

# Action Report

## Medical Board of California

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**Medical Board of California Meetings**

**2001**

Nov. 1 - 3 San Diego

**2002**

Jan. 31-Feb. 2 Los Angeles  
May 9 -11 Sacramento  
July 25-27 San Francisco  
Oct. 31-Nov. 2 San Diego

*All meetings are open to the public.*

The Medical Board of California Joins the Nation  
in Sorrow for the Events of  
**September 11, 2001**  
and in its Commitment to the Future

**Effective Pain Management—A Legal Update**

The problem of chronic pain and questions surrounding prescribing for pain were issues of note throughout the 1990s, and are receiving continued scrutiny today. The Medical Board of California has been actively addressing these issues since 1994, when the Board held its "Summit on Effective Pain Management: Removing the Impediments to Appropriate Prescribing." The result of this work was the formal adoption by the Board in July 1994 of its Guidelines for the Treatment of Intractable Pain, created to complement new law—Business and Professions Code section 2241.5—which established California public policy as supportive of the responsible practice of pain management. These Guidelines are intended to reassure physicians that they are free to use their best professional judgment, consistent with established medical standards, when treating patients for pain, rather than on a fear of discipline by the Medical Board. They are republished at the end of this article.

During the 1990s, the Legislature passed six bills of particular note dealing with pain management. They, too, are briefly summarized in this article

*As we go to press, AB 487 (Aroner) is pending on the Governor's desk. If signed, this bill will require most practicing physicians to obtain 12 continuing education credits within the next four years in pain management and end-of-life care.*

to remind physicians of these laws and of the Legislature's ongoing interest in this matter of utmost importance to California patients and their families.

The Medical Board employs a multifaceted approach to promote the ability of physicians to provide appropriate pain relief treatment, as established by emerging community standards. The Board recognizes that discipline of physicians for the under-treatment of pain is, by itself, ineffectual as an incentive to effective pain management. Patient protection, the primary role of the Medical Board, should also include the promotion of good medical practice by positive means. Therefore, the Medical Board of California is actively engaged in

encouraging the dissemination of the latest information and educational resources to promote appropriate pain relief.

The first step was the creation and publication of the pain relief guidelines of 1994. The Board has repeatedly informed physicians that if they follow these guidelines, they should not fear charges from the

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**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.*

# President's Report

As the calamity that was September 11, 2001 unfolded, we became witness to the profound bravery of firefighters, police and paramedics. In addition, the Medical Society of the State of New York reports 8,000 physicians volunteered in a selfless expression to aid in medical care, without regard to the risks entailed. One particularly moving expression of this dedication to the welfare of those imperiled was captured on a news clip of a physician in the eye of the storm, calling through the ash, "Does anybody need a doctor?"



**Bernard S. Alpert, M.D.**  
**President of the Board**

Webster's best allows the -ship suffix to be attached to professions, and Dr. Maxine Papadakis, Associate Dean for Student Affairs at UCSF, one of our state's eight fine medical schools, has actually introduced the concept into the formal evaluation of medical students. What is physicianship? It is the rubric under which one could list all the reasons we became physicians. It is the crucible in which the core elements of professionalism in being a physician are housed; and with its tenets comes the learned and exclusive access to a unique and invaluable body of knowledge upon which all citizens depend as armor against our greatest vulnerabilities. It is critical.

We now react to the great shock our system has received. This requires new policies and ideas. Some feel that signs of the impending shock were sociologically apparent and palpable. I cannot but sense a similar prodromal unsteadiness in our healthcare delivery system. The landscape and demographics of California's healthcare have evolved to a point of requiring more than maintenance. Keen attention, innovation, and adaptation are needed to steady our course. To the call, "Anybody need a doctor?," present-day California answers "yes."

One example of an issue that captures the above is that of the uninsured and underserved, intertwined groups of a magnitude having great systemic impact. Complexity precludes full analysis in one column, but a brief look at some facts, trends, mismatches, and paradoxes argues the need for innovative solutions.

First, some background: California is home for a large number of medically uninsured—reports indicate up to seven million—for a plethora of reasons. A large,

underserved population, primarily Hispanic, exists in regions throughout the state, and especially in Southern California, where difficulty with physician access has produced a public outcry. Over 30 percent of our state's population is Hispanic. Two percent of our physician work force is Hispanic. Approximately 17,000 U.S. medical students graduate per year to fill 24,000 residency training positions.

Let us look singularly at the issue of the underserved population. One of the leading remedies currently being given legislative consideration is that of importing a corps of physicians from Mexico to work in the specific areas

impacted. As envisioned by its supporters, this may or may not require state licensure modifications. The merits and details of this proposal are the subject of evaluation and debate.

In one respect I find heartening the concept of another nation, Mexico in this case, assisting California with physician access. Our history is not replete with such offers. Are there not, however, other innovative domestic modalities that might be considered, such as incentivizing physician recruitment in these areas by medical school loan relief, income tax relief, "empowerment zone" type augmented reimbursement, or even a Berry Plan type model in which service is exchanged for a designated, predetermined benefit?

Consider establishing a branch of one of our medical schools in the underserved regions, where patients would receive care in the same model that has worked for many years in our teaching and county hospitals and satellite locations such as currently exist in Fresno. Should we train more U.S. medical students, either in existing or additional schools, along with some of the incentives mentioned? What is the ideal ratio of domestic graduates to residency training positions? Do we know?

Other provocative questions emerge: Would learning medical, conversational Spanish or Chinese in medical school be more valuable than biochemistry? Should

*(Continued on page 17)*

# Is Your Medical Assistant Practicing Beyond His or Her Scope of Training?

The Medical Board receives numerous inquiries concerning the use of medical assistants in a physician's office. (By law, a medical assistant may not be employed for inpatient care in a licensed general acute care hospital.)

Medical assistants are unlicensed, and may *only* perform basic administrative, clerical and technical supportive services as permitted by law. An unlicensed person *may not diagnose or treat or perform any task that is invasive or requires assessment*. The responsibility for the appropriate use of unlicensed persons in healthcare delivery rests with the physician.

The classification of medical assistant is defined under the provisions of the Medical Practice Act (Business and Professions Code sections 2069-2071). The law defines a "medical assistant" as a person who may be unlicensed who performs basic administrative, clerical, and technical supportive services under the supervision of a licensed physician or podiatrist.

Under the law, "technical supportive services" are deemed simple, routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician or podiatrist. "Supervision" is defined to require the licensed physician or podiatrist *to be physically present in the treatment facility during the performance of those procedures*.

Prior to performing technical supportive services, a medical assistant shall receive training by a licensed physician and surgeon or podiatrist or instructor in an approved school program to assure the medical assistant's competence in performing a service at the appropriate standard of care.

A medical assistant, who has completed the minimum training prescribed by regulation, may administer medication by intradermal, subcutaneous, or intramuscular injections, perform skin tests, and other technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or podiatrist.

"Specific authorization" means a specific written order prepared by the supervising physician or podiatrist authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record; or a

standing order prepared by the supervising physician or podiatrist authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed in the patient's medical record.

Other technical supportive services which a medical assistant may perform have been established by regulation to include: applying and removing bandages and dressings, removing sutures, performing ear lavage, preparing patients for examinations, and shaving and disinfecting treatment sites. (The regulations governing medical assistants can be found in the California Code of Regulations at sections 1366-1366.4 of Title 16, Division 13.) Medical assistants who have completed the minimum training prescribed by regulation may draw blood.

Medical assistants are *not* allowed to perform such invasive procedures as:

- placing the needle or starting and disconnecting the infusion tube of an IV.
- administering medications or injections into the IV line.
- charting the pupillary responses.
- inserting a urine catheter.
- independently performing telephone triage.
- injecting collagen.
- using lasers to remove hair, wrinkles, scars, moles or other blemishes.
- administering chemotherapy.

Medical assistants may not interpret the results of skin tests, although they may measure and describe the test reaction and make a record in the patient chart.

*In summary*, medical assistants are not licensed, and it is not legal to use them to replace highly trained, licensed professionals. The medical assistant is present to assist and perform support services in the physician's office.

Those duties must be appropriate with the medical assistant's required training, which cannot be compared with licensed nurses or other health professionals who meet rigorous educational and examination requirements.

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**"An unlicensed person may not diagnose or treat or perform any task that is invasive or requires assessment."**

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# Law Expands Scope of Optometric Practice and Supervision of Optometric Assistants

On January 1, 2001, a new law (SB 929, Polanco, Chapter 676, Statutes of 2000) expanded the scope of practice for optometrists by specifying additional diseases and conditions that optometrists may treat (in particular, certain types of glaucoma) with specified medications, and it also specified the extent of physician involvement that is required under various circumstances. Further, the law amends section 2544 of the Business and Professions Code, which sets forth additional duties that an assistant (rather than a technician) may perform under the direct responsibility and supervision of an ophthalmologist or optometrist. (Read SB 929 at: [www.medbd.ca.gov](http://www.medbd.ca.gov), under *What's New*.)

The Medical Board believes that it is important to communicate to physicians, especially ophthalmologists, information concerning these changes in optometric scope of practice and the obligations imposed on physicians in connection therewith. Consultation and referral requirements from optometrists to ophthalmologists are also required within specified time frames for use of oral medications for the following conditions: preceptal cellulitis, blepharitis, traumatic iritis, peripheral keratitis and herpes simplex.

## Optometric Diagnosis and Treatment Authority

The law changes a number of the identified conditions that optometrists may diagnose and treat, and requires consultation or referral to an ophthalmologist under certain circumstances. It makes changes to the list of topical pharmaceutical agents that may be used for these purposes, and requires optometrists to again refer or consult with ophthalmologists under certain circumstances. For example, if a patient with a central corneal ulcer fails to improve within 24 hours of the initiation of treatment by an optometrist, consultation is now required by law.

## Treatment of Glaucoma

SB 929 imposes obligations on ophthalmologists that must be met in order for optometrists to treat glaucoma. The legislation provides for certification of optometrists to treat primary open angle glaucoma in patients over the age of 18, if certain requirements are met. The legislation requires that an optometrist collaborate directly with an ophthalmologist for the treatment of 50 patients not previously diagnosed with glaucoma, each for a period of two years, before the optometrist may independently treat patients with primary open angle glaucoma. With respect to each of these 50 patients, the collaborating ophthalmologist *must* receive and

review the optometrist's proposed treatment plan for the patient, comment on it where appropriate, and examine the patient in question before the optometrist may commence treatment of the patient.

Where the law requires an optometrist to consult with an ophthalmologist, the optometrist is required to maintain a written record in the patient's file and furnish a copy upon request by the consulting ophthalmologist, and that all collaborations, consultations, and referrals be made to an ophthalmologist located geographically appropriate to the patient. Once an ophthalmologist accepts the responsibility to review an optometrist's case, a relationship has been established with that patient and the ophthalmologist must continue to remain involved throughout the patient's treatment. In addition, because the ophthalmologist has responsibility for the patient, the ophthalmologist should maintain a file on all correspondence, records and conversations with the optometrist regarding the patient.

Ophthalmologists should note that it is the position of both the Medical Board and the Board of Optometry that multiple optometrists cannot receive credit for the same patient. In addition, ophthalmologists need to recognize that in the role of collaborating with optometrists in the treatment of patients, the ophthalmologist must ensure the optometrist's care of the patient is both continuous and comprehensive. All physicians should be aware of the limitations on the scope of practice of optometrists and be vigilant in protecting patients who are the subject of collaboration with an optometrist.

## Other Areas of Collaboration

SB 929 allows optometrists to perform the procedures lacrimal dilation and irrigation, but only for patients over the age of 12, and then only after obtaining a certificate based upon proof that the optometrist performed 10 such procedures under the preceptorship of an ophthalmologist.

The law prohibits optometrists from using topical steroids or any other medication for the treatment of post-surgical inflammation. This will limit the collaboration between an optometrist and an ophthalmologist after surgery, as an optometrist will not be able to treat with medication inflammation that results from the surgery.

## Ophthalmologic and Optometric Assistants

An assistant in the office of a physician and surgeon or optometrist, acting under the licensee's direct responsibility and supervision, may fit prescription lenses. Under the

*(Continued on page 5)*

# Do You Require an Establishment License If an Esthetician is Practicing at Your Medical Facility?

If you are considering hiring an esthetician at your medical facility, please contact the Bureau of Barbering and Cosmetology for information on applying for an *establishment license*. Per Business and Professions Code section 7347, an *establishment license* is required for any premises where any activity licensed under the Bureau of Barbering and Cosmetology is practiced.

Currently, under California law, only licensed physician assistants and registered nurses may operate lasers or other medical devices, including intense pulse light devices under a physician's supervision for hair removal or any other purpose.

Medical assistants or any other unlicensed staff in a physician's office may not legally treat patients with these kinds of devices. In addition, electrologists, estheticians, or cosmetologists may not operate lasers or intense pulse light devices under the scope of their licenses.

In California, electrology services may be legally performed only by state-licensed electrologists in state-licensed salons or barbershops. Cosmetologists and estheticians may not remove unwanted body/facial hair by electrolysis, but they may remove superfluous hair from clients by several other means.

Chemical exfoliation services may be legally performed only by state-licensed cosmetologists and estheticians in state-licensed salons and barbershops, or by physicians in medical offices. (See, Consumers Guide to Barbering & Cosmetology Service, [www.dca.ca.gov/barber/formspubs](http://www.dca.ca.gov/barber/formspubs), page 16, and California Code of Regulations, [www.dca.ca.gov/barber/laws/art12.htm#991](http://www.dca.ca.gov/barber/laws/art12.htm#991), sections 991 and 992.)

For additional information on obtaining an establishment license, please contact the Bureau of Barbering and Cosmetology at (800) 952-5210 or (916) 327-6250.

## Web Site Update Regarding Gynecologic Cancer Materials

The July 2001 *Action Report* contained an article titled, "Gynecologic Cancer Materials Now Available in Four Languages. Request Your Free Packet of Materials."

These materials can now be ordered through the Office of Women's Health at the Department of Health Services: Please go to [www.dhs.ca.gov/director/owh](http://www.dhs.ca.gov/director/owh) to request these materials.

## Optometric Practice (continued from page 4)

direct responsibility and supervision of the ophthalmologist or optometrist, an assistant also may prepare patients for examination; collect preliminary patient data, including taking a patient history; perform simple noninvasive testing of visual acuity, pupils and ocular motility; perform automated visual field testing; perform ophthalmic photography and digital imaging; perform tonometry; perform lensometry; perform nonsubjective auto refraction in connection with subjective refraction procedures performed by an ophthalmologist or optometrist; administer cycloplegiacs, mydriatics, and topical anesthetics that are not controlled substances, for ophthalmic purposes; perform pachymetry, keratometry, A scans, B scans, and electrodiagnostic testing.

## Doctor's Certification of Disability Required to Obtain Disabled Person Parking Placard

An individual interested in obtaining a Disabled Person (DP) Parking Placard must complete and sign an Application for Disabled Person Parking Placard (REG 195 form) and have a doctor sign the disability certification.

Qualifying conditions include: heart or circulatory disease, lung disease, a diagnosed disease or disorder which significantly limits the use of lower extremities, certain specific documented visual problems, loss, or permanent loss of the use of one or both legs or both hands.

A doctor's certification is not required for *permanent* loss of a lower extremity or both hands, if the individual appears in person at a DMV office.

A person is eligible for a temporary parking placard if he or she is temporarily disabled for six months or less. The temporary placard is valid for 180 days or less from the date DMV issues it or the date noted by a doctor on the application, whichever is less.

A person who is not a California resident, but who plans to travel here and is disabled or a disabled veteran, can obtain a temporary placard good for not more than 90 days from the date of issuance or the date noted by the doctor on the application form.

# An Update on the Epidemiology of Lyme Disease in California

The Federal Drug Administration's approval of the first human Lyme disease (LD) vaccine (LYMERix™, GlaxoSmithKline Pharmaceuticals) in 1998 focused national attention anew on LD, from both physicians and the public. Medical strategies for the prevention and diagnosis of LD depend chiefly on the patient's likelihood of exposure to *Borrelia burgdorferi*, the bacterial agent that causes LD. The purpose of this update is to provide current epidemiologic information on LD, particularly as it pertains to California.

Lyme disease was first described in 1977 as a cluster of oligoarticular arthritis in children and adults near Lyme, Connecticut. Investigations eventually identified the

spirochetal agent, *Borrelia burgdorferi*, and the tick vector, *Ixodes scapularis* (the "deer tick"), of this disease.



**Western black-legged tick, shown actual size at left.**

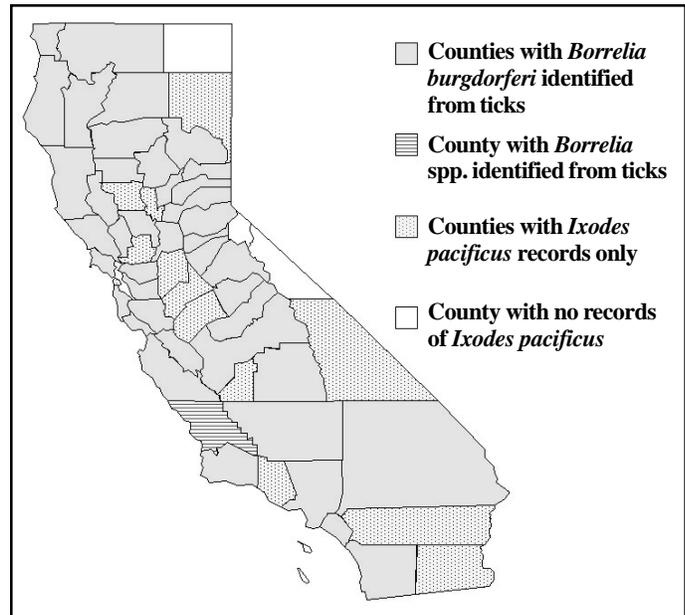
Source: California Department of Health Services

Services (CDHS) in 1989; as of 2000, over 1,700 cases have been reported from 52 of 58 counties.

Early symptoms of LD occur 3 to 30 days after the bite of an infected tick. Symptoms of early Lyme disease can include erythema migrans (EM), described as a red, blotchy, expanding rash, accompanied by fever, headache, neckache, muscle and joint pain. The EM is not always present or may go undetected by a patient or physician if it occurs in a location difficult to see (e.g., scalp) or if the patient has dark skin. Weeks to months after the bite of an infected tick, the spirochetes disseminate, resulting in cardiac conduction defects (atrio-ventricular block) and cranial and peripheral

The Centers for Disease Control and Prevention (CDC) made LD a nationally notifiable condition in 1982. Over 125,000 cases have since been reported nationwide, making LD the most frequently reported vector-borne disease.

The first recognized human case in California occurred in 1978 in a hiker from Sonoma County. Passive surveillance for LD cases began at the California Department of Health



**Figure 1: Distribution of infection with *Borrelia* spp. in the western black-legged tick (*Ixodes pacificus*). *Borrelia burgdorferi* is the agent that causes Lyme disease. *Borrelia* spp. refers to bacterial isolates closely related, but not identical, to *Borrelia burgdorferi*. (Source of data: Mosquito and Vector Control Agencies of California, University of California, Berkeley, Vector-Borne Disease Section, California Department of Health Services)**

neuropathies often exhibited as a unilateral facial palsy, or numbness and pain in arms and legs.

If left untreated or improperly treated, late LD can occur weeks, months, or years after infection. Chronic arthritis, manifested as recurrent swelling of one or a few joints, is the most common feature of late LD. Chronic muscle pain and encephalopathies, such as memory loss and difficulty in concentrating, may also be present.

Diagnosis is based primarily on clinical presentation and supportive history, such as exposure to ticks or environments where ticks occur.

The enzyme immunoassay (ELISA) followed by a confirmatory western blot are serologic tests useful to support the clinical diagnosis. However, it should be noted that false negative results, particularly early in the disease (< 4-6 weeks post infection), as well as false positive results, occur.

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## Lyme Disease (continued from page 6)

Treatment with antibiotics during the early symptoms can cure the infection and can prevent progression to late LD. Several reviews have been published that discuss diagnosis and treatment of this complex disease (1-4).

The tick that transmits *B. burgdorferi* to humans in California is the western black-legged tick, *Ixodes pacificus*. Of the tick's three life stages—larva, nymph and adult—only nymphs and adults can transmit LD bacteria to humans. However, nymphs transmit *B. burgdorferi* to humans more frequently than do adult ticks because nymphs are small (~ 1 mm) and thus difficult to see. Also, in many parts of California, a higher percentage of nymphs than adults carries *B. burgdorferi*.

For example, in Mendocino County, one of the few Californian counties where long-term studies on Lyme disease have been performed, the nymphal infection rate was 41.3% (5) while the adult tick infection rate in that county was 4% (6). In general, nymphs are active from March through July whereas adult ticks are most active from November through March. However, if conditions are favorable, ticks may be active at any time of the year. *Ixodes pacificus* have been collected from 55 of 58 California counties. The *B. burgdorferi* bacterium has been identified from *I. pacificus* ticks in 41 California counties (figure 1).

Californians' contact with *B. burgdorferi*-infected ticks will increase as residential communities expand into areas where there was once only wildlife. Recreational activities in natural areas will similarly increase, placing people in contact with ticks. Both physicians and the public need to be aware of the attendant risks of Lyme and other tick-borne diseases.

The LYMERix™ vaccine (GlaxoSmithKline Pharmaceuticals) is a recently approved tool for LD prevention. Based on current information on vaccine safety and efficacy, and the known epidemiology of LD in California, CDHS does not recommend the LD vaccine for **routine** use anywhere in California.

For more information on Lyme disease in California and to obtain a copy of the Guidelines for Lyme Disease Vaccine Use in California for Health Care Providers, please visit the California Department of Health Services, Division of Communicable Disease Control Web site: [www.dhs.ca.gov/ps/dcdc/html/disbindex.htm](http://www.dhs.ca.gov/ps/dcdc/html/disbindex.htm), or contact the CDHS Vector-Borne Disease Section at (916) 324-3738.

### Reference List

- (1) Rahn DW, Evans J. Lyme Disease. 1 ed. Philadelphia, PA: American College of Physicians, 1998.
- (2) Steere AC. Lyme disease. N Engl J Med 2001 July; 345(2):115-25.

## TICK AVOIDANCE TIPS

Tick avoidance remains the best line of defense against Lyme disease and other tick-borne diseases that occur in California, including Rocky Mountain spotted fever, ehrlichiosis, babesiosis, and tick paralysis.

People who live or recreate in areas where ticks occur should be advised to:

- Wear long pants and long-sleeved shirts. Tuck pant legs into boots or socks, and tuck shirts into pants.
- Wear light-colored clothing so ticks can be easily seen.
- Use a repellent registered for use against ticks. Always follow directions on the container and be extra careful when applying to children.
- Stay in the middle of the trail: avoid trail margins, brush and grassy areas when in tick country.
- Inspect yourself frequently for ticks while in tick habitat. Once out of tick habitat, thoroughly check your entire body for ticks. Parents should examine their children, especially on the scalp and hairline, after activities in tick-infested areas.
- Remove ticks promptly to decrease the risk of spirochete transmission. Ticks must be attached and feeding for at least 24 hours before they are capable of transmitting the *Borrelia* organism.

- (3) Nadelman RB, Nowakowski J, Fish D et al. Prophylaxis with single-dose doxycycline for the prevention of Lyme disease after an *Ixodes scapularis* tick bite. N Engl J Med 2001 July; 345(2):79-84.
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- (5) Tälleklint-Eisen L, Lane RS. Variation in the density of questing *Ixodes pacificus* (Acari:Ixodidae) nymphs infected with *Borrelia burgdorferi* at different spatial scales in California. Journal of Parasitology 1999; 85(5):824-31.
- (6) Clover JR, Lane RS. Evidence implicating nymphal *Ixodes pacificus* (Acari: ixodidae) in the epidemiology of Lyme disease in California. American Journal of Tropical Medicine and Hygiene 1995; 53(3):237-40.

# Two New Tools for Chlamydia Management

By George W. Rutherford, M.D., University of California, San Francisco, Co-Chair, California Chlamydia Action Coalition, and Gail Bolan, M.D., Chief, Sexually Transmitted Disease (STD) Control Branch, California Department of Health Services, Co-Chair, California Chlamydia Action Coalition

New chlamydia clinical practice guidelines and guidance for patient-delivered partner therapy for chlamydia are now available.

The California Chlamydia Action Coalition, in partnership with PricewaterhouseCoopers and the California HealthCare Foundation, has released a new clinical practice guideline on screening for chlamydia infection. In addition, the California Department of Health Services has just released a new set of implementation guidelines for patient-delivered partner therapy for patients with chlamydia. These new tools are the latest in a broad series of initiatives the Coalition and the Department of Health Services have undertaken to control chlamydia in California.

*Chlamydia trachomatis* is the most common communicable disease reported in California with an estimated 600,000 new infections each year. The majority of these infections are asymptomatic and go undetected. Untreated chlamydia infection can lead to pelvic inflammatory disease (PID), tubal infertility, ectopic pregnancy and chronic pelvic pain. An estimated nine out of 10 chlamydia infections in California are currently undetected and untreated because patients have no symptoms nor reasons to seek care and providers do not screen. This is especially true for women. It is estimated that 75-80% of infected women have no symptoms, and as a result may not be diagnosed and treated until complications develop.

## Chlamydia Clinical Practice Guidelines

Early identification through annual screening and subsequent treatment can significantly reduce the medical short and long-term complications in women and have been shown to be cost-effective. A 1996 randomized controlled trial of chlamydia screening and treatment in Group Health of Puget Sound demonstrated a 56% reduction in the incidence of PID in the 12 months following this intervention.\*

Studies from a variety of practice settings in California, including HMOs, have consistently demonstrated high prevalence of chlamydia (5%-15%) in younger women. For example, in California in 1999, approximately 6% of girls 15-19 years of age and 4% of women 20-24 tested in a large northern California HMO were infected. Screening younger women for chlamydia is recommended by the Centers for Disease Control and Prevention (CDC), the U.S. Preventive Services Task Force and a variety of professional

organizations. Recently NCQA included *Chlamydia Screening in Women* as a HEDIS clinical performance measure.\*\*

The clinical practice guideline recommends the following:

- Screen all sexually active women 15 through 25 years old annually for chlamydia, consistent with Centers for Disease Control and Prevention and U.S. Preventive Services Task Force guidelines, as well as the National Committee on Quality Assurance's Health Plan and Employer Data Information Set (HEDIS) performance measurement expectations.
- Use nucleic acid amplification technology tests for screening [(e.g., Ligase Chain Reaction (LCR), Polymerase Chain Reaction (PCR), Strand Displacement Amplification (SDA), and Transcription Mediated Amplification (TMA)]. These tests have high sensitivity and specificity, are suitable for a screening program, and can be performed using urine specimens, allowing chlamydia screening even if a pelvic or genital exam is not being done.
- Treat infected patients with either Azithromycin 1 gm po as a one-time dose or doxycycline 100 mg po bid for seven days. Dispense treatment on site if possible. Instruct patients to abstain from sexual intercourse for seven days after single dose therapy or until completion of a seven-day regimen **and** until seven days after all of their partners are treated.
- Evaluate, test and treat all sexual partners within the last two months if possible. See below for more information on prescribing without an examination.
- Report infected patients to the local health department where the patient resides.
- Test infected patients for other sexually transmitted diseases including syphilis, gonorrhea and HIV.
- Because chlamydia reinfection is common, several experts recommend rescreening infected patients 10 weeks to six months after treatment.

The clinical practice guidelines were mailed to managed care organizations (both commercial and Medi-Cal),

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## Chlamydia Management

(continued from page 8)

medical groups and independent practice associations, professional societies, academic medical centers and statewide health care organizations and associations in October 2001. A series of supporting and reference materials will be made available in a quality improvement “toolbox” later this fall. Please visit the California Chlamydia Action Coalition Web site at: [www.ucsf.edu/castd/chlamydia\\_coalition.html](http://www.ucsf.edu/castd/chlamydia_coalition.html) for copies of the clinical practice guideline and a variety of other materials related to chlamydia and sexually transmitted diseases in general and later this year for the “toolbox”.

### New Guidance for Treating Partners of Chlamydia Patients

The risk of adverse reproductive health complications of chlamydia infection increases significantly with repeat infections, which occur in 15-30% of young women within six months. To prevent repeat infections, partners must be provided timely and appropriate antibiotic treatment. However, because infected partners, and indeed most patients, are generally asymptomatic, they may be unlikely to seek medical treatment. Even when providers counsel patients about the need for partner treatment, some partners have limited or no access to medical care or choose not to seek care.

To address this problem, the California Department of Health Services has developed the first-ever comprehensive set of guidelines for physicians to prescribe and nurse-practitioners, physician assistants and certified nurse-midwives to dispense antibiotic therapy for the sex partners of individuals infected with genital *Chlamydia trachomatis*, even if they have not been able to perform an exam of the patient’s partner(s). California is the first state to legalize this strategy (Health and Safety Code Section 120582). The guidance provides information on the most appropriate patients, medication, prescribing and counseling procedures. The following summarizes the most important points:

**First-choice strategy:** Providers are still required to attempt to bring partners in for evaluation, testing and treatment.

**Most appropriate patients:** Data support the treatment of females with male partners\*\*\*. Other patients may also be treated under the law.

**Diagnosis:** Laboratory-confirmed genital chlamydia infection without co-infection with gonorrhea or other complications.

**Prescribing:** Ideally, providers should give a separate prescription for the patient and the patient’s partner(s). It is

also acceptable to include the name of the patient and partner(s) on one prescription. In the event the patient will not or cannot name the partner(s), the provider may write a prescription for the patient “and partner(s) as appropriate,” with the corresponding number of doses.

**Most appropriate partners:** Males who are uninsured or unlikely to seek medical services.

**Medication:** The law does not specify, but the recommended prescription is for Azithromycin (Zithromax) 1 gram (250 mg tablets x 4) orally once.

**Number of doses** are limited to the number of known sex partners in past 60 days.

**Education materials** must accompany medication. These materials will be available at [www.ucsf.edu/castd](http://www.ucsf.edu/castd).

**Patient counseling:** Providers should recommend abstinence until seven days after treatment and until seven days after partners have been treated.

**Evaluation:** Based on local data, the state of California recommends providers should re-test patients for chlamydia three to four months after treatment.

**Adverse reactions:** The law does not protect the provider from liability, as is the case for any medical treatment. Providers should report any adverse reactions by calling their local STD controller or (866) 556-3730 (toll-free).

For complete guidelines, information regarding materials for patients and their partners, the text of revisions to the Health and Safety Code, and telephone numbers for local health departments for information on local chlamydia efforts, please visit the California Chlamydia Action Coalition’s Web site at [www.ucsf.edu/castd](http://www.ucsf.edu/castd) or call the California Department of Health Services’ STD Control Branch at (510) 540-2657.

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\*Scholes D, Stergachis A, Heidrich FE, Andrilla H, Holmes KK. Prevention of pelvic inflammatory disease by screening for cervical chlamydial infection. *N Engl J Med* 1996; 334:1362-6.

\*\*HEDIS *Chlamydia* screening measure definition: “The percentage of women age 16 through 26 years who were identified as sexually active, who were continuously enrolled during measurement [i.e., prior] year, and who had at least one test for chlamydia during the measurement year.”

\*\*\*Schillinger J, Kissinger P, Berman S, Marin D, Calvet H. A Randomized Trial of Patient-Delivered Therapy to Prevent Recurrent Chlamydial Infection Among Adolescent and Young Women. National STD Prevention Conference. Milwaukee, 2000.

# Adult Immunization for Influenza and Pneumococcal Disease

## 2000 Behavioral Risk Factor Surveillance System (BRFSS) Data and the Role California Physicians Can Play in Improving Adult Immunizations

By Howard Backer, M.D., M.P.H., Nisha Gandhi, M.P.H. and Amanda Roth, M.P.H., M.S.W.  
Immunization Branch, California Department of Health Services

Influenza virus and pneumococcal bacteria cause two of the most common and deadly infections among individuals ages 65 years and older. Influenza epidemics have resulted in an average of more than 48,000 hospitalizations and 18,000 deaths annually among older persons in the United States. Invasive pneumococcal disease caused nearly 20,000 hospitalizations and 3,400 deaths among persons 65 years of age and older in 1998. Simple immunizations could have prevented much of the morbidity and mortality associated with these infections.

The BRFSS is the largest telephone survey in the United States, designed by the Centers for Disease Control (CDC) to provide national and state-by-state estimates of health risk behaviors among U.S. adult populations. The 2000 California BRFSS included questions about influenza and pneumococcal immunizations that provide a current profile of immunization rates and practices among Californians ages 65 years and older.

Of the self-reports by California respondents aged 65 and older, 69.6% reported having received a flu shot in the past 12 months, and 60.5% reported having had a pneumococcal shot. **Note:** *The following populations that are recommended to get both influenza and pneumococcal vaccine BUT are not directly represented in the survey are: nursing home and long-term care facility residents and those high-risk individuals with chronic illness or weakened immune systems (e.g., heart and lung disease, diabetes).*

These immunization coverage levels for both infections are comparable to the nationwide estimates. While California's coverage levels for both immunizations have increased significantly since 1990, the rate of gain must increase if we are to meet the public health National Healthy People goal of 90% immunization in 2010.

Due to small numbers of individuals ages 65 years and older sampled in the 2000 BRFSS, racial and/or ethnic estimates cannot be made for flu and pneumococcal immunizations. However, other published national data indicate that African-Americans and Hispanic patients have lower rates of immunization with these vaccines than whites do. Immunization against influenza and pneumococcal infection

is also recommended for adults *under* the age of 65 with chronic diseases who are at increased risk for serious illness or death from these infections, but vaccination rates among these groups are much lower. See the recommendations of the Advisory Committee on Immunization Practices (ACIP) for additional high-risk groups.

When asked where they got their flu shots, BRFSS respondents most frequently reported receiving them in a doctor's office (68.6%). Hospital or emergency departments (8.2%) and senior/community centers (7.7%) were the second and third most common responses, respectively. Furthermore, research has shown that the most important factor predicting up-to-date immunization for adults is the number of visits to their physician and the recommendation of their physician to obtain the immunizations. These factors are even more important than patient race or ethnicity, education, poverty, and insurance status. This emphasizes the importance of office-based strategies to assure immunization of adult patient populations, similar to those that pediatric and family practitioners have used to vaccinate children.

National and State health policy supports improved immunization of senior adults. Both influenza and pneumococcal vaccines for seniors age 65 and older are covered by Medicare Part B, so there should be no financial barrier for vaccine. In addition, the California Department of Health Services (DHS) has been providing influenza vaccines since 1973 and pneumococcal vaccines since 1989 free of charge to public health departments for seniors and others at high risk.

Influenza and pneumococcal immunization rates are now included as Health Plan Employer Data and Information Set (HEDIS) measures, generating even more incentives for health plans and providers to immunize seniors. Pneumonia prevention has been a recent focus of Medicare Quality Review Organizations (PROs).

One of the largest remaining barriers is practice patterns. Practitioners consistently overestimate the number of adequately vaccinated patients in their practice because they

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## Adult Immunization

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are only aware of the patients they have seen recently in the office. The following interventions have been proven effective to increase immunization coverage:

- Busy practitioners need to incorporate reminder-recall systems to assure not only that they vaccinate patients who come into the office during influenza vaccination season, but also provide a reminder to *all* of the patients in their practice who should be immunized.
- When giving influenza, also give pneumococcal vaccine, if needed. Since records are often lacking, rely on patient history of prior immunizations and if in doubt, vaccinate.
- Document vaccine delivery in the chart and for the patient. Charts should be organized with a preventive service record in the front that is easily reviewed and updated. (One such record is available from [www.ahrq.gov/ppip/ppptools.htm#office](http://www.ahrq.gov/ppip/ppptools.htm#office).)
- Practitioners should work with healthcare facilities in their community to develop pre-printed orders or standardized nursing procedures to assure immunization of all eligible adults, prior to discharge from an acute-care facility and on admission to a long-term care facility (and a mechanism to notify the primary practitioner to update their records).

Finally, physicians need to communicate the benefits and safety of these vaccines to their patients. Surprisingly, one of the main reasons that seniors do not receive these vaccines is their fear of side effects. The current inactivated influenza vaccine is extremely safe causing only one to two days of local soreness, if anything. Fever and other systemic symptoms most often occur in persons who have had no prior exposure to the influenza virus vaccine (e.g., young children). Many seniors are concerned that the vaccine causes a flu illness; they do not understand that coincidental respiratory disease can occur after vaccination.

Investigations to date indicate no substantial increase in Guillain-Barré syndrome associated with influenza vaccines since the 1976 swine influenza vaccine.

For assistance in improving immunization rates in your practice, patient educational materials, and practice tools, contact your chief of quality assurance, regional Medicare PRO, or the immunization coordinator in your county health department. For more information about the California Immunization Program, call (510) 540-2065. Additional resources as well as professional and patient information on the influenza and pneumococcal vaccines can be obtained from:

**National Immunization Program:**

[www.cdc.gov/nip](http://www.cdc.gov/nip)

**Immunization Action Coalition:**

[www.immunize.org](http://www.immunize.org)

**100% Immunization Campaign:**

[www.immunizeseniors.org](http://www.immunizeseniors.org)

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# News From the U.S. Food and Drug Administration

## Good Clinical Practice in FDA-Regulated Clinical Trials

A new “subsite” on the FDA Web site has been launched to address Good Clinical Practice in FDA-Regulated Clinical Trials. The address is [www.fda.gov/oc/gcp/default.htm](http://www.fda.gov/oc/gcp/default.htm). It will provide information about FDA oversight of clinical trials, including guidances, information sheets, regulations, educational materials, and FDA contacts. It will also provide information about FDA’s new Good Clinical Practice Staff in the Office of Science Coordination and Communication (OSCC).

## Influenza Virus Vaccine 2001-2002

Availability of the influenza vaccine supply this season may continue to be a concern. The trivalent influenza vaccine prepared for the 2001-2002 season will include A/Moscow/10/99-like (H3N2), A/New Caledonia/20/99-like (H1N1), and B/Sichuan/379/99-like antigens. For the A/Moscow/10/99-like (H3N2) antigen, U.S. manufacturers will use the antigenically equivalent A/Panama/2007/99 (H3N2) virus. For the B/Sichuan/379/99-like antigen, they will use one of the antigenically equivalent viruses B/Johannesburg/05/99, B/Victoria/504/2000, or B/Guangdong/120/2000. These viruses will be used in manufacturing because of their growth properties and because they are representative of currently circulating influenza A (H3N2) and B viruses. For lot release information go to [www.fda.gov/cber/flu/flu.htm](http://www.fda.gov/cber/flu/flu.htm).

## Antibiotic Resistance: A Multi-Agency Action Plan to Address the Growing Threat

Antibiotic resistance is on the rise and becoming a major public health threat. The continuing emergence of difficult-to-treat or untreatable nosocomial pathogens threaten the lives of hospitalized individuals and those with chronic conditions. In fact, about 70 percent of bacteria that cause infections in hospitals are resistant to at least one of the drugs most commonly used to treat them; some organisms are resistant to all approved antibiotics.

Common community acquired and food borne infections of humans, including those due to pathogens, show trends toward increasing resistance to standard available therapies. Resistant organisms and their genes cross national and regulatory boundaries involving foods, animals, and humans. The costs of treating antimicrobial resistant infections place a significant burden on society.

The factors responsible for increasing antibiotic resistance include: misuse and overuse of antimicrobials in humans,

lack of knowledge and poor public education among patients, lack of restrictions on antibiotic use in developing countries and overuse and misuse in agriculture. Research has shown that antibiotics are given to patients more often than evidence-based guidelines recommend.

Whether the problems are driven by unawareness, misunderstanding, or marketing practices, behaviors must change before treatable diseases once again become *untreatable*. Better surveillance for resistance is needed, as is intensive education of health professionals and the public regarding optimum usage of antimicrobials.

However, even if all antibiotic use were indeed to become appropriate, resistance would not disappear. Thus, both continuing research and the development of new and innovative drugs, vaccines and improved diagnostics for infectious diseases will continue to be urgently needed.

The Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA) led a task force of 10 agencies and departments that created an action plan to combat antimicrobial resistance.

This plan has four major components—surveillance, prevention and control, research, and product development:

- **Surveillance**—CDC will work with state health departments to design and implement a plan that will define national, regional, state and local antimicrobial resistance surveillance responsibilities so that these entities are coordinated and use similar methodology. FDA, USDA and CDC plan to develop systems that can monitor patterns of antimicrobial drug use in human medicine, in agriculture and in consumer products.
- **Prevention and control**—HHS and partners will launch a national public education campaign to reduce the overuse and misuse of antimicrobial drugs and to improve antibiotic use in healthcare systems. Clinical guidelines for health professionals on how best to use antimicrobials will be prepared. FDA is working to assess the human health impact of antimicrobials that may be used in food-producing animals. CDC will identify effective strategies to promote appropriate antimicrobial drug use and reduce infection rates in clinical practice.

(Continued on page 13)

## REMINDER

# New Standard of Care Regulations for Childhood Lead Poisoning Screening

The California Department of Health Services has adopted regulations establishing a standard of care on evaluating and screening for childhood lead poisoning as part of periodic health assessments during early childhood.

In summary, the regulations require:

- a) Anticipatory guidance on lead hazards and the risk of lead poisoning, at each periodic health assessment visit between six months and six years;
- b) A blood-lead test at 12 and 24 months for children receiving services from a publicly supported program for low-income children, since they are at increased risk for lead poisoning; and
- c) A blood lead test at 12 and 24 months for children who do not receive services from a publicly supported program but are found to be at risk because their caregiver answers “yes” or “don’t know” to the risk assessment question: “Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently renovated?”

If the actions described in b) or c) above were not carried out, the provider must do so as soon as he or she becomes aware of the omission in a child between the ages of 12 months and six years. A blood lead test also must be ordered if a change in circumstances has put a child at risk for lead poisoning.

The complete regulations can be found in the California Code of Regulations Title 17, Division 1, Chapter 9, Sections 37000-37100. The Medical Board’s *Action Report* dated April 2000 also ran a more detailed article titled, “New State Policy On Blood Lead Screening Can Help Providers Find More Children With Lead Poisoning,” which included a “Practitioner Reference Card” for your use. You may obtain a copy of that *Action Report* by calling the Medical Board at (916) 263-2389.

For questions about the standard of care, please contact Yan Chin, M.D., M.P.H., (510) 622-4869 and for information about the State’s Childhood Lead Poisoning Prevention Program, Valerie Charlton, M.D., M.P.H., Chief, Childhood Lead Poisoning Prevention Branch, (510) 622-4867.

## News From the U.S. Food and Drug Administration

(continued from page 12)

- **Research**—NIH will take the lead to provide the research community with new information and technologies, including genetic blueprints for various microbes, to identify targets for desperately needed new diagnostics, treatments and vaccines that could assist in preventing the emergence and spread of resistant pathogens. NIH plans to develop clinical studies to test new antimicrobials and novel approaches to treating and preventing infections caused by resistant pathogens. NIH continues to facilitate new rapid diagnostic methods, their development and evaluation.
- **Product Development**—HHS plans to create an Interagency Antimicrobial Product Development Working Group that will help to identify and publicize priority health needs for new products that prevent resistance or treat resistant infections.

For more information go to:  
[www.fda.gov/oc/opacom/hottopics/anti\\_resist.html](http://www.fda.gov/oc/opacom/hottopics/anti_resist.html)

# Adverse Events Reporting System

## FDA's MedWatch is a Partnership Waiting to Happen

The Internet is jammed with resources for physicians, but perhaps none with such potential importance as the FDA's MedWatch Web site, which serves as a gateway for medical product safety information and provides a service that sends out urgent safety alerts in the flash of an e-mail. Surprisingly, many professionals remain unaware of this free service. "It's free, it's easy to subscribe, it's private and confidential," says Norman Marks, M.D., medical director of the MedWatch program. "We don't share names. All one has to do is go to [www.fda.gov/medwatch](http://www.fda.gov/medwatch) and there on the homepage they will see the box that says 'join the MedWatch e-list'. Just click on it, fill in the blanks, and that's it."

"The FDA wants to get any important safety information out to the practitioners, ideally at the point of care, so they can use it when they are making decisions with their patients," says Marks. "In that way, we can facilitate the good work that physicians are doing every day. Our commitment at the FDA and our MedWatch program is to provide clinicians with timely safety information, ideally at the point of care. That's our part of the deal," says Marks. "Their part, we hope, would be to appreciate the value of the safety alerts and recognize that their spontaneous voluntary reporting of serious adverse events is what lets us generate that medical product safety information."

"It's common knowledge," says Marks, "that certain rare but serious adverse events won't have been identified during the pre-marketing phase of drug and device development. While these pre-approval studies are evaluated rigorously, there may not have been a sufficient number of patients in the study, or perhaps the study did not cover a long enough time period to identify the rare harm or injury. At any rate, in the real world, new adverse events will emerge over time. Each adverse event or product quality problem for a drug goes into a computerized database called the Adverse Event Reporting System (AERS). The post-marketing drug-risk assessment staff of safety evaluators and epidemiologists use that data to develop a more formal investigation, a science-based process where the outcome, whether it follows an evaluation of several weeks to several months, may lead to

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**"The FDA wants to get any important safety information out to the practitioners, ideally at the point of care, so they can use it when they are making decisions with their patients."**

**Norman Marks, M.D.**

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FDA action that results in recommendations for safer use of that product."

Once a modified use strategy and labeling change has been agreed upon by the FDA and the manufacturer, MedWatch gets that information out to physicians immediately in the form of MedWatch Alerts. "These alerts are important information that the physician would want to know now rather than waiting for the PDR to come out a year later, or waiting for a letter to show up on their desk. We want all physicians to know that they can get that important safety information now just by signing up for our e-list," says Marks.

About 12,000 individual practitioners have signed up for the MedWatch Alerts e-mail distribution list. In addition, MedWatch has 190 partner organizations such as the Texas State Medical Society and the American Academy of Family Physicians. The partners distribute the MedWatch Alerts to their members by posting the information on their Web sites, sending it out through their own distribution lists, or putting the information in their newsletters or bulletins. The MedWatch Alerts also are posted on the MedWatch Web site.

*Future plans:* Marks says MedWatch is hoping to tailor the Alerts soon so that each branch of medicine can choose which category of safety alert they would like to receive and which they would not. Right now, everyone on the list gets all Alerts.

Another innovation for the near future will be to put the MedWatch information into a format compatible with the hand-held computer devices. "My sense, from talking to doctors and other professionals, is that the Palm Pilots and the hand-held devices are being used by residents, medical students and even physicians," says Marks. "These little devices are small enough, powerful enough and portable enough that they can be carried around in pockets, so we're working on arrangements to have our safety update information available on their hand-held devices for access at the bedside, the operating suite and the office exam room."

# Medical Consultant Positions (Enforcement) and (Advisory) Available at Medical Board of California

Final Filing Date: November 30, 2001

The Medical Board of California is currently examining for the position of Medical Consultant (Enforcement) and (Advisory), Medical Board of California.

**Permanent Intermittent** positions exist statewide with the Department of Consumer Affairs, Medical Board of California. Salary Range \$54.42 - \$57.60 Hourly.

***Only those who meet the following requirements will be admitted to the examination for this classification:***

Possession of a current unrestricted license for the practice of medicine in California; possession of a valid medical specialty certificate issued by the American Board of Medical Specialties; and, five years of experience within the last seven years in the practice of medicine, excluding internship and postgraduate training (or five years of experience performing research or working in fields related to medical issues, if applying for an Advisory position).

## **Medical Consultant (Enforcement)**

**Knowledge of:** Medicine and surgery, including recent developments and practices; hospital organization, procedures, and record keeping; provisions of the Business and Professions Code relating to the practice of medicine and surgery and the laws, rules and regulations of the Medical Board of California relating to medical practice; methods of diagnosis and treating medical disorders; pathology and interpretation of autopsy findings; medical specialties.

**Ability to:** Conduct effective interviews; exercise sound medical judgment in reviewing conflicting medical reports and preparing opinions; analyze problems and take effective action; perform administrative tasks; dictate correspondence and prepare reports; communicate effectively both orally and in writing.

## **Medical Consultant (Advisory)**

**Knowledge of:** Principles and practices of general medicine and surgery; current developments in the field of general medicine and surgery; medical research methods and techniques; critical medical issues and trends in practice, education, and emerging medical specialties.

**Ability to:** Plan, organize and conduct special studies and surveys, consult on and interpret results of surveys and studies; analyze problems and/or issues and make recommendations; prepare written and oral reports which are clear, concise, and objective; communicate effectively with administrative and technical staff, peers, Board members, and applicants with regard to areas of responsibility.

If you have Internet access, the Examination Bulletin and Application can be found at the Department of Consumer Affairs' Web site at [www.dca.ca.gov](http://www.dca.ca.gov). Click on Jobs at DCA, and scroll down to Open Examinations.

**If you do not have Internet access, to request an Examination Bulletin and Application send a postcard or e-mail by November 16, 2001 to:**

Department of Consumer Affairs  
Attention: Joanne Wight, Selection Services  
400 R Street, Suite 2000  
Sacramento, CA 95814

**e-mail: [Joanne\\_Wight@dca.ca.gov](mailto:Joanne_Wight@dca.ca.gov)**

**Please provide the following information:**

Name, address, phone/fax number, and medical license number. If you need additional information, please call Joanne Wight at (916) 324-4395.

**The final filing date to submit the Examination Application is November 30, 2001.**

## Effective Pain Management

(continued from page 1)

Medical Board that they have engaged in illegal overprescribing. In addition to their republication here, the guidelines are on the Board's Web site at [www.medbd.ca.gov](http://www.medbd.ca.gov).

The Board also has worked with the Physician Assessment and Clinical Education (PACE) program at the University of California, San Diego, to make widely available its Physician Prescribing course to provide expanded education in the latest standards of prescribing, including prescribing for pain management. This course provides invaluable information to assist in educating physicians regarding the latest in prescribing practices.

The Board sponsors its own Pain Management Seminar, certified for Category I CME, which provides both medical and regulatory perspectives on this subject and educates attendees about how to identify patients who need management of their pain as distinct from those who are engaged in illegal drug-seeking behavior.

Finally, the Board is developing enhanced communication efforts to bring the latest concepts in pain management to its over 109,000 physicians. These efforts will include enhanced links from its Web site and expanded discussions on pain management in future newsletters.

### Recently Passed Pain Management Laws

(To access these laws, go to [www.leginfo.ca.gov](http://www.leginfo.ca.gov), click on "California Law," check the code and search for the section you want to review.)

**SB 402** (Green, Chapter 839, Statutes of 1997, Health & Safety Code section 124961) established the "Pain Patient's Bill of Rights." Physicians may refuse to prescribe opioid medication for patients who request the treatment for severe chronic intractable pain; however, they must inform the patient that other physicians specialize in the treatment of such pain with methods that include the use of opiates.

**AB 2305** (Runner, Chapter 984, Statutes of 1998, Business & Professions Code section 725, Health & Safety Code section 1367.215) Physicians who are in compliance with the California Intractable Pain Act will not be subject to disciplinary action. Healthcare service plans must approve or deny coverage for terminally ill enrollees within 72 hours of receipt of the information.

**AB 2693** (Migden, Chapter 789, Statutes of 1998, Health & Safety Code section 11159.2) Prescriptions for Schedule II controlled substances used by terminally ill patients are exempt from the use of a triplicate form. Prescriptions falling under this exemption must contain the phrase "11159.2 exemption."

**SB 1140** (Committee on Health and Human Services, Chapter 791, Statutes of 1998, Business & Professions Code sections 2191 and 2196.2) requires the Medical Board and the Board of Registered Nursing to consider including a course on pain management in their continuing education requirements. The Medical Board must periodically develop and disseminate information and educational material regarding pain management techniques and procedures to each licensed physician and surgeon and to each general acute care hospital, and must consult with the Department of Health Services in developing materials to be distributed.

**AB 791** (Thomson, Chapter 403, Statutes of 1999, Business & Professions Code section 2089) Pain management and end-of-life care are now parts of the curriculum requirements for students entering medical school on or after June 1, 2000.

**AB 2018** (Thomson, Chapter 1092, Statutes of 2000, Health & Safety Code sections 11161 and 11164) allows physicians to request from the Department of Justice a sufficient supply of triplicate prescription forms to meet the needs of their patient population. Physicians or employees may complete the forms, provided the physician signs it. Pharmacists are allowed to notify the prescriber of an unintended error on the form and obtain approval for correction, so the patient does not have to return to the office for a corrected prescription, as long as a corrected copy is sent or faxed from the physician to the pharmacist within seven days.

### Medical Board Guidelines for the Treatment of Intractable Pain

#### 1. HISTORY/PHYSICAL EXAMINATION

A thorough medical history and physical examination must be accomplished.

#### 2. TREATMENT PLAN, OBJECTIVES

The treatment plan should state objectives by which treatment success can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. Several treatment modalities or a rehabilitation program may be necessary.

*(Continued on page 17)*

## Effective Pain Management

(continued from page 16)

### 3. INFORMED CONSENT

The physician should discuss the risks and benefits of the use of controlled substances with the patient or guardian.

### 4. PERIODIC REVIEW

The physician should periodically review the course of opioid treatment of the patient and any new information about the etiology of the pain. Continuation or modification of opioid therapy depends on the physician's evaluation of the progress toward treatment objectives.

### 5. CONSULTATION

The physician should be willing to refer the patient as necessary for additional evaluation and treatment to achieve treatment objectives. Physicians should give special attention to those pain patients who are at risk for misusing their medications. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation and consultation with addiction specialists, and may entail the use of agreements between the provider and the patient to specify rules for medication use.

### 6. RECORDS

The physician should keep accurate and complete records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, agreements with the patient, and periodic reviews.

### 7. COMPLIANCE WITH CONTROLLED SUBSTANCES LAWS AND REGULATIONS

To prescribe substances, the physician must be appropriately licensed in California and comply with federal and state regulations for issuing controlled substances prescriptions. Documented adherence to these guidelines will substantially establish the physician's responsible treatment of patients with intractable pain and will serve to defend that treatment practice in the face of complaints which may be brought.

## President's Report

(continued from page 2)

courses such as these be available as CME and participation be encouraged, for example, by waiving a physician's license renewal fee in exchange for this public service? I prefer incentives to mandates in problem solving. A dynamic tension will always exist when facing problems of the nature and magnitude as these.

The fellowship pledge of the American College of Surgeons holds the physician "to place the welfare of my patients above all else." Eight thousand physicians acted on this weighty charge when New York called. We salute them for their physicianship. We should now confront our system problems with renewed awareness, commitment and determination to engage, inform and work with our elected representatives in reforming and advancing healthcare delivery in California.

## TDD Numbers

Medical Board telephone numbers for the hearing-impaired (TDD):

### **Division of Licensing**

(916) 263-2687

### **Central Complaint Unit**

(916) 263-0935

# ADMINISTRATIVE ACTIONS: MAY 1, 2001 TO JULY 31, 2001

## PHYSICIANS AND SURGEONS

ARFANIA, JAMSHID, M.D. (A25755)

Palos Verdes, CA

B&P Code §822. Violated terms and conditions of Board-ordered probation. Ability to practice medicine safely is impaired due to mental or physical illness. Revoked. June 15, 2001

BALETTE, ROBERT EDMUND, M.D. (A48109)

Los Angeles, CA

B&P Code §§726, 2234(b). Committed sexual misconduct and gross negligence in the care and treatment of 1 patient. Revoked. July 18, 2001. Judicial review is being pursued.

BANSAL, SANJAY, M.D. (G66178)

Santa Rosa, CA

B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in that on a routine basis for several years the microkeratome blades and the microkeratome assembly used in LASIK eye surgery were reused without sterilization or disinfection. Revoked, stayed, 3 years probation with terms and conditions. June 15, 2001

BLATT, DAVID EBNER, M.D. (C39040)

Chicago, IL

B&P Code §141(a). Stipulated Decision. Reprimanded by Illinois for failing to confirm a patient's presenting diagnosis of being HIV positive during the course of the patient's treatment from 1990 through 1996. Public Letter of Reprimand. May 24, 2001

CHRISTOPHERSON, JANICE RENEE, M.D.

(A68142) San Jose, CA

B&P Code §822. Stipulated Decision. Suspended indefinitely until there is evidence of the control or absence of any condition, mental or physical, that impairs her ability to practice safely. May 28, 2001

COLMAN, LARRY MELVIN, M.D. (C32794)

Palos Verdes Estates, CA

B&P Code §§2234(e), 2261. Failed to comply with Board-ordered probation and committed dishonest acts by reporting false information on Quarterly Affidavit Forms submitted to the Board. Public Reprimand. July 20, 2001

## Explanation of Disciplinary Language and Actions

**“Effective date of decision”** — Example: “May 10, 2001” at the bottom of the summary means the date the disciplinary decision goes into operation.

**“Gross negligence”** — An extreme deviation from the standard of practice.

**“Incompetence”** — Lack of knowledge or skills in discharging professional obligations.

**“Judicial review is being pursued”** — The disciplinary decision is being challenged through the court system— Superior Court, maybe Court of Appeal, maybe State Supreme Court. The discipline is currently in effect.

**“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.

**“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.

**“Public Letter of Reprimand”** — A lesser form of discipline that can be negotiated for minor violations before the filing of formal charges (accusations). The licensee is disciplined in the form of a public letter.

**“Revoked”** — The license is canceled, voided, annulled, rescinded. The right to practice is ended.

**“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.

**“Stipulated Decision”** — A form of plea bargaining. The case is negotiated and settled prior to trial.

**“Surrender”** — Resignation under a cloud. While charges are pending, the licensee turns in the license — subject to acceptance by the relevant board.

**“Suspension from practice”** — The licensee is prohibited from practicing for a specific period of time.

**“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).

CONE, ROBERT R., M.D. (A28969)  
Tijuana, BCN CP Mexico  
B&P Code §§2234, 2234(b)(c)(d)(e), 2261, 2266.  
Committed acts of gross negligence, repeated negligence, and incompetence in the care and treatment of 2 patients. Also committed dishonest acts, provided false statements in documents and committed perjury. Revoked. May 24, 2001

ELLIS, WILLIAM, M.D. (G19742)  
El Cerrito, CA  
B&P Code §2234. Stipulated Decision. No admissions but charged with failing to note in a patient's medical records or advise the patient of a complication from a surgical procedure performed on the patient's eye. Public Reprimand. June 18, 2001

FELDMAN, CLARK ALAN, M.D. (G32145)  
Los Angeles, CA  
B&P Code §2234. Stipulated Decision. Initiated or attempted to initiate social relationships with 3 former patients without adequate documentation of the termination of the physician-patient relationship. Public Letter of Reprimand. June 26, 2001

GALLA, ARTHUR F., M.D. (A18055)  
San Carlos, CA  
B&P Code §§2234(b)(d), 2266. Stipulated Decision. Committed acts of gross negligence and incompetence by failing to order appropriate, medically indicated tests and failing to maintain adequate medical records in the care and treatment of 1 patient. Public Reprimand. June 6, 2001

GASTELUM, CHRISTIAN JOHN, M.D. (A74589)  
Diamond Bar, CA  
B&P Code §§480(a)(1)(a)(2)(a)(3), 480(c). Denial of license based on failing to disclose a misdemeanor conviction on his application for licensure. Probationary license issued, 5 years probation with terms and conditions. May 24, 2001

GOHAR, KEVIN, M.D. (A42317)  
Santa Monica, CA  
B&P Code §2234, 2234(a)(b)(c)(d)(e). Stipulated Decision. Misrepresented facts in documents, committed gross negligence and repeated negligent acts in the care, treatment and management of spinal surgery patients. Revoked, stayed, 7 years probation with terms and conditions. June 15, 2001

GUERRERO, CARLOS, M.D. (G45844)  
Bakersfield, CA  
B&P Code §§475(a)(1)(a)(2)(a)(3), 480(c)(a)(1)(a)(2), 2236(a). Stipulated Decision. Failed to disclose conviction of a crime on his license application. License granted, revoked, stayed, 5 years probation with terms and conditions. May 3, 2001

HADI, GHASSAN EL-ABDALLAH, M.D. (A52261)  
La Verne, CA  
B&P Code §2266. Stipulated Decision. Failed to maintain adequate medical records in the care and treatment of 1 patient. Public Letter of Reprimand. May 31, 2001

HOLMES, RANDOLPH PETER, M.D. (G42202)  
Whittier, CA  
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct by failing to provide appropriate medical care to 1 patient. Public Reprimand. May 31, 2001

HURRIA, KESHO NATH, M.D. (A32102)  
Anaheim, CA  
B&P Code §2234(c)(d). Committed repeated negligent acts and demonstrated incompetence in the post-operative care and treatment of a patient's ankle fracture. Revoked, stayed, 5 years probation with terms and conditions. July 20, 2001

ISRAELSTAM, DAVID M., M.D. (C26177)  
Madison, WI  
B&P Code §§2234, 141(a). Reprimanded by Wisconsin for unprofessional conduct relating to physician-patient boundary issues in the treatment of a psychiatric patient. Public Letter of Reprimand. May 17, 2001

JABLONSKY, ROBERT PAUL, M.D. (A46510)  
Dinuba, CA  
B&P Code §2234. Stipulated Decision. No admissions but charged with acts of gross negligence and incompetence in the care and treatment of 2 patients. Public Reprimand. June 18, 2001

JAQUA, TERRY LEE, M.D. (A41023)  
Apple Valley, CA  
B&P Code §2266. Stipulated Decision. Failed to maintain adequate and accurate medical records by failing to completely and accurately document examinations, comments and conversations with a patient. Public Reprimand. June 7, 2001

JOHNSON, G. NICHOLAS, M.D. (C35219)  
Sausalito, CA  
B&P Code §§822, 2234, 2234(e), 2236(a).  
Committed unprofessional conduct in the care and treatment of a minor patient in that he performed a pelvic exam without parental consent and failed to communicate medical findings to the subsequent treating physician; convicted of a crime involving moral turpitude; determined by expert medical evaluation to be impaired in his ability to practice medicine safely due to physical or mental illness. Revoked. July 20, 2001

KIM, JOO ROCK, M.D. (A38085)  
Bakersfield, CA  
B&P Code §2234. Stipulated Decision. Failed to provide appropriate medical care to 1 patient. Public Reprimand. July 10, 2001

KIRBY, KAREN YVONNE, M.D. (G67502)  
Santa Cruz, CA  
B&P Code §§2236(a), 2239(a). Stipulated Decision. Convicted of driving under the influence of alcohol or drugs and the use, consumption or self-administration of dangerous drugs and a controlled substance. Revoked, stayed, 5 years probation with terms and conditions. July 26, 2001

KREVSKEY, SEYMOUR, M.D. (C17412)  
Birmingham, MI  
B&P Code §§141(a), 2305. Stipulated Decision. Reprimanded by Michigan for the conviction of a misdemeanor. Public Reprimand. July 11, 2001

LEVY, MAURICE MOISE, M.D. (A41579)  
Los Angeles, CA  
B&P Code §2234. Stipulated Decision. Prescribed antibiotic and steroid medications to a patient in a manner inconsistent with the traditional use of these medications; also the medical records concerning this patient did not establish whether the patient was properly monitored for side effects connected with these medications. Public Letter of Reprimand. July 25, 2001

LIGHT, ELIOT STUART, M.D. (C40086)  
Pacific Grove, CA  
B&P Code §2234(c). Stipulated Decision. Committed acts of repeated negligence for failure to adequately assess and review patient history, failure to timely diagnose medical condition, and failure to keep adequate and accurate medical records in the care and treatment of 1 patient. Revoked, stayed, 3 years probation with terms and conditions. May 14, 2001

LYNCH, ROBERT D., M.D. (G6327)  
La Jolla, CA  
B&P Code §§725, 2234. Improperly diagnosed and treated 2 patients for seizure disorders, using an experimental treatment program, and failed to inform the patients as to the experimental nature of the treatment. Public Letter of Reprimand. July 27, 2001

MCNAMARA, MICHELLE MAE, M.D. (G76675)  
Vestavia Hills, AL  
B&P Code §§141(a), 2234. Stipulated Decision. Reprimanded by Illinois for failure to register at each place of business or professional practice where controlled substances were distributed or dispensed. Public Letter of Reprimand. May 7, 2001

MEEK, DAVID CAMPBELL, M.D. (C32666)  
Georgetown, CA  
B&P Code §725. Stipulated Decision. Excessively performed, and/or approved performance by medical staff, numerous examinations on a 30-month-old child without medical indication, at the request of the child's parent. Public Reprimand. July 30, 2001

MITCHELL, JESSE DAVID, M.D. (C43311)  
Laguna Hills, CA  
B&P Code §2266. Stipulated Decision. Maintained incomplete, sparse and undated medical records regarding liposuction and abdominoplasty surgery performed on 1 patient. Public Letter of Reprimand. July 23, 2001

MODILEVSKY, LEONID, M.D. (A40608)  
Huntington Park, CA  
B&P Code §§490, 2236(a). Stipulated Decision. Convicted in the United States District Court of 3 counts of subscribing to false income tax returns. Revoked, stayed, 3 years probation with terms and conditions. July 16, 2001

MONTENEGRO, JOSE MARIA, M., M.D. (C35541)  
Carlsbad, CA  
B&P Code §§820, 822, 2234(b)(c), 2241, 2242,  
2266, 4081, 4332. Committed acts of gross  
negligence, repeated negligent acts, over-prescribed  
to addicts and failed to maintain adequate medical  
records in the care and treatment of 5 patients.  
Revoked, stayed, 7 years probation with terms and  
conditions. July 13, 2001. Judicial review is being  
pursued.

NETTL, FRANCIS MICHAEL, M.D. (G61057)  
San Diego, CA  
B&P Code §§2234(b)(d)(e), 2266. Committed acts of  
gross negligence and incompetence and failed to  
maintain adequate and accurate medical records in  
the care and treatment of 1 patient. Revoked.  
July 5, 2001

ORDON, ANDREW PAUL, M.D. (G42231)  
Beverly Hills, CA  
B&P Code §141(a). Stipulated Decision. The  
Connecticut Medical Examining Board issued a civil  
penalty charging incompetent and/or negligent care  
in the care and treatment of 1 patient. Public  
Reprimand. July 19, 2001

ORDOUBADI, NASSER, M.D. (C50124)  
McMinnville, OR  
B&P Code §§2234(e), 2236(a). Convicted in federal  
court of conspiracy to commit mail fraud and  
healthcare fraud. Revoked. July 30, 2001

PATEL, JAGDISH RAMBHAI, M.D. (A38262)  
Schererville, IN  
B&P Code §§141(a), 2234. Stipulated Decision.  
Reprimanded by Indiana for failure to maintain  
adequate medical records in the care and treatment  
of 3 patients. Public Letter of Reprimand.  
May 17, 2001

POURZIA, GHOLAMREZA F., M.D. (A45667)  
Long Beach, CA  
B&P Code §2234(b)(c)(d). Committed acts of gross  
negligence, incompetence and repeated negligent  
acts in the care and treatment of 3 patients.  
Revoked, stayed, 3 years probation with terms and  
conditions. May 9, 2001. Judicial review is being  
pursued.

## Help Your Colleague by Making a Confidential Referral

If you are concerned about a fellow physician who you think is abusing alcohol or other drugs or is mentally ill, you can get assistance by asking the Medical Board's Diversion Program to intervene.

The intervention will be made by staff trained in chemical dependency counseling or by physicians who are recovering from alcohol and drug addiction. As part of the intervention, the physician will be encouraged to seek treatment and be given the option of entering the Diversion Program. Participation in Diversion does not affect the physician's license.

Physicians are not required by law to report a colleague to the Medical Board. However, the Physicians Code of Ethics requires physicians to report a peer who is impaired or has a behavioral problem that may adversely affect his or her patients or practice of medicine to a hospital well-being committee or hospital administrator, or to an external impaired physicians program such as the Diversion Program.

Your referral may save a physician's life and can help ensure that the public is being protected. All calls are confidential. Call (916) 263-2600.

**Medical Board of California  
Physician Diversion Program  
1420 Howe Avenue, Suite 14  
Sacramento, CA 95825**

POWERS, THOMAS R., M.D. (AFE19276)  
Redlands, CA  
B&P Code §822. Stipulated Decision. Suspended indefinitely until there is evidence of the control or absence of any condition, mental or physical, that impairs his ability to practice safely. July 9, 2001

QURTOM, HELMY ABDUL-FATTAH, M.D.  
(A52829) Beltsville, MD  
B&P Code §§141(a), 2236(a). Stipulated Decision. Disciplined by the Maryland Board of Physician Quality Assurance for conviction of one count of theft of U.S. Government Property, stealing student assistance benefits totaling \$7,220.00 from the U.S. Department of Education. Revoked, stayed, 3 years probation with terms and conditions. July 31, 2001

REISS, ROBERT ALLEN, M.D. (G61155)  
La Jolla, CA  
B&P Code §§725, 2241, 2266. Stipulated Decision. Excessively prescribed Methadone to a patient with a history of drug addiction and failed to maintain adequate and accurate medical records pertaining to this patient. Public Letter of Reprimand. June 20, 2001

ROSENMAN, MICHAEL, M.D. (A52422)  
Las Vegas, NV  
B&P Code §§141(a), 2234. Stipulated Decision. Disciplined by Nevada for failure to diagnose and treat a patient which resulted in the delay of treatment for diabetes. Public Letter of Reprimand. June 4, 2001

SAGMAQUEN, ROLANDA R., M.D. (A21885)  
Fresno, CA  
B&P Code §§2236(a), 2238. Violated terms and conditions of Board-ordered probation in that she pled guilty to conspiracy to distribute and to possess with the intent to distribute a controlled substance. Revoked. May 15, 2001

SALERNO, EGISTO, M.D. (37903)  
San Diego, CA  
B&P Code §§2234(b)(c), 2266. Failed to document historical and objective information to support medical assessment and treatment in the care and treatment of 1 patient. Suspended, stayed, 2 years probation with terms and conditions. June 18, 2001

SCHOEN, STEPHEN M., M.D. (G3431)  
San Rafael, CA  
B&P Code §§2234, 2266. Stipulated Decision. Failed to establish and maintain proper physician-patient boundaries and failed to maintain adequate medical records in the care and treatment of a psychiatric patient. Public Letter of Reprimand. June 15, 2001

SEET, RAY POON-PHANG, M.D. (G20523)  
Novato, CA  
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct in the care and treatment of several patients. Revoked, stayed, 7 months probation with terms and conditions. May 7, 2001

SUTTERFIELD, THOMAS, C., M.D. (G12670)  
Palm Desert, CA  
B&P Code §822. Stipulated Decision. Suspended indefinitely until there is evidence of the control or absence of any condition, mental or physical, that impairs his ability to practice safely. May 28, 2001

SY, EVANCIA, M.D. (A45994)  
Harbor City, CA  
B&P Code §§810, 2234, 2234(e), 2236(a). Criminally convicted of insurance fraud and grand theft. Revoked. July 9, 2001

TEKOLA, ABRHAM, M.D. (A50974)  
Sacramento, CA  
B&P Code §§726, 2234(b)(c). Stipulated Decision. Sexual misconduct with 2 patients. Revoked, stayed, 4 years probation with terms and conditions. May 10, 2001

TRABULUS, NORMAN, M.D. (G2909)  
Van Nuys, CA  
B&P Code §§820, 2234, 2234(d). Mental and/or physical impairment affecting the ability to practice medicine safely. Revoked. May 30, 2001

VALDIVIA, RODOLFO C., M.D. (A28101)  
El Paso, TX  
B&P Code §§141(a), 2236(a), 2305. Disciplined by Texas for conviction of sexually assaulting a child. Revoked. May 21, 2001

YUSUF, FRANK M., M.D. (A32239)  
Lancaster, CA  
B&P Code §2234(c). Stipulated Decision. Committed acts of repeated negligence in the care and treatment of a patient by delaying exploratory surgery to determine the cause of extensive post-operative bleeding. Public Letter of Reprimand.  
July 25, 2001

### **DOCTOR OF PODIATRIC MEDICINE**

AGER, ALAN LAWRENCE, D.P.M. (E1607)  
San Geronimo, CA  
B&P Code §§2234(e), 2236(a), 2238. Criminally convicted in federal court for structured currency transactions and drug trafficking. Revoked.  
May 14, 2001

### **PHYSICIAN'S ASSISTANT**

PETERS, PAUL, P.A. (PA12933)  
Los Angeles, CA  
B&P Code §§2236(a), 3502, 3527(a), 3531.  
Stipulated Decision. Criminally convicted for making unlawful threats. Also practiced outside the scope of a physician assistant. Revoked, stayed, 3 years probation with terms and conditions.  
July 18, 2001

### **SURRENDER OF LICENSE WHILE CHARGES PENDING**

### **PHYSICIANS AND SURGEONS**

ALEXANDER, WILLIAM, M.D. (G14545)  
May 1, 2001

DEMONTERICE, ANU, M.D. (G14647)  
May 28, 2001

DUNN, WILLIAM J., M.D. (C22621)  
June 30, 2001

HARRIS, CHRISTOPHER ELLIOTT, C., M.D.  
(G85374)  
July 30, 2001

HEFFERNON, WANDA JUNE, M.D. (G81259)  
June 14, 2001

KIM, JEFFREY S., M.D. (A28958)  
May 17, 2001

LEADER, WILLIAM OCALLAGHAN, M.D. (A41125)  
June 27, 2001

REGESTER, WILLARD D., M.D. (A15936)  
June 15, 2001

RILEY, ANTHONY BRUCE, M.D. (G62098)  
July 3, 2001

TOM, DANNY, M.D. (C33746)  
June 7, 2001

### **PHYSICIAN'S ASSISTANTS**

SAUCIER, BILLY, P.A. (PA11026)  
June 21, 2001

STEWART, KENNETH LESLIE, P.A. (PA11748)  
June 21, 2001

### ***For further information...***

Copies of the public documents attendant to these cases are available at a minimal cost by calling the Medical Board's Central File Room at (916) 263-2525.

Department of Consumer  
Affairs  
Medical Board of California  
1426 Howe Avenue  
Sacramento, CA 95825-3236

**Business and Professions  
Code Section 2021(b) &  
(c) require physicians to  
inform the Medical  
Board in writing of any  
name or address change.**



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**ACTION REPORT - OCTOBER 2001**  
Candis Cohen, Editor (916) 263-2389

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