigative Control Unit.

The Supervisory Performance Bonus Award was established to recognize supervisors who consistently exercise an outstanding level of performance in their duties. This represents a \$500 bonus. Renee Threadgill has been instrumental in leading and participating in several staff projects which do not fall under her usual duties. Ms. Threadgill was the lead individual in developing the "Guidelines for Expert Consultants." She was also involved in other projects such as the Report Writing and Subpoena Policy Committees.

## Disciplinary Actions: November 1, 1994 to January 31, 1995

### Decisions: Physicians and Surgeons

**ALT, WILLIAM J., M.D. (C-20614) Muskegon, MI**  
B&P Code §2305. Disciplined by Michigan Board for failing to provide proper care and treatment to patients. California: Revoked. Default. December 30, 1994.

**ALVAREZ, FRANCISCO J., M.D. (C-29114) Laguna Niguel, CA**  
B&P Code §2234 (b),(c),(d),(e). Gross negligence and incompetence in management of breast augmentation surgery. Severe infection from surgical sponge left in breast following surgery in Tijuana. Revoked. Default. January 17, 1995.

**ANDERSON, CLARENCE, M.D. (C-28053) Redlands, CA**  
B&P Code §§726, 2234(b), (c), (d). Stipulated Decision. Sexual relations with female patient. Gross negligence, repeated negligence, and incompetence in OB/GYN management of the delivery of twins, one in a vertex position and the second in a transverse position. Alcohol addiction. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. December 29, 1994.

**BARR, ROBERT M., M.D. (A-9377) San Jose, CA**  
B&P Code §§725, 2234(a), 2069, 2264, 2238, 2241. Stipulated Decision. Excessive prescribing of pain medications, and deficient record keeping. Also, improper supervision of unlicensed medical assistants to perform physical therapy in auto accident cases. Revoked, stayed, 5 years' probation on terms and conditions. December 16, 1994.

**BASINGER, GERALD, M.D. (G-19374) Redding, CA**  
B&P Code §§726, 2234 (b),(e). Fondled breasts and vaginal area of patients under anesthesia. Gross negligence, sexual misconduct, corruption. Revoked. January 11, 1995.

**BOCHNER, ALFRED, M.D. (C-25822) Menlo Park, CA**  
B&P Code §2241. Prescribed controlled substances to an addict or habitue. Revoked, stayed, 5 years' probation on terms and conditions. January 20, 1995.

**BURKETT, ROX CHARLES, M.D. (G-29053) Tiburon, CA**  
Violated probation of prior discipline. Left California to practice in Idaho without notifying the board. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. January 12, 1995.

**CAPATI, NAZARIO, M.D. (C-40454) Niellsville, WI**  
B&P Code §2305. Disciplined by Wisconsin Board. California: Revoked. Default. January 17, 1995.

**CULALA, PASCUAL, M.D. (A-30663) San Jose, CA**  
B&P Code §2236. Stipulated Decision. Conviction for filing false insurance claim for medical damages in auto accident case. A later second conviction for Medi-Cal fraud. Revoked, stayed, 10 years' probation on terms and conditions, including 90 days' actual suspension. December 16, 1994.

**DANNIS, HARVEY, M.D. (C-37548) Anaheim, CA**  
B&P Code §§725, 2234 (b),(d),(e), 2242. Stipulated Decision. Supplied numerous patients with clearly excessive drugs upon request, without adequate medical indication, in orthopedic practice. Revoked, stayed, 7 years' probation on terms and conditions, including 60 days' actual suspension. December 28, 1994.

**FANDINO, SENADOR, M.D. (A-32604) San Diego, CA**  
B&P Code §§2234 (b),(d),(e), 2236. Stipulated Decision. Conviction for insurance fraud in preparing false medical records

### 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: "July 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 "October 10, 1991" is finally being reported for the first time four years later in 1995.

for patient's attorney in auto accident case. Gross negligence and incompetence in mismanaging a patient with a mass in left breast. Revoked, stayed, 7 years' probation on terms and conditions, including 6 months' actual suspension. January 1, 1995.

**FRANZ, JOSEPH W., M.D. (A-28633) Temecula, CA**  
B&P Code §2234 (b),(c),(d),(e). Stipulated Decision. Gross negligence, incompetence and repeated negligent acts in providing prenatal care to pregnant patients without making adequate provisions for the delivery of their infants. Patients ended up at hospital emergency rooms for labor and delivery because respondent had no obstetrical or hospital privileges. Prior discipline. Revoked, stayed, 7 years' probation on terms and conditions, including a ban on treating pregnant patients or providing prenatal services. November 1, 1994.

**GREWAL, HARINDER, M.D. (A-32070) Anaheim, CA**  
B&P Code §§810, 725, 2234 (c),(d),(e), 2242. Stipulated Decision. False billing, excessive prescribing, repeated negligent acts, incompetence in treating patients for PMS (premenstrual syndrome). Revoked, stayed, 5 years' probation on terms and conditions. January 12, 1995.

**HALCOMB, WILLIAM W., M.D. (A-27934) Mesa, AZ**  
B&P Code §2305. Stipulated Decision. Surrender of license to Texas Board while under investigation. California: Revoked, stayed, 5 years' probation on terms and conditions. January 17, 1995.

**HAMZEH, MOHAMMED R., M.D. (A-41378) Los Angeles, CA**  
B&P Code §§725, 2234(d), 2242, 2261. Stipulated Decision. Incompetence in the care of 2 patients. Overprescribed controlled substances without a prior examination and medical indication therefor. Wrote false prescriptions. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. December 1, 1994.

**HOLMES, JAMES HENRY, M.D. (G-30996) Stockton, CA**  
B&P Code §§2237, 2242. Stipulated Decision. Conviction for prescribing a controlled substance without legitimate purpose. Prescribed tylenol with codeine #3 on numerous occasions without medical indication therefor. Revoked, stayed, 5 years' probation on terms and conditions. November 25, 1994.

**KRAMER, STUART BERYL, M.D. (G-18896) Granada Hills, CA**  
B&P Code §2241.5. Stipulated Decision. Failed to properly and adequately keep records of prescriptions for controlled substances in accordance with B&P Code §2241.5 (Intractable Pain Treatment Act). One year suspension, stayed, 2 years' probation on terms and conditions. January 17, 1995.

**KRISHNAREDDY, DIVAKAR, M.D. (A-35665) Brea, CA**  
B&P Code §2234 (b),(c),(d). Stipulated Decision. Gross negligence, repeated negligence and incompetence in orthopedic practice. Mismanaged a hip replacement surgery; and in a second surgery, explored the wrong disc and failed to catch his error, necessitating additional surgery by another surgeon.

Revoked, stayed, 5 years' probation on terms and conditions. November 11, 1994.

**KUMPEL, FRIEDRICH, M.D. (A-23236) Delano, CA**  
B&P Code §§726, 2234 (b),(c). Sexual abuse and sexual misconduct of female patients during examinations in the examining room. Gross negligence and repeated negligent acts. Revoked. December 7, 1994.

**KUNZ, ARTHUR, M.D. (C-42551) Tucson, AZ**  
B&P Code §§2305, 2239. Disciplined by the U.S. Navy for falsifying a document allowing him, as a navy physician, to moonlight in a civilian hospital emergency room. Alcohol abuse problem in the recent past. Revoked, stayed, 5 years' probation on terms and conditions. November 30, 1994.

**LASCFHIAZZA, DOMINIC, M.D. (A-20050) Blythe, CA**  
B&P Code §2234 (c). Stipulated Decision. Repeated negligent acts for failure to perform a pelvic and a pap smear on a patient seen once every 2 months from 1981 to February 1989. The patient died April 1989 from terminal invasion of cervical cancer. Revoked, stayed, 3 years' probation on terms and conditions. December 14, 1994.

**LITWILLER, MALCOLM, M.D. (G-17029) Ross, CA**  
B&P Code §2234. Stipulated Decision. Therapist and patient engaged in a romantic relationship, constituting unprofessional conduct. Revoked, stayed, 5 years' probation on terms and conditions. November 17, 1994.

**LOWE, FRANK, M.D. (A-15531) Santa Ana, CA**  
B&P Code §§810, 2234 (e), 2261, 2262. Stipulated Decision. Dishonest medical reports and false billings to defraud insurance companies on auto accident personal injury cases. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. December 16, 1994.

**MARCUS, FRANKLIN J., M.D. (A-44735) Cambridge, MA**  
B&P Code §2305. Stipulated Decision. Reprimand by Michigan Board for larceny conviction involving the removal of computer equipment from the workplace. California: Public reprimand. January 26, 1995.

**McFADDEN, MICHAEL J., M.D. (A-18526) San Francisco, CA**  
B&P Code §2234 (c). Stipulated Decision. Placing an elderly patient, unable to care for herself, in an inadequate apartment with a camp cot for a bed, constituted repeated negligent acts and a breach of fiduciary duty. Revoked, stayed, 5 years' probation on terms and conditions. November 4, 1994.

**PALMIERI, ROGER J., M.D. (A-29954) Newport Beach, CA**  
B&P Code §§2234 (b),(c), 2238, 2239, 2236. Conviction for unlawful possession of controlled substances and opium pipe, and possession of rock cocaine. Used cocaine illegally. Sexual intercourse with patient. Gross negligence, repeated negligent acts and abandonment of patients. Violated probation of prior discipline. Revoked. November 4, 1994.

**RITCHIE, RAND CECIL, M.D. (G-41327) Santa Maria, CA**  
B&P Code §§2234(e), 496, 2236. Stipulated Decision. Alcohol abuse problems. Convictions for driving under the influence of alcohol or with a blood alcohol in excess of 0.08%. Revoked, stayed, 5 years' probation on terms and conditions. December 15, 1994.

**RODRIGUEZ, SERGIO LUIS, M.D. (C-38767) Liberty, TX**  
B&P Code §2305. Disciplined by Texas Board for mental impairment affecting safe practices. Revoked. Default. November 28, 1994.

**ROMERO, ANTONIO A., M.D. (A-34298) Downey, CA**  
B&P Code §§490, 2306, 2236, 2234(e). Disciplined by Louisiana Board for 1987 conviction for filing false claims to Louisiana Medicaid program totalling \$268. Ohio Board also took action based on Louisiana's discipline. California: Public reprimand. December 8, 1994.

**SHAH, MUKESH, M.D. (A-44952) Brea, CA**  
B&P Code §§726, 2234, 2234(e). Sexual abuse, dishonesty and general unprofessional conduct. Revoked. May 4, 1994. Judicial review recently completed.

**SHEPPARD, STEPHEN A., M.D. (A-27522) Brookings, OR**  
B&P Code §§2236, 2242, 2238. Stipulated Decision. Conviction of furnishing a controlled substance to a person not under his treatment for a pathology or condition. Prescribing without a good faith prior exam and medical indication therefor. Revoked, stayed, 5 years' probation on terms and conditions. December 30, 1994.

**SHURPIN, LESLIE S., M.D. (G-19062) Beverly Hills, CA**  
B&P Code §2242. Stipulated Decision. Prescribed controlled substances without good faith prior exam and medical indication therefor. Revoked, stayed, 5 years' probation on terms and conditions. December 15, 1994.

**SOLOMON, MAURICE C., M.D. (G-23212) Colorado Springs, CO**  
B&P Code §2305. Stipulated Decision. Disciplined by Colorado Board for substance abuse. California: Revoked, stayed, 5 years' probation on terms and conditions. January 30, 1995.

**SPRINGER, CLYDE H., M.D. (C-39730) Encino, CA**  
B&P Code §2305. Disciplined by New York Board by default for incompetence, negligent acts and abandonment of a pregnant patient. California: Revoked, stayed, 5 years' probation on terms and conditions. January 12, 1995.

**TALBERT, MICHAEL, M.D. (C-36274) Orosi, CA**  
B&P Code §822. Mental impairment. Revoked, stayed, 5 years' probation on terms and conditions. January 30, 1995.

**TAM, WILFRED, M.D. (A-14245) Bakersfield, CA**  
B&P Code §2234(c). Stipulated Decision. Repeated negligent acts in the treatment and care of hospitalized patients. Revoked, stayed, 10 years' probation on terms and conditions. January 30, 1995.

**TRUONG, HANK MY, M.D. (A-42440) San Diego, CA**  
B&P Code §§2234(b),(c),(d),(e), 2261, 2262. Stipulated Decision. Gross negligence, incompetence and repeated negligent acts in multiple failures in mismanaging a patient with breast cancer. Dishonesty in altering patient records with fraudulent intent. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. November 26, 1994.

**VALENTE, MARIS, M.D. (G-6162) Sepulveda, CA**  
B&P Code §§490, 2236. Stipulated Decision. "Convicted of a misdemeanor offense which is substantially related to the qualifications, functions or duties of a physician." Revoked, stayed, 1 year probation on terms and conditions. January 30, 1995.

**WERNER, THOMAS C., M.D. (G-14242) Stockton, CA**  
B&P Code §2236. Conviction of lewd or lascivious act upon a 7 year-old child. Revoked, stayed, 7 years' probation on terms and conditions. November 4, 1994.

**YAMINI, SOHRAB, M.D. (A-40040) Los Angeles, CA**  
B&P Code §§2234, 2236, 2630. Stipulated Decision. Employed an unlicensed person who performed physical therapy on patients without appropriate supervision. Public reprimand. December 7, 1994.

## ACUPUNCTURISTS

**GIL, TAE SUNG, C.A. (AC-1346) Hacienda Heights, CA**  
B&P Code §4955. Stipulated Decision. Misdemeanor conviction involving payment to receive advance answers to the 1982 acupuncture exams, to obtain a license. 36 months' probation on terms and conditions, including the retaking of the exams. December 6, 1994.

**KIM, IHN, C.A. (AC-2424) Los Angeles, CA**  
B&P Code §§123, 125, 496, 4955. Misdemeanor conviction involving a conspiracy to give money to a public official for an advance copy of the answers to the 1984 state acupuncture exams, to obtain a license. Revoked. Default. December 4, 1994.

**KWON, EUN KYUNG, C.A. (AC-2427) Lakewood, CA**  
B&P Code §§123, 125, 496, 4955. Misdemeanor conviction in connection with paying money for answers to the 1984 state acupuncture exams in obtaining the license. Revoked. Default. November 5, 1994.

**LEE, SOON SEAN, C.A. (AC-2661) Los Angeles, CA**  
B&P Code §4955. Stipulated Decision. Paying money to buy advance receipt of answers to the 1985 state acupuncture exams to obtain license. Revoked, stayed, 5 years' probation on terms and conditions, including 2 years' actual suspension and the retaking of the exams. November 5, 1994.

**WU, M. LONNIE, C.A. (AC-2655) Santa Barbara, CA**  
B&P Code §§2052, 4955 (f),(g),(h),(i). Stipulated Decision. Incompetence, gross negligence, unlawful practice of medicine by an acupuncturist in prescribing a potentially lethal dose of

aspirin to a 9 month old baby. Revoked, stayed, 3 years' probation on terms and conditions. December 4, 1994.

**YOON, SUNG HEE, C.A. (AC-2190) Los Angeles, CA**  
B&P Code §§ 123, 125, 496, 4955. Conspired with others to obtain license through payment of money to qualify for the 1983 state acupuncture exams. Revoked. Default. November 5, 1994.

### HEARING AID DISPENSERS

**FIANTACO, JOHN (HA-2231) El Toro, CA**  
B&P Code §3401(d),(g),(m). Bilked clients by collecting money for hearing aids and then failed to deliver the devices or refund the money. Conviction for grand theft. Revoked. Default. November 8, 1994.

**PARKER, MARSHA (HA-3056) Truckee, CA**  
B&P Code §§3401(h), 3306. Employed an unlicensed person to engage in the practice of fitting and selling hearing aids. Revoked. Default. November 8, 1994.

**REED, ERNEST (HA-56) Hayward, CA**  
B&P Code §§3401, 3365, 3367. Stipulated Decision. Sold hearing aids to numerous clients, failed to fix or adjust the devices to satisfactory working order, or refund money. Failed to respond to complaints. Receipts omitted the Song-Beverly warranty language of Civil Code 1791, et al. Revoked. December 29, 1994.

**RICHERT, MICHAEL (HA-3185) Arroyo Grande, CA**  
B&P Code §§ 490, 3401(d). Conviction for petty theft related to the sale of a hearing aid owned by his employer to an elderly patient at a price about 50% below the market, as an act of compassion. No personal gain. Revoked, stayed, 5 years' probation on terms and conditions. December 30, 1994.

**SCAGGS, MARK (HA-3021) Bahama, N.C.**  
B&P Code §§3365, 3401, 3427.5. Numerous violations of the Hearing Aid Dispenser laws involving dishonesty, warranty, and failure to repair and return the devices. Revoked. Default. January 13, 1995.

**SCAGGS, TODD (HA-2766) Santa Ana, CA**  
B&P Code §3401 (d),(m). Convictions for falsely impersonating another, and unlawful driving. Conviction for commercial burglary (forgery of credit card). Conviction for possession of cocaine. Conviction for possession of marijuana. Conviction for petty theft. Revoked. Default. January 13, 1995.

### PHYSICIAN ASSISTANT

**FINE, HARVEY M., P.A. (PA-10099) Stockton, CA**  
B&P Code §§2234(e), 2237, 2262, 3531, 3527(a). Stipulated Decision. Conviction for improperly issuing prescriptions for codeine #3 and for falsifying medical records. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. November 17, 1994.

### PHYSICAL THERAPISTS

**COLLETTI, GARY M., P.T. (PT-7597) Granada Hills, CA**  
B&P Code §§726, 2660 (1). Sexual misconduct with female patient. Revoked, stayed, 5 years' probation, including 180 days' actual suspension. December 1, 1994.

**HANSEN, ROBERT, P.T. (PT-6774) Irvine, CA**  
B&P Code §§810, 2227, 2630, 2660. Stipulated Decision. Misdemeanor convictions for aiding and abetting the unlicensed practice of physical therapy. Revoked, stayed, 5 years' probation on terms and conditions, including 120 days' actual suspension. January 18, 1995.

**ROSEN, E., P.T. (PT-7926) Pengrove, CA**  
B&P Code §§2630, 2660(i). Stipulated Decision. Use of unlicensed physical therapy aides without adequate supervision. One year suspension, stayed, 5 years' probation on terms and conditions. January 9, 1995.

### PHYSICAL THERAPY ASSISTANT

**SOTO ALFRED (AT-1772) El Cajon, CA**  
B&P Code §§490, 2260(d). Stipulated Decision. Obtained license with false application concealing conviction for stealing gasoline. Revoked, stayed, 4 years' probation on terms and conditions, including 20 days' suspension. January 5, 1995.

### DOCTORS OF PODIATRIC MEDICINE

**ALEXANDER, DONALD, D.P.M. (E-1737) Napa, CA**  
B&P Code §2234 (b),(c). Repeated negligent acts in treating patient without consent and without recording treatment in patient charts. Gross negligence in treatment of patient with severe gangrenous ulceration. Revoked, stayed, 3 years' probation on terms and conditions. January 18, 1995.

**BENARD, RALPH S., D.P.M. (E-739) San Francisco, CA**  
Stipulated Decision. Minimal involvement serving as a second assistant surgeon in alleged mismanaged podiatric surgery and care. Agreed restrictions on retired status license. November 24, 1994.

**GASSLER, JOSEPH R., D.P.M. (E-3112) Baldwin, NY**  
B&P Code §2305. Disciplined by New York Board for conviction for false statements and information in support of claims for reimbursement from New York Medicaid, resulting in false payments of \$420,500. California: Revoked. Default. November 11, 1994.

**SHRIFTER, JEFFREY, D.P.M. (E-2631) Thousand Oaks, CA**  
B&P Code §2234(b). Stipulated Decision. Repeated negligent acts in the administration of medications and failure to record; failure to take timely x-rays; failure to take cultures of infections. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. January 18, 1995.

**STEINBRONER, ROBERT, D.P.M. (E-2639)**

**Corona Del Mar, CA**

B&P Code §§2234, 2238, 2239. Stipulated Decision. Self use of controlled substances. Violation of statutes regulating drugs. Revoked, stayed, 5 years' probation on terms and conditions. January 18, 1995.

### PSYCHOLOGISTS

**BERG, GREG K., Ph.D. (PSY-5800) Gilroy, CA**

B&P Code §§726, 2960 (i),(j),(o),(n). Stipulated Decision. Gross negligence. Sexual misconduct and relationship with a patient. Fraud and dishonesty. Revoked. November 10, 1994.

**BRAGER, ROBERT C., Ph.D. (PSY-8499) San Diego, CA**

B&P Code §2960 (a),(n). Stipulated Decision. Misdemeanor conviction for presenting a false prescription for Vicodin at a pharmacy. Revoked, stayed, 3 years' probation with terms and conditions. November 11, 1994.

**BYLUND, STEVEN, Ph.D. (PSY-8750) Santa Maria, CA**

B&P Code §§726, 2960 (i),(k),(n),(o). Sexual relations with patient. Revoked. January 30, 1995.

**SHAPIRO, SUSAN, Ph.D. (PSY-19233) Los Angeles, CA**

B&P Code §2960 (i),(j),(c),(k),(n),(p). Stipulated Decision. Gross negligence. Breach of professional confidentiality. Operated outside the field of experience. Dishonesty. Revoked, stayed, 5 years' probation on terms and conditions. January 27, 1995.

**SHERVEN, JUDITH K., Ph.D. (PSY-5776) Los Angeles, CA**

B&P Code §2960 (j). Gross negligence in therapy practice. 60 days' suspension, stayed, 2 years' probation with terms and conditions, including 15 days' actual suspension. December 22, 1994.

**SIMON, GEROLD R., Ph.D. (PSY-7100) Torrance, CA**

B&P Code §§810, 822, 2960 (b),(j),(k),(n),(o). Gross negligence. Self use of drugs. Sexual relations with a patient. False billings to insurance. Revoked. December 9, 1994.

### RESPIRATORY CARE PRACTITIONERS

**MARINO, RAYMOND (RCP-2676) Palmdale, CA**

Violated probationary conditions of prior discipline. Revoked. Default. November 26, 1994.

**NGUYEN, FRANCOIS HOA (RCP-517) Laguna Hills, CA**

B&P Code §§3750(d), 3752, 3752.5. Conviction for assaulting his wife with his car and leaving the scene while she was seriously injured. Revoked. Default. November 21, 1994.

**PERRY, BLAIR (RCP-10096) South Bend, IN**

B&P Code §§3718, 3750. Unprofessional conduct. Revoked. Default. November 11, 1994.

**SENECAL, ROBERT (RCP-8390) Shingle Springs, CA**

B&P Code §§3750.5(b), 3752.5. Conviction for driving with 0.08 percent blood alcohol. Conviction for hit and run. Revoked. Default. January 12, 1995.

**SILVA, MICHAEL (RCP-3097) San Francisco, CA**

B&P Code §3750.5 (a),(b). Heroin addiction; rehabilitation; drug relapse. Prior discipline for drug violations. Revoked. December 6, 1994.

**TACKEL, MICHAEL (RCP-9377) Hayward, CA**

B&P Code §§3750(d), 3752, 3752.5, 3752.6. Conviction for lewd exposure in public place. Conviction for driving under the influence of alcohol causing bodily injury to another person. Alcohol problem. Revoked. November 15, 1994.

**THOMAS, CHERYL (RCP-5197) Rialto, CA**

B&P Code §3750(d). Stipulated Decision. Conviction for welfare fraud. Great deal of mitigation. Revoked, stayed, 5 years' probation on terms and conditions. November 26, 1994.

### VOLUNTARY SURRENDER OF LICENSE WHILE CHARGES PENDING

### PHYSICIAN & SURGEON

**FOROUGH, SHOA, M.D. (A-35908) Paramount, CA**

December 15, 1994

**GANDOTRA, SURESH, M.D. (A-29677) Anaheim, CA**

January 20, 1995

**JONES, KENNETH R., M.D. (G-37003) Victorville, CA**

December 2, 1994

**MARSHBURN, INEZ B., M.D. (G-4667) Los Angeles, CA**

December 9, 1994

**PALMER, ROBERT CLEMMER, M.D. (G-20990)**

**Albuquerque, NM**

January 18, 1995

**PERSON, EDWARD A., M.D. (C-26581) San Diego, CA**

December 19, 1994

**RICCI, DOMINICK, M.D. (A-37179) La Jolla, CA**

December 28, 1994

**WOODBURN, RICHARD, M.D. (A-26567) San Antonio, TX**

January 9, 1995

### PHYSICAL THERAPIST

**BUNN, BERNARD C., P.T. (PT-444) Aptos, CA**

November 28, 1994.

### PSYCHOLOGISTS

**McEUN, ORIN L., Ph.D. (PSY-7508) Riverside, CA**

December 8, 1994.

**RANDALL, FRANK, Ph.D. (PSY-2157) Lancaster, CA**

January 6, 1995.

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**ACTION REPORT-APRIL 1995**

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

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

# Medical Board of California

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

April 1995

## 39 State Boards Conduct Self Examinations California Compares Well; Needs to Do Better

Medical boards in 39 states have participated in a sweeping evaluation of the way they license and discipline physicians. In a report released by the Federation of State Medical Boards, California compares favorably in most areas, but has reason to roll up its sleeves in a few.

The evaluation was based on a 300-question document known as the Self Assessment Instrument, or SAI. The questions were grouped in seven divisions covering general information including demographics of the state and physician population, the structure and powers of the board, licensing authority, disciplinary activities, physician and public education about laws and policies, communication, public information, legislative and policy-making activities, and physician impairment.

### SAI Development

The SAI was developed by a nationwide committee of board members and executives, under the guidance of the Federation of State Medical Boards (the organization of all medical and osteopathic boards in the U.S. and its territories). After a two-year process of development and field testing, the SAI was sent to all member boards. Responses applied either to fiscal year 1992-93 or calendar year 1993 at the discretion of the individual board.

While its primary purpose was to permit each board to perform a comprehensive evaluation of its own programs, laws and policies, boards were asked to provide a copy of the completed SAI to the Federation. Thirty-nine boards submitted completed questionnaires, and these were compiled into a massive database under contract with a private research firm. A summary report on the responses was released by the Federation in October 1994. The summary does not identify how individual boards

responded to the numerous questions, but provides a general picture of how medical regulation is done nationwide.

The sheer size of physician regulation in California stands out from all other factors in how boards do their jobs. With over 100,000 active licenses, and 75,000 physicians residing in the state, the MBC is a giant compared with most states. The 39 medical boards reported an average of 25 employees, compared with California's 260. The MBC program budget was \$356 per year for each physician residing in California, one of the highest funding levels. This money was used to license almost 4,400 new physicians (national average 800), and to respond to 9,087 complaints (850 average).

### Rehabilitating Physicians

California has comparable numbers of physicians in its Diversion Program at 3.5 per 1,000 physicians residing in the state (nationally 4:1,000). California physicians are monitored by the program within a week. The California intake process takes nine days more than the nationwide average of 36 days for evaluation. Because we use Diversion Evaluation Committees, California does not need another 72 days for a Board action (like many other states) to place a doctor in the program.

Like the majority (53%) of other boards, participation in the Diversion Program is confidential, and like 80% of boards, self-referred participants are not reported to the MBC. Health facilities in 57% of states, including California (per Business and Professions Code section 805), are required to report disciplined physicians. Like California, 39% of the states said that other health professions are required to notify the Board of similar disciplinary actions.

(Cont. on p. ii)

### 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.

# Highlights of the Executive Summary...

[California's responses to each datum are in brackets following the nationwide value.]

## Impaired Physicians

- Slightly under 4 [3.45] physicians per 1,000 licensees in the state are in approved rehabilitation programs. Identification of physicians with problems is better in states with high [medium] ratios of board staff to licensees, and lower ratios of physicians to population.
- 57% of boards require health care institutions to report disciplined physicians [yes], fewer than 1/2 require physicians to report themselves [yes], and about 39% require other health professions to report impaired doctors [no].
- License renewal forms in 58% of the responding states include information aimed at identifying impaired physicians [yes]. While 35% of states require triplicate prescriptions [yes], less than 1% [0%] of impaired physicians are identified through these systems.
- On average, it takes about 36 days [45 days] to evaluate an impaired physician, and another 72 days [7 days for DEC] for the board to take action following completion of the evaluation [California board does not take direct action; delegated to DEC's].
- Only 1/5 of boards require that participants in rehabilitation programs be reported to the board [no; by law this is confidential except for board referrals], and 53% guarantee confidentiality of participants [yes].
- 1/3 of the boards track all rehabilitation participants

[yes], 45% track only board referrals, and 41% keep records of those who complete rehabilitation [no].

## Education/Information

- Most boards provide some kind of educational or informational materials for applicants, licensees and the public, but expend less than 1% [0.2%] of budget on these activities. About 14% of reporting boards require applicants to demonstrate some knowledge of the medical practice act, regulations, jurisprudence and mandatory reporting obligations [no].
- About 1/3 of the boards have manuals or guidelines for executives, attorneys and investigators [yes], while over 1/2 have such materials for office staff [yes]. 24 boards reported having a newsletter [yes], 17 identify disciplinary actions [yes], and 15 of those summarize the details of the action [yes]. Media interviews ranged from a low of 6 to a high of 1,000 [300] in the report year.
- Almost 80% of boards have access to a medical library [yes] and 3/4 also have database resources [yes]. Almost all boards have access to experts and medical consultants [yes].

## Legislative Activities

- Boards sponsor an average of 2 [13] bills per year, and respond to about 17 [35] other legislative proposals. 7 out of 10 boards review their own statutes periodically for legislative issues [yes].

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## SAI: California Compares Well; Needs to Do Better (Cont. from p. i)

The biggest single hurdle facing California, in relation to the performance of other state medical boards, is in the length of time needed to complete disciplinary actions. While most states were able to investigate, litigate and discipline within a single year, California cases that went all the way to hearing took an average of 18 months.

The California board received 122.5 complaints per 1,000 physicians, more than twice the average of other states, but had fewer disciplinary actions per 1,000 than other states. One reason for this is the higher level of proof required in California actions. However, discipline in California was almost twice as likely to end in revoking the license (35% of actions, compared to 19.8% overall). In general, once a case goes to formal discipline in California, the sanctions imposed are more significant than elsewhere. Similarly,

comparatively few decisions in California are appealed (7.3%) and very few of those are successful (1.2%).

Regular readers of the *Action Report* have followed the major changes the Board has achieved in the past two years to enhance its effectiveness and efficiency. These changes have shortened the time from receiving a complaint to resolving it. Substantial improvements in the way the Board works with the Attorney General are now showing real results and similar recommendations have been made to the Office of Administrative Hearings. New penalties and sanctions such as public letters of reprimand and citations and fines have been introduced. A new study of enforcement priorities in California will, when completed this year, provide new methods to shorten the investigation and accusation process.

# ...Regulating A Leviathan

## Licensing

Boards with large physician populations take significantly longer to notify examinees of scores [10 days], to respond to application requests [5 days], and to respond to applicants' written questions [20 days].

- As of January 1995, there were 102,140 total California-licensed physicians—76,964 instate, and 25,176 with out-of-state addresses.
- California has the highest ratio of physicians to population of any state, and is higher than the nation as a whole.
- The average board received about 850 [4,334] applications in the year the SAI was completed, issued about 800 [4,357] licenses, renewed about 8,300 [51,000] licenses, issued about 565 [not applicable] graduate training licenses and about 33 [6] special licenses.
- Approximately 80% of the boards check physical condition [no], 86% check mental fitness [yes], and over 97% check for chemical dependency of applicants [yes].
- Application verification varies widely: only 21% of boards check fingerprints [yes]; 78% check personal documents [yes]; 76% check with residency programs [yes]. The board's staff-to-licensee ratio [medium] is a major factor on how extensively applications are checked.
- About 1/3 of boards still have members interview all applicants [no; because of the sheer numbers involved, this is not feasible], and about 60% interview selected applicants [no].
- Over 3/4 of boards have board members review applications for renewal of licenses [no; this is routinized, and only nonstandard responses are reviewed, such as no signature, no CME verification, etc.], and over 1/2 compare renewal information to existing files and records on the applicant [no; again, sheer numbers make this unfeasible].

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*“With over  
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## Enforcement

Of all disciplinary actions, probation made up 33.2% [25%], public censure 32.5% [0% (this category did not exist at the time of the report; now the Board can issue public letters of reprimand)], limitations and restrictions 20.3% [6.6%], and revocations constituted 19.8% [35%]. In the year of the SAI, boards took an average of 60 [282] informal actions, and 83% [100%] of the informal actions were confidential. (To understand these highlights more precisely, please review the footnotes on the charts on the following pages.)

- A small number of boards attempt to identify violators proactively: 3 boards conduct practice audits [no], 14 examine prescribing patterns [no], and 3 conduct morbidity/mortality studies [no].
- In the SAI sample year, the average board received about 820 [9,087] complaints, involving almost 500 [data not reported] different licensees, and resolved about 750 [7,438] cases. About 4.5% of raw complaints led to pre-hearing stipulations or consent orders [data not reported]; and about 2.1% [1%] went to formal hearings. This “average board” conducted 22 [92] hearings.
- Over 1/2 of all complaints nationwide [64%] come from consumers, and about 1/3 [1/4] of all complaints are investigated. The average board took 33.4 [256] disciplinary actions, or about 3.5% [2.8%] of raw complaints and almost 11% [11.3%] of investigated complaints. Almost 29% [12%] of complaints were dismissed or referred to other agencies.
- From the receipt of a complaint, the average board needed 27 [26] weeks to close or dismiss a complaint; 37 [65] weeks to negotiate a stipulation or consent agreement; and 47 [78] weeks to complete a hearing. While the time frames shown here are comparatively long, California has significantly shortened these times. One important change is that securing medical records, which often took months in the past, was greatly speeded up by passage of a law imposing a \$1,000/day fine for those who refuse to comply with a subpoena or court order to produce the records.

**TABLE 1: EFFECTS OF LEVEL OF BOARD AUTONOMY\* ON FUNCTIONS OF BOARDS**

	FULLY AUTONOMOUS		SEMI-AUTONOMOUS		NON-AUTONOMOUS		CALIF. REPLIES		
	Number/ 39 boards	%	Number/ 39 boards	%	Number/ 39 boards	%	Calif. is Semi-autonomous		
1	Average annual budget per physician (based on physicians with address in state)		\$227		\$270		\$156		\$356 <sup>1</sup>
<b>LICENSING</b>									
2	Use written guidelines or criteria for evaluating applications			53%		75%		82%	Yes
3	Use written guidelines or criteria for evaluating renewal forms			45%		50%		90%	
4	Issue special licenses			55%		75%		90%	Yes
<b>ENFORCEMENT</b>									
5	Physicians subject to <u>formal</u> discipline / 1,000 in-state licensees		5.4		4.9		4.0		3.46 <sup>2</sup>
6	<u>Informal</u> actions taken per 1,000 in-state licensees		8.6		17.4		5.5		3.81
7	Informal actions are confidential or non-confidential			Confidential		Confidential		Non-confidential	Confidential <sup>2</sup>
8	Percentage of disciplinary actions appealed			11.7%		7.4%		5.1%	7.3%
9	Average time to dismiss or close complaint		27 weeks		12 weeks		39 weeks		26 wks
10	Average time to reach consent agreement or stipulation		33.4 wks		40.3 wks		71.5 wks		65 wks <sup>3</sup>
11	Time to complete case through disciplinary hearing		46.7 wks		39 weeks		76.5 wks		78 wks <sup>3</sup>
<b>IMPAIRED PHYSICIANS</b>									
12	Health facilities required to report impairment			72.2%		33.3%		33.3%	Yes
13	Board will act on anonymous complaints			75%		75%		36.4%	Yes
14	Use renewal forms to assist in identification of impaired physicians			66.7%		50%		45.4%	Yes
15	Average time from complaint to evaluation of impaired physician		46 days		20 days		21.8 days		7 days <sup>4</sup>
16	Time from complaint to board taking action		92 days		100 days		20 days		N/A <sup>5</sup>
17	# of diversion participants coming before board after relapse/violation of probation		1.7 / 1.7		1.3 / 0.5		1.3 / 0.5		N/A <sup>5</sup>

\*Based on responses to 5 questions: Is the board an independent and autonomous agency? Does the board act to employ its staff? Does the board act to dismiss its staff? Does the board control its budget and spending? Is the EO hired for or assigned to the board by another state agency? All answers were expected to be "yes" except last question. 4-5 expected answers = autonomous; 2-3 expected answers = semi-autonomous; 0-1 expected answers = non-autonomous.

**FOOTNOTES:**

1. Biennial California license renewal fee in 1995 is \$600. As of 1/1/95, there were 102,140 valid licenses in effect, of which 76,964 had California addresses. These numbers do not include military physicians or retirees, who do not pay a fee.
2. "Formal discipline" in California refers to revocation, suspension, probation and various special terms and conditions. Recently, these were expanded to include citations and fines, and public letters of reprimand; however, those were not included in the SAI data. Also, in compiling the data, the Federation of State Medical Boards counted multiple sanctions against the same respondent separately; however, the data California reported counted multiple sanctions against the same respondent as one formal discipline.
3. While the timeframes shown here are comparatively long, California has significantly shortened these times. One important change is that securing medical records, which often took months in the past, was greatly speeded up by passage of a law imposing a \$1,000/day fine for those who refuse to comply with a subpoena or court order to produce the records.
4. California uses Diversion Group Facilitators to initially evaluate candidates for the Diversion Program, which accounts for relatively swift action here.
5. Management of California's Diversion Program is delegated to staff and does not require action by the board itself to place a physician in the program.

**TABLE 2: EFFECTS OF BOARD BUDGET PER INSTATE LICENSEE ON FUNCTIONS OF BOARDS**

		LOW: LESS THAN \$125 / PHYSICIAN		MEDIUM: \$125.01 - \$280 / PHYSICIAN		HIGH: MORE THAN \$280 / PHYSICIAN		CALIF. REPLIES
		Number/ 39 boards	%	Number/ 39 boards	%	Number/ 39 boards	%	HIGH \$356
<b>ENFORCEMENT</b>								
1	Complaints per 1,000 instate licensees	40		55.5		79.6		122.5 <sup>1</sup>
2	Physicians subject to <u>formal</u> discipline per 1,000 instate licensees	4.8		5.3		6.7		3.48 <sup>2</sup>
3	Summary suspensions issued per 1,000 instate licensees	1.03		0.4		0.2		0.08 <sup>3</sup>
4	% of disciplines resulting in revocations		27.4%		12.3%		7.1%	27% <sup>4</sup>
5	% of disciplines resulting in suspensions		9.5%		6.6%		1.9%	19.5% <sup>4</sup>
6	% of disciplines resulting in probations		10.0%		22.4%		11.9%	54% <sup>4</sup>
7	% of informal actions which are confidential		97.5%		85.4%		66.7%	100%
8	% of disciplinary cases taking less than 1 year to complete		54.5%		47.4%		33.7%	N/A <sup>5</sup>
9	Average time from receipt of complaint to completion of discipline after hearing	77.5 wks		42.7 wks		36.7 wks		78 wks <sup>6</sup>
10	Average time from receipt of complaint to completion of stipulated (consent) agreement	59.5 wks		30.5 wks		35.5 wks		65 wks <sup>6</sup>
11	Average time from receipt of complaint to closure or dismissal of case	23.5 wks		22.7 wks		54 wks		26 wks
12	Immunity for complainants acting in good faith		60% of boards		76.5% of boards		100% of boards	Yes
13	% of boards holding complaints confidential		83.3%		61.1%		40%	Yes
14	% of boards that prioritize complaint cases		66.7%		68.4%		80%	Yes
15	% of cases leading to pre-hearing stipulations		10.2%		9.8%		4.7%	None reported <sup>7</sup>
<b>IMPAIRED PHYSICIANS</b>								
16	Board has formal program to identify impaired physicians		33.3%		44.4%		50%	Yes
17	# of physicians per 1,000 instate licensees evaluated for impairment	4.07		3.41		2.28		1.32
18	# of physicians per 1,000 instate licensees being monitored by program	6.01		4.95		2.07		3.45
19	% of boards where participation is confidential		33.3%		50%		80%	Yes
<p>1. This is the highest ratio in the nation.</p> <p>2. In California, "Formal Discipline" refers to revocation, suspension, probation, and various special terms and conditions. Recently these were expanded to include citations and fines, and public letters of reprimand. However, those were not included in the SAI data. Also, in compiling the data, the Federation of State Medical Boards counted multiple sanctions against the same respondent separately; however, the data California reported counted multiple sanctions against the same respondent as one formal discipline.</p> <p>3. Fewer summary suspensions are granted in California, but only 1.2% were appealed successfully. Also, California must meet a level of proof known as "clear and convincing evidence", which is second only to "beyond a reasonable doubt" (in criminal cases) and is used in only 14 states.</p> <p>4. The SAI counted multiple sanctions against the same respondent separately. In California's original response to the SAI, multiple sanctions against the same respondent were counted as one discipline. These figures reflect the SAI methodology.</p> <p>5. Some cases actually were completed in under a year, but data were not available at the time the SAI was completed.</p> <p>6. Since the SAI data were compiled (1993) these times have been shortened.</p> <p>7. Numerous cases were resolved by stipulation during the period covered by the SAI, but data were not available then.</p>								

**TABLE 3: EFFECTS OF RATIO OF INSTATE PHYSICIANS  
PER 1,000 POPULATION ON FUNCTIONS OF BOARDS**

		LOW: LESS THAN 0.45 PHYSICIANS PER 1,000		MEDIUM: 0.461 - 2.26 PHYSICIANS PER 1,000		HIGH: MORE THAN 2.26 PHYSICIANS PER 1,000		CALIF. REPLIES
		Number / 39 boards	%	Number/ 39 boards	%	Number/ 39 boards	%	2.49 / 1,000
<b>ENFORCEMENT</b>								
1	% of complaints that lead to <u>formal</u> discipline		12.9%		12.7%		8.4%	2.8% <sup>1</sup>
2	% of disciplines ending in reprimand		6.6%		6.7%		14.6%	2.6% <sup>2</sup>
3	% of disciplines ending in summary suspension		5.3%		6.6%		7.1%	1.2% <sup>3</sup>
4	Board prioritizes complaints		54.4%		61.9%		100%	Yes
5	Board will investigate/act on oral or phone complaints		25%		57.1%		60%	Yes
6	Complaints held confidential		25%		65%		72.7%	Yes
7	Refer non-jurisdictional complaints to appropriate agencies		2.3%		20.9%		34.3%	Yes
8	% of complaints went to formal hearings		6.2%		3.7%		2.0%	1.0% <sup>4</sup>
<b>IMPAIRED PHYSICIANS</b>								
9	# of physicians per 1,000 instate who volunteered for diversion or other treatment	1.92		0.96		0.6		1.01
10	# of physicians per 1,000 instate who were identified to board by others	1.87		1.88		1.65		0.31
11	# of physicians per 1,000 instate referred to rehabilitation	1.28		1.85		1.85		0.9
12	# of physicians per 1,000 instate evaluated by board for rehabilitation	5.14		2.79		1.97		1.32
13	Licensee required by board to self-report impairment		66.7%		50%		44.4%	Yes
14	Complaints about impairment confidential		50%		81.9%		81.8%	Yes
15	Board uses renewal forms to help ID impaired physicians		40%		57.1%		72.7%	Yes

1. "Formal discipline" in California refers to revocation, suspension, probation and various special terms and conditions. Recently, these were expanded to include citations and fines, and public letters of reprimand; however, those were not included in the SAI data. Also, in compiling the data, the Federation of State Medical Boards counted multiple sanctions against the same respondent separately; however, the data California reported counted multiple sanctions against the same respondent as one formal discipline.

2. At the time the SAI data were compiled, the Board did not have authority to issue a PUBLIC letter of reprimand; this figure represents a small number of reprimands which were imposed as a result of a formal hearing or stipulated decision. 1995 data will include increased reprimands.

3. Fewer summary suspensions are granted in California, but only 1.2% were appealed successfully. Also, California must meet a level of proof known as "clear and convincing evidence", which is second only to "beyond a reasonable doubt" (in criminal cases) and is used in only 14 states.

4. This percentage is proportionately low because California receives the highest number of complaints in the nation. Also, California's success rate in hearings is much higher than states that do not adhere to the "Clear and Convincing Evidence" standard. Fewer California disciplinary actions are appealed to the courts, and appeals are rarely successful.

**TABLE 4: EFFECTS ON FUNCTIONS OF BOARDS  
OF SIZE OF BOARD STAFF PER 1,000 LICENSEES IN STATE**

		LOW: UP TO 2 STAFF PER 1,000 PHYSICIANS		MEDIUM: 2.1 - 4 STAFF PER 1,000 PHYSICIANS		HIGH: MORE THAN 4 PER 1,000 PHYSICIANS		CALIF. REPLIES
		Number/ 39 reporters	%	Number/ 39 reporters	%	Number/ 39 reporters	%	3.5 / 1,000 physicians
1	Average annual budget per physician	\$123		\$240		\$259		\$356
<b>ENFORCEMENT</b>								
2	Complaints received per 1,000 licensees instate	52.2		52.7		88		122.5
3	Physicians subject to formal discipline per 1,000 licensees instate	2.9		5.8		6.7		3.46
4	Summary suspensions issued as % of cases		9.9%		5.7%		2.1%	1.2% <sup>1</sup>
5	% of summary suspensions that resulted in eventual discipline		59.4%		74.5%		100%	100% <sup>1</sup>
6	# of informal actions taken per 1,000 licensees instate	4.8		14.2		17.2		3.8 <sup>2</sup>
7	Board will act on telephone complaint		41.7%		52.9%		80%	Yes
8	Board will act on anonymous complaint		50%		52.9%		66.7%	Yes
9	% of cases dismissed after investigation		48.7%		54%		75.8%	15.8% <sup>3</sup>
10	% of staff time consumed in monitoring probationers		23.4%		11.3%		8.4%	3.0% <sup>4</sup>
<b>IMPAIRED PHYSICIANS</b>								
11	# of impaired physicians identified or reported to board per 1,000 licensees instate	1.58		1.6		3.54		1.32
12	# of impaired physicians evaluated for diversion or other treatment per 1,000 licensees instate	2.67		2.46		5.72		1.32
13	# of impaired physicians referred for treatment per 1,000 licensees instate	1.19		1.57		4.96		0.9
14	# of impaired physicians monitored by board per 1,000 licensees instate	2.9		3.64		7.95		3.45
15	# of physicians disciplined for impairment per 1,000 licensees instate	0.91		1.09		3.4		Not reported <sup>5</sup>
16	# of impaired physicians practicing under probation or limitation per 1,000 licensees instate	1.57		2.08		6.76		0.32
17	Participation in diversion or treatment confidential		62.5%		56.2%		33.3%	Yes
18	Physician can participate in diversion or treatment regardless of ability to pay		83.3%		73.3%		40%	Yes

- Summary suspensions are more difficult to obtain under California law, but when obtained, their validity is upheld.
- New "informal" sanctions including citation and fine authority and public letters of reprimand were authorized beginning January 1, 1994.
- The percent of cases closed after investigation is lower in California than in other states because of more effective triage of cases at the intake level. More cases are closed without investigation, with or without mediation or informal action, and investigative resources are focussed on more serious cases.
- Since these data were compiled, more staff have been added to the Board's probation monitoring unit. Also, under a new policy, medical experts are used to assist in monitoring probationers.
- In general, physicians are not disciplined for impairment in California. Disciplinary action focusses on the acts, e.g. negligence, incompetence, etc., rather than on the causes. A physician may be ordered into Diversion as part of a disciplinary order resulting from a violation; conversely, a physician who drops out of Diversion may be disciplined for related violations.

**TABLE 5: EFFECTS ON FUNCTIONS OF BOARDS  
OF TOTAL NUMBER OF PHYSICIANS RESIDING IN THE STATE**

		SMALL: UNDER 6,000 PHYSICIANS		MEDIUM: 6,001 - 16,000 PHYSICIANS		LARGE: OVER 16,000 PHYSICIANS		CALIF. REPLIES
		Number/ 39 reporters	%	Number/ 39 reporters	%	Number/ 39 reporters	%	74,210 <sup>1</sup>
1	Average annual budget per physician for instate physicians / for all licensees	\$263		\$202		\$181		\$356/ \$262
2	Ratio of physicians living instate to population	1 : 2,953		1 : 934		1 : 465		1 : 401 <sup>2</sup>
<b>ENFORCEMENT</b>								
3	Complaints received per 1,000 licensees instate	54.2		48.3		37.4		122.5
4	% of disciplines resulting in suspensions		0%		7.0%		9.7%	19.5% <sup>3</sup>
5	% of disciplines resulting in probation		12.6%		20.3%		20.7%	54% <sup>3</sup>
6	% of disciplines resulting in practice limitations		24.7%		20.3%		12.4%	3.3%
7	% of discipline cases resolved in less than 1 year		39.1%		39.3%		64.2%	N/A <sup>4</sup>
8	Board identifies problem physicians proactively		36.4%		41.7%		54.5%	No
9	% of complaints that are anonymous		2.9%		2.4%		11.7%	3.0%
10	% of boards that investigate anonymous complaints		46.1%		50%		63.6%	Yes
11	% of summary suspensions that eventually result in discipline of physician		66.7%		55.9%		88.5%	100%
12	% of disciplinary actions that are appealed		14.5%		7.1%		5.0%	7.3%
13	% of disciplinary actions that are overturned on appeal		3.1%		1.4%		0.7%	1.2%
<b>IMPAIRED PHYSICIANS</b>								
14	Physicians per 1,000 instate who voluntarily identify themselves as impaired	1.2		0.99		0.63		1.01
15	Impaired physicians evaluated by board per 1,000 physicians instate	3.57		3.02		2.24		1.32
16	Impaired physicians referred to rehabilitation per 1,000 physicians instate	2.14		2.06		1.23		0.9
17	Number of impaired physicians summarily suspended by board	1.19		0.35		0.17		15 <sup>5</sup>
18	Impaired physicians monitored or tracked by board per 1,000 physicians instate	5.83		3.38		2.41		3.45
19	Board accepts and acts on anonymous information about impaired physicians		61.5%		61.5%		100%	Yes
20	Average time to act on information	47.6 days		65.6 days		111.9 days		7 days <sup>6</sup>

1. Total licenses in effect in 1993: 100,858; instate address: 74,210; out-of-state address: 26,648. January 1995: 102,140 total, 76,964 instate, and 25,176 with out-of-state addresses.

2. California has the highest ratio of physicians to population of any state, and is higher than the nation as a whole.

3. The SAI counted multiple sanctions against the same respondent separately. In California's original response to the SAI, multiple sanctions against the same respondent were counted as one discipline. These figures reflect the SAI methodology.

4. Some cases actually were completed in under a year, but data were not available at the time the SAI was completed.

5. What we actually reported was 15 physicians terminated from Diversion Program.

6. California uses Diversion Group Facilitators to initially evaluate potential participants, greatly reducing the time required to place a physician in the program.