INITIAL REPORT

MEDICAL BOARD OF CALIFORNIA ENFORCEMENT PROGRAM MONITOR

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We thank the members of the Medical Board for their support and patience throughout the past year. We look forward to discussing the many issues raised in this report and to implementing them to improve and enhance the public protection afforded by MBC's enforcement program.

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EXECUTIVE SUMMARY

INTRODUCTION

This Executive Summary provides an overview of the concerns and recommendations presented in the Initial Report of the Medical Board of California (MBC) Enforcement Program Monitor (Monitor).

As a result of the Legislature's 2001–02 sunset review of MBC, Senate Bill 1950 (Figueroa) added section 2220.1 to the Business and Professions Code,[1] which provided for the appointment of an independent enforcement monitor and charged the monitor with evaluating "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." The statute tasks the Monitor with several specific analyses, including a required evaluation of the Board's diversion program for substance-abusing physicians.

The MBC Enforcement Monitor project began in late October 2003, and will continue through November 1, 2005. The Monitor and her colleagues — with the full cooperation of the management and staff of both the Medical Board and the Health Quality Enforcement Section of the Attorney General's Office — have studied the legislative history of six major legislative enactments that have shaped the structure and purpose of MBC's enforcement program; surveyed previous studies and reports on MBC's enforcement and diversion programs; reviewed MBC-generated documents and procedure manuals relevant to its enforcement and diversion programs; interviewed 92 experts and witnesses; gathered and analyzed statistical data; and conducted extensive research into initial issues and concerns relating to the Board's enforcement and diversion programs.

During 2005, the Monitor will present the findings and recommendations in this Initial Report to the Joint Committee on Boards, Commissions and Consumer Protection at the Board's sunset review proceeding, draft and advocate 2005 legislation to implement Monitor

[1] Unless otherwise noted, all further statutory references in this Executive Summary are to the Business and Professions Code.

recommendations that require legislative approval, and study several components of the Board's enforcement program that we were not able to cover in depth this year.

In this report, the Monitor makes findings and recommendations which may be addressed on a number of levels — internal administrative or procedural change, regulatory amendment, legislative change, budget and staffing enhancements, and/or structural change. Some of these recommendations are concrete and ready for consideration by the Board. Others are less fully developed concepts whose merits and precise implementation will be the subject of discussion between the Monitor and all of the stakeholders during 2005. Finally, others urge the Medical Board to engage in a constructive public dialogue on certain issues, having been fully informed by the discussion contained and data revealed in this report.

This Executive Summary presents the major findings and recommendations of the Initial Report using the following organizational scheme:

- Introduction
- Overview of MBC and its Enforcement Program
- The Evolution of MBC's Enforcement Program
- MBC's Enforcement Program: General Description and Threshold Concerns
- Complaint Receipt and Screening: Central Complaint Unit
- Field Investigations: District Offices
- Expert Reviewer Program
- Prosecutions: Health Quality Enforcement Section
- Hearings: Medical Quality Hearing Panel
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- Public Education and Outreach
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- Conclusion

OVERVIEW OF MBC AND ITS ENFORCEMENT PROGRAM

Created in the Medical Practice Act, the Medical Board of California (MBC) is a semi-autonomous occupational licensing agency within the state Department of Consumer Affairs (DCA). MBC consists of 21 members: twelve California-licensed physicians and nine non-physician "public members," all serving four-year terms. Uniquely, MBC is comprised of two autonomous divisions — the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). DOL, which

consists of four physicians and three public members, focuses on the licensure of physicians and the regulation of several non-physician health care professions. DMQ, which consists of fourteen members (eight physicians and six public members), is the Board's enforcement arm. DMQ is responsible for reviewing the quality of medical practice carried out by its physician licensees, conducting disciplinary proceedings in cases of unprofessional conduct, and generally enforcing the disciplinary and criminal provisions of the Medical Practice Act, other relevant statutes and regulations, and applicable professional standards. The Legislature has declared that, in exercising its disciplinary authority, "[p]rotection of the public shall be the highest priority for the Division of Medical Quality . . . . Where [physician] rehabilitation and protection are inconsistent, protection shall be paramount."

The Business and Professions Code sets forth grounds for MBC disciplinary action, including gross negligence (an extreme departure from applicable professional standards); repeated negligent acts; incompetence; the commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician; and the violation of any provision of the Medical Practice Act. In MBC disciplinary matters, the burden of proof is on the Board, and MBC must prove its case by "clear and convincing evidence to a reasonable certainty." The Code also sets forth an array of sanctions that DMQ may impose on a licensee for a disciplinable violation, including license revocation, suspension, probation on specified terms and conditions, the issuance of a public reprimand, citations, fines, and civil penalties.

In 2003–04, MBC regulated over 117,000 physicians, of which 91,000 reside and practice medicine in California. The Medical Board receives no funding or support from the state's general fund. MBC is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a "special-fund agency." In 2003–04, MBC's annual budget was $38.5 million, of which $28.2 million — or 73% — was spent on enforcement.

THE EVOLUTION OF MBC'S ENFORCEMENT PROGRAM

Chapter IV of this Initial Report describes the evolution of the Board's enforcement program through the enactment of six pieces of landmark legislation over the past 30 years. These bills — AB 1 (Keene) in 1975, SB 2375 (Presley) in 1990, SB 916 (Presley) in 1993, SB 609 (Rosenthal) in 1995, AB 103 (Figueroa) in 1997, and SB 1950 (Figueroa) in 2002 — have largely shaped the purpose, structure, authority, and resources of the Medical Board's enforcement program.

MICRA and the promise of balanced reform. Prior to 1975, the former "Board of Medical Examiners" — a physician-dominated board which exercised its disciplinary authority through regional "medical quality review committees" also controlled by physicians — was largely ineffective in disciplining physicians for negligence or incompetence. Instead, patient injury caused

by physician negligence or incompetence was handled through the civil tort system. In 1975, medical malpractice insurers announced massive premium increases, allegedly needed to pay jury verdicts and remain profitable. Outraged physicians turned to the Legislature for a solution. The result was AB 1 (Keene), the Medical Injury Compensation Reform Act of 1975 (MICRA), a measure carefully designed to comprehensively address three issues — tort reform, medical quality control, and insurance regulation — that were of interest to the four sets of stakeholders "at the table" (physicians, lawyers, insurance companies, and patients). According to Assemblymember Keene, "[a] general policy . . . decision was made that all interested parties must sacrifice in order to reach a fair and rational solution to the insurance crisis. AB 1 was drafted to include all reforms in order to prevent any one interest group from sabotaging any single-objective bill."

In its tort reform provisions, AB 1 capped non-economic damages (such as pain and suffering) in medical malpractice actions at $250,000; limited the contingency fee that plaintiff's counsel may charge in medical malpractice actions, provided (under the so-called "collateral source rule") that the jury in a medical malpractice action may be told of certain benefits payable to plaintiff (such as social security payments and benefits received under group health plans); and imposed a number of other disincentives to the filing of medical malpractice actions.

In exchange for these unprecedented concessions, the medical profession agreed to accept and support enhanced regulation of its ranks — with an emphasis on policing the quality of medical care provided and the removal of incompetent and negligent physicians from the marketplace. According to Assemblymember Keene, "[h]ealth quality control provisions were essential to regain public confidence in the health care delivery system, and to assure that incompetent doctors are not allowed to practice and generate lawsuits."

To implement health quality control, AB 1 abolished the Board of Medical Examiners and created a new "Board of Medical Quality Assurance" (BMQA) consisting of 19 members — twelve physicians and seven public members. For the first time, a dedicated enforcement arm — the Division of Medical Quality — was created and charged with overseeing the Board's enforcement staff, reviewing the quality of practice carried out by physicians, and making decisions in disciplinary matters. AB 1 also established a "central file" mechanism to capture information on complaints and reports of misconduct against physicians; set the stage for the transfer of investigative authority and the investigative function (in the person of professional investigators who would specialize in physician discipline matters) from DCA to BMQA; and established a number of "mandatory reporting requirements" to assure that actions taken by other entities against potentially dangerous doctors are reported to the Board so that they might be investigated and appropriately disciplined. AB 1 thus formed the promise of balanced medical regulatory reform for California.

SB 2375 (Presley). Despite AB 1's influx of authority, information, and resources to BMQA, a series of reports during the 1980s indicated that BMQA's effectiveness in policing the

medical profession was doubtful. The Auditor General, Assembly Office of Research, Little Hoover Commission, and Legislative Analyst all found fault with the Board's public outreach, mounting case backlogs, and overall enforcement performance. In April 1989, the Center for Public Interest Law released a report entitled *Physician Discipline in California: A Code Blue Emergency*, which further documented the minimal output, fragmented structure, and questionable priorities of BMQA's enforcement program. *Code Blue* called for increased resources and structural reorganization of BMQA, the Attorney General's Office which prosecutes MBC enforcement cases, the Office of Administrative Hearings whose administrative law judges (ALJs) preside over MBC disciplinary hearings, and the courts' review of MBC disciplinary decisions. BMQA rejected *Code Blue*'s allegations, contending that any flaws in its enforcement performance were due to the state's failure to approve additional enforcement program staffing and to factors beyond its control; it opposed any structural reform and decided only to change its name to "Medical Board of California" (MBC).

However, the impact of *Code Blue* and a series of events during 1990 — including a judge's public castigation of MBC for its failure to discipline Dr. Milos Klvana, a physician whose negligence had resulted in the deaths of nine infants; the Legislature's decision to withhold one-half of MBC's budget until it addressed a backlog of almost 900 uninvestigated cases; and a national report ranking MBC 42nd among the states in the number of serious disciplinary actions taken against physicians — combined to bring about the 1990 passage of SB 2375 (Presley), the first major MBC structural reform bill since AB 1 in 1975.

SB 2375 created a new Health Quality Enforcement (HQE) Section in the Attorney General's Office whose prosecutors were directed to specialize in medical disciplinary matters and to "work closely with each major intake and investigatory unit . . . [of MBC] to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." Similarly, SB 2375 created the Medical Quality Hearing Panel, a specialized panel of ALJs within the Office of Administrative Hearings to hear medical discipline cases, and authorized those ALJs to issue "interim suspension orders" to immediately halt the practice of very dangerous physicians in egregious cases. The bill also enhanced required reporting to the Board on physician negligence and misconduct; increased the maximum penalty against hospitals and HMOs that fail to report adverse peer review action to MBC; required MBC to compile and report certain disciplinary information to the Legislature and the public in its annual report every year; required DMQ to establish a goal of allowing no more than six months to elapse from receipt of a complaint to completion of the investigation; and — perhaps most important — clarified that protection of the public is DMQ's "paramount" priority in exercising its disciplinary authority.

MBC and HQE began to implement SB 2375 in 1991, but both were understaffed and unable to fully comply with the law's requirements of HQE presence at MBC's complaint intake and

investigative offices. In 1991, the Auditor General found that MBC was unable to meet the bill's six-month investigation goal — in fact, the average MBC investigation took 14 months to complete. Exacerbating the investigative delay, HQE took over 200 days to file an accusation in a fully investigated case, and another 264 days elapsed from the filing of the accusation to the completion of the hearing by OAH. In sum, DMQ, HQE, and OAH took an average of 2.8 years to process a serious discipline case from receipt of the complaint to a disciplinary decision (which is then subject to judicial review). The Auditor General also questioned the Board's 1990 closure of a number of cases that had been referred for investigation. In 1992, allegations by MBC's investigators about the closure of those complaints resulted in a formal audit of MBC's enforcement program by the Bureau of Internal Affairs of the California Highway Patrol (CHP).

The CHP Report and SB 916 (Presley). The findings in CHP's January 1993 report — which were widely reported in newspapers across the state — rocked the Board. CHP found that, in 1990, MBC had dispatched a "three-member management team" to the Board's investigative offices which ordered the closure of 200–300 cases. In addition to the improper closure of those cases, CHP found that other cases had been "poorly investigated" and inappropriately closed. CHP's report prompted calls for the repeal of MICRA in many quarters, based on the conclusion that the promised balance of medical regulatory reforms had not materialized. In particular, critics argued that if the "enhanced" MBC regulatory system was not working for consumers, then MICRA's benefits to the medical profession and insurance industry should be repealed. In March 1993, MBC responded to the CHP report by convening a two-day "Medical Summit" of community, consumer, and medical profession leaders to discuss these problems and identify solutions. Several proposals raised at the Summit were amended into SB 916 (Presley), Senator Presley's follow-up legislation to 1990's SB 2375.

Enacted in 1993, SB 916 (Presley) contained a number of reforms responsive to the CHP report and raised at the Medical Summit, and other proposals that had introduced in but amended out of SB 2375 in 1990. SB 916 enhanced MBC's detection of problem physicians by requiring hospitals and health care facilities to expedite the filing of reports on adverse peer review actions; requiring plaintiffs to notify MBC of their intent to sue a physician for medical malpractice; and requiring medical societies, health facilities, government agencies, and others who receive complaints about physicians to inform the complainant that only MBC is authorized to take disciplinary action against physicians. SB 916 improved the authority of MBC investigators to request and receive medical records from physicians under investigation, and authorized the imposition of a $1,000-per-day fine on physicians who refuse to comply with a lawful MBC request for medical records. The bill also established intermediate sanctions for offenses that do not merit revocation; abolished the Board's MQRCs; authorized DMQ to establish panels or lists of experts to assist it in administering its enforcement program; streamlined judicial review of MBC disciplinary decisions; expanded the Board's public disclosure policy; and authorized MBC to increase its biennial renewal fees from $500 to $600.

SB 609 (Rosenthal) and AB 103 (Figueroa). The goals of SB 916 were furthered by the passage of two subsequent bills. SB 609 (Rosenthal) in 1995 revised DMQ's disciplinary decisionmaking process and the procedure for judicial review of DMQ decisions. AB 103 (Figueroa), enacted in 1997, expanded MBC's public disclosure policy, requiring MBC to post on the Internet information about its licensees' current standing, prior disciplinary action, felony convictions reported to MBC after 1991, current accusations filed by the Attorney General, all malpractice judgments and arbitration awards reported to the Board after 1993, and all hospital disciplinary actions resulting in the termination or revocation of a physician's staff privileges for medical disciplinary cause or reason.

In January of 1997, HQE and MBC — dissatisfied with the length of time that fully investigated cases sat at HQE before accusations were filed — formally implemented SB 2375's requirement of HQE assistance for MBC investigators by launching the "Deputy in District Office" (DIDO) program, whereby an HQE DAG physically works in MBC district offices one or two days per week to permit onsite prosecutor guidance of investigations. By July of 1998, after phasing in the DIDO program and other changes, HQE had dramatically reduced average time for filing pleadings, down from 134 days to 28 days from case transmittal.

MBC's 1997–98 sunset review. The DIDO program and other factors accumulated to stretch MBC's enforcement budget to its breaking point. During the late 1990s, MBC experienced a 23% increase in complaint volume with no corresponding increase in investigative staff, excessive caseloads for MBC investigators, and a 10% vacancy rate in investigator positions because trained MBC investigators were leaving the Board for other agencies with higher pay and lower caseloads of lesser complexity. Faced with California Medical Association (CMA) opposition to a license fee increase, MBC implemented its "cost recovery" authority (under which it may be reimbursed for some of its investigative and enforcement costs by disciplined physicians) and scoured its budget for other revenues that could be redirected to enforcement. These tactics forestalled a fee increase request until 1998, when MBC underwent its first "sunset review" by the Joint Legislative Sunset Review Committee (JLSRC). Although the JLSRC recognized "a significant increase in the number of complaints filed" with MBC between 1992–93 and 1996–97, it also found that MBC had (since 1994–95) slashed its overall case processing time in most areas and increased its disciplinary output — largely due to the centralization of the complaint intake process and the recent success of the DIDO program in reducing accusation filing time. Although JLSRC staff stressed that MBC's average investigative processing time was 13 months (as opposed to the six-month goal established in SB 2375) and recommended that a fee increase be considered, the Joint Committee declined to approve a fee increase to support additional investigators.

When it became clear that sunset review would not yield the increase it had delayed since 1995, MBC sought the increase through the Department of Consumer Affairs' 1998 omnibus fee bill.

The Board sought a $90 biennial increase to finance ten new investigator positions and cut the 13-month average investigative lag time; it also needed additional revenue because employee salaries had been raised after a four-year cap, and a new Department-wide computer system requiring MBC contribution was on the horizon. CMA announced it would consider an increase only if the Board agreed to a full review of the performance of and costs charged by HQE, the elimination of cost recovery, a redefinition of the "repeated negligent acts" basis for discipline, and an alternative to section 805 reporting for physicians who "voluntarily" take a leave of absence from their hospital privileges to check into drug/alcohol treatment programs. The Board refused to agree to these terms, and CMA's opposition resulted in the deletion of MBC's fee increase from the omnibus bill. Upset with CMA for its refusal to support the Board's enforcement program, several Board members called for repeal of MICRA's cap on noneconomic damages in medical malpractice actions. According to one Board member, MBC must "support upward modification of the MICRA cap so that California's citizens would, lacking administrative redress, have greater access to civil redress."

MBC reintroduced its fee increase legislation in 1999, arguing that its fees had not been adjusted since 1994, and its investigative staff had not been increased since 1992. Since that time, the Board had experienced a 60% increase in the number of complaints received. In addition, MBC contended that its investigators carried higher caseloads than investigators at other state agencies. In response, CMA introduced competing legislation that would afford the Board a fee increase in exchange for 14 substantive changes in MBC's procedures and disciplinary authority. After negotiations throughout 1999, CMA reduced its 14 demands to five by January 2000: (1) redefinition of "repeated negligent acts" to preclude discipline for actions "during a single course of treatment" unless the physician's actions constitute "a pattern of conduct likely to jeopardize patient care"; (2) an amendment to section 805 prohibiting hospitals from notifying MBC's enforcement program when a physician takes a leave of absence in order to enter substance abuse treatment; (3) imposition of a mandatory $6,000 cap on cost recovery for physicians; (4) a requirement that MBC adopt regulations codifying enforcement program priorities that mandate "the prioritization of cases involving a serious risk to patient safety for investigation and prosecution"; and (5) a 50% reduction in initial license fees for physicians who are in residency programs. In exchange, CMA offered a $90 biennial fee increase. At its July 2000 meeting, the Board rejected CMA's offer, deciding that the bill's concessions in terms of consumer protection were not worth the resources offered by the bill. In fact, MBC determined that the bill would not increase resources for the Board's enforcement program and that the cap on cost recovery might backfire and actually decrease enforcement program resources. Both bills died in 2000.

As of October 2001, the state-imposed hiring freeze temporarily mooted the fee increase issue as state agencies, including special-funded agencies such as MBC with no impact on the general fund, were prohibited from filling vacant employee positions. The impacts of the hiring freeze — which lasted until June 2004 — and subsequent legislative actions abolishing vacant

positions have had devastating impacts on the Board's enforcement program. Since 2001, MBC has lost a total of 44.8 staff positions — including 29 enforcement positions. MBC's field investigations staff was reduced from 90 in 2000–01 to 71 by June 30, 2004 — a 25% loss. Since the hiring freeze began in October 2001, HQE has lost a total of six prosecutor positions — all in its Los Angeles office; in addition, two Los Angeles HQE deputies are out on extended medical leaves.

2001–02 sunset review and SB 1950 (Figueroa). In the meantime, MBC began its second sunset review in December 2001 with enforcement output data that had declined since its first review. As the Board prepared for its final sunset hearing in the spring of 2002, a wave of media stories criticized its public disclosure policy and overall enforcement performance. In particular, the *Orange County Register*'s April 2002 "Doctors Without Discipline" series was disturbingly reminiscent of the *Los Angeles Times*' coverage of the Klvana case twelve years earlier, in that it focused primarily on MBC's handling of one obstetrician who had botched deliveries and injured or killed infants. The series illuminated a lengthy eight-year delay between the Board's 1993 receipt of a section 805 report on the physician and its 2001 filing of an accusation against the physician; MBC's failure to seek an interim suspension order against the physician until 2002, despite multiple complaints, investigations, lawsuits, section 805 reports, and patient deaths; its declining enforcement output; its failure to check court files for the filing and outcome of medical malpractice actions; its "mandatory" reporting statutes that were easily evaded by physicians (and their lawyers) who wished to avoid being reported to MBC; and its loopholed public disclosure policy.

The *Register* series prompted the Joint Legislative Sunset Review Committee to postpone MBC's sunset hearing while its staff conducted an investigation into the mechanics of the Board's enforcement program. Staff's background paper found that: (1) every category of Board enforcement activity had declined since its last sunset review, even as complaints from patients increased; (2) few complaints become the basis of a formal investigation, few investigations lead to an accusation, and few accusations result in administrative hearings; (3) internal Board practices require the routine closure of most quality of care patient complaints because they fail to satisfy the "gross negligence" basis for discipline — closures that occur without routine consultation with a specialist in the same field, without review by HQE, and without consideration whether they may constitute "repeated negligent acts" or "incompetence"; (4) the Board does not receive all the information to which it is legally entitled; (5) MBC's complaint and investigation priorities are questionable; and (6) the Board's public disclosure policy misleads the public by failing to disclose malpractice settlements and misdemeanor criminal convictions — information deemed essential to every other medical stakeholder's evaluation of whether to associate with a physician.

MBC's 2001–02 sunset review resulted in the passage of SB 1950 (Figueroa), which attempted to address the flaws in MBC's enforcement program illustrated in the media reports and its sunset review. SB 1950 created an independent "enforcement monitor" charged with reviewing

MBC's enforcement and diversion programs for a two-year period. The bill established a list of five types of "priority cases" whose processing, investigation, and prosecution should be expedited by MBC and HQE; set forth a new complaint processing procedure that requires quality of care complaints to be reviewed a specialist with the "pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint" before they may be referred for investigation; closed loopholes in the Board's mandatory reporting statutes; expanded MBC's public disclosure policy and authorized it to disclose information about some civil malpractice settlements; revised the definition of "repeated negligent acts"; and revised the Board's composition by adding two new public member positions.

This thirty-year evolution of MBC's enforcement program serves to remind policymakers and stakeholders that the fundamental premise underlying the program is the balance of regulatory reforms so carefully crafted in AB 1 (Keene) and its progeny. The MICRA bill offered and still offers the promise of improving the future of the regulation of medical practice in California for all parties. But the long series of critiques, studies, and attempted legislative solutions reviewed here indicates that the disciplinary effectiveness portion of the reform program has consistently lagged. Further work remains to be done to fulfill the 30-year promise of balanced reform.

MBC's ENFORCEMENT PROGRAM: GENERAL DESCRIPTION AND THRESHOLD CONCERNS

A. General Description of Functions

MBC's enforcement program is large, complex, fragmented, and expensive. DMQ oversees a large enforcement staff that receives, screens, and investigates complaints and reports of physician misconduct and negligence. These staff are based at headquarters in Sacramento and at twelve (12) district offices throughout California. Once DMQ's investigative staff (assisted by physician employees called "medical consultants" and often external expert physician reviewers) have determined that sufficient evidence exists to take disciplinary action, the matter is transmitted to a separate agency — the Health Quality Enforcement (HQE) Section of the Attorney General's Office; HQE has six offices throughout the state. A deputy attorney general (DAG) from HQE then files an "accusation," a written statement of formal charges, which triggers a panoply of due process rights for the subject physician. Absent settlement, the charges then become the subject of an evidentiary hearing presided over by an administrative law judge (ALJ) from another separate agency — the Medical Quality Hearing Panel of the Office of Administrative Hearings, at which each side presents its case. After the case is "submitted," the ALJ drafts a proposed decision, including findings of fact, conclusions of law, and recommended discipline. That proposed decision is referred back to MBC's Division of Medical Quality, where it is reviewed by one of two "panels" of DMQ, each consisting of seven members (four physicians and three public members). The assigned DMQ

panel makes MBC's final disciplinary decision, which is then subject to potentially three levels of review by the courts. Contested MBC disciplinary matters often consume five to eight years, during which time most respondent physicians are free to continue practicing medicine.

B. Threshold Concerns about MBC's Enforcement Program

1. Overall, the enforcement process takes too long to protect the public. The average length of time for a serious complaint to reach its disciplinary conclusion during 2003–04 was 2.63 years. Many cases take much longer. The total average time from the filing of a serious complaint to a judicially-reviewed disciplinary decision is thus 1,369 days, or 3.75 years. MBC does not control all of this process, but MBC and HQE have direct control over the complaint processing, investigation, and prosecution activities of this process, and must target and attack these troubling delays.

2. MBC resources are inadequate. In recent years, the Medical Board has suffered a devastating combination of blows to its funding and staffing, including:

An outdated license fee structure in which its $600 biennial renewal fee was last adjusted in January 1994, despite a 27.9% increase in the California Consumer Price Index in that period. If $300 per year was an appropriate license renewal fee in 1994, it is 28% less appropriate today. In MICRA, the medical profession agreed to a balanced reform program in which it received an unprecedented cap on malpractice damages in exchange for strengthened Medical Board enforcement to address dangerous or incompetent physicians. MICRA's $250,000 malpractice cap has been frozen since 1975, providing much greater real dollar protection for physicians, but MBC's resources to protect the public have been effectively reduced by 28% since 1994.

The statewide hiring freeze of 2001–03, and resulting position losses, cost MBC a total of 44.8 staff positions, including 29 enforcement program positions. In 2004, MBC's enforcement program staff consists of 20 fewer positions than it had in 1991–92, when it received 22% fewer complaints and took 75% fewer disciplinary actions. HQE has lost six DAG positions — all in its Los Angeles office, and OAH lost two ALJ positions. The loss of its enforcement program positions required MBC to disband Operation Safe Medicine (its proactive program to target unlicensed "back-room clinics" in low-income areas), eliminate an Internet Crimes Unit targeting unlawful Internet drug sales, and ask its supervisorial investigators to take on partial caseloads.

Increased costs of doing business, such as salary adjustments and benefit premium increases, have continued notwithstanding the hiring and budget freezes.

MBC estimates that it will need a fee increase to $800 biennially to support a restoration of service levels comparable to 1994. The proposed fee level is comparable to the license fees charged

by other similar agencies, such as the Board of Podiatric Medicine's $900 biennial fee and the State Bar's $390 annual fee.

3. MBC and HQE's management structure and information systems need improvement. The Monitor has a number of concerns about various aspects of the management structure and management information systems of both MBC and HQE.

Medical Director position. MBC lost its Medical Director position during the hiring freeze and "sweep" of vacant positions. Reinstatement of this important post is a priority for MBC management, and the Monitor supports that effort.

Diversion Program management. For many years, the Medical Board has permitted the Diversion Program to effectively function in a vacuum, separate from overall MBC management, resulting in breakdowns in key Diversion functions that pose a risk not only to the public but also to the physicians participating in the Program. The administration of the Diversion Program must be more fully integrated into MBC management.

Relationship between MBC and HQE. The statutes creating and delegating responsibility to HQE require it to direct discipline-related MBC prosecutions and to assist DMQ in intake and investigations. The much delayed Deputy in District Office (DIDO) program has provided investigators with legal guidance, lowered accusation filing times, and is better than the prior "hand-off" structure, but it has proven unsatisfactory in many respects. The "vertical prosecution" model first suggested in 1990 would resolve these problems and should be revisited.

Enforcement policy/procedure manuals. MBC has a multitude of enforcement policy and procedural manuals, many of which are not regularly updated and most of which are inadequately reviewed by HQE. These update and review functions should be performed routinely and on a regular basis. HQE has no procedure manual at all.

Management information systems. MBC's management information system (the CAS system shared with other Department of Consumer Affairs agencies) suffers from numerous inadequacies and problems impeding MBC's licensing and enforcement programs, and undermining its public disclosure program. Similarly, the Attorney General's Office has long lacked an adequate management information system to capture accurate information on its processing and prosecution of disciplinary matters, and is only now implementing its improved ProLaw system.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #1: Lost enforcement positions should be reinstated. MBC should continue its efforts to reinstate the 29 abolished enforcement positions and four HQE attorney

positions, to enable the Board to rebuild its enforcement program, recreate Operation Safe Medicine and its Internet Crimes Unit, and expedite the processing of quality of care cases.

Recommendation #2: Renewal fees should be increased. The statutory ceiling on the Board's $600 biennial license renewal fee should be increased to $800 to cover inflation, restoration of lost enforcement positions, and increased costs of doing business.

Recommendation #3: DCA and MBC must upgrade their management information systems.

Recommendation #4: MBC should regularly update all enforcement manuals, and HQE should draft a policy and procedure manual.

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

A. General Description of Functions

The Medical Board's Central Complaint Unit (CCU) is responsible for receiving, acknowledging, screening, and processing all complaints and reports the Medical Board receives about the medical care provided by and conduct of California physicians. CCU is located in Sacramento, and is currently staffed by two managers, 15 analysts, 5 management services technicians, and a number of support staff, as well as a cadre of physician "medical consultants" under contract with the Unit who review complaints and medical records to assist in determining whether complaints should be referred for formal investigation. As of October 2003, an attorney from the Health Quality Enforcement Section and a MBC supervising investigator were assigned to CCU. In 2002, CCU was divided into Quality of Care (QC) and Physician Conduct (PC) sections. Staff of these sections review and analyze incoming complaints and reports; if necessary, secure medical records of the complainant and ensure their review by a medical consultant; and determine whether each should be closed or forwarded to one of MBC's twelve regional district offices for formal investigation.

Chapter VI provides a detailed description of CCU complaint initiation and processing (before and after significant 2002 changes); the division of the CCU into its two constituent sections and their functions; CCU case processing priorities after SB 1950; the "specialty reviewer" requirement for QC cases; the recent additions of an HQE attorney and an MBC investigator to assist CCU's operations; review of "simple departure" matters; sources of complaints and reports resulting in investigation and disciplinary action, including action in SB 1950 "priority cases"; and a note on the medical marijuana issue.

B. Initial Concerns of the MBC Enforcement Monitor

1. CCU's average complaint processing time is longer than historically reported. CCU has been counting as "complaints" several categories of information — including notices of intent to file lawsuits (NOIs), National Practitioner Data Bank (NPDB) reports, and "change of address citations" — that should not be counted as complaints. As a result, CCU's reported complaint total is artificially high and its reported average complaint processing time is artificially low. Factoring out these items yields a total of 8,240 complaints received in 2003–04 and a 79-day average CCU case processing time.

2. CCU complaint processing takes too long. Business and Professions Code section 2319(a) establishes a goal of six months' elapsed time for MBC to handle a complaint through the completion of the investigation (one year in complex matters). This timeframe includes CCU case processing time. CCU's 2003–04 average case processing time of 79 days (2.63 months) is 12 days longer than it took CCU to process complaints in 2002–03.

CCU's processing of quality of care cases — which requires the procurement of patient medical records and the review of those records by a "specialty reviewer" — took an average of 140 days in 2003–04. Approximately 10 of those days were consumed by complaint receipt and initiation; medical records procurement took 66 days; and medical consultant review took another 64 days. Thus, CCU's processing of QC complaints consumes 140 days of the 180-day goal in section 2319(a).

3. CCU's implementation of the specialty reviewer requirement for QC complaints has caused a number of problems. Effective January 1, 2003, SB 1950 (Figueroa) added section 2220.08, which requires CCU to ensure that QC matters are reviewed by a physician "with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." This "specialty reviewer" requirement has required CCU to recruit and train new medical consultants in a number of different specialties and subspecialties so that QC complaints can be reviewed by a physician with relevant expertise. The Monitor studied the time it took CCU to locate a reviewer and secure review of relevant medical records during calendar year 2003. In five "high-volume" specialties (those that are often the subject of complaints and in which CCU has a number of experienced reviewers), 1,270 reviews were completed within an average of 35 days each. In a number of "low-volume" specialties (those in which CCU has no or few trained reviewers), 486 reviews were completed within an average of 69 days each — nearly twice as long on average as the "high-volume" specialty reviews. Few disagree with the concept of improving quality by bringing greater expertise to bear, where feasible. However, MBC's implementation of the specialty reviewer requirement has introduced increased cost and substantial delay in the processing of QC cases, and the requirement does not

appear to have made a significant difference in the quality of reviews performed since January 1, 2003.

4. The codification of mandatory case processing priorities is resulting in unintended consequences. SB 1950 (Figueroa) added section 2220.05, which requires MBC to "prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously." The statute sets forth five categories of "priority cases," and CCU now tags these cases as "U1" through "U5" priority cases. Proper case prioritization is a sound public policy goal, but the codification of these priorities has caused unintended consequences that warrant exploration. Specifically, the language of the statute and the way in which MBC has implemented the section 2220.05 priorities have elevated *patient outcome* over factors which may be as or more important in enforcement circumstances, including imminence of harm, strength of evidence, and culpability. Patient injury or death is always tragic. But the mere presence of a tragic outcome should not always dictate prioritization of enforcement activity.

For example, many cases classified as U1 are section 801 reports of civil malpractice settlements, which often occur several years after the event that prompted the lawsuit, making it possibly inappropriate to classify the complaints as U1 because the physician is simply not "a danger to the public" as required in section 2220.05(a)(1). Conversely, other kinds of complaints posing serious risk of real-time harm and accompanied by strong evidence are relegated to lower status or not included at all on the priorities list. A good argument can be made that it is more important for MBC to move now on a complaint of recent egregious sexual misconduct (U4) or practicing while impaired (U5) than a section 801 report of a civil settlement involving the death of a patient five years ago (U1).

Adequate protection of the California public requires an enforcement presence in other important areas of medical misconduct. While still giving serious health harm its due significance, MBC should permit its supervisors to identify non-fatal or grievous injury cases where the immediacy of the threat, the strength of the evidence, the need for enforcement deterrence, and the prospects for effective action call for MBC to act. The intent behind section 2220.05 was undeniably good, but the priorities statute should be refined to effectuate the intent of SB 1950 (Figueroa) and the overall public protection mandate of the Board.

5. Many of MBC's most important detection mechanisms are failing it. Business and Professions Code section 800 *et seq*. sets forth an extensive "mandatory reporting scheme" intended to enable MBC to detect physician negligence, incompetence, and wrongdoing so that it might investigate and take appropriate disciplinary action. These are valuable information sources for the Board's disciplinary process, but many of them are failing the Board and the public, including:

■ ***Malpractice Payouts***. Many section 801 and 801.1 notices by insurers of malpractice payouts are not filed within the required 30-day time period, are incomplete, and/or are useless to the Board (for example, many fail to include the address or contact information of the plaintiff in the malpractice action). MBC and HQE contend that malpractice action documents required to be forwarded to MBC under section 804 are often destroyed.

■ ***Coroner's Reports***. Section 802.5 requires a coroner to file a report with MBC whenever the coroner "receives information" that a death may be the result of a physician's gross negligence or incompetence, but MBC receives few coroner's reports — never more than 40 in a given year.

■ ***Physician Self-Reporting of Criminal Convictions***. Section 802.1 limits physician self-reporting of criminal convictions to felonies, but many misdemeanor convictions are "substantially related to the qualifications, functions, or duties" of a physician and are grounds for disciplinary action. Physicians should self-report them to MBC.

■ ***Court Clerk Reporting***. Section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC, but there is a low level of compliance with these statutes by court clerks.

■ ***Hospital Reporting of Adverse Peer Review Action***. Section 805 reporting by hospitals, health care facilities, and HMOs is one of the most valuable source of complaints to MBC, and is the greatest area of failure. Compliance with section 805 is even lower than it appears: Over 500 California hospitals filed only 157 section 805 reports with MBC in 2003–04 — and one-third of those peer review actions were taken *after* MBC disciplined the physician's license. Only six disclosable section 805 reports were filed with MBC in 2003–04.

■ ***Regulatory Gag Clauses***. In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians through the inclusion of "regulatory gag clauses" in civil settlement agreements. Regulatory gag clauses should be statutorily banned for all regulated trades and professions and particularly for physicians in light of the irreparable harm doctors can cause.

6. The staffing allocations of CCU's sections should be revisited. Because CCU receives more PC than QC complaints, CCU should revisit the allocation of staffing between its QC and PC sections, and should arrange for sufficient cross-training of analysts to deal with illness, vacations, and other CCU analyst absences.

7. Detection of repeated negligent acts has improved, but could be enhanced. CCU's new procedure calls for review of prior complaint history before a QC case is closed for a "simple departure." This is beneficial and should be extended to PC matters as well.

8. Subject physicians are not always notified when complaints are closed or forwarded for investigation.

9. CCU should regularly review and update its procedure manuals.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #5: CCU should discontinue counting NOIs, NPDB reports, and "change of address citations" as complaints, and accurately report its true complaint total and average complaint processing time. CCU has already discontinued counting NOIs and NPDBs as complaints.

Recommendation #6: Code of Civil Procedure section 364.1 should be repealed. The "notices of intent" forwarded to MBC contain very little useful information, and CCU and MBC district offices now have access to the Civil Index, a more reliable record of civil actions filed.

Recommendation #7: CCU must establish a firm policy on medical records procurement, and HQE must assist CCU in enforcing that policy. MBC and HQE should stop tolerating delays, enforce existing laws, and utilize all available tools to ensure compliance with medical records laws.

Recommendation #8: MBC and HQE should expand the role of HQE attorneys in CCU. MBC and HQE should expand and fund the role of HQE in CCU in compliance with Government Code section 12529 *et seq*., and in particular, HQE should play a much greater role in medical records procurement in CCU.

Recommendation #9: CCU should revisit its implementation of the "specialty reviewer" requirement in section 2220.08. MBC's current interpretation of the statute may be unduly narrow, is causing potentially unnecessary delay in the processing of quality of care cases, and is costing the Board time, money, and the use of expert reviewers at the district office level.

Recommendation #10: Section 2220.08 should be amended to permit CCU to refer directly to the field (without specialty review) any new complaint relating to a physician who is the subject of a pending investigation, accusation, or on probation. In addition, consideration should be given to amending section 2220.08 to provide an exception to the specialty reviewer requirement where CCU is unable to locate a specialist after a 30-day good-faith search.

Recommendation #11: The Monitor and all stakeholders in MBC's enforcement program should collaborate to refine the language of section 2220.05's "mandatory case

processing priorities" to effectuate the intent of SB 1950 (Figueroa) — "ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously."

Recommendation #12: Insurers should be penalized for failure to comply with existing reporting requirements.

Recommendation #13: Misdemeanor criminal convictions should be reported to MBC.

Recommendation #14: MBC should educate coroners about their reporting requirements under section 802.5.

Recommendation #15: The Department of Consumer Affairs should join with the Judicial Council to design an educational program for courtroom clerks, judges, and public prosecutors to enhance their compliance with the reporting requirements in Business and Professions Code section 800 *et seq*.

Recommendation #16: The study of peer review authorized in SB 16 (Figueroa) should be funded and conducted as soon as possible.

Recommendation #17: MBC's sunset legislation should include a provision banning the inclusion of regulatory gag clauses by licensees of any agency created in Division 2 of the Business and Professions Code.

Recommendation #18: CCU should revisit the staffing allocations of its two sections, and MBC should consider augmenting the staff of this important unit so its analysts are not overburdened with excessive caseloads and to accommodate the cross-training of analysts.

Recommendation #19: CCU should institute a review process for "simple departures" in PC cases — especially in complaints alleging sexual misconduct and drug/alcohol offenses — to ensure that it is not overlooking potential investigations and prosecutions of repeat offenders.

Recommendation #20: CCU should ensure that subject physicians are notified when complaints are closed or forwarded for investigation.

Recommendation #21: CCU should ensure that its policy and procedure manuals are regularly updated to accommodate changes in the law, MBC policy, and CCU structure.

FIELD INVESTIGATIONS: DISTRICT OFFICES

A. General Description of Functions

Complaints and reports about California physicians which have passed through the screening process of the Central Complaint Unit are referred to MBC's district offices for investigation. MBC maintains twelve field offices ("district offices") staffed by peace officer investigators, supervising investigators, and medical consultants (physician employees). A complaint that warrants additional scrutiny after CCU screening is referred the district office in the geographical area where the subject physician practices. The case is assigned to an MBC investigator who — assisted by the medical consultant, supervising investigator, and an HQE attorney — reviews the existing file and conducts the investigation, including the gathering of medical records or evidence; locating and interviewing complainants and other witnesses; interviewing the subject physician; and in quality of care cases securing review of the investigative report and the evidence by a physician "expert reviewer." In 2003–04, Medical Board investigators opened 1,887 investigations, closed 2,117 investigations, referred 580 matters to HQE for administrative enforcement action, and referred 37 cases for criminal action.

Chapter VII provides a detailed description of the district offices' role in the current investigative process; the district offices' structure and declining resources; the role of the Attorney General in the investigative process (including the limited advisory role of the Deputy in District Office program); the role of medical consultants in the investigative process; and statutory timeframes for MBC investigations.

B. Initial Concerns of the MBC Enforcement Monitor

1. MBC investigations are plagued by delays and excessive case cycle times. The Medical Board has consistently failed to comply with the statutory goals set by the Legislature for the investigative process, including an average of six months total time to completion of investigation (one year for complex matters). The average elapsed time for an MBC investigation is now 261 days, up from a similarly-calculated 243 days in 2002–03, and fully 27% take an average of 15 months (or 2.5 times the state's goal). Multiple personnel and process issues contribute to these long cycle times (many beyond the control of district office staff), including the general difficulty of MBC cases; reductions in district office staff; losses of other valuable resources (such as medical consultant time); investigator recruitment and retention challenges; a changed case mix toward greater complexity; and increased defense counsel use by physicians.

MBC's cadre of investigators are competent and dedicated, and they are doing a good job of maintaining the volume and quality of casework despite challenges. However, even with MBC

investigator caseloads at record lows (presently 18 cases per investigator), there is persistent noncompliance with the six-month processing goal, and case cycle times are again trending upward. Despite good efforts, MBC investigations take too long and suffer many avoidable delays, which result from a pervasive "hurry up and wait" phenomenon, in which investigators must wait to get complete medical records (an average of 74 days, despite the 15-day period in state law and CCU's prior expenditure of 66 days to obtain records in QC cases); wait for the medical consultant to assist; wait for the subject to agree to be interviewed (an average of 60 days); wait for the medical consultant's memo and identification of the essential expert reviewer; and wait for the expert review (an average of 69 days — over twice MBC's goal). Successfully addressing the causes of these lengthy built-in delays will significantly reduce the stubbornly long case cycle times in MBC investigations.

2. Attorney/investigator coordination and teamwork is inadequate. Notwithstanding dedicated work by MBC and HQE staff, the current system linking MBC investigators and HQE prosecutors suffers from inadequate coordination and teamwork. MBC investigators generally function without true, close coordination with the trial prosecutor who will ultimately handle the case. Despite the good intentions underlying the DIDO program, most MBC investigators still receive only limited legal support for their investigative work; they rarely work directly with assigned trial counsel during the critical formative phases of the case; and they seldom play a significant role in the pre-hearing and hearing process to which their work is directed. This system of limited investigator/trial attorney joint work and cooperation is typical of the "hand-off prosecution model" best suited to simple street crime prosecutions. MBC's hand-off model stands in sharp contrast to the "vertical prosecution model" widely used in complex white collar crime and regulatory matters.

Current MBC/HQE "hand-off prosecution" process. The current enforcement process at MBC involves (1) an investigator with limited legal guidance and support investigating a case, preparing the file, and "handing off" or transmitting the case to (2) an HQE attorney who has had no role in the shaping or preparation of the case and must function with little or no investigative support in the pre-hearing and hearing process. This "hand-off" system is woefully inadequate for complex white collar crime-type cases of the sort usually handled by MBC — where the subject is highly technical, the facts and legal issues are complicated, and the process requires a lengthy commitment of time and enthusiasm to achieve a sound result.

This MBC "hand-off" investigation/prosecution process has long been criticized as inadequate and inefficient. The DIDO program, formally undertaken in 1997, has provided limited legal advice and assistance for district office investigators. But it is a halfway measure which has produced inconsistent and partial results, ranging from useful assistance to little benefit, and has never accomplished the desired integration of investigators and prosecutors into a closely-knit and effective

team. Even under the DIDO program, the current investigator/attorney relationship has serious limitations and weaknesses, including inadequate communication and coordination; unclear and frustrating working relationships; no joint investigative plan; inadequate follow-up and assistance for the prosecutor at trial; reduced commitment to cases; and missed training opportunities.

The vertical prosecution model. In many — and perhaps most — other law enforcement agencies involved in complex matters, prosecutors and investigators work together in teams from the day a case is assigned for investigation, in a process known as the "vertical prosecution model" for enforcement actions. The vertical prosecution model is based on the realization that this process is an inherently *legal* one: The purpose of these complex investigations is to *prepare cases for trial* or other legal disposition — a function which requires legal input and which benefits from having that guidance and assistance from its inception.

Under this model, the trial attorney and the investigator are assigned as the team to handle a complex case as soon as it is opened as a formal investigation. In this system the prosecutor and the investigator work together during the investigative phase to develop the investigative plan and ensure the gathering of necessary evidence to prove the elements of the offense and to address anticipated legal defenses; provide legal analysis of the incoming evidence to help shape the direction of the case; prepare subpoenas or help secure search warrants to prod uncooperative subjects or third-party witnesses; deal directly with defense attorneys when issues arise; and address settlement or plea matters, which often appear early in such cases. In turn, the investigator contributes a peace officer's experience and insight into the investigative plan and case strategy, and performs the field investigative tasks.

A number of different organizational structures or formats can be used to achieve the benefits of vertical prosecution. However, the essential elements of any such model are early coordination of the efforts of attorneys, investigators, and other staff; continuity of teamwork throughout the life of a case; mutual respect for the importance of the professional contributions of both attorneys and investigators; and early designation of trial counsel.

The precise implementation of these essential elements is flexible. For example, this model is generally best implemented by an organizational structure where the attorney and investigator staff are employees of the same agency. This approach can also succeed where the team members work for different organizations.

Precedents for the vertical prosecution model at other agencies are plentiful, including federal agencies (including the U.S. Department of Justice's Antitrust Division and the Federal Trade Commission), state agencies (including successful implementation of the vertical prosecution model at the State Bar of California, as well as the California Department of Justice's Medi-Cal Fraud

Section, the Special Prosecutions Unit, and Major Fraud Section) and local agencies (more than 40 of the 58 district attorneys' offices in California maintain specialty consumer protection, major fraud, and environmental law sections, and *all* of these prosecution units work with in-house investigators in a vertical prosecution format).

Application of the vertical prosecution model to MBC. Applied to MBC, the benefits of vertical prosecution would be numerous and substantial: (1) improved efficiency and effectiveness arising from better communication and coordination of efforts; (2) reduced case cycle times; (3) improved commitment to cases; (4) improved morale, recruitment, and retention of experienced prosecutors and investigators; (5) improved training for investigators and prosecutors; and (6) the potential for improved perception of the fairness of the process.

3. Delays in medical records procurement are chronic. The lengthy waiting time for the procurement of essential medical records is among the greatest problems facing MBC's district offices and among the principal sources of overall case processing delays. Medical Board staff report that in fiscal year 2003–04, the average timeframe from a request for records by MBC investigators to receipt of all records was 74 days (or 2.5 months), despite the statutory 15-day timeframe in Business and Professions Code sections 2225 and 2225.5. Combining investigations' 74-day average with CCU's average 66-day records-gathering period, medical records procurement at MBC consumes an average of 140 days — or 77% of the 180-day goal in section 2319. Both MBC investigators and HQE prosecutors demonstrate apparent tolerance for physicians' lengthy delays in complying with medical records requests. Requests for assistance to HQE by either CCU staff or district office investigators are comparatively infrequent, and actual enforcement actions are even less frequent.

Alternatives to the present practice have been utilized periodically or may be available for use, including firm compliance deadlines, prompt use of subpoena enforcement and sanctions actions, warrantless searches (where patient releases have been obtained), and other measures. However, these tactics have until now represented extremely rare exceptions to the usual records procurement process.

4. Subject interview policies are inconsistent and ineffective. Medical Board investigators must conduct subject interviews as a key part of the district office investigative process. The current average time between initial request and actual subject interview is 60 days for the district offices as a whole, which represents a large portion of the typical nine-month investigative timeframe. Contributing to this delay is inconsistency among district offices regarding the use and conduct of these subject interviews. Some investigators rely on persuasion; others pursue a strict policy enforcing these procedures. The more permissive policy of informal persuasion, voluntary requests, and waiting for cooperation contributes significantly to the problem of excessive case cycle

times. The prompt use of the administrative subpoena authority, after a reasonable interval for cooperation, has worked well in certain district offices and should be implemented statewide. Similarly, sound public policy calls for subject interview tape-recording in most if not all circumstances today. To the extent that current subpoena authority, or authority to record interviews, is perceived as unclear, statutory changes to clarify the specific authority of the Medical Board, and to require physician cooperation as function of professional responsibility, may be appropriate.

5. Medical consultant availability, training, and utilization are inadequate. Problems of medical consultant availability, training, and proper use contribute significantly to lengthy investigations and inefficient operations. Budget constraints have caused a 15% reduction in available consultant hours agency-wide in 2003–04. These reductions made it more difficult to obtain required medical consultant assistance, exacerbating a situation of reduced investigative and support staff, and requiring unproductive down time in cases waiting for consultant attention. In particular, these reductions often mean that medical consultants are unavailable for or greatly delayed in reviewing expert opinions and participating in the decision to transmit cases. Some offices report that this function is hardly performed at all by assigned consultants. This aspect of the medical consultant's function is among the most important of all, and is central to the speed and quality of QC case processing. Other concerns about medical consultant practices merit the attention of the Medical Board: (1) medical consultants may have inadequate information about prior complaints and inquiries in order to identify patterns of misconduct by subject physicians; (2) medical consultants need to play an even greater role in the identification and recruitment of physicians to serve as expert reviewers; and (3) medical consultant training is inadequate.

6. Expert witness availability and use are systemic weaknesses. Investigators lament the unavailability of experts, especially in highly specialized fields, the inadequacy of training provided to experts, and the inconsistent performance and uses made of these experts. These concerns are addressed in detail in the "Expert Reviewer Program" section below.

7. Ongoing training of investigators, medical consultants, and experts is inadequate. MBC, which in years past has had an exemplary training program in place, has substantially reduced formal training for investigators, medical consultants, experts, and others, as an accommodation to pressing budgetary concerns. If MBC is to significantly improve its case cycle times and efficiency, a systematic and professionalized training program for its field investigators, medical consultants, and expert reviewers is required.

8. Coordination with state and local prosecutors is underutilized. Many of MBC's peace officer investigators have substantial knowledge of the criminal and civil law enforcement options available to the agency as potential tools to address complaints against medical practitioners involving both quality of care and physician conduct issues. However, prosecutors throughout the

state cite the inadequacy of early communication or consistent coordination between MBC investigators and state and local law enforcement agencies in cases where non-administrative enforcement tools (such as Penal Code section 23 probation orders or civil unfair competition actions) may be appropriate.

9. Recruitment and retention problems exacerbate MBC personnel shortages. Recruitment and retention problems plague personnel management at the Medical Board. Supervisors and field investigators uniformly report that valuable, experienced investigators are lost and well-qualified applicants go elsewhere because of salary disparities between the pay of the MBC and other agencies hiring peace officers. MBC regularly loses in competition with other agencies over highly qualified investigative personnel.

10. Procedural and training manuals must be updated continuously. MBC investigations and other enforcement processes are today guided by policy and procedure manuals which in most cases have not been consistently reviewed or approved by HQE — MBC's legal counsel and principal partner in enforcement. In addition, at least some of these manuals have not been updated adequately by MBC management and thus are sufficiently outdated to be inaccurate as to Board policy.

11. Investigators need full and easy access to all law enforcement databases and to appropriate commercial databases. MBC investigators complain of inconvenient access to the law enforcement databases which are essential to modern police work, and budgetary limitations which prevent them from using commercial databases, such as Merlin, Westlaw/Dialog, and similar systems, which investigators in other California agencies are funded and permitted to use.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #22: MBC and HQE should fully implement the vertical prosecution model. MBC investigators and HQE prosecutors should work together in a true vertical prosecution system featuring case teams established at the initiation of the investigation and remaining together until the case is fully litigated or resolved. The Monitor believes the vertical prosecution system could best be implemented by merging existing MBC investigators and supervisors into HQE; however, the model could also be implemented within other organizational arrangements.

Recommendation # 23: MBC and HQE must revise their medical records procurement and enforcement policy to ensure prompt and full compliance with existing law. As discussed in related Recommendation #7, MBC and HQE should adopt and strictly enforce a comprehensive medical records procurement policy which is consistently applied in all MBC enforcement cases. This policy should involve strict deadlines and prompt use of subpoena enforcement and sanctions

actions. MBC and HQE should also consider: (1) formation of a small "strike team" of prosecutors familiar with and skilled in subpoena preparation and enforcement actions; (2) clarifying or strengthening, as needed, the professional obligation of California physicians to comply with lawful MBC requests for medical records; (3) the joint development of MBC/HQE protocols for the proper use of warrantless searches (where patient releases have been obtained) and for the use of Code of Civil Procedure section 1822.5 administrative inspection warrants in appropriate cases; and (4) a statutory amendment to shift attorney's fees to the investigation subjects when MBC and HQE prevail in subpoena enforcement actions.

Recommendation #24: MBC should develop and enforce a consistent new policy on physician interviews. Physician interviews should proceed in a prompt and orderly sequence of requests, subpoenas, and enforcement, as needed, with appropriate consideration given to legislation requiring subject physicians to appear at interviews upon reasonable notice, requiring tape-recording, and clarifying the duty of licensees to cooperate with MBC disciplinary inquiries.

Recommendation #25: MBC should improve cooperation and case referrals between its enforcement staff and state and local prosecutors involved in criminal and civil prosecutions.

Recommendation # 26: MBC should continue its efforts to restore lost investigative resources to provide staff for special projects and major case response teams. Reinstatement of lost investigator positions should be sought to enable MBC to undertake proactive and undercover operations, such as the Operation Safe Medicine and the Internet Crimes Unit, and to support the formation of two rapid response teams to handle major cases of unusual complexity and emergency matters with potential for serious health or safety consequences.

Recommendation #27: MBC should improve and regularize investigator training, and update all enforcement program procedure manuals.

Recommendation #28: MBC should expand and improve the medical consultant program. Medical consultant hours should be increased, at least to restore the 15% reduction suffered in the fiscal year 2003–04 budget, and preferably to add a similar incremental increase to permit substantially increased consultant assistance, especially in the review of expert reviewer opinions and contributions to the decision to transmit a case. Medical consultants should also assist in recruiting and training expert reviewers.

Recommendation #29: MBC should improve investigator access to law enforcement information systems.

EXPERT REVIEWER PROGRAM

A. General Description of Functions

In quality of care disciplinary matters against a physician, expert opinion testimony is required to prove or disprove that the physician performed in accordance with the prevailing standard of care. Because the burden of proof is on the Board, it must produce one or more physician witnesses with experience and expertise in the specialty or procedure at issue. That expert witness must review all the evidence in the case, testify to the standard of care applicable to each procedure performed, opine as to whether the subject physician's conduct departed from that standard of care and to what degree, and explain the justification or basis for his opinion. This burden requires MBC to recruit, train, and select expert witnesses who are willing to review disciplinary investigations against other physicians, write detailed memoranda and opinions, and — if necessary — testify orally at an evidentiary hearing. To enable expert review of QC cases, MBC created an "Expert Reviewer Program" in 1994 and has since recruited and trained a list of over 750 expert reviewers in all specialties throughout the state.

Chapter VIII details MBC's appointment process and minimum qualifications for its expert reviewers; the ways in which MBC recruits experts; the method by which district office investigators and medical consultants select an expert for any given QC matter; the payment and immunity from civil liability afforded to MBC expert reviewers; and the experts' feedback to MBC on the quality of their experience as an expert reviewer.

B. Initial Concerns of the MBC Enforcement Monitor

1. Average expert reviewer cycle times are excessive. MBC instructs its experts to review medical records and other materials and submit an expert opinion within 30 days. However, the average turnaround time for expert opinions is 69 days — over two times its goal. Further, MCs and investigators note that the 69-day timeframe discussed above does not include the time it takes them to simply locate a qualified reviewer.

2. There is a lack of qualified experts in many specialties, and the CCU specialty reviewer requirement is siphoning off some experts who would otherwise review cases in the field. Despite MBC's recruitment efforts, there are not always a sufficient number of qualified experts in high-demand specialties and subspecialties willing to work for $100 per hour. This leads to delay in locating qualified experts and in the use of "off-the-list" experts on some occasions. Further, section 2220.08's requirement that "specialty reviewers" evaluate quality of care complaints in CCU has led CCU to "borrow" experts from the Expert Reviewer Program's list. This costs MBC more money (because experts on the Expert Reviewer Program list are paid more than are CCU

experts, and because experts often do more work than is necessary at the CCU stage) and deprives MBC field offices of using those physicians as expert reviewers for completed investigations.

3. There is no requirement that expert testimony be reduced to writing and/or exchanged before hearing. MBC requires its experts to reduce their expert opinions to writing — and those expert opinions are immediately discoverable by the defense. However, defense counsel frequently instruct their experts not to reduce their opinions to writing so the HQE DAG has no idea of the substance of defense counsel's expert opinion until that expert takes the stand at the evidentiary hearing. This practice results in the unfair "sandbagging" of the DAG at the hearing, and stifles the possibility of prehearing settlement. Litigation surprise regarding this central element of the administrative action is costly to the respondent and MBC, unfair to the DAG, and disserves all parties to the process and the public interest as a whole.

4. The expert reviewer handbook contained errors. The *Individual Study Program for Expert Reviewers* provided to the Monitor in 2003 was last updated in October 2002, and did not appear to have been revised to conform to the changes made by SB 1950 (Figueroa). It contained a significant error regarding the definition of "repeated negligent acts" and other lesser errors. The manual has been reviewed by HQE and the errors have been corrected.

C. Initial Recommendations of the MBC Enforcement Monitor

<u>Recommendation #30</u>: The Medical Practice Act should be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the hearing. The exchange of expert witness opinions prior to hearing will lead to more settlements and will remove the current and unfair "sandbagging" of the DAG at hearings on most occasions.

<u>Recommendation #31</u>: MBC should make better use of its district office medical consultants, existing expert witnesses, Board members, and the California Medical Association to recruit more expert reviewers. MBC clearly needs more qualified experts who have time to devote to reviewing MBC cases and returning expert opinions in a timely manner. Once its medical consultant hours are restored, the Board should make better use of its district office medical consultants to aggressively recruit expert reviewers in their local communities. Additionally, it should attempt to utilize its existing expert witnesses, Board members, and CMA to assist in recruiting more expert reviewers.

<u>Recommendation #32</u>: MBC should consider paying its experts more, and resume in-person training sessions for its experts. Although physicians who serve MBC as expert witness clearly aren't in it for the money, 49% of the experts who returned MBC's survey said they weren't

paid enough for their services. Defense experts are routinely paid $500–$750 per hour, and MBC simply cannot compete for the best experts at $100 per hour. If MBC's budget change proposal is approved, MBC should consider increasing its expert witness fees, and a resumption of local, in-person training sessions for expert witnesses conducted by district office supervisors and medical consultants.

PROSECUTIONS: HEALTH QUALITY ENFORCEMENT SECTION

A. General Description of Functions

After a Medical Board district office has completed an investigation yielding sufficient evidence of chargeable physician misconduct, the case is transmitted to the Attorney General's Health Quality Enforcement (HQE) Section for administrative action, or to the appropriate state or local prosecutor for criminal or civil law enforcement action. Under Government Code section 12529 *et seq*., HQE is responsible for prosecuting disciplinary proceedings against MBC licensees; in addition, it is charged with assisting MBC with complaint intake and investigation activities in support of those prosecutions. To implement its responsibility to assist with investigations, HQE created the Deputy in District Office (DIDO) program in 1997. To implement its responsibility to assist with complaint intake, HQE formally assigned a deputy attorney general to CCU on October 1, 2003.

HQE is staffed by a Senior Assistant Attorney General, six Supervising Deputies Attorney General (SDAGs), and 36 deputies attorney general (DAGs) stationed in six offices across the state. In 2003–04, HQE received 580 cases transmitted from MBC investigators (up about 15% from the prior year, but on par with the three-year average of preceding years), filed 262 accusations (down from a 2001–02 high of 329 but about average for the past five years), obtained 48 prefiling stipulations and 202 postfiling stipulations, and conducted 45 administrative hearings.

Chapter IX provides a detailed description of HQE's role in the current enforcement process; HQE's structure and resources; Attorney General/HQE management information systems; HQE enforcement outputs; and HQE case cycle times.

B. Initial Concerns of the MBC Enforcement Monitor

1. HQE cycle times remain lengthy, including recent increases in the filing phase. Despite the presence of a cadre of experienced DAGs, many of whom are highly skilled and motivated, HQE remains burdened with lengthy case processing times. In particular, HQE is experiencing rapid erosion of earlier progress in the filing phase — the one aspect over which the Attorney General has primary (although not exclusive) control. MBC statistics now show an average

107-day period between transmittal of the case by MBC and the filing of the accusation, which converts a confidential investigation into a matter of public record. HQE's understaffed Los Angeles office averages more than five months to the filing of pleadings. HQE management uses different statistical definitions and reports shorter filing times, but readily acknowledges that average time to file pleadings has doubled in the past three years, an increase HQE attributes primarily to reductions in attorney staff.

2. HQE attorney staffing is insufficient to meet its statutory and operational requirements. HQE's six offices have suffered a 15% loss of staff positions in the past three years, with the greatest impact felt in the Los Angeles office. Senior managers presently contend that HQE does not have "a sufficient number of experienced and able [DAGs]" to meet the statutory mandate of Government Code section 12529, especially in HQE's Los Angeles office as a function of the loss of six DAG positions since early 2002. The overall HQE staffing picture is similar: inadequate DAG staff to move all MBC cases rapidly to conclusion. Reduced staffing in key locations (most critically in the Los Angeles office) has resulted in unacceptable delays in case pleading and litigation, and insufficient opportunities for remaining DAG and SDAG staff to engage in training and mentoring of newer attorneys.

3. Attorney/investigator coordination and teamwork is inadequate. Notwithstanding good faith efforts, the current system linking HQE prosecutors with MBC investigators is characterized by inadequate coordination and teamwork. HQE prosecutors generally receive "hand-off" cases which have been investigated and assembled with little or no input whatsoever from the HQE trial prosecutor who will handle the case. Although the DIDO program has provided a varying measure of additional HQE legal input into the investigative process, most HQE prosecutors still complain that they do not play a role in shaping the cases they receive or the investigative plans and strategies behind them, leading to frequent problems of late changes in case focus, amended pleadings, and lengthy delays while cases are re-evaluated and re-investigated. Complex medical cases continue to evolve as the litigation develops, and HQE DAGs today do not have significant investigator assistance with crucial follow-up or adequate assistance from the investigating officer during the pre-hearing and hearing process.

The principal discussion of the present HQE and MBC case coordination relationship is found above in the "Field Investigations: District Offices" section of this Executive Summary, and that section is incorporated here.

The DIDO compromise and the vertical prosecution alternative. From the perspective of the trial attorneys in HQE assigned to try these cases, it is clear that the Legislature's compromise on the preferred vertical prosecution model proposed in 1990, which is codified in Government Code section 12529, offers at least some of the benefits of vertical prosecution, but has not produced the

true teamwork system required for optimal efficiency and effectiveness. The DIDO program is certainly better than the prior "hand-off" situation in which investigators lacking any legal guidance whatsoever were investigating cases and handing them off to a prosecutor who lacked any investigative assistance and who had no role in guiding the investigation prior to the "hand-off."

However, DIDO has many flaws and has not yielded the benefits a true vertical prosecution system would provide. The present DIDO program is widely perceived as inefficient and even a wasteful use of the DIDO DAG's time, coming as it does at the cost of depriving HQE of a line prosecutor without creating a true case team. And HQE personnel correctly perceive that DIDO is not implemented uniformly throughout the state. And this only worsens the existing measure of confusion among HQE attorneys and MBC investigators and supervisors as to the chain of command and the roles of the participants.

HQE attorneys agree that the DIDO program does not enable the trial attorney to invest in a case from the first day or guide its investigation, and thus most of the efficiencies and advantages of a true team approach to this casework are lost. The overwhelming consensus among HQE attorneys and supervisors favors the full implementation of the vertical prosecution model in which an attorney/investigator team is formed at the inception of an investigation and works together to the case's conclusion.

4. Attorney assistance is not used sufficiently in MBC's medical records procurement process. HQE prosecutors are seldom used for subpoena enforcement actions and most DAGs make little or no use of section 2225.5 sanctions for failure to produce medical records, notwithstanding strong statutory authority and supporting case law. As a result of this infrequent use of these enforcement tools, doctors and their lawyers pay little attention to section 2225.5 sanctions because they are generally aware of the infrequent enforcement of these sanctions, and because the potential sanctions exposure is comparatively modest in light of most doctors' incomes. Serious delays in medical records procurement are pervasive in the 1800-plus investigations handled each year, making it difficult to understand how the modest level of subpoena enforcement and sanctions actions is sufficient to address this problem each year.

5. HQE and MBC make inadequate use of their ISO/TRO powers and the Penal Code section 23 authority. When MBC identifies a physician who is an imminent danger to the public if he continues to practice medicine, it is authorized to seek interim remedies to protect the public, including interim suspension orders (ISOs), temporary restraining orders (TROs), and probation order proceedings under Penal Code section 23. MBC's enforcement output statistics indicate a troubling decline in the efforts to use the powerful ISO/TRO authority in the recent past. ISOs/TROs sought by HQE on behalf of the Medical Board diminished from a high of 40 in 2001–2002 to 26 in the 2003–04 fiscal year (a decline of 40%). Given the importance of these public safety circumstances, a decline in the use of these tools is a source of concern to the Monitor.

6. Needed improvements in HQE case tracking and management information systems have begun and must be properly implemented. The Attorney General's Office as a whole has long been subject to criticism for its outdated and antiquated management information system. To address these concerns, the Attorney General has installed the long-awaited ProLaw management information system. Implementation of ProLaw is still in its gestational stage, and at this early point even the staff of the Attorney General's Office is unclear as to what kind of management reports it can produce and/or what kind of information they must input in order to generate those reports. At the very least, there is a clear consensus that this long-overdue update to the AG's management information system is necessary and must be fully implemented.

7. HQE has no formal policy and procedure manual to ensure uniformity and assist in training. HQE presently has no formal policy and procedure or operations manual in place regarding its functions and process. This leads to diverging policies and inconsistencies among HQE offices. In addition, most training in HQE for new DAGs appears to be infrequent and informal, with the majority of the guidance provided by SDAGs and more experienced HQE staff on an *ad hoc* and verbal basis as questions arise. Anticipated loss of institutional memory and practical trial experience could be compensated for, to at least some extent, by a properly drafted policy and procedure manual which preserves the benefits of that experience.

8. The current venue statute for adjudicative hearings results in substantial and unnecessary costs for HQE, OAH, MBC, and — ultimately — disciplined physicians and the physician population generally. Government Code section 11508 generally assigns the venue for administrative hearings to the judicial district in which the transaction in question occurred or where the respondent resides. This statute frequently requires the costly scheduling of administrative hearings in cities in which HQE and OAH have no office facilities. Requiring adjudicative hearings to be held in cities in which HQE and OAH already have office facilities will substantially lessen costs for MBC, and in many cases for the respondent as well.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #33: MBC and HQE should fully implement the vertical prosecution model. As described in related Recommendation #22 above, full implementation of the vertical prosecution model — in which an attorney/investigator team is formed at the inception of an investigation and works together to the case's conclusion — would greatly improve the efficiency and effectiveness of HQE's prosecution efforts and MBC's enforcement process as a whole. The Monitor believes the vertical prosecution system could best be implemented by merging existing MBC investigators and supervisors into HQE. However, this system could be otherwise effectuated through coordinated assignments to case teams by the respective agencies.

Recommendation #34: MBC and HQE must revise their medical records procurement and enforcement policy to ensure prompt and full compliance with existing laws, and the role of HQE attorneys in medical records procurement issues should be expanded. As described in related Recommendations #7 and #23, HQE and MBC should adopt and strictly enforce a comprehensive medical records procurement policy which is consistently applied in all MBC enforcement cases.

Recommendation # 35: The Attorney General's Office should come into full compliance with Government Code section 12529 *et seq*. by adequately staffing HQE to restore lost attorney positions and to fulfill all missions required by these statutes.

Recommendation #36: MBC and HQE should improve their cooperation with state and local prosecutors, including increased use of Penal Code section 23.

Recommendation #37: MBC and HQE should make better and more extensive use of the powerful interim suspension order and temporary restraining order tools.

Recommendation #38: HQE should develop a formal policy and procedure manual to improve consistency and assist in prosecutor training.

Recommendation #39: Government Code section 11508 should be amended to locate venue for HQE administrative hearings in the cities of Sacramento, Oakland, Los Angeles, and San Diego. The statutory presumption should be that these hearings are to take place in large-city locations in which HQE and OAH already have offices.

HEARINGS: MEDICAL QUALITY HEARING PANEL

A. General Description of Functions

The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state agency adjudicative hearings in a variety of areas. OAH currently employs a director, four presiding judges, and 34.4 ALJs based in four California cities (Sacramento, Oakland, Los Angeles, and San Diego). A special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH in 1990's SB 2375 and refined in 1993's SB 916. The purpose of the creation of the MQHP is to enhance the expertise and independence of the ALJs who preside over physician discipline hearings. MQHP ALJs specialize in physician discipline matters, may be required to have medical training, and are afforded assistance by panels of independent experts who may be called as witnesses by the ALJ to testify on the record about any matter relevant to a proceeding and subject to cross-examination by all parties. MQHP ALJs are

authorized to entertain motions for and issue interim suspension orders restricting or suspending the license of a physician pending the conclusion of the disciplinary matter, as an alternative to the temporary restraining order remedy in superior court.

Evidentiary hearings on accusations filed by MBC are presided over by an MQHP ALJ. During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument. Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline. At the Board's request, the ALJ may also recommend that the licensee pay "cost recovery" to reimburse the Board for its investigative and enforcement costs incurred up to the first day of the evidentiary hearing. The ALJ's ruling is a "proposed decision" which is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision. In recommending discipline, the MQHP ALJ is guided by a set of "disciplinary guidelines" approved by DMQ; these guidelines set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.

B. Initial Concerns of the MBC Enforcement Monitor

Due in part to the 2003 Administration change (and an April 1, 2004 change in leadership at OAH) and in part to the press of other issues that we were required to address in this report, the Monitor did not examine OAH's performance in-depth during the first year of this project. During the second year, we plan to look at the following issues.

1. OAH was impacted by the hiring freeze and budget cuts. OAH was not immune from the October 2001 hiring freeze or the subsequent position "sweeps" and budget cuts. OAH lost two ALJ positions and a number of support staff positions. The OAH Director has stated that these losses have not directly impacted the MQHP, but they have affected the office as a whole. OAH has requested eight new ALJ positions and four support staff positions.

2. The time it takes to schedule and conduct evidentiary hearings is lengthy. An average period of 443 days passes between filing of the accusation and conclusion of the evidentiary hearing — over 14 months. Some of these hearings are one- or two-day matters; others should last weeks but — due to the schedules of the attorneys, respondent, and judge — must be conducted in many non-contiguous blocks over the course of many months. Based on a limited review, it seems that the delay in scheduling and conducting MBC hearings is not due to a shortage of judges or bureaucratic limitations on OAH's part. Instead, it appears that understaffing in HQE's Los Angeles office (which normally files approximately 60% of all accusations in California) and the limited number of defense counsel who regularly defend physicians in MBC disciplinary matters account for much of the delay in scheduling and holding hearings. In OAH's view, it has sufficient MQHP

ALJs to hear cases more rapidly than they are being heard — but they can't, due to a shortage of attorneys in HQE and the limited number of defense attorneys who handle MBC cases.

3. DMQ members perceive that MQHP ALJs are not following MBC disciplinary guidelines. During 2001–02 and 2002–03, DMQ nonadopted an unusually high number of proposed ALJ decisions: 25% in 2001–02 and 28% in 2002–03. Some DMQ members perceive that MQHP ALJs do not follow the Board's disciplinary guidelines when imposing discipline in physician cases. Although the percentage of nonadoptions declined to 16% in 2003–04, the Monitor will attempt to examine whether ALJs are adhering to MBC's disciplinary guidelines.

4. Whether ALJs are receiving medical training as authorized by Government Code section 11371 is unclear. As noted above, one of the ways in which SB 2375 (Presley) and SB 916 (Presley) sought to enhance the expertise of MQHP ALJs was to provide them with medical training "as recommended by the Division of Medical Quality . . . and approved by the Director of the Office of Administrative Hearings." It is unclear whether ALJs are receiving medical training.

C. Initial Recommendations of the MBC Enforcement Monitor

As noted above, the Monitor did not examine OAH extensively during the first year of this project. The Monitor intends to look into the above-described issues and others during the second year of the project, and report on OAH in the next report.

DECISIONS: DIVISION OF MEDICAL QUALITY

A. General Description of Functions

The Medical Board's Division of Medical Quality (DMQ), which consists of fourteen of MBC's 21 members (eight physicians and six public members), is the Board's enforcement arm. DMQ adopts final adjudicative decisions in disciplinary matters against its licensees. Adjudicative or "quasijudicial" decisionmaking, which generally governed by the Administrative Procedure Act (APA), differs fundamentally from all other types of agency decisionmaking. The courts and Legislature have adopted special rules to ensure that the due process rights of the respondent — who stands to lose a vested constitutional property right — are preserved. Of critical importance, the respondent is also entitled to a decisionmaker who is neutral and unbiased, and who decides the matter based upon evidence that has been lawfully gathered and admitted at a public hearing.

DMQ is the final decisionmaker in all MBC disciplinary matters in which an accusation has been filed. However, DMQ does not personally preside over or even attend APA evidentiary hearings; that responsibility is delegated to an administrative law judge (ALJ) from the Office of

Administrative Hearings' Medical Quality Hearing Panel (MQHP), who presides over the hearing and prepares a proposed decision (PD) for DMQ's review. Nor does DMQ negotiate the terms of stipulated settlements that avoid an evidentiary hearing; that responsibility is delegated to its counsel (HQE) and its staff, who negotiate proposed settlements with the respondent and his/her counsel and present them to DMQ for review. DMQ reviews all proposed case dispositions that follow the filing of an accusation — including all PDs (including ALJ recommendations that an accusation be dismissed), stipulated settlements, license surrenders, and default judgments. In APA jargon, DMQ is authorized to "adopt" or "nonadopt" proposed case dispositions; in so doing, it is the final judge in the disciplinary matter. It makes the final agency decision which is then subject to judicial review. It is also authorized to reconsider its own decisions before they become effective, either on its own motion or upon a petition filed by one of the parties.

DMQ panels review and act upon an average total of 54 PDs and 195 stipulated settlements each year. DMQ adopts most PDs (84% in 2003–04) and approves most stipulations (95% in 2003–04). The Division reviews and acts on approximately 20 petitions for reconsideration each year. In 2003–04, DMQ reviewed and reached a final decision on most PDs within 30 days (with the exception of the cases it nonadopted).

B. Initial Concerns of the MBC Enforcement Monitor

1. The added value of DMQ review of proposed decisions is unclear. In 1989, *Code Blue* argued that DMQ review of proposed decisions should be eliminated in favor of permitting the ALJ to make the final agency decision based on the agency's disciplinary guidelines and subject to a petition for judicial review by either side. Legislation to implement this concept was unsuccessfully attempted in 1989, 1990, and 1993. The prior attempts to eliminate DMQ review of proposed decisions were intended to achieve two goals: (1) streamline the decisionmaking process to expedite it for the benefit of both the respondent and the public; and (2) create a limited number of decisionmakers who have both subject matter expertise and independence from the profession — as opposed to perpetuating a time-consuming and expensive system with layer after layer after layer of decisionmakers who are sequentially required to learn the details of a disciplinary matter. These twin touchstones — subject matter expertise and independence — have formed the foundation of prior proposals to permit the administrative judge who has presided over the hearing to make the final agency decision (subject to a petition for judicial review by either side).

DMQ panel members who are reviewing a proposed decision in an adjudicative matter have only the proposed decision. They have no access to the evidence presented at the hearing, including expert testimony. They were not present at the hearing and had no opportunity to observe the witnesses, their credibility and demeanor, or the evidence. They are not judges and generally have no familiarity with the rules of evidence or administrative procedure. They may not have any

familiarity with the subject matter of the particular case, usually have no idea how similar cases have been decided, and usually consist in majority of people in the same profession or trade as the accused licensee. While some DMQ members may have medical expertise, it is not always "on point" expertise relevant to the specialty at issue. And the fact that many DMQ members are physicians judging other physicians leaves MBC open to a "perception" criticism that some of its members may empathize with the respondent.

In contrast, the judge was at the hearing and has seen and heard the witnesses, received all the documentary evidence, and heard the expert testimony submitted by both sides. The judge specializes in physician discipline matters and is familiar with the rules of procedure and evidence in administrative proceedings. The judge has both knowledge of the evidence and is independent of the profession — the twin touchstones that are most important in making a decision that is consistently fair and in the public interest. And if the judge makes a mistake — as judges sometimes do — that case will go to court more quickly and at less cost for both the agency and the respondent.

Historically, DMQ nonadopts very few proposed decisions, and rejects very few stipulations. The time DMQ must spend on fact-finding in individual cases leaves less time for other kinds of decisionmaking that is vitally needed and to which the members are better suited. The cost of the current system — including time, money, and lost opportunity costs — seems to outweigh the system's output: the nonadoption of very few proposed decisions and the rejection of very few stipulations.

2. The consistency of DMQ decisionmaking is unclear. DMQ decisionmaking is fragmented. DMQ is split into two panels, neither of which knows of the other's decisionmaking in similar cases. DMQ membership is constantly shifting and changing. There is little or no *stare decisis* — the legal doctrine under which courts adhere to precedent (prior decisionmaking in similar cases) on questions of law in order to ensure certainty, consistency, and stability in the administration of justice — in administrative agency proceedings. Although Government Code section 11425.60 permits DMQ to designate all or any part of a disciplinary decision as a "precedent decision" to promote consistency in decisionmaking, encourage settlements, and avoid costly litigation, DMQ has made no use of its "precedent decision" authority.

3. The procedure utilized at DMQ oral arguments is flawed. When DMQ nonadopts a proposed decision, it is required to afford the parties an opportunity for oral argument before making its final decision. DMQ's oral argument proceedings are most unusual. The usual reason for a nonadoption is that DMQ is considering a harsher penalty than that recommended by the ALJ; thus, the respondent physician is turned into a petitioner. That respondent must be mystified when he arrives at the hearing to find that the Board is represented by its own counsel — HQE. In effect, the "client" hears argument from its own counsel, with which it frequently interacts and upon whom it depends for legal advice on a myriad of matters.

MBC regulations require an ALJ to preside over oral arguments, to ensure that someone legally trained is available to rule on evidentiary objections, require counsel and the respondent to stick to evidence that was admitted at the hearing, and control the proceeding. However, the ALJ presiding over oral argument cannot be the same ALJ who presided over the hearing and whose decision was nonadopted in the matter at issue; so the ALJ presiding at oral argument necessarily has little or no knowledge of the sometimes voluminous record in the underlying matter. The required presence of the ALJ adds more expense to this process, and interrupts the hearing schedule of that MQHP ALJ. The respondent must be given an opportunity to address DMQ; however, neither the statute nor the regulations require that the respondent be put under oath when he makes a statement or answers questions. Respondents sometimes stray from the record and/or the topic at hand, and are subject to objections. Well-meaning DMQ panel members often ask questions outside the record, and are subject to more objections. This entire process and its attendant costs could be obviated if the original ALJ's decision were designated as the final decision.

4. DMQ's procedures on motions for a stay in order to seek reconsideration appear unfair. Some defense counsel we interviewed complained that their motions for a short stay of the effective date of a disciplinary decision are "always denied," while HQE's motions for a stay are "always granted." In addition, they argued that MBC's Enforcement Chief (and not the DMQ panel) rules on motions for stay — which is why HQE motions for stay are "always granted" and defense motions for stay are "always denied." Although it appears MBC is within the law in permitting its Enforcement Chief to rule on motions for stay, the Monitor agrees with defense counsel that this appears to be a rather one-sided procedure wherein a representative of the prosecutor is able to make decisions affecting the final outcome of a disciplinary matter.

5. DMQ does not notify both parties if it rejects a stipulated settlement. Defense counsel also complained that when DMQ rejects a stipulated settlement, it notifies only the HQE DAG and not the defense attorney. Sometimes it takes a lengthy period of time for the HQE DAG to contact the respondent's counsel to convey the information that a stipulation has been rejected — during which time respondent's counsel has no information on the fate of his client.

C. Initial Recommendations of the MBC Enforcement Monitor

<u>Recommendation #40</u>: DMQ should engage in a public dialogue on the value and costs of DMQ review of proposed decisions and stipulated settlements. The defense bar and the California Medical Association are concerned about the fairness and consistency of both DMQ decisionmaking and the procedures that result in DMQ decisionmaking.

<u>Recommendation #41</u>: MBC should explore its "precedent decision" authority under Government Code section 11425.60 and begin to make use of it. A well-written legal ruling that

represents the will of the Division can guide licensees, HQE, respondent's counsel, and OAH, and will serve to encourage consistency in subsequent decisionmaking, promote settlements in similar cases, and avoid the time and cost of litigation.

Recommendation #42: DMQ should address the procedural issues raised by defense counsel related to motions for a stay of the effective date of a disciplinary decision in order to file a petition for reconsideration. To preserve both the appearance and actuality of fairness to all parties, MBC enforcement staff should not rule on these motions.

Recommendation #43: Government Code section 11371(c) should be repealed. Section 11371(c), which required OAH to publish a compilation of all MQHP ALJ decisions in order to promote consistency in decisionmaking, has been superseded by Government Code section 11425.60.

Recommendation #44: DMQ should notify counsel for both HQE and the respondent when it rejects a stipulated settlement.

Recommendation #45: Business and Professions Code section 2230(b) should be amended to reflect SB 1950's addition of two new members to DMQ.

JUDICIAL REVIEW OF DMQ DECISIONS

A. General Description of Functions

A physician whose license has been disciplined may seek judicial review of MBC's decision by filing a petition for writ of mandate (also called a "writ of administrative mandamus") in superior court under Code of Civil Procedure (CCP) section 1094.5. Under MBC's unique venue statute, a writ challenging DMQ's disciplinary decision may be filed in any city in which the Board has an office.

In conducting its review of the agency's decision, the superior court reviews the record of the administrative hearing (including the transcripts of the testimony that was presented at the hearing and the exhibits that were introduced). Generally, the focus of the court's review is to determine whether the agency's findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency's discretion or constitutes an abuse of that discretion. If the court determines that the findings and conclusions are supported by the weight of the evidence and that the Board acted within its discretion, the court will uphold MBC's decision and deny the petition. If not, the court can grant the petition in part (with respect to those findings it does not find

supported) and deny the petition in part (affirming those portions of the decision which it concludes are supported by the weight of the evidence). The court can also grant the petition altogether, explaining how the findings are not supported by the evidence, the conclusions are not supported by the findings, or how — in its opinion — the penalty constitutes an abuse of discretion. Whenever a petition is granted in whole or in part, the matter is remanded to the Board for further proceedings consistent with the court's ruling.

Either side may challenge the superior court's decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal. If the appellate concludes the petition lacks merit on its face and does not believe additional briefing would be helpful, it may summarily deny the writ on the merits, thus obviating the need for oral argument and a written opinion. In most instances, however, the court issues an alternative writ. When an alternate writ is issued, the parties engage in full briefing, the court entertains oral argument, and it issues a written decision. The appellate court determines whether the superior court's findings are supported by substantial evidence and are correct on matters of law. The appellate court's decision may be appealed to the California Supreme Court. Such review is entirely discretionary and is rarely attempted or granted.

B. Initial Concerns of the MBC Enforcement Monitor

1. MBC's venue statute is encouraging "forum-shopping" and inefficient use of judicial resources, and is unnecessarily costing HQE and MBC substantial amounts of money every year. Under Business and Professions Code section 2019 (which is unique to MBC), a respondent unhappy with a DMQ disciplinary decision may file a petition for writ of mandate in San Diego, Los Angeles, Sacramento, or San Francisco — regardless of where the administrative hearing was held and regardless of where the HQE DAG who prosecuted the case works. This has led to apparent "forum-shopping" on the part of defense counsel in search of a sympathetic judge. This practice is resulting in the inefficient use of judicial resources — overburdening one court disproportionately while other courts are relatively unused by MBC petitioners. Additionally, it is costing MBC and HQE thousands of additional dollars to fly HQE DAGs all over the state for writ hearings.

2. MBC is inappropriately subsidizing the cost of the preparation of administrative hearing transcripts for writ proceedings. When a licensee files a CCP section 1094.5 petition for writ of mandate challenging a DMQ disciplinary decision, that petitioner must request the record of the administrative proceeding from the Office of Administrating Hearings. Under section 1094.5, "[e]xcept when otherwise prescribed by statute, the cost of preparing the transcript shall be borne by petitioner." However, due to the interaction of CCP section 1094.5 and Government Code section 69950, the petitioner generally pays only about one-half of the actual cost of the preparation of the transcript, and MBC is billed for the rest. MBC's underwriting or cross-subsidization of the cost of the preparation of the record in writ of mandate proceedings — to the tune of thousands of

dollars per transcript and many more thousands of dollars each year — is unnecessary and particularly inappropriate in light of its current financial plight.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #46: Business and Professions Code section 2019 should be amended to require legal proceedings challenging the Board's decision following an administrative hearing to be instituted in Sacramento, San Francisco, Los Angeles, or San Diego — whichever is closest to where the administrative hearing was held.

Recommendation #47: Government Code section 11523 should be amended to eliminate the reference to Government Code section 69950 and instead require the petitioner to pay the actual cost of the transcript up front.

PUBLIC DISCLOSURE

A. General Description of Functions

In addition to removing incompetent, negligent, dishonest, and impaired physicians from the marketplace through its enforcement program, another way in which MBC implements its "paramount" public protection priority is by disclosing licensee information to the public, to enable consumers to make informed choices when selecting a health care practitioner. The Board's public disclosure policy is an important complement to its enforcement program. This report describes many limitations on the Board's ability to protect the public through its enforcement program — including limitations that are within its control and others that are beyond its control. As a result of these flaws, it is unreasonable to expect that MBC will be able to promptly excise all dangerous physicians from the marketplace. Even assuming these flaws are addressed and resolved, consumers are simply entitled to information about the people to whom they are entrusting the health and lives of themselves and their families. It is thus reasonable to expect MBC, as a complement to its enforcement program, to provide consumers with true, accurate, and complete information about its licensees so they can make informed choices and protect themselves from physicians with whom they would prefer not to deal.

Chapter XIII describes legislation that has expanded MBC's public disclosure policy since 1993, when it disclosed nothing but its own disciplinary decisions against physicians. Today, MBC discloses "public information" on physicians in two ways: (1) Under sections 2027 and 803.1, MBC makes use of the Internet to disclose a variety of information on California physicians, including the status of the license (and whether it is subject to an ISO, TRO, or has been revoked, suspended, put on probation, or restricted by MBC — including limitations that are part of a probationary order or

stipulation); prior disciplinary action taken by other state medical boards; felony convictions reported to MBC after 1991; current accusations filed by HQE; malpractice judgments and arbitration awards reported to MBC after 1993; hospital peer review actions that resulted in termination or revocation of privileges; public letters of reprimand; and infractions, citations and fines. In 2002, SB 1950 authorized MBC to disclose on the Internet some medical malpractice settlements. Most categories of information disclosed on the Internet are disclosed for a ten-year period; a few are disclosed indefinitely. (2) MBC discloses other "public information" that is not subject to Internet disclosure in response to specific request or a formal Public Records Act request. MBC does not disclose other "public information" (including misdemeanor criminal convictions and some civil malpractice settlements) at all; consumers may obtain this "public information" at county courthouses.

B. Initial Concerns of the MBC Enforcement Monitor

1. The fragmented tangle of overlapping statutes frustrates the purpose of MBC's Web site, unnecessarily exposes MBC to litigation, and results in the disclosure of different information depending on the mode of inquiry. One important purpose of MBC's Web site was to provide the public with easy access to all public information about California physicians. However, that intent has been frustrated by the language of the statutes themselves. As a result of the interaction of many statutory provisions, there are essentially four categories of "information" on physicians and three ways to obtain some (but not all) of it — and one receives different information depending on how and who one asks. The statutes appear to contain internal inconsistencies, inadvertent drafting errors, and other problems that are exposing MBC to costly litigation. The better approach may be to draft clean-up amendments that harmonize the various provisions and ensure that all "public information" known to the Medical Board is posted on its Web site.

2. SB 1950's civil settlement disclosure provision has had minimal effect. For the first time, 2002's SB 1950 authorized MBC to disclose some civil malpractice settlements. MBC must classify physician specialties as "high-risk" or "low risk," and may disclose three or more civil settlements against a "low-risk" physician and four or more civil settlements against a "high-risk" physician if the requisite number of settlements is agreed to within a ten-year period. MBC is not permitted to disclose the actual dollar amount of a settlement, but instead must classify it as "above average," "average," or "below average" as compared to other settlements agreed to by physicians in the same specialty during the prior ten years. Additionally, when it discloses civil settlements, the Board is required to attach a lengthy disclaimer mandated in section 803.1(c). In almost two years since SB 1950 became effective, the Medical Board has disclosed civil malpractice settlements on a grand total of seven physicians — all of whom have agreed to four or more settlements since January 1, 2003.

It is unclear why consumers are deprived of information on civil settlements, which are increasingly public information since the Judicial Council adopted rules prohibiting the sealing of court records in 2001. Civil malpractice settlements are reached in the context of a public judicial proceeding financed with taxpayer money in which the physician has every opportunity to be represented by counsel and to reject the settlement — and the proceeding pertains to the physician's professional performance (and not to his personal life). Most importantly, insurers, hospitals and HMOs, and the Board itself demand, obtain, and rely upon a physician's complete malpractice history before determining whether to ensure, grant privileges to, or license that physician. Only consumers are left in the dark.

3. MBC is not authorized to disclose misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician. Since 1993, MBC has disclosed felony criminal convictions against physicians. However, it has never disclosed misdemeanor criminal convictions — including those convictions which were originally charged as felonies and/or "wobblers" but were pled down to misdemeanors. Conviction of a misdemeanor that is substantially related to the qualifications, functions, and duties of a physician is grounds for disciplinary action. A misdemeanor criminal conviction is either an admission or a finding by a jury or court — beyond a reasonable doubt — of the commission of an act which has been categorized as a crime by the Legislature. Further, a misdemeanor criminal conviction is public information.

4. MBC is not disclosing all significant terms and conditions of probation on its Web site. Although state law requires MBC to post information about "probations" and "limitations" on its Web site, the Board does not consistently do so — due in part to limitations imposed by its CAS computer system. MBC is working to resolve this issue by revamping its Web site to afford online access to public documents — including all terms and conditions of probation.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #48: Sections 2027 and 803.1 should be consolidated and harmonized to implement the purposes behind AB 103 (Figueroa)'s creation of MBC's Web site: "allowing the public easy access to important information about physicians, particularly in the area of medical negligence . . . ." The fine-tuning of these two sections would also eliminate drafting errors and inconsistencies between the two statutes that have caused confusion and expensive litigation; save MBC time and money by ensuring that most public information is posted on the Board's Web site; and ensure that information disclosed to consumers by MBC is consistent and accurate regardless of the way in which the consumer asks for it.

Recommendation #49: All medical malpractice settlements exceeding $30,000 should be disclosed on MBC's Web site with the disclaimer currently required in section 803.1(c).

Subsequent experience has now shown that the compromised reached in 2002 — which has resulted in the disclosure of the settlements of only seven physicians — is not a "publicly credible program of public disclosure" as demanded by the Board and the JLSRC in 2002. Especially in light of the fact that all other stakeholders demand and rely on a physician's complete malpractice history, MBC's disclosure of medical malpractice settlements should be expanded.

Recommendation #50: All misdemeanor criminal convictions substantially related to the qualifications, functions, and duties of a physician should be disclosed on MBC's Web site. As recommended by the Federation of State Medical Boards, these "substantially related" criminal convictions should include "misdemeanors involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol, and violations of public health and safety codes."

Recommendation #51: MBC should disclose all significant terms and conditions of public probation orders on its Web site. MBC should continue in its efforts to revise its Web site so that consumers can access public documents — including complete Board disciplinary decisions and stipulations that set forth all significant terms and conditions of probations.

Recommendation #52: Section 2027 should be amended to permit MBC to disclose the resignation or surrender of hospital privileges after the hospital has notified the physician of an impending investigation under section 805(c). The number of disclosable section 805 reports has dwindled significantly to six in 2003–04, such that the intent behind section 2027(a)(6) — public disclosure of serious peer review actions — is being defeated.

PUBLIC EDUCATION AND OUTREACH

A. General Description of Functions

In 2002, MBC created a Public Education Committee (PEC), whose goals are to (1) increase the number of Californians who know of the existence of the Board and its enforcement program by bringing together representatives of organizations to develop better ways of communication, and (2) encourage officials and entities that are required to report certain information to the Board to do so. Under PEC's guidance, MBC uses a number of methods — including its Web site, its *Action Report* licensee newsletter, speeches and presentations, brochures and fact sheets, and the media — to educate and communicate with consumers, licensees, mandated reporters, prospective expert reviewers, and other stakeholders regarding the Board's enforcement program. Additionally, the enforcement program is responsible for communicating with complainants and complained-of physicians during complaint processing and investigations.

B. Initial Concerns of the MBC Enforcement Monitor

1. Physicians are not required to provide patients with information about the existence of the Board and its disciplinary jurisdiction. Other California regulatory agencies — including healthcare-related agencies — require their licensees to provide some form of notice to clients, patients, and customers about the existence and jurisdiction of the regulatory agency. The Medical Board has not implemented such a requirement. Data collected for this report reveal that many patients who are injured by physicians do not file a complaint with the Medical Board, thus thwarting the Board's ability to protect future patients. The Monitor believes that, as a matter of sound public policy, the Medical Board should make better efforts to meet its obligation to assist victims of medical wrongdoing in understanding how to be involved with its enforcement program.

2. The Board does not communicate consistently with physicians during the complaint review and investigative process. MBC has made a concerted and apparently successful effort to improve its communications with complainants throughout the complaint handling process. Its communications with subject physicians seem less consistent.

3. MBC should communicate with local county medical societies about their obligations under Civil Code section 43.96. This provision requires medical societies, hospitals, and local government agencies that receive a written complaint against a physician to affirmatively notify the complainant that they have no jurisdiction over the physician's license and that only MBC may discipline a physician's license. MBC should ensure that these entities — which consumers often confuse with the Medical Board — are not filtering meritorious complaints away from MBC's enforcement program.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #53: Physicians should be required to inform patients about the Medical Board's existence, disciplinary jurisdiction, address, and toll-free complaint number. MBC should implement a system to ensure that its licensees inform the patient public about its existence and enforcement role. Physicians could be given a variety of options to accomplish this consumer education — for example, a fact sheet, a posted waiting room notice, or a disclosure on a discharge summary, invoice, or other document routinely given to patients.

Recommendation #54: As suggested in related Recommendation #20, MBC's enforcement program should ensure that complained-of physicians are appropriately notified of complaint dispositions.

Recommendation #55: MBC should periodically communicate with local county medical societies and remind them of their obligations under Civil Code section 43.96, to ensure that those private organizations are properly referring complainants to the Medical Board.

MBC'S DIVERSION PROGRAM

A. General Description of Functions

Created in 1980, the Medical Board's Diversion Program "diverts" substance-abusing physicians out of the enforcement program described above and into a program that is intended to monitor them while they attempt to recover from the disease of addiction. The Diversion Program designs a contract that includes terms and conditions of participation for a five-year monitoring period, including random bodily fluids testing, required group meeting attendance, required worksite monitoring, and often substance abuse treatment and/or psychotherapy. Those who comply with the terms and conditions of their Diversion Program contract may be "successfully terminated" from the Program after three years of continuous sobriety. Those who violate the terms and conditions of their Diversion Program contract may be "unsuccessfully terminated" from the Program and referred to the enforcement program for disciplinary action. During their participation in the Program, these physicians generally retain their full and unrestricted license to practice medicine, and many of them are in fact permitted to practice medicine subject to the terms and conditions of their contracts. Many of them participate in absolute confidentiality — their participation in the Diversion Program is secreted from the Board's enforcement program, their patients, and the public.

The Diversion Program is a *monitoring* program, not a treatment program. It does not provide substance abuse treatment; its staff are not authorized or trained to do so. Instead, it evaluates the needs of its participants; provides a rehabilitative plan that directs them to treatment — including inpatient detoxification, medical and psychiatric evaluation, and psychotherapy, as appropriate; monitors their compliance with the terms and conditions of their contract with the Program; and is authorized to terminate them from the Program (and refer them to the enforcement program) if they do not comply.

DMQ is responsible for administering the Diversion Program. In 2000, MBC created a standing Committee on the Diversion Program to oversee the Program; the Committee meets quarterly and makes recommendations to DMQ.

The Diversion Program is staffed by ten employees, including a Program Administrator, five regional case managers (CMs) responsible for ensuring that participants in their geographic area comply with the terms and conditions of their Diversion Agreement, and four support staff in Sacramento (including a "Collection System Manager" (CSM) who is responsible for overseeing the

Program's urine testing system). These employed staff are assisted by 13 "group facilitators" (GFs) based throughout the state; GFs facilitate biweekly group meetings of Diversion Program participants in their community. Additionally, approximately 30 local businesses across the state serve as urine specimen collectors for the Diversion Program. Pursuant to a random schedule generated by the CSM, these collectors are expected to conduct observed urine collections on the dates specified and to immediately transmit the specimens to a Program-approved laboratory for testing. Lab test results are emailed to the CSM and downloaded to each participant's file in the Program's computerized Diversion Tracking System (DTS).

Other external guidance is provided to the Diversion Program in the form of Diversion Evaluation Committees (DECs), regional five-member panels that meet with applicants to the Diversion Program and advise the Program Administrator whether the applicant should be accepted and on appropriate terms and conditions of the Diversion Agreement (including practice restrictions). The DECs act in an advisory capacity to the Program Administrator. Finally, an external "Liaison Committee to the Diversion Program" (LCD) created by DMQ and CMA in 1982 consists of physicians and other licensed professionals whose careers are dedicated to substance abuse detection, treatment, and rehabilitation; the LCD is intended to bring clinical expertise and external information to DMQ and the Medical Board staff who administer the Diversion Program.

As the Diversion Program has not been externally audited in 18 years, SB 1950 (Figueroa) directed the Enforcement Monitor to examine the Program. As such, Chapter XV provides detailed information on the methodology used by the Monitor in determining whether the Program is functioning consistent with its statutes, regulations, and procedure manuals. Chapter XV also describes the statutory purpose of the Program; its structure, staffing, and funding; and the functioning of the Program and its various monitoring mechanisms intended to detect relapse or pre-relapse behavior. Chapter XV also describes prior audits and studies of the Diversion Program, including a series of three audits by the Auditor General in the 1980s which found significant deficiencies with the Program's monitoring of substance-abusing physicians and with the Medical Board's failure to properly oversee and administer the Program.

B. Initial Concerns of the MBC Enforcement Monitor

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary

purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are random urine screening requirements, case manager attendance at required group meetings, required worksite monitoring, and regular reporting by treating psychotherapists. All of these monitoring mechanisms are failing the Program and the public, and the Program lacks internal quality controls that would otherwise enable staff to detect these failures. As a result, Program staff and oversight authorities are unaware of the deficiencies that exist in the Program and falsely assume that the Program is effectively monitoring participants when it is not.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means for monitoring participants' sobriety and detecting relapses. Available data suggest that more than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major objective measure of participant compliance with the terms of the contract and with the Program's requirements. However, the results of our review suggest that the confluence of various deficiencies in the current system delays the Program's detection of participant relapses (in some cases for an extended period of time) or prevents that detection entirely. In our view, these deficiencies seriously undermine the integrity of the major objective measurement of participant compliance, and may expose the public to unacceptable risk.

Specifically, there are not sufficient positive controls on the current collection system to provide assurance of six major components: (1) all active participants are included in the master collection schedule generated by the CSM; (2) the participant is scheduled for the correct number of tests per month pursuant to the Diversion Program's "frequency of testing" policy; (3) collections are actually completed on the random date assigned by the CSM; (4) the same number of collections is completed as is scheduled for each participant; (5) collected specimens are received at and processed by the laboratory; and (6) test results are correctly downloaded and appended to each participant's record in the DTS. Due to the absence of sufficient positive controls over the scheduling and collection process, participants can be tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there is a problem. Also, test results may be inadvertently appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there is a problem. All of these events have occurred. Specifically, we found significant defects in four areas of the Diversion Program's urine collection system:

(A) Collection scheduling process deficiencies. In this area, we found that new participants are not always promptly scheduled for urine collections. Although the Program assures the public of "immediate drug testing," our review of 20 recently completed intakes suggests that about 25%

of new participants are not promptly scheduled for any collections (or tested) for a period of at least a month following completion of their intake interview — and most of these participants are permitted to practice medicine. Further, urine collections are not always promptly restarted when a participant completes treatment following a relapse; our review of 20 recent relapse cases identified four cases where urine collections were not promptly restarted following completion of treatment. Finally, the CMs and local urine collectors are undermining the integrity of the Program's random urine testing schedule by failing to ensure that the CSM is notified of the need to add new participants to the random urine collection scheduling system. Our review of 20 recently completed intake cases identified nine cases — almost 50% of the cases we reviewed — where the participants were not randomly scheduled for collections through the CSM for periods ranging from one month to as many as four months following completion of their intake interview or, if applicable, release from treatment. When a participant is not scheduled for testing through the CSM, the case manager and/or collector unilaterally determine when to test the participant. The practice of ignoring or repeatedly overriding the random collection schedule generated by the CSM undermines the integrity of the random collection scheduling system.

(B) Specimen collection process deficiencies. Here, we found that collectors do not usually obtain urine specimens on the dates specified in the CSM's master collection schedule. We compared scheduled collections with actual collections for periods ranging from four to eleven months for each of 20 recently completed intake cases, and found that collections were actually completed on the date that had been scheduled only 40% of the time. There are no controls over many of the changes to the random collection schedule that are made and, in most cases, the reasons for the changes are not documented. Also, collectors disproportionately shift collections from weekend days (Friday, Saturday, and Sunday) to weekdays, particularly Tuesday and Thursday. Among the 20 recently completed intake cases that we reviewed, 22% fewer collections were completed on weekends compared to the number that were scheduled for those days. Significantly more collections were completed on both Tuesdays and Thursdays than were scheduled. The reduced frequency of testing on weekends and increased frequency of testing on Tuesdays and Thursdays potentially enables participants to "game" the system by anticipating when they are least likely to be tested. Finally, we found that collectors do not always make up for collections that are skipped for the convenience of the collector or the participant; as a result, many participants complete fewer collections than are scheduled and required. The systemic rescheduling of collections by case managers and/or collectors raises serious questions about the integrity of the Diversion Program's random collection scheduling system.

(C) Reporting and recordkeeping deficiencies. The Diversion Program's arrangement with the lab calls for positive results to be reported to the Program within 72 hours. However, our review of 20 recent relapse cases identified four cases where positive test results were not reported for timeframes ranging 10 to 14 days after the sample was obtained. In another case, test results were

not reported for as long as 3 to 4 weeks after the sample was obtained. In most cases, reporting delays are attributable to failure by the collector to submit the specimen to the laboratory on a timely basis. Further, there are gaps in the collection records maintained in the DTS. Although DTS is supposed to contain a record of urine test results for all participants from late 2001 to the present, the Diversion Program does not have positive controls to assure that test results are actually received from the laboratory and downloaded to the DTS, test results are appended to the correct participant's DTS file, and the information transmitted from the lab is correct. Finally, the Program requires local urine collectors to file a monthly report detailing the dates of all urine collections on all participants, including the specimen chain of custody number; this monthly report could help Program staff in detecting errors. The Manual also requires local collectors to "cite reasons for adjusting a collection date." However, the vast majority of collectors fail to file monthly reports, and Program staff do not insist on compliance with this requirement.

(D) Urine collection system oversight deficiencies. Program staff do not adequately monitor the collectors. As noted above, collectors appear to have broad discretion to unilaterally modify the collection schedules prepared by the CSM or, in some cases, skip collections altogether. As a result, many participants are not tested on the dates scheduled or are not tested as frequently as required. It is unclear whether Program staff even know these events are occurring. Additionally, Diversion Program staff do not routinely, or even periodically, review individual participant urine collection records. If a positive test is reported for a participant, the case manager initiates consultations with all concerned parties in response to that specific report. However, if no positive test results are reported, Diversion Program staff assume that all required collections have been completed as scheduled, submitted to the laboratory for testing, and reported as negative results. These assumptions are sometimes false. In most cases, specimens are not collected on the dates scheduled and, in many cases, specimens are not collected as frequently as required. In some cases, specimens are not collected at all for extended periods of time and nobody, other than the participant, is aware that this is occurring. Finally, prior to April 2004, the Program had no policy for response to so-called "negative-dilute" test results. Sometimes, participants who have resumed use of drugs or alcohol attempt to "dilute" their urine by ingesting large quantities of liquid. In many cases, negative-dilute test results clearly reflect a participant's efforts to disguise his relapse. Therefore, negative-dilutes should be recognized and addressed immediately. After the Monitor pointed out several instances where a pattern of negative-dilute specimens was followed by a relapse, the Program implemented a new policy to handle negative-dilute test results.

The results of our review suggest that at least several dozen of the Diversion Program's current participants have, at some point, not been tested for an extended period of time when they should have been. The results of our review also suggest that many more participants are not being consistently tested as often as they should be. Nobody currently makes any effort to track or monitor actual collections on a proactive basis for purposes of (1) controlling unapproved changes to the

collection schedule that otherwise might be made for the convenience of the collectors or participants, (2) assuring that the required number of tests is actually completed for each participant, and (3) detecting relapse behaviors in advance or in lieu of actually receiving a positive test result.

To summarize, the Diversion Program today in 2004 is plagued by the same problem found by the Auditor General in 1985 and again in 1986: The Diversion Program cannot guarantee the public that its participants are being tested as frequently as it requires. Focusing specifically on Diversion Program participants who are permitted to practice medicine, about one-half of recent intakes were not tested as often as required during the first one to four months of participation. About 25% of new participants were not tested at all for at least one month following completion of the intake interview. The relapse cases we reviewed indicated that five of the 20 participants who relapsed — all of whom were practicing medicine — were not tested as often as required. The public is exposed to unnecessary risk.

The Monitor alerted Diversion Program and MBC management to the confluence of these problems within the Program's urine collection system in June 2004, and management immediately convened a small working group consisting of two Board members, MBC and Diversion staff, and representatives of the Monitor team. The working group has met three times and is working toward resolution of these problems.

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The Program's case managers represent another "monitoring" mechanism of the Diversion Program. The *Diversion Program Manual* requires case managers to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants. Case managers are required to report their group meeting attendance in monthly reports to the Program Administrator. However, few case managers file monthly reports as required. In August 2004, we looked at the Program Administrator's binders of CM monthly reports for 2003 and 2004. One case manager submitted one monthly report in 2003 and none in 2004, and another submitted no monthly reports in 2003 and two in 2004 — so there is no documentation as to whether they have attended group meetings as required by Program policy. Three other case managers submitted monthly reports fairly regularly during both years; two of those CMs reported attending the meetings of only one or two groups in their locale per month, while the other attended the meetings of five to seven groups per month. The problem of inconsistent or inadequate contact by case managers with participants was identified by the Auditor General in 1982, 1985, and 1986. The problem of inadequate reporting by case managers and inadequate supervision of the case managers by the Program Administrator was identified by the Auditor General in 1985 and 1986. Little has changed.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are "monitored" by non-impaired

physicians. However, the Program has set forth no workable definition of the duties, qualifications, or expectations of a "worksite monitor." Although some Diversion Program materials convey the idea that participants are "supervised" while practicing medicine, that is not the case. There are no requirements that the worksite monitor actually be onsite at the same time as the participant, supervise the participant in any way, or even meet with or talk to the participant. There are no qualifications or criteria for someone functioning as a "worksite monitor"; the monitor is not even required to be a physician. In fact, the Program Administrator stated that, on occasion, the Program is required to approve a physician's office manager — someone who is hired and fired by the participant — as the worksite monitor. Additionally, people functioning as worksite monitors are not consistently filing quarterly reports as required by the Program. The quarterly worksite monitoring reports constitute a promise made by the Diversion Program to the public, and are a key mechanism for communication between the worksite monitors and the case managers. The Program's failure to adequately define the duties, qualifications, and functions of "worksite monitors" and the failure of worksite monitors to submit quarterly reports were identified by the Auditor General in 1982, 1985, and 1986. Little has changed.

(4) Treating psychotherapist reporting is deficient. The Diversion Program assures the public that impaired physicians are also monitored by treating psychotherapists who are required to file quarterly written reports with the Program. However, this monitoring requirement is not being satisfied. Neither the case managers, the Program Administrator, nor the DECs (which annually review all Program participants) are ensuring that quarterly treating psychotherapist reports are filed.

b. The Program is so understaffed that staff could not correct these failures in its monitoring mechanisms even if they knew about them.

There is significant understaffing at all levels of the Diversion Program. During the past ten years, the Program has suffered a 22% increase in participation with no increase in staffing. The Program Administrator is expected to handle functional supervision, program oversight, and program development — a burdensome combination of duties which one person cannot competently handle alone. Beginning in March 2002, the caseloads of some Program case managers were deemed so excessive that Program management curtailed entry into the Program by participants who would be served by those case managers and simultaneously lessened the participant monitoring expected of those case managers. Of particular importance, the Collection System Manager position is significantly understaffed. Although the *Diversion Program Manual* promises a dedicated CSM position responsible for the overall oversight and coordination of the collection system process, the individual currently serving as the CSM is able to spend only about two hours per month on CSM duties.

In our observation and based on our reviews of Diversion Program files, the case managers and the Program Administrator are so overloaded that all they are able to do is react to relapses. The

case managers do not adequately monitor their caseloads, enter all required data in the DTS, or forward all required materials to Sacramento. Neither the case managers nor the Program Administrator were aware of any of the problems we found with the urine collection system described above. The four Sacramento-based support staff cannot possibly keep up with their Program-related work responsibilities (including the calendaring and staffing of all DEC meetings all over the state) plus the work necessary to accommodate the needs of the Diversion Committee, the Liaison Committee, and the Division of Medical Quality. Many issues referred by the Diversion Committee to staff for study — or to the Liaison Committee to be assisted by staff — simply fall through the cracks and are never resolved because of the paucity of analytical staff.

The Program's staff must be significantly augmented. Having said that, the Monitor must emphasize that the mere addition of staff alone will not solve the Diversion Program's problems. As described above, the Program lacks significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. If those monitoring mechanisms fail (as they have), and if there are inadequate internal quality controls to detect that failure (as there are), both the physicians in the Diversion Program and the public whose safety is the "paramount" priority of the Medical Board are exposed to serious risk. It is abundantly clear that the Program has functioned without adequate internal controls for 24 years. These controls must be designed, installed, and adequately staffed.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held. Compounding the failure of its monitoring mechanisms and understaffing problems described above, the Diversion Program is plagued by an almost complete lack of clear and enforceable rules, standards, or expectations to which participants are held. The Diversion Program's decisionmaking is characterized by an unacceptable "case-by-case basis" mentality which promotes inconsistent decisionmaking and serves the interests of neither the participants nor the public.

The Diversion Program's statutes and regulations are skeletal at best, and set forth few enforceable rules, standards, or expectations for either the Program or its participants. None of the monitoring mechanisms described above are mentioned in, much less governed by, statute or regulation. All of these monitoring mechanisms are contained in an unenforceable "procedure manual" that has rarely if ever been scrutinized by DMQ — which is statutorily responsible for administration of the Program — or even the Diversion Committee.

The *Diversion Program Manual* similarly sets forth no clear rules and no mechanisms to ensure standardized and consistent decisionmaking about potentially dangerous physicians. Diversion Program decisionmaking is excessively fragmented. When a relapse occurs, that event (which is detected by the Program days or even weeks after the test) sets in motion a complex and

time-consuming chain of communications between various Program personnel (the CM, GF, the DEC consultant assigned to the participant, and perhaps the entire DEC which may be polled by telephone) and the participant, the lab, the participant's worksite monitor and/or hospital monitor, and the hospital well-being committee. These contributors to the ultimate Program decision, who are already hampered by inadequate recordkeeping, have no clear standards to guide their decisionmaking — a dynamic which can lead to inconsistent decisionmaking. The Program is further hampered by the absence of consistently applied and enforceable rules regarding consequences for relapse, and criteria justifying termination from the Program. Lacking any clear statutory or regulatory guidance, the *Manual* contains one policy regarding relapse, which states that "a participant will be considered for termination when the participant has more than three relapses while in the Program." This "three-strikes-and-you-may-be-out" policy is arguably underground rulemaking and, in any event, is inconsistently applied.

In 1982, the Auditor General detailed six cases in which participants egregiously violated the terms of their Diversion contracts but were not terminated from the Program; according to the Auditor General, "[t]hese deficiencies result from a lack of established standards and guidelines for terminating participants." In 1985, the Auditor General detailed three matters where the participant repeatedly violated significant terms and conditions of the contract and should have been suspended from the practice of medicine and/or terminated from the Program but was not; the Auditor General concluded that the Medical Board must "[s]pecify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination," and "develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly." Twenty years later, DMQ has still failed to establish meaningful and enforceable standards for the handling of relapse by Diversion Program participants and for termination from the Program. Nor has it addressed the loopholes in the law that permit "chronic relapsers" to repeatedly enter, withdraw from, and reenter the Program. In light of the Program's budget constraints, understaffing, and significant absence of internal controls, it is unfair to subject the public to a repeat offender who is able to manipulate the system and remain licensed.

3. Contrary to statute, the Division of Medical Quality has never taken "ownership" of or responsibility for the Diversion Program. State law requires DMQ to administer the Diversion Program and oversee its functioning. MBC's Diversion Program is one of only four in the nation to be housed directly within a state medical board — subject to its direct supervision and oversight. One must assume that the purpose of this in-house structure is to enable members of the Medical Board to affirmatively oversee the Diversion Program to ensure that the public is protected from impaired physicians. However, this has not happened. Instead, in 1982, the Division of Medical Quality effectively delegated its authority over the Diversion Program to the Liaison Committee — which has no statutory existence or authority — and to the staff of the Diversion Program, which in the past has interpreted Liaison Committee directives and recommendations as orders, and has implemented them without DMQ or Diversion Committee review.

The Auditor General reports of the 1980s universally found that the Division has failed to adequately supervise and oversee the Diversion Program. The 1985 report could not be more clear: "The diversion program of the Board of Medical Quality Assurance does not protect the public while it rehabilitates physicians who suffer from alcoholism or drug abuse. . . . The medical board has allowed these problems to develop because it has not adequately supervised the diversion program."

In 1998, DMQ made an effort to reclaim its jurisdiction over the Diversion Program, and in 2000 established a standing Committee on the Diversion Program to meet quarterly to discuss Diversion-related issues. The Committee has done its best to fashion procedures to enable it to oversee the Program, including its review of "Quarterly Quality Review" reports on the Program's responses to intakes, relapses, and releases. However, the Committee remains at the mercy of staff in terms of the information that it receives — and at no time has staff apprized the Committee of any of the serious issues described above by the Monitor. The Committee has attempted to address a number of major issues which have been repeatedly raised; they are referred either to staff or to the Liaison Committee and remain unresolved due to the volunteer nature of LCD, its infrequent meeting schedule and unclear agenda, and the Diversion Program's lack of staff.

The governance of the Diversion Program must be transformed into an accountable structure with a sufficient number of staff who are able and willing to implement DMQ's instructions, with monitoring mechanisms that provide DMQ with an ability to meaningfully oversee both staff and participant compliance with policies and procedures (preferably statutes and regulations) that it has approved and the Program's response to specific cases. If this structure is not possible, or if DMQ is unwilling to fully design and participate in it, then the Diversion Program should be abolished and the licenses of impaired physicians should be suspended until they prove that they are capable of safe medical practice.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC management. For many years, the Medical Board — both the Board and its staff — has permitted Diversion to effectively function in a vacuum. Considering the current confidentiality under which the Diversion Program operates, it is not unreasonable that the identities of self-referred Diversion Program participants be concealed from the enforcement program and from MBC management. However, the entire operation of the Diversion Program has been walled off from the rest of MBC management. This separation has resulted in breakdowns in key Diversion Program monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which have not been communicated to MBC management so that management might address it. In Chapter XV, the Monitor describes several examples of this management failure, including the fact that the Diversion Program has allowed its *Diversion Program Manual* to become almost completely obsolete.

5. The Program's claim of a "74% success rate" is misleading. In its March 2000 brochure, the Program announced that "[f]rom the inception of the Diversion Program in 1980 to March 1, 2000, there have been 981 participants. Six hundred sixty-three (663) of these have completed the program successfully. After factoring out physicians who did not complete for reasons unrelated to their disorders, this results in a 74 percent success rate." This is misleading. While it appears to convey effectiveness in assisting participants to recover from substance abuse, it means only that 663 physicians completed the program and were "successfully terminated." The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Monitor has also heard Program staff and supporters make statements to the effect that "no patient has ever been injured by a physician in the Diversion Program." This is similarly misleading. Injury to patients is not a type of information that the Program captures or publicizes. As demonstrated above, the Program does not even know whether its participants are being drug-tested as frequently as its own policies require, or whether they have adequate worksite supervision, or whether their treating psychotherapists are properly reporting on their patients' progress. The Program should be less concerned with "spin" about its effectiveness and more concerned about real-time monitoring of impaired physicians to protect the public.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #56: Based on the information contained in this and prior reports on the Diversion Program, the Medical Board must reevaluate whether the "diversion" concept is feasible, possible, and protective of the public interest. The Medical Board's paramount priority is public protection. It is unclear why a board charged with public protection as its paramount priority would permit physicians who are addicted to drugs or alcohol to practice medicine before they have recovered from that addiction. If such a board believes that impaired but recovering physicians should be permitted to practice medicine while they are in recovery and susceptible to relapse, that board must insist on comprehensive monitoring mechanisms which are demonstrably effective in detecting both relapse and pre-relapse behaviors, to protect both the participant and the public at large. According to the clear findings in three Auditor General reports and this report, this Board's Diversion Program has never consistently — if ever — had those monitoring mechanisms in place in all cases and at all times, thus exposing the public to unacceptable risk in violation of Business and Professions Code sections 2001.1, 2229, and 2340. The Medical Board must determine whether it is possible to develop, resource, and ensure the effective monitoring mechanisms demanded by state law, or whether the public interest demands that the licenses of impaired physicians be suspended during periods of impairment.

Recommendation #57: If the Board determines that it is possible to implement the "diversion" concept consistent with the public interest, the Board must then determine

whether to house that diversion program within the Medical Board or contract it out to a private entity. This Board has evaluated that question on several occasions (most recently during its 2002 strategic planning session), and has determined to preserve the Program within the Medical Board. However, the Board did not have access to the findings in this report at that time. Nor did it have full and objective information on the alternative structures currently used by other state medical boards or California agencies. The Board must undertake an informed and objective study of all other models used by other state agencies with diversion programs.

Recommendation #58: If the Medical Board decides that "diversion" is feasible and that administration of the Diversion Program should remain within the Medical Board, the Division of Medical Quality must spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that limit the Program's effectiveness both in terms of assisting participant recovery and in terms of protecting the public. This overhaul must include an influx of staff resources (including — at the very least — the addition of a manager to supervise the case managers, a sufficient number of case managers so their caseloads never exceed 50 cases, and a full-time Collection System Manager whose entire job is devoted to ensuring the integrity of the Program's urine collection system) and the installation and staffing of internal quality controls to assure the Division, Program participants, and the public that the Program's monitoring mechanisms are effective in detecting relapse into drug/alcohol use. The restructuring must also include the long-overdue adoption by DMQ of meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse (see Recommendation #62 below). If the Division adopts clear standards applicable to relapse and termination from the Program, it may be that significant staffing additions are unnecessary because noncompliant participants will be terminated from the Program more quickly.

Recommendation #59: The Division of Medical Quality must reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it is currently structured. Consistent with its comprehensive restructuring of the Diversion Program in Recommendation #58 above, the Division must determine whether there is a need for external clinical expertise and — if so — convert the Liaison Committee into a workable advisory panel that serves the needs of DMQ as determined by DMQ.

Recommendation #60: The Division of Medical Quality must determine whether Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Diversion Program. Significant staffing constraints plague the Diversion Program, and those staffing constraints negatively impact its ability to monitor participants and protect the public. Even the Program has recognized that it cannot simply keep accepting more participants. DMQ must decide how the Program is to be structured and funded.

If Program participation must be capped, the Division must further consider who should have priority — Board-ordered participants, Board-referred participants who enter under a statement of understanding with the enforcement program, or self-referred physicians.

Recommendation #61: Regardless of whether Diversion Program participation is deemed an entitlement or is capped to accommodate staffing and protect the public, the Diversion Program's budget should be earmarked and separated from other MBC program budgets. The Diversion Program should be funded by a specified and identifiable portion of MBC license fees paid by all California physicians, and by participation fees paid by participants (who currently pay nothing toward the overhead of the Program). In particular, the Monitor agrees with the Auditor General's 1995 recommendation that physicians who are ordered to participate in the Diversion Program as a term of probation should pay their proportionate share of the overhead costs of the Program. Indigent physicians who are so impaired that they are unable to work should not have to pay participation fees. DMQ should research and evaluate other sources of revenue to fund its Diversion Program, including contributions from state medical societies, malpractice carriers, and hospitals.

Recommendation #62: DMQ must establish enforceable standards and consistent expectations of participants and Diversion Program staff through legislation or the rulemaking process, oversee a comprehensive revision of the Diversion Program's policy manual, and ensure that Diversion Program management is integrated into overall MBC management. The Monitor recommends that DMQ consider enforceable standards in a number of areas: (1) to prevent chronic relapsers from consuming scarce Program resources, DMQ should consider adopting a "deferred entry of judgment" mechanism similar to that in Penal Code 1000; (2) alternatively, the Division should consider banning Diversion Program participation to anyone who was previously a participant in the Program pursuant to an SOU, a stipulation, or Board-ordered probation within a specified number of years and who failed to successfully complete the Program; (3) in adopting criteria for termination from the Program, the Division should consider adopting in regulation the Program's current "three-strikes-and-you-may-be-out" policy (which is arguably underground rulemaking); and (4) the Monitor also recommends that the Division consider a required (or at least presumed) "cease practice" period at the commencement of Program participation to enable a full-scale interdisciplinary evaluation of the extent of the physician's addiction, afford time for necessary treatment, and encourage the physician to focus on recovery.

Additionally, DMQ must ensure that the *Diversion Program Manual* is completely rewritten to incorporate the impact of all relevant statutory and regulatory changes. And MBC management must effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management, to ensure that Diversion staff are knowledgeable of enforcement procedures which impact its Board-ordered participants.

Recommendation #63: DMQ should explore various methods of assessing the long-term effectiveness of the Diversion Program in assisting physicians in recovering from substance abuse.

Recommendation #64: The Medical Board should continue its efforts to replace and upgrade the Diversion Tracking System.

Recommendation #65: The Medical Board's Diversion Program should undergo a full performance audit by the Bureau of State Audits every five years. Under no circumstances should 18 years pass between external performance audits of this critically important program which is permitted to operate in secrecy.

CONCLUSION

To be effective, a report such as this must focus for the most part on the shortcomings in the system under scrutiny. However, the Monitor also notes that there is much that is good at the Medical Board of California and the Health Quality Enforcement Section of the Attorney General's Office, and that the Monitor has consistently encountered a spirit of cooperation and a commitment to progress among the public servants who undertake this important duty. In particular, the Monitor has found a dedicated and hardworking MBC staff who have diligently maintained their mission in the face of substantial resource reductions, and an equally dedicated and skilled staff of attorneys in HQE, who have also labored to do more with less. MBC's new Executive Director David Thornton brings in-depth knowledge of enforcement processes and impressive experience and management skill to this post, and he is rapidly responding to the organizational problems facing MBC, including many of those described in this Initial Report. Both the Board and HQE are blessed with experienced senior managers with extensive system knowledge and a highly constructive attitude toward institutional change and improvement. The Board itself is conscientious and public-spirited, with outstanding professional credentials and demonstrated commitment to public protection.

MBC, HQE, and associated organizations must continue to address substantial concerns to better meet their statutory obligation to protect the California public. If given adequate resources and an improved structure and process, MBC and HQE should be expected and required to achieve significant improvements in prompt and efficient handling of consumer complaints by a well-trained staff utilizing consistent criteria and procedures; timely and effective enforcement action, facilitated by close coordination and teamwork, and appropriately tailored to the circumstances of each case; educating and communicating with the medical community and the public these agencies serve; and an effective Diversion Program that demonstrably protects the public while monitoring and assisting troubled physicians.

To help promote and document such improvements, the MBC Enforcement Monitor will continue to work closely for the statutory term with the Legislature, the Department of Consumer Affairs, MBC, and HQE and their respective managements and staffs, the medical community, and the public whose protection is the agency's central mandate.

Chapter I

OVERVIEW OF THE MEDICAL BOARD OF CALIFORNIA

A. MBC Generally

Created in the Medical Practice Act,[2] the Medical Board of California (MBC) is a semi-autonomous occupational licensing agency within the state Department of Consumer Affairs (DCA). MBC consists of 21 members who serve four-year terms. By law, twelve of MBC's members must be California-licensed physicians; the remaining nine members are so-called "public members" (non-physicians). Nineteen of MBC's members (including all of the physician members and seven of the public members) are appointed by the Governor; the remaining two public members are appointed by the Assembly Speaker and Senate Rules Committee, respectively.

MBC is semi-autonomous in that, pursuant to Business and Professions Code section 109(a), its members make final licensing and enforcement decisions (subject to judicial review). The Board is authorized to adopt regulations pursuant to the rulemaking requirements set forth in the Administrative Procedure Act, subject to review by both the DCA Director[3] and the Office of Administrative Law.[4] MBC is also subject to the Bagley-Keene Open Meeting Act,[5] which generally requires it and its divisions and committees to meet in public in order to make decisions; and the California Public Records Act,[6] which — subject to certain exemptions — subjects its agency documents to public review and scrutiny.

Uniquely, MBC is comprised of two autonomous divisions — the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). MBC members are not merely appointed to the

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[2] Bus. & Prof. Code § 2000 *et seq*.

[3] *Id*. at § 313.1.

[4] Gov't Code § 11349.1.

[5] *Id*. at § 11120 *et seq*.

[6] *Id*. at § 6250 *et seq*.

Board; they are specifically appointed to one of the two divisions. Comprised of seven members (four physicians and three public members), DOL focuses on the licensure of physicians and the regulation of several non-physician health care professions.[7] DMQ, which consists of fourteen members (eight physicians and six public members), is the Board's enforcement arm; it oversees a large enforcement staff and adopts final decisions in disciplinary matters against its licensees. The Legislature rarely directs "the Medical Board" to do anything; instead, it aims its directives expressly at one of the divisions. Neither division reviews or ratifies the decisions of the other. No other DCA agency is structured this way.

The Medical Board is authorized to select an Executive Director, who serves at its pleasure. In turn, the Executive Director hires staff to head the Board's licensing and enforcement divisions, and other important management, investigative, analytical, and support staff.

In 2003–04, MBC regulated over 117,000 physicians, of which 91,000 reside and practice in California. The Medical Board receives no funding or support from the state's general fund. MBC is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a "special-fund agency." In 2003–04, MBC's annual budget was $38,470,000, down from $38,609,000 in 2002–03 and $38,488,000 in 2001–02.

Like other DCA agencies, MBC is subject to regular and comprehensive "sunset review" conducted jointly by the Joint Committee on Boards, Commissions and Consumer Protection[8] and the Department of Consumer Affairs. Under existing law,[9] the Medical Board will cease to exist on July 1, 2006. To continue the Board's existence and role in licensing and disciplining physicians, the Legislature must enact extension legislation in 2005.

B. MBC's Enforcement Program

As noted above, MBC is responsible not only for licensing physicians, but also for reviewing the quality of medical practice carried out by its physician licensees, conducting disciplinary proceedings in cases of unprofessional conduct, and generally enforcing the disciplinary and criminal provisions of the Medical Practice Act, other relevant statutes and regulations, and applicable

[7] In addition to physicians, DOL licenses registered dispensing optician firms (including contact lens dispensers and spectacle lens dispensers), research psychoanalysts, and licensed midwives; it also regulates unlicensed medical assistants.

[8] *See* Bus. & Prof. Code § 473 *et seq*. From 1995–2004, this joint committee was known as the Joint Legislative Sunset Review Committee (JLSRC). After 2003 legislation amended Business and Professions Code section 473 *et seq*. to substantially expand the JLSRC's jurisdiction, SB 136 (Figueroa) (Chapter 909, Statutes of 2004) changed its name to the "Joint Committee on Boards, Commissions and Consumer Protection."

[9] Bus. & Prof. Code § 2001.

professional standards.[10] MBC accomplishes this latter function through its Division of Medical Quality.

MBC's enforcement program is large, complex, and fragmented. DMQ oversees a large enforcement staff that receives, screens, and investigates complaints and reports of physician misconduct and negligence. These staff are based at headquarters in Sacramento and at twelve district offices throughout California. Once DMQ's investigative staff (assisted by physician employees called "medical consultants" and often external expert physician reviewers) have determined that sufficient evidence exists to take disciplinary action, the matter is transmitted to a separate agency — the Health Quality Enforcement (HQE) Section of the Attorney General's Office; HQE has six offices throughout the state. A deputy attorney general from HQE then files an "accusation," a written statement of formal charges, which triggers a panoply of due process rights for the subject physician. Absent settlement, the charges then become the subject of an evidentiary hearing presided over by an administrative law judge (ALJ) from another separate agency — the Medical Quality Hearing Panel of the Office of Administrative Hearings — at which each side presents its case. After the case is "submitted," the ALJ drafts a proposed decision, including findings of fact, conclusions of law, and recommended discipline. That proposed decision is referred back to MBC's Division of Medical Quality, where it is reviewed by one of two "panels" of DMQ, each consisting of seven members (four physicians and three public members). The assigned DMQ panel makes MBC's final disciplinary decision, which is then subject to potentially three levels of review by the courts. Contested MBC disciplinary matters often consume five to seven years, during which time most respondent physicians are free to continue practicing medicine.

Business and Professions Code section 2234 sets forth grounds for MBC disciplinary action, including gross negligence (an extreme departure from applicable professional standards); repeated negligent acts; incompetence; the commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician; and the violation of any provision of the Medical Practice Act. In MBC disciplinary matters, the burden of proof is on the Board, and MBC must prove its case by "clear and convincing evidence to a reasonable certainty."[11]

Business and Professions Code section 2227 sets forth an array of sanctions that DMQ may impose on a licensee for a disciplinable violation, including license revocation, suspension, probation on specified terms and conditions, and the issuance of a public reprimand. Through probation, DMQ may restrict a license (for example, it may prohibit a physician from prescribing certain types of controlled substances, practicing without a third-party chaperone, or engaging in solo

[10] *Id*. at § 2004.

[11] *See*, *e.g.*, *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

practice) or condition continued practice on participation in the Board's Diversion Program for substance-abusing licensees; require a physician to take and pass a professional competency exam, psychiatric examination, ethics and/or other continuing education courses, or to undergo psychotherapy or other medical evaluation and treatment; and/or require participation in the Physician Assessment and Clinical Education (PACE) program. Additionally, section 2233 permits DMQ to issue a "public letter of reprimand"; section 125.9 allows Division staff to impose citations and fines on physicians for minor violations of the Medical Practice Act; and other Code sections permit DMQ to assess civil penalties against physicians for specified misconduct.

Theoretically, both the ALJ's recommendation and DMQ's imposition of specific disciplinary sanctions are based on "disciplinary guidelines" formulated by DMQ. These guidelines, which are regularly reviewed and updated by MBC enforcement staff and the Division, are incorporated by reference in DMQ regulation[12] and represent DMQ's preferred range of sanctions for every given violation of the Medical Practice Act and applicable professional standards. They are intended to promote statewide consistency in disciplinary decisionmaking to ensure that similarly situated physician respondents are treated similarly — an important component of due process and equal protection.

MBC's enforcement program is enormously important to California consumers, who depend on it to rid the marketplace of physicians who are negligent, incompetent, dishonest, or impaired. MBC is the only entity in the state that is authorized to revoke, suspend, or restrict the license of a California physician in order to protect "the public at large, *i.e.*, all consumers of medical services in California."[13] It is fair to say that most California consumers visit a physician regularly, that most physicians see and treat dozens of patients per day, and that negligence or misconduct by a physician can easily cause the "irreparable harm" that justifies the existence of most state licensing programs. Even one moment of negligence or impairment by a physician can result in serious injury to or death of a patient. Thus, the importance of the effective, efficient, and decisive functioning of MBC's enforcement program cannot be overstated.

MBC's enforcement program is also important to physicians who practice medicine in California. Those who become licensed as physicians have spent many years in and many dollars on medical school, clinical education and postgraduate training programs, and often additional training and examinations necessary to become certified by national specialty boards; the law views their license as a property right which may not be taken by the state absent substantive and procedural due process. Obviously, all segments of society need competent and qualified physicians to assist in preventing, detecting, and treating disease and other medical conditions — such that

[12] 16 CAL. CODE REGS. § 1361.

[13] *Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 10.

trained physicians should not be lightly excised from the marketplace for insignificant reason. In this era of managed care, the impact of MBC investigative and disciplinary activity can have momentous ramifications on a physician's ability to practice medicine. Thus, the fairness, consistency, and quality of MBC disciplinary decisionmaking are of significant import to California's physician population.

These sometimes competing priorities have been reflected in the Legislature's evolving definition of the paramount goal of MBC's enforcement program. Prior to 1990, Business and Professions Code section 2229 directed MBC, in exercising its disciplinary authority, to "take such action as is calculated to aid in the rehabilitation of the licensee" — for example, by ordering additional education or restricting (rather than revoking) the license. In 1990, however, the Legislature amended section 2229 to unambiguously declare that "[p]rotection of the public shall be the highest priority for the Division of Medical Quality . . . ."[14] Physician rehabilitation is still recognized as a goal for DMQ in exercising its disciplinary authority; however, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount."[15]

Enforcement is expensive. Consistent with prior years dating back to the early 1990s, MBC spent $28.2 million — or 73% — of its total $38.5 million budget on enforcement in fiscal year 2003–04.

C. MBC's Diversion Program

The Medical Board's Diversion Program was created in 1980 legislation that enacted Business and Professions Code section 2340 *et seq*. In the enabling legislation, the Legislature stated its intent "that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety."[16] Consistent with MBC's overall paramount public protection priority, this language thus requires the Board to "identify and rehabilitate" impaired physicians and return

[14] Bus. & Prof. Code § 2229(a), added by Cal.Stats.1990, c. 1597. *See infra* Ch. IV for a detailed discussion of the "paramount priority" of MBC's enforcement program.

[15] Bus. & Prof. Code § 2229(c). This declaration of legislative intent was later replicated for MBC generally in AB 269 (Correa) (Chapter 107, Statutes of 2002), which added section 2001.1 to the Business and Professions Code. Section 2001.1 declares that "[p]rotection of the public shall be the highest priority of the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

[16] Bus. & Prof. Code § 2340.

them to the practice of medicine, but only if this can be done "in a manner which will not endanger the public health and safety."

Although the enabling language makes reference to physicians with mental or physical illness, the Diversion Program has historically been structured to monitor substance-abusing physicians. Impaired physicians who are eligible for participation in the Program are "diverted" from MBC's disciplinary track (which might otherwise revoke or suspend their license to practice medicine) and required to enter into a contract with the Diversion Program. In the contract, the participant — who retains his or her full and unrestricted license to practice medicine, and whose participation is usually secreted from MBC's enforcement program and the public — agrees to abstain from the use of drugs and alcohol, submit to random bodily fluids testing, attend support group meetings with similarly impaired physicians, undergo psychotherapy and/or substance abuse treatment, retain a "worksite monitor" who practices at the same facility, and cease practicing medicine if so instructed by the Program due to relapse or other noncompliance with the terms of the contract.

The Division of Medical Quality is statutorily responsible for overseeing the Diversion Program,[17] which is administered by a staff of approximately ten MBC employees. Although several of the Program's components (including bodily fluids collection, laboratory testing, and facilitation of support group meetings) have been contracted to the private sector, the "case management" function of the program and overall Program administration have been housed within the Medical Board since the Program's inception in 1981. The overhead costs of the Program — over $1 million in 2003–04 — are subsidized entirely through licensing fees paid by all California physicians. As of June 30, 2004, 258 physicians were participating in the Diversion Program.

[17] *Id*. at § 2346.

Chapter II

STATUTORY MANDATE OF THE MBC ENFORCEMENT MONITOR

Business and Professions Code section 2220.1 establishes the position, role, functions, and authority of the Medical Board Enforcement Program Monitor.[17]

Section 2220.1 was enacted in SB 1950 (Figueroa) (Chapter 1085, Statutes of 2002), which resulted from MBC's 2001–02 sunset review by the Joint Legislative Sunset Review Committee (JLSRC) and the Department of Consumer Affairs. During that review, the Board's physician discipline system was heavily criticized in the media — primarily in an April 2002 *Orange County Register* series — for a number of critical flaws, including lengthy case processing delays (during which physicians who have injured patients continue to practice), excessive fragmentation (leading to inconsistencies in the investigation and prosecution of physicians), questionable case processing priorities, and a loopholed public disclosure policy that permitted physicians to evade disclosure of their misdeeds and failed to provide sufficient information to enable patients to protect themselves and their families from dangerous physicians. In addition, the *Orange County Register* series revealed a number of other failures that exacerbate the flaws in MBC's system, including inadequate reporting of serious physician misconduct to the Medical Board by hospitals, courts, and insurance companies.

SB 1950 addressed several of the flaws identified by the media and the JLSRC during MBC's sunset review. As discussed below, SB 1950 established statutory case processing priorities for the Board; specified additional malpractice judgments, settlements, and arbitration awards that must be reported to the Board by insurers; closed a loophole that was preventing the disclosure of serious malpractice judgments; and authorized — for the first time in California — the public disclosure by MBC of some civil malpractice settlements. Finally, the bill created an "an independent enforcement monitor"[18] to study the Board's enforcement program for a two-year period and make recommendations to strengthen and improve it.

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[17] Section 2220.1 — which is attached as Appendix A — was added by SB 1950 (Figueroa) (Chapter 1085, Statutes of 2002); amended by SB 364 (Figueroa) (Chapter 789, Statutes of 2003); and again amended by SB 136 (Figueroa) (Chapter 909, Statutes of 2004).

[18] The need for an "independent" monitor was stressed in the analyses of SB 1950 (Figueroa) prepared by the Senate Business and Professions Committee (May 7, 2002), the Assembly Health Committee (August 15, 2002), and Assembly Floor staff (August 24, 2002).

The "enforcement monitor" concept is not new. The California Legislature has created "enforcement monitor" positions at three other occupational licensing agencies in the past two decades.[19] The concept is similar to that of an external independent auditor — independent of the board to be studied, and independent of the profession regulated by that board. Under all "enforcement monitor" legislation, the agency must cooperate with the monitor, who is delegated significant investigative authority and charged with conducting a lengthy in-depth study of a particular regulatory program, making findings and recommendations, and proposing legislative, regulatory, or administrative changes to improve the efficiency, effectiveness, and quality of the program and its decisionmaking.

Section 2220.1 charges the Medical Board Enforcement Monitor with evaluating "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system."[20] Over a two-year period, the Monitor must focus on "improving the quality and consistency of complaint processing and investigation, reducing the timeframes for completing complaint processing and investigation, reducing any complaint backlog, . . . [and] assuring consistency in the application of sanctions or discipline imposed on licensees . . . ."[21] The Monitor's study must "include the following areas: the accurate and consistent implementation of the laws and rules affecting discipline, appropriate application of investigation and prosecution priorities, particularly with respect to priority cases, as defined in Section 2220.05, board and Attorney General staff, defense bar, licensee, and patients' concerns regarding disciplinary matters or procedures, and the board's cooperation with other government agencies charged with enforcing related laws and regulations governing physicians and surgeons."[22]

The MBC Monitor is also tasked with several specific duties:

(1) The Monitor must "assess[] the relative value to the board of various sources of complaints or information available to the board about licensees in identifying

[19] SB 1543 (Presley) (Chapter 1114, Statutes of 1986) enacted Business and Professions Code section 6086.9, which created a State Bar Discipline Monitor charged with evaluating and recommending improvements to the State Bar's attorney discipline system. SB 2029 (Figueroa) (Chapter 1005, Statutes of 2000) enacted Business and Professions Code section 7092, which created the Contractors State License Board (CSLB) Enforcement Monitor position to study and recommend changes to CSLB's contractor enforcement program. SB 26 (Figueroa) (Chapter 615, Statutes of 2001) enacted Business and Professions Code section 1601.3 to create the Dental Board Enforcement Monitor post at the Dental Board of California. Additionally, SB 1542 (Figueroa), recently signed by Governor Schwarzenegger (Chapter 572, Statutes of 2004), creates a "Bureau of Automotive Repair Administration and Enforcement Monitor" effective in January 2005.

[20] Bus. & Prof. Code § 2220.1(c)(1).

[21] *Id*. at § 2220.1(c)(2).

[22] *Id*.

licensees who practice substandard care causing serious patient harm."[23] This duty is restated and clarified in Business and Professions Code section 2220.1(d), which requires the Monitor's Initial Report — that is, this report — to "include an analysis of the sources of information that resulted in each disciplinary action imposed since January 1, 2003, involving priority cases, as defined in Section 2220.05."[24]

(2) The Monitor must "evaluate the method used by investigators in the regional offices for selecting experts to review cases to determine if the experts are selected on an impartial basis and to recommend methods of improving the selection process."[25]

(3) Finally, the Monitor is required to "evaluate the effectiveness and efficiency of the board's diversion program and make recommendations regarding the continuation of the program and any changes or reforms required to assure that physicians and surgeons participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired due to alcohol or drug abuse or mental or physical illness."[26]

During the two-year period, the Monitor is required to publish two reports — an initial report on November 1, 2004 (which will be the subject of MBC's 2004–05 sunset review by the Joint Committee on Boards, Commissions and Consumer Protection), and a final report on November 1, 2005. The statute requires the Monitor to "make every effort to provide the board with an opportunity to reply to any facts, findings, issues, or conclusions in his or her reports with which the board may disagree."[27]

To enable the Monitor to accomplish these duties, section 2220.1 requires "the board and its staff" to "cooperate with [the Monitor]," and to "provide data, information, and case files as requested by the enforcement monitor to perform all of his or her duties."[28] The legislation also

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[23] *Id*.

[24] *See infra* Ch. VI.A., and specifically Ex. VI.F., for this required analysis. Business and Professions Code section 2220.08(d), which imposes new procedures for complaint processing on the Board's Central Complaint Unit, also charges the Monitor with analyzing a specific issue in this Initial Report — "whether a complaint received by the board relating to a physician and surgeon who is the subject of a pending investigation, accusation, or on probation should be reviewed pursuant to this section or referred directly to field investigation." *See infra* Ch. VI.A. for this required analysis.

[25] Bus. & Prof Code § 2220.1(c)(2). *See infra* Ch. VIII.A. for this required analysis.

[26] Bus. & Prof Code § 2220.1(c)(2). *See infra* Ch. XV for this required analysis.

[27] Bus. & Prof. Code § 2220.1(d).

[28] *Id*. at § 2220.1(c)(3).

expressly delegates to the Enforcement Monitor "the same investigative authority" as the Director of the Department of Consumer Affairs.[29] Business and Professions Code section 153 sets forth the investigative authority of the DCA Director: "The director may investigate the work of the several boards in his department and may obtain a copy of all records and full and complete data in all official matters in possession of the boards, their members, officers, or employees, other than examination questions prior to submission to applicants at scheduled examinations."

As noted above, the Enforcement Monitor is expressly charged with reviewing MBC's Diversion Program. As participation in the Diversion Program is frequently absolutely confidential, Diversion Program case files — and the substance abuse/mental health treatment records that are often found in them — are of special sensitivity. Substance abuse/mental health treatment records are entitled to confidentiality under both federal and state law. However, those laws make an exception to the confidentiality requirement for "qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation," so long as those personnel do not "identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner."[30]

Thus, the Monitor is expressly authorized to inspect — and the Board and its staff are required to provide and have so provided — documents within the possession of the Board that are relevant to the Monitor's statutorily-required inquiry. This includes public information and a vast array of non-public, confidential information — including complaints, investigative materials, case files (both Enforcement and Diversion), substance abuse/mental health treatment records, and policy and procedure manuals of all types.

Finally, section 2220.1 sets forth the appointment process for the Monitor. Under the statute, the DCA Director supervises the Monitor. The statute requires the DCA Director to advertise the position, and mandates that eligible applicants must have "experience in conducting investigations and familiarity with state laws, rules, and procedures pertaining to the board and with relevant administrative procedures."[31] On July 2, 2003, then-DCA Director Kathleen Hamilton published a request for proposals (RFP) concerning the MBC Enforcement Monitor position, and called for proposals by August 18, 2003. The Center for Public Interest Law (CPIL), based at the University of San Diego School of Law and experienced in two prior enforcement monitor projects, submitted a proposal prior to the deadline. On August 25, 2003, Director Hamilton notified CPIL that its proposal had been selected. On October 21, 2003, CPIL's contract with DCA was finalized, and CPIL began the Enforcement Monitor project the next day.

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[29] *Id*. at § 2220.1(c)(4).

[30] *See* 42 U.S.C. § 290dd-2(b)(2)(B); 42 C.F.R. § 2.1(b)(2)(B); Health and Safety Code § 11977(c)(3).

[31] Bus. & Prof. Code § 2220.1(b).

Chapter III

SCOPE AND METHOD OF INITIAL INQUIRY AND INITIAL REPORT

A. Scope and Method of Initial Inquiry

Business and Professions Code section 2220.1 mandates a broad scope for the Monitor's project as a whole. The mission of the two-year project is to analyze the enforcement and diversion programs of the Medical Board of California and to assist with efforts to improve the overall performance of those programs. The two-year project, which began in late October 2003, requires the submission of an initial report on November 1, 2004; this report will be the subject of a public hearing by the Joint Committee on Boards, Commissions and Consumer Protection, and will generate "sunset" legislation and other recommendations for administrative change during 2005. During the second year of the project, the Monitor will assist with the Board's sunset legislation, monitor the Board's progress in implementing any recommended administrative changes, continue to monitor the Board's enforcement and diversion programs, and publish a final report on November 1, 2005 — at which time the Enforcement Monitor project is scheduled to officially conclude.

Because of the timing of the Board's sunset hearing and the potential for reform legislation during 2005, the Monitor has attempted to study, evaluate, and discuss the most significant components of both programs in this initial report, so that responsive legislation relevant to these components might be introduced in 2005. However, and as discussed in Chapter XVII and elsewhere, we were unable to look in detail at several components of the enforcement program during the first year of the project; those will be the subject of examination during second year and in-depth reporting on November 1, 2005.

Generally, our initial inquiry has included five principal components:

(1) **Review and analysis of the extensive existing literature** relevant to the Medical Board's enforcement and diversion programs, including sixteen independent studies of MBC; two major reports on the California Legislature's enactment of AB 1 (Keene) in 1975; two "sunset review" reports prepared by MBC; and two lengthy reports by the Joint Legislative Sunset Review

Committee on MBC. A list of these reports is attached as Appendix B. In addition, the Monitor and staff reviewed numerous investigation files and read MBC disciplinary decisions and court rulings reviewing those decisions. A full description of the methodology utilized in examining the Diversion Program is included in Chapter XV.

(2) **Review and analysis of all relevant MBC-generated internal and public documents** which address policy, procedure, and training issues, including MBC's *Enforcement Operations Manual* and eighteen other policy and procedure manuals utilized by the enforcement and diversion programs. In addition, we reviewed MBC-generated annual reports and "agenda packets" for its quarterly meetings dating back to the early 1990s, MBC's 2002 Strategic Plan, and MBC-generated "Performance Measurement Indicator Reports" prepared since the adoption of its 2002 Strategic Plan. A list of these materials is attached as Appendix C.

(3) **Interviews of 92 persons** (some on multiple occasions) with expertise concerning MBC's enforcement and/or diversion programs, including:

- Former Department of Consumer Affairs Director Kathleen Hamilton, current Department of Consumer Affairs Director Charlene Zettel, and members of the executive staff of the Department of Consumer Affairs;

- Staffs of the committees of the state Legislature charged with oversight of MBC, including Bill Gage, Ed Howard, and Jay Greenwood;

- MBC Executive Director Dave Thornton, Deputy Executive Director Joyce Hadnot, and Enforcement Chief Joan Jerzak;

- Senior MBC enforcement program managers, supervisors, and advisors;

- MBC enforcement staff representing almost every job classification involved in the enforcement program, including investigators, staff services analysts, medical consultants (both current and former), supervisors, and many others who work both at the Board's headquarters in Sacramento and at MBC's twelve district offices throughout the state;

- Senior Assistant Attorney General Carlos Ramirez, Chief of the Health Quality Enforcement (HQE) Section within the Attorney General's Office; five of HQE's six Supervising Deputies Attorney General; and numerous deputies attorney general who plead and try disciplinary matters on behalf of the Medical Board;

- Members of the Liaison Committee to the Diversion Program;
- Local prosecutors from five district attorney's offices statewide, as well as state regulators who interact with MBC's enforcement program;
- Consumers, consumer-victims, and consumer groups, including representatives of the alternative medicine community;
- Medical profession representatives; and
- Private sector attorneys, including members of the defense bar who regularly represent physicians in Medical Board enforcement proceedings.

In addition to formal interviews, the Monitor met on about two dozen occasions with legislative and executive branch personnel; Medical Board members, staff, and legal counsel; and Department of Consumer Affairs personnel on issues related to the Enforcement Monitor project. Finally, the Monitor received and responded to approximately 25 letters from physicians, defense counsel, and consumers who have participated in MBC enforcement proceedings, and examined some of the case files relevant to those inquiries.

(4) **Statistical data compilation and analysis**, especially in conjunction with Ben Frank, Director of the NewPoint Group, who has supervised the compilation and analysis of key performance statistics for the project as a whole; and

(5) **Legal research**, including statutes, regulations, and case law from California and other states.

We present two *caveats* about the data presented in this report. The first concerns the scope of the data. The Medical Board's enforcement program serves not only the Medical Board, but also several of the so-called "allied health licensing programs" (AHLPs). In past years, eight AHLPs — which regulate non-physician health care practitioners — were statutorily part of the Medical Board, subject to its jurisdiction, and utilized its enforcement program. Recently, many of the AHLPs have successfully sought legislation separating themselves from the jurisdiction of MBC; however, some of them still contract for the use of components of MBC's enforcement program to varying degrees. For example, the Board of Podiatric Medicine utilizes the Medical Board's Central Complaint Unit to receive and screen complaints, MBC's investigators to perform field investigations, the Health Quality Enforcement Section to prosecute cases, and the Medical Quality Hearing Panel to hear its disciplinary matters. At the other end of the spectrum, neither the Respiratory Care Board nor the Physical Therapy Board uses CCU or MBC's investigators, while they both use HQE. In addition,

the Medical Board directly regulates some non-physician health care professions, including registered dispensing opticians; as such, its enforcement program handles complaints against those licensees. Although MBC serves these other agencies, the thrust of SB 1950 (Figueroa) and the Enforcement Monitor statute reveals the Legislature's intent to strengthen MBC's *physician* discipline program. As such, for the most part, the data presented in this report focus on MBC's handling of cases against physicians. We have generally excluded AHLP enforcement data — which (in any event) constitute only a small proportion of overall MBC enforcement program workload.

A second caveat about the data presented in this report involves the presence of minor differences between some of the statistics shown in this report and comparable statistics that have been published by MBC and/or the Department of Consumer Affairs. In order to properly complete analyses of all of the issues and areas of concerns that are included in our scope of work, a number of special compilations of MBC complaint tracking system statistical data were prepared for us by MBC staff. In most cases, these special compilations were prepared within a few weeks of MBC's compilation of comparable statistical data for MBC's and DCA's published reports. However, MBC's complaint tracking system is dynamic in the sense that it is continuously updated to reflect the status of every individual complaint. Sometimes, after being closed, a complaint or investigation may be reopened. Also, reopened complaints and investigations will, at some point, be re-closed. These types of changes can marginally impact the results of various statistical compilations that are produced from the complaint tracking system at slightly different points in time, including tabulations of the number of complaints closed and referred to investigation by CCU, and tabulations of the number of investigation closures and referrals for disciplinary action. Except where otherwise noted in this report, minor differences between the statistics shown in this report and comparable statistics published by MBC and/or DCA are attributable to legitimate changes that were made to complaint tracking system data between the dates when the statistical data used in the different reports were compiled.

B. Scope of the Initial Report

In Chapter IV of this initial report, we present a chronology of the evolution of the Medical Board's enforcement program, focusing on the purpose of its creation and the extent to which that purpose has been achieved. The chronology discusses five major legislative enactments that have shaped MBC's enforcement program throughout the past thirty years.

In each succeeding chapter, the report proceeds to discuss, in chronological order as the process actually unfolds, the various components of the Medical Board's enforcement program. Each chapter contains a narrative description of the functioning of the unit or component, the Monitor's initial concerns with the functioning of that unit or component, and the Monitor's initial recommendations to address those concerns. Some components — such as the functioning of the

Central Complaint Unit, the Board's investigative field offices, prosecutions by the Health Quality Enforcement Section of the Attorney General's Office, and the Diversion Program — are comprehensively addressed in this initial report. Because of the time it took to fully research and develop those steps in the process, other components — such as the conduct of evidentiary hearings by the Medical Quality Hearing Panel within the Office of Administrative Proceedings, the Board's Probation Unit, and its Citation and Fine Unit — have not been comprehensively addressed in this initial report, and will be the subject of in-depth research during 2005 and coverage in the Monitor's final report on November 1, 2005.

In this report, the Monitor makes findings and recommendations that are addressable on a number of levels — internal administrative or procedural change, regulatory amendment, legislative change, budget and staffing enhancements, and/or structural change. Some of these recommendations are concrete, complete, and ready for consideration by the Board. Others are less fully developed concepts whose merits and precise implementation will be the subject of discussion between the Monitor and all interested stakeholders during 2005. Finally, others urge the Medical Board to engage in a constructive public dialogue on certain issues, having been fully informed by the discussion contained and data revealed in this report.

Chapter IV

THE EVOLUTION OF MBC's ENFORCEMENT PROGRAM

A. Introduction: Fulfilling the Promise of the Reform Act (MICRA)

To understand and improve the enforcement program of the Medical Board of California, it is necessary to understand the history of that program — why it was created, how it has been structured and funded, and how it has been carried out by those responsible for its implementation.

This chapter documents the history of MBC's enforcement program from its modern-day creation in 1975. This historical review focuses on five watershed legislative developments and the issues and events which brought them about. First and foremost was the pivotal reform legislation of AB 1 (Keene) in 1975,[32] the Medical Injury Compensation Reform Act ("MICRA" or "Reform Act"), which established the fundamental strategic plan for modern medical practice reform in California. Then in sequence this chapter reviews the highly significant legislative efforts that have followed the Reform Act: SB 2375 (Presley) in 1990,[33] SB 916 (Presley) in 1993,[34] SB 609 (Rosenthal) in 1995,[35] AB 103 (Figueroa),[36] and SB 1950 (Figueroa) in 2002.[37] Together, the Reform Act and the legislation that followed have shaped the purpose, structure, authority, and resources of the Medical Board's enforcement program.

Readers of this chapter will recognize that the "major problems of the day" in medical regulatory reform — including the problems that led to the 2002 creation of the Medical Board Enforcement Monitor — are not new. Rather, they are chronic and cyclical. They have been identified and analyzed on numerous occasions. Their solution has been attempted on numerous

[32] Cal.Stats.1975, 2nd Ex.Sess., c. 1.

[33] Cal.Stats.1990, c.1597.

[34] Cal.Stats.1993, c.1267.

[35] Cal.Stats.1995, c.708.

[36] Cal.Stats.1997, c.359.

[37] Cal.Stats.2002, c.1085.

occasions by the Board and the Legislature. And it is clear that these problems have not been adequately resolved. But as we will see, important progress has been made, and progress will continue if California rededicates itself to the public-spirited balance of reforms envisioned by the Reform Act of 1975.

This historical review[38] serves important goals in the cause of balanced medical regulatory reform that addresses the needs of all industry stakeholders. This chapter:

- Describes the seminal 1975 agreement underlying the Reform Act, which established the strategic plan for MBC's enforcement program, and then examines the extent to which all parties to that agreement have fulfilled their obligations under that strategic vision.

- Documents the evolution of the purpose of the Board's enforcement program — from one whose principal goal was to rehabilitate physicians to one whose "paramount priority" is public protection.

- Demonstrates the importance of proper and active legislative oversight of agency performance.

- Discusses numerous proposals made throughout the years to address the problems that still beset MBC today. Some of these proposals have been watered down in implementation, and often these have failed to resolve the problems. Other meritorious proposals have been rejected. We revisit these proposals and discuss their merits to enable today's policymakers to avoid reinventing the wheel.

- Charts the evolution of Board (and staff) attitudes and approaches toward their roles.[39] Prior to the 1990s, MBC was a narrowly composed and highly reactive board comprised mostly of physicians who were unaware of their responsibilities as government officials, uninterested in their public protection role, and concerned primarily with satisfying the wishes of the medical profession. Enforcement was not a priority, public (non-physician) input was not welcomed, and the Board was hostile toward anyone who tried to remind it of its role as a government agency dutybound to protect the public.

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[38] Much of this chronology is taken from the pages of the *California Regulatory Law Reporter*, published by the Center for Public Interest Law (CPIL) since 1980. In turn, the *Reporter* is based on Board and legislative documents (all of which are on file at CPIL), and CPIL attendance at and observation of Board meetings since 1980. The precise citations to the many reports and critiques contained in this chapter appear in Appendix B.

[39] The Monitor has attended almost all of MBC's quarterly meetings since August 1986.

Starting in about 1992, the Medical Board changed. With the appointment of new members, training sessions by the Wilson administration's Department of Consumer Affairs (DCA), and a sincere desire not to repeat the mistakes of its past, the Medical Board has emerged as a more proactive body, taking an interest in numerous issues affecting both the profession and the public. It has been and is now a diverse board blessed with talented and well-motivated members, both physician and public representatives, each of whom respects the input of others. The Board's members today demonstrate a clear commitment to their first duty as government officials to protect the public.

The historical overview below is facilitated by the basic structure of medical profession regulation: a multi-member board required by law to meet in public in order to make decisions. The resulting public participation in and scrutiny of discussions and decisions produces "government in the sunshine." This dynamic illuminates the agency's past performance and allows empirical measurement of efficacy.

In sum, this chapter will demonstrate the central theme of the MBC Enforcement Monitor's Initial Report: The 30-year history of events surrounding the Medical Board's enforcement program is the story of repeated promises of balanced medical regulatory reform — promises that have not yet been fully realized, and that the recommendations in this report endeavor to keep.

B. The Promise of Balanced Reform: MICRA and Its Effects

Prologue: The Board of Medical Examiners. Prior to 1975, the Medical Board was known as the Board of Medical Examiners (BME). It consisted of ten physicians and one non-physician "public member." Physician discipline was not a priority for BME; it largely delegated that responsibility to physician-dominated regional "medical quality review committees" (MQRCs), five-member panels empowered to hold medical disciplinary hearings and make recommendations to the Board. According to an August 1975 report of the Auditor General, BME licensed 72,000 physicians in 1974, of which 46,000 were actively practicing in California. During 1974, the Board took disciplinary action against 50 doctors, including 30 for narcotics/alcohol-related offenses; five for theft, bribery, embezzlement, and/or tax evasion; four for fraudulent billing; four for mental incompetence; three for sexual misconduct; and one — *one* — for incompetence and gross negligence. Only two of these 50 decisions were reached in less than one year; most of them took two to three years to complete.

BME's disciplinary track record — and its general failure to discipline incompetence and negligence — contrasted starkly with the incidence of medical negligence documented in a 1977 report jointly commissioned by the California Medical Association (CMA) and the California Hospital

Association (CHA).[40] That report estimated that, during 1974, at least 140,000 "potentially compensable events" occurred in California hospitals resulting from the adverse effects of treatments and procedures, incomplete diagnosis or treatment, or incomplete prevention or protection. Of these "events," CMA/CHA estimated that 20,000–27,000 were accompanied by evidence sufficient to establish tort liability under the standards of evidence applicable in 1974. According to a partial reporting of medical malpractice action results, the tort system yielded 141 judgments and settlements over $50,000 in 1974. Yet BME took one disciplinary action for incompetence and negligence.

AB 1 (Keene): The Medical Injury Compensation Reform Act of 1975. The above data indicate that in 1975 the post-damage tort system — with its attendant costs, delay, and incomplete coverage — was the principle mechanism for dealing with physician negligence. While theoretically responsible for removing incompetent and negligent physicians from the marketplace to protect the public (and thus mooting tort recompense), BME's performance was largely moribund. The result was predictable. In 1975, prior to effective state insurance rate regulation, malpractice insurers announced massive rate hikes, allegedly in order to pay jury verdicts and remain profitable. "Lucky" physicians were greeted with premium demands of two to five times the cost of their prior insurance; 2,000 unlucky physicians in southern California were told their coverage would not be renewed at any price. Outraged, the medical profession turned to the Legislature, demanding containment of the tort system's costs that (the doctors believed) caused these rate hikes, and threatening to practice without insurance or not practice at all. In a regrettable and still familiar dynamic, the doctors blamed the insurers, the insurers blamed the trial lawyers, and the trial lawyers blamed the doctors.

The result was the Medical Injury Compensation Reform Act (MICRA), enacted in AB 1 (Keene) during a 1975 special session. The Legislature found that "there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state." According to then-Assemblymember Keene, the measure was deliberately designed to comprehensively address three issues — tort reform, medical quality control, and insurance regulation — that were of interest to the four sets of stakeholders "at the table" — physicians, lawyers, insurance companies, and patients. "A general policy . . . decision was made that all interested parties must sacrifice in order to reach a fair and rational solution to the insurance crisis . . . . AB 1 was drafted to include all reforms in order to prevent any one interest group from sabotaging any single-objective bill."[41]

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[40] California Medical Association and California Hospital Association, *Report on the Medical Insurance Feasibility Study* (1977).

[41] Assemblyman Barry Keene, *California's Malpractice Crisis*, in A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE (David G. Warren and Richard Merritt, eds. 1976) at 30.

In its tort reform provisions, AB 1 capped non-economic damages (such as pain and suffering) in medical malpractice actions at $250,000, a dramatic change. It also limited the contingency fee that plaintiff's counsel may charge in medical malpractice actions, provided (under the so-called "collateral source rule") that the jury in a medical malpractice action may be told of certain benefits payable to plaintiff (such as social security payments and benefits received under group health plans), and imposed a number of other disincentives to the filing of medical malpractice actions.

In exchange for these unprecedented concessions, the medical profession agreed to accept and support enhanced regulation of its ranks — with an emphasis on policing the quality of medical care provided and the removal of incompetent and negligent physicians from the marketplace.[42] According to Assemblymember Keene, "[h]ealth quality control provisions were essential to regain public confidence in the health care delivery system, and to assure that incompetent doctors are not allowed to practice and generate lawsuits."[43]

To implement health quality control, AB 1 abolished the Board of Medical Examiners and created a new "Board of Medical Quality Assurance" (BMQA) consisting of 19 members — twelve physicians and seven public members. BMQA was divided into three divisions: (1) a seven-member Division of Licensing (DOL) responsible for administering examinations, issuing physician licenses, and administering a new continuing education requirement aimed at eliminating "lifetime licensure" and ensuring "continuing competency" of physicians throughout their careers; (2) a seven-member Division of Medical Quality (DMQ) charged with overseeing the Board's enforcement staff, reviewing the quality of practice carried out by physicians, and making decisions in disciplinary matters; and (3) a five-member Division of Allied Health Professions (DAHP) responsible for overseeing the regulation of a number of non-physician "allied health licensing programs" (AHLPs) which were under the jurisdiction of the Board.

In addition, AB 1 established a "central file" mechanism to capture information on complaints and reports of misconduct against physicians, and set the stage for the transfer of investigative authority and the investigative function (in the person of professional investigators who would specialize in physician discipline matters) from the Department of Consumer Affairs to BMQA. It expanded the MQRC system and added public members to those local committees. AB 1 also added a number of so-called "mandatory reporting requirements" to assure that actions taken

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[42] According to Assemblymember Keene, "The California Medical Association (CMA) was willing to support AB 1, even though it was uncomfortable with the health quality reforms, because its members realized that tort reforms were essential to the future of medicine in California. (Indeed, the bill did contain all eight points that the CMA had sought in terms of tort reform)." *Id*. at 32.

[43] *Id*. at 30.

by other entities against potentially dangerous doctors are reported to the Board so that they might be investigated and appropriately disciplined. Business and Professions Code sections 801 and 802[44] required insurers and insureds to report to BMQA the payment of judgments, settlements, and arbitration awards in medical malpractice actions; section 803 required court clerks to report criminal charges and convictions against physicians to BMQA; and section 805 required hospitals and other health care institutions to report adverse "peer review" disciplinary action taken against the privileges of physicians to the Board.

Despite the number of reforms to BMQA's structure, AB 1 codified an unfortunate limitation on the Board's enforcement authority. The bill added new section 2372.1 to the Business and Professions Code, which directed DMQ and its MQRCs to "wherever possible take such action as is calculated to aid in the rehabilitation of a certificate holder or where due to lack of continuing education or other reasons restriction on scope of practice is indicated to order such restrictions as are indicated by the evidence. It is the intent of the Legislature that committees shall seek out those certificate holders who have demonstrated deficiencies in competency and then take such actions as are indicated, with priority given to those measures, including further education, restrictions on practice, or other means that will remove such deficiencies as are found from the evidence."

In 1976, BMQA considered a license fee increase to enable it to implement AB 1 (Keene). At that time, BMQA's license fee was $20 per year. At its January 9, 1976 meeting, DOL considered an emergency increase to $75 per year ($150 biennially). Over the objection of CMA, DOL approved the increase by a vote of 4–3. This fee increase enabled the transfer of investigators from the Department of Consumer Affairs to BMQA in 1977.

In 1980, the Legislature enacted a bill authorizing BMQA to create a "diversion program" for substance-abusing and mentally/physically ill physicians. Under this concept, physicians who abuse drugs and/or alcohol or who are mentally or physically ill may be "diverted" from the disciplinary track into a program that monitors their compliance with terms and conditions of a contract that is aimed at ensuring their recovery. Consistent with AB 1's "physician rehabilitation" goal, the Legislature stated its intent in section 2340 that BMQA "seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety." DMQ was expressly charged with establishing criteria for the acceptance, denial, or termination of physicians from the program and with responsibility for overseeing the functioning of the program.

[44] Unless otherwise noted, all further statutory references are to the California Business and Professions Code.

In August 1982, the Auditor General released a report on BMQA's enforcement and diversion programs. As to enforcement during 1981, the Auditor General documented 3,071 complaints received, 1,646 investigations conducted, 180 accusations filed, and 123 disciplinary actions taken (up from 50 in 1974). The Auditor General noted that BMQA's statute impeded it from exercising its disciplinary authority in at least three ways: (1) BMQA was authorized to discipline a physician's license only for "gross negligence" (an extreme departure from applicable standards) or incompetence ("lack of knowledge or ability in discharging professional medical obligations"), whereas an additional 1,285 cases were "closed with merit" because a medical expert was unwilling to testify that the conduct involved was more than "simple negligence," (2) BMQA — unlike other state and federal agencies — was "limited in its access to patient records while investigating cases," and (3) BMQA could not require physicians to take competency examinations.

As to the Diversion Program, the Auditor General criticized DMQ for failing to establish any formal policies governing surveillance of participant compliance with the terms and conditions of their contracts. Specifically, the Auditor General found wide variability in the frequency of Program staff's contacts with participants, inadequate monitoring of participant compliance with specific terms of their contracts, inadequate verification of participant attendance at required support group meetings, failure to ensure that treating psychotherapist reports were submitted to the Program, and failure to ensure that participants obtained "worksite monitors" to oversee their medical practice. Additionally, the Auditor General criticized the Diversion Program for inadequate recordkeeping (noting that "records on each participant are scattered among three separate files" across the state) and for failure to terminate participants who do not comply with the terms of their contract; this latter deficiency was attributed to DMQ's failure to establish clear standards and guidelines for terminating participants. In 1985 and 1986, the Auditor General issued two more reports on BMQA's Diversion Program; these reports are reviewed in Chapter XV.

In July 1988, the Assembly Office of Research (AOR) issued a report entitled *No Such Listing: Consumer Access to the Board of Medical Quality Assurance*. In this study, AOR surveyed all telephone books available to the public in the State Capitol and State Library. Of 63 phone books examined, only 11 contained a phone number for BMQA. AOR contacted Pacific Bell, which at that time distributed directories to 90% of California calling areas. As of June 1988, BMQA appeared in only 33 of 172 directories. Finally, test calls to information operators seeking BMQA's number revealed the response that "no such listing exists" even though the caller identified BMQA as a state agency. AOR found that BMQA's public outreach efforts were "minimal," and suggested that BMQA attempt to achieve its stated 1987 goal of establishing a toll-free consumer information number.

In late 1988, a large backlog of complaints began to accumulate at BMQA, causing consumer complainants to contact their legislators and attracting the attention of the Legislature and the

Legislative Analyst's Office (LAO). At DMQ's December 1988 meeting, the Board's enforcement chief announced that almost 800 complaints — 80% of which involved "a potential for patient harm or needing additional information before a case disposition decision could be made" — were backlogged and unassigned to BMQA investigators. About 65% of the cases with a potential for patient harm had been unassigned for a minimum of three to six months. In response, DMQ adopted a "prioritization" policy under which complaints involving actual or high potential for patient harm were to be given top priority by BMQA investigators, who had — according to the enforcement chief — two to three times the caseloads of any state agency investigating consumer complaints. In early 1989, BMQA increased its renewal fee to $145 ($290 biennially), but only to maintain the reserve fund required by law and not to add investigators, create a toll-free complaint line, or implement public education programs about BMQA's existence and enforcement program.

In February 1989, LAO released its review of BMQA's proposed 1989–90 budget, and documented the unassigned case backlog of 800 cases. Finding that a majority of the backlogged cases "may have a potential for physical harm to the public" which is "undesirable and inconsistent with the Board's stated mission," LAO noted that BMQA had failed to request any additional staff to handle the backlog and required BMQA to report to the Legislature on "how it plans to address the projected number of unassigned cases in 1989–90." The 1989–90 Budget Bill required the Board to file quarterly reports with the Joint Legislative Budget Committee detailing the status of the backlog.

Also in February 1989, the Little Hoover Commission released its third report in six years condemning the quality of medical care provided by the state's nursing homes for the elderly. The Commission found that "many of the 115,000 persons who are spending their final days in California's nursing homes face poor medical care — or none at all — and there is no one in charge of protecting them." Along with the Department of Health Services' Licensing and Certification Division, the Commission singled out BMQA for criticism, finding that BMQA had been "singularly inactive in this area, having neither adopted standards of care for nursing homes nor instituted a citation and fine system for those who fail to provide adequate care."

Code Blue. In April 1989, the Center for Public Interest Law (CPIL) released a report entitled *Physician Discipline in California: A Code Blue Emergency*. Based on a three-year investigation, *Code Blue* presented evidence indicating the minimal output, fragmented structure, and questionable priorities of BMQA's enforcement program.

First, *Code Blue* revealed that BMQA's enforcement performance — despite multiple fee increases, the infusion of information about physician misconduct from a variety of sources, and MICRA's promise of a strengthened physician discipline system — had actually declined since the Auditor General's 1982 report. During 1987–88, BMQA received 4,685 complaints, opened 1,900 investigations, filed 109 accusations, and took 92 disciplinary actions. During that same year,

BMQA was notified that 715 physicians suffered medical malpractice judgments or settlements in excess of $30,000, and 249 physicians had been the subject of adverse peer review action by hospitals. Of BMQA's 92 disciplinary actions, exactly twelve (12) were for negligence or incompetence; the vast majority of BMQA's disciplinary actions "piggybacked" off criminal convictions or disciplinary actions taken by another state medical board.

CPIL noted that, in a regulatory setting where delay can cause irreparable harm and cost lives, the highly fragmented physician discipline process administered by BMQA, its 14 MQRCs, its eight regional offices, and its "enforcement partners" over whom BMQA has no control — including the Licensing Section within the Attorney General's Office (whose generalist prosecutors filed charges and tried disciplinary matters against physicians, pharmacists, contractors, accountants, and numerous other DCA licensees), the Office of Administrative Hearings (whose administrative law judges (ALJs) preside over evidentiary hearings in physician discipline matters and make recommendations to DMQ), and the judicial system (which reviews DMQ disciplinary decisions and entertains motions for temporary restraining orders (TROs) to stop practice in appropriate cases) — frequently required *six to eight years* to reach a result. In 99% of those cases, the accused physician continued to practice during that entire period. During 1987–88, BMQA sought no TROs to suspend practice pending the conclusion of the long disciplinary process; it had sought only three TROs since 1985–86. Neither BMQA nor any of its enforcement partners kept systematic records of the throughput or output of the enforcement program — inhibiting informed, data-based enforcement policymaking by either the Board or the Legislature. Further, BMQA disclosed almost no information about dangerous licensees to the public. Although it received many reports of criminal convictions and civil judgments against doctors (all of which is public information), BMQA refused to disclose any of that information to consumers seeking it; it disclosed only its own disciplinary actions, which were few and far between.

In *Code Blue*, CPIL argued that the heart of the problem lay in the fact that BMQA investigators — who lack a law school education and are supervised by management who were responsive to the politically-appointed physician majority on the Board — were investigating complex cases with no legal guidance whatsoever. BMQA investigators were "handing off" an investigation report to a prosecutor who was unable to specialize in medical disciplinary matters and was often unfamiliar with BMQA's statute and regulations, had no input into the investigation, and was without investigative assistance after receiving the case. CPIL contended that the number and complexity of BMQA disciplinary matters justified the creation of a unit of prosecutors in the Attorney General's Office to specialize in medical discipline cases, and that BMQA's investigators should be transferred to that unit to effectuate a "vertical prosecution model" similar to that used by other law enforcement agencies investigating and prosecuting complex white-collar crime cases — investigators and prosecutors working together on cases from the day they are referred for investigation.

Similarly, CPIL proposed the creation of a special panel of ALJs within the Office of Administrative Hearings, to enable them to specialize in physician discipline proceedings. *Code Blue* argued that these ALJs — as an alternative to superior courts — should be empowered to issue "interim suspension orders" in egregious cases, and to grant remedies short of license suspension, including practice restrictions and required testing. CPIL also called for a streamlining of BMQA's disciplinary decisionmaking process and its judicial review. *Code Blue* questioned the value of DMQ review of proposed ALJ decisions, inasmuch as DMQ members are not present at the hearing, do not have access to the transcript of the hearing or the evidence presented, and generally have no knowledge of the rules of evidence or the specific specialty at issue. CPIL argued that the OAH ALJ should make the final agency decision (based on disciplinary guidelines fashioned by DMQ), subject to a petition from either party which would be submitted to a special panel of the Court of Appeal (thus eliminating superior court review of DMQ disciplinary decisions).

Code Blue also proposed a number of other reforms — including the creation of a toll-free line whereby consumers could inquire about the disciplinary histories of their physicians; the required disclosure of information concerning criminal arrests and convictions, civil malpractice actions, hospital disciplinary actions, prior disciplinary actions by BMQA or other state medical boards, and pending high-priority investigations (with appropriate disclaimers); expanded reporting requirements to ensure the Board learns of problem physicians; enactment of a "cost recovery" mechanism enabling BMQA to recoup some of its investigative costs from disciplined licensees; imposition of a case cycle "goal" requiring investigators to complete most investigations within six months; and a requirement that BMQA report significantly more detailed annual enforcement data to the Legislature. Finally, CPIL proposed that the Medical Practice Act be amended to elevate public protection above "physician rehabilitation" in DMQ's priority hierarchy.

In May 1989, Senator Robert Presley introduced SB 1434 (Presley) to implement the recommendations in *Code Blue*. At its May 1989 meeting, BMQA — opposed to SB 1434 and arguing that all it needed was additional staff — defended itself by noting that between 1983–84 and 1988–89, it had requested an additional 33.5 enforcement positions but had only been granted 3.5 permanent positions and three additional limited-term positions. The Board also agreed to increase its renewal fees to at least $360 biennially, and to support then-pending legislation increasing its fee ceiling to $400 biennially.

In July 1989, in hopes of fending off SB 1434 and decreasing the backlog that was attracting legislative attention, BMQA agreed to increase its enforcement staff by adding 18 permanent investigator positions and 10 additional limited-term enforcement positions, and to create a toll-free complaint line. However, it refused to approve any other changes to the structure of its enforcement program. Due to CMA and BMQA opposition, SB 1434 became a two-year bill.

The Board did agree to one change, however. In September 1989, AB 184 (Speier) was enacted by the Legislature and signed by the Governor. This Board-sponsored bill removed the "medical quality" concept from the Board's name and renamed BMQA as the Medical Board of California (MBC). SB 1330 (Presley) also passed in 1989, increasing MBC's biennial fee ceiling to $400. However, MBC kept its renewal fee at $360.

At a December 1989 meeting, DMQ conducted a special review of its discipline program, and concluded that many of its weaknesses were due to factors that were beyond its control. For example, long delays in investigations were attributable to inadequate salaries for MBC investigators and constant turnover in those positions. During investigations, physicians and health care facilities often balked at producing medical records, further contributing to the delay. The Attorney General's Office and the Office of Administrative Hearings, which are required participants in MBC's enforcement program, were completely outside MBC's control. Finally, many MBC disciplinary cases boiled down to "a battle of the experts," and accused physicians are often able to produce higher-paid and better qualified experts, resulting in decisions favorable to the respondent physician. Although it resolved to address as many of these problems as possible, DMQ essentially absolved itself from responsibility for many of the problems documented in the LAO and CPIL reports.

In January 1990, despite significant media coverage of *Code Blue* and newspaper editorials strongly supporting MBC structural reform, Senator Presley was forced to withdraw SB 1434 due to CMA and MBC opposition.

C. The Perfect Storm: SB 2375 (Presley) and Its Effects

The Perfect Storm. During early 1990, a "perfect storm" of events combined to result in the eventual passage of SB 2375 (Presley), the first major MBC structural reform bill since AB 1 (Keene) in 1975.

On February 5, 1990, Los Angeles Superior Court Judge Judith Chirlin sentenced Dr. Milos Klvana to 53 years to life in prison following his December 1989 conviction on 47 felony counts, including nine counts of second-degree murder. Klvana, who was previously convicted on 26 counts of illegal prescribing in 1978 but only placed on probation by MBC, was found responsible for the deaths of nine infants between 1982 and 1986. After a ten-month trial that was widely publicized in the *Los Angeles Times*, the jury found that Klvana — who operated a birthing clinic in a low-income area of Los Angeles — had overdosed their mothers on Pitocin, a labor-inducing drug. MBC investigated four of those deaths, but allowed Klvana to continue practicing due to "lack of sufficient evidence." Despite its investigations and the facts that a February 1984 memo from one of MBC's own medical consultants concluded that Klvana had committed gross negligence and had been the subject of a $1 million medical malpractice judgment in 1986, MBC took no action to restrict Klvana

from practicing until March 1988 — well after Klvana had been arrested and jailed. In sentencing Klvana on February 5, Judge Chirlin did not restrict her harsh comments to the defendant. She cited the "abject failure" of the Medical Board, and stated that MBC "must share in the blame and accept responsibility for at least some of the deaths in this case." After detailing the Board's conduct in the case, Judge Chirlin asked: "And this is the board we have to protect us against unscrupulous and incompetent doctors? How many more dead babies or dead patients of other incompetent doctors will it take before the Board . . . is forced to take a serious and in-depth look at its procedures?" Noting DMQ's December 1989 self-examination of its disciplinary program, Judge Chirlin expressed outrage at the Board's internal investigation and stated that "the Board did an even worse job investigating itself than it did in investigating Dr. Klvana."

Within a week, Senator Presley introduced SB 2375 (Presley), a reintroduction of SB 1434 which he had withdrawn only one month earlier. Accompanying Senator Presley at the press conference announcing the bill's introduction were Judge Chirlin, Los Angeles Deputy District Attorney Brian Kelberg (who prosecuted Klvana), and Klvana jury foreman Jaime Pulido. Senator Presley vowed passage of the bill to "fill the holes in MBC's physician discipline process that had allowed Klvana to victimize the public for a ten-year period."

Also in February 1990, LAO released a new report documenting an increase in the number of backlogged cases unassigned to investigators to at least 870. LAO also noted that only seven of the 18 newly authorized investigator positions had been filled, and opined that "the Board's effectiveness in protecting the public is questionable." In a March 1990 letter to the legislature, MBC admitted that the backlog had soared to 914 cases in December 1989, but had dropped to about 600 cases by March 1990; MBC offered no explanation for the sudden drop. In the 1990–91 budget bill, the Legislature allocated only one-half of MBC's annual budget, and notified the Board that it would receive the other half only if it reduced its backlog of unassigned cases. In response, Board management ordered the unassigned cases to be assigned to investigators.

Meanwhile, in May 1990, the *Los Angeles Times* published a two-day follow-up series to the Klvana prosecution, which focused on MBC's "lagging" disciplinary performance and CMA's "powerful" influence in the Legislature ("doctors' lobby uses clout to block agency reforms"). Lengthy stories in the *Los Angeles Daily News* and on the CBS television affiliate in Los Angeles offered similar critiques.

In June 1990, the U.S. Department of Health and Human Services released a draft report announcing that California ranked near the bottom of the nation in physician discipline. During 1987, California was 42nd among the states in the number of serious disciplinary actions taken against physicians. The report noted that California has "relied particularly heavily" on private "nondisciplinary" actions against physicians, such as warning letters, educational conferences, and

its diversion program for physicians who abuse drugs and alcohol. DHHS found that other states "have discontinued the use of such private approaches," citing "public suspicions of boards being too understanding or lenient toward physicians."

These events — and the statewide publicity that accompanied them — stimulated strong public and legislative support for MBC structural reform. After four sets of amendments to SB 2375 (Presley), CMA agreed to take a neutral position on the bill in June 1990. After many objections and further amendments to the bill, MBC finally agreed to support the bill in the legislative session's last days. In September 1990, Governor Deukmejian signed the landmark bill (Chapter 1597, Statutes of 1990).

SB 2375 (Presley). "Presley I" — also known as the Medical Judicial Procedure Improvement Act — was a 39-part bill that made a number of significant changes to the physician discipline system implemented by MBC and its enforcement partners. In SB 2375, the Legislature declared that "the physician discipline system administered by the board's Division of Medical Quality is inadequate to protect the health, safety, and welfare of the people of California against incompetent or impaired physicians. It is, therefore, the intent of the Legislature to restructure the physician discipline system of the Medical Board of California . . . ."[45]

Although SB 2375 did not include *Code Blue*'s proposed streamlining of the decisionmaking process, it included the following important reforms:

- The bill enacted Government Code section 12529 *et seq*. to create a new Health Quality Enforcement (HQE) Section in the Attorney General's Office. Carved from the Licensing Section, HQE prosecutors specialize in medical disciplinary matters and related cases generated by the allied health licensing programs. SB 2375 did not transfer MBC's investigators to the Attorney General's Office as proposed in *Code Blue*. However, the statute expressly required the HQE chief to "assign attorneys to assist [DMQ] in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . , to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."

[45] The Legislative findings included: "It is, therefore, the intent of the Legislature to restructure the physician discipline system of the Medical Board of California in order to give it authority to act quickly in extreme cases to impose interim protective measures or final sanctions short of license revocation or suspension; more information from a variety of enhanced reporting sources and increased public outreach; procedures which afford a fair review and hearing by an experienced administrative law judge without excessive delay; procedures to ensure a high quality hearing; and enhanced resources to finance such a system in the interests of protecting the people of California. It is therefore the intent of the Legislature to improve the discipline system of licensed physicians and allied health professionals by creating a more expeditious and efficient adjudicatory system and providing it the adequate resources for its performance. It is also the intent of the Legislature that the pay scales for investigators of the Medical Board of California be equivalent to the pay scales for special investigative agents of the Department of Justice, in order to attract and retain experienced investigators." SB 2375 (Presley), Cal.Stats.1990, c.1597.

■ Similarly, SB 2375 enacted Government Code section 11371 to create the Medical Quality Hearing Panel, a specialized panel of ALJs within the Office of Administrative Hearings to hear medical discipline cases. The bill requires the MQHP ALJs to "have medical training as recommended by the Division of Medical Quality and approved by the Director of the Office of Administrative Hearings." To assist the panel ALJs in piercing "hired-gun" expert testimony, the law also requires DMQ to make "panels of experts" available to the MQHP ALJs, and permits them to call one of the panel members as an expert witness in a Medical Board evidentiary hearing (on the record and subject to examination by both sides).

■ SB 2375 also added section 11529 to the Government Code, which authorizes DMQ to seek and OAH ALJs to issue "interim suspension orders" (ISOs) to immediately halt the practice of very dangerous physicians in egregious cases. This alternative to the civil court TRO process was unique to MBC in 1990, but was soon replicated for most DCA agencies.

■ Although the bill failed to enact *Code Blue*'s proposals to eliminate DMQ review of the ALJ's decision and superior court review of DMQ's decision, it added new section 2337 which provided for fast-track judicial review of DMQ disciplinary decisions.

■ The bill enhanced required reporting to the Board on physician negligence and misconduct. For example, SB 2375 added section 802.5 to the Business and Professions Code to require coroners to file a report with MBC when they suspect that a physician's gross negligence is a cause of death. The bill added sections 803.5 and 803.6 to require local prosecutors to report to MBC the filing of felony charges against physicians, court clerks to transmit conviction records and preliminary hearing transcripts to MBC, and probation officers to transmit certain probation reports on physicians to MBC. Although the bill enhanced the flow of information into MBC, it did not impose any new public disclosure requirements on the Board — as had been recommended in *Code Blue*.

■ SB 2375 amended section 805 to increase the maximum penalty against hospitals and HMOs that fail to comply with the peer review reporting requirements in that section.

■ The bill added section 2313, which requires MBC to compile and report certain disciplinary information to the Legislature and the public in its annual report every year. This "accountability provision" enables the Board, the Legislature, and the public to compare year-to-year statistics and discern time delays and backlogs.

■ SB 2375 added section 2319, which required DMQ to establish a goal — by January 1, 1992 — of allowing no more than six months to elapse from receipt of a complaint to completion of the investigation. For cases involving "complex medical or fraud issues or complex business or

financial arrangements," the goal is one year from receipt of the complaint to completion of the investigation.

■ The bill also amended section 2307 to lengthen the time (in most cases) between revocation and the filing of a petition for reinstatement from one to three years.

■ SB 2375 amended Civil Code section 43.8 to provide absolute immunity from civil liability for physicians who serve as expert reviewers and expert witnesses in MBC disciplinary matters.

■ Finally, and perhaps most important, SB 2375 amended section 2229 to shift DMQ's primary priority from physician rehabilitation to public protection. As amended by SB 2375, section 2229 provides that "[p]rotection of the public shall be the highest priority for the Division of Medical Quality . . . in exercising [its] disciplinary authority." The provision recognizes physician rehabilitation as a goal, but expressly states that "[w]here rehabilitation and protection are inconsistent, protection shall be paramount."

In 1991, the Attorney General's Office created the new Health Quality Enforcement Section. The new HQE chief reported to DMQ at its February 1991 meeting that the section consisted of 22 deputies, and had set a goal of filing an accusation within 60 days of its receipt of a completed investigation. In May 1991, however, HQE announced that it was severely understaffed due to a "clerical error" in determining the appropriate number of attorneys to staff the section. Fully investigated cases began to accumulate at HQE, and the unit was taking almost seven months to file an accusation in a fully investigated case. Because of the staffing crisis, HQE and MBC did not immediately implement the other provisions of SB 2375 (those requiring HQE to place prosecutors onsite at MBC's investigative offices and at its intake unit, which was then being centralized in Sacramento) on a formal basis. For his part, the OAH Director announced in May 1991 his appointment of all 27 OAH ALJs to the new Medical Quality Hearing Panel — thus defeating the specialization purpose of the statute.

In April 1991, the Auditor General released a new report finding that MBC would not be able to comply with the January 1992 deadline for completing investigations within the six-month goal established by SB 2375; in fact, the average MBC investigation took fourteen months. The Auditor General documented an unusually high vacancy rate in MBC's investigator positions and excessive investigative caseloads (27:1 before MBC assigned the 900 backlogged cases to investigators and 29:1 after it assigned them, while investigators at comparable agencies maintained average caseloads of 5–10 cases). Exacerbating the investigative delay, HQE took over 200 days to file an accusation in a fully investigated case ("exceeding its 60-day goal by 233%"); and another 264 days elapsed from the filing of the accusation to the completion of the hearing by the Office of Administrative

Hearings. In sum, DMQ, HQE, and OAH took an average of 2.8 years to process a serious discipline case, from receipt of the complaint to a disciplinary decision (which is then subject to judicial review). The Auditor General also reviewed a sample of cases closed during 1990, and found no basis for the Board's "closed without merit" determination in 17% of the cases sampled; further, another 15% of the "closed without merit" cases had been closed without required supervisory approval. MBC disputed the Auditor General's findings at a May 1991 hearing before the Senate Business and Professions Committee, and summarized its accomplishments over the past year — including its assignment of over 900 backlogged complaints to its investigators.

During the fall of 1991, MBC raised its renewal fees to $400 biennially, and agreed to consider another fee increase to finance additional HQE staff. At the request of Board members, staff began to present an "enforcement matrix" to the Board at its quarterly meetings, to enable the Board to monitor the number of enforcement cases moving through the system, case cycle times, and "case aging data."

However, no new attorneys were added to HQE. By the spring of 1992, HQE attorneys were carrying caseloads of 30 each, and it took them an average of 486 days — well over a year — to file accusations in completed investigations. MBC finally agreed to increase licensing fees to $480 biennially ($240 per year) to finance 22 additional attorneys. At the same time, DMQ rejected the ideas of implementing its citation and fine authority under section 125.9 (which had been in place since 1987) and creating a cost recovery system such as that recommended in *Code Blue*.

D. Continuing Crisis: The CHP Report and SB 916 (Presley)

In June 1992, the DCA Director requested a formal investigation of "[s]erious allegations of misconduct . . . [within MBC, which] may have jeopardized the health, safety and welfare of hundreds of California citizens." Specifically, the Director sought an investigation of allegations by MBC peace officer investigators that widespread "case dumping" was ordered by management at the Medical Board during 1990 to reduce investigative backlogs. In other words, MBC investigators claimed that they had been ordered to close cases rather than investigate them, in order to reduce the investigative backlog documented by LAO. Although other charges of misconduct were alleged, the Director was particularly concerned about the "case dumping" charges because they appeared to be supported by the April 1991 Auditor General report which found a series of unsupported and unreviewed case closures. The California Highway Patrol's (CHP) Bureau of Internal Affairs agreed to undertake the investigation, and MBC employees were ordered to cooperate with the CHP.

Also in June 1992, CBS News' "60 Minutes" aired a segment on MBC's enforcement program entitled *Negligent Doctors*. Reporter Mike Wallace profiled the Board's handling of a number of notorious cases (including Klvana) in which physicians with lengthy and egregious

disciplinary histories had to be criminally charged and jailed before MBC took any action against their licenses. "60 Minutes" took particular aim at MBC's "public disclosure policy," which still precluded the Board from informing consumers that a physician had suffered criminal convictions, medical malpractice judgments and settlements, and loss of hospital privileges — even though those facts were known to the Board. At its July 31 meeting, MBC charged that the segment was biased and distributed a handout which attempted to respond to various issues raised. However, the Wilson administration was embarrassed by the spectacle, and MBC's executive director — beleaguered by the ongoing CHP investigation and the "60 Minutes" exposé — resigned under pressure in November 1992.

The CHP Report. On January 20, 1993, CHP released a report on its investigation of MBC's enforcement program and, specifically, its handling of backlogged complaints during 1990. CHP found that "employees of the MBC dispose[d] of some citizens' complaints in an inappropriate manner." Specifically, CHP found that MBC dispatched a "three-member management team . . . to conduct an audit of various District offices in an effort to determine whether the backlogged cases should be handled by a means other than through investigation . . . . [T]he team directed the closure of approximately 200 to 300 complaints." Because the majority of these complaints were closed "without merit," they had been purged and destroyed, making them unavailable for CHP to review. However, CHP reviewed a number of cases ordered closed "with merit" (which are kept for five years), and found that 80% of them needed further work and/or follow-up before such a decision could have been properly made. According to CHP, "it is important to note that the audit team did not conduct, or direct any District Supervisors to conduct, further investigation and/or follow-up prior to their making a final determination as to the closure of the 200 to 300 complaints. On the contrary, the majority of the Supervisors testified . . . [that] the decisions by the audit team were given and received as direction to close the cases . . ." (emphasis original). Thus, CHP concluded that the MBC management team's directive to MBC peace officers to close almost 300 cases "may have been inappropriate . . . . Finally, instructions provided [by the management team] to the various District Supervisors to not forward closing letters to the complainants of closed investigations was inconsistent with Board policy and procedure."

In addition to the improper closure of the 200 to 300 cases described above, CHP investigated other cases that MBC investigators alleged were inappropriately handled. CHP found at least nine cases — most involving a patient death — that had been "poorly investigated" ("investigations were incomplete, witness statements were missing, and the investigative reports were confusing") and inappropriately closed. CHP also found that MBC had failed to review and appropriately process section 801 and National Practitioner Data Bank reports of civil settlements against physicians. In addition, CHP documented a number of other incidents of misconduct by MBC employees, including numerous hiring and promotion improprieties and misuse of state time, vehicles, telephones, credit cards, and undercover driver's licenses. Finally, CHP reviewed a number

of allegations concerning the Diversion Program and — while it did not make definitive findings — expressed concern that group facilitators characterized as "volunteers" were in fact making up to $7,000 per month for holding two meetings per week; one case manager was not collecting urine samples from participants as frequently as required; some Diversion staff made "threatening" comments to participants; and the Program Manager improperly accepted expensive gifts from participants in the Program.

The findings of the CHP report were widely covered in almost every newspaper in California, and prompted calls for the repeal of MICRA in many quarters, based on the conclusion that the promised balance of medical regulatory reforms had not materialized. In particular, critics argued that if the "enhanced" MBC regulatory system was not working for consumers, then MICRA's benefits to the medical profession and insurance industry should be repealed. Within a month after the release of the CHP report, Senator Presley and CPIL introduced SB 916 (Presley), another comprehensive physician discipline system reform bill. In the meantime, the Board — whose membership was evolving into a majority of Wilson administration appointees — had replaced its executive director and enforcement chief. Prodded by DCA, the Board's new management announced an eight-point plan to address the deficiencies identified in the CHP report. Among other things, MBC promised to reopen six cases that had been improperly closed in 1990, tighten investigative policies and procedures by revising its enforcement manuals, enhance consumer access to MBC by increasing the staffing of its toll-free complaint line, and audit the Diversion Program to determine whether it should remain within MBC or be outsourced to a private entity.

In March 1993, MBC and DCA convened a two-day "Medical Summit" of community, consumer, and medical profession leaders to discuss the many problems of MBC's enforcement program and to develop solutions to those problems. Thereafter, MBC convened a series of task forces to address certain issues raised at the Summit — including the Board's lack of intermediate remedies, its public disclosure policy, the Diversion Program, and medical input into MBC enforcement decisionmaking (that is, the Board's use of medical consultants (physician employees) in its district offices and expert reviewers). The task forces met to take public comment and testimony throughout March and April, and readied recommendations for the Board's May 1993 meeting.

At its May 1993 meeting, MBC adopted the Enforcement Task Force's recommendation that it create several levels of intermediate sanctions, including a public letter of reprimand and a public citation and fine system. Over the objection of CMA, the Board also adopted the Complaint Processing and Information Disclosure Task Force's recommendation to liberalize its public disclosure policy and require disclosure of the following information (if known to the Board): felony convictions, medical malpractice judgments in excess of $30,000, prior discipline in California and in other states, involuntary revocation or restriction of hospital privileges, and completed MBC investigations at point of referral to HQE (instead of delaying public disclosure until the accusation

is actually filed). The Board also voted to seek legislation abolishing the regional MQRCs and its Division of Allied Health Professions, and to redirect DAHP's five members to the Division of Medical Quality, which would then be split into two six-member panels for purposes of reviewing proposed ALJ decisions and expediting the discipline process. These provisions were amended into SB 916 (Presley).

In addition, Senator Presley added a number of other reforms to SB 916 that had been suggested in *Code Blue* but were omitted from SB 2375 or were included in SB 2375 but had not been properly implemented. For example, early versions of SB 916 again called for the transfer of MBC's peace officer investigators to the supervision of the Attorney General's Office — to permanently prevent a repeat of the interference with MBC peace officer investigations documented in the CHP report. As introduced, SB 916 also included provisions limiting the number of ALJs who could be appointed to the Medical Quality Hearing Panel in the Office of Administrative Hearings, eliminating DMQ and superior court review of ALJ disciplinary decisions (in favor of a specialized panel of Court of Appeal justices), requiring HQE to place two prosecutors in charge of MBC's Central Complaint Unit, expanding MBC investigators' access to medical records and establishing a $1,000-per-day fine for failure to comply with a lawful request for medical records, creating a Medical Board Discipline Monitor to investigate the entire MBC enforcement program and make recommendations for reform, and increasing physician licensing fees to $300 per year to enable HQE to hire additional prosecutors.

During the summer of 1993, SB 916 was extensively negotiated and frequently amended. Like AB 1 almost 20 years earlier, SB 916 evolved into a bill containing at least one provision for each of the major parties — MBC, DCA, CMA, CPIL, and the Attorney General's Office. To obtain its desired provision(s), each party had to give up other provisions it wanted, or grudgingly accept provisions it opposed. The parties finally agreed to a version of SB 916 that was enacted by the Legislature and signed by Governor Wilson on October 11, 1993.

SB 916 (Presley). "Presley II," a 59-part bill, made the following significant changes to MBC's enforcement program:

■ To enhance MBC's detection of problem physicians, SB 916 amended section 805 to require hospitals and health care facilities to expedite the filing of reports on adverse peer review actions; added section 364.1 to the Civil Code, which requires medical malpractice plaintiffs to transmit the 90-day intent-to-sue letter required by Civil Code section 364 to the Medical Board at the same time it is sent to the defendant physician; and added section 43.96 to the Civil Code, which requires medical societies, health facilities, government agencies, and others who receive complaints about physicians to "inform the complainant that the Medical Board of California . . . is the only authority in the state that may take disciplinary action against the license of the named licensee, and

. . . provide to the complainant the address and toll-free number of . . . [MBC]." Despite this infusion of new information into MBC, SB 916 did not include the provision expressly requiring the placement of two prosecutors over the Central Complaint Unit; nor did it transfer MBC's investigators to the supervision of HQE to enable creation of a vertical prosecution model.

■ The bill amended section 2225 to enhance MBC investigators' authority to request and receive medical records from physicians under investigation, and added new section 2225.5 to permit the imposition of a $1,000-per-day fine on physicians who refuse to comply with a lawful MBC request for medical records.

■ SB 916 added new section 2233 to authorize the Board to issue, "by stipulation or settlement," a public letter of reprimand in lieu of filing or prosecuting an accusation. The bill specified that a public letter of reprimand must be limited to cases involving minor violations and issued under guidelines established by the Board in regulations.

■ The bill amended Government Code section 11371 to require the OAH Director to appoint no fewer than five and no more than 25% of the ALJs within OAH to the Medical Quality Hearing Panel created in SB 2375. SB 916 also required OAH to publish the decisions of its MQHP, "together with any court decisions reviewing those decisions, or any court decisions relevant to medical quality adjudications," in a quarterly "Medical Discipline Report" to be funded by MBC.

■ SB 916 abolished DAHP and transferred its members to DMQ. The bill also abolished MBC's MQRCs and delegated authority to OAH ALJs to preside over medical discipline evidentiary hearings. New section 2332 authorized DMQ to establish panels or lists of experts to assist it in administering its enforcement program. As did SB 2375, SB 916 preserved the DMQ review step, but amendments to section 2230 required DMQ to divide into two panels for purposes of reviewing proposed ALJ decisions and stipulations.

■ In the area of judicial review, SB 916 eliminated superior court review of DMQ decisions and amended section 2337 to provide that review of a final decision by DMQ shall be by way of a petition for writ of mandate to a court of appeal, which shall exercise its independent judgment in reviewing the administrative proceeding. The effective date of this provision, which also authorized the Judicial Council to adopt rules allocating MBC cases to a particular panel or panels within each district, was delayed until January 1, 1995 (and was further postponed to January 1, 1996 in 1994's SB 1775 (Presley)).

■ The bill codified the Board's new public disclosure policy, requiring MBC to adopt regulations mandating the disclosure of (in addition to its own disciplinary actions) felony convictions, medical malpractice judgments in excess of $30,000, temporary restraining orders and

interim suspension orders, Board-ordered limitations on practice, public letters of reprimand, citations, fines, and disciplinary action taken by medical boards in other states. Before SB 916 was enacted, CMA opposition resulted in the deletion of peer review actions from the public disclosure provision.

■ The "Medical Board Discipline Monitor" proposal was stricken from the bill; instead, new section 116 authorized the DCA Director to audit and review inquiries and complaints regarding MBC licensees at the request of a consumer or licensee. The bill also required the State Auditor (formerly the Auditor General) to audit MBC's discipline system on or before March 1, 1995, including a review and evaluation of services provided to the Board by the Attorney General's Office and documentation of the costs of HQE and OAH.

■ Finally, SB 916 amended section 2435 to authorize MBC to increase its biennial renewal fees from $500 to $600. This fee increase, which DMQ implemented via emergency rulemaking in November 1993, was used primarily to enhance the staffing of HQE so that fully investigated cases did not sit for over one year prior to the filing of the accusation.

In late 1993, the Board's Diversion Task Force — which had been appointed after the Medical Summit to study Diversion-related findings in the CHP report — recommended that the Diversion Program remain within the Medical Board and that several issues raised by the CHP, including the method of payment to group facilitators, should be delegated to the Liaison Committee to the Diversion Program, a joint MBC/CMA committee that meets in private, reviews Diversion-related issues, and makes recommendations to DMQ. The Task Force recommended no substantive changes to the Diversion Program. DMQ disbanded the Task Force.

Consistent with SB 916's addition of the "public letter of reprimand" sanction as a mid-level remedy, MBC finally agreed to implement its citation and fine authority under Business and Professions Code section 125.9 (which had existed since 1987). In early 1994, DMQ adopted citation and fine regulations identifying minor violations of the Business and Professions Code and MBC's regulations which justify the issuance of a citation, an order of abatement, and/or a fine not to exceed $2,500. DMQ also adopted regulations implementing new section 2233's "public letter of reprimand" authority, and codifying the public disclosure policy set forth in SB 916.

Also in 1994, after a 16-month study resulting from the Medical Summit, MBC adopted the recommendation of its Task Force on Medical Quality Review to overhaul the enforcement program's use of medical consultants (MCs) and expert reviewers. The Task Force was confronted with complaints from both investigators and HQE prosecutors that MBC's full-time district office MCs — many of whom were retired from the practice of medicine — did not select the best expert reviewers available in quality of care cases, failed to monitor the progress of expert reviewers and

ensure their opinions were clearly explained and adequately justified, and refused to accept supervision by non-physician district office supervising investigators. Further, HQE prosecutors complained that the Board lacked even minimum qualifications for MCs and for expert reviewers chosen by the MCs, such as active medical practice, recent experience in the relevant specialty, and an absence of malpractice payouts and disciplinary history. After nine public hearings and an extensive study of its current system and alternatives, MBC decided to (1) abolish its full-time Chief Medical Consultant position in favor of a more flexible position entitled "Medical Consultant to the Board" — of which there could be more than one — who would be selected by and report to the Board's Executive Director; (2) abolish its full-time MC positions in favor of hiring "permanent intermittent" physician employees — physicians who would continue to actively practice medicine and maintain board certification, but would also work part-time at MBC under the supervision of district office supervising investigators to advise and provide medical input into the investigative process; and (3) adopt minimum qualifications for expert reviewers, including active practice (or retired for no more than two years), board certification, and at least five years of experience in the specialty at issue in the case being reviewed; a clear license with no prior discipline, no accusation pending, and no complaints closed with merit; and completion of a required MBC expert reviewer training course.

In January 1995, MBC published an article in its *Action Report* newsletter recognizing "a near-crisis" in hospitals' apparent failure to comply with section 805, which requires them to file a report with MBC when they take adverse peer review action against the privileges of physicians for a medical disciplinary cause or reason. Although 249 section 805 reports were filed in 1987–88, the state's 550 hospitals filed only 124 section 805 reports in 1993–94, and many of those were late or incomplete. The drop in 805 reporting was especially disturbing because three recent legislative changes which (1) enhanced the required reporting of peer review action, (2) conferred absolute immunity from civil liability on those required to report, and (3) increased the penalty for failure to report were expected to double the level of section 805 reporting — not halve it. MBC called on health care facilities to rise above the "business considerations" which had already been addressed by the Legislature and enable the Board to carry out its fundamental consumer protection role by complying with the statute.

In March 1995, the State Auditor released its audit of MBC's enforcement program as required by SB 916. Focusing on 1993–94, the Auditor found that MBC received 7,902 complaints (a 17% increase over the prior year), closed 71% of them in the Central Complaint Unit (a 14% increase over the prior year), referred 2,046 for formal investigation (a 7% decrease over the prior year), referred 601 cases to HQE for the filing of an accusation (a 39% increase over the prior year), and took a total of 224 disciplinary actions (a 50% increase over the prior year). The audit noted that because HQE prosecutors were laboring with caseloads of 30 each, backlogs of unfiled cases were growing, and HQE had requested funding to hire additional attorneys. The Auditor noted that

effective January 1, 1993, AB 2743 (Frazee) (Chapter 1289, Statutes of 1992) added section 125.3 to the Business and Professions Code, enabling MBC to create a cost recovery mechanism (such as that recommended in *Code Blue* six years earlier) to recoup some of its investigative and enforcement costs from disciplined licensees. The Auditor found that MBC spent over $25 million on enforcement during 1993–94, could have recovered $6.3 million in cost recovery, but recovered only $94,000 because of its failure to properly implement its cost recovery authority. Specifically, MBC sought reimbursement for only 5.28% of its eligible investigative costs during 1993–94, and failed entirely to request reimbursement for the costs it incurred on medical consultant review and expert review of quality of care cases, the costs of psychiatric competency examinations, or its cost to administer the Diversion Program as against physicians ordered to participate in it as an alternative to disciplinary action or pursuant to a stipulated settlement. The Auditor General urged MBC to recoup more of its investigative and enforcement costs from disciplined licensees.[46]

In May 1995, MBC's enforcement chief — noting a 23% increase in MBC complaint volume during the prior two years with no corresponding increase in investigative staff, excessive caseloads for MBC investigators, and a 10% vacancy rate in investigator positions because trained MBC investigators were leaving the Board for other agencies with higher pay and lower caseloads of lesser complexity — urged DMQ to seek a fee increase to finance more investigators and prosecutors, and lower case cycle times and backlogs. Faced with CMA opposition, the Division rejected that request in May 1995, but (in exchange) instructed staff to implement the cost recovery authority available since 1993, as recommended by the State Auditor.

Upon reconsideration of the enforcement chief's fee increase request in November 1995, and reminded of its public protection priority, the 23% steady increase in complaint volume, the 15-month average investigative timeframe (and a two-year timeframe for the filing of accusations in serious cases warranting discipline), and the medical profession's MICRA promise to support an adequately resourced enforcement program, the full Board voted to seek legislation during 1996 to increase the cap on physician renewal fees to $700 biennially effective January 1, 1997.

During 1996, however, MBC's newly-selected executive director sought and received permission from the Board to delay a fee increase bill until he could get a handle on the Board's budget and attempt to fund new investigators by cutting expenditures in other areas and utilizing unexpected savings. Among other things, a long-anticipated salary increase for MBC employees did not materialize in 1996; MBC was not required to contribute $1 million toward the cost of a new

[46] MBC's cost recovery authority under section 125.3(c) is limited to "investigative and enforcement costs [incurred] up to the date of the hearing . . . ." The Auditor General urged MBC to seek legislation authorizing it to seek reimbursement of fees and costs during the hearing as well. CPIL and CMA opposed this proposal, arguing that such expanded cost recovery would unduly chill the willingness of accused physicians to exercise their right to a public disciplinary hearing. As a result, MBC sought no changes to its cost recovery authority.

Department computer tracking system because the contract fell through; its licensee base was increasing and bringing in unanticipated and unbudgeted revenues; and the Board's implementation of its cost recovery authority was beginning to bear fruit. As such, the executive director expressed a desire to examine the Board's entire budget and wring all possible efficiencies from it before seeking a fee increase. MBC approved his proposal, and eventually decided to wait until its 1997–98 sunset review to seek a fee increase.

• SB 609 (Rosenthal) and AB 103 (Figueroa)

SB 609 (Rosenthal). In the meantime, SB 916's January 1, 1996 implementation date for elimination of superior court review of DMQ decisions was fast approaching. During 1995, MBC, CMA, CPIL, and the Judicial Council negotiated another bill that further revised the procedure for judicial review of DMQ decisions. In September 1995, SB 609 (Rosenthal) — an important bill affecting DMQ review of ALJ recommendations and judicial review of DMQ decisions — was enacted. Instead of eliminating superior court review, the bill revised section 2337 to preserve superior court review but to potentially short-cut appellate review of the superior court's decision in appropriate cases. Specifically, section 2337 provides that appeal of a superior court decision affirming a DMQ disciplinary order must be by way of a petition for extraordinary writ. This mechanism permits the appellate court to reject a nonmeritorious case after full briefing, but without the oral argument and written decision required by a direct appeal.[47] Among other things, SB 609 also amended section 2335 to require DMQ, in reviewing a proposed ALJ decision in a disciplinary proceeding, to give "great weight" to the findings of fact made by the ALJ, and to require DMQ members to attend oral argument and read the entire record before voting to increase the penalty; and added section 2336 to require DMQ to adopt regulations governing the conduct of oral argument after nonadoption of an ALJ decision.

Meanwhile, both HQE and MBC were dissatisfied at the average length of time that a fully investigated case sat at HQE before an accusation was filed. Although this timeframe had dropped from a high of 486 days in 1992 to 274 days in 1994 to 134 days in 1996, the delay in the filing of the accusation means a delay in the point at which the matter becomes public information. In 1996, the two enforcement partners finally decided that HQE had sufficient staffing to formally implement SB 2375's provision (enacted in 1990) requiring the HQE chief to assign attorneys to work onsite at MBC district offices "to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." On January 1, 1997, MBC and HQE launched the "Deputy in District Office" (DIDO) program, whereby a deputy attorney general (DAG) from HQE physically

[47] The constitutionality of section 2337's extraordinary writ requirement was later upheld in *Leone v. Medical Board of California* (2000) 22 Cal. 4th 660.

works in MBC district offices one or two days per week to permit onsite prosecutor guidance of investigations. As announced in 1997, DIDO DAGs were expected to (1) review all new incoming cases, to provide guidance and determine whether MBC should seek an ISO or TRO; (2) become involved in subpoena drafting and enforcement to assist investigators in obtaining requested medical records; (3) review all completed investigations before their referral to HQE, to ensure that all investigative "loose ends" are tied up and the matter is ready for pleading; (4) review all cases proposed for closure at the district office level; and (5) draft the initial pleading in cases being referred to HQE for filing. When DIDO was launched, HQE hoped that accusation filing time would drop from 134 days to about 90 days as a result of earlier prosecutor involvement in investigation design and medical records procurement; however, the results were much more dramatic. After phasing in the DIDO program to all district offices over an 18-month period, HQE was filing accusations within 28 days of case transmittal by July 1, 1998. Despite the apparent success of the DIDO program at the district offices, HQE and MBC still failed to formally implement SB 2375's provision requiring the involvement of prosecutors at the Central Complaint Unit.

AB 103 (Figueroa). During 1997, then-Assemblymember Liz Figueroa tackled MBC's public disclosure policy. She introduced AB 103 (Figueroa) to require MBC to create an Internet Web site and to disclose numerous pieces of information relevant to physician practice. As introduced, AB 103 — which was modeled after the precedent-setting "physician profile" public disclosure policy of the Massachusetts Board of Registration in Medicine — would have required Internet disclosure of the current standing of the licensee; whether the license is subject to an ISO or TRO; whether the licensee has ever been subject to discipline by MBC or another state medical board; all felony convictions reported to the Board after 1993; all cases forwarded to HQE for filing and all current accusations filed by HQE; all medical malpractice judgments, settlements, and arbitration awards; and hospital disciplinary actions that result in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. Immediate CMA opposition resulted in the deletion of medical malpractice settlements from the disclosure provisions of the bill. However, the rest of the bill remained relatively intact.

As enacted in 1997 and effective January 1, 1998, AB 103 added section 2027 to the Business and Professions Code, and required MBC to post on the Internet information about its licensees' current standing (including ISO/TRO information), prior discipline by the board of another state or jurisdiction, felony convictions reported to the board after 1991, all current accusations filed by the Attorney General, all malpractice judgments and arbitration awards reported to the Board after 1993, and all hospital disciplinary actions resulting in the termination or revocation of a physician's staff privileges for medical disciplinary cause or reason.

• 1997–98 Sunset Review

During the fall of 1997, MBC underwent its first "sunset review" by the Joint Legislative Sunset Review Committee with the following enforcement program statistics. During 1996–97, MBC received 10,123 complaints; it closed 8,161 of them without investigation (80%) and referred 2,039 (20%) for investigation. It referred 567 completed investigations to HQE, and HQE filed 296 accusations or petitions to revoke probation (2%). MBC took 340 disciplinary actions (3%), including 49 revocations, 87 voluntary surrenders, and 112 straight probation orders (with no suspension). CCU's average case cycle time was 64 days (down from 91 in 1994–95) and the average investigative cycle time was 336 days (220 days over the six-month goal established in 1990). At HQE, an average of 134 days elapsed between the time HQE received a completed investigation and the filing of the accusation. The results of a "consumer satisfaction survey" were not favorable. While 43% of respondents were very satisfied with knowing where to file a complaint, their satisfaction level dropped significantly when it came to how well MBC kept them informed about their complaint status (19% very satisfied and 40% very dissatisfied), the time it took to process a complaint (19% very satisfied and 45% very dissatisfied), and the final outcome of the case (10% very satisfied and 75% dissatisfied). Forty-six percent (46%) were very dissatisfied with the Board's overall service, and only 16% were very satisfied.

During its sunset review, MBC stated that, despite various program and procedural improvements and fee increases occasioned by SB 2375 and SB 916, it suffered from an "unreasonably heavy investigator caseload [26 cases per investigator], lack of compliance by physicians in providing patient medical records, lack of compliance with section 805 peer review and other reporting requirements, and outdated, ineffective data processing capabilities with the current computer enforcement tracking system (the Department of Consumer Affairs' CAS system)." MBC sought extension of its existence, a fee increase to support more investigators (as voted by the Board in November 1995), and "single-signature authority" for its executive director to suspend a physician's license in egregious cases (as opposed to the existing interim suspension authority). The JLSRC recognized "a significant increase in the number of complaints filed" with MBC between 1992–93 and 1996–97, but also found that MBC had (since 1994–95) slashed its overall case processing time in most areas and increased its disciplinary output — largely due to the centralization of the complaint intake process and the recent success of the DIDO program in cutting the time it took to file accusations. Although JLSRC staff stressed that MBC's average investigative processing time was 13 months (as opposed to the six-month goal established in SB 2375) and recommended that a fee increase be considered, the Joint Committee declined to approve a fee increase to support additional investigators. The Legislature's 1998 sunset bill for the Medical Board, SB 1981 (Greene), merely extended the existence of the Board through 2003; amended section 2225.5 to make failure to comply with a court order enforcing a subpoena for medical records a misdemeanor; and otherwise failed to substantively address any of MBC's stated problems.

When it became clear that sunset review would not yield the increase it had delayed since 1995, MBC sought the increase in another way — by inserting a provision in SB 1930 (Polanco), a 1998 omnibus fee bill for DCA agencies. The Board sought a $90 biennial increase to finance ten new investigator positions and cut the 13-month average investigative lag time; it also needed additional revenue because employee salaries had been raised after a four-year cap, and a new Department-wide computer system requiring MBC contribution was on the horizon. CMA objected to the proposed fee increase. According to Board members, CMA began its negotiation of the requested fee increase by presenting a 14-point "talking paper" demanding — among other things — a full review of the performance of and costs charged by HQE, the elimination of cost recovery, a redefinition of the "repeated negligent acts" basis for discipline in section 2234, and an alternative to section 805 reporting for physicians who "voluntarily" take a leave of absence from their hospital privileges to check into drug/alcohol treatment programs before it would consider agreeing to a fee increase. When the Board refused to agree to these terms, CMA persuaded Senator Polanco to remove MBC's provision from his omnibus bill.[48] CMA cited "unresolved concerns regarding the costs and efficiency of the Attorney General's office in its representation of the Medical Board in enforcement matters." While conceding that the Attorney General is a required participant in MBC enforcement proceedings and that it is a separate constitutional officer not directly accountable to the Medical Board, CMA refused to agree to a fee increase until the Attorney General provided "quality detailed billing in order for the Board to understand exactly what it purchases as the HQE pursues a case."[49]

At its August 1998 meeting, Board members criticized CMA for its opposition to the bill and resolved to explore all options to conserve money and help consumers help themselves — including abolition of the $800,000-per-year Diversion Program, expanded cost recovery against physicians to recoup MBC's investigative costs, increased fines, a change in the Board's composition to a public member majority, disclosure of all malpractice settlements on the Internet, and raising or repealing MICRA's cap on noneconomic damages in medical malpractice actions. According to one Board member, MBC must "support upward modification of the MICRA cap so that California's citizens would, lacking administrative redress, have greater access to civil redress." The regulatory balance so carefully crafted had not been achieved in practice. The Board vowed to renew its fee increase proposal in the Legislature in 1999.

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[48] The Department of Consumer Affairs had determined that MBC's fee increase proposal had demonstrated the need for the fee increase. However, in California, occupational licensing agencies are generally unable to secure the passage of legislation increasing licensing fees unless the affected trade association "signs off on the board's proposal, providing either endorsement or, at least, tacit agreement." Senate Business and Professions Committee, *Analysis of SB 1930 (Polanco)* (Apr. 21, 1998).

[49] On its Web site, CMA posted its "Top Ten Accomplishments for the First Six Months of 1998," and included the following: "Thwarted attempts by the Medical Board of California to raise each physician's license fee by 15% ($90 bi-annually)."

In addition to blocking the fee increase in SB 1930 (Polanco) in 1998, the medical profession was successful in advocating the enactment of an urgency bill imposing a statute of limitations on MBC accusation filing. AB 2719 (Gallegos) (Chapter 301, Statutes of 1998) requires MBC to file an accusation within three years of its discovery of acts which are the basis of disciplinary charges or within seven years of the acts — whichever occurs first. According to the Board, the statute of limitations law exacerbated MBC's needs for additional investigators; without them, its chances of completing complex medical investigations and filing cases within the defined time period would substantially diminish. Because AB 2719 did not specify whether it was retroactive or prospective only, defense counsel for respondent physicians immediately moved to dismiss dozens of prosecutions pending on the date it was signed on grounds that the statute of limitations had been exceeded — costing MBC thousands of dollars in additional attorneys' fees to successfully defeat those motions.

As promised, MBC sponsored AB 265 (Davis) in 1999, which again called for an increase in the Board's biennial renewal fee to $690. The Board argued that its fees had not been adjusted since 1994, and its investigative staff had not been increased since 1992. Since that time, the Board had experienced a 60% increase in the number of complaints received. In addition, MBC contended that its investigators carry higher caseloads than do investigators at other state agencies — over 30 cases per investigator as of June 30, 1998 — despite the Auditor General's 1991 admonition to the Board to reduce average investigator caseloads to levels existing at comparable law enforcement agencies. According to MBC, this excessive caseload level was causing high attrition and low morale among investigators. MBC promised to use the fee increase to increase efficiency, improve investigation cycle times, and reduce investigator caseloads to a more manageable level of 20 or fewer per investigator. In response, CMA again produced its 14-point "talking paper" and announced it would considering supporting a fee increase only if "a substantial number of our reform proposals are adopted."

Also in 1999, CMA introduced SB 1045 (Murray), a competing bill that would have afforded the Board an unspecified fee increase in exchange for substantial changes in MBC's procedures and disciplinary authority. Among other things, SB 1045 would have deprived MBC's enforcement program of section 805 reports on physicians who take a leave of absence from hospital privileges in order to enter drug/alcohol treatment, and instead "diverted" those reports to the Diversion Program; required MBC's executive director to review any prosecution where the combined investigative/prosecution time exceeds 200 hours; required DMQ investigators to give a *Miranda*-type warning to physicians who are under investigation and are called in for interviews, and limited the circumstances under which such interviews may be tape-recorded; exempted physicians — and only physicians — from the cost recovery mechanism in section 125.3; required DMQ to adopt a list

of priorities to guide its investigations and prosecutions[50]; redefined "repeated negligent acts" to exclude "negligent acts that occur during a single course of treatment . . . unless those acts constitute a pattern of conduct reasonably likely to jeopardize patient safety"; characterized the provision of expert medical testimony as "the practice of medicine" subject to MBC disciplinary action; imposed detailed billing and documentation requirements on HQE; and created a "strike force" in HQE for the purpose of investigating alleged violations of the ban on corporate medicine. Desiring time to negotiate the complexities of the two bills privately, the Attorney General persuaded their authors to convert their bills into two-year bills and delay resolution of MBC's proposed fee increase until 2000.

During late 1999 and early 2000, a working group of representatives from MBC, CMA, HQE, and several legislative committees met privately to attempt a compromise on SB 1045. When those attempts failed, the working group expanded to include representatives of DCA, CPIL, the Consumer Attorneys of California, and other groups. By January 2000, CMA had reduced its 14 demands to five: (1) redefinition of "repeated negligent acts" to preclude discipline for actions "during a single course of treatment" unless the physician's actions constitute "a pattern of conduct likely to jeopardize patient care"; (2) an amendment to section 805 prohibiting hospitals from notifying MBC's enforcement program when a physician takes a leave of absence in order to enter substance abuse treatment; (3) imposition of a mandatory $6,000 cap on cost recovery for physicians; (4) a requirement that MBC adopt regulations codifying enforcement program priorities that mandate "the prioritization of cases involving a serious risk to patient safety for investigation and prosecution"; and (5) a 50% reduction in initial license fees for physicians who are in residency programs. In exchange, CMA offered a $90 biennial fee increase.

The proposal was opposed in one or more of its elements by the other parties. HQE opposed the redefinition of "repeated negligent acts." Although CPIL was willing to entertain a time-limited experimental cap on cost recovery, it opposed the elimination of section 805 reports when physicians leave their hospital privileges to enroll in substance abuse treatment. MBC objected to reduced fees for residents and the proposed cap on cost recovery, arguing that CMA was "giving with one hand and taking with the other." Eventually, DCA, other DCA boards with cost recovery authority, and HQE all opposed any cap on cost recovery — signaling a veto even if the bill were passed. At its July 2000 meeting, the full Board voted to oppose the compromise, deciding that the bill's

[50] SB 1045 stated CMA's investigative and prosecutorial priorities as follows: "(1) sexual misconduct with one or more patients where the physician presents a danger to the public; (2) repeated acts of excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor; (3) fraud involving multiple patients; (4) drug or alcohol abuse by a physician involving death or serious bodily injury to a patient; (5) an extreme departure from the standard of care or gross negligence which results in death or serious bodily injury to one or more patients, such that the physician presents a danger to the public; and (6) incompetence which results in death or serious bodily injury to a patient."

concessions in terms of consumer protection were not worth the increased resources offered by the bill. In fact, MBC determined that the bill — because of its give-and-take nature — would not increase resources for the Board's enforcement program and that the cap on cost recovery might encourage angry respondents and their lawyers to drive up the cost of their proceedings with full knowledge that the Board could not recoup those costs — such that the bill might actually decrease enforcement program resources. Based on the opposition of MBC and DCA (which portended a veto), the authors of SB 1045 and AB 265 dropped their bills.

During the fall of 2000, the Senate Business and Professions Committee held a public hearing on health care facilities' failure to comply with section 805. Although the Legislature had stated that "peer review, fairly conducted, will aid the appropriate state licensing boards in their responsibility to regulate and discipline errant healing arts practitioners,"[51] California's 550+ hospitals filed only 82 section 805 reports in 1998–99 — a record low. The hearing was prompted in part by an August 2000 article in the *San Francisco Chronicle* which described the intentional (and negotiated) refusal of a San Francisco hospital to report internal peer review action against its chief of cardiovascular surgery, whose subsequent practice resulted in extensive patient harms. The Committee received testimony from MBC, which had sounded the alarm about declining section 805 compliance five years earlier. Among other things, MBC proposed an increase in the civil penalty for failure to report from $5,000 to $50,000, "based on the Board's experience that a $5,000 penalty is an inadequate deterrent to nonreporting."

The hearing led to the 2001 enactment of SB 16 (Figueroa) (Chapter 614, Statutes of 2001), which made a number of changes to section 805: (1) it increased the maximum fine for willful failure to file an 805 report to $100,000, and to $50,000 for other failures to file; (2) it specified that willful failure to file an 805 report by a licensed healing arts practitioner may constitute unprofessional conduct; and (3) it authorized MBC and other healing arts agencies to audit, as specified, any peer review body to determine its compliance with its responsibilities to file 805 reports and to establish an electronic notification system for the filing of 805 reports. Finally, the bill added section 805.2, which states the Legislature's intent "to provide for a comprehensive study of the peer review process as it is conducted by peer review bodies . . . in order to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusive, and their relevance to the conduct of peer review in California." The bill required MBC to contract with the Institute of Medical Quality for the performance of the study, set forth a list of eight issues that IMQ must address, and required a written report from IMQ by November 1, 2002. In Governor Davis' signing message, he indicated his expectation that MBC would implement SB 16 within its existing resources.

In January 2001, MBC enforcement staff created two proactive programs to address abuses causing harm to the public. First, it created "Operation Safe Medicine" (OSM), a "strike force"

[51] Bus. & Prof. Code § 809(a)(5); *see also Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 12.

consisting of four investigators, a supervising investigator, and an office technician. The purpose of OSM was to address an increase in fraudulent "medical practice" by unlicensed individuals in unregulated clinics in California's immigrant communities, predominantly in southern California. In these communities, health care coverage is scarce; health care needs are not always met by qualified physicians and other licensed health care personnel; and unlicensed, unscrupulous individuals are only too willing to step in to fill the void. By September 2001, OSM had infiltrated two unlicensed clinics and worked with local prosecutors on the filing of felony charges against two unlicensed individuals purporting to provide medical diagnosis and treatment for children. Also in 2001, MBC converted one of its investigative positions to an "Internet Crimes Specialist" to target violations ranging from misleading advertising on Web sites to the prescribing of drugs without a prior good faith examination (as required by California law) to trafficking in narcotics. The Internet Crimes Specialist was directed to monitor online activities to detect violations and gather evidence; conduct investigations and initiate prosecutions against violators; and work with other state, local, and federal jurisdictions involved in similar activities.

At its February 2001 meeting, DMQ entertained a request by CMA to reevaluate its public disclosure policy in light of the emergence of the Internet as a major tool of communication. Specifically, CMA sought nondisclosure of "withdrawn accusations" in cases where MBC files an accusation; the physician agrees to undergo a competency examination, clinical training, or coursework; the physician completes the requirement; and MBC withdraws the accusation. CMA's request prompted a wide-ranging discussion of MBC's public disclosure policy, which had been updated most recently in 1998's AB 103 (Figueroa). Since then, several other states had enacted Massachusetts-style "physician profile" Web sites disclosing numerous categories of information, including malpractice settlements; and the Federation of State Medical Boards had adopted a proposal in April 2000 recognizing "the increasing demand for public access to physician-specific information by state medical boards" and encouraging the disclosure of all substantially related criminal convictions, medical malpractice judgment and settlement information, and all hospital disciplinary actions that are required to be reported to the state medical board. Following further discussion at their July 2001 meetings, DMQ and the full Board agreed to appoint a Public Information Disclosure Committee to reevaluate MBC's public disclosure policy.

On October 23, 2001, Governor Davis — confronted with massive general fund deficits — imposed a hiring freeze on most state agencies, regardless of the source of their funding. Under a hiring freeze, state agencies are prohibited from filling employee positions that become vacant due to resignation or retirement. Thus, despite the fact that MBC is a special-fund agency whose salary savings due to the freeze would not assist the general fund deficit whatsoever, it was required to cease filling all positions that became vacant, including enforcement positions.

G. 2001–02 Sunset Review: SB 1950 (Figueroa)

In December 2001, MBC began its second sunset review with enforcement output data that had declined since its first review. During 2000–01, MBC received almost 11,000 complaints; it closed 7,690 of them without investigation (71%) and referred 2,320 (18.5%) for investigation. It referred 510 completed investigations to HQE, and HQE filed 256 accusations or petitions to revoke probation (2.3%). MBC took 288 disciplinary actions (2.6%), including 39 revocations, 49 voluntary surrenders, and 91 straight probation orders (with no suspension). However, the Board had improved its case processing times. CCU's average case cycle time was 53 days and the average investigative cycle time was 204 days (still 77 days over the six-month goal established in 1990). At HQE, an average of 112 days elapsed between the time HQE received a completed investigation and the filing of the accusation. Investigator caseloads had dropped to an average of 18 cases per investigator. MBC's 2000 "consumer satisfaction survey" results revealed greater satisfaction with the Board's communication efforts; about 80% of respondents stated they were satisfied with the information and assistance provided by MBC staff. However, 57% were not satisfied with the Board's explanation of the outcome of their case, and 65% were not satisfied with the overall service provided by MBC.

In January 2002, MBC's Public Information Disclosure Committee held a daylong hearing to take public comment on proposed changes to the Board's public disclosure policy. Consumer advocates argued that, in addition to the information already disclosed by MBC, it should also post on the Internet all information defined as "public information" under the California Public Records Act (including all accusations), substantially related misdemeanor criminal convictions, completed MBC investigations at point of referral to HQE, medical malpractice judgments that are settled on appeal, medical malpractice settlements, and physician training and board certification information. CMA disagreed with the notion of disclosing accusations — especially where they have been dismissed or withdrawn in exchange for an agreement by a physician which has been satisfied. CMA and the insurance industry also objected to the disclosure of malpractice settlements, citing the fact that physicians and their insurers often agree to settle a case not because the physician has been negligent but because the cost of trying the case will outweigh the settlement amount.

As MBC prepared for its final sunset hearing in the spring of 2002, a wave of media stories criticized its enforcement performance and dramatically changed the tenor and direction of the review. A *San Diego Union-Tribune* article described several high-profile medical malpractice judgments — disclosable under MBC's policy — which were quickly appealed and then settled, leading MBC to characterize them as nondisclosable "settlements" and refuse to disclose them. Similarly, a *San Francisco Chronicle* article faulted the Board for its refusal to disclose malpractice judgments settled on appeal, malpractice settlements (even multiple settlements), and criminal convictions — and for leading consumers to believe doctors have "clean records" despite the existence of these events.

But the most damaging series was published in the *Orange County Register* in April 2002 just prior to MBC's final sunset hearing. The series, entitled "Doctors Without Discipline," was disturbingly reminiscent of the *Los Angeles Times*' coverage of the Klvana case twelve years earlier, in that it focused primarily on MBC's handling of one obstetrician who had botched deliveries and injured or killed infants. Indeed, the series illuminated a lengthy eight-year delay between the Board's 1993 receipt of a section 805 report on the physician and its 2001 filing of an accusation against the physician (during which time a child died at the hands of the same physician); MBC's failure to seek an interim suspension order against the physician until 2002, despite multiple complaints, investigations, lawsuits, section 805 reports, and patient deaths; the Board's declining enforcement output ("the Board investigates about 20% of the 10,600 complaints it receives on average every year . . . . About 3 percent lead to formal charges against physicians, and about 1 percent result in doctors losing their licenses"); its failure to check court files for the filing and outcome of medical malpractice actions; its "mandatory" reporting statutes that were easily evaded by physicians (and their lawyers) who wished to avoid being reported to MBC; and its loopholed public disclosure policy that failed to enable patients to protect themselves and their families from dangerous doctors. The series also documented a number of other external failures that exacerbated the flaws in MBC's system, including inadequate reporting of serious physician misconduct to the Medical Board by hospitals, courts, and insurance companies.

The publication of the *Register* series caused the Joint Legislative Sunset Review Committee to postpone MBC's sunset hearing, and to conduct an in-depth investigation into the mechanics of its enforcement program. JLSRC staff drafted a series of 115 questions about the intricacies of the Board's enforcement program, required MBC to answer them in an expedited fashion, examined all of its policy and procedure manuals, and rescheduled the hearing on MBC's sunset review for May 1, 2002.

In the meantime, MBC convened a special meeting on April 24, 2002 to discuss the case featured in the *Register* and to review a revamped public disclosure policy that had been drafted by its Public Information Disclosure Committee. Under the draft policy, MBC would disclose (in addition to all items currently disclosed) any public document filed against any physician and the disposition thereof; all malpractice settlements over $150,000, and three or more settlements within a ten-year period that are between $30,000–$150,000; substantially related misdemeanor convictions; completed investigations that have been referred to HQE for the filing of an accusation; any other public information that is in the possession of the Board that may have an adverse impact on the safe delivery of medical care by a physician (for example, the fact that a physician is required to register as a sex offender); and each licensee's specialty, postgraduate training, and gender. DMQ placed the draft policy on the agenda for its May 2002 meeting.

On May 1, 2002, the JLSRC convened and reviewed a background briefing on the results of its staff's review of MBC responses to the 115 questions and its enforcement procedure manuals.

The background paper featured several findings: (1) every category of Board enforcement activity declined since its last sunset review, even as complaints from patients increased; (2) few complaints become the basis of a formal investigation, few investigations lead to an accusation, and few accusations result in administrative hearings; (3) 65% of complainants are dissatisfied with the results of their complaint to the Board; (4) internal Board practices require the routine closure of most quality of care patient complaints because they fail to satisfy the "gross negligence" basis for discipline — closures that are accomplished without routine consultation with a specialist in the same field or HQE, as required by SB 2375 (Presley), and without a comprehensive review for whether they may constitute "repeated negligent acts" or "incompetence"; (5) the Board does not receive all the information to which it is legally entitled — information that is essential to its enforcement program; (6) MBC's complaint and investigation priorities are questionable; (7) the Board's procedure manuals indicate internal confusion about governing legal standards; and (8) the Board's public disclosure policy misleads the public by failing to disclose malpractice settlements and misdemeanor criminal convictions — information deemed essential to every other medical stakeholder's evaluation of whether to associate with a physician.

The JLSRC heard testimony from some of the victims of the physician featured in the *Register*, and then invited public comment. Consumer advocates renewed their call for an independent "enforcement monitor" (as proposed nine years earlier in SB 916) to examine the entirety of MBC's enforcement program and make recommendations for reform, closure of the loopholes in MBC's mandatory reporting scheme that permits physicians and their employers to evade reporting to the Board, and immediate liberalization of MBC's public disclosure policy to allow consumers to learn the very same information available to the Medical Board before it licenses physicians, medical malpractice carriers before they insure physicians, and hospitals before they grant privileges to physicians. MBC representatives expressed support for the enforcement monitor concept, an improved and expedited complaint handling process, clarification of the Board's mandatory reporting statutes, and an enhanced public disclosure policy. The Department of Consumer Affairs agreed to the appointment of an independent enforcement monitor. CMA reminded the JLSRC that it had previously supported the creation of HQE, the specialized panel of ALJs in OAH, interim suspension authority for the ALJs, and the study of peer review authorized in 2001's SB 16 (Figueroa). However, CMA opposed the disclosure of "unanalyzed, ambiguous information" that would not be helpful to consumers — specifically, complaint and settlement information. CMA argued that public disclosure is no substitute for discipline; if a physician is truly dangerous, MBC should take disciplinary action against that physician and publicize that action. The insurance industry also objected to the disclosure of any malpractice settlement information on grounds that such disclosure would discourage specialists to take on high-risk patients, delay the settlement process and compensation to injured victims, and lead to a 10% increase in medical malpractice premiums.

At the conclusion of the May 1 hearing, the JLSRC voted to support five "work in progress" recommendations for inclusion in SB 1950 (Figueroa), MBC's sunset legislation: (1) the Department Director should appoint an independent enforcement monitor to evaluate MBC's enforcement program and report its findings and recommendations to the Legislature and Department; (2) MBC should continue to assess and improve its consumer satisfaction ratings of its complaint handling; (3) MBC's public disclosure policy should be amended to require the disclosure of all substantially related criminal convictions against physicians, malpractice settlements over $30,000, current specialty and completed postgraduate training, and completed investigations that have been referred to HQE; further, the JLSRC recommended that insurers be fined for failure to report malpractice judgments and settlements to MBC, plaintiffs' attorneys should file a copy of malpractice actions with MBC (and MBC should treat such filing as a complaint), all judgments should be reported to and disclosed by MBC (regardless of whether they are settled on appeal), and judgments and settlements entered against medical corporations controlled by a physician whose actions led to the judgment or settlement should be reported to MBC; (4) two more public members should be added to the Medical Board; and (5) the Board — with a revamped composition as described above — should continue to regulate the medical profession in California until the JLSRC and the Department can review the enforcement monitor's findings and recommendations.

At its May 2002 meeting, the Public Information Disclosure Committee, DMQ, and the full Board debated the draft public disclosure policy first unveiled on April 24. After receiving input from CMA, CPIL, and the insurance industry, the Committee — and later DMQ and the full Board — voted to seek legislation requiring MBC disclosure of all medical malpractice settlements over $30,000; all misdemeanor criminal convictions that are substantially related to the duties, qualifications, and functions of a physician; and completed investigations at point of referral to HQE. With regard to malpractice settlements, MBC agreed to accompany their disclosure with disclaimers and "contextual" information about whether the specialty is one in which physicians are statistically sued frequently and whether the amount is high, low, or average for that specialty. These provisions were amended into the May 20, 2002 version of SB 1950.

During the summer of 2002, representatives of MBC, DCA, HQE, CPIL, CMA, and the insurance industry negotiated the terms of SB 1950 with the staff of Senator Figueroa and other legislators. The product was much like AB 1 (Keene) and SB 916 (Presley) — a bill containing at least one provision that each stakeholder wanted, and others that each opposed.

SB 1950 (Figueroa). On September 29, 2002, Governor Davis signed SB 1950 (Figueroa) (Chapter 1085, Statutes of 2002), which attempted to address the flaws in MBC's enforcement program illustrated in the media reports and MBC's sunset review. Many of the major provisions of SB 1950 are discussed in detail elsewhere in this report; however, following is a list of some of the more significant changes made by the bill:

■ SB 1950 added section 2220.1, which creates an independent "enforcement monitor" appointed by the DCA Director and charged with reviewing the entire MBC enforcement program and its Diversion Program for a two-year period.

■ The bill extended the Medical Board's existence until the findings and recommendations of the enforcement monitor can be evaluated. However, it also changed MBC's composition by adding two public members to DMQ, thus converting MBC into a 21-member board consisting of twelve physicians and nine public members. DOL consists of seven members (four physicians and three public members) and DMQ now consists of fourteen members (eight physicians and six public members). For purposes of reviewing ALJ decisions, DMQ divides into two panels each consisting of seven members (four physicians and three public members).

■ SB 1950 added section 2220.05, which sets forth a list of five types of "priority cases" whose processing, investigation, and prosecution should be expedited by MBC and HQE. The provision directs MBC to "ensure that its resources are maximized for the protection of the public" by identifying and expediting the processing of certain types of matters "representing the greatest threat of harm." The new section also requires MBC to identify, in its annual report, the number of disciplinary actions, TROs, and ISOs taken in each "priority" category.

■ The bill also added section 2220.08, which sets forth a new case procedure for the processing of quality of care complaints by the Central Complaint Unit. Before any quality of care complaint is referred to an MBC field office for investigation, it must be reviewed by "one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." That evaluation must include the review of relevant patient records, a statement or explanation of the care and treatment provided by the complained-of physician, expert testimony or literature provided by the complained-of physician, and any additional information requested by the expert reviewer that may assist him or her in determining whether the care rendered constitutes a departure from the standard of care.

■ SB 1950 closed loopholes in the Board's mandatory reporting statutes by clarifying that a medical malpractice judgment in any amount must be reported to MBC "whether or not vacated by a settlement after entry of the judgment, that was not reversed on appeal . . . ." It also required the reporting of settlements over $30,000 "if the settlement is based on the licensee's negligence, error, or omission in practice, or by the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee."

■ The bill amended section 803.1 to authorize the Board to disclose information about some civil malpractice settlements. The Board must categorize each medical specialty as "high-risk" or

"low-risk." If a physician in a "high-risk" specialty enters into four malpractice settlements in a ten-year period, they will be disclosed for ten years; if a physician in a "low-risk" specialty enters into three malpractice settlements in a ten-year period, they will be disclosed for ten years. The Board may not disclose the actual dollar amount of the settlement; when it is authorized to disclose the settlements of a particular physician, it must disclose the total number of physicians in that specialty, the number of those physicians in that specialty who have entered into a settlement agreement in the prior ten-year period, whether the amounts of the settlements being disclosed are above average, average, or below average for the most recent ten-year period, and the number of years the licensee has practiced in that specialty. Any disclosure of settlement information must be accompanied by a lengthy disclaimer included in the statute. SB 1950 also required MBC to disclose its licensees' specialty and approved postgraduate training. Finally, SB 1950 prohibited the Board from disclosing on the Internet accusations that have been "dismissed, withdrawn, or settled," and limited MBC's Internet disclosure of all categories of information except section 805 reports and felony convictions to a ten-year period.

■ SB 1950 amended section 2234(c) to redefine the basis for discipline known as "repeated negligent acts."

■ The bill amended section 2246 to require an ALJ who finds that a physician has engaged in multiple acts of sexual exploitation to include a proposed order of revocation.

■ SB 1950 amended section 2350 to add "mental illness" as a basis for "diversion" from enforcement and participation in the Diversion Program.

■ The bill amended section 2435 to authorize MBC to increase its biennial renewal fees to $610 — in other words, SB 1950 allowed MBC to increase its fees by $5 per year.

In September 2002, as a result of the continuing hiring freeze and budget control language included in the 2002–03 budget bill, MBC lost 15.5 staff positions — including eight enforcement positions. The hiring freeze continued throughout 2002–03 and 2003–04, and MBC was not authorized to fill most positions that became vacant. As a result of the 2002–03 and 2003–04 budget bills and an additional 12% budget reduction imposed during 2003, MBC lost a total of 44.8 staff positions — including 29 enforcement positions. MBC's field investigations staff was reduced from 90 in 2000–01 to 71 by June 30, 2004 — a 25% loss. MBC was forced to disband Operation Safe Medicine and to move its Internet Crimes Specialist back to field investigations. Since the hiring freeze began in October 2001, HQE lost a total of six prosecutor positions — all in its Los Angeles office; in addition, two Los Angeles HQE deputies are out on extended medical leaves.

On August 25, 2003, the DCA Director appointed Julianne D'Angelo Fellmeth of CPIL as the Medical Board Enforcement Monitor.

On October 1, 2003, MBC and HQE formally implemented the provision of CPIL's SB 2375 (Presley) (enacted in 1990) requiring a deputy attorney general to work onsite at the Central Complaint Unit to "assist [DMQ] in intake . . . . Attorneys shall be assigned to work closely with each major intake . . . unit . . . , to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." HQE assigned an attorney to work half-time at CCU, and MBC assigned a supervising investigator to work full-time at CCU.

On October 22, 2003, the MBC Enforcement Monitor began work on this project.

H. Conclusion: Fulfilling the Promise of Balanced Reform

A generation has elapsed since the landmark Medical Injury Compensation Reform Act of 1975 first articulated the promise of balanced medical regulatory reform for California. Realizing that all interested parties, including physicians, lawyers, insurance companies, and patients, "must sacrifice in order to reach a fair and rational solution" to the perceived crisis, Assemblymember Keene designed AB 1 to achieve a delicate balance of tort reform, insurance regulation, and improved medical quality control.[52]

The necessary connection between these policy goals is obvious and important: Relief for physicians and insurers — including unprecedented limits on punitive damages and other major reforms to the tort and insurance process — was inextricably linked to improved protection for the public in the form of a more effective physician discipline system. That linkage is undisputably sound. Reform fair to all parties means that the reduced disciplining effect of the tort sanctions must be balanced by the enhanced disciplining mechanism of the Medical Board.

This beneficial balance, so carefully crafted in AB 1 and its progeny, offered and still offers the promise of improving the future of medicine in California for all parties. But the long series of critiques, studies, and attempted legislative solutions reviewed here indicates that the disciplinary effectiveness portion of the reform program has consistently lagged. As we will see, there is further work to be done to fulfill the 30-year promise of balanced reform.

[52] See Keene, *California's Malpractice Crisis*, *supra* note 41, at 30.

Chapter V

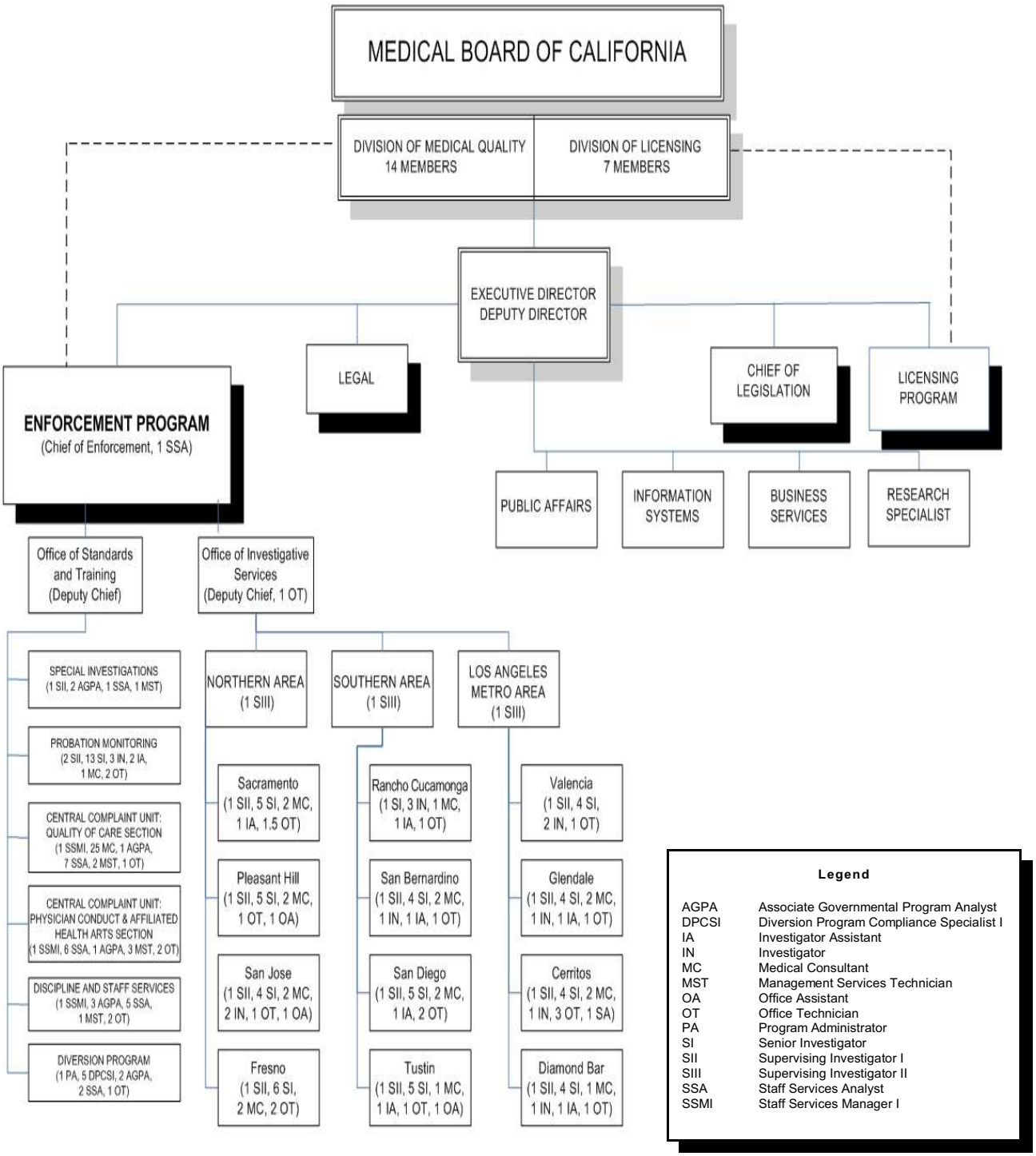
MBC'S ENFORCEMENT PROGRAM: GENERAL DESCRIPTION AND THRESHOLD CONCERNS

A. General Description of Functions

The Medical Board's enforcement program is complex, fragmented, and expensive. Individuals from three separate agencies participate in its proceedings, and it cost the Board $28.2 million in 2003–04. Although its various components will be described and critiqued in detail in succeeding chapters, a brief description of the various steps of the process is provided here — along with an enforcement program organizational chart, a flowchart of the pathway of a complaint through the process, detailed data to give the reader a sense of the complexity of the process and the number of complaints handled by the various participants, and a discussion of several Monitor concerns that cut across the entirety of the enforcement program.

Central Complaint Unit. Prior to 1990, complaints and reports of physician misconduct were received by complaint intake personnel located at local district offices of the Medical Board. When that decentralized complaint intake system proved unsatisfactory, MBC centralized its complaint intake function in the Central Complaint Unit (CCU) in Sacramento. As reflected in Exhibit V-A below, CCU is presently divided into two sections — the Quality of Care Section (which handles complaints related to diagnosis and/or treatment provided by a physician to a patient in the context of the physician/patient relationship) and the Physician Conduct Section (which handles all other complaints). In most quality of care cases, CCU procures the medical records of the complainant and requests a response or explanation from the subject physician. The medical records and explanation are reviewed by a CCU "medical consultant" (a physician practicing in a similar specialty as the complained-of physician) who recommends whether the matter warrants formal investigation. In non-quality of care cases, CCU may procure medical records and forward them for medical consultant review (if applicable), and/or request a response or explanation from the subject physician; CCU then processes the case as appropriate depending on the type of case and sufficiency of the evidence. Cases that survive CCU screening are referred for formal investigation.

Ex. V-A. MBC Enforcement Program Organizational Chart
(October 2004)



Source: Medical Board of California

Field Investigations. MBC maintains twelve field offices (called "district offices") staffed by professional peace officer investigators and supervising investigators. A case that has survived CCU screening is referred "to the field" in the geographical area where the subject physician practices and is assigned to one of MBC's investigators. That investigator — assisted by district office "medical consultants" (again, licensed physicians), the supervising investigator, and a deputy attorney general from the Health Quality Enforcement (HQE) Section of the Attorney General's Office — develops an investigative plan appropriate to the type of case and conducts the investigation. Investigations typically include the gathering of additional medical records; interviews with the complainant(s), witnesses, and the subject physician; and — in quality of care cases — review of the entire investigative report and the evidence by an "expert reviewer" (again, a licensed physician in the same or similar specialty as the complained-of physician) who opines on the standards of care applicable to the particular matter, whether the subject physician's conduct fell below those standards, in what way(s), and to what degree. If the investigative report and the expert review indicate that the subject physician has committed a serious and disciplinable violation, the matter is referred to HQE for the drafting of an accusation against the physician's license, and/or (in appropriate cases) to local prosecutors for the filing of criminal charges.

Administrative Prosecutions. Once a Medical Board investigator completes an investigative report recommending the filing of an accusation in a given case and that recommendation (often supported by expert testimony) is approved, the matter is transferred to HQE where it is assigned to a deputy attorney general (DAG). The DAG reviews the investigative file and determines whether it is complete and sufficient to prove a disciplinary violation. If so, the DAG prepares an "accusation" (a formal written statement of charges)[53] and returns it to the Medical Board's executive director for approval.[54] The accusation is deemed "filed" when the executive director signs it. The accusation is then served on the subject physician, who is now called the "respondent."[55]

The filing of the accusation triggers the adjudication process governed by the Administrative Procedure Act (APA),[56] which is designed to ensure that an accused licensee is afforded appropriate

[53] Gov't Code § 11503.

[54] In less serious cases not warranting license revocation, suspension, or probation, MBC may issue a citation and fine, Bus. & Prof. Code § 125.9, or opt to offer the physician a "public letter of reprimand" in lieu of filing or prosecuting an accusation. *Id*. at § 2233.

[55] Gov't Code § 11500(c).

[56] *Id*. at § 11370 *et seq*.; *see also* Bus. & Prof. Code § 2230(a).

procedural due process before his or her property right (the license) is taken.[57] According to caselaw interpreting the APA, the agency is the moving party, has the burden of proof, and must prove a disciplinary violation by "clear and convincing proof to a reasonable certainty."[58]

Once the accusation is filed, the respondent may file a notice of defense.[59] If such a notice is filed, MBC transfers the case file back to the DAG, who secures a hearing date from the Office of Administrative Hearings (see below). Thereafter, the parties engage in limited discovery[60] and — barring a settlement that is approved by MBC enforcement staff and the Division of Medical Quality — present their respective cases at a public evidentiary hearing presided over by an administrative law judge (ALJ) from the Office of Administrative Hearings. At the hearing and throughout any post-hearing proceedings, the HQE DAG represents the Medical Board; the respondent may be represented by private counsel at his/her own expense.

Office of Administrative Hearings' Medical Quality Hearing Panel. The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state agency adjudicative hearings in a variety of areas. As noted in Chapter IV, a special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH in 1990's SB 2375 and refined in 1993's SB 916; ALJs appointed to the MQHP are permitted to specialize in physician discipline matters.[61] The law requires an MQHP ALJ to preside over MBC evidentiary hearings.[62]

During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument.[63] Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline.[64] At the Board's request, the ALJ may also recommend that the licensee pay "cost recovery" to reimburse the Board for its investigative and enforcement costs incurred up to the first

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[57] *See*, *e.g.*, Gov't Code § 11425.10.

[58] *See*, *e.g.*, *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

[59] Gov't Code § 11506.

[60] *Id*. at 11507.6.

[61] *Id*. at § 11371.

[62] *Id*. at § 11372.

[63] *Id*. at § 11513.

[64] *Id*. at § 11425.50.

day of the evidentiary hearing.[65] The ALJ's ruling is a "proposed decision"[66] which is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision (see below).

In filing charges and recommending discipline, the DAG and the ALJ are guided by a set of "disciplinary guidelines" approved by DMQ; these guidelines set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[67]

Division of Medical Quality Review. Following completion of the evidentiary hearing, the ALJ's proposed decision is transmitted to MBC headquarters for review by DMQ. For purposes of reviewing ALJ proposed decisions, the fourteen-member DMQ divides into two seven-member panels (Panel A and Panel B); a proposed decision is assigned to one of the panels for review.[68] Within 90 days of receipt of the proposed decision, the assigned DMQ panel must review the ALJ's ruling and decide whether to "adopt" it as the final agency decision for purposes of judicial review, or "nonadopt" it because it is defective or inappropriate in some way.[69] If the panel nonadopts the ALJ's proposed decision because it believes the penalty should be more harsh than that recommended by the ALJ, the panel must order a record of the evidentiary hearing, make it available to both parties,[70] and afford the parties an opportunity for oral argument before the panel prior to deciding the case.[71] In imposing disciplinary sanctions, the DMQ panel must consider the Division's "disciplinary guidelines," which set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[72]

Judicial Review of DMQ's Decision. A physician whose license has been disciplined by DMQ may seek judicial review of the Division's decision by filing a petition for writ of mandate in

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[65] Bus. & Prof. Code § 125.3.

[66] Gov't Code § 11517.

[67] Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board's disciplinary guidelines.

[68] Bus. & Prof. Code § 2230(b).

[69] *Id*. at § 2335(c)(3).

[70] Gov't Code § 11517(c)(2)(E).

[71] Bus. & Prof. Code § 2335(c)(4).

[72] *See supra* note 67.

superior court under Code of Civil Procedure section 1094.5.[73] Generally, the focus of the court's review is to determine whether DMQ's factual findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency's discretion or constitutes an abuse of that discretion.[74] Following its review, the superior court may affirm DMQ's decision, or may reverse and/or vacate it and remand it to DMQ for further proceedings.

Either side may challenge the superior court's decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal.[75] If the court believes the petition is meritorious, it will grant an alternative writ, order full briefing, entertain oral argument, and issue a written decision. If the court believes the petition is nonmeritorious, it may summarily deny the writ, thus obviating the need for oral argument and a written opinion in the matter.

If the appellate court affirms the superior court's decision, either party may petition the California Supreme Court to review the case. Such review is entirely discretionary and is rarely attempted or granted.

MBC Enforcement Program Flowchart. Exhibit V-B below presents the pathway of a complaint or report of physician misconduct through the MBC enforcement program described above. Additionally, it presents MBC's fiscal year 2003–04 "throughput" — the number of cases that entered each step and their overall disposition.

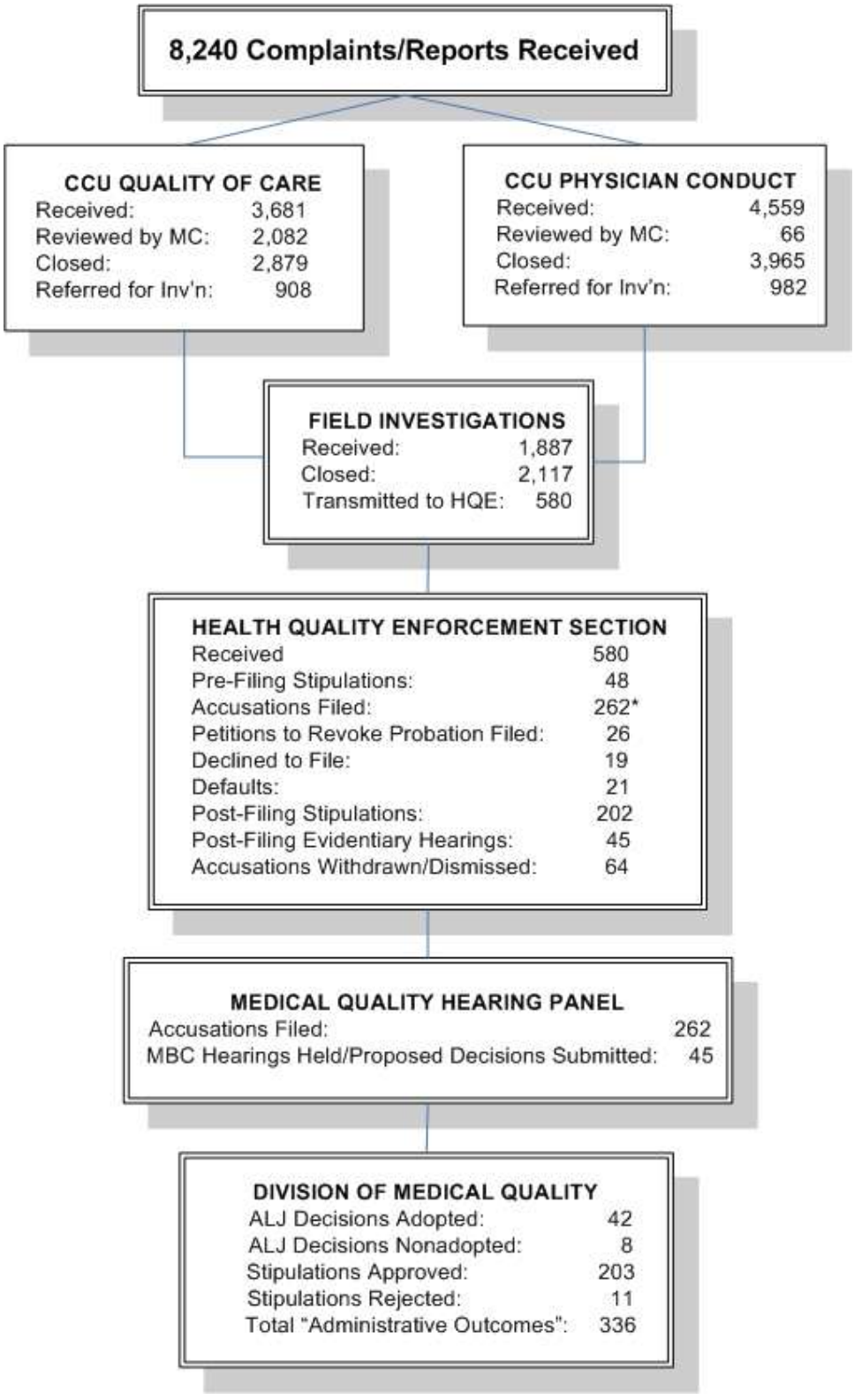
Exhibit V-C below presents MBC enforcement data from 1991–92 (the year in which HQE was created) to the present. The data in this "master" Enforcement Program Statistical Profile will be analyzed, explained, and referred to frequently throughout the remainder of this Initial Report.

[73] Gov't Code § 11523.

[74] Civ. Proc. Code § 1094.5(b).

[75] Bus. & Prof. Code § 2337.

Ex. V-B. 2003–04 MBC Enforcement Program Throughput



*Multiple cases against the same physician are frequently combined into one accusation.

Source: Medical Board of California

Ex. V-C. Enforcement Program Statistical Profile
Physicians and Surgeons

Workload Measure		3-Year Averages 1991/92 through 1993/94	3-Year Averages 1994/95 through 1996/97	3-Year Averages 1994/95 through 1999/00	2000/01	2001/02	2002/03	2003/04
Active Licensees		102,680	103,266	106,835	109,289	112,273	115,354	117,806
Complaint Intake and Review	Complaints Received - B&P Code, Section 800 and 2240(a) Reports	1,010	1,191	1,441	1,538	1,454	1,385	1,240
	Complaints Received - Govt. & Law Enforcement	NA	1,844	1,855	1,953	1,996	1,737	1,593
	Complaints Received - Profession	NA	153	270	279	264	295	283
	Complaints Received - Public & Other	5,730	3,800	4,046	4,450	4,845	5,478	5,124
	Total Complaints Received (Excl. NOI and NPDB Reports)	6,740	6,988	7,612	8,220	8,559	8,895	8,240
	Complaints Closed Without Investigation	4,289	5,616	5,608	5,011	6,818	6,072	6,837
	Complaints Referred for Investigation, Including Change of Address Citations	2,608	2,026	2,125	2,320	2,608	2,138	1,887
	Total Complaints Closed/Referred for Investigation	6,897	7,642	7,734	7,331	9,426	8,210	8,724
	NOI Reports Closed	47	1,934	2,282	2,247	2,244	2,377	2,148
	NPDB Reports Closed	114	2,106	776	432	415	284	273
	Pending Complaints (End of Period)	3,397	1,555	1,279	2,229	1,403	2,019	1,566
Investigation	Investigations Closed or Referred, Including Change of Address Citations	2,066	2,095	2,304	2,374	2,449	2,361	2,117
	Referrals to District Attorney (DA) Offices	80	63	70	58	82	47	37
	Referrals to Attorney General's Office (AGO)	460	497	595	510	589	494	580
	Pending Investigations (End of Period, Excluding Legal Actions)	2,303	1,824	1,406	1,346	1,531	1,251	1,060
	Pending Investigations Per Investigator (Including AHLP Cases)	33	26	21	18	20	21	18
Probation (Incl. AHLP)	Active, In-State Cases (End of Period)	475	569	500	503	498	516	547
	Cases Per Investigator	53	63	42	39	36	40	46
	Pending Investigations (End of Period)	69	94	13	35	78	73	43
	Pending Legal Action Cases (End of Period)	77	18	37	46	53	39	42
	Pending Investigations & Legal Actions Per Investigator	17	12	1	3	6	6	4
Legal Actions	TROs/ISOs Ordered	25	28	28	17	26	12	22
	Accusations Filed	282	289	327	238	329	258	262
	Petitions to Revoke Probation Filed	10	15	31	18	21	18	26
	Accusations Withdrawn/Dismissed	33	75	88	54	48	45	64
	Pending Legal Actions (End of Period; Including AHLP; Excl. Probation)	584	572	496	547	655	608	494
	Pending Legal Actions Per Investigator (Including AHLP Cases)	23	8	7	7	9	10	8
Disciplinary Actions	Citations and Administrative Fines Issued	NA	141	290	513	520	532	423
	Revocation	51	59	50	39	38	40	37
	Surrender	29	67	77	49	47	67	65
	Suspension	0	1	2	5	6	4	2
	Suspension and Probation	29	30	16	16	19	27	31
	Probation Only	51	127	109	91	69	87	98
	Public Reprimand	NA	44	50	50	52	58	51
	Total, Excluding Citations	162	328	304	250	231	283	284
Diversion Program	Accepted Into Program	64	58	63	70	52	47	53
	Successful Completions	53	40	33	46	46	38	37
	Terminations and Withdrawals	22	18	18	7	10	10	23
	Active, In-State Participants (End of Period)	226	213	256	273	269	262	258
	Pending Applicants (End of Period)	24	49	48	41	53	43	29
	Out-of-State Monitored Licensees (End of Period)	0	12	17	15	11	15	17
	Total Monitored at End of Period	250	274	321	329	333	320	304
B&P Mandated Reports	Sections 801/801.1 - Malpractice Reporting by Insurers	746	894	1,024	921	872	872	787
	Sections 801(e)/802/803.2 - Malpractice Self-Reporting	79	130	232	391	313	281	228
	Section 803 - Malpractice Reporting by Courts	10	21	26	25	30	16	3
	Section 802.5 - Coroners	16	9	32	33	38	24	18
	Sections 802.1/803.5 - Criminal Charges and Convictions	0	18	26	37	38	24	33
	Section 805 - Health Care Facilities (Competence)	159	119	101	124	151	162	157
	Section 2240(a) - Self-Reported Surgical Death/Complications	0	0	0	7	12	6	14
	Total B&P Mandated Reports	1,010	1,191	1,441	1,538	1,454	1,385	1,240

Sources: Medical Board of California Annual Reports, California Department of Consumer Affairs Annual Statistical Profiles, and MBC Complaint Tracking System data.

B. Threshold Concerns of the MBC Enforcement Monitor

Following is a description of concerns about MBC's enforcement program that cut across all of its components and the program as a whole.

1. Overall, the enforcement process simply takes too long to protect the public.

In Exhibit V-D below, we recap the actual, total, average length of time consumed by the entire process for a serious quality of care complaint — the type of complaint targeted by SB 1950 (Figueroa) — during fiscal year 2003–04:

EX. V-D. FY 2003-04 Average Quality of Care Complaint Processing Time

CCU processing	79 days[76]
Field investigations (including expert review)	261 days[77]
HQE prior to accusation filing	107 days[78]
HQE post-filing/ OAH hearing and proposed decision/ DMQ review and decision	513 days[79]
TOTAL TIME TO FINAL DMQ DECISION	**960 days = 2.63 years**

Source: Medical Board of California

That 2.63 years is an average; many cases take much longer. It does not account for the serious delays often occasioned by the section 2220.08 "specialty reviewer" requirement in CCU.[80] It does not account for excessive delays in accusation filing and prosecution by HQE's Los Angeles office, which files about 60% of the accusations in the state and has been uniquely plagued with debilitating staffing losses.[81] And it also does not count the time consumed by judicial review if DMQ's decision is ultimately challenged by the respondent physician. Petitions for writ of mandate

[76] *See infra* Ch. VI.B.2.

[77] *See infra* Ex. VII-A and Ch. VII.B.1.

[78] *See infra* Ch. IX.A. and Ex. IX-B.

[79] Medical Board of California, *2003–04 Annual Report* at vi.

[80] *See infra* Ch. VI.B.3.

[81] *See infra* Ch. IX.A.

decided by superior courts in 2003–04 consumed an additional 409 days (1.12 years),[82] and in 47% of those cases, DMQ's disciplinary decision was stayed[83] — meaning the physician was free to continue practicing during judicial review. The total average time from the filing of a serious quality of care complaint to a judicially-reviewed disciplinary decision is thus 1,369 days, or 3.75 years.

The Monitor understands that MBC has no control over the court system. It also has no direct control over its resources and staffing, and — as described below — both have suffered in recent years. However, it does have direct control over its own complaint processing. HQE has direct control over its prosecution activities. The ensuing chapters break down the cycle time at each step of the process and identify steps that consume an excessive amount of time, such as medical records procurement, subject interviews, and expert reviews. With the support of the Legislature and Administration, MBC and HQE must target and attack these time-consuming steps once and for all.

2. MBC resources are inadequate.

In recent years, the Medical Board has suffered a devastating combination of blows to its funding and staffing, and excessive increases in the costs of doing business. These events are described below.

Outdated License Fee Structure. MBC is funded almost exclusively by physician licensing fees, and those fees were last adjusted to $600 biennially ($300 per year) in January 1994 — eleven (11) years ago. An outdated license fee structure means that MBC resources are inadequate to meet the Legislature's and the public's demand for service improvement. Service and work requirements associated with regulating each licensee have remained constant or increased since 1994, while the number of licensees and citizens using physician services has increased significantly. Under these circumstances, MBC has experienced a substantial reduction in inflation-adjusted per licensee funding, roughly equal to the 27.9% increase in the California Consumer Price Index in the past eleven years. If $300 was an appropriate license renewal fee in 1994, it is roughly 28% less appropriate today.

As described in Chapter IV, MBC determined that it needed a renewal fee increase to $700 biennially in 1995. Thereafter, it decided to delay a fee increase request in order to examine other parts of its budget and wring all possible efficiencies from its budget as a whole. By doing this, it was able to delay its fee increase request for three years. Instead of being rewarded for its efforts and its efficiency, however, MBC was penalized. Its attempts to secure an increase in the legislative cap on fees in 1998, 1999, and 2000 were met with strong CMA resistance and counteroffers that were

[82] *See infra* Ch. XII.B.

[83] *Id*.

unacceptable to MBC, and were ultimately abandoned. As a result, MBC's fees have not been increased in eleven years.

It is unclear why a profession should be permitted to control the level of resources used by its regulatory agency to police its ranks in the broader public interest.[84] Consumer advocates note that "renewal fees" — as with any industry-wide assessment — are predominantly passed on to consumers. As discussed in Chapter IV, the medical profession — in exchange for a cap on physician liability in medical malpractice lawsuits — agreed in 1975 to support a strengthened Medical Board enforcement program aimed at removing the dangerous physicians whose actions injure patients, create those lawsuits, and impose costs across the physician population in the form of higher malpractice premiums. The medical profession and the insurance industry still reap the benefit of that bargain: The $250,000 cap on noneconomic damages in medical malpractice lawsuits — the lowest cap in the nation — has not been lifted or adjusted since 1975. Today, the inflation-adjusted value of that $250,000 cap is $71,000.[85] A recent study of 257 plaintiff verdicts in malpractice trials from 1995 through 1999 revealed that the MICRA cap on noneconomic damages was imposed in 45% of the cases, reducing total liability in those cases from $421 million to $295 million.[86] The malpractice premiums paid by California physicians are the lowest in the nation.[87] However, the professional association representing physicians has repeatedly blocked fee increases requested by MBC to permit it to more effectively police the profession. Notwithstanding some merit to some of its objections to MBC enforcement practices, that successful and long-term opposition to necessary resources is arguably in breach of the agreement it made in 1975.

Impacts of the Hiring Freeze. Another series of events has plagued MBC, its staffing, and its resources. As discussed in Chapter IV, Governor Davis responded to the state's severe general fund budget crisis by issuing Executive Order D-48-01 on October 23, 2001, which imposed an

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[84] *But see supra* Ch. IV.F., n. 48 (Senate Business and Professions Committee's acknowledgment of the general policy that legislation increasing licensing fees will not be considered unless the affected trade association "signs off on the board's proposal, providing either endorsement or, at least, tacit agreement").

[85] Rachel Zimmerman and Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., October 8, 2004, at 1.

[86] Nicholas M. Pace, Daniela Golinelli, Laura Zakaras, Rand Institute for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA* (2004).

[87] The National Practitioner Data Bank surveyed mean and median malpractice premium payments in every state during 2000 and cumulatively between 1990 and 2000. During 2000, California physicians paid a median of $55,000 for medical malpractice insurance — the lowest in the nation and less than half the average median of $125,000. Cumulatively between 1990 and 2000, California physicians paid a median of $41,500 for malpractice insurance — again the lowest in the nation. Whether the MICRA cap, enhanced insurance rate regulation by the California Insurance Commissioner under 1988's Proposition 103, a combination of both, and/or other factors have resulted in California's low premiums is a matter of sharp debate, was not addressed in the Rand Institute study cited in footnote 86, and is beyond the scope of this report.

immediate statewide hiring freeze. According to the Order, "when business are faced with declining revenues and increasing expenditures, they take actions to reduce spending, and . . . the State of California must take similar actions without delay to ensure that it lives within its means." Thus, the Governor ordered that "[a]ll State agencies and departments, regardless of funding source, are prohibited from filling vacancies that would constitute a new hire to State Government." Shortly after taking office, Governor Schwarzenegger extended the freeze on November 20, 2003.

Thus, MBC — a special fund agency that receives no money from the general fund, whose revenue was not declining (except due to inflation), and whose salary savings due to the freeze would not assist the general fund deficit — was required to leave most vacant positions vacant, wherever they arose. At the end of fiscal years 2001–02 and 2002–03, the state then mechanically abolished many of the vacant positions that had accumulated, resulting in permanent staff position losses, and ordered a further 12% budget reduction in 2003–04.[88] As a result of these actions, MBC has lost a total of 44.8 staff positions since 2001, including 29 enforcement program positions (a 16.2% reduction since 2000–01) — one Supervising Investigator II, three Supervising Investigator Is, fifteen Senior Investigators, and ten investigator assistants and enforcement program clerical staff. In 2004, MBC's enforcement program staff consists of 20 fewer positions than it had in 1991–92, when it received 22% fewer complaints and took 75% fewer disciplinary actions. And the effects of the hiring freeze and budget cuts were not confined to MBC. HQE lost six DAG positions — all in its Los Angeles office, and OAH lost two ALJ positions.

The loss of its enforcement program positions required MBC to disband Operation Safe Medicine, a proactive strike unit created in January 2001 to target unlicensed and fraudulent medical practice in "back-room clinics" in low-income areas, and the Internet Crimes Specialist position intended to target misleading Web advertising, the prescribing of drugs without a prior good faith examination, and online narcotics trafficking.[89] The staffing cuts have required investigative supervisors to take on a partial caseload or other responsibilities in addition to their supervisorial duties. The Board lost an investigative supervisor position that designed and conducted training programs for investigators — so investigator training (other than required POST training) has for the most part ceased, and a senior investigator who had been assigned to HQE to provide trial support to HQE prosecutors approaching evidentiary hearings. The budget cuts have also forced the enforcement program to cut the hours of its district office medical consultants — who are needed to enable the Board to efficiently process quality of care cases; the decrease in MC hours is inconsistent with SB 1950's mandate that MBC focus on expediting quality of care cases in which patients have been injured. And although the freeze was lifted on July 1, 2004, its impacts continue.

[88] Legal issues surrounding the application of a hiring freeze, staffing cuts, and spending restrictions to a special-fund agency are untested and raise troubling policy issues.

[89] *See supra* Ch. IV.F.

MBC is required to reduce its expenditures by 5% in 2004–05 (for a total of almost $700,000); it is meeting that requirement through salary savings, by holding positions that become vacant open for three months before filling them.

Legislative attempts to ameliorate the impacts of the hiring freeze were thwarted during 2004. Senator Liz Figueroa introduced SB 1735, which would have lifted the hiring freeze on special-fund agencies, permitted them to reinstate abolished positions if funding is available, and prohibited the state from borrowing money from special-fund agencies. AB 1797 (Bermudez) would have declared that "the safety of California's patients is, in part, dependent on an effective and adequately staffed program that regulates the practice of physicians" and exempted the enforcement functions of MBC from the hiring freeze. Both bills died in committee.

Increased Costs of Doing Business. While MBC has been unable to fill vacant staff positions, it has been forced to incur higher costs in a number of areas — which explains why its overall expenditures have not significantly decreased with the loss of almost 45 positions. Without increased revenue, the Board has been forced to absorb a 5% salary increase for staff in July 2004, significant increases in workers' compensation premiums and employee benefits for its peace officer investigators, and an increase in the hourly rate paid to the Attorney General's Office. Additionally, SB 1950's addition of Business and Professions Code section 2220.08 — requiring the Board to implement a "specialty reviewer" requirement in the Central Complaint Unit — has meant additional costs to MBC that are discussed in Chapter VI below.

The Board recently submitted a budget change proposal (BCP) seeking to reinstate its 29 lost enforcement positions and at least four of the lost HQE positions; the BCP also included $1.3 million to cover the increased hourly rate charged by HQE, $970,000 to cover increased workers' compensation costs, an additional $450,000 for MBC's expert reviewer program (for both CCU and field office reviewers), and additional funding for the Board's district office medical consultants. On October 13, 2004, the Department of Finance rejected the BCP due to "insufficient fund reserves to support additional expenditures." MBC estimates that it will need a fee increase to $800 biennially to support the BCP. The proposed fee level is not inconsistent with the license fees charged by other comparable agencies; for example, the biennial renewal fee of the Board of Podiatric Medicine is $900 ($450 annually); the State Bar charged $390 in annual license fees during 2004 and is authorized to charge the same during 2005.[90] Fees have not increased for eleven years — accomplishing a 27.9% real spending reduction to 2004, as noted above. American Medical Association, California Medical Association, and local medical society membership dues total more than two times the annual bill for public protection.

[90] *See Assembly Floor Analysis of SB 1490 (Committee on Judiciary)* (June 25, 2004), Cal. Stats. 2004, c. 384.

3. MBC and HQE's management structure and information systems need improvement.

The Monitor has a number of concerns about various aspects of the management structure and management information systems of both MBC and HQE.

Medical Director Position. As discussed in Chapter IV, MBC abolished its "Chief Medical Consultant" (CMC) position in 1994 after a 16-month study that revealed confusion about the supervisorial hierarchy for the CMC and the district office medical consultants. The Board voted to create a more flexible position to be selected by and report to the Board's Executive Director. That position was not filled until July 2000, when MBC hired Dr. Neal Kohatsu, MD, MPH, as its new Medical Director. For three years, Dr. Kohatsu played an important role by assisting the Board and its staff in policy and program development, serving as a liaison to health care constituencies, and working with those constituencies to define issues of importance. While at MBC, he engaged in several important scientific studies with medical faculty at the University of California at San Francisco, including two published studies on characteristics that are potential predictors of physician discipline in California. Regrettably, Dr. Kohatsu left MBC in 2003 for a faculty position at the University of Iowa; because of the hiring freeze, MBC was unable to fill his position, and it was subsequently abolished. Reinstatement of the Medical Director position is a priority for MBC management, and the Monitor supports that effort.

Diversion Program Management. As required by SB 1950 (Figueroa), the Monitor has evaluated MBC's Diversion Program for substance-abusing physicians in Chapter XV below. One of the Monitor's key findings — as described more fully in that chapter — is that the management of the Diversion Program is not well-integrated into overall MBC management. For many years, the Medical Board — both the Board and its staff — has permitted Diversion to effectively function in a vacuum, separate not only from MBC enforcement management (as might be expected) but also from overall MBC management. As described in Chapter XV, this separation has resulted in a breakdown in key Diversion functions that poses a risk not only to the public but also to the physicians participating in the Program — and which breakdown was not communicated to MBC management. The Division of Medical Quality is statutorily required to oversee the Diversion Program,[91] and it reasonably delegates some of that responsibility to MBC management. However, management has not and cannot carry out that duty unless the administration of the Diversion Program is more fully integrated into MBC management.

Relationship between MBC and HQE. As described in Chapter IV above and Chapters VII and IX below, the Health Quality Enforcement (HQE) Section of the Attorney General's Office was created in SB 2375 (1990) to specialize in prosecuting physician and other health care

[91] Bus. & Prof. Code §§ 2346, 2352.1.

practitioner disciplinary matters. The statutes creating and delegating responsibility to HQE[92] do not merely create the section and require it to direct discipline-related MBC prosecutions. They also superimpose HQE over MBC complaint intake/processing and investigations by requiring the HQE Chief to "assign attorneys to assist [DMQ] in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . , to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."

As described above, MBC and HQE did not implement the "investigations" portion of SB 2375 until 1997, when it launched the Deputy in District Office (DIDO) program, under which HQE DAGs physically work in MBC district offices one or two days per week to provide assistance and guidance on investigative plans, identification of matters requiring immediate attention, and medical records procurement; DIDO DAGs also review all cases proposed for closure at the district office level, and (at least in southern California district offices) draft the initial pleading in cases being referred to HQE for filing. MBC and HQE did not formally implement the "intake" portion of SB 2375 until October 1, 2003; that effort is described in Chapter VI below.

As described more fully in Chapters VII and IX, the DIDO program — while certainly better than the prior situation in which investigators with no legal guidance worked up cases and handed them off to a prosecutor who had no input into the investigation and no post-handoff investigative assistance, and while very successful in lowering the average amount of time it takes HQE to file accusations in fully investigated cases — has proven unsatisfactory in many respects. Among other things, the DIDO program has created a strained relationship between MBC and HQE. MBC investigators we interviewed — when discussing their interactions with their investigative supervisor and the on-site DIDO DAG — universally expressed a "who's my boss?" confusion. This strained relationship becomes particularly acute when a trial DAG — the prosecutor who is going to represent the Board at the evidentiary hearing — needs additional investigative work after the case has been transmitted to and accepted by HQE. The existing "supplemental investigation" process requires supervising DAGs and supervising investigators to engage in a time-consuming and bureaucratic written request and negotiation process, which is inappropriate as a disciplinary matter nears evidentiary hearing. As noted below, the Monitor believes the "vertical prosecution" model first suggested in 1990 would resolve these problems and should be revisited.

Enforcement Policy/Procedure Manuals. MBC has a multitude of enforcement policy and procedural manuals. Unfortunately, most MBC manuals produced for us in late 2003 (and listed in Appendix C) had not been updated to reflect the many changes made by 2002's SB 1950 (Figueroa) and other important legislation. The Diversion Program Manual has not been updated since 1998

[92] Gov't Code § 12529 *et seq*.

and is effectively obsolete. No manual adequately and accurately addresses the role and function of the district office medical consultants, and the Medical Consultants' Reference Book has not been updated since 1996. Some MBC manuals contained inconsistencies, errors of fact, and/or errors of law that were identified in the Joint Legislative Sunset Review Committee's May 1, 2002 background paper[93] or by the Monitor[94]; those errors have since been corrected. Finally, HQE has no policy and procedure manual whatsoever. Because most HQE prosecutors are among the office's most senior attorneys, this may not pose a problem now; but when those senior attorneys retire over the next ten years, HQE will require a policy and procedure manual.

The existence of the Monitor position and the pendency of this Initial Report has prompted MBC enforcement staff in all quarters to revise and update many of its manuals. However, this function should be performed routinely and on a regular basis, and — especially in areas where legal interpretation is involved — with the consultation and approval of HQE.

Management Information Systems. The Monitor has numerous concerns about the management information systems of MBC, HQE, and the Diversion Program.

MBC is required to utilize the "Consumer Affairs System" (CAS), a mainframe computer program maintained by the Department of Consumer Affairs' Office of Information Services. CAS is so antiquated that the Department is reluctant to support further upgrades to it. Several attempts to replace it entirely have failed. Because CAS fails to meet its needs, MBC is forced to track some information manually or with additional small database programs.

CAS has limitations that impact the enforcement program. For example, CAS permits intake personnel to enter or "code" only limited information about incoming complaints. An alleged misdiagnosis or botched liposuction resulting in patient death must be coded as

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[93] In its May 1, 2002 background paper, JLSRC staff noted that, according to the *CCU Procedure Manual*, Business and Professions Code section 801 requires insurers to report payout information when "a malpractice settlement, judgment, or arbitration award of over $30,000 has been made" (which is an incorrect statement of law), while the *Enforcement Operations Manual* provides that an "arbitration award of any amount shall be reported to MBC" (which is correct). The CCU manual has been corrected.

JLSRC staff also found that the *Medical Consultant Procedure Manual* purported to interpret Business and Professions Code section 2234(c) ("repeated negligent acts") to require a showing of a "pattern" of departures from the standard of care. According to *Zabetian v. Medical Board* (2000) 80 Cal. App. 4th 462, 469, this interpretation is not correct because the Legislature expressly rejected the word "pattern" when considering the bill that originally added section 2234(c). That manual has been corrected.

[94] At a 2003 oral argument on a nonadoption, the Monitor was alerted to a repetition of the incorrect section 2234(c) interpretation (requiring a showing of a "pattern" of misconduct) in the *Individual Study Program for Expert Reviewers* (October 2002) when a defense attorney argued the necessity of a "pattern" and informed the DMQ panel that "your own procedure manual requires you to find a pattern" in order to discipline for repeated negligent acts. That error has been corrected.

"negligence/incompetence." Alleged prescribing of any medication — whether it is Vicodin, Viagra, or medical marijuana — without a good faith prior examination must be coded as "drug prescribing violation." This lack of detail inherent in the system has made it almost impossible for MBC to meaningfully respond to allegations of "profiling" or "selective prosecution" by various interest groups over the years — including CMA (which has alleged that MBC improperly targets "easy one-patient cases"), the alternative medicine community, and medical marijuana advocates. CAS does not have a "word search" capability enabling MBC (or the public) to systematically analyze its handling of any particular type of case.

CAS also limits the Board's ability to collect information about its handling of individual cases. Chapter VII describes MBC's recent institution of codes to capture the time spent by investigators in procuring medical records, scheduling subject physicians for interviews, and securing expert review of an investigative file. In the medical records area, the date records are requested is entered, and the date records are received is entered. While this may be sufficient in other areas, it is not sufficient for medical discipline matters. Investigators commonly seek medical records from four or five sources on any given patient, and more than one patient may be involved in a particular investigation — requiring the investigator to issue multiple requests for medical records to multiple physicians and facilities. The system will not accommodate this situation. The "records requested" date cannot be matched up with the "records received" date for each individual request — thus hindering MBC from accurately tracking the time it takes to procure medical records.

Finally, CAS affects MBC's public disclosure of information on its licensees. CAS data are largely "imported" onto the Board's Web site, so limitations on CAS' data fields result in limitations on the amount and type of information that MBC can disclose to the public via its Web site. For example, CAS' format does not have space to accommodate the entry of all significant terms and conditions of probation which are part of a public disciplinary order and would be important to a patient seeking a physician. The Board is working to address this issue, which is discussed more fully in Chapter XIII below.

The Diversion Program has its own in-house Diversion Tracking System (DTS), which is only three years old. DTS is supposed to contain a file on each participant which includes all information on the participant, the terms and conditions of his/her Diversion Program contract (including restrictions on medical practice), and his/her participation in the Diversion Program, including results of all bodily fluids testing (which are downloaded directly into DTS from the laboratory that tests participants' urine samples), absences from required group meetings, and dates of worksite monitor and therapist reports. As described in Chapter XV, DTS is used inconsistently by Diversion Program staff, resulting in the Program's inability to access all relevant information when it is most needed — when a participant has relapsed into drug/alcohol use and decisions about practice restrictions must be made very quickly to protect the public. In addition, we found inconsistencies between information found on DTS on a particular participant and information in

that participant's central file. We also found numerous errors and gaps in DTS which were unknown to Program staff, mostly stemming from the lab's download of incorrect urine testing information and DTS' failure to correctly post lab test information to the right participant's file. Diversion Program management believes that DTS is already obsolete, and has asked MBC's Information Systems Branch to design a new system.

For many years, the Attorney General's Office lacked an adequate management information system to capture adequate and accurate information on its processing and prosecution of disciplinary matters, including an itemized billing function that permitted its clients to know what they were paying for. Over the past decade, this issue arose frequently in the Legislature as occupational licensing agencies were increasingly being held accountable for their enforcement performance but were unable to obtain relevant information on the Attorney General's handling of their matters. In 2002, the Office finally implemented ProLaw, a relatively sophisticated case management system, in some of its units. ProLaw arrived at HQE in February 2004; all staff were trained in its use throughout the spring of 2004, and case management information has been tracked since July 2004. HQE management is comfortable with the case management aspect of the system, but has not had sufficient experience with other aspects of the system that enable it to generate usable reports on, for example, average time it takes from acceptance of a matter to the filing of the accusation (some of that kind of information is generated through other, non-ProLaw systems). As such, any evaluation of whether ProLaw has enabled HQE to better measure its performance and increase its accountability to its client agencies would be premature.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #1: Lost enforcement positions should be reinstated. MBC should resubmit its BCP to reinstate the 29 abolished enforcement positions and four HQE attorney positions, to enable the Board to rebuild its enforcement program, recreate Operation Safe Medicine and its Internet Crimes Unit, and expedite the processing of quality of care cases — the primary goal of SB 1950 (Figueroa).

Recommendation #2: Renewal fees should be increased. To support the additional expenses in the BCP, the statutory ceiling on the Board's biennial license renewal fee should be increased to $800 to cover inflation, the 29 reinstated enforcement positions and four HQE positions, additional funds for district office medical consultants who assist in the efficient processing of quality of care cases, the reinstatement of training programs for investigators and other enforcement program staff, additional funding for MBC's expert reviewer program (including the CCU "specialty reviewer" requirement in Business and Professions Code section 2220.08), and MBC's increased costs of doing business. This ceiling simply restores MBC's real, inflation-adjusted revenues to 1994 levels.

Recommendation #3: DCA and MBC must upgrade their management information systems. The Department of Consumer Affairs should continue its efforts to replace the CAS system with a system that integrates enforcement and licensing information, and accommodates more complete coding of complaints and reports to provide the Medical Board and its staff with relevant information about the substance of its caseload and the details of case aging and time consumed by each step of the process. MBC should continue its efforts to revise the Diversion Tracking System. In addition, HQE should fully implement ProLaw so it is used to its full capacity to increase HQE accountability to MBC and its other client agencies.

Recommendation #4: MBC should regularly update all enforcement manuals, and HQE should draft a policy and procedure manual. All MBC enforcement policy and procedure manuals should be regularly updated and reviewed by a team consisting of MBC management, legal counsel, and HQE representatives. The Diversion Program manual must be completely rewritten. HQE should draft a policy and procedure manual in anticipation of the impending retirement of many of its most senior prosecutors. This is an often-overlooked but important management function that must be recognized, resourced, and regularly performed.

In addition, the Monitor recommends that Diversion Program management be more fully integrated into overall MBC management, so as to enable the Division of Medical Quality and MBC management to accurately evaluate the performance of the Diversion Program Manager and staff and the Program itself. This recommendation is addressed in Chapter XV.

Finally, the Monitor believes that creation of a "vertical prosecution" model will produce higher-quality investigations and prosecutions of MBC disciplinary matters, and will serve to address the sometimes strained relationship between MBC and HQE. This recommendation is addressed in Chapters VII and IX.

Chapter VI

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

A. General Description of Functions

The Medical Board's Central Complaint Unit (CCU) is responsible for receiving, acknowledging, screening, and processing all complaints and reports the Medical Board receives about the medical care provided by and conduct of California physicians.

CCU is located in Sacramento, and is currently staffed by two managers, 15 analysts, 5 management services technicians, and a number of support staff. None of these staff positions were lost during the state's recent hiring freeze and subsequent vacant position elimination procedure required by the Budget Acts of 2002 and 2003. In addition, CCU is supported by a cadre of physicians under contract with the Unit who review complaints and medical records to assist in determining whether complaints should be referred for formal investigation. As of October 2003, a deputy attorney general from the Health Quality Enforcement Section of the Attorney General's Office and a supervising investigator from MBC's field investigations staff joined CCU; their roles are described below.

CCU processes written complaints and reports received by mail. Most complaints are filed on MBC's complaint form, which is available online[95] or by calling the Board's toll-free complaint line.[96] CCU will occasionally take and transcribe oral complaints of an urgent nature over the telephone. CCU staff are also responsible for answering MBC's complaint line in order to respond to inquiries, mail complaint forms and information, and otherwise direct callers to appropriate locations. Simply put, CCU's complaint processing responsibility requires it to review and analyze incoming complaints and reports, and determine whether each should be closed or forwarded on to one of twelve MBC regional district offices for formal investigation.

[95] Consumers may access MBC's consumer complaint form at www.caldocinfo.ca.gov or www.medbd.ca.gov under "Forms and Publications." The same link provides reporting forms for the "mandated reporters" identified in Business and Professions Code section 800 *et seq*. described below.

[96] MBC's toll-free complaint number is 1-800-633-2322.

CCU Complaint Initiation and Processing. Once a complaint or report is received, it is screened by a senior program analyst to ensure that it contains sufficient information to be processed, and then "initiated" in MBC's automated enforcement tracking system known as CAS (Consumer Affairs System) by a management services technician (MST). The MST assigns the complaint a number, pulls the prior licensing and disciplinary history of the complained-of physician, and enters various types of information about the new complaint, including the following: (1) the kind or category of the allegation;[97] (2) the specialty area of medicine that is the subject of the complaint or report; (3) the date the complaint was received by MBC — this triggers the statute of limitations applicable to the Board;[98] (4) the "investigation type" — that is, whether the complaint has been filed against a Board licensee, a nonlicensee, or a candidate for licensure; (5) the source of complaint or report; (6) the priority assigned to the complaint (see below); (7) the name and address where the incident occurred, if known; and (8) the date of the incident, if known. The MST generates a letter to the complainant acknowledging receipt of the complaint,[99] and transfers the complaint file to one of the staff services analysts (SSAs) for further processing.

The SSA then reads and analyzes the complaint or report, and takes further action based on whether the complaint (1) is "jurisdictional" — that is, within the regulatory scope of the Medical Board; (2) concerns the quality of care provided by the subject physician (for example, a misdiagnosis), or (3) pertains more generally to conduct of the physician rather than the quality of care provided (for example, refusal to provide the patient's medical records to the patient).

If a complaint is "non-jurisdictional," the SSA forwards it to the appropriate agency and/or closes the matter, and informs the complainant. Some complaints are mediable. For example, if a physician refuses to provide medical records to the patient, the SSA may telephone the physician, explain the law, and persuade the physician to turn over the records. In such a matter, the case is closed.

In order to analyze a quality of care (QC) complaint, CCU must procure the medical records of the patient from the complained-of physician (and often other treating physicians and institutions),

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[97] In entering the kind or category of the allegation, the CAS system limits CCU MSTs to generic categories such as "negligence/incompetence," "drug prescribing violation," "unlicensed practice," "sexual misconduct," and "unprofessional conduct."

[98] Subject to specified exemptions, Business and Professions Code section 2230.5 requires MBC to file a formal accusation within three years of the date it discovers the event that is the subject of the complaint, or within seven years after the event — whichever occurs first. MBC regulations define "discovers" to mean "the date the board received a complaint or report describing the act or omission," and "the date, subsequent to the original complaint or report, on which the board became aware of any additional acts or omissions alleged as the ground for disciplinary action against the same individual." 16 CAL. CODE REGS. § 1356.2.

[99] Business and Professions Code section 129(b) requires MBC and other DCA agencies to acknowledge receipt of complaints within ten days.

which are subject to the physician-patient privilege and may not be released by the physician absent the patient's permission. Thus, CCU must secure the signature of the patient on a "release" or waiver of the privilege and request all relevant medical records on the patient, which may include charts, X-rays, laboratory test results, photographs, invoices, and correspondence. CCU may also request that the physician provide a summary or explanation of the care and treatment provided to the patient. Once the SSA receives those medical records and other documents, the entire file is reviewed by one of the CCU's medical consultants — generally Sacramento-area physicians who "triage" QC cases, determine whether there has been a departure from the applicable standard of care, and recommend that the case should be closed (because it reveals no violation or involves conduct that does not merit disciplinary action) or referred to the appropriate regional field office for formal investigation.

Non-quality of care cases may involve alleged sexual misconduct, drug or alcohol abuse, false advertising, fraud, or criminal activity (among others). If the proper analysis of these cases requires the patient's medical records, CCU will secure the waiver, request the records, and turn the matter over to a medical consultant for a recommendation on whether the case should be closed or go forward. If not, CCU will process the case as appropriate depending on the type of case and sufficiency of the evidence.

Pre-2002 CCU Complaint Processing. Prior to mid-2002, CCU's SSAs were generalists who were "tied to" the geographic region served by a particular MBC district office, meaning that a given SSA would be assigned all cases that — if referred for formal investigation — would be transmitted to a particular regional district office. As such, SSAs handled all types of cases, including both QC cases and non-QC cases.

From its inception in 1990, CCU utilized three categories for prioritizing complaints: "urgent," "high," and "routine." Cases classified as "urgent" included allegations of sexual misconduct, self-use of drugs or alcohol, mental illness, physicians terminated from the Board's Diversion Program for substance-abusing physicians, section 805 reports of adverse peer review action by hospitals, felony convictions, unlicensed practice of medicine involving patient harm, coroner's reports of physician negligence resulting in death, and complaints against physicians on probation. Complaints classified as "high priority" included drug prescribing violations, quality of care cases involving a patient death, complaints against physicians currently under investigation, complaints against physicians with multiple prior investigations, criminal conviction cases (other than felonies), certain unlicensed practice of medicine cases, and quality of care cases involving gross negligence or incompetence. Complaints classified as "routine" included allegations of fraud, false advertising, failure to release medical records, failure to sign death certificates, fictitious name permit violations, patient abandonment, workers' compensation complaints, and quality of care/medical malpractice cases that do not pose a danger to public health and safety.

Prior to 2003, CCU was assisted in processing and screening quality of care cases by a group of approximately 12 Sacramento-area physicians, most of whom were in active medical practice. Most of these medical consultants specialized in family practice or internal medicine; a few specialized in obstetrics/gynecology, psychiatry, or ophthalmology. Their role was to (1) review quality of care complaints and the medical records and other information gathered by CCU; (2) summarize (in a written report) the patient's complaint (including relevant patient history) and the subject physician's treatment of the patient; (3) describe the standard of practice for the treatment of such a patient; (4) specifically describe any departures from the described standard of practice by the physician; (5) state their opinion as to whether the overall care of the patient constitutes either no departure from the standard of practice, a "simple departure" from the standard of practice,[100] an "extreme departure" from the standard of practice,[101] or incompetence;[102] and (6) based on their opinion, recommend appropriate disposition of the matter. Generally, medical consultants would stop by CCU once or twice a week, gather new complaint files, and drop off reviewed cases and dictated opinions for transcription. Under this system, it is possible that a complaint involving a neurological procedure might be reviewed by an internist or pediatrician. However, if a medical consultant felt that he or she did not have sufficient relevant expertise to review a particular case, CCU would either refer it to another CCU medical consultant with relevant expertise or refer it to the field so it could be reviewed by a specialist expert reviewer selected by a district office medical consultant.

Certain kinds of complaints and reports were deemed important enough to refer directly to the field without extensive CCU screening. Prior to 2003, those matters included the following: (1) section 805 reports of adverse peer review action against a physician's privileges; (2) reports of drug-related criminal convictions against a physician; (3) complaints of serious sexual misconduct; (4) complaints concerning excessive prescribing (where MBC might want to engage in undercover operations); (5) new complaints against a physician whose license was already on probation; and (6) new complaints against a physician who was already under investigation or against whom an accusation was pending.

Post-2002 CCU Case Processing. During mid-2002, MBC was undergoing sunset review and SB 1950 (Figueroa) was being developed in the Legislature. As described in Chapter IV,[103] the

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[100] CCU's *Medical Consultant Procedure Manual* defines a "simple departure" as conduct that "deviated from the standard of practice but does not warrant further investigation (a single negligent act that is not considered an extreme departure)."

[101] CCU's *Medical Consultant Procedure Manual* provides examples of "extreme departures," as follows: "failure to do basic diagnostic tests, failure to recognize or act upon common symptoms, failure to use accepted effective treatments or diagnostic procedures, using outdated procedures, failure to refer a patient to a specialist when appropriate."

[102] CCU's *Medical Consultant Procedure Manual* defines "incompetence" as "lack of knowledge or ability in carrying out professional medical obligations."

[103] *See supra* Ch. IV.G.

sunset committee's background paper and various amendments to the bill indicated the Legislature's intent that MBC focus its resources first on quality of care matters in which patients have been injured. To implement that legislative intent, MBC enforcement management instituted a number of changes in the way CCU processes complaints and reports on physicians.

■ ***Division of Unit***. During the summer of 2002, CCU was divided into two sections: the Quality of Care (QC) Section and the Physician Conduct (PC) Section. For purposes of case referral, a "quality of care" case is defined as one "directly related to the doctor/patient relationship in which the physician diagnoses and/or provides treatment for a condition, disease, injury or physical or mental condition."[104] In practice, QC cases tend to be those requiring collection of the patient's medical records and review of those records by a physician. "Physician conduct" cases include all other kinds of complaints, including failure to provide adequate treatment due to physician impairment, sexual misconduct, and the provision of an opinion about a patient's condition (for example, evaluations for an injury or disability). Anticipating that it would receive more QC cases than PC cases, CCU allocated seven SSAs to the QC section and six SSAs to the PC section. The QC SSAs are still generally "tied to" specified MBC district offices, while the PC SSAs specialize in certain types of complaints (for example, sexual misconduct, physician impairment, fraud, and complaints against doctors of podiatric medicine).

■ ***Case Processing Priorities***. Effective January 1, 2003, SB 1950 enacted section 2220.05, which declares that "[i]n order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

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[104] Medical Board of California, Central Complaint Unit, *CCICU Procedure Manual* at Ch. 4. The *Manual* illustrates types of cases that should be categorized as QC cases and be referred to the QC Section, including allegations that a diagnosis was incorrect or delayed, the treatment provided was inappropriate for the condition (or no treatment was provided), the treatment was provided in a negligent manner causing harm or injury to the patient, medication prescribed was inappropriate for either the condition or the patient, medication prescribed was inadequate to treat the patient's pain, medication prescribed was excessive, or the physician failed to adequately document the patient's medical record.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. . . .[105]

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(5) Practicing medicine while under the influence of drugs or alcohol."

Thus, as of January 1, 2003, the CCU MSTs initiating complaints into MBC's computer system assign a priority code to each case according to the section 2220.05 priorities. In MBC parlance, section 2220.05 "priority cases" are called "U1" or "U3" or "U5," depending on which subsection of 2220.05(a) is applicable. For cases not falling into a section 2220.05 priority category, CCU continues to utilize the pre-existing prioritization categories of "urgent," "high," and "routine." In addition, U1–U5 priority cases are physically "red-tagged" so that CCU analysts can visually distinguish them from the rest of their caseload.

■ ***"Specialty Reviewer" Requirement***. Also effective January 1, 2003, SB 1950 (Figueroa) added section 2220.08, which prescribes a specific review process for quality of care cases in CCU. The statute requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been "reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." Section 2220.08 specifies that such "specialty review" must include a review of relevant patient records, a statement or explanation of the care and treatment provided by the subject physician, any additional expert testimony or literature provided by the subject physician, and any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care. The "specialty reviewer" requirement does not apply to section 805 reports or to egregious cases in which MBC seeks to obtain an interim suspension order or other emergency relief. It also does not permit subject physicians to endlessly delay referral of a complaint to the field; the statute requires the Board to request the medical records and other materials for review, and provides that if the Board does not receive them within ten days of its request, "the complaint may be reviewed by the medical experts and referred to a field office for investigation without the information."

[105] Business and Professions Code section 2220.05(a)(3) emphasizes that a physician prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing practices shall not be prosecuted for excessive prescribing.

The "specialty reviewer" requirement has required CCU to recruit and train new medical consultants in a number of different specialties and subspecialties so that QC complaints and reports can be reviewed by a physician with relevant expertise. Further, CCU's policy on cases that may be sent directly to the field without extensive CCU processing has been slightly modified. CCU still sends section 805 reports and potential ISO cases directly to the field because they are expressly exempt from section 2220.08's expert reviewer requirement. Additionally, it still sends serious sexual misconduct and excessive prescribing cases to the field because those are not classified as quality of care complaints (to which section 2220.08 applies). However, it does not always send new complaints against a physician whose license is already on probation and new complaints against a physician who is already under investigation or against whom an accusation was pending to the field without specialty review.

Section 2220.08(d) requires the Monitor to recommend "whether a complaint received by the board relating to a physician and surgeon who is the subject of a pending investigation, accusation, or on probation should be reviewed pursuant to this section or referred directly to field investigation." The Monitor agrees with CCU management that such a complaint should be referred directly to the field without specialty review if the investigator investigating the original case (or the probation monitor, or the DAG prosecuting the pending accusation) wants it at that time without specialty review. The investigator, probation monitor, or DAG should be immediately informed of the new complaint and given the option of its immediate referral without specialty review. MBC has been accused of failing to detect patterns and failing to address repeat offenders; if a physician is already under investigation, the subject of a pending accusation, or on probation, the investigator, prosecutor, or probation monitor should receive new complaints as soon as possible so they can be integrated into the existing investigation and/or prosecution.

■ ***Additions to CCU***. Effective October 1, 2003, two persons were newly assigned to CCU. The half-time assignment of an HQE deputy attorney general (DAG) to CCU represents MBC/HQE's long-overdue implementation of SB 2375's requirement that HQE "assign attorneys to assist the division . . . in intake . . . . Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."[106] At the same time, MBC assigned a Supervising Investigator to work full-time at CCU — such that CCU now has built-in legal and investigative expertise to assist in the processing and review of complaints. Initially, their skills were not well integrated into the Unit. The CCU DAG and Supervising Investigator reviewed only quality of care complaints that

[106] Gov't Code § 12529.5(b); *see also* Ch. IV.C. A brief and limited effort to provide some measure of guidance pursuant to section 12529 was undertaken by HQE in 1991–93. An HQE supervising attorney was assigned to review some of the case closures at CCU during this period, but the experiment was limited in scope and was terminated shortly thereafter.

were proposed for closure without being reviewed by a medical consultant; they reviewed no other QC or PC cases. Additionally, they attempted (on a part-time basis) to reinstitute MBC's undercover Internet Crimes Unit; assisted with reviewing unusual and/or borderline cases; and undertook special tasks such as procedure manual review.

By September 2004, their roles had expanded considerably. The CCU DAG now reviews all medical consultant-reviewed quality of care cases in which a simple departure has been found, and all medical consultant-reviewed cases in which there is a split of opinion between MCs. Additionally, he has become involved in a few cases in which subject physicians or health care institutions have failed to produce requested medical records, and has reviewed and assisted in revising the *CCU Medical Consultant Procedure Manual* and various CCU forms. The CCU Supervising Investigator now reviews quality of care complaints that are proposed for closure without being reviewed by a medical consultant, physician conduct cases being recommended for referral to investigation, and complaints being recommended for closure due to insufficient evidence. In addition, he assists with medical records procurement issues, performs undercover investigations of suspected Internet prescribing violations, serves as a liaison between MBC and other agencies concerning the unlicensed practice of medicine, designs and teaches training courses for CCU analysts, reviews proposed updates to MBC's *Enforcement Operations Manual*, and assists in the recruitment of new medical consultants and expert reviewers.

The CCU DAG and Supervising Investigator have teamed together to tackle other important issues. The Supervising Investigator now investigates the circumstances behind criminal convictions of physicians that have been reported to CCU, works up an investigative file, and refers it to the DAG, who reviews it as would a DIDO DAG before transmitting it to HQE for the filing of an accusation. The CCU DAG and Supervising Investigator have also identified problems in MBC's Citation and Fine Unit and have developed important modifications to the procedures of both CCU and the Citation and Fine Unit that govern the issuance of citations and fines. They now review cases in which either CCU or a district office has determined to issue a citation and/or and fine to ensure that adequate evidence has been gathered to support the issuance of a citation and fine.

Overall, these new "outside" participants have added value to the CCU process of evaluating and screening complaints and reports of physician misconduct. The DAG and Supervising Investigator estimate that, in the ten months they have worked at CCU, they have reviewed 650 cases; in only 12–15% of those cases did they disagree with CCU's recommendation to close a case. In those cases, they recommended further CCU fact-gathering before a closure, and — eventually — only about 3% of the cases that CCU had initially recommended for closure were sent to the field. This result generally supports the conclusion that CCU's complaint processing and decisionmaking are of high quality.

■ ***Review of "Simple Departures."*** During MBC's 2001–02 sunset review, JLSRC staff expressed deep concern that MBC was closing (on grounds of "insufficient evidence") quality of care cases in which a medical consultant had opined that the subject physician had committed a "simple departure" from the standard of care without checking to see whether that physician had been the subject of prior complaints in which other "simple departures" had been found — such that the physician might be disciplined for "repeated negligent acts" under section 2234(c). Effective April 1, 2003, MBC instituted a new procedure for the review of "simple departures" by a senior program analyst and CCU's senior medical consultant. When a medical consultant-reviewed quality of care complaint results in a finding of "simple departure" and is proposed for closure due to "insufficient evidence" (because one act of negligence is not grounds for MBC discipline), the senior program analyst assesses whether the subject physician has a prior complaint history; if so, that history is gathered from CAS and MBC files and is reviewed by the senior CCU medical consultant and the CCU DAG for a recommendation whether the cases should be combined and investigated for repeated negligent acts under section 2234(c).

Detection of Physician Misconduct: Sources of Complaints and Reports. Unlike other occupational licensing agencies, MBC is not solely dependent on consumers for information about physician misconduct. For many years, the California Legislature has mandated that other institutions (including medical malpractice insurance carriers, courts, and hospitals) file reports with MBC about events that may indicate a problem physician. Exhibit VI-A below displays the number of incoming complaints and reports, by source,[107] about California physicians to MBC for the past few years.

Ex. VI-A. Number and Source of Complaints/Reports Received

SOURCE	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04
BPC 800 Reports	1,538	1,454	1,385	1,240
Gov't/Law Enforcement Agencies	1,953	1,996	1,737	1,593
Medical Profession	279	264	295	283
Public/Other	4,450	4,845	5,478	5,124
SUBTOTAL	**8,220**	**8,559**	**8,895**	**8,240**
CCP 364.1	2,247	2,244	2,377	2,148
NPDB	432	415	284	273
TOTAL RECEIVED	**10,899**	**11,218**	**11,556**	**10,661**

Source: Medical Board of California

Following is an explanation of the "source" categories included in Exhibit VI-A:

[107] CCU captures the source of all complaints and reports according to 67 different categories. For convenience at this stage of our report, we have collapsed those 67 categories to six; these six source categories are explained in more detail below.

■ **"BPC 800 Reports"** include reports filed with the Medical Board by various "mandated reporter" individuals and institutions under a series of requirements contained in Business and Professions Code section 800 *et seq*., as follows:

- Section 801(b) requires medical malpractice insurers to file a "complete report" with the Medical Board when they pay out on a malpractice settlement over $30,000, an arbitration award of any amount, or a civil judgment of any amount. Additionally, section 803(b) requires malpractice insurers to report to MBC the entry of a civil judgment in any amount in a claim for damages for death or personal injury caused by the insured's negligence, error, omission in practice, or rendering of unauthorized professional services.[108]

- Section 801.1(b) requires state and local government agencies that self-insure physicians (for example, the University of California) to file a "complete report" with MBC when they pay out on a malpractice settlement or arbitration award over $30,000.

- Section 802(b) requires a physician who does not have malpractice insurance to self-report to MBC medical malpractice settlements over $30,000 and arbitration awards of any amount. If the physician does not so report within 45 days, the physician's counsel is required to file the report with MBC.

- Section 802.1 requires a physician to self-report to MBC the filing of felony charges against the physician and the conviction of the physician of any felony (including any guilty verdict or plea of guilty or no contest).

- Section 802.5 requires a coroner to file a report with MBC whenever the coroner performs an autopsy or otherwise "receives information" from a board-certified pathologist indicating that a death may be the result of a physician's gross negligence or incompetence.

- Section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC.

- Section 803.2 requires "employers" (including professional corporations, medical groups, health care facilities, and HMOs) of physicians who agree to pay judgments

[108] Additionally, Business and Professions Code section 804(d) requires insurers and other specified mandated reporters to maintain for one year all written patient medical or hospital records, depositions, and other discovery generated during the civil action that led to the settlement or other event being reported to MBC.

or arbitration awards in any amount and settlements of $30,000 or more on behalf of a physician to report that physician to MBC. The report must include the name and license number of the physician.

- Section 803.5(a) and (b) require prosecutors and court clerks to notify MBC of any felony criminal filings against a physician "immediately upon obtaining information that the defendant is a licensee of the board." Section 803.5 also requires the prosecutor to notify the court clerk that the defendant is a physician, and "the clerk shall record prominently in the file that the defendant holds a license" from MBC. Section 803.6 requires the clerk of the court in which a physician has been charged with a felony to transmit any felony preliminary hearing transcripts concerning the physician to MBC. Section 803.5(b) requires the clerk of the court in which a physician is convicted of any crime to, "within 48 hours after the conviction, transmit a certified copy of the record of conviction" to MBC.

- Section 805 requires hospitals and HMOs to report to MBC the denial, termination, or revocation of a physician's staff privileges for "medical disciplinary cause or reason." In addition, hospitals and HMOs are required to file a "section 805 report" when (a) "restrictions [on staff privileges] are imposed, or voluntarily accepted . . . for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason," (b) staff privileges are summarily suspended, if the suspension remains in effect for a period in excess of 14 days; and (c) any of the following occur after the physician learns of either an impending investigation or the denial or rejection of the application for staff privileges for a medical disciplinary cause or reason: (1) the physician resigns or takes a leave of absence from his/her staff privileges; (2) the physician withdraws or abandons an application for privileges; and (3) the physician withdraws or abandons an application for renewal of those privileges.

■ **"Government/Law Enforcement Agencies"** may also file and/or refer complaints and reports to MBC. These may include agencies of the federal government (such as the U.S. Drug Enforcement Administration, the Food and Drug Administration, or the Department of Health and Human Services), medical and other health care licensing boards from other states, other California agencies (including the state Department of Health Services, Department of Managed Health Care, the Department of Consumer Affairs and its constituent agencies, and the "Criminal Identification and Information" (CII) system of the Attorney General's Office, which contains fingerprints of all licensed physicians and notifies MBC whenever any of them have been arrested), and local law enforcement entities (such as district attorneys' offices and local police or sheriff departments).

■ **"Medical Profession"** includes complaints filed against physicians by physicians, other healing arts licensees, and physician professional organizations and medical societies.

■ **"Public/Other"** includes complaints filed by patients and their family members, friends, or advocates (for example, attorneys and clergy members), pharmacists, consumer groups, employees or co-workers of the complained-of physician, and confidential informants. MBC accepts anonymous complaints.

■ **"CCP 364.1"** stands for section 364.1 of the California Code of Civil Procedure (CCP). CCP section 364 precludes any person from filing a medical malpractice action against a "health care provider" (including a physician) unless he first provides at least 90 days' notice to the physician; the "notice of intent" (NOI) must "notify the defendant of the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered." CCP section 364.1 requires the plaintiff to send a copy of the 90-day NOI required by section 364 to the Medical Board, ostensibly to alert MBC that a civil malpractice action may soon be filed against one of its licensees.

■ **"NPDB"** is the acronym for the National Practitioner Data Bank maintained by the U.S. Department of Health and Human Services' Health Resources and Services Administration. Since 1990, NPDB has received reports of and maintained records on licensure and disciplinary actions by state medical boards, malpractice payouts by insurance carriers, and hospital disciplinary actions against physicians licensed in all 50 states. Respectively, state medical boards, insurance companies, and hospitals generally check with the NPDB before licensing, insuring, or granting privileges to a physician. The concept behind the NPDB is to prevent problem physicians from moving from state to state and gaining licensure and other privileges by lying about their past. The NPDB's records are not available to the public. However, they are available to the Medical Board, and MBC receives a copy of reports filed with the NPDB by insurers when they pay out on a reportable settlement, judgment, or arbitration award.

Sources of Complaints Resulting in Investigation and Prosecution. Exhibit VI-B below presents a breakdown of all complaints received by MBC in 2003–04, by referral source, and the percentage of complaints submitted by each source that were referred for investigation and prosecution (either by HQE or by local prosecutors).

We can draw several conclusions from these data. First, the predominant source of complaints is patients, their advocates, and their families. However, those complaints are rarely referred for investigation — only 9% of patient complaints went to investigation during 2003–04 (which is consistent with 2002–03, in which 11% of patient complaints were referred for investigation). The principal sources of complaints referred for investigation were mandatory reports required by Business and Professions Code section 800 *et seq*., especially section 805 reports of

adverse peer review action taken by hospitals (73% of section 805 reports were referred for investigation), section 802.5 reports by coroners (45% referred), section 803/803.5 reports by court clerks of physician criminal convictions and civil judgments (31% referred), section 801/801.1/803.2 reports by insurers and employers of malpractice payouts (24% referred), and section 802/802.1 self-reporting by physicians (22% referred). Other high-yield sources are medical and osteopath boards in other states, other government agencies, and local police or sheriff departments.

Ex. VI-B. FY 2003–04 Physician Complaint Processing and Investigations By Referral Source

Referral Source	FY 2003–04								
	Complaints Received	Reviewed By Medical Consultant	Complaints Closed By CCU	Referred to Investigation		Non-Legal Closures	Legal Closures		
				Number	Percent		Attorney General*	District Attorney*	Percent
Patient, Patient Advocate, Family Member or Friend	4,516	1,245	4,368	441	9%	420	121	12	24%
Out of State Medical/Osteopathic Boards	375	1	289	83	22%	6	77	0	93%
Section 801, 801.1 & 803.2 (Insurers & Employers)	797	620	624	194	24%	148	54	1	27%
Section 805 (Health Facilities)	157	0	44	120	73%	76	46	1	38%
Department of Health Services	99	27	74	36	33%	32	27	0	46%
M.D. Licensees	243	11	219	52	19%	34	21	1	39%
DOJ - Criminal Identification & Information Bureau (CII)	230	0	238	63	21%	26	29	0	53%
Other Governmental Agencies	91	14	65	30	32%	24	12	0	33%
Anonymous	325	3	296	58	16%	57	14	0	20%
Insurance Company	61	13	56	25	31%	16	8	2	38%
Police/Sheriff Departments	31	1	12	19	61%	16	5	0	24%
Section 802 & 802.1 (Self-Reporting)	228	159	170	47	22%	48	6	0	11%
Other	110	2	97	28	22%	25	4	2	19%
Newsclipping	12	1	6	8	57%	4	3	0	43%
Section 803 & 803.5 (Courts)	20	4	18	8	31%	3	5	0	63%
Employee or Co-worker of Subject	47	1	34	12	26%	8	4	1	38%
Pharmacist or Employee	17	1	14	9	39%	6	3	0	33%
Attorney General & Dept. of Justice	11	2	6	7	54%	2	4	0	67%
Coroner (including Section 802.5)	22	12	12	10	45%	7	4	0	36%
Confidential Informant	18	2	13	8	38%	5	0	0	0%
B&P 2240(A) - Self-Reported Surgical Complications	14	5	8	3	27%	2	2	0	50%
District Attorney	7	1	5	3	38%	2	0	0	0%
Allied Health Licensee	8	0	7	0	0%	1	0	0	0%
Other DCA Boards and Bureaus	45	2	29	4	12%	4	0	0	0%
Other Healing Arts Licensee	15	0	13	5	28%	3	0	2	40%
Hospital (Non-805 Report)	13	0	7	2	22%	1	0	0	0%
Jury Verdict Weekly	2	1	3	0	0%	0	1	0	100%
Court Clerk - Non-Felony Conviction	8	0	9	1	10%	0	1	0	100%
WE Tip	23	0	26	1	4%	1	0	0	0%
Medical Society or Association	6	1	7	1	13%	1	0	0	0%
Total, Excluding Medical Board	7,551	2,129	6,769	1,278	16%	978	451	22	33%
Medical Board	689	19	75	612	89%	541	129	15	21%
Total, Including Medical Board	8,240	2,148	6,844	1,890	22%	1,519	580	37	29%
National Practitioner Data Bank (NPDB) Reports	273	0	273	0	0%	0	0	0	0%
Notice of Intent (NOI) Reports (CCP 364.1)	2,148	0	2,148	0	0%	0	0	0	0%

* May include dual referrals.
Source: Medical Board of California

Sources of Section 2220.05 Priority Complaints. Exhibit VI-C below presents a breakdown of all complaints received in 2003–04 by priority and by referral source. This chart notes the priorities assigned to incoming complaints — both section 2220.05 priority cases (U1–U5) and MBC's "urgent/high/routine" prioritization of cases that do not fall within any U1–U5 category.

Ex. VI-C. FY 2003–04 Physician Complaints Received By Priority By Referral Source

Referral Source	U1 Death or Serious Injury	U3 Excessive Prescribing	U4 Sexual Misconduct	U5 Prctng. Under the Influence	Subtotal Priority U1–U5	Urgent	High	Routine	Total
Patient, Patient Advocate, Family Member or Friend	822	99	74	4	999	425	803	2,290	4,517
Section 801, 801.1 & 803.2 (Insurers & Employers)	772		5		777	10	7	3	797
Section 802 & 802.1 (Self-Reporting)	217	1			218	3	3	4	228
Anonymous	19	28	5	15	67	82	20	156	325
M.D. Licensees	14	14	2	2	32	46	14	151	243
Department of Health Services	19	6			25	22	18	34	99
Coroner (including Section 802.5)	16				16		2	4	22
Police/Sheriff Departments		3	9	1	13	9	3	6	31
Other Governmental Agencies	8	4	1		13	22	10	47	92
B&P 2240(A) - Self-Reported Surgical Complications	13				13	1			14
Employee or Co-worker of Subject	2	3	3	2	10	11	1	25	47
Section 803 & 803.5 (Courts)	3				3	8	7	2	20
Section 805 (Health Facilities)	3		2	2	7	127	12	11	157
Insurance Company	2	5			7	14		40	61
Attorney General & Department of Justice	4	1			5	1	2	3	11
Pharmacist or Employee		5			5	4	1	7	17
Other	3	1	1		5	22	1	82	110
Out of State Medical/Osteopathic Boards	3	1			4			371	375
Newsclipping	3				3	5		4	12
Confidential Informant	1	1		1	3	8		7	18
Other Healing Arts Licensee		2			2	2	1	10	15
WE Tip		2			2	3		18	23
Other DCA Boards and Bureaus	1	1			2	21	4	17	44
District Attorney					0	5		2	7
DOJ-Criminal Identification & Information Bureau (CII)					0	45	180	5	230
Allied Health Licensee					0	1	1	6	8
Medical Society or Association					0			6	6
Hospital (Non-805 Report)					0	4	2	7	13
Court Clerk - Non-Felony Conviction					0		7	1	8
Jury Verdict Weekly					0			2	2
Total, Excluding Medical Board	1,925	177	102	27	2,231	901	1,099	3,321	7,552
Medical Board	82	23	12	1	118	86	22	462	688
Total, Including Medical Board	2,007	200	114	28	2,349	987	1,121	3,783	8,240
National Practitioner Data Bank (NPDB) Reports								273	273
Notice of Intent (NOI) Reports (CCP 364.1)								2,148	2,148

Source: Medical Board of California

Exhibit VI-C reveals that of 8,240 complaints received, 2,349 (28%) were assigned a section 2220.05 U1–U5 priority — and 2,007 of the 2,349 priority cases were assigned a U1 priority (85%). The clear majority of the complaints received by MBC in 2003–04 (72%) did not fall into any U1–U5 priority category. Note also that no case was categorized as a section 2220.05 U2 priority ("drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient"). These issues are discussed below in Chapter VI.B.

QC vs. PC Complaint Processing. Exhibits VI-D and VI-E below illustrate MBC's processing of quality of care and non-quality of care complaints in calendar year 2003 (the first full year of the restructured Central Complaint Unit, and the first full year of the section 2220.05 priorities) and in fiscal year 2003–04.

Ex. VI-D. Quality of Care Complaint Processing By CCU By Referral Source

Referral Source	CY 2003					FY 2003/04					Average
	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	
Patient, Patient Advocate, Family Member or	2,096	1,280	1,702	365	18%	2,058	1,201	1,816	322	15%	16%
Section 801, 801.1 & 803.2 (Insurers &	851	552	552	207	27%	791	620	617	196	24%	26%
Section 805 (Health Facilities)	111	0	30	76	72%	103	0	23	84	79%	75%
Section 802 & 802.1 (Self-Reporting)	227	173	154	46	23%	219	159	170	38	18%	21%
Out of State Medical/Osteopathic Boards	20	0	7	13	65%	63	1	27	33	55%	60%
Department of Health Services	45	26	22	19	46%	52	23	28	25	47%	47%
M.D. Licensees	53	9	31	15	33%	46	9	27	24	47%	40%
Anonymous	46	1	27	16	37%	81	2	61	14	19%	28%
Insurance Company	24	14	5	10	67%	9	9	8	12	60%	63%
Coroner (including Section 802.5)	15	13	8	9	53%	18	12	9	10	53%	53%
Other Governmental Agencies	22	6	16	10	38%	22	6	13	8	38%	38%
Pharmacist or Employee	10	1	2	7	78%	7	1	4	7	64%	71%
Newsclipping	9	1	3	4	57%	5	1	3	4	57%	57%
Other	5	0	2	2	50%	8	1	3	4	57%	54%
Attorney General & Dept. of Justice	3	4	2	1	33%	5	2	1	4	80%	57%
Police/Sheriff Departments	8	1	3	5	63%	7	1	3	3	50%	56%
B&P 2240(A) - Self-Reported Surgical	9	5	5	2	29%	14	5	8	3	27%	28%
Employee or Co-worker of Subject	5	1	4	2	33%	7	0	2	3	60%	47%
Section 803 & 803.5 (Courts)	9	8	9	2	18%	3	4	6	0	0%	9%
Other DCA Boards and Bureaus	10	1	6	2	25%	7	2	4	2	33%	29%
Confidential Informant	4	3	5	1	17%	3	2	2	2	50%	33%
WE Tip	7	0	6	2	25%	2	0	2	1	33%	29%
Other Healing Arts Licensee	5	1	4	1	20%	3	0	3	1	25%	23%
Hospital (Non-805 Report)	2	0	1	0	0%	6	0	1	1	50%	25%
Allied Health Licensee	2	0	3	1	25%	2	0	1	0	0%	13%
Jury Verdict Weekly	2	0	2	1	33%	1	0	1	0	0%	17%
Medical Society or Association	2	2	3	0	0%	0	1	1	0	0%	0%
District Attorney	1	1	1	0	0%	1	1	1	0	0%	0%
Total, Excluding Medical Board	3,603	2,103	2,615	819	24%	3,543	2,063	2,845	801	22%	23%
Medical Board	179	21	37	140	79%	138	19	34	107	76%	77%
Total, Including Medical Board	3,782	2,124	2,652	959	27%	3,681	2,082	2,879	908	24%	25%
National Practitioner Data Bank (NPDB)	304	0	306	0	0%	273	0	273	0	0%	0%
Notice of Intent (NOI) Reports (CCP 364.1)	2,365	0	2,321	0	0%	2,148	0	2,148	0	0%	0%

Source: Medical Board of California

Ex. VI-E. Non-Quality of Care Complaint Processing By CCU By Referral Source

Referral Source	CY 2003					FY 2003/04					Average
	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	
Patient, Patient Advocate, Family Member or Friend	2,555	75	2,519	147	6%	2,458	44	2,553	119	4%	5%
DOJ - Criminal Identification & Information Bureau	232	0	217	59	21%	230	0	238	63	21%	21%
Out of State Medical/Osteopathic Boards	298	0	227	50	18%	312	0	262	50	16%	17%
Anonymous	281	1	195	54	22%	244	1	235	44	16%	19%
Section 805 (Health Facilities)	55	0	17	38	69%	54	0	21	36	63%	66%
M.D. Licensees	198	2	167	20	11%	197	2	192	28	13%	12%
Other	103	3	93	5	5%	101	0	94	24	20%	13%
Other Governmental Agencies	68	9	36	20	36%	70	9	51	22	30%	33%
Police/Sheriff Departments	22	0	7	15	68%	24	0	9	16	64%	66%
Insurance Company	72	5	54	16	23%	52	4	48	13	21%	22%
Department of Health Services	56	6	44	16	27%	47	4	46	11	19%	23%
Employee or Co-worker of Subject	39	1	25	8	24%	40	1	32	9	22%	23%
Section 801, 801.1 & 803.2 (Insurers & Employers)	13	0	13	0	0%	6	0	7	9	56%	28%
Confidential Informant	14	0	7	5	42%	15	0	11	6	35%	38%
Section 803 & 803.5 (Courts)	13	0	9	4	31%	17	0	12	6	33%	32%
Other Healing Arts Licensee	16	0	12	5	29%	12	0	10	4	29%	29%
Newsclipping	5	0	1	5	83%	7	0	3	4	57%	70%
Attorney General & Dept. of Justice	6	0	6	5	45%	6	0	5	3	38%	41%
District Attorney	5	0	3	2	40%	6	0	4	3	43%	41%
Other DCA Boards and Bureaus	17	1	13	3	19%	38	0	25	2	7%	13%
Pharmacist or Employee	9	0	9	0	0%	10	0	10	2	17%	8%
Court Clerk - Non-Felony Conviction	8	0	9	1	10%	8	0	9	1	10%	10%
Medical Society or Association	8	0	5	1	17%	6	0	6	1	14%	15%
Hospital (Non-805 Report)	7	0	5	1	17%	7	0	6	1	14%	15%
WE Tip	18	0	15	14	48%	21	0	24	0	0%	24%
Section 802 & 802.1 (Self-Reporting)	6	0	0	6	100%	9	0	0	0	0%	50%
Allied Health Licensee	7	0	5	1	17%	6	0	6	0	0%	8%
Coroner (non-Section 802.5)	1	0	2	0	0%	4	0	3	0	0%	0%
Jury Verdict Weekly	1	1	1	0	0%	1	1	2	0	0%	0%
Total, Excluding Medical Board	4,133	104	3,716	501	12%	4,008	66	3,924	477	11%	11%
Medical Board	573	0	28	536	95%	551	0	41	505	92%	94%
Total, Including Medical Board	4,706	104	3,744	1,037	22%	4,559	66	3,965	982	20%	21%

Source: Medical Board of California

As reflected in the exhibits above, during calendar year 2003 CCU received 3,782 QC complaints and 4,706 PC complaints. These numbers conflict with the assumption upon which CCU section staffing was premised — that MBC would receive more QC complaints than PC complaints. This trend continued in fiscal year 2003–04, during which time CCU received 3,681 QC complaints and 4,559 PC complaints.

Disciplinary Actions Taken in Section 2220.05 Priority Cases. The statute creating the MBC Enforcement Monitor position requires the Monitor to "assess . . . the relative value to the board of various sources of complaints or information available to the board about licensees in identifying licensees who practice substandard care causing serious patient harm . . . ."[109] In this initial report, the Monitor is required to present "an analysis of the sources of information that resulted in each disciplinary action imposed since January 1, 2003, involving priority cases, as

[109] Bus. & Prof. Code § 2220.1(c)(2).

defined in Section 2220.05."[110] Exhibit VI-F below includes information on MBC disciplinary actions taken during that timeframe. The exhibit provides the total number of disciplinary actions taken in both section 2220.05 priority categories and in MBC's pre-existing "urgent/high/routine" categories which are still used to prioritize cases not falling within section 2220.05; it also provides a breakdown for each specific type of disciplinary action (*e.g.*, revocation, surrender, probation with suspension, etc.).

It is important to note that many of the disciplinary actions taken during the 18-month period that the Monitor was required to examine resulted from complaints filed well before the January 1, 2003 effective date of section 2220.05, and most of them were referred for investigation under MBC's pre-existing priority system before that date as well. To accommodate and meet the legislative mandate, MBC staff compiled all disciplinary actions taken during this timeframe and — in hindsight — assigned section 2220.05 codes to them as appropriate so the Monitor could submit this required information.

The data in Exhibit VI-F are susceptible of several conclusions which require explanation. The most fruitful source of complaints in which disciplinary action was taken during this timeframe was out-of-state medical boards and osteopathic medical boards. Twenty-two percent (22%) of the 482 disciplinary actions taken by MBC resulted from out-of-state disciplinary action. However, none of these cases was classified as a section 2220.05 priority case. This is a function of the way MBC codes incoming reports of out-of-state physician discipline. Even though many out-of-state disciplinary actions upon which MBC's subsequent disciplinary action was premised involved "death or serious bodily injury" to a patient (such that they conceivably could have been classified as U1 priorities), technically MBC is not reopening that case, rehearing the evidence, and taking disciplinary action for that death or serious bodily injury — instead, it is basing its own disciplinary action on the other state's disciplinary action.[111] As such, all 109 cases were coded as "routine." Although MBC might have coded those out-of-state disciplines involving death or injury as U1 in order to "pad" its statistics, it did not. This decision is probably appropriate. Many of the physicians disciplined in this category do not reside in California and pose little threat to California consumers; they reside in another state (where they committed the act resulting in discipline) but also have a California license.

The Business and Professions Code section 800 *et seq*. "mandatory reporting statutes" continue to be high-yield sources of information leading to disciplinary actions in priority cases. Of the 114 disciplinary actions taken in section 2220.05 priority cases, 29% resulted from mandatory reporting. This is consistent with the data in Exhibit VI-B above.

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[110] *Id*. at § 2220.1(d).

[111] *See id*. at § 2305 (most disciplinary actions taken by another state or jurisdiction are grounds for disciplinary action in California).

Ex. VI-F. Disciplinary Actions By Referral Source By Priority
January 1, 2003 through June 30, 2004

Referral Source	Total Disciplinary Actions			Revocation			Surrender			Probation with Suspension			Suspension Only			Probation Only			Public Reprimand/PLR			Other Actions		
	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total
Out of State Medical/Osteopathic Boards	-	109	109	-	25	25	-	27	27	-	-	-	-	-	-	-	20	20	-	30	30	-	7	7
Medical Board	15	69	84	2	9	11	4	15	19	2	4	6	-	-	-	7	31	38	-	4	4	-	6	6
Patient, Patient Advocate, or Family Member	24	44	68	1	2	3	6	4	10	3	6	9	-	-	-	6	9	15	5	13	18	3	10	13
B&P 805 Reports (Health Care Facilities)	17	27	44	-	-	-	-	9	9	4	-	4	-	-	-	8	8	16	2	7	9	3	3	6
B&P 801 Reports (Insurers)	14	23	37	-	1	1	-	3	3	-	-	-	-	1	1	6	10	16	4	4	8	4	4	8
Department of Health Services	5	20	25	-	1	1	1	4	5	-	5	5	-	-	-	2	8	10	1	1	2	1	1	2
Other	7	10	17	1	2	3	3	4	7	-	1	1	1	-	1	1	2	3	1	-	1	-	1	1
M.D. Licensee and Medical Society or Association	4	13	17	1	2	3	-	1	1	2	2	4	-	-	-	-	4	4	1	2	3	-	2	2
Other Governmental Agencies	3	12	15	1	-	1	-	4	4	-	3	3	-	-	-	2	4	6	1	-	1	-	-	-
Anonymous	5	7	12	-	-	-	-	2	2	2	1	3	-	-	-	2	2	4	1	-	1	-	2	2
Insurance Company	3	8	11	-	2	2	3	1	4	-	2	2	-	-	-	-	2	2	-	-	-	-	1	1
B&P 802 Reports (Self-Reports)	2	8	10	1	1	2	-	-	-	-	4	4	-	-	-	-	2	2	1	1	2	-	-	-
Police/Sheriffs Department	6	3	9	-	-	-	3	-	3	1	1	2	-	-	-	2	1	3	-	1	1	-	-	-
DOJ Criminal Identification & Information (CII)	-	8	8	-	2	2	-	2	2	-	-	-	-	-	-	-	2	2	-	1	1	-	1	1
Drug Enforcement Administration	4	2	6	1	-	1	2	1	3	-	-	-	-	1	1	1	-	1	-	-	-	-	-	-
B&P 803 Reports (Criminal Charge/Convictions)	1	3	4	-	-	-	-	2	2	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-
District Attorney	2	1	3	1	2	3	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pharmacist or Employee	2	1	3	-	-	-	1	-	1	-	-	-	-	-	-	1	1	2	-	-	-	-	-	-
Total	114	366	482	8	49	57	24	79	103	14	29	43	1	2	3	36	107	145	18	64	82	11	38	49

Source: Medical Board of California

The Medical Board itself was the second most productive source of complaints leading to all disciplinary actions during the 18-month period. The Medical Board is considered the "source" of complaints leading to disciplinary action in a number of different scenarios: (1) CCU or a district office investigator is investigating a case against Dr. X, obtains medical records and — based on the records — realizes that Dr. Y is equally or more culpable, and initiates a complaint against Dr. Y; (2) when an investigator is looking into a case, she will often run a "Civil Index" check (a check on all civil malpractice actions filed against the subject physician) and may find additional victims of the subject physician who have not filed a complaint with MBC, whereupon the investigator will initiate a new complaint against that physician; (3) if a physician whose license is on probation violates the terms of that probation and MBC files a petition to revoke the probation, MBC is listed as the source of the complaint leading to the petition; (4) when a physician whose license has been revoked petitions for reinstatement of his license, the physician's post-revocation conduct and rehabilitation is the subject of an investigation by a district office investigator, and MBC is listed as the source of that investigation; (5) when a self-referred participant in the Diversion Program is terminated for failure to comply with his/her Diversion contract, MBC is listed as the source of that action; (6) if a physician who is on probation decides to simply surrender his/her license, MBC is listed as the source of that surrender; and (7) occasionally, when MBC is investigating an allegation of unlicensed practice, it finds a physician who is aiding and abetting the unlicensed practice and initiates a complaint against that physician.

Of the 482 disciplinary actions taken during this 18-month period, 114 (23%) were taken in section 2220.05 priority cases, and 368 (76%) were taken in nonpriority cases. However, this does not support a conclusion that 76% of MBC's disciplinary actions were taken in cases where "there was no patient harm." As noted above, many of the 109 out-of-state disciplinary actions by other medical and osteopathic boards (upon which MBC took disciplinary action) involved patient harm; yet those were coded as nonpriority. Many of the disciplinary actions in which MBC was the "source" involve physicians whose licenses were revoked or were on probation, and the underlying matters involved patient harm; but the follow-up petition for reinstatement or petition to revoke probation was coded as "routine" rather than as a U1–U5 priority.

Finally, it should be pointed out that this analysis may be premature. As noted above, many disciplinary actions taken between January 1, 2003 and June 30, 2004 resulted from complaints filed and referred for investigation well before January 1, 2003 — before the effective date of the section 2220.05 priorities. It may well be that some complaints referred for investigation then would not be referred today — including complaints about fraud and unlicensed practice.

A Note on the Medical Marijuana Issue. The Monitor has received several letters, emails, and telephone calls from physicians who recommend medical marijuana under the Compassionate Use Act of 1996. Although the number of physicians involved is quite small and the issue is fairly narrow compared to the more global task of the Monitor in evaluating the entirety of MBC's enforcement program, it deserves comment.

The Compassionate Use Act, which was added to California law by Proposition 215 and is codified at Health and Safety Code section 11362.5, provides that "seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."[112] The Act also states that "no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."[113]

The Compassionate Use Act reflects one of the most controversial social-legal-political-health issues in society today. It has spawned numerous lawsuits in both state and federal courts — many of which are still working their way through the judicial system such that they remain unresolved. The federal government does not recognize California's Compassionate Use Act or the medical use of marijuana, which it still classifies as a Schedule 1 drug — meaning it has no medicinal value.

Nonetheless, the Act is the law in California, and it prohibits MBC from disciplining physicians "for having recommended marijuana to a patient for medical purposes." Since the Act became effective, four physicians who recommend medical marijuana have been disciplined. These physicians contend that MBC has violated the Compassionate Use Act in letter and in spirit both by disciplining them and by selectively and unfairly "targeting" them for investigation and prosecution. They have convened an organization of like-minded physicians and patients who have maintained an active presence at all DMQ and MBC meetings for the past three years.

In presentations at public MBC meetings observed by the Monitor over the past few years, and in public administrative and court filings, the medical marijuana advocates consistently press several themes. Their complaints — and MBC's responses to them — include the following:

(1) "Only a handful of physicians, less than twenty, recommend medical marijuana, and MBC has investigated or taken disciplinary action against most them." According to MBC, it has received 14 complaints regarding physician recommendation of medical marijuana since 1997. It investigated eight of them. It has taken disciplinary action in four of them, and one case under investigation is pending. The rest have been closed without investigation or disciplinary action.[114]

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[112] Health and Safety Code § 11362.5(b)(1)(A).

[113] *Id*. at § 11362.5(c).

[114] Medical Board of California, Letter to Honorable Wilma Chan, Chair, Joint Legislative Audit Committee (Aug. 9, 2004) at Attachment 3 (Medical Marijuana Investigations). As noted in Chapter V.B., MBC's computer system requires it to code incoming complaints very generically, with labels such as "negligence/incompetence," "drug

(2) "Investigation and prosecution of physicians for recommending medical marijuana is not among the section 2220.05 mandatory case processing priorities established in SB 1950 (Figueroa)." In response, MBC cites section 2220.05(a)(3), which classifies as a "priority complaint" one that alleges "[r]epeated acts of prescribing . . . controlled substances without a good faith prior examination of the patient and medical reason therefor." According to MBC, it "has implemented this statutory directive and applies it evenhandedly, whether the drug prescribed is Vicodin, Viagra, or medical marijuana."[115] Regardless, section 2220.05 does not preclude MBC from investigating or taking disciplinary action in complaints that do not fall within the ambit of section 2220.05.

(3) "The Board inappropriately and disproportionately responds to complaints from law enforcement authorities about doctors who recommend medical marijuana, when no patient has filed a complaint about any doctor who recommends medical marijuana." According to MBC, law enforcement authorities were the sole source of six of the 14 complaints, and were one of several sources in two others. The sources of the other six complaints were spouses, parents, and/or teachers of the patient to whom medical marijuana had been recommended, and colleague physicians of the doctor who recommended medical marijuana. According to MBC, patients rarely complain about physicians who prescribe drugs for them (even excessively), and the mere fact that "law enforcement" is the source of a complaint does not make the source somehow suspicious or untrustworthy.

(4) "The statute says: '*Notwithstanding any other provision of law*, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes' (emphasis added). The 'notwithstanding any other provision of law' language confers absolute immunity on doctors for their actions related to recommending or approving medical marijuana. Whether such doctors accompany a medical marijuana recommendation with the conduct that would ordinarily accompany the prescription or recommendation of any medication (such as a good faith prior examination of the patient) is legally irrelevant, because all such conduct is absolutely immunized under the Compassionate Use Act."[116]

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prescribing violation," and "unprofessional conduct." It does not enable a search for cases by specific type; nor can it perform a "word search" for all cases involving — for example — "medical marijuana." In response to a request by Assemblymember Hannah-Beth Jackson and Senator John Vasconcellos to the Joint Legislative Audit Committee for an audit of MBC's handling of complaints against physicians who recommend medical marijuana, MBC searched its CCU database and canvassed all of its district offices for information on medical marijuana cases in order to produce the data described above.

[115] Medical Board of California, Letter to Honorable Wilma Chan, Chair, Joint Legislative Audit Committee (Aug. 9, 2004).

[116] According to Administrative Law Judge Jonathan Lew, whose proposed decision was adopted by a DMQ panel on March 18, 2004, this legal argument was made by Tod H. Mikuriya, MD, in response to an MBC accusation alleging unprofessional conduct, gross negligence, negligence, and incompetence arising out of his care and treatment of 16 patients to whom he recommended medical marijuana. Proposed Decision in the Matter of the Accusation Against

The Medical Board disagrees with this position — and has done so by way of a published disciplinary decision and a policy statement adopted by the full Board at its May 7, 2004 meeting. In the disciplinary matter, DMQ rejected the "absolute immunity" argument and instead found that the immunity afforded by the statute is conditional, and "does not exempt [physicians who recommend medical marijuana] from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached."[117] In the policy statement (which is posted on MBC's Web site), the full Board affirmed the position taken by DMQ in the disciplinary matter: Physicians who recommend medical marijuana to their patients for a medical condition must use the same accepted standards of medical responsibility as they would in recommending or approving any other medical or prescription drug treatment. Those accepted standards include a history and good faith examination of the patient, development of a treatment plan with objectives, informed consent, periodic review of the treatment's efficacy, consultation as necessary, and proper recordkeeping that supports the decision to recommend the use of medical marijuana.

Recently, the Joint Legislative Audit Committee was asked to initiate an audit of MBC's handling of medical marijuana complaints. After a full investigation and public hearing, the Committee declined the request on August 12, 2004.

It is fair to say that the Medical Board and its enforcement program have struggled with this controversial issue over the years, but it appears to the Monitor that MBC has responded in a constructive way to the difficult legal and policy issues presented. The disciplinary decision and policy statement conform to the Board's "paramount" priority to protect the public, and set forth clear and reasonable standards to which physicians who recommend medical marijuana will be held — standards that are no different from the standards applicable to any physician who recommends or prescribes any medication. The Monitor will continue to observe and evaluate MBC's implementation of its policy statement and its handling of these cases during the second year of the project.

Tod H. Mikuriya, MD, Case No. 12-1999-98783 (Jan. 30, 2004), adopted by the Division of Medical Quality on March 18, 2004. In this decision, DMQ revoked Dr. Mikuriya's license, stayed the revocation, and placed his license on probation for a term of five years subject to a number of terms and conditions. Dr. Mikuriya is challenging this order in court.

[117] *Id.* In so concluding, DMQ agreed with the U.S. Ninth Circuit Court of Appeals in its recent decision in *Conant v. Walters* (2002) 309 F.3d 629, 647: "[D]octors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. If a doctor abuses this privilege by recommending medical marijuana without examining the patient, without conducting tests, without considering the patient's medical history or without otherwise following standard medical procedures, he will run afoul of state as well as federal law. But doctors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine."

B. Initial Concerns of the MBC Enforcement Monitor

1. CCU's average complaint processing time is longer than historically reported.

For a number of years, MBC has been counting as "complaints" several categories of information that should not be counted as complaints. As a result, CCU's reported complaint total is artificially high and its reported average complaint processing time is artificially low.

Notices of Intent and National Practitioner Data Bank Reports. As described above, section 801 requires insurers to report to MBC malpractice payouts on physicians. Additionally, insurers are required to report malpractice payouts to the National Practitioner Data Bank, and they send of copy of their NPDB report to MBC. In its 1993 report on MBC's enforcement program, the CHP found that 120 section 801 reports and 2,000 NPDB reports ("some involving settlements in excess of $1,000,000") were sitting unprocessed in the Central Complaint Unit. From then on, CCU began to process — and count as a complaint — every complaint and report it received. When 1993's SB 916 (Presley) enacted Code of Civil Procedure section 364.1 (requiring civil malpractice plaintiffs to send a copy of their "90-day notice of intent to sue letter" to the Medical Board at the same time they send it to the prospective defendant physician), CCU — having just been criticized by the CHP — immediately began to process them and count them as complaints. As to NPDB reports and section 364.1 "notices of intent" (NOIs), CCU would initiate a complaint (to enter it into the system) but close that complaint on the same day.

As the years have passed, the number of NOIs and NPDB reports have increased. As reflected in Exhibit V-C, CCU has annually received between 2,200–2,500 NOIs and 300–400 NPDB reports in recent years — about one-quarter of CCU's reported complaint total. However, these notices have limited significance and should not be grouped with true complaints for statistical purposes. By themselves, NOIs and NPDB reports provide little relevant information to MBC. NOIs are merely a warning that a plaintiff might sue a physician for medical malpractice 90 days hence, and frequently provide little substantive information about the malpractice to be alleged. NPDB reports do not even identify the patient. Further, they are duplicative of other complaints and reports received by CCU. For example, when a patient sues a physician for medical malpractice, it is conceivable that MBC will receive (1) the NOI, (2) a complaint from the patient, (3) a report from the physician's insurer about a judgment or settlement in the matter, and (4) a copy of that same insurer's report to the NPDB. All of these duplicative complaints and reports about the same matter have been counted as separate complaints since 1993, and have skewed CCU's complaint total upward.

Further, because NOIs and NPDB reports are so different in character from other complaints, and because complaints based on NOIs and NPDB reports are opened and closed on the same day,

inclusion of these two notices as "complaints" skews CCU's overall complaint processing time downward and presents a potentially misleading picture. For example, in its 2002–03 annual report, MBC reported that CCU received a total of 11,556 complaints and took an average of 53 days to process complaints. However, 2,661 of the reported 11,556 complaints (23%) were NOIs and NPDB reports opened and closed on the same day[118] — and excluding them yields a more accurate average CCU complaint processing time of 64 days (not 53 days, as reported).

The Monitor has recommended that CCU discontinue counting NOIs and NPDB reports as "complaints." CCU and enforcement management agreed with the Monitor's suggestion, and both NOIs and NPDBs have been excluded from the "complaints received" total reported in MBC's 2003–04 annual report.

Change of Address Citations. The inclusion of another category of case as both a "complaint" and an "investigation" is further skewing downward the average case cycle times in both CCU and investigations. Known as "change of address citations," these occur when MBC's Licensing Unit mails a physician licensee his/her license renewal notice and it is returned to the Board because the address is incorrect — the physician has moved but has failed to notify MBC in a timely manner as required by law. When this occurs (and it occurs 300–340 times per year), a complaint is initiated by CCU and it is immediately (on the same day) referred to the Board's Citation and Fine Unit for the issuance of a citation. For some reason, these are counted both as "complaints" and "investigations," although neither CCU nor investigations has handled the matter. As reflected in Exhibit VI-G below, the exclusion of "change of address citations" from CCU's average 2002–03 complaint processing time yields an average 67-day timeframe (as opposed to the 53 days reported in MBC's 2002–03 annual report and the 64-day average when NOIs and NPDBs are excluded — see above).

Ex. VI-G. FY 2002–03 CCU Physician Complaint Processing Timeframes By Disposition and Day Range

Day Range	Closed By CCU[1]		Referred to Investigation[2]		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	2,272	37.3%	1,025	57.3%	3,297	41.9%
1 to 2 Months	955	15.7%	193	10.8%	1,148	14.6%
2 to 3 Months	918	15.1%	159	8.9%	1,077	13.7%
3 to 4 Months	715	11.7%	144	8.0%	859	10.9%
4 to 6 Months	802	13.2%	162	9.1%	964	12.2%
More than 6 Months	427	7.0%	106	5.9%	533	6.8%
Total, Excluding Change of Address Citations	**6,089**	**100.0%**	**1,789**	**100.0%**	**7,878**	**100.0%**
Average Timeframe, Excluding Change of Address Citations	**71 Days**		**52 Days**		**67 Days**	
Change of Address Citations (1-Day Processing Timeframe)	0	0.0%	340	16.0%	340	4.1%
Total, Including Change of Address Citations	**6,089**	**100.0%**	**2,129**	**100.0%**	**8,218**	**100.0%**
Average Timeframe, Including Change of Address Citations	**71 Days**		**44 Days**		**64 Days**	

[1] Excludes NOI and NPDB Reports. Includes 12 complaints that took longer than a full year.

[2] Includes 3 complaints that took longer than a full year.

Source: Medical Board of California

[118] *See supra* Ex. V-C.

As noted above, MBC has agreed not to count NOIs and NPDB reports as "complaints" in its 2003–04 annual report, and — partly as a result of their exclusion — average CCU complaint processing time jumped from a reported 53 days in 2002–03 to 76 days in 2003–04.[119] However, and as reflected in Exhibit VI-H below, the exclusion of 327 "change of address citations" reflects an actual 79-day CCU average complaint processing time.

Ex. VI-H. FY 2003–04 CCU Physician Complaint Processing Timeframes By Disposition and Day Range

Day Range	Closed By CCU[1]		Referred to Investigation[2]		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	2,446	35.7%	835	53.4%	3,281	39.0%
1 to 2 Months	1,034	15.1%	155	9.9%	1,189	14.1%
2 to 3 Months	919	13.4%	140	9.0%	1,059	12.6%
3 to 4 Months	724	10.6%	122	7.8%	846	10.1%
4 to 6 Months	918	13.4%	144	9.2%	1,062	12.6%
More than 6 Months	803	11.7%	167	10.7%	970	11.5%
Total, Excluding Change of Address Citations	**6,844**	**100.0%**	**1,563**	**100.0%**	**8,407**	**100.0%**
Average Timeframe, Excluding Change of Address Citations	**82 Days**		**66 Days**		**79 Days**	
Change of Address Citations (1-Day Processing Timeframe)	0	0.0%	327	17.3%	327	3.7%
Total, Including Change of Address Citations	**6,844**	**100.0%**	**1,890**	**100.0%**	**8,734**	**100.0%**
Average Timeframe, Including Change of Address Citations	**82 Days**		**54 Days**		**76 Days**	

[1] Excludes NOI and NPDB reports. Includes 64 complaints that took longer than a full year.

[2] Includes 14 complaints that took longer than a full year.

Source: Medical Board of California

Chapter VII below describes the much greater impact on average investigative case cycle time of excluding change of address citations.[120]

The Monitor does not believe that CCU intends to mislead in any way with regard to its total number of complaints or its complaint processing timeframes. As described above, CCU started counting NOIs and NPDBs as complaints in response to criticism by the CHP in 1993. And it is unclear why "change of address citations" have been counted as both citations *and* complaints; CCU management believes the outdated CAS system may require MBC to count "change of address citations" as complaints and investigations in order to process them.

In any event, the purpose of such statistical tools in a management information system is to assist in the accurate tracking and evaluation of work done. This purpose can only be served when categories of work outputs are logical and consistent, and when those categories do not group together tasks which are inherently different and non-comparable. It does not help the management

[119] Another factor leading to the increase in CCU average case processing time from 53 days in 2002–03 to a reported 76 days in 2003–04 is the delay caused by the specialty reviewer requirement in Business and Professions Code section 2222.08, which is discussed below.

[120] *See infra* Ex. VII-A.

process to group tasks requiring little or no true complaint-handling work — essentially bookkeeping notations — together with tasks requiring substantive work. MBC can and should maintain records of these one-day recordkeeping tasks, but they should be maintained separately from the substantive complaints and citations.

2. CCU complaint processing takes too long.

Business and Professions Code section 2319(a) requires MBC to establish a goal "that an average of no more than six months will elapse from the receipt of a complaint to the completion of an investigation." For cases involving "complex medical or fraud issues or complex business or financial arrangements," section 2319(b) permits an average of one year from receipt of the complaint to conclusion of the investigation. These "goal" timeframes include the time it takes CCU to process and screen complaints.

As described in Chapter VII, MBC's average investigative time by itself exceeds the 180-goal established in section 2319. CCU's average case processing time must be added to that in computing MBC's compliance with the section 2319 goal.

For fiscal year 2002–03, MBC reported 53 days as CCU's average complaint processing time. As reflected in Exhibit VI-G above, however, it actually took CCU an average of 67 days — or 2.23 months — to process all complaints during 2002–03 (excluding one-day NOIs, NPDB reports, and "change of address citations").

For fiscal year 2003–04, MBC has excluded all NOI and NPDB report processing from its average complaint processing timeframe, and reports an average 76-day complaint processing timeframe. When excluding "change of address citations" from the calculation, CCU's average rises to 79 days (2.63 months) — 12 days longer than it took CCU to process complaints in 2002–03.

It is instructive to look at the difference between average case processing times for QC complaints as opposed to PC complaints. As described above, QC complaint processing generally involves (1) a CCU request for the patient's signature on a release; (2) a CCU request for the patient's medical records; and (3) review of those medical records and other materials submitted by the subject physician by a "specialty reviewer" under section 2220.08. In 2003–04, the average time from receipt of a QC complaint to completion of the medical consultant's review was 140 days (4.66 months, which by itself almost exhausts the 180-day goal in section 2319). Approximately ten of these days are consumed by complaint receipt and initiation. During the remaining 130 days, the CCU analyst requests and waits for medical records, CCU locates a "specialty reviewer" medical consultant, and the consultant reviews the matter and writes an opinion.

CCU estimates that, on average, medical records procurement during 2003–04 took 66 days, and medical consultant review took another 64 days. The time consumed by the "specialty reviewer" requirement is discussed in more detail below. However, the time consumed by CCU in procuring medical records deserves mention here. Business and Professions Code section 2225(d) requires physicians to produce medical records within 15 days of request by the Medical Board, "unless the licensee is unable to provide the documents within this time period for good cause. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct." Average medical records procurement time in CCU takes over four times the statutory 15-day period. CCU's procedure involves an initial request followed by a waiting period of three weeks. If no records arrive, CCU sends a second letter which mentions the possibility of $1,000-per-day fines authorized in section 2225.5. If there is still no response after two weeks, either a third letter is mailed or (since mid-2004) CCU asks its assigned DAG to telephone the physician and urge compliance with the request. This lengthy process results in an average 66-day CCU turnaround time between request for and receipt of medical records, and is exacerbated by the *additional* 74-day average spent by field offices on medical records procurement.[121] Combined, MBC spends an average of 140 days — or 77% of the 180-day "goal" established in section 2319 — on medical records procurement alone.

As discussed in Chapters VII and IX, the medical records procurement issue is a serious problem at MBC and HQE. The Monitor believes that CCU, MBC field investigators, and HQE attorneys are handicapped by a "culture" of routine toleration of lengthy delays by physicians and health care institutions in responding to lawful MBC requests for medical records. This tolerance of delay is occurring within the context of quality of care cases — the focus of SB 1950 (Figueroa). The medical records procurement issue must become the target of a focused effort by both MBC and HQE. Lengthy delays should no longer be tolerated, and MBC should use the tools available to it (including warrantless searches where MBC has a patient release, an administrative inspection warrant under Code of Civil Procedure section 1822.5, prompt issuance of subpoenas under Government Code section 11180 *et seq*., immediate subpoena enforcement in the event of noncompliance, and requests for the fines available in section 2225.5) to force compliance with the medical records laws.[122]

3. CCU's implementation of the specialty reviewer requirement for QC complaints has caused a number of problems.

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[121] *See infra* Ch. VII.B.

[122] This is not a new problem, and the Monitor is not the first to recommend this solution. In an October 7, 2002 memo to the members of the Board's Enforcement Committee, Committee Chair Ron Wender, MD, suggested adoption of a "zero tolerance policy regarding obtaining records. Business and Professions Code section 2225 with the imposition of a $1,000/day civil penalty will be utilized for lack of compliance."

As described above, SB 1950 (Figueroa) added section 2220.08, which requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been "reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required."[123]

This specialty reviewer requirement has been implemented rather strictly by CCU,[124] and the method of implementation has caused substantial delay in the processing of quality of care cases in certain specialties (including neurology, radiology, and cardiology). A major goal of SB 1950 was to expedite the processing of QC cases, especially QC cases in the section 2220.05 priority categories, and the specialty reviewer requirement has not yet served that goal.

We compiled data on all reviews completed by CCU medical consultants during calendar year 2003. We also analyzed the total number of reviews that were pending as of December 31, 2003. The term "pending cases" includes two categories: (1) those that had been assigned to an identified reviewer as of December 31, 2003, and (2) those that were unassigned as of December 31, 2003 and were sitting on a shelf in the Central Complaint Unit. We also separated our analysis into two categories: (1) "high-volume specialties" — those specialties that are often the subject of complaints and in which CCU has a number of trained and experienced reviewers, and (2) "low-volume specialties" — specialties and subspecialties in which relatively few physicians practice and/or are less often the subject of complaints, and in which CCU has no (or very few) trained and experienced reviewers. Exhibits VI-I and VI-J below are the products of our analysis.

[123] None of the legislative analyses of SB 1950 discuss this provision in detail. However, its genesis may be attributed to the following statement in the Joint Legislative Sunset Review Committee's May 1, 2002 background paper on MBC's 2001–02 sunset review: "There appears to be no formal requirement that a Medical Consultant evaluating a complaint *must* consult with a physician expert in the relevant sub-specialty before the Consultant can recommend that the case be closed, either with or without merit. Whether a Medical Consultant who is, say, a pediatrician, should be permitted to render an opinion on, say, an oncology case, is left to the Consultant's discretion." The background paper also noted that 24 specialties are currently recognized by the American Board of Medical Specialties, but the CCU medical consultants used in the prior year represented only ten of those specialties.

[124] Several defense attorneys complained that CCU is shipping some complaints to the field without affording their clients the "right" to a specialty review under section 2220.08. However, CCU's procedure manual is quite clear that all quality of care complaints must undergo specialty review. Some complaints properly go to the field without specialty review. By implication, non-quality of care complaints need not undergo specialty review. Also, the statute excepts some cases from the specialty reviewer requirement — including section 805 cases and matters in which MBC intends to seek interim relief.

Ex. VI-I. CY 2003 CCU Medical Consultant Reviews of QC Cases: High-Volume Specialties

Specialty	Completed Reviews (CY2003)				Total Pending Reviews		Unassigned		Assigned			
	Number	Days Unassigned	Days Assigned	Total Days	Number	Total Days	Number	Total Days	Number	Days Unassigned	Days Assigned	Total Days
Internal/General Medicine	795	12	21	33	106	35	70	27	36	21	30	51
Obstetrics & Gynecology	177	16	28	44	36	38	25	24	11	40	31	71
Pediatrics	67	15	23	38	7	67	4	18	3	83	49	132
Psychiatry	84	10	20	30	6	32	5	15	1	21	92	113
Surgery	147	25	16	40	12	71	6	49	6	47	46	93
High-Volume	**1,270**	**14**	**21**	**35**	**167**	**39**	**110**	**27**	**57**	**31**	**34**	**65**

Source: Medical Board of California

Ex. VI-J. CY 2003 CCU Medical Consultant Reviews of QC Cases: Low-Volume Specialties

Specialty	Completed Reviews (CY2003)				Total Pending Reviews		Unassigned		Assigned			
	Number	Days Unassigned	Days Assigned	Total Days	Number	Total Days	Number	Total Days	Number	Days Unassigned	Days Assigned	Total Days
Anesthesiology	28	32	39	71	22	55	13	24	9	58	42	100
Cardiology	52	60	28	88	8	56	5	36	3	39	50	89
Dermatology	18	71	20	91	13	51	12	43	1	73	67	140
Emergency Medicine	3	19	14	33	9	30	6	22	3	14	33	47
Endrocrinology	2	87	30	117	0	0	0	0	0	0	0	0
Gastroenterology	21	22	31	53	4	37	1	15	3	19	25	44
Hematology/Oncology	10	52	22	74	10	37	10	37	0	0	0	0
Neonatal/Perinatal	3	82	38	120	1	7	1	7	0	0	0	0
Nephrology	3	0	31	31	0	0	0	0	0	0	0	0
Neurological Surgery	10	23	14	37	5	109	4	97	1	118	36	154
Neurology	3	61	22	83	16	90	6	46	10	72	45	117
Ophthalmology	54	27	23	50	12	44	10	32	2	36	68	104
Orthopaedic Surgery	43	58	27	85	28	68	24	55	4	80	66	146
Orthopaedics	48	43	21	64	7	36	6	35	1	6	36	42
Otolaryngology	25	49	16	65	3	84	1	50	2	38	64	102
Pathology	2	80	14	94	0	0	0	0	0	0	0	0
Pain Medicine	7	55	8	63	3	64	0	0	3	23	41	64
Physical Medicine & Rehabilitation	11	111	15	126	1	1	1	1	0	0	0	0
Reconstructive Surgery	52	30	20	50	37	78	14	34	23	26	79	105
Pulmonology	8	24	30	54	1	42	1	42	0	0	0	0
Radiology	54	41	26	67	20	56	16	36	4	83	52	135
Rheumatology	2	43	28	51	1	26	1	26	0	0	0	0
Spine Surgery	2	58	58	116	10	110	6	75	4	92	71	163
Urology	25	68	21	89	7	37	3	14	4	40	13	53
Low-Volume	486	45	24	69	218	63	141	40	77	47	56	103

Source: Medical Board of California

As for the high-volume specialties, CCU medical consultants completed 1,270 reviews within an average of 35 days during calendar year 2003. As of December 31, 2003, 167 cases were pending: 110 had not yet been assigned to a reviewer, and 57 were assigned to and pending with an identified reviewer as of December 31, 2003. Combined, the "pending" cases had been pending for an average of 39 days. As for the low-volume specialties, CCU medical consultants completed 486 reviews within an average of 69 days during calendar year 2003 — nearly twice as long on average as compared with completed high-volume specialty reviews. As of December 31, 2003, 218 cases were pending. Only 77 of those cases had been assigned to an identified reviewer, and they had already been with that reviewer for an average of 103 days — suggesting that physicians in these high-demand specialties do not give high priority to reviewing MBC cases at $75 per hour. The remaining 141 cases were literally sitting on a shelf in CCU, and had been there for an average of 40 days. Many investigators we interviewed agreed with the sentiment expressed by one of their colleagues: "One reason our caseloads are so low is that cases are clogged in CCU waiting for specialty review — and they're trickling down here a little older. I got one case that's already close to the statute of limitations."

Delay in the processing of QC cases is not the only result of CCU's implementation of the specialty reviewer requirement. CCU has had to devote significant time (the total of about two personnel-years) to recruiting and training new specialty reviewers, limiting the amount of time these employees can spend on their other assigned duties. In addition, because CCU has been unable to locate qualified reviewers on its own, it has "borrowed" expert witnesses from the list of experts used by the district offices (discussed in Chapter VIII below). These experts must be paid more than CCU medical consultants ($100 per hour for expert reviewers vs. $75 per hour for CCU medical consultants), they are accustomed to performing a full and in-depth review for district offices (which is often unnecessary at the CCU level) and thus use more hours than do experienced CCU reviewers, and their use strips the district offices and HQE prosecutors of the ability to use them in the same case — lessening the overall number of medical experts available to MBC in quality of care cases.

Further, there is no consensus that the quality of reviews or fairness to physicians has improved due to the use of specialty reviewers. Certainly the quantity of reviews completed has not improved. Exhibit VI-K below reviews CCU dispositions following a medical consultant review for calendar years 2000, 2001, and 2002 (before the specialty reviewer requirement was enacted), and 2003 (when it became effective). The exhibit indicates that fewer medical consultant reviews are being completed now (2,383 in CY 2003, as compared with 2,995 in 2000, 2,972 in 2001, and 3,065 in 2002), and of those being completed, the same percentage is being closed (approximately 80%) vs. referred for investigation (approximately 20%). And as for quality, we interviewed investigators, medical consultants in district offices, and prosecutors who read and rely on CCU expert reviews every day. Few have noticed an appreciable increase in the quality of reviews performed since January 1, 2003; most indicated that any heightened quality is not worth the delay

and cost inherent in locating members of very highly-paid specialties to review boxes of records at $100 per hour.

Ex. VI-K. CCU Disposition of Physician Complaints Following Medical Consultant Review

Disposition	CY 2000		CY 2001		CY 2002		3-Year Average		CY 2003	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Closed (no violation)	1,995	66.6%	1,667	56.1%	1,893	61.8%	1,852	61.5%	1,460	61.3%
Closed (insufficient evidence)	369	12.3%	581	19.5%	507	16.5%	486	16.1%	354	14.9%
Closed (info on file)	30	1.0%	65	2.2%	52	1.7%	49	1.6%	61	2.6%
Closed - Other	23	0.8%	41	1.4%	22	0.7%	29	1.0%	30	1.3%
Subtotal	2,417	80.7%	2,354	79.2%	2,474	80.7%	2,415	80.2%	1,905	79.9%
Referred to INV	578	19.3%	618	20.8%	591	19.3%	596	19.8%	478	20.1%
Total	2,995	100.0%	2,972	100.0%	3,065	100.0%	3,011	100.0%	2,383	100.0%

Source: Medical Board of California

Few would disagree with the concept of improving quality by bringing greater expertise to bear, where feasible. The challenge in this connection is how to advance SB 1950's sound goal in a manner which does not unduly encroach on SB 1950's equally important goal of improved case cycle times.

The Monitor believes that MBC may be interpreting the statute too narrowly. The American Board of Medical Specialties recognizes 24 specialties; yet CCU utilized physicians in 29 specialties to review QC cases in 2003. The statute does not require review by someone in an identical specialty or subspecialty, or even someone in the "same or similar" specialty or subspecialty. The statute requires a review by a physician "with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." Not every complaint against a subspecialist pertains to the subspecialty; some complaints go to (in the words of an experienced CCU medical consultant we interviewed) "the basic, core skills of a physician. Did you get informed consent? Did your treatment follow and support your diagnosis?" In those types of cases, it would appear that generalists would be able to review medical records competently for purposes of recommending whether the case should be referred for formal investigation and full review by a medical expert in the specialty. The Monitor recommends that MBC revisit its CCU expert reviewer policy with an eye toward refining its requirements and lowering the average amount of time it takes for review of "low-volume" specialties.

In addition, consideration should be given to amending section 2220.08 to provide an exception to the "specialty reviewer" requirement where CCU is unable to locate a specialist after a 30-day good-faith search. Review at the CCU level is not supposed to be a full-scale expert opinion; it is merely a review to determine whether the complaint should be referred for investigation — where it will be reviewed in detail by a specialist. The goal of SB 1950 (Figueroa) is expedited handling of quality of care cases in which patients have been harmed — and allowing such cases to

languish for 35–70 days while CCU searches for a specialist reviewer when one may not be needed is inconsistent with that goal.

4. The codification of mandatory case processing priorities is resulting in unintended consequences.

SB 1950 (Figueroa) added section 2220.05, which requires MBC to "prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously." No one quarrels with this sound goal. The addition of section 2220.05 was apparently borne of dissatisfaction with MBC's pre-existing priority system.[125] However, the codification of mandatory case processing priorities — or perhaps MBC's good-faith implementation of that mandate — has caused unintended consequences that warrant exploration.

It is important to begin with what the statute actually says and what it does not say. Section 2220.05 says that complaints falling into one of five stated categories — which attempt to capture physicians "representing the greatest threat of harm" — should be "identified and disciplined expeditiously." It says that in its annual report of its enforcement output to the Legislature, MBC must indicate the number of temporary restraining orders, interim suspension orders, and disciplinary actions taken in each of the five categories. The statute does not say that MBC may investigate, prosecute, and take disciplinary action only in cases falling into one of the five priority categories. And it does not say that MBC may not investigate, prosecute, and take disciplinary action in cases falling outside the five categories. Nonetheless, defense counsel are interpreting it that way in sometimes misleading fashion. The Monitor has observed defense counsel arguing that discipline should not be imposed in a given case — including cases investigated and filed long before section 2220.05 became effective — because it does not fit within the section 2220.05 priorities.[126]

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[125] The Joint Legislative Sunset Review Committee's May 1, 2002 background document for MBC's 2001–02 sunset review states: "Board Complaint and Investigative Priorities are Questionable. 'Urgent' complaints receive the highest Board investigative priority, but what is classified as 'urgent' is open to question. The Board's *Policy and Procedure – Complaint Handling Priorities* states that 'High priority complaints are to be processed expeditiously as next in order following urgent complaints.' 'Quality of care – Patient Death' and 'Quality of Care – Gross Negligence/ Incompetence' cases are classified as 'high priority,' not 'urgent.' In contrast, sexual misconduct allegations or a doctor's self-abuse of drugs or alcohol are considered 'urgent.'"

[126] *See, e.g.*, Answer to Petition for Review filed in the California Supreme Court by David Louis Bearman in *Bearman v. Superior Court (Joseph, Real Party in Interest)*, No. S124693 (petition for review denied June 30, 2004). In this subpoena enforcement action stemming from a complaint received by MBC in April 2001 (one and one-half years before section 2220.05 became effective), defense counsel argued to the California Supreme Court in May 2004 that it should not review the court of appeal's decision invalidating a Medical Board subpoena because the subject matter of the relevant complaint "does not even appear on the [section 2220.05] list."

Further, both the language of the statute and the way in which MBC has implemented the section 2220.05 priorities have elevated *patient outcome* over factors which may be as or more important in enforcement circumstances, including imminence of harm, strength of evidence, and culpability. Patient injury or death is always tragic. Sometimes it is the fault of the doctor; many times it is not. But the mere presence of a tragic outcome should not necessarily dictate prioritization of enforcement activity. MBC's goal should be to best protect the public; maximizing public protection often means considering all relevant law enforcement factors, of which patient harm is only the most serious. However, and as reflected in Exhibit VI-C above, one net effect of the statute has been the elevation of all cases where there has been a death or "serious bodily injury"[127] to a patient to U1 status ("gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public"). Exhibit VI-C reveals that over one-fourth of the complaints received during 2003–04 were assigned a U1–U5 priority, and that 85% of those were assigned a U1 priority. Thus, most section 2220.05 priority cases are U1; there were no U2s in 2003–04 (because the U2 category is subsumed by U1), and relatively few U3s, U4s, and U5s. Exhibit VI-L below, which breaks out all complaints pending in CCU as of June 30, 2004, illustrates the concentration of U1 cases.

Not everything can be assigned a U1 priority. If everything is a U1 priority, in effect we have no priority system. But almost every priority case is classified as a U1 priority in the present system.

Ex. VI-L. Pending Complaints as of June 30, 2004

Quality of Care Complaints

Total Pending Complaints	Pending at MC/Specialist	Priority	
1,022	511	U1 (Patient Death/Injury)	358
		U2 (Substance Abuse)	0
		U3 (Excess Prescribing)	13
		U4 (Sexual Misconduct)	0
		U5 (Practice-Drugs/Alcohol)	0
		Non-Priority	140

Non-Quality of Care Complaints

Total Pending Complaints	Pending at MC/Specialist	Priority	
557	0	U1 (Patient Death/Injury)	0
		U2 (Substance Abuse)	0
		U3 (Excess Prescribing)	0
		U4 (Sexual Misconduct)	0
		U5 (Practice-Drugs/Alcohol)	0
		Non-Priority	0

Source: Medical Board of California

[127] The term "serious bodily injury" is not defined in section 2220.05 or any other California statute; thus, CCU's classification of complaints involving injury is necessarily subjective. In an attempt to comply with the intent of the statute, CCU assigns a U1 priority to almost every complaint or report involving injury to a patient.

Further, Exhibit VI-C tells us that 989 of the 2,007 complaints classified as U1 (49%) are section 801/801.1/802/803.2 reports of civil malpractice settlements. Civil settlements often occur several years after the event that prompted the lawsuit. In cases where three or four years have elapsed since the event and the physician has not been the subject of any subsequent complaint or report, it is inappropriate to classify the complaints as U1 because the physician is simply not "a danger to the public" as required in section 2220.05(a)(1). However, that is a judgment call, and MBC has chosen to err on the side of caution and demonstrate absolute compliance with the letter and spirit of the statute.

Conversely, other kinds of complaints posing serious risk of real-time harm and accompanied by strong evidence are relegated to lower status or not included at all on the priorities list. A good argument can be made that it is more important for MBC to move now on a complaint of recent egregious sexual misconduct (U4) or practicing while impaired (U5) than a section 801 report of a civil settlement involving the death of a patient five years ago (U1). A good argument can likewise be made that a felony conviction, aiding and abetting unlicensed practice in backroom clinics, and even some probation violations deserve more expedited treatment than a stale 801 report of a civil settlement stemming from a death five years ago.

Adequate protection of the California public also requires an enforcement presence in other important areas of medical misconduct. No one disputes that a death is a greater tragedy than economic harm or non-fatal unlicensed practice, but a system which inhibits MBC from bringing at least some actions to stop economic harm or unlicensed conduct sends a dangerous signal that such misconduct is tolerated in California. Today, fraud (including egregious insurance fraud that does critical systemic damage to our health care system) and deceptive business practices which injure honest practitioners and consumer victims are relegated to a very low priority by MBC in its current interpretation of its mandate.

A system can be devised to ensure that serious harm or death is given all appropriate priority, while still permitting judicious use of resources to maintain a vital law enforcement presence in other areas of importance. While still giving serious health harm its due significance, MBC should permit its supervisors to identify non-fatal or grievous injury cases where the immediacy of the threat, the strength of the evidence, the need for enforcement deterrence, and the prospects for effective action call for MBC to act. MBC can still make a patient death a high priority, while stopping the drug-addicted surgeon from walking into the operating room tomorrow morning.

All of this suggests that the intent behind section 2220.05 was undeniably good, but putting that intent into words and action is exceedingly complex. The Monitor believes the priorities statute should be refined to effectuate the intent of SB 1950 (Figueroa) and the overall public protection

mandate of the Board — "ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously."

5. Many of MBC's most important detection mechanisms are failing it.

Business and Professions Code section 800 *et seq*. sets forth an extensive "mandatory reporting scheme" intended to enable MBC to detect physician negligence, incompetence, dishonesty, and impairment so that it might investigate and take disciplinary action if appropriate. As described in Chapter IV, several of these statutes were enacted in AB 1 (Keene) in 1975, and were further refined to close loopholes in SB 2375 (Presley) (1990), SB 916 (Presley) (1993), and SB 1950 (Figueroa) (2002) — indicating strong legislative intent that MBC be notified of these events so that its discretion to investigate and its public protection mandate might be preserved. As reflected in Exhibits VI-B and VI-F above, section 800 reports are valuable sources of information to the Board leading to investigation, prosecution, and disciplinary action — including disciplinary action taken in section 2220.05 priority cases. However, many of these mechanisms are failing the Board and the public.

■ ***Malpractice Payouts***. Sections 801 and 801.1 require insurance companies and employers of physicians that self-insure to report to MBC specified judgments, settlements, and arbitration awards against physicians within 30 days of the event. Under section 804(b), the reports must be "complete" in that they must include eight specified items of information; section 804(d) further provides that insurers and self-insured employers of physicians that have received "a copy of any written medical or hospital records prepared by the treating physician or the staff of the treating physician or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the claim prompting the Section 801 or 801.1 report, or a copy of any depositions in the matter that discuss the care, treatment or medical condition of the person shall provide with the report copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California to the insurer . . . ." Section 804(d) further requires insurers and self-insured governmental agencies to "maintain the records and depositions referred to in this subdivision for at least one year from the date of the Section 801 or 801.1 report."

The Monitor has looked at a number of section 801 and 801.1 reports (although no provision could be made for a true statistical sampling). Hardly any of them were filed within the required 30-day time period, and most of them were incomplete to the point of being almost useless to the Board (for example, most failed to include the address or contact information of the plaintiff in the malpractice action). During our interviews of dozens of MBC and HQE staff, we were consistently told that the materials required to be forwarded to MBC by section 804 are not forwarded; in fact, on many occasions, they are destroyed as soon as the settlement is reached, making it difficult if not impossible for MBC to proceed in such a matter.

Unlike section 805 applicable to hospitals, sections 801 and 801.1 contain no penalty for failure to file the required report, failure to file a complete report, and/or failure to produce the records that are required to be produced and kept for one year from the date of the report. During its 2001–02 sunset review of MBC, the JLSRC agreed that these laws should provide "penalties against medical malpractice insurers that fail to report malpractice settlements, judgments, and awards to the Board to match those placed on hospitals that fail to file an 805 Report — up to a $50,000 fine for a negligent failure to file, and up to $100,000 for a willful failure to file."[128] The Monitor agrees.

■ ***Coroner's Reports***. Section 802.5 requires a coroner to file a report with MBC whenever the coroner performs an autopsy or otherwise "receives information" from a board-certified pathologist indicating that a death may be the result of a physician's gross negligence or incompetence. As reflected in Exhibit V-C, MBC receives very few coroner's reports — never more than 40 in a given year.

■ ***Physician Self-Reporting of Criminal Convictions***. Section 802.1 limits physician self-reporting of criminal convictions to felonies. It is unclear why misdemeanor criminal convictions are not also required to be reported. Many misdemeanor convictions are the result of a felony charge which is pled down to a misdemeanor; others are the result of a "wobbler" charge (a crime that may be charged either as a felony or a misdemeanor in the discretion of the prosecutor) that is pled down to a misdemeanor. Many misdemeanor criminal convictions are "substantially related to the qualifications, functions, or duties" of a physician and are grounds for disciplinary action.[129] Court clerks are required to report them to MBC;[130] physicians should self-report them as well.

■ ***Court Clerk Reporting***. Similarly, section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC; section 803.5(a) requires prosecutors and court clerks to notify MBC of felony criminal filings against physicians "immediately upon obtaining information that the defendant is a licensee of the board;" and section 803.5(b) requires the clerk of the court in which a physician is convicted of a felony to "within 48 hours after the conviction, transmit a certified copy of the record of conviction" to MBC. In 2003–04, MBC received three reports from court clerks under section 803(a)(2), and 33 reports of criminal charges and convictions from court clerks and physicians. The

[128] In his October 7, 2002 memo to the Enforcement Committee (*see supra* note 122), Dr. Wender agreed: "[MBC should] institute a system to closely monitor insurance company and hospital compliance with lawful medical records requests; . . . [and] require insurance companies to provide an accurate synopsis of malpractice awards, judgments, and settlements exceeding $30,000 to include the depositions of the defendant, plaintiff, and defendant experts as well as pertinent exhibits."

[129] Bus. & Prof. Code §§ 490, 2236.

[130] *Id.* at § 2236(c).

Board's Public Education Committee has investigated the low level of compliance with these statutes by court clerks. They generally do not comply because (1) they do not know the reporting requirements exist, and (2) even if they know of the reporting requirement, they may not know the defendant is a physician.[131]

■ ***Hospital Reporting of Adverse Peer Review Action***. Section 805 reporting by hospitals, health care facilities, and HMOs is one of the most valuable source of complaints resulting in investigation, prosecution, and disciplinary action, and is the greatest area of failure. According to the Office of Statewide Health Planning and Development, there are 521 hospitals in California; additionally, there are numerous other health care facilities and managed care organizations that are subject to the reporting requirements of section 805. In 2003–04, MBC received only 157 section 805 reports. This is actually a high number compared with 124 filed in 1993–94[132] and the record low of 82 in 1998–99.

In *Arnett v. Dal Cielo*,[133] a hospital challenged MBC's authority to subpoena peer review records, arguing that the Board is not entitled to them under Evidence Code section 1157 and that forcing hospitals to turn peer review records over to MBC would stifle physicians' willingness to serve on peer review committees, thus "chilling" the entire process. In a unanimous decision, the California Supreme Court upheld the Board's authority to subpoena peer review records on physicians under investigation by MBC, and articulated the importance of the conduct of peer review at hospitals and the reporting of adverse peer review actions to the Medical Board of California — whose duty to protect "all consumers of medical services in California" outweighs a hospital's interest in protecting only its own patients, and whose "paramount public protection priority" similarly trumps a hospital's "private purpose of reducing the exposure of the hospital to potential tort liability." In other words, the Court demanded compliance with section 805 because one of the purposes behind private peer review is to support MBC's enforcement program — not the other way around.

Since the *Dal Cielo* decision, a number of events have occurred that have affected compliance with section 805. First, 1998's AB 103 (Figueroa) — for the first time — authorized MBC to publicly disclose some peer review decisions: those that result in "termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason."

Next, after the record low 82 section 805 reports in 1998–99, the Senate Business and Professions Committee held a public hearing in the fall of 2000 to investigate whether hospitals were

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[131] *See infra* Ch. XIV.A.

[132] When MBC learned of that only 124 section 805 reports had been filed in 1993–94, it published a front-page story in its January 1995 *Action Report* licensee newsletter decrying the apparent noncompliance with section 805 and calling on hospitals to obey the law and help MBC protect the public. *See supra* Ch. IV.D.

[133] 14 Cal. 4th 4 (1996).

in fact failing to comply with the reporting requirement, or not engaging in peer review, or whether they have restructured their peer review processes to avoid the events that trigger the reporting requirement. Numerous witnesses — including MBC — testified that the penalty for failure to report was simply too low to deter noncompliance; several hospitals intentionally failed to report for their own reasons and simply paid the low fine as a cost of doing business. As a result of the public hearing, SB 16 was enacted in 2001.[134] Among other things, SB 16 increased the maximum fine for willful failure to file an 805 report from $10,000 to $100,000, and from $5,000 to $50,000 for other failures to file. The bill also made failure to file an 805 report by a physician reporter unprofessional conduct and grounds for disciplinary action. Importantly, SB 16 also added section 805.2, which states the Legislature's intent "to provide for a comprehensive study of the peer review process as it is conducted by peer review bodies . . . in order to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusive, and their relevance to the conduct of peer review in California." In his signing message, Governor Davis indicated his expectation that MBC would come up with the $300,000 needed to conduct the study within its existing resources. Because the Legislature has not increased MBC's license fees since 1994 and due in part to the 2001 budget cuts, that study has never been funded and never been conducted.

Although the number of section 805 reports is up slightly in recent years, the evidence indicates that compliance with section 805 is lower than it appears. The Board received 157 reports in 2003–04, but fully one-third of those were taken by hospitals against a physician's privileges *after* the Medical Board disciplined the physician's license. Thus, rather than peer review assisting MBC in detecting dangerous physicians, the tail is wagging the dog and MBC is prompting hospitals to finally take peer review action against physicians. The case highlighted by the *Orange County Register* in its April 2002 "Doctors Without Discipline" series[135] illustrates hospitals' continuing failure to report adverse peer review action to the Board. Further, the number of disclosable 805 reports has dwindled to almost none; only six (6) disclosable section 805 reports were filed in 2003–04.

■ ***Regulatory Gag Clauses***. In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians through the inclusion of "regulatory gag clauses" in civil settlement agreements. When a patient sues a physician for medical malpractice, the physician may decide to settle with the patient. However, as a condition of settlement, the physician demands that the consumer agree not to contact the Medical Board, not to cooperate with the Medical Board (should the Board contact the patient upon receiving the section 801 report of the settlement), and/or to withdraw a complaint pending before the Board. The impact of these clauses is momentous for MBC — consumers who have just been involved in litigation with a physician who has injured them will not readily risk further breach

[134] *See supra* Ch. IV.F.

[135] *See supra* Ch. IV.G.

of contract litigation with that same physician by cooperating with MBC. They will not sign a release authorizing MBC to obtain their records from the physician who injured them. Even if MBC somehow subpoenas those records and files an accusation, the victim will not readily testify at the hearing against that physician.

Regulatory gag clauses cause many serious problems — both for the Medical Board that is being deprived of information about its own licensees by its own licensees and for unsuspecting patients who continue to be exposed to unscrupulous and/or incompetent physicians because MBC cannot take appropriate disciplinary action against them — the very antithesis of the purpose of all regulatory agencies and especially the Medical Board. Regulatory gag clauses also encourage an irresponsible business model that affirmatively injures people: Despite repeated malpractice actions and repeated settlements, physicians are able to gag their victims so they cannot contact or cooperate with MBC, leaving the doctors free to turn right around and do it again — with MBC unable to do anything about it because it doesn't have a cooperative victim.

In support of a 2004 bill to ban the inclusion of regulatory gag clauses in civil settlement agreements,[136] MBC recently documented some of the costs of regulatory gag clauses.[137] The Board described a dozen recent cases from all over the state in which a regulatory gag clause hindered or prevented investigations and/or prosecutions. These cases documented the considerable time CCU must spend attempting to persuade reluctant patients that the use of regulatory gag clauses by physicians has been invalidated by the courts[138] — which court decision seems not to have deterred physicians from inserting gag clauses into settlement agreements. If CCU cannot persuade the patient to sign a release for medical records (which records are otherwise privileged), it can request HQE to subpoena the records and then enforce the subpoena through a motion before the courts. This process takes time — and some cases in which gag clauses were used had to be closed because the accusation could not be filed within the Board's statute of limitations.[139] This process also costs money — in one case arising out of San Jose, the existence of a gag clause in a civil settlement agreement cost MBC an additional 24 months in investigative time and $25,000 in attorneys' fees for the preparation and enforcement of a subpoena.

Regulatory gag clauses should be statutorily banned for all regulated trades and professions and particularly for physicians in light of the irreparable harm they can cause if they are incompetent,

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[136] AB 320 (Correa), vetoed by Governor Schwarzenegger on September 22, 2004.

[137] Medical Board of California, *Investigation of Impact of Regulatory Gag Clauses: Preliminary Findings* (January 13, 2004).

[138] *Mary R. v. Division of Medical Quality of the Board of Medical Quality Assurance* (1983) 149 Cal. App. 3d 308.

[139] Bus. & Prof. Code § 2230.5.

negligent, dishonest, or impaired. No physician should be permitted to deprive MBC of information about misconduct committed by that physician in the course and scope of the practice of medicine regulated by the State of California.

6. The staffing allocations of CCU's sections should be revisited.

The split of CCU into two sections has allowed SSAs to specialize in particular kinds of complaints, which can lead to greater efficiency because of familiarity with the subject matter and the process. However, the Monitor believes that CCU should revisit the allocation of staffing between the quality of care and physician conduct sections. That staffing was based on the pre-2003 assumption that MBC would receive more QC than PC complaints. As illustrated in Exhibits VI-D and VI-E, the reverse is true: MBC receives more PC than QC complaints. As a result of the current staffing allocations, QC analysts — who spend a lot of time waiting for patient releases, medical records, and medical consultant review and could probably handle slightly higher caseloads — have lower caseloads than do PC analysts. While it is true that some PC complaints can be closed very quickly, other kinds of PC complaints are quite complex and are vitally important to public protection.

All CCU analysts carry massive caseloads. As of September 2004, the eight QC analysts carried an average of 68 cases each, while the six PC analysts carried an average of 97 each. Of particular concern, the *one* PC analyst who processes all complaints alleging sexual misconduct and drug/alcohol offenses — both of which are section 2220.05 priority categories — had 94 cases on his desk as of September 16, 2004. If and when he is ill, called for jury duty, goes on vacation, or is out of the office for any reason, those potentially very serious complaints just sit there and accumulate.[140] There is little or no cross-training of SSAs or an assigned back-up in these priority case areas, and insufficient staffing to enable other SSAs to leave their work for his work.

7. Detection of repeated negligent acts has improved, but could be enhanced.

As described above, CCU has responded to the JLSRC staff's 2002 concern that CCU appeared to be closing quality of care cases in which a "simple departure" had been determined without checking whether that physician had been the subject of prior complaints in which other "simple departures" had been found — such that the physician might be prosecuted for "repeated negligent acts" under section 2234(c). CCU's new procedure calls for identification of "simple departure" findings in QC cases by a senior program analyst, and review of that physician's prior complaint history by CCU's senior medical consultant and assigned DAG.

[140] MBC notes that incoming complaints that accumulate on the desk of any absent CCU analyst are examined on a weekly basis.

Thus, CCU has instituted a review process for "simple departures" in the QC area. However, to our knowledge, it has not instituted a similar review for "simple departures" in the PC area — in complaints alleging sexual misconduct, practicing while under the influence of drugs/alcohol, and other important areas. Inasmuch as these two areas are priority categories under section 2220.05, it would seem appropriate to trigger a review of "simple departure" findings in PC cases in order to detect repeat offenders.

8. CCU should ensure that subject physicians are notified when complaints are closed or forwarded for investigation.

MBC policy sets standards for CCU communication with complainants and with subject physicians. As noted above, state law requires MBC to acknowledge the receipt of a complaint to the complainant within ten days. Thereafter, the CCU policy and procedure manual requires CCU to communicate with the complainant if and when: (1) CCU needs a signed release for medical records; (2) the complaint is sent to a medical consultant; (3) the complaint is referred for investigation; and (4) the complaint is closed. CCU also mails various brochures on the enforcement program to complainants at various stages of the process.

When we interviewed members of the defense bar, they expressed concern that CCU does not always notify their clients when a complaint is received, closed, or referred for investigation. As for the subject physician, CCU communicates with that physician if it needs medical records. At that point in the process, CCU sends the physician a letter including "a comprehensive summary of the substance" of the complaint[141] and requesting all relevant medical records. Thereafter, if the

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[141] *See* Bus. & Prof. Code § 800(c). The defense attorneys also complained about MBC's implementation of section 800(c), a provision requiring MBC to maintain a "central file" on each licensee that contains specified information, including complaints. Section 800(c) permits a licensee to "inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source *or by providing a comprehensive summary of the substance of the material*. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, *or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications*" (emphasis added).

In responding to section 800(c) requests by licensees for complaint information, MBC has chosen to prepare "comprehensive summaries" rather than to release the actual complaint with the identity of the complainant redacted. Defense attorneys object to this procedure on several grounds. First, they contend the summaries are not always "comprehensive." They note that if MBC files an accusation, the complaint is discoverable and defense counsel will obtain it anyway. More importantly, defense counsel assert that obtaining a copy of the actual complaint would help their clients respond more promptly to CCU requests for medical records, and would relieve the anxiety that their clients suffer when called in for a "subject interview" with an investigator about a complaint they know little about.

In response, MBC notes that not all complaints are typed neatly on a form where all information about complainant identity (for purposes of redaction) is easily located. Some complaints are lengthy handwritten missives, and it is more time-consuming to MBC staff to find and redact all identifying information (as required by the statute) than

complaint is closed, section 9.2 of CCU's procedure manual requires it to notify the subject of the closure if he or she has been contacted during the review process.[142]

If CCU does not need medical records from the physician (because, for example, it is non-quality of care case that does not require medical records, or it is an 805 report that is referred directly to the field without CCU screening), then — under current policy — it is possible that the physician will not learn of the pendency of the complaint until it has been referred for investigation. Although physicians might wish for such notice as a matter of courtesy, the Monitor is not disturbed by the fact that MBC does not provide that notice. Generally, a prosecutor is under no obligation to inform a subject that a consumer or patient complaint has been filed or that he is under investigation. In fact, imposing a blanket rule that all subjects of complaints be informed of a pending investigation would interfere with potential undercover operations, and might encourage the destruction or alteration of medical records.

If the complaint is referred for investigation and additional medical records and/or a subject interview is needed, the district office investigator will inform the physician of the pendency of the investigation. If the district office thereafter decides to close the case, the Board's Enforcement Operations Manual is somewhat inconsistent on whether the physician must be notified of the closure. On the one hand, the *Manual* states: "It is the Medical Board of California (MBC) Enforcement Program policy to notify the complainant(s) and subject on all case dispositions, not just those cases closed with no violation or insufficient evidence."[143] On the other hand, if the district office decides to close a case, the manual instructs the assigned investigator to notify the physician only if he/she was contacted by that investigator during the course of the investigation.[144] Similarly, the *Manual* is unclear whether the subject will be notified if the matter is transmitted to HQE.

MBC's stated policy is appropriate: It should "notify the complainant(s) and subject on all case dispositions . . . ." However, its procedure manuals are inconsistent on this issue and should be clarified.

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to ascertain the gist of the complaint and prepare a comprehensive summary (as permitted by the statute). MBC believes the "summary" option is more efficient. More fundamentally, from a law enforcement perspective, MBC does not believe a complained-of physician should be permitted to know (at least at the outset) the precise details of a complaint about — say — sexual misconduct. When MBC investigates such a complaint, it wants the physician's candid response to the event that is the subject of the complaint as he recalls it. As a matter of sound investigative policy, it is often better to promote spontaneity and candor rather than canned, prepared responses. There is a balance between attempting to "trick" someone who is under investigation and allowing him to prepare canned answers for every single aspect of the complaint. Section 800(c) strikes that balance well, and the Monitor is not prepared to recommend that it be amended.

[142] *See also* Medical Board of California, *Enforcement Operations Manual*, at Ch. 7, § 7.1.

[143] *Id*. at Ch. 8, § 8.7.

[144] *Id*.; see also *id*. at Ch. 7, § 7.1.

9. CCU should regularly review and update its procedure manuals.

CCU's two procedure manuals (the *CCICU Manual* for analysts and the *CCU Medical Consultant Procedure Manual* for medical consultants) were provided to us in October 2003. The *CCICU Manual* had been updated to include the changes made by SB 1950 (Figueroa) (2002), but the *Medical Consultant Procedure Manual* had not. It has since been updated.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #5: CCU should discontinue counting NOIs, NPDB reports, and "change of address citations" as complaints, and accurately report its true complaint total and average complaint processing time. As noted above, CCU has already — in MBC's 2003–04 annual report — discontinued counting NOIs and NPDBs as complaints. CCU should ascertain whether there is any good reason to count "change of address citations" as both complaints and investigations when they are neither; if no sound reason exists, CCU should discontinue counting them as complaints and including them in its calculation of its average complaint processing time.

Recommendation #6: Code of Civil Procedure section 364.1 should be repealed. The "notices of intent" forwarded to MBC under CCP section 364.1 contain very limited information and are generally not helpful to MBC. CCU and MBC district offices now have access to the Civil Index, a more reliable record of all filed civil actions (to which it had no access in 1993 when CCP section 364.1 was enacted).

Recommendation #7: CCU must establish a firm policy on medical records procurement, and HQE must assist CCU in enforcing that policy. CCU spends an average of 66 days procuring medical records in quality of care cases — four times the statutory 15-day period. Physicians ignore lawful requests for records by MBC because they don't think MBC will enforce the law. MBC — including CCU — should stop tolerating delays, enforce existing laws, and utilize the tools available to it to force compliance with medical records laws.

Recommendation #8: MBC and HQE should expand the role of HQE attorneys in CCU. The assignment of a deputy attorney general and supervising investigator to CCU has resulted in enhanced screening of complaints, important modifications to the Citation and Fine Program, and other valuable contributions. MBC and HQE should expand and fund the role of HQE in CCU in compliance with Government Code section 12529 *et seq*. Specifically, HQE should play a much greater role in medical records procurement in CCU (see Recommendation #7 above).

Recommendation #9: CCU should revisit its implementation of the "specialty reviewer" requirement in section 2220.08. MBC's current interpretation of the statute may be overly strict,

is causing a serious and potentially unnecessary delay in the processing of quality of care cases, and is costing the Board time, money, and the use of expert reviewers at the district office level.

Recommendation #10: Section 2220.08 should be amended to permit CCU to refer directly to the field (without specialty review) any new complaint relating to a physician who is the subject of a pending investigation, accusation, or on probation. The investigator, probation monitor, or DAG should be immediately informed of the new complaint and given the option of its immediate referral without specialty review. In addition, consideration should be given to amending section 2220.08 to provide an exception to the specialty reviewer requirement where CCU is unable to locate a specialist after a 30-day good-faith search.

Recommendation #11: The Monitor and all stakeholders in MBC's enforcement program should collaborate to refine the language of section 2220.05's "mandatory case processing priorities" to effectuate the intent of SB 1950 (Figueroa) — "ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously."

Recommendation #12: Insurers should be penalized for failure to comply with existing reporting requirements. As recommended by the Joint Legislative Sunset Review Committee in 2002, sections, 801, 801.1, and other provisions requiring insurers and others to file reports of civil malpractice payouts to MBC and to keep medical and other records produced in the legal proceeding leading to those payouts should be amended to include a deterrent-producing penalty for failure to report, failure to file a complete report, and/or failure to produce the records that are required by existing law.

Recommendation #13: Misdemeanor criminal convictions should be reported to MBC. Sections 802.1 and 803.5 should be amended to require physicians to self-report and prosecutors to report misdemeanor criminal convictions to MBC. Misdemeanors are crimes, not bad bedside manner. If they are substantially related to the qualifications, functions, and duties of a physician, they are grounds for disciplinary action and MBC should know about all of them.

Recommendation #14: MBC should educate coroners about their reporting requirements under section 802.5. Coroner reports are a valuable source of information leading to investigations and disciplinary actions, but MBC receives very few reports from them. MBC should design a fact sheet or brochure notifying coroners of the reporting requirement, explaining the importance of coroner reporting and informing them how to obtain the reporting form, and should periodically remind coroners of their reporting responsibility.

Recommendation #15: The Department of Consumer Affairs should — on behalf of all of its regulatory agencies with mandatory reporting requirements — join with the Judicial

Council and other interested stakeholders to design an educational program for courtroom clerks, judges, and public prosecutors to enhance their compliance with the reporting requirements in Business and Professions Code section 800 *et seq*. Many DCA agencies have reporting requirements, and no single agency can or has done an effective job of educating courtroom clerks about their reporting responsibilities. The Department should undertake such an effort on behalf of all of its agencies with reporting requirements, and in fact has begun to dialogue with the Judicial Council on this issue. This educational program should include information on the section 800 reporting requirements and also the important and underutilized mechanism in Penal Code section 23, which permits a DCA agency (or a deputy attorney general representing it) to appear in court during a criminal proceeding against an individual licensed by that agency, and to recommend specific conditions of probation "necessary to promote the interests of justice and protect the interests of the public." The educational program could profitably be undertaken working with the California District Attorneys Association, whose members are required to report certain information to MBC and to alert courtroom clerks that a defendant is a physician, and to judges who supervise those courtroom clerks and preside over criminal matters in which Penal Code section 23 assistance may be offered.

Recommendation #16: The study of peer review authorized in SB 16 (Figueroa) should be funded and conducted as soon as possible. SB 16, which added section 805.2 to authorize an important study of the actual conduct of peer review in California, was enacted in 2001. Governor Davis required MBC to fund the study from its own budget — which was not possible after the hiring freeze and budget cuts starting in October 2001. Senator Figueroa attempted follow-up legislation (SB 2025) authorizing MBC to fund the study in 2002, but the provision was removed from the bill. Section 805 reports are among the most valuable sources of information to the Board about problem physicians — yet fully one-third of them received by MBC in 2003–04 reported peer review actions taken after (and probably due to) MBC disciplinary action. Section 805 is not working as intended, and the study must be funded and conducted — so that section 805 might be amended to conform to the actual conduct of peer review — as soon as possible.

Recommendation #17: MBC's sunset legislation should include a provision banning the inclusion of regulatory gag clauses by licensees of any agency created in Division 2 of the Business and Professions Code. The practice of paying people not to contact regulatory agencies is tantamount to extortion and suborning perjury, and should be banned as against public policy. A California Court of Appeal has already invalidated the use of regulatory gag clauses by physicians, but that ruling has not deterred physicians from continuing to include them in civil settlement agreements — to the great detriment of MBC and the consumers it is required to protect as its "paramount priority."

Recommendation #18: CCU should revisit the staffing allocations of its two sections, and MBC should consider augmenting the staff of this important unit so its analysts are not

overburdened with excessive caseloads and to accommodate the cross-training of analysts to handle important matters expeditiously.

Recommendation #19: CCU should institute a review process for "simple departures" in PC cases — especially in complaints alleging sexual misconduct and drug/alcohol offenses — to ensure that it is not overlooking potential investigations and prosecutions of repeat offenders on grounds of repeated negligent acts.

Recommendation #20: CCU should ensure that subject physicians are notified when complaints are closed or forwarded for investigation. Board policy requires subjects to be notified on all case dispositions. However, its procedure manuals are inconsistent on this issue and should be clarified.

Recommendation #21: CCU should ensure that its policy and procedure manuals are regularly updated to accommodate changes in the law, MBC policy, and CCU structure. Both the DAG and the supervising investigator now assigned to CCU should play a key role in this regular review and revision of all CCU procedure manuals.

Chapter VII

FIELD INVESTIGATIONS: DISTRICT OFFICES

A. General Description of Functions

Complaints and reports about California physicians which have passed through the screening process of the Central Complaint Unit (see generally Chapter VI) are referred to MBC's district offices for investigation. This chapter describes the investigative process of the district offices and the Monitor's initial concerns about that process, and presents the Monitor's initial recommendations for its improvement.

District offices' role in current process. As illustrated in the organizational chart in Exhibit V-A above, MBC maintains twelve field offices (called "district offices") staffed by professional peace officer investigators and supervising investigators. A complaint that warrants additional scrutiny after CCU screening is referred "to the field" in the geographical area where the subject physician practices. The case is assigned to one of MBC's investigators, who reviews the existing file, develops an investigative plan for the particular matter, and conducts the investigation. In this work the investigator is assisted, in appropriate circumstances, by a district office "medical consultant" (a licensed physician retained to assist in such matters), the district office's supervising investigator, and in some instances a deputy attorney general from the Health Quality Enforcement (HQE) Section of the Attorney General's Office.

The subsequent investigation typically includes the gathering of additional medical records or other documentary evidence; locating and interviewing the complainant(s) and other witnesses; interviewing the subject physician; and — in quality of care cases — securing review of the entire investigative report and the evidence by an "expert reviewer" (again, a licensed physician in the same or similar specialty as the complained-of physician) who opines on the standards of care applicable to the particular matter, whether the subject physician's conduct fell below those standards, in what way(s), and to what degree. Particular cases may also involve other less frequent tasks, including drafting and serving investigational subpoenas, inspecting the location where events at issue occurred; conducting undercover operations; or drafting and serving search warrants. A complete investigation report is prepared by the investigator and, as appropriate, the expert reviewer provides required expert analysis of the alleged violation.

If the investigation indicates no violation of the Medical Practice Act or the matter is determined to be "non-jurisdictional" (outside the scope of MBC authority), the complaint is closed under the characterization "closed–no violation."[145] If insufficient evidence is found to file formal charges (for example, evidence is found of simple negligence only as opposed to an extreme departure from the relevant standard of care, or MBC is unable to obtain expert opinion to support an actionable violation), the case is characterized as "closed–insufficient evidence." Where the investigation reveals sufficient evidence to allege violations of the Medical Practice Act, the matter is reviewed by the appropriate supervising investigator and deputy attorney general and then transmitted to HQE for administrative action, or — where appropriate — to local prosecutors for the filing of criminal charges. (Technically, at this point the investigation is closed and a "disciplinary case" is opened for recordkeeping purposes.)

When a case is transmitted to HQE for administrative accusation, the assigned investigator retains the case as a "pending legal action," and may be asked to perform supplemental investigative tasks. The amount of such post-transmittal assistance varies widely, and in many cases consists of little further contact between investigator and trial prosecutor. Personnel guidelines for MBC investigators encourage the closing or transmittal of 2–3 investigations per month, and the overwhelming majority of investigator time is spent on current investigations in the district offices. In some instances, HQE attorneys have found substantial resistance to their requests for follow-up tasks on the part of MBC investigators; other instances find a better level of supplemental investigative assistance.

As reflected in Exhibit V-C above, Medical Board investigators opened 1,887 investigations, closed 2,117 investigations, referred 580 matters to HQE for administrative enforcement action, and referred 37 cases for criminal action in 2003–04.

District offices' structure and resources. The MBC enforcement program's organizational chart (Exhibit V-A above) shows the structure and staffing of the MBC district offices. A Deputy Chief of Enforcement oversees the Office of Investigative Services, and is responsible for twelve district offices, which are administratively divided into a "Northern Area" (Sacramento, Pleasant Hill, San Jose, and Fresno), a "Southern Area" (Rancho Cucamonga, San Bernardino, Tustin, and San Diego), and the "Los Angeles Metropolitan Area" (Valencia, Glendale, Cerritos, and Diamond Bar). Each administrative area is supervised by a Supervising Investigator II.

A typical district office is supervised by a Supervising Investigator I, and is comprised of four or five Senior Investigators, two medical consultants (serving on a part-time basis, as described below), and two or three support staff including investigative assistants and office technicians.

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[145] For details on MBC terminology and criteria relating to investigations, *see* Medical Board of California, *Enforcement Operations Manual*, Ch.7, at §7.1; *see also* Bus. & Prof. Code § 800(b).

The district offices' total current investigator staffing includes three Supervising Investigator IIs, thirteen Supervising Investigator Is, 70 Senior Investigators, and nine Investigative Assistants. This staffing level represents a troubling loss of 29 enforcement program positions — including 19 sworn (peace officer) investigator positions — in the past three years.[146] These resource reductions have cut the normal district office complement of Senior Investigators from six to five, and have required the curtailment of several important district office initiatives, including: (1) Operation Safe Medicine, a specialized unit in southern California addressing the growing problem of unlicensed practice of medicine; (2) a small unit conducting Internet prescribing investigations; and (3) an investigator position dedicated to providing post-accusation assistance to HQE prosecutors.

As of October 1, 2004, the district offices reported 1,060 active investigations, with an additional 494 cases maintained on the records as "AG Assigned Cases" (where possible follow-up tasks might be required). The present average investigator caseload is 18 active investigations and eight "AG Assigned Cases."[147]

Role of the Attorney General in the investigative process. Prior to 1997, district office investigators worked with little input from the attorneys of the Attorney General's Office, notwithstanding that those attorneys would ultimately prosecute MBC's cases. In 1990, SB 2375 (Presley) added Government Code section 12529 *et seq*. to require the Attorney General's Office "to assign attorneys to assist [DMQ] in intake and investigations to direct discipline-related prosecutions."[148] This provision specifically directs that "[a]ttorneys shall be assigned to work closely with each major . . . investigatory unit" to assist in the handling of complaints "from receipt through disposition."[149] However, it was not until January 1, 1997, that this statutory requirement was formally implemented, with the introduction of the "Deputy in District Office" or "DIDO" program.

In the DIDO program, deputies attorney general (DAGs) from HQE work in MBC district offices one or more days a week in order to provide legal assistance and guidance to investigators. In concept, DIDO DAGs advise investigators on legal issues; assist in subpoena enforcement to help investigators obtain requested medical records; review completed investigations before their referral to HQE (to ensure that all "loose ends" are tied up and the matter is ready for pleading); and, in some offices, draft initial pleadings in investigations being transmitted from district offices to HQE for accusation filing. In practice, the nature and degree of assistance provided by DIDO DAGs varies

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[146] Medical Board of California, *2003–04 Annual Report*, at iv.

[147] *Id*. at vi.

[148] SB 2375 (Presley), Cal.Stats. 1990, c. 1597.

[149] *Id.*

considerably among the various district offices and the differing DIDO attorneys. Some DIDOs have developed a close working relationship with district office investigators and provide active support of all types described above; other DIDOs have a less immediate rapport with district office staff, and provide less active support.

Role of medical consultants in the investigative process. Each MBC district office is also staffed with one or two medical consultants, who are licensed physicians working on a part-time basis under the direction of the Supervising Investigator to provide medical advice and information in support of MBC investigations. The role of the medical consultants includes: providing medical expertise to assist MBC investigators in evaluating the professional competence and conduct of doctors; interpreting the medical significance of information and evidence; arranging for and coordinating the expert review of medical records; inspection of medical records to assure conformance with the law; and assisting with physician and witness interviews and counseling, as appropriate.[150]

MBC medical consultants must possess a valid license to practice medicine in California, a valid medical or osteopathic specialty certificate, and at least five years of experience within the last seven years in the practice of medicine and surgery or in one of the specialties.[151] In current practice, the typical medical consultant is a recently retired or part-time practitioner who works 10–15 hours per week at a district office assisting in the investigative and expert review process. While all current MBC medical consultants retain their active license to practice, and some continue to practice on a part-time basis, a number of them have been entirely out of the active practice of medicine for more than two years (raising an issue regarding compliance with the job description requirement of five years experience within the last seven years).

The medical consultant participates in the typical case path by: (1) reviewing the initial file and records to assist in the decision whether to interview the subject doctor; (2) assisting in the obtaining of necessary records, including drafting declarations in support of subpoenas for records, where necessary; (3) helping the assigned investigator conduct the subject interview and in deciding whether the case should be closed or sent to an expert reviewer; (4) locating the expert reviewer and arranging for the reviewer to have the appropriate case materials; and (5) assisting in the review of the expert opinion and contributing to the decision on transmitting the case.

Statutory goals for MBC investigative process. In 1990, following extensive criticism of lengthy delays in MBC investigations, SB 2375 (Presley) added Business and Professions Code

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[150] California State Personnel Board specification for "Medical Consultant (Enforcement)," published in Medical Board of California, *Medical Consultant Information Booklet* (1999), at 1.

[151] *Id*.

section 2319, which establishes the goal that "an average of no more than six months will elapse from the receipt of the complaint to the completion of the investigation." Cases involving "complex medical or fraud issues or complex business or financial arrangements" should be investigated within one year.[152] As indicated in Exhibit VII-A below, in fiscal year 2003–04, the average timeframe for the completion of only the investigative portion of MBC case processing was 261 days.

Ex. VII-A. FY 2003–04 Investigation Timeframes By Disposition and Day Range

Day Range	Non-Legal Closure		Referred for Legal Action[1]		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	83	7.0%	144	23.8%	227	12.7%
1 to 3 Months	133	11.2%	36	6.0%	169	9.4%
3 to 6 Months	239	20.2%	80	13.2%	319	17.8%
6 to 9 Months	248	20.9%	69	11.4%	317	17.7%
9 to 12 Months	195	16.5%	80	13.2%	275	15.4%
12 to 18 Months	206	17.4%	110	18.2%	316	17.7%
18 to 24 Months	67	5.7%	67	11.1%	134	7.5%
More than 24 Months	14	1.2%	19	3.1%	33	1.8%
Total, Excluding Change of Address Citations	**1,185**	**100.0%**	**605**	**100.0%**	**1,790**	**100.0%**
Average Timeframe, Excluding Change of Address Citations	**256 Days**		**269 Days**		**261 Days**	
Change of Address Citations (2-Day Avg. Processing Timeframe)	327	21.6%	0	0.0%	327	15.4%
Total, Including Change of Address Citations	**1,512**	**100.0%**	**605**	**100.0%**	**2,117**	**100.0%**
Average Timeframe, Including Change of Address Citations	**201 Days**		**269 Days**		**220 Days**	

[1] Includes both AGO and DA referrals. Dual referred cases are counted once.

Source: Medical Board of California

B. Initial Concerns of the MBC Enforcement Monitor

1. MBC investigations are plagued by delays and excessive case cycle times.

The Medical Board's enforcement program is plagued by excessive case cycle times and persistent and troubling delays in the investigative process. The Medical Board has consistently failed to comply with the statutory goals set by the Legislature for the investigative process. As described above, section 2319 establishes as the goal for the MBC discipline system that "an average of no more than six months will elapse from the receipt of the complaint to the completion of the investigation."[153] These provisions were added by the Legislature in 1990 with the goal of MBC meeting these standards by *January 1, 1992.* At no time since that target date has the Board come close to meeting these efficiency goals.

As illustrated in Exhibit VII-A above, the average elapsed time for an MBC investigation is now 261 days (when one-day closures of "change of address citations" are factored out), up from a

[152] Bus. & Prof. Code § 2319(a) and (b).

[153] *Id.*

similarly-calculated 243 days in 2002–03. This elapsed investigative time must be added to the typical CCU complaint processing time, presently averaging 79 days (see Exhibit VI-H above). The resulting accumulated average of 340 days to completion of investigation means that MBC complaints take roughly twice as long on average as the state's statutory goal of 180 days for these cases. And many MBC cases take far longer than that to reach investigative completion. As of 2003–04, roughly two-thirds of all investigations take longer than the six-month goal, and fully 27% take an average of 15 months, or 2.5 times as long as the state says these case should require.

These case cycle times have been a concern for many years, and MBC made substantial progress in reducing investigative timeframes during the 1990s. The current average elapsed investigative time of 261 days compares favorably to the 1991 average of 315 days, reflecting noteworthy improvements in staff and process during much of the past decade.[154] However, some of this progress has now eroded, and in any event such improvement is relative, when investigation (which is just one component of the multi-phase MBC process) still takes an average of nine months, and successful disciplinary cases take an average of 2.63 years to complete.[155] Substantial public dissatisfaction with the MBC process — including rates of dissatisfaction "with the overall service provided by MBC" of between 60% and 79% in the most recent years in which such surveys were conducted — must be attributed in large part to this agonizingly slow process.[156]

To be sure, there are multiple personnel and business process factors which contribute to these delays and long cycle times, and many of these are beyond the control of district office staff. Our interviews and research revealed a number of contributing causes of lengthy case timeframes:

■ **Complexity and difficulty of MBC cases.** Any balanced assessment of the lengthy MBC investigation must begin with an acknowledgment of the inherent complexity of many Medical Board investigations, which often involve highly technical medical issues, complicated facts, and multiple victims and witnesses. These complexities are compounded by the challenge of the applicable burden of proof, which requires "clear and convincing proof to a reasonable certainty"[157] — as opposed to the preponderance standard applicable at physician discipline cases in many other states — to establish violations.

■ **Reductions in district office staff**. As discussed above, MBC was making progress reducing the historically long cycle times, but the more recent erosion of that progress is at least

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[154] *See* Medical Board of California, *2002 Sunset Review Report* (May 2002) at 80.

[155] *See supra* Ex.V-D (2003–04 average total elapsed time of 960 days, or 2.63 years).

[156] *See* Medical Board of California, *2002 Sunset Review Report* (May 2002) at 65 (dissatisfaction rates ranging from 79% in 1997 to 60% in 2000, the last year such surveys were conducted).

[157] *See Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

partly due to the loss of 19 line investigator positions in the past three years. This 25% loss of investigative staff, coupled with equivalent losses in support staff, have placed a proportionally larger burden on remaining staff and have often meant significant losses of valuable experienced field operatives.

■ **Losses of other valuable resources.** Continuing delays are also partly attributable to other resource reductions. During fiscal year 2003–04, the district offices were forced to absorb a 15% reduction in total medical consultant hours, meaning unavailability or delay in obtaining the medical consultations needed to move cases forward. A similar, but less easily measured, resource strain has resulted when expert reviewers in key specialty areas, already in short supply, have been tapped by the newly-implemented specialty reviewer process at MBC's Central Complaint Unit, resulting in delays in finding and engaging the essential expert reviewers.[158]

■ **Recruitment and retention challenges.** In addition to the problems arising from reduced staff size, MBC faces a substantial institutional challenge in recruiting and retaining highly qualified peace officer investigators. Especially when contrasted with competing hiring agencies such as the California Department of Justice, MBC peace officer pay and benefits are not high enough to avoid loss of staff to those other agencies.[159] This problem has cost MBC some of its better and more experienced investigators and impedes replacement hiring, especially in high-cost regions such as the Bay Area.

■ **Changed case mix.** Improvements in CCU's complaint handling and screening have resulted in fewer easily-closed "technical" violations being sent to the district offices, increasing the number of complex cases under investigation in the field. This factor will necessarily tend to increase average case cycle time if the proportion of complex or difficult cases is greater.

■ **Defense counsel use.** There is evidence of a substantial trend toward doctors retaining and using defense counsel earlier and more frequently in the investigation process. Although a physician's right to retain counsel is unquestioned, the practical effect is often greater procedural delay as counsel interpose objections, complicate the records procurement process, and insist on scheduling and process accommodations.

In general, MBC's remaining cadre of investigators are competent and dedicated, and they are doing a good job of maintaining the volume and quality of casework despite these challenges. MBC's district offices are closing or referring for legal action more cases than they are receiving.

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[158] *See supra* Ch. VI.B.3.

[159] Source: Medical Board of California staff (Apr. 20, 2004).

In 2003–04, district offices investigators closed 2,117 cases and received only 1,887, a pattern of closings exceeding openings which has been attained in three of the past four years.[160] Partly as a result, investigations pending at the close of the fiscal year have declined from 1,531 to 1,060 in the past two years.[161]

However, despite MBC investigator caseloads at near record lows (presently 18 cases per investigator, exclusive of "AG Assigned cases")[162] — dramatically lower than investigator caseloads at other agencies such as the Contractors State License Board and the State Bar of California[163] — there is still a persistent pattern of noncompliance with section 2319's six-month case processing goal. And although MBC's investigators are working hard to maintain work volume in a time of reduced resources, case cycle times are again trending upward.

Despite the good efforts of MBC investigators, MBC investigations still take too long and suffer many avoidable delays. Some of the contributing factors listed above are not immediately susceptible of change. But these delays also result in no small part from a pervasive "hurry up and wait" phenomenon — largely beyond the control of district office investigators in the current system — the causes of which may indicate ways for dramatic improvement in case cycle times.

These troubling sources of delay persist in part because MBC field investigators must continually wait at many stages of their process. They must:

(1) Wait to get complete medical records, or to obtain certified copies of those records. The average timeframe for receipt of requested medical records at MBC field offices is *74 days* (five times longer than the 15-day statutory period in section 2225).[164]

(2) Wait for the medical consultant to review the medical records and the investigation report in QC cases and recommend whether the subject physician should come in for an interview. With the reduction in medical consultant work hours, many investigators tell us this process can require weeks or months of additional delay.

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[160] *See supra* Ex. V-C.

[161] *Id.*

[162] *Id.*

[163] *See, e.g.,* Papageorge and Fellmeth, *Final Report of the CSLB Enforcement Monitor* (April 1, 2003) at 46, Ex. III-G (average CSLB investigator caseload was 39.03 cases as of December 31, 2002). As of October 1, 2004, State Bar investigators in Los Angeles carried an average of 34 open cases each; their counterparts in the Bar's San Francisco office carried an average of 37 cases each. Interview with Russell Weiner, Deputy Chief Trial Counsel, State Bar of California (Oct. 18, 2004).

[164] Source: Medical Board of California staff (Sept. 10, 2004).

(3) Wait for the subject to agree to be interviewed and to appear for the interview. The current average time between initial request and actual subject interview is 60 days.[165]

(4) Wait for the medical consultant to draft a memo on the subject interview and recommend whether case should go forward to expert review, a process that again is subject to delays attributable to limited availability of medical consultant work hours, and also subject to the differing report writing skills and diligence of different consultants.

(5) Wait while the medical consultant locates an appropriate expert reviewer, and then wait to receive that expert reviewer's opinion. This delay is often attributable to the continuing shortage of qualified and willing experts, especially in particular problem specialties such as neurology, obstetrics/gynecology, and neonatology, and is also a function of the investigators' limited control over these high-demand specialists. The current average wait to receive the expert reviewer's report is 69 days, or more than twice as long as the MBC's own performance goal of 30 days.[166]

Successfully addressing the causes of these lengthy built-in delays will significantly reduce the stubbornly long case cycle times in MBC investigations.

2. Attorney/investigator coordination and teamwork is inadequate.

The performance of the MBC's investigative staff and HQE's prosecutors, and the nature of the working relationship between the HQE and MBC, have been studied closely in this project. MBC investigators and HQE prosecutors are hard-working and skilled professionals, and much good disciplinary work is done every day by these dedicated public servants. All parties acknowledge good faith and good efforts on all sides. However, there is clearly room for improvement in the cost, speed, and effectiveness of the administrative enforcement system as presently constituted, as indicated by the lengthy case cycle times and comparatively modest case outputs noted by the state Legislature and other critiques.[167]

Notwithstanding good faith efforts, the current system linking MBC investigators and HQE prosecutors is characterized by inadequate coordination and teamwork. MBC investigators generally function without true, close coordination with the trial prosecutor who will ultimately handle the case. MBC investigators seldom work directly with or receive guidance from the attorney who actually

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[165] Source: Medical Board of California staff (Sept. 10, 2004).

[166] *Id.*; *see infra* Ch. VIII.B.1.

[167] *See generally* Center for Public Interest Law, *Physician Discipline in California: A Code Blue Emergency* (Apr. 5, 1989); Joint Legislative Sunset Review Committee, *Review and Evaluation of the Medical Board of California* (Apr. 1998); Joint Legislative Sunset Review Committee, *Medical Board of California, 2002 Sunset Review* (May 2002).

prosecutes their cases. Despite the good intentions of the DIDO program, most MBC investigators still receive only limited legal support for their investigative work; they rarely work directly with assigned trial counsel during the critical formative phases of the case; and they seldom play a significant role in the pre-hearing and hearing process to which their work is directed.

This system of limited investigator/trial attorney joint work and cooperation is typical of the "hand-off prosecution model" best suited to more simple street crime prosecutions. MBC's hand-off model stands in sharp contrast to the "vertical prosecution model" widely used in complex white collar crime and regulatory matters.

Current MBC/HQE "hand-off prosecution" process. Rather than early and continuing attorney/investigator teamwork that typifies the handling of complex cases in most prosecutors' offices, the enforcement process at MBC involves (1) an investigator with limited legal guidance and support investigating a case, preparing the file, and "handing off" or transmitting the case to (2) an HQE attorney who has had no role in the shaping or preparation of the case and must function with little or no investigative support in the pre-hearing and hearing process. Although the "hand-off" system may work adequately in simple street crime cases, it is woefully inadequate for complex white collar crime-type cases of the sort usually handled by MBC— where the subject is highly technical, the facts and legal issues are complicated, and the process requires a lengthy commitment of time and enthusiasm to achieve a sound result.

This MBC "hand-off" investigation/prosecution process has long been criticized as inadequate and inefficient. The 1989 *Code Blue* report characterized this "fragmented and unsupervised" system as poorly structured to handle medical cases which "are often complex and involve difficult questions of proof."[168] These criticisms were central to the purposes of SB 2375 (Presley), which originally proposed a true vertical prosecution approach, then enacted a compromise creating a specialized Health Quality Enforcement Section in the Attorney General's Office which would "assign attorneys to assist [DMQ] in . . . investigations and to direct discipline-related prosecutions."[169] And thirteen years after *Code Blue*, the Board's own *2001 Sunset Review Report* spoke of the important goal of assigning prosecutors early in cases to "reduce the length of time needed by deputies to prepare accusations and for prosecution, and produce a higher quality product."[170]

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[168] Center for Public Interest Law, *Physician Discipline in California: A Code Blue Emergency* (Apr. 5, 1989) at 68.

[169] *See supra* Ch. IV.B. and IV.C. for details on the purposes of SB 1434 (Presley) and SB 2375 (Presley), and the ultimate compromise resolution on this issue.

[170] *See* Medical Board of California, *Sunset Review Report* (Sept. 1, 2001) at 79.

As described above, in 1997 a formal effort was finally undertaken to address this shortcoming with the "Deputy in District Office" (DIDO) program. DIDO, itself a product of the compromise in SB 2375 in 1990, has provided limited legal advice and assistance for district office investigators. To the extent the DIDO program has brought some of the benefits of a true vertical prosecution model, it represented an improvement. But from its inception, the DIDO program was a halfway measure intended to offer some of attributes of vertical prosecution without significant systemic change. According to numerous investigators and HQE attorneys we interviewed, the DIDO program has produced inconsistent and partial results, ranging from useful assistance to little benefit, depending largely on geographical area and the personalities of the staff involved. None of the involved personnel view the DIDO program as accomplishing a true integration of investigators and prosecutors into a closely-knit and effective team.

Even under the DIDO program, the current investigator/attorney relationship has serious limitations and weaknesses:

■ **Inadequate communication and coordination**. With few exceptions, the present system (even with DIDOs in place) permits only inadequate communication and consultation between the primary field investigator — who is now responsible for key strategic decisions, crucial witness interviews, and expert contacts — and the deputy attorney general who is going to plead the accusation and try the case.[171] To understand the commonsense problems with this absence of communication, imagine a football team playing without a huddle or any other play calling, such that the wide receivers and running backs have to guess where the quarterback wants them to go. A common complaint from HQE attorneys *and* MBC investigators is that "we aren't on the same page" in many aspects of the investigation and prosecution process — typically because there has been little communication or coordination during key stages of the process.

This startling lack of teamwork and coordination throughout the life of a case leads to wasted efforts, inefficiencies, and last-minute requests for additional investigation when cases are nearing administrative hearing. In terms of inefficiencies, the DIDO program often requires *three* DAGs to sequentially review and learn a case: (1) the initial DIDO for acceptance of the case and sometimes initial pleading; (2) the supervising DAG for review and assignment; and (3) the trial DAG for pleading (or pleading amendments) and prosecution. Many DAGs and investigators interviewed see this multi-layered process as redundant and wasteful of limited DAG resources.

■ **Unclear and frustrating working relationships**. The present DIDO system often involves a poorly delineated system of voluntary advice or "informal" assistance by the visiting

[171] DIDO DAGs in certain district offices, primarily located in southern California, sometimes draft the accusations resulting from district office investigations, but this system still results in little or no contact between the key investigator and the actual trial lawyer. This approach often results in duplicative efforts and the necessity of amended accusations.

DIDO DAG to the field investigators. Some DIDOs are able to add considerable value by legal advice and assistance by virtue of their own personalities and initiative; others, we are told, seem unwilling and add very little to the process; and still others are simply not often consulted by investigators and medical consultants. The absence of clear roles and functions for the DIDO DAGs *vis a vis* investigators and supervisors leads to frequent confusion, frustration, and — occasionally — a breakdown of cooperation. DIDO DAGs without a clear role and mandate often add little value; investigators, unsure of the function of the DIDO, are often confused as to "who's my boss?" — that is, whether to listen to their own supervisors or the DIDO DAGs — and this engenders problems and frictions. Investigators, supervising investigators, and DIDO DAGs all told us there are "too many chefs in the kitchen" and that the chain of command is unclear. That these roles vary widely from district office to district office, and by region, only adds to the confusion. Under the DIDO program, which features DAGs in primarily "advisory" roles, there is no accountability or clear team structure to ensure cooperation and coordination of efforts between investigators and attorneys.

■ **No joint investigative plan.** A simple street crime investigation demands no special knowledge or elaborate investigative plan — an interview or two for the simple elements of the offense, a few items of physical evidence for exhibits, or a single lab test may suffice. But in complex disciplinary matters involving highly technical medical questions and challenging legal standards, a careful investigative plan addressing all issues and contingencies is often the key to success. The present hand-off model virtually guarantees that the trial DAG cannot participate in the initial investigative planning, and forces even highly skilled peace officers to have to speculate on the issues and facts the trial deputy may need or face.

■ **Inadequate follow-up and trial assistance**. The hand-off model often leads to inadequate investigative follow-up and hearing assistance. HQE attorneys cite many instances where the trial DAG facing an upcoming hearing date often must use a cumbersome and inappropriate "request for supplemental investigation" process, directed to the original Senior Investigator or the Supervising Investigator I, in order to obtain essential follow-up investigative work. And most DAGs lament the absence of a true investigating officer to assist at the administrative hearing.

Even street crime prosecutors working on non-complex matters generally have the full assistance of a trained "IO" (investigating officer) during the immediate pre-trial and trial phases. Anyone who has tried cases in the pressure cooker of the adversary process understands the value of having two competent professionals available to share tasks and emergencies, handle witnesses, address last-minute evidentiary or legal issues, and provide independent judgment. The adage "two heads are better than one" is nowhere more true than in a live-witness contested trial.

HQE attorneys often have examples of fine post-accusation assistance from particular MBC investigators, but usually have many more experiences of frustration in working through the MBC

bureaucracy to get a follow-up interview or other task completed. We ask our HQE prosecutors to work without investigator assistance in trying a complicated medical case when we don't ask a deputy city attorney to try a two-hour misdemeanor without the IO there to assist.

- **Reduced commitment to cases**. Even with the DIDO program in place, the failure to implement a true team model undermines the potential for commitment and dedication to the cases. This contrasts with an integrated team approach, where each teammate knows his/her role, knows who to look to for continuing leadership, and views the team's success as his/her own. The value of continuing personal commitment to cases is considered a critical personnel reason for the vertical prosecution model. If my primary concern as an investigator is to close cases quickly to meet a numeric performance standard, then I have little or no lasting commitment to the case or its ultimate success at hearing. I have small personal stake in the case itself or the team of professionals handling it. The assembly line moves past me rapidly; I cannot invest a personal commitment in the end product, since I only add pieces on the conveyor belt as it speeds on to someone else, and I seldom see the end result.

Managing professionals is often the challenge of providing correct incentives for excellence. Where a professional believes his or her success is tied to the success of his team and its case, that professional is personally motivated in a way that no hand-off process can provide.

- **Missed training opportunities.** The "hand-off" model also means MBC investigators miss perhaps the single most valuable training opportunity for improving field work: seeing the fruits of the investigation withstand the rigors of an administrative hearing. It is difficult to overstate the benefits of this experience for any investigator, as only an actual trial can fully illuminate the importance of sound interview techniques, evidence foundation and organization, anticipation of defenses and cross-examination strategies, and numerous other aspects of the investigative process.

This report takes no issue with the good faith of those who have designed and implemented the DIDO program, or with the many DAGs who have served ably in that role. But the experiment with the DIDO program to date indicates that the time for such halfway measures is past. In actual practice, the DIDO program has been insufficient to fully address the fundamental inefficiencies of what remains a "hand-off" model of prosecution. With a few noteworthy exceptions, the DIDO measure has not succeeded in providing the benefits of genuine teamwork. Investigators still proceed largely on their own; they still make what amount to legal/strategic decisions about witness interviews and documentary evidence without close legal support or the involvement of the attorney who must plead and try the case; and many still view the act of transmitting the case to HQE as the end of their real involvement in the matter. Just as unfortunate, the current system deprives HQE deputies of the enormous benefit of the continuing insights of the field investigator closest to the witnesses and facts, and deprives the trial attorneys of true "IOs" (investigating officers) to assist in the all-important pre-hearing and hearing phases of the enforcement process.

In sum, the DIDO program "halfway house" has helped, but has never delivered the efficiencies and benefits of a true investigator/prosecutor team. It has also led to "who's my boss?" confusion and poorly defined and uncomfortable relationships between MBC staff and HQE attorneys. *Code Blue*'s 1989 recommendation is even more compelling today: the basic working model of the current MBC and HQE cooperative process is inherently flawed and should be replaced with the investigation/prosecution model best suited to complex regulatory casework.

The vertical prosecution model. In many — and perhaps most — other law enforcement agencies involved in complex matters, prosecutors and investigators work together in teams from the day a case is assigned for investigation, in a process known as the "vertical prosecution model" for enforcement actions.[172] The vertical prosecution model is based on the realization that this process is an inherently *legal* one: The purpose of these complex investigations is to *prepare cases for trial* or other legal disposition — a function which requires legal input and which benefits from having that guidance and assistance from its inception.

Under this model, the trial attorney and the investigator are assigned as the team to handle a complex case as soon as it is opened as a formal investigation. The "team" approach of this model generally refers to a team assembled for *the case at hand* — all the benefits of teamwork can be accrued this way, and it is not necessary that attorneys and investigators be assigned to one another for other matters. Indeed, most offices choose to form different teams for different cases, thus maximizing training and the development of multiple working relationships.

Under this model, the prosecutor and the investigator work together during the investigative phase to develop the investigative plan and ensure the gathering of necessary evidence to prove the elements of the offense and to address anticipated legal defenses; provide legal analysis of the incoming evidence to help shape the direction of the case; prepare subpoenas or help secure search warrants to prod uncooperative subjects or third-party witnesses; deal directly with defense attorneys when issues arise; and address settlement or plea matters, which often appear early in such cases.

In turn, the investigator contributes a peace officer's experience and insight into the investigative plan and case strategy, and performs the field investigative tasks, including identification and location of witnesses and subjects; interviews of witnesses and subjects; obtaining and participating in the review of documentary and technical evidence; accessing criminal history and other databases; identifying and assisting with experts; planning and executing undercover

[172] The term "vertical prosecution" is a reference to the continuous involvement of attorney and investigator team members as a case works it work its way up through the investigation and prosecution process, which is often visualized as a vertical chain of events beginning with investigation, and proceeding to pleading, preliminary examinations or hearings, pre-trial motions, trial, and appeal(s). The principal alternative is a model where different prosecutors and investigators handle the case as it works its way up the chain of events.

operations; preparation of affidavits and specifications for search warrants, and service of those warrants; arrests and surrenders; witness assistance and evidentiary matters during trial; investigative report preparation; and other tasks usually associated with the work of trained peace officers and professional investigators.

It is critical to note that the vertical prosecution model works best where all participants recognize and respect the contributions of all team members, and where attorneys, investigators, and other team members perform the functions for which they are trained and best suited.[173] Investigators in a vertical prosecution team are responsible for the tasks which are appropriately theirs, including essentially all the field investigative tasks involving witnesses, evidence, and related procedures. Prosecutors in a vertical prosecution team perform the tasks for which they are trained and licensed, including the legal analysis and advocacy essential to preparing evidence for trial and presenting that evidence at trial.

Because the intrinsic goal of this process is a trial of the agency's charges, most vertical prosecution teams are led by the prosecutor assigned as the lead trial attorney. This does not relegate investigators or any other team members to a position of lesser dignity or importance, and vertical prosecution teams work well only where the professional contributions of all participants are appreciated and respected. No team can succeed without the contributions of *every* team member, and mutual respect and professional colleagueship are essential to the team's goals. Sports teams provide a useful analogy here: There can only be one quarterback on a football team, and the quarterback generally calls the plays. But the plays — and the team as a whole — will fail without the equally valuable contributions of each lineman and back.

A number of different organizational structures or formats can be used to achieve the benefits of vertical prosecution. However, the essential elements of any such model are:

- **Early coordination** of the efforts of attorneys, investigators, and other staff;

- **Continuity of teamwork** throughout the life of a case;

- **Mutual respect** for the importance of the professional contributions of both attorneys and investigators, and the value of having both available in all stages of the case; and

[173] There are sound reasons of law and policy to maintain the distinctions between the activities of attorneys and investigators in this process. Issues of prosecutorial immunity are implicated when an attorney moves beyond the tasks related to the advocacy function, making it important to preserve appropriate roles. *See Imbler v. Pachtman* (1976) 424 U.S. 409; *Buckley v. FitzSimmons* (1993) 509 U.S. 259; *Genzler v. Longanbach* (9th Cir. 2004) ___ F.3d ___, 2004 Daily Journal D.A.R. 12,027 (Sept. 27, 2004). Although this concern is significant and appropriate, it is clearly manageable with proper attention to professional roles, as indicated by the continuing success of the vertical prosecution approach in a large number of federal, state, and local law enforcement agencies, including the examples discussed below in this section.

■ **Early designation of trial counsel**, recognizing that the prosecutor who ultimately puts on the case must be assigned from the case's inception to help shape and guide it because the purpose of any investigation is the *preparation of a case for trial*.

The precise implementation of these essential elements is flexible. For example, this model is generally best implemented by an organizational structure where the attorney and investigator staff are employees of the same agency. However, this approach can also succeed where the team members work for different organizations, although the coordination effort may be somewhat greater. Even for those vertical teams working within the same organization, there can be separate administrative or personnel systems, with team members reporting to different supervisors, as long as there is a common institutional commitment to the team concept. This model benefits from housing the team members in the same location, but it can be implemented even without that advantage. However, the essential components of early and continuous teamwork throughout the life of the case are present in all vertical prosecution systems.

The continuity element is arguably the most important. Complex cases — such as medical licensing disciplinary matters — change and evolve during the investigation and trial process. New leads, additional witnesses or victims, expert or other witness impeachment materials, and numerous other follow-up tasks are often vital to preparation of such matters for trial. Only a team which has put together a case from its inception is well-equipped to adjust the prosecution effort as required for success.

Like any human system, success in a vertical prosecution format is ultimately dependent on the thoughtful and balanced way it is implemented. In bringing together professionals with differing skills, it is critical to make the best use of all types of professional competence, and equally vital to preserve the morale and self-esteem of all participants. "Teamwork" in this context is based on mutual respect and colleagueship. Teamwork doesn't mean attorneys become dictatorial or inflexible, and teamwork doesn't mean investigators lose reasonable professional independence in handling their fieldwork or are asked to do tasks beneath their job descriptions. The proof that all such concerns can be readily addressed is the fact that so many agencies employ this teamwork approach with great and lasting success. A properly formed and operated vertical prosecution team is a tightly knit and smoothly functioning elite unit with high morale and a track record of success.

The present MBC/HQE hand-off system does not bring the vital professionals together in a team of this kind, and the result is a less effective and less efficient disciplinary process.

Precedents for the vertical prosecution model at other agencies. Vertical prosecution is widely used as the organizational principle for specialized or complex law enforcement cases. Examples of other major agencies employing the vertical prosecution model include:

■ **Federal agencies.** Analogous complex casework is routinely handled by federal agencies in a vertical or team system. The U.S. Department of Justice's white collar crime divisions, such as the Antitrust Division, assemble teams of deputies attorney general, investigators, analysts, and economists to handle complex antitrust matters from initial inquiry through grand jury investigation and charging, to trial and appeal. Federal regulatory agencies, such as the Federal Trade Commission and the Securities Exchange Commission, regularly assign teams of professionals and support staff to specific cases or investigations. For example, FTC "consumer protection specialists" who perform functions essentially identical to those of MBC investigators are assigned, along with trial attorney staff, at the outset of every formal investigation in the FTC's eight regional offices.

■ **State agencies.** California and other states make extensive use of the vertical prosecution model for complex law enforcement casework. In what is perhaps the closest agency analogy to MBC's disciplinary system, the State Bar of California adopted the vertical prosecution model in January 2002 for its enforcement program, and has found it so successful that the program is presently being expanded.[174] In the State Bar system, deputy trial counsel and State Bar investigators are formed into teams working together from moment a complaint is converted from an inquiry into a formal investigation. (Interestingly, the State Bar system has also adopted the teamwork approach for two major case/rapid response teams (in northern and southern California) it has organized for the purpose of "identifying those respondents who constitute the most serious and immediate threat of harm to the public and focusing dedicated staff resources for a swift investigation and prosecution against them."[175])

It is significant that other California regulatory boards and bureaus already enjoy at least some of the benefits of the vertical prosecution model by virtue of the policies of the Department of Consumer Affairs' Division of Investigation. In administrative hearings conducted for other boards and bureaus by the Licensing Section of the Attorney General's Office, the Division of Investigation frequently makes its investigators available to serve as investigating officers working with the trial DAGs. Investigators thus follow their cases through the litigation process and provide team support for the trial attorneys in their cases. This is a key component and benefit of the team model, and this system has worked well for DCA.

It should also be noted that the California Department of Justice has ample previous experience with the vertical prosecution model, having successfully applied it in such units as the Medi-Cal Fraud Section, the Special Prosecutions Unit, and the Major Fraud Section (operated in the 1980s).

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[174] *See 2002 Report on the State Bar of California Disciplinary System* (April 2003) at 14–16.

[175] *Id.*

■ **Local agencies.** Nowhere is the adoption of the vertical prosecution model more complete and successful than in the offices of the district attorneys of California, which prosecute nearly all the complex felonies in the state and many of the civil law enforcement actions brought in such areas as consumer protection, antitrust, and environmental protection. The Los Angeles District Attorney's Office — the nation's largest local prosecutor's office with nearly 1,000 prosecutors and more than 260 peace officer investigators — has applied the vertical prosecution model to specialized and complex cases since 1954, when the Office formed its first vertical prosecution unit, the Major Fraud Division. Today, 39 special divisions and sections — comprising more than 150 prosecutors and 70 investigators — handle all of the most complex prosecutions for the office. Each of these units operates in a vertical prosecution mode, with case teams consisting of deputy district attorneys, investigators, and other specialists (such as forensic accountants) working collaboratively throughout the life of each case. More than 40 of the 58 district attorneys' offices in California maintain specialty consumer protection, major fraud, and environmental law sections, and *all* of these prosecution units work with in-house investigators in a vertical prosecution format.

The universal success of the vertical prosecution approach, and its widespread adoption by federal, state, and local agencies doing this form of work, argue persuasively for the application of this principle to the complex disciplinary proceedings of the Medical Board.

Application of the vertical prosecution model to MBC. In the specific context of California's medical regulatory system, the benefits of vertical prosecution — featuring a closer and better working relationship between MBC investigators and HQE prosecutors — would be numerous and substantial:

■ **Improved efficiency and effectiveness arising from better communication and coordination of efforts**. Vertical prosecution would enable the HQE prosecutor and the MBC investigator to communicate often and work together to coordinate their activities (although this does not require daily contact or full-time assignment to any individual case or team). Unlike the present system, this model would permit the trial DAG to invest in his or her case early; guide its investigation based on joint attorney and investigator input into the investigative plan; assist the investigator with medical records requests and enforcement; provide early ISO/TRO analysis and litigation (as needed); participate in the selection of the expert and identification of documents and records that should go to the expert (who will be one of the prosecutor's key witnesses at hearing); and identify at an early stage weak or problematical cases which should be subject to dismissal or early settlement.

■ **Reduced case cycle times**. Case timeframes will shorten as prosecutors become more available for and more committed to early records procurement and other evidence gathering; prompt preliminary relief, such as ISOs, in appropriate cases; and early case evaluation (leading to earlier case disposition).

■ **Improved commitment to cases**. Vertical prosecution has undeniable benefits in terms of promoting a sense of investment in and commitment to cases. MBC investigators and HQE attorneys will be no different from their counterparts in other agencies: Personal involvement with the ultimate disciplinary outcome will generate greater commitment to that outcome. This is both sound organizational theory and simple human nature. We care about something more if it is "ours." It is axiomatic in prosecution management that the attorney who helps work up the case is the attorney who will be the most committed to the case at trial. The best of hand-off cases still suffers from the hand-off.

■ **Improved morale, recruitment, and retention**. These benefits will accrue from greater efficiency of operations and the greater sense of professional accomplishment which naturally flows from successful team results and following cases through to disciplinary conclusion. In particular, if a transfer of MBC investigators to the Department of Justice is the chosen vehicle for the vertical prosecution system, the added prestige of Special Agent status and the resulting higher salary for former MBC peace officers would help with the current problems of recruiting top quality investigators and retaining the precious skills of experienced medical investigators.

■ **Improved training for investigators and prosecutors.** Practical training for both kinds of professionals would be enormously improved. Trial attorneys would gain a greater appreciation for the challenges of the investigative process. And through direct participation in the actual pre-trial and trial process, investigators will achieve a much better understanding of the significance of legal strategies, evidence issues, interview techniques, and witness selection and preparation. Mutual training can only benefit both types of staff, and — in particular — participating in the administrative hearing process will do more for enhancing investigative skills than any other single form of training.

■ **Potential for improved perception of the fairness of the process**. A vertical prosecution system, especially one which unifies MBC's investigators with the Department of Justice HQE staff, would improve the public perception of the independence and integrity of the enforcement process. This would address the concern, expressed periodically by public critics of MBC and by studies such as the CHP audit in 1993, that MBC investigations are subject to political pressures or undue influence by the physician-dominated Board.[176] (This benefit would accrue only if the structural implementation of the vertical prosecution model entails the transfer of MBC investigators to another agency.)

In sum, the benefits of the vertical prosecution model — including closer cooperation, optimum use of the different professional skills of attorneys and peace officers, continuous mutual

[176] *See supra* Ch.IV.D.; California Highway Patrol, Bureau of Internal Affairs, *Administrative Investigation of the Medical Board of California (Preliminary Report)* (Jan. 11, 1993).

training, and improved morale and investment in case outcomes — are substantial and have been proven in numerous other regulatory and law enforcement agencies. Vertical prosecution is not a novel concept with uncertain application; it is the mainstream of modern law enforcement philosophy in complex white collar crime matters and this is increasingly true for disciplinary agencies also, such as the State Bar of California. Nor is vertical prosecution a new recommendation for the Medical Board. Fifteen years ago, *Code Blue* concluded: "Where cases are complex, as is often the case, it is necessary to have the person who must conduct the hearing and the person who must gather the evidence working together from the start."[177] In order to raise its enforcement performance to the next level, MBC must move into the mainstream of law enforcement and apply the vertical prosecution model to physician discipline cases in California.

3. Delays in medical records procurement are chronic.

The lengthy waiting time for the procurement of essential medical records is among the greatest problems facing the MBC district offices and among the principal sources of overall case processing delays. Monitor interviews consistently found this problem of paramount concern among MBC investigators, who described it as the "biggest problem for MBC investigations," "a major issue for all district offices," and the "single greatest source of delay" in the disciplinary process.

Medical Board staff report that in fiscal year 2003–04, the average timeframe from a request for records by MBC investigators to receipt of all records was *74 days* (or two and one-half months), despite the statutory 15-day time frame in Business and Professions Code sections 2225 and 2225.5, and despite the fact that failure to comply with such records requests is unprofessional conduct and subject to disciplinary action and fines of up to $1,000 per day.[178] This 74-day average investigative timeframe is in addition to the average 66-day period that CCU spends in records-gathering in QC cases (see Chapter VI.B.2 above). In sum, medical records procurement consumes an average of 140 days — or 77% of the 180-day goal established in section 2319.

At both CCU and the district offices, there is a tradition in which both investigators and HQE prosecutors demonstrate apparent tolerance for physicians' lengthy delays in complying with medical records requests. Requests for assistance to the Attorney General by either CCU staff or district office investigators are comparatively infrequent, and actual enforcement actions are even less frequent. According to HQE management, only 22 subpoena enforcement actions were brought by

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[177] Center for Public Interest Law, *Physician Discipline in California: A Code Blue Emergency* (Apr. 5, 1989), at 68.

[178] Business and Professions Code section 2225(d) requires, in pertinent part: "Where documents are requested from licensees . . . they shall be provided within *15 days of receipt* of the request, unless the licensee is unable to provide the documents within this time period for good cause. Failure to produce the requested documents or copies thereof . . . shall constitute *unprofessional conduct*" (emphases added). *See also id.* at § 2225.5(a) and (d).

HQE on MBC's behalf in fiscal year 2001–02, and 17 such actions were brought in 2002–03. Similarly, HQE brought three actions for sanctions for delay in records production (pursuant to Business and Professions Code section 2225.5) in 2001–02, and about ten such actions in 2002–03. Although documents were ultimately obtained in these matters, after varying delays, only two of these actions successfully obtained monetary sanctions. MBC investigators report that serious delays in records procurement are pervasive in the 1800-plus investigations handled each year, making it difficult to understand how 19 subpoena enforcement actions and a half dozen sanction actions (most without sanctions ordered) are sufficient to address this problem each year.

A fairly typical scenario today is for the investigator to request records, then wait, then request again, then wait, then use jawboning tactics or repeat phone calls, and wait some more, then perhaps request again or go to the physician's office with a copy of the patient's release to attempt immediate access. If no records are forthcoming, the investigator may prepare a records subpoena and declaration in support, and then serve it. If the subpoena is ignored, the investigator may seek to persuade the appropriate DAG to prepare and file a subpoena enforcement action, as described above.

Most MBC investigators report that this scenario — or variations on it — ultimately results in the production of the relevant medical records in the course of time. However, virtually all interviewed investigators reported frustration with the inherent waiting periods and delays, and with the absence of a consistent program of records procurement enforcement. In such a process, it is not difficult to identify where two months' worth of delay (between the 15-day statutory deadline and the 74-day average) creeps steadily in.

Alternatives to the present practice have been utilized periodically or may be available for use. For example, MBC investigators occasionally execute warrantless searches where they have obtained the patient's release; additionally, they can in certain cases use the administrative inspection warrant authority found in Code of Civil Procedure section 1822.5, as was undertaken successfully by Medical Board and district attorney staff in the 1995 investigation in *People v. Bosley Medical Group, Inc*.[179] However, these tactics have until now represented extremely rare exceptions to the usual records procurement process.

4. Subject interview policies are inconsistent and ineffective.

Medical Board investigators regularly conduct subject interviews as a key part of the district office investigative process. The *Enforcement Operations Manual* requires MBC investigators to attempt to interview all subject physicians prior to transmitting a case to HQE for disciplinary

[179] LA Super. Ct. No. BC 159287.

action.[180] Many physicians voluntarily consent to be interviewed, and appear at district offices for that purpose. If a physician subject declines to be interviewed, the Medical Board is authorized to issue an investigational subpoena for testimony, sometimes known as an administrative subpoena, under the general administrative subpoena authority granted to the Attorney General and various department chiefs, including the Director of the Department of Consumer Affairs, pursuant to Government Code section 11180 *et seq*.

Pursuant to the *Enforcement Operations Manual*, the decision to issue such an investigational subpoena is made on a case-by-case basis, depending on the factual circumstances of the case.[181] The relevant Supervising Investigator II has the delegated authority to make this decision on behalf of MBC, and that supervisor makes a joint decision with the appropriate attorney from HQE.

It is the position of the Office of the Attorney General that the use of an administrative subpoena under section 11180 *et seq*. confers on the Board the right to place the witness under oath and the right to record his or her statements.[182]

In practice, there is much inconsistency among district offices and MBC investigators regarding the use and conduct of these subject interviews. All investigators seek to conduct these interviews in cases where transmittal to HQE is anticipated, but practices vary considerably beyond that point. Some district office investigators rely primarily on persuasion to obtain subject consent to the interview, and only rarely resort to the administrative subpoena authority. Other district offices follow a more formalized practice of seeking voluntary interviews but routinely issuing subpoenas to compel testimony upon encountering delay or reluctance. Some investigators routinely tape record, or seek to record, these subject interviews; others do not, or do not insist if there is an objection from the subject or defense counsel.

The Monitor believes the more permissive interview policy and the statewide inconsistencies together impede the efficiency of MBC investigations. The policy of informal persuasion, voluntary requests, and waiting for cooperation contributes significantly to the problem of excessive case cycle times. The current average time between initial request and actual subject interview is 60 days for the district offices as a whole, which represents a large portion of the typical nine-month investigative timeframe.[183] Consistent with courtesy and professionalism, a reasonable opportunity for voluntary cooperation should certainly be extended to a licensed physician, but a timeframe of

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[180] Medical Board of California, *Enforcement Operations Manual* (Rev. 1/03), Ch. 6, at § 6.2.

[181] *Id.* at Ch. 5, at § 5.3.

[182] *Id.*

[183] Source: Medical Board of California staff (Sept. 10, 2004).

15–30 days should be the outside boundary of such courtesy. The prompt use of the administrative subpoena authority, after a reasonable interval for cooperation, has worked well in certain of the district offices and commends itself for use statewide.

Similarly, a casual or relaxed policy with regard to tape recording of interviews encourages physicians and their counsel to object or attempt to set unreasonable constraints. Most investigators and detectives in law enforcement today make routine use of modern digital tape recording technology in suspect or witness interviews. Current technology produces excellent and easily usable recordings and minimizes previous objections to more primitive recordings. The Monitor shares the mainstream view that tape recording improves the accuracy and reliability of interviews and subsequent reports, forestalls later misunderstandings and disputes, and protects the interests of *both* parties by ensuring a high-quality record of what took place in the interview is available to both sides. Sound public policy calls for subject interview recording in most if not all circumstances today.

Inconsistency of practice among the various district offices also undermines the overall success of the MBC investigative process. Consistency of practice is superior on grounds of fair and equal treatment of all subjects. But it is also crucial to establishing a clear understanding of the policies and ground rules of the MBC investigative process within the community of physicians and their counsel. This minimizes misunderstandings and disputes, and encourages cooperation based on secure knowledge of the requirements of the Medical Board. A policy of early and adequate subject interviews, firmly and consistently enforced by subpoena as necessary, speeds the investigative process and promotes prompt decisionmaking, which is ultimately in the interests of all parties.

To the extent that current subpoena authority, or authority to record interviews, is perceived as unclear, consideration should be given to statutory changes to clarify the specific authority of the Medical Board. The regulatory procedures of other California agencies[184] and other states[185] provide specific interview authority for medical boards, and could serve as a model if further clarification of the general authority of Government Code section 11180 is desirable. In addition, existing statutory requirements regarding records production could be expanded to include physician interviews among the required forms of physician cooperation with MBC disciplinary inquiries (in a manner analogous to the equivalent requirement of cooperation imposed on California attorneys by Business and Professions Code section 6068(i)).

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[184] The California Board of Accountancy has direct subpoena authority under Business and Professions Code section 5108.

[185] *See, e.g.*, Ariz. Gen. Stat. 32-1451(C), providing specific authority for the Arizona medical board to order "investigational interviews between representatives of the board and the doctor" in the conduct of its investigations.

5. Medical consultant availability, training, and utilization are inadequate.

Medical consultants play a vital and varied role in the Medical Board's complaint handling and investigation process. The Monitor believes problems of medical consultant availability, training, and proper use contribute significantly to lengthy investigations and inefficient operations.

Medical consultant availability is largely a function of the Board's budget for this important form of consulting assistance. The budget for medical consulting hours suffered a 15% reduction in the 2003–04 fiscal year, reducing total available consultant hours agency-wide from 16,500 to 14,025. District office staff were unanimous in their view that these reductions made it more difficult to obtain required medical consultant assistance, exacerbating a situation of reduced investigator and support staff, and requiring unproductive down time in cases waiting for consultant attention.

In particular, these reductions often mean that medical consultants are unavailable for or greatly delayed in reviewing expert opinions and participating in the decision to transmit cases. Some offices report that this function is hardly performed at all by assigned consultants. This aspect of the medical consultant's function is among the most important of all, and is central to the speed and quality of QC case processing. Delays or problems with this critical function translate directly into overall case delays and negatively affect quality of decisionmaking on these cases. We heard numerous variations on one supervisor's comment that "QC cases are consistently getting delayed because of decreased medical consultant hours." There is universal recognition that the district offices need more medical consultant assistance, whether by increasing the number of available consultants or increasing the hours of existing ones. Consideration may need to be given to a return to the full-time medical consultant program if the part-time model cannot be funded and staffed to avoid chronic shortages of this essential component of the process.

Other concerns about medical consultant practices merit the attention of the Medical Board:

- Medical consultants and investigators both expressed concern that medical consultants in the CCU and the district offices may have inadequate information about prior complaints and inquiries in order to identify patterns of misconduct by subject physicians, making it more difficult to correctly assess the viability of a complaint in the district offices.

- Another issue relates to the medical consultants' important function of identification and recruitment of physicians to serve as expert reviewers in MBC disciplinary matters. Expert reviewer availability remains a critical concern, and medical consultants might be used more systematically to reach out to their respective medical communities to encourage more participation in the expert

reviewer program. This is especially critical for those specialty areas, such as neurology and obstetrics/gynecology, where expert scarcity is causing significant delay.

■ Improved management of the medical consultant program calls for improvements to the MBC management information system in this regard. Today, MBC is not adequately tracking medical consultant report preparation timeframes, making it even more difficult to correctly allocate resources to the medical consultant program and avoid queuing for consultant assistance in the district offices.

■ Both medical consultants and investigators are troubled by the demise of previous efforts to train new medical consultants in the procedures of MBC and the efficient performance of the medical consultant function. In a related issue, the medical consultant procedure manual has not been updated since 1996, and is not itself a consistent and comprehensive guide but rather a collection of memos and individual documents without effective organization.

■ An additional concern relates to medical consultant compliance with the job classification requirement of active practice in five of the last seven years. Several medical consultants currently on staff have been fully retired from medical practice for more than two years and thus cannot now meet the technical requirement of the classification. Review or revision of the classification may be in order, but consideration should be given to the present issue of noncompliance.

6. Expert witness availability and use are systemic weaknesses.

Expert witness availability, use, and performance are together identified by district office staff as one of the two principal challenges to quick and efficient casework. Investigators lament the unavailability of experts, especially in highly specialized fields, the inadequacy of training provided to experts, and the inconsistent performance and uses made of these experts. These concerns are addressed in detail in Chapter VIII below.

7. Ongoing training of investigators, medical consultants, and experts is inadequate.

MBC's investigators are an experienced and professional group of peace officers, and MBC's two dozen medical consultants and more than 750 expert reviewers include many professionals of outstanding regulatory experience. However, the Monitor has heard numerous concerns from many of MBC's own investigators and medical consultants lamenting the dramatic curtailment of the previous program of continuing specialized training for these staff members. MBC, which in years past has had an exemplary training program in place, has substantially reduced formal training for investigators, medical consultants, experts, and others, as an accommodation to pressing budgetary concerns.

Perhaps by necessity, MBC has viewed continuing specialized training as a luxury which can be jettisoned during difficult budgetary times. But if MBC is to significantly improve its case cycle times and efficiency, a systematic and professionalized training program for its field investigators, medical consultants, and expert reviewers is required. And as with any such large organization, training efforts will be viewed as important and meaningful only if there is a commitment to ongoing training and its importance at the highest management levels.

8. Coordination with state and local prosecutors is underutilized.

Many of MBC's peace officer investigators have substantial knowledge of the criminal and civil law enforcement options available to the agency as potential tools to address complaints against medical practitioners involving both quality of care and physician conduct issues. However, prosecutors throughout the state have raised the issue of the inadequacy of early communication or consistent coordination between MBC investigators and state and local law enforcement agencies in cases where non-administrative enforcement tools may be appropriate.

Numerous prosecutors in some of the largest offices in the state report they have received few or no cases referred from MBC investigators for criminal prosecution or civil unfair competition/false advertising/unlawful practices enforcement. Some of the larger offices have seen "one or two" such referrals in the past decade. MBC statistics support these observations: Only 37 MBC cases were referred by staff investigators for criminal prosecution in 2003–04, or about one for every million citizens in California. It is difficult to view that as the likely number of criminal matters involving 37 million Californians who generated 8,000+ complaints to MBC last year. And most state and local officials interviewed were unable to recall a single instance of a business practices matter — such as fraud or false advertising — being referred by MBC, notwithstanding that professional conduct matters amount to more than 50% of all complaints received by the Medical Board. Prosecutors in certain counties reported that even complaints of unlicensed practice, which should be frequently forwarded to those agencies, are rarely received from MBC staff.

Similarly, MBC investigators report inconsistencies in the responses they receive from the various law enforcement agencies throughout the state. Some investigators recounted frustration at the law enforcement priorities and expressions of disinterest on the parts of busy city and county prosecutors.

Clearly there are criminal and civil enforcement matters arising in MBC investigations which could profitably be shared with state and local prosecutors. Increased early case cooperation in appropriate types of investigations can only benefit all concerned agencies.

There is today very little in the way of a formal communication protocol between local prosecutors and non-licensing state prosecutors, and opportunities for increased efficiency and

effectiveness are being missed. A key example is the pattern of limited use of the powerful Penal Code section 23 license sanction procedure. Many prosecutors and court officials are unfamiliar with the Penal Code section 23 process, and numerous appropriate cases for quick and efficient license sanctions are missed today. A one-hour hearing may take the place of an 18-month administrative process, and yet many such opportunities go unexploited, according to sources at MBC and local law enforcement agencies.

Occupational licensing agencies, such as MBC, and state and local prosecutors have a mutual obligation to work together smoothly and consistently to better serve the public. High quality communication among investigators and prosecutors who handle medical licensee cases — both during cases and between cases — requires consistent effort, but pays real dividends in increased enforcement effectiveness.

9. Recruitment and retention problems exacerbate MBC personnel shortages.

Recruitment and retention problems plague personnel management at the Medical Board. Supervisors and field investigators uniformly report that valuable, experienced investigators are lost and well-qualified applicants go elsewhere because of salary disparities between the pay of MBC and other agencies hiring peace officers. These disparities are inconsistent with the express intention of the Legislature in SB 2375 (Presley) to the effect that "the pay scales for investigators of the Medical Board of California be equivalent to the pay scales for special investigative agents of the Department of Justice, in order to attract and retain experienced investigators."[186]

Earlier efforts to reduce this disparity were initially successful but have now been eroded by subsequent developments. In 1991, all DCA investigators were reclassified to the "Investigator, DCA" pay classification which allow MBC to give its investigators a 10% pay differential above the prior level. For a period of time this gave MBC the ability to pay its investigators on a par with competing agencies hiring peace officers. But in the intervening years the competing agencies have raised their pay levels, while DCA has been unable to match these changes. Requests for recruitment and retention pay, geographic pay, and related increases have been rejected by Department of Personnel Administration.

Today, substantial pay differentials once again place MBC at a hiring and retention disadvantage, especially at the top steps of the senior investigator positions. Competing employers, such as the Department of Justice and the Department of Corrections, now can offer top step pay of between 10% and 15% more than MBC, making the Medical Board uncompetitive and encouraging

[186] SB 2375 (Presley), Cal.Stats.1990, c.1597.

a troubling outflow of the most experienced personnel.[187] This problem is especially acute in high-cost-of-living areas of the state, such as parts of Los Angeles and the Bay Area, because MBC offers no geographical pay differential. MBC regularly loses in competition with other agencies over highly qualified investigative personnel.

10. Procedural and training manuals must be updated continuously.

MBC investigations and other enforcement processes are today guided by policy and procedure manuals which in most cases have not been consistently reviewed or approved by HQE — MBC's legal counsel and principal partner in enforcement. In addition, at least some of these manuals have not been updated adequately by MBC management and thus are sufficiently outdated to be inaccurate as to Board policy.[188] In addition, certain enforcement functions have no true procedure manuals at all (including the important medical consultant function). As detailed further in Chapter V above, there is inadequate updating of many of these important guides and inadequate consistent legal review for all of them.

11. Investigators need full and easy access to all law enforcement databases and to appropriate commercial databases.

Access to computerized information sources and databases is among the most important of modern investigative tools, often permitting investigators to obtain in minutes what formerly took hours or days of painstaking data-gathering on criminal history, subject or witness addresses, and other background, employment, or business organization information and related matters.

MBC investigators interviewed by Monitor project staff complained of inconvenient access to the law enforcement databases which are essential to modern police work, including the Department of Justice's CLETS criminal history information system and DMV records. Inadequate or inconvenient terminal access was mentioned in several locations. MBC investigators also expressed dissatisfaction with budgetary or other limitations which in some cases prevented them from using commercial databases, such as Merlin, Westlaw/Dialog, and similar systems, which investigators in other California agencies are funded and permitted to use. These commercial systems often serve as cost-effective means of performing quick background work, and appropriate access would help speed district office investigations.

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[187] Source: Medical Board of California staff (Apr. 20, 2004).

[188] *See supra* Ch.V.B.3. MBC staff have made numerous updates to the *Enforcement Operations Manual*, which as a result is more comprehensive and current than other of MBC's manuals. But even with regard to the *EOM*, adequate HQE review is a continuing concern.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #22: MBC and HQE should fully implement the vertical prosecution model. MBC investigators and HQE prosecutors should work together in a true vertical prosecution system featuring case teams established at the initiation of the investigation and remaining together until the case is fully litigated or resolved. Investigators and prosecutors in these teams would continue to perform the professional tasks for which each is best suited, but all such efforts would be coordinated from the inception of each case to maximize efficiency and effectiveness. The Monitor believes the vertical prosecution system could best be implemented by merging existing MBC investigators and supervisors into HQE. However, this system could be otherwise effectuated through coordinated assignments to the case teams by the respective agencies. The precise organizational logistics of the vertical prosecution system are important and must be carefully planned, but even more important are the essential components of early and continuous coordination and teamwork among investigators and prosecutors throughout the enforcement process. The specifics of implementation should be finalized only after appropriate consultation with MBC and HQE management and staff, and other stakeholders, in order to tailor this prosecution model to all relevant circumstances.

Recommendation # 23: MBC and HQE must revise their medical records procurement and enforcement policy to ensure prompt and full compliance with existing law. As discussed in related Recommendation #7, MBC and HQE should adopt and strictly enforce a comprehensive medical records procurement policy which is consistently applied in all MBC enforcement cases. Under this policy, the assigned MBC investigator should make an appropriate records request, and allow no more than 30 days (twice the section 2225 statutory standard) before making a final request with a short compliance deadline. If all requested medical records are not received by that deadline, the case investigator and prosecutor should work together immediately to serve a subpoena with an appropriately short compliance period. A subject's failure to comply would result in immediate subpoena enforcement action, including a motion for section 2225.5 sanctions of $1,000 for each day of noncompliance. In egregious cases (such as continuous or repeated refusal to comply with a court order or requests for records), administrative action against the physician's license should be commenced, seeking suspension or revocation.

Vigorous and consistent statewide application of this policy may result in an initial increase in enforcement actions but will ultimately establish a well-understood community-wide standard of routine and prompt compliance with these lawful medical records requests. As MBC Enforcement Committee Chair Ronald Wender, MD, has recommended, MBC should have "a zero tolerance policy regarding obtaining records."[189]

[189] Ronald H. Wender, MD, Chair, MBC Enforcement Committee, *New Proposal for Reorganization of the Enforcement Program* (Oct. 7, 2002) at 2.

As necessary to fully implement this new and consistent policy, MBC and HQE should closely consider the following initiatives:

(1) Formation of a small "strike team" of prosecutors familiar with and skilled in subpoena preparation and enforcement actions to speed and improve HQE response to such problems;

(2) Clarifying or strengthening, as needed, the professional obligation of California physicians to comply with a lawful MBC request for medical records. Presently, section 2225(d) and section 2225.5(d) state that failure to comply with a lawful request for medical records is unprofessional conduct, and thus is subject to disciplinary action against the non-complying licensee. It may be beneficial to add a statutory provision affirmatively requiring physician cooperation with MBC disciplinary inquiries analogous to the requirements of attorneys under Business and Professions Code section 6068(i);

(3) The joint development of MBC/HQE protocols for the proper use of warrantless searches where patient releases have been obtained, and for the use of CCP section 1822.5 administrative inspection warrants in appropriate cases such as the *Bosley* matter described above; and

(4) An amendment to the Business and Professions Code to shift attorney's fees to the subjects of investigations when MBC and HQE must file subpoena enforcement actions and prevail in those actions.

Recommendation #24: MBC should develop and enforce a consistent new policy on physician interviews. Physician interviews should proceed in a prompt and orderly sequence of requests, subpoenas, and enforcement, as needed. Although existing statutory authority appears sound, consideration should be given to appropriate legislation requiring subject physicians to appear at interviews upon reasonable notice, and requiring tape-recording of interviews to ensure accuracy and fairness to all parties to the proceedings. As necessary, cooperation with this subject interview policy could be addressed in a clarified statutory duty of licensees to cooperate with MBC disciplinary inquiries, analogous to the obligation imposed on attorneys by Business and Professions Code section 6068(i).

Recommendation #25: MBC should improve cooperation and case referrals between its enforcement staff and state and local prosecutors involved in criminal and civil prosecutions. MBC should develop appropriate case selection and referral criteria, and establish effective inter-agency working relationships, to improve cooperation and mutual case referrals between MBC investigators and all levels of prosecutors, including those from the Attorney General's Office as well as district attorneys' offices and city attorneys' offices who actively bring criminal and civil enforcement actions against medical licensees.

Both quality of care cases and physician conduct cases can be of great interest to these non-HQE prosecutors, many of whose offices maintain consumer protection or fraud units (and even medico-legal units) which actively seek appropriate cases for criminal prosecution or civil unfair competition/unlawful business practice enforcement under Business and Professions Code sections 17200 and 17500 and related statutes. MBC should cultivate good working relationships with these prosecutors to promote mutual understanding of case selection criteria and to ensure smooth case referrals. This should be achieved by the participation of MBC staff, including CCU staff and investigators, as appropriate, in such activities as the frequent California District Attorneys Association meetings and conferences established for this purpose.[190]

In addition to cooperation and case referrals, improved coordination with both prosecutors and judges should be undertaken to assist in training on enforcement issues of mutual interest. For example, MBC and HQE staff should initiate an expanded training program for prosecutors and judges to improve familiarity with MBC's mandatory reporting statutes and the use of legal mechanisms such as Penal Code section 23 actions, many of which are underutilized today.

Recommendation # 26: MBC should continue its efforts to restore lost investigative resources to provide staff for special projects and major case response teams. The Monitor recommends restoration of the nineteen peace officer positions and ten additional enforcement program positions which the Medical Board has lost over the past three years. Reinstatement of lost investigator positions should be sought to enable MBC to undertake proactive and undercover operations, such as the Operation Safe Medicine and the Internet Crimes Unit, which are initiatives of great public safety importance but which have been drastically curtailed as a function of personnel reductions and resource prioritization.

In addition to those proactive operations, the Monitor believes restored investigator staff should be directed to the formation of two rapid response teams, located in southern and northern California, to handle major cases of unusual complexity and emergency matters with potential for serious health or safety consequences. The task force concept of past years should be revisited to improve MBC's quick-reaction capacity in these exigent matters, which often require an immediate infusion of skilled investigative and prosecutor resources to prevent public harm and achieve quick legal remedies such as interim suspension orders or temporary restraining orders. Enforcement Committee Chair Ronald Wender, MD, has endorsed the establishment of such strike teams in northern and southern California, concluding "[t]he result would be increased efficiency and greater public protection."[191]

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[190] Bi-monthly meetings of CDAA's Consumer Protection Council, held in both northern and southern California, are examples of existing opportunities to meet prosecutors and develop these working relationships.

[191] Ronald H. Wender, MD, Chair, MBC Enforcement Committee, *New Proposal for Reorganization of the Enforcement Program* (Oct. 7, 2002) at 5.

Improvements in MBC investigator pay scales would similarly assist in restoring MBC investigator staff to levels necessary to expand its special projects and rapid response teams and reduce case cycle times.

Recommendation #27: MBC should improve and regularize investigator training, and update all enforcement program procedure manuals. MBC should reinstate regular, sequential investigator training programs, many of which have been delayed or curtailed due to recent budgetary constraints. Coordinated training with sister agencies and organizations, including the Attorney General's Office and the California District Attorneys Association, should be considered as a means of maximizing training resources and effectiveness. All MBC policy or procedure manuals used in district offices, including the *Enforcement Operations Manual*, and training materials for medical consultants and expert reviewers, should be regularly updated and reviewed by appropriate MBC and HQE management staff (see related Recommendation #21 above).

Recommendation #28: MBC should expand and improve the medical consultant program. The Monitor recommends a series of steps to expand upon and improve the existing medical consultant program. Medical consultant hours should be increased, at least to restore the 15% reduction suffered in the fiscal year 2003–04 budget, and preferably to add a similar incremental increase. Greater availability of medical consultant assistance will pay immediate dividends in expediting the processing of quality of care cases in the district offices, where unavailability of these consultants is a frequent source of delay. In particular, more medical consultant time will permit substantially increased consultant review of expert reviewer opinions and contributions to the decision to transmit a case — consultant functions that are key to the speed and success of the entire investigative process, and which are reportedly underperformed or not performed in some offices today.

In addition, medical consultants should receive in-person training to help them better understand their functions in both CCU and the district offices, and to help standardize and rationalize the use of medical consultants in investigations. In turn, experienced MBC medical consultants should be directly involved in a restored training program for expert reviewers (see Recommendation #32 below). Medical consultants should be more directly involved in the recruitment of new expert reviewer candidates, as the medical consultants (who are physicians with recent practice experience in their communities) are often best positioned to assist in this effort.

Recommendation #29: MBC should improve investigator access to law enforcement information systems. Existing investigator access to databases available for peace officers, including the CLETS system and DMV records, should be made more readily and conveniently available to district office staff, including as necessary the installation of additional access terminals or computer links. MBC investigators should be funded and permitted to make use of commercial

investigative databases, such as Merlin, Westlaw/Dialog, and their equivalents, which are widely used in other law enforcement agencies. And to further improve cooperation with local prosecutors, MBC should seek appropriately limited access to the CDAA Consumer Protection Information Network and the Attorney General/CDAA Consumer Fraud Index.

Chapter VIII

EXPERT REVIEWER PROGRAM

A. General Description of Functions

In quality of care disciplinary matters against a physician, expert opinion testimony is required to prove or disprove that the physician performed in accordance with the prevailing standard of care.[192] Because the burden of proof is on the Board, it must produce one or more physician witnesses with experience and expertise in the specialty or procedure at issue. That expert witness must review all the evidence in the case, testify to the standard of care applicable to each procedure performed, opine as to whether the subject physician's conduct departed from that standard of care and to what degree, and explain the justification or basis for his opinion. This burden requires MBC to recruit, train, and select expert witnesses who are willing to review disciplinary investigations against other physicians, write detailed memoranda and opinions, and — if necessary — testify orally at an evidentiary hearing.

As described in Chapter IV, MBC — dissatisfied with the selection procedure for and performance of its expert witnesses — created a new "Expert Reviewer Program" in 1994.[193] The Board adopted minimum qualifications for its expert reviewers and established procedures for the appointment, training, oversight, evaluation, and reappointment of a pool of expert reviewers who would be available when investigations reach a point where independent and objective expert input is essential. In the past decade, MBC's Expert Reviewer Program has recruited and trained a list of over 750 expert reviewers in all specialties throughout the state. The Board recruits for experts in a variety of ways, but primarily through its *Action Report* licensee newsletter, speeches and presentations made by Board members and staff to hospital personnel and medical societies, and recruitment efforts by district office medical consultants in their local communities.

Appointment as an expert reviewer. A physician interested in becoming a Medical Board expert reviewer must complete an application (which is available on MBC's Web site) which is

[192] *Hanson v. Grode* (1999) 76 Cal. App. 4th 601, 606–07; *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal. 4th 992, 1001.

[193] *See supra* Ch. IV.D.

reviewed by Board staff to ensure that the physician meets the minimum qualifications for the program (see below). If so, the physician completes a training program that consists of viewing a 45-minute videotape and reading a manual prepared especially for MBC expert witnesses.[194] The physician is then appointed to a two-year term as an expert reviewer, and his name is added to a computerized list of experts (by specialty, subspecialty, and geographic location) that is maintained and updated quarterly at headquarters and is available to all MBC district offices. The expert's résumé is scanned into the database as well, so that district office staff have access to the physician's complete educational and professional history. The expert serves for a term of two years, at which point he must apply for reappointment to another term.

Minimum qualifications. Currently, physicians who review disciplinary cases and testify as experts for MBC must have a current California license in good standing, with no prior discipline, no pending accusation, no current complaints, and no complaints closed within the past five years for insufficient evidence. They must be board-certified by one of the specialty boards approved by the American Board of Medical Specialties (or an equivalent board). They must have a minimum of three years of experience in their specialty, and must be in "active practice"[195] or retired from active practice for no more than two years at the time of appointment as an expert witnesses. Peer review experience is recommended but not required.

Method of selection. Expert witnesses are retained by MBC after the investigation in a quality of care matter has been completed, and the investigator and district office medical consultant agree that the investigation tends to indicate a disciplinable violation that should be reviewed by an expert witness. Generally, the district office medical consultant is responsible for obtaining an appropriate expert reviewer to review the investigation report and medical records, and provide a written expert opinion. However, the MC often undertakes this function in conjunction with the investigator, and the investigator is responsible for monitoring the status of the expert review to ensure the written expert opinion is submitted in a timely manner.

The MC first looks to the list of trained experts maintained by the Expert Reviewer Program and selects an expert; the investigator must query the expert's disciplinary history and the Civil Index to ensure that she still meets the Program's requirements. Once these checks have been completed,

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[194] Veteran investigators told us that, in years past, district office supervisors and medical consultants conducted training sessions for experts in which they would review examples of well-written expert reports, discuss the guidelines for writing an expert report, and answer the experts' questions. Many investigators and district office supervisors believe MBC — when its funding is restored — should resume these in-person training sessions for expert witnesses because they enhance the quality of the experts' work.

[195] "Active practice" is defined as at least 80 hours per month in direct patient care or clinical activity or teaching, at least 40 hours of which is direct patient care. Medical Board of California, *Enforcement Operations Manual*, at Ch. 13, § 13.1.

the MC or investigator contacts the expert and assesses her actual experience and expertise in the procedure or treatment at issue in the matter, and availability to perform the review. During the initial telephone contact, the MC or investigator discusses several factors listed on a "conflicts checklist" to ensure that the expert has no "disqualifying criteria" that would make her ineligible to review the particular matter. "Disqualifying criteria" include personal or financial conflicts of interest, a complaint history, or insufficient number of years of experience in the specialty at issue.

Once an expert is chosen, the investigator and medical consultant — sometimes assisted by the DIDO DAG in the district office — assemble the investigative file, medical records, and other documentary evidence, determine which materials to forward to the expert, and send the package to the expert with a cover letter. Experts are expected to review the materials, draft a memorandum in a specified format,[196] and return the file within 30 days. MBC requires its experts to reduce their opinions to writing, and written opinions of MBC experts are discoverable; they are always shared with the defense. However, many defense counsel instruct their experts not to reduce their opinions to writing so they cannot be discovered by HQE prior to the hearing.

Occasionally, it is necessary for the investigator and medical consultant to "go off the list" in an effort to find a qualified expert who is willing to review records and testify. In subspecialties in which there are few practitioners, all the practitioners know each other and may have personal conflicts or be unwilling to testify against a colleague. Sometimes MBC is required to select an expert who has not formally applied to, been evaluated by, and been trained by the Expert Reviewer Program. This is approved in rare circumstances; however, such "off-the-list" experts are expected to meet the Program's minimum qualifications, and must be approved by a Supervising Investigator II.

Payment and protection. MBC expert witnesses are paid $100 per hour for reviewing records and writing a detailed expert opinion. If they provide oral testimony at an evidentiary hearing, they are paid $200 per hour for that testimony.

Civil Code section 43.8 provides absolute immunity from civil liability for physicians who serve as expert reviewers and expert witnesses for MBC.[197] Additionally, if a Medical Board expert

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[196] The expert opinion must (1) describe the records reviewed, (2) summarize the case, (3) state the standard of care at the time of the event(s) in question, (4) determine if the care in question was or was not a deviation from the standard of practice, (5) define the deviation from the standard in terms of no departure, simple departure, or extreme departure, and (6) summarize the review.

[197] *Johnson v. Superior Court of Los Angeles County (Gass, Real Party in Interest)* (1994) 25 Cal. App. 4th 1564, 1568–70 ("[s]ection 43.8 was amended in 1990 as part of Senate Bill No. 2375, which implemented a comprehensive reform of this state's system of discipline against medical practitioners . . . . Expert consultants are vital to the Boards' task. Suffice it to say that the threat of being sued for malicious prosecution would deter all but the most fearless experts from serving as consultants to the Boards. Without those experts, the Boards' disciplinary activities

is sued civilly over acts taken in the course and scope of assisting MBC as an expert reviewer, the Attorney General's Office will defend the expert and assert the immunity.[198]

Evaluation of experts by investigators, MCs, and DAGs. Investigators, medical consultants, and DAGs are encouraged to complete evaluation forms on the performance of expert reviewers in reviewing records, drafting the expert opinion, and providing oral testimony. This information assists the Expert Reviewer Program in determining whether to renew the appointment of an expert reviewer and/or reuse the expert in future proceedings.

Evaluation of experience by experts. In July 2003, the Expert Reviewer Program began to circulate a "feedback" survey form to experts to enable them to evaluate their experience as an expert. In the past year, 214 experts returned a completed form to MBC. Over 94% said they would be willing to accept more MBC cases for review. Over 96% said they were "encouraged to render an unbiased opinion." On the issue whether MBC's reimbursement rate is appropriate for expert review, the experts were split: 47% said yes, and 49% said no. On the issue whether they would be willing to review more cases if they received continuing medical education credit rather than money, 89% said no.

Business and Professions Code section 2220.1(c)(2) requires the MBC Enforcement Monitor to "evaluate the method used by investigators in the regional offices for selecting experts to review cases to determine if the experts are selected on an impartial basis and to recommend methods of improving the selection process." The selection method is described above. The Monitor believes MBC selects its expert witnesses on an impartial basis for a number of reasons:

(1) While the database of experts consulted by investigators and MCs contains information on whether (and how many times) a particular expert has been used and general impressions of the expert's performance, it does not contain information on how the expert has opined in prior cases (for example, whether the expert found no departure or an extreme departure).

(2) The "conflicts checklist" that is used by MCs and investigators when initially contacting a prospective expert requires MBC to affirmatively determine that the expert has no personal or financial conflict of interest which would prevent him from being objective and unbiased. The form also requires the investigator or MBC to tell the prospective expert that "the request for this review does not imply that there is a deviation from the standard of care." And most investigators and MCs we interviewed said they inform prospective experts that MBC wants an objective and unbiased opinion — whatever that opinion might be.

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would soon grind to a halt").

[198] Bus. & Prof. Code § 2317.

(3) As noted above, over 96% of experts who returned MBC's survey form said they were "encouraged to render an unbiased opinion."

(4) Almost every investigator and medical consultant we interviewed said they have little interest in how the expert opines. They are primarily interested in the expert's ability to carefully review medical records, clearly articulate the standard of care, adequately explain whether the subject physician's conduct departed from that standard, and justify the basis for their opinion. When they find an expert with superior evaluative and written communications skills, they readily admit that they "go back to the well" and use that expert whenever they have a case in that expert's specialty — but solely because the expert is experienced, competent, and can clearly communicate a well-reasoned opinion.

(5) Although MBC has no standards or policy on the reuse of experts, it constantly advertises for new experts and encourages MCs and investigators to choose experts who have not been used before. MCs and investigators admit they are sometimes reluctant to use a new expert because they have no familiarity with his work. In the words of one investigator, "We're guilty of overutilizing certain experts, not because they come back with a departure finding but because they're quick and do a thorough job. My worst fear as an investigator is to send a case to an inexperienced expert who returns a 'no violation' finding. You're done — you can't go 'expert-shopping.'"

(6) In a deliberate effort not to bias expert witnesses, MBC's *Enforcement Operations Manual* instructs investigators, MCs, and DAGs to ensure that the materials given to expert witnesses at the outset of their review do not contain information that might bias the expert (such as prior disciplinary action or malpractice history of the subject physician) or the opinion of any other physician who has reviewed the case.[199] The *Manual* directs investigators, MCs, and DIDO DAGs to ensure that the reports of the CCU reviewer and district office medical consultant do not contain explicit opinions about whether the subject physician's conduct departed from the standard of care. Also, in section 801 cases following a civil judgment or settlement, the *Manual* instructs MCs and investigators to withhold depositions of expert witnesses in the civil case from the MBC expert until after he has had an opportunity to review all the evidence and reach his own conclusion. After the MBC expert has opined, he may be shown the civil depositions or other expert opinions in the matter and asked if those opinions change his opinion. But at the outset, MBC wants its experts to render an independent and unbiased opinion.

[199] Medical Board of California, *Enforcement Operations Manual*, at Ch. 7, § 7.4.

B. Initial Concerns of the MBC Enforcement Monitor

1. Average expert reviewer cycle times are excessive.

Within the past year, MBC instituted the use of codes in its computer system to capture the average number of days between the time a completed investigation is shipped to an expert reviewer and the time the expert opinion is returned to MBC. While MBC's goal is 30 days, the average turnaround time for expert opinions is 69 days — over two times its goal.

Further, MCs and investigators note that the 69-day timeframe discussed above does not include the time it takes them to simply locate a qualified reviewer. Many investigators and MCs complain that prospective experts fail to return phone calls to apprize MBC of their interest in the matter and/or availability — and this lag time is exacerbated by the fact that most MCs are part-time and not in the office every day; therefore, they are not able to easily ascertain whether their call has been returned, whether they should make another call, and/or whether they should choose a different expert.

2. There is a lack of qualified experts in many specialties, and the CCU specialty reviewer requirement is siphoning off some experts who would otherwise review cases in the field.

Despite MBC's recruitment efforts, there are not always a sufficient number of qualified experts in high-demand specialties and subspecialties willing to work for $100 per hour. This leads to delay in locating qualified experts and in the use of "off-the-list" experts on some occasions. Further, section 2220.08's requirement that "specialty reviewers" evaluate quality of care complaints in CCU has led CCU to "borrow" experts from the Expert Reviewer Program's list. This costs MBC more money (because experts on the Expert Reviewer Program list are paid more than are CCU experts, and because experts often do more work than is necessary at the CCU stage) and deprives MBC field offices of using those physicians as expert reviewers for completed investigations.

3. There is no requirement that expert testimony be reduced to writing and/or exchanged before hearing.

As described above, MBC requires its experts to reduce their expert opinions to writing — and those expert opinions are immediately discoverable by the defense. However, defense counsel frequently instruct their experts not to reduce their opinions to writing so the HQE DAG has no idea of the substance of defense counsel's expert opinion until that expert takes the stand at the evidentiary hearing.

This practice results in the unfair "sandbagging" of the DAG at the hearing, and stifles the possibility of prehearing settlement. Although true bilateral discovery is not a feature of

administrative hearings under the Administrative Procedure Act, the general discovery principle of eliminating undue litigation surprise is a public policy with important application here. The expert medical opinions in these MBC administrative hearings go to the heart of the Board's case and are partly or entirely dispositive of the result. Litigation surprise regarding this central element of the administrative action disserves all parties to the process and the public interest as a whole.

Litigation surprise over expert testimony is very costly to respondents, as it often means unnecessary trial preparation and hearing expenses because potential early case dispositions, including possible dismissals of accusations, cannot take place (in the absence of expert views raising doubts about MBC's case). This surprise is equally costly to MBC and the public, as scarce investigator and attorney resources are often allocated to preparation and trial of matters which could have been resolved more expeditiously. Several DAGs we interviewed stated that, had they seen the defense expert's opinion at an earlier point in the process, they would not have filed an accusation (much less proceeded to hearing), or would have been willing to negotiate a prompt case settlement agreeable to the physician. And absence of early expert opinion exchange clearly harms the public interest in quicker resolution of cases, shorter case cycle times, and fewer costly formal hearings.

Defense counsel may perceive some short-term adversarial advantage in depriving the trial DAG of full knowledge of the weaknesses of MBC's case, according to defense experts. And at least some defense counsel may be influenced consciously or unconsciously by a financial incentive to take cases to hearing. However, the Monitor is confident that many defense counsel, and virtually every client, would rather the client be spared the filing of an accusation (if at all possible) or spared the burdensome hearing by virtue of a prompt settlement. Keeping the representatives of the public in the dark until the last possible minute does not, in truth, advance the long-term interests of any party to this process. A procedure requiring pre-trial exchange of written expert direct testimony (similar to current federal court practice in many complex litigation matters, such as antitrust cases) would benefit both parties and the cause of quick and efficient justice.

4. The expert reviewer handbook contained errors.

The *Individual Study Program for Expert Reviewers* provided to the Monitor in 2003 was last updated in October 2002, and did not appear to have been revised to conform to the changes made by SB 1950 (Figueroa). It contained a significant error regarding the definition of "repeated negligent acts"[200] and other lesser errors. The manual has been reviewed by HQE and the errors have been corrected.

[200] The *Individual Study Program for Expert Reviewers* (October 2002) states that MBC must demonstrate either an extreme departure or a "pattern of departures" from the standard of care. No such showing of a "pattern" is necessary to prove repeated negligent acts. *See Zabetian v. Medical Board* (2000) 80 Cal. App. 4th 462, 468. However, at a 2003 oral argument on a nonadoption, the Monitor heard a defense attorney inform a DMQ panel that "your own procedure manual requires you to find a pattern" in order to discipline for repeated negligent acts.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #30: The Medical Practice Act should be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the hearing. The exchange of expert witness opinions prior to hearing will lead to more settlements and will remove the current and unfair "sandbagging" of the DAG at hearings on most occasions.

Recommendation #31: MBC should make better use of its district office medical consultants, existing expert witnesses, Board members, and the California Medical Association to recruit more expert reviewers. MBC clearly needs more qualified experts who have time to devote to reviewing MBC cases and returning expert opinions in a timely manner. Once its medical consultant hours are restored,[201] the Board should make better use of its district office medical consultants to aggressively recruit expert reviewers in their local communities; additionally, it should attempt to utilize its existing expert witnesses who are familiar with the process to recruit other experts. According to MBC Enforcement Committee Chair Dr. Ron Wender, expert review "should be considered community service and medical staffs of hospitals should be approached in addition to individuals in the same way as the peer review function is done within hospitals . . . . [MBC should] utilize the California Medical Association, as well as the medical school faculties throughout the state and key designated hospital staff for this project."[202]

Recommendation #32: MBC should consider paying its experts more, and resume in-person training sessions for its experts. Although physicians who serve MBC as expert witness clearly aren't in it for the money, 49% of the experts who returned MBC's survey said they weren't paid enough for their services. Defense experts are routinely paid $500–$750 per hour, and MBC simply cannot compete for the best experts at $100 per hour. If MBC's budget change proposal is approved, MBC might want to consider raising its expert witness fees. Additionally, if its funding is restored, MBC should resume local, in-person training sessions for expert witnesses conducted by district office supervisors and medical consultants, to ensure that experts have an opportunity to interact with district office personnel, understand the Board's expectations, and are receive "hands-on" training in the skills required to be an effective expert witness.

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[201] *See supra* Ch. VII.B.5.

[202] Ronald H. Wender, MD, Chair, MBC Enforcement Committee, *New Proposal for Reorganization of the Enforcement Program* (Oct. 7, 2002).

Chapter IX

PROSECUTIONS: HEALTH QUALITY ENFORCEMENT SECTION

A. General Description of Functions

After a Medical Board district office has completed an investigation yielding sufficient evidence of chargeable physician misconduct, the case is transmitted to the Attorney General's Health Quality Enforcement Section for administrative action, or to the appropriate state or local prosecutor for criminal or civil law enforcement action. This chapter describes the prosecution of these matters by HQE and other agencies, and presents the Monitor's initial concerns and recommendations for improvements to that process.

Health Quality Enforcement Section. Effective January 1, 1991, SB 2375 (Presley)[203] added Government Code section 12529 *et seq.,* creating the Health Quality Enforcement Section (HQE) in the Attorney General's Office. A detailed discussion of the genesis of HQE and this requirement for specialized prosecution is found in Chapter IV.C. above.[204]

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[203] Cal.Stats. 1990, c. 1597.

[204] As described in Chapter IV, SB 2375's language creating HQE and requiring its involvement in MBC complaint handling and investigations was a fallback position from the author's and sponsor's original proposal to transfer MBC peace officer investigators into HQE to create a "vertical prosecution" model. According to a Senate Judiciary Committee analysis of SB 2375, "[i]t appeared to have been the intent of the sponsor to have placed Board investigators under the direct control of the Attorney General, and to generally move the disciplinary process out from under the Board and division in order that it not be compromised. This was greatly opposed by the Board and the profession. What is currently proposed is somewhat of a hybrid model." Senate Judiciary Committee, *Analysis of SB 2375 (Presley) for June 7, 1990 Hearing* (1990). The statute preserves MBC's discretion as the decisionmaking "client," but also injects HQE into the complex mix that produces that decisionmaking. The Senate Judiciary Committee analysis continues: "Instead of bringing investigators to the Department of Justice, the bill would bring the Department of Justice to the investigators. Deputy attorneys general within a new Bureau of Health Quality Enforcement in the Department of Justice, headed by a Chief Counsel appointed by the Attorney General, would be located in field offices to assist in investigations for purposes of ensuring quality evidence, to assist and participate in training, and to review the process of intake and disposition of complaints. Accusations would be filed by the executive officer in consultation with the Chief Counsel. The relationship would thus be parallel rather than hierarchical, with independent attorneys on site advising and counseling in the process. Essentially, this creates an independent 'watchdog' within the system that would chill any tendency toward impropriety, yet not usurp the existing role of the Board, the Division, or the Director." *Id*.

HQE's role in current process. Pursuant to section 12529, "[t]he primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California [and specified allied health care boards] . . . and to provide ongoing review of the investigative activities conducted in support of those prosecutions . . . ."[205] HQE is further obligated by statute to assist the MBC in intake and investigations and "to direct discipline related prosecutions" as well as to "provide consultation and related services and engage in case review" with MBC complaint handling and investigative staff.[206]

HQE's deputies attorney general (DAGs) receive completed investigations in MBC disciplinary matters; file accusations and/or petitions for interim suspensions orders or motions for temporary restraining orders; appear in criminal matters pending against physicians to seek probation orders under Penal Code section 23; engage in pre-hearing discovery and settlement negotiations in MBC disciplinary matters; try MBC cases before administrative law judges (ALJs) of the Medical Quality Hearing Panel of the Office of Administrative Hearings; argue cases to a panel of MBC's Division of Medical Quality if the panel nonadopts the ALJ's decision; and participate in judicial review of final MBC disciplinary decisions.

In addition, under the requirements of section 12529 *et seq*., HQE attorneys perform a variety of advisory and support functions for investigations under way in MBC district offices under the "Deputy in District Office" or "DIDO" program described in detail above in Chapter VII.A. As of October 1, 2003, HQE has placed a DAG in the Central Complaint Unit to assist in the intake function as mandated in Government Code section 12529.5(b), as described above in Chapter VI.A.

HQE's structure and resources. HQE is required by statute to be "staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board."[207] The Attorney General's Office presently maintains HQE as a unit headed by a Senior Assistant Attorney General, consisting today of 36 DAGs undertaking these specialized healthcare administrative prosecutions, and six Supervising DAGs (SDAGs) overseeing those activities. HQE staff are located in six offices in Los Angeles, San Diego, San Francisco, Oakland, Sacramento, and Fresno, each typically under the control of an SDAG.

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[205] Gov't Code § 12529(a).

[206] *Id*. at § 12529.5(b).

[207] *Id*. at § 12529(c).

As recently as late 2000, there were a total of 42 DAGs authorized or funded for these six offices.[208] Since early 2002, HQE has lost a total of six DAG positions, and has had to absorb other long-term staff reductions (such as one DAG on extended medical leave for over a year, and another recently returned from extended maternity leave). All of these losses and resulting vacancies have occurred in the Los Angeles HQE office, making it impossible for HQE to comply with the statutory mandate of Government Code section 12529 to adequately staff all of the MBC district offices in the Los Angeles area.

Attorney General/HQE management information systems. The Office of the Attorney General and HQE have maintained various forms of recordkeeping to manage their functions, but for many years these have been universally perceived — by outside critics and the Attorney General's Office itself — to be inadequate to accurately track and manage these cases and properly bill clients, where necessary. As described in Chapter V above, the long-promised statewide ProLaw system was finally implemented in HQE beginning in July 2004, and is now in the very early stages of implementation.

HQE enforcement throughput. As summarized in Exhibit IX-A below, HQE received 580 cases transmitted from MBC investigators in 2003–04, up about 15% from the prior year, but on par with the three-year average of preceding years.[209] In 2003–04, HQE attorneys filed 262 accusations, down from a 2001–02 high of 329 but about average for the past five years as a whole. HQE staff obtained 48 prefiling stipulations and 202 postfiling stipulations in the past fiscal year, and conducted 45 administrative hearings, reflecting a steady increase in stipulations and a flat trend in trials. HQE's use of the ISO/TRO tools was down in 2003–04 some 40% from its 2001–02 high (26 ISOs/TROs sought in 2003–04 vs. 40 sought in 2001–02).

[208] This total consists of 39 authorized positions and three additional positions funded by MBC in recognition of MBC workload demands. For the past three years, MBC has submitted a budget change proposal to the Department of Finance asking for four additional authorized positions to meet workload demand, including DAG staffing of CCU, but the Department of Finance has consistently disapproved the BCP requests. Source: HQE staff (Oct. 6, 2004).

[209] The reader is cautioned that the number of cases filed in any given year represents a different universe of cases from those resolved in any given year.

Ex. IX-A. Health Quality Enforcement Section: Enforcement Throughput

	Activity	FY 1999–00	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04
HQE	Cases transmitted to HQE by MBC	491	510	589	494	580
	Pre-filing public letters of reprimand	19	17	19	17	29
	Other pre-filing stipulations	15	15	14	12	19
	Cases in which HQE declined to file	31	24	25	34	19
HQE/ OAH	ISO/TRO sought (can be pre- or post-filing of accusation)	21	34	40	24	26
	Full ISOs/TROs granted	13	10	17	12	19
	Partial restriction granted	6	7	9	0	3
	Stipulations not to practice (can be pre- or post-filing of accusation)	2	3	5	5	0
	Accusations filed	262	238	329	258	262
	Petitions to revoke probation filed	28	18	21	18	26
	Post-filing public letters of reprimand	14	10	13	11	12
	Other post-filing stipulations	242	185	158	206	202
	Accusations withdrawn	71	45	32	35	44
	Evidentiary hearings held	49	44	39	44	45
	Accusations dismissed after hearing	12	9	16	10	20
	Defaults (respondent failed to appear)	30	14	15	22	21

Source: Medical Board of California

Exhibits IX-B and IX-C below and MBC's *2003–04 Annual Report* reflect HQE case cycle times as calculated by MBC, with particular emphasis on time to filing of accusation in the six HQE offices. Average accusation filing time is down considerably from its historical high of over 365 days, but is now rising steadily from the 60–70 day level reported by HQE management in the 2001–2003 period to the present 107 days average for 2003–04. The average Los Angeles office time to filing in excess of five months is an indicator of the continuing staffing shortages plaguing that office. Overall, current filing time statistics indicate that a substantial and growing number of cases are taking several months or more to reach the filing stage.

Ex. IX-B. Attorney General's Office Case Cycle Times: Processing Time to Filing of Pleading (FY 2003–04)

HQE Office	Total number of pleadings filed	Total number of days pending in AG's office before pleading filed	Average age when pleading filed
Fresno	7	740	105.574 (3.52 months)
Los Angeles	89	14,012	157.438 (5.24 months)
Oakland	11	2,324	211.272 (7.04 months)
Sacramento	40	4,557	113.925 (3.80 months)
San Diego	77	5,974	77.584 (2.59 months)
San Francisco	67	3,387	50.552 (1.69 months)
TOTALS	**291**	**30,994**	**106.51 (3.55 months)**

Source: Medical Board of California

Ex. IX-C. Attorney General's Office Case Cycle Times: Age of Pending Cases with No Pleading Filed (6/30/2004)

HQE Office	Total number of unfiled cases	Total number of days pending as of 6/30/04	Average days per unfiled case
Fresno	4	122	30.5 (1.02 months)
Los Angeles	51	6,002	117.686 (3.92 months)
Oakland	3	55	18.333 (0.61 months)
Sacramento	12	1,278	106.5 (3.55 months)
San Diego	28	5,134	183.357 (6.11 months)
San Francisco	23	3,739	162.565 (5.42 months)
TOTALS	**121**	**16,330**	**134.96 (4.5 months)**

Source: Medical Board of California

Exhibit IX-D below summarizes recent trends in HQE Penal Code section 23 appearances and orders issued. HQE staff have achieved excellent ratios of success in obtaining these important summary forms of licensure sanction, but there are comparatively very few such appearances and such orders for a state with 117,000 practicing physicians.

Ex. IX-D. HQE Penal Code § 23 Appearances

Activity	FY 1999–00	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04
Total PC 23 Appearances	9	10	10	9	16
Total PC 23 Orders Issued	11	11	12	8	15

Source: Medical Board of California

B. Initial Concerns of the MBC Enforcement Monitor

1. HQE cycle times remain lengthy, including recent increases in the filing phase.

Despite the presence of a cadre of experienced DAGs, many of whom are highly skilled and motivated, HQE remains burdened with lengthy case processing times. In particular, HQE is experiencing rapid erosion of earlier progress in the filing phase — the one aspect over which the Attorney General has primary (although not exclusive) control. (See Exhibits IX-B and IX-C above.) Overall, the current average elapsed time for a completed MBC enforcement matter hovers at 2.63 years (a troubling processing time which has been the subject of continuing critiques[210]), but many aspects of this overall process are not within the Attorney General's direct control.

However, HQE's timeframe for the filing of pleadings is a component of this overall delay, and the recent trend is discouraging. As noted above and as discussed in Chapter XIII below, the filing of the accusation turns a confidential investigation into a matter of public record which is posted on MBC's Web site, and a delay in accusation filing means a delay in notice to the public about a potentially dangerous physician. Unsatisfactory average filing times in excess of one year was one of the reasons for the process changes, including the creation of the Health Quality Enforcement Section in SB 2375 (Presley) and its progeny.[211] Implementation of HQE, the DIDO program, and other changes led to a laudable reduction in average case filing times to the 60–70 day level — and below in some HQE offices. However, the most recent MBC statistics now show an average 107-day filing time (using the Board's methodology), with the understaffed Los Angeles office averaging more than five months to the filing of pleadings.

HQE management reports that its recordkeeping system uses different definitions of key events in order to screen out delays not attributable to HQE, and — as a result — HQE statistics indicate shorter filing timeframes. HQE notes that MBC filing time statistics include time (up to 5–10 days) attributable to MBC Executive Director consideration of accusations submitted by HQE for filing. In addition, there appears to be bona fide disagreements as to the dates when certain cases are accepted for pleading by the DIDOs. Under its definitions of these events, HQE reports timeframes of 48.70 to 62.62 days for its average time to file pleadings in 2003-04.[212] However, HQE management readily agrees that overall time to filing has doubled in the past three years — a troubling increase it attributes largely to reduced staff. (The Monitor notes that this kind of recordkeeping dispute as to when matters were handed back and forth is yet another telling illustration of the problems of a "hand-off" prosecution system.)

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[210] *See supra* Ex. V-D.

[211] *See supra* Ch. IV.C. and IV.D. for critiques of delays in MBC case prosecutions.

[212] Source: HQE management memo (Oct. 26, 2004).

In the final analysis, few dispute that the Attorney General's Office faces a challenge in bringing this component of overall MBC case processing back into line with the expectations of the Legislature and the public.

2. HQE attorney staffing is insufficient to meet its statutory and operational requirements.

HQE's six offices have suffered a 15% loss of staff positions in the past three years, with the greatest impact felt in the Los Angeles office. Senior managers presently contend that HQE does not have "a sufficient number of experienced and able [DAGs]" to meet the statutory mandate of Government Code section 12529, especially in the Los Angeles HQE office, as a function of the loss of six DAG positions since early 2002. In the important Los Angeles office, HQE is currently unable to comply with section 12529.5 by staffing the Valencia office with a DIDO DAG, and HQE anticipates that an expected retirement will mean HQE will not be able to staff the Diamond Bar office with a DIDO DAG as of January 2005.

The overall HQE staffing picture is similar: inadequate DAG staff to move all MBC cases rapidly to conclusion. Reduced staffing in key locations (most critically in the Los Angeles office) has resulted in unacceptable delays in case pleading and litigation, and insufficient opportunities for remaining DAG and SDAG staff to engage in training and mentoring of newer attorneys.[213]

In addition, HQE has not been sufficiently staffed to be able to supply CCU with DAGs to review incoming cases and proposed closures as specifically required by law in Government Code section 12529.5(b). The implementation of section 12529.5(b) was not begun formally in CCU until October 2003, some 12 years after the statute became effective. The recent assignment of the first-ever deputy attorney general to this task is a start but only a start. As described in Chapter VI, the role of the current lone DAG assisting CCU is expanding and his contributions are valuable. Today, the CCU DAG now reviews all QC cases in which a simple departure is found, and other QC cases in which there is a split of opinion between the medical consultant and the supervising medical consultant. However, this still falls well short of "working closely with each major intake . . . unit . . . to assist in the evaluation and screening of complaints . . . ." For example, the CCU DAG is not yet reviewing PC cases (or there is confusion about that), is only reviewing a very small percentage of cases going forward, and has to date played only a modest role in medical records procurement. This position has not been fully integrated into the many other CCU activities where legal input would be beneficial.

[213] Many of these recent staffing constraints may be attributable to the threat of potential lay-offs faced by the Attorney General's Office for most of 2004, a threat which may now be easing.

3. Attorney/investigator coordination and teamwork is inadequate.

Notwithstanding good faith efforts, the current system linking HQE prosecutors with MBC investigators is characterized by inadequate coordination and teamwork. HQE prosecutors generally receive "hand-off" cases which have been investigated and assembled with little or no input whatsoever from the HQE trial prosecutor who will handle the case. Although the DIDO program has provided a varying measure of additional HQE legal input into the investigative process, most HQE prosecutors still complain that they do not play a role in shaping the cases they receive or the investigative plans and strategies behind them, leading to frequent problems of late changes in case focus, amended pleadings, and lengthy delays while cases are re-evaluated and re-investigated. Complex medical cases continue to evolve as the litigation develops, and HQE DAGs today do not have significant investigator assistance with crucial follow-up needed as these changes take place. And few if any HQE prosecutors enjoy the enormous benefit of continuous assistance from a peace officer investigator who is present during the pre-hearing and hearing process.

The principal discussion of the present HQE and MBC case coordination relationship is found above in Chapter VII.B.2., and the analysis of that section is incorporated here.

The DIDO compromise and the vertical prosecution alternative. Reflecting from the perspective of the trial attorneys in HQE assigned to handle these matters, it is clear that the Legislature's compromise on the preferred vertical prosecution model proposed in 1990, which is codified in Government Code section 12529, offers at least some of the benefits of vertical prosecution, but has not produced the true teamwork system required for optimal efficiency and effectiveness.

The DIDO program's formal implementation, some six years after section 12529 *et seq.* became effective, has helped to reduce the timeframe for the drafting and filing of accusations from over a year in 1991 to 107 days now[214] (although this shorter timeframe is not due solely to the implementation of DIDO) — and even this level of progress is very important because the filing of the accusation makes the matter public and can protect consumers. The DIDO program has placed attorneys onsite at district offices regularly where they are at least theoretically able to provide legal guidance during the investigative process. The DIDO program is certainly better than the prior "hand-off" situation in which investigators lacking any legal guidance whatsoever were investigating cases and handing them off to a prosecutor who lacked any investigative assistance and who had no role in guiding the investigation prior to the "hand-off."

However, DAGs and managers in HQE were nearly unanimous in their conclusion that DIDO has many flaws and has not yielded the benefits a true vertical prosecution system would provide.

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[214] *See supra* Ex. IX-B (106.51 days to filing of pleading on average).

The present DIDO program is widely perceived as inefficient and even a wasteful use of the DIDO DAG's time, coming as it does at the cost of depriving HQE of a line prosecutor without creating a true case team. Exacerbating this resource concern, our interviewees often noted the redundancy and inefficiency of having three valuable DAGs sequentially review and learn a case in order to move it through the current process: (1) the DIDO for acceptance (and pleading in some offices); (2) an SDAG for evaluation and assignment; and (3) the trial DAG for pleading and prosecution.

HQE personnel correctly perceive that DIDO is not implemented uniformly throughout the state. And this only worsens the existing measure of confusion among HQE attorneys and MBC investigators and supervisors as to the chain of command and the roles of the participants. Many DIDO DAGs manage to work out this confusion on a one-on-one basis, but many in the system complain of lack of clarity and an excess of chefs in the kitchen.

HQE attorneys note all the disadvantages detailed above in Chapter VII regarding the present "hand-off" system (even with the DIDO modification): The present system does not enable the trial attorney to invest in a case from the first day, or guide its investigation. The current system does not enable the trial attorney to assist in medical records procurement; does not enable the trial attorney to participate in the selection of an expert or the determination of what materials should be forwarded to the expert; and does not permit the accusation to be drafted by the DAG who will try the case, at least in many offices including those in southern California where approximately 60% of MBC's cases originate. And most frustrating of all to many trial DAGs, the present system results in little or no follow-up support from the case investigators, resulting in frequent and time-consuming requests for additional investigation after case has been transmitted to HQE, and completely depriving these trial lawyers of the skilled and knowledgeable "IO" (investigating officer) who assists at the hearing in most every other form of complex prosecution. In this latter connection, several HQE staff members lamented the demise of the recent experiment in which an MBC investigator was placed full-time in the Los Angeles HQE office to assist trial DAGs with follow-up investigation immediately before hearings. That experiment worked very well by these reports, and demonstrates the type of positive experience and teamwork that vertical prosecution could bring.

The overwhelming consensus among HQE attorneys and supervisors favors the full implementation of the vertical prosecution model in which an attorney/investigator team is formed at the inception of an investigation and works together to the case's conclusion. This system is described in detail in Chapter VII.B. above.

4. Attorney assistance is not used sufficiently in MBC's medical records procurement process.

A detailed discussion of this issue is found above in Chapter VII.B.3, and is incorporated here. In overview, HQE prosecutors are seldom used for subpoena enforcement actions and most

DAGs make little or no use of section 2225.5 sanctions for failure to produce medical records, notwithstanding strong statutory authority and supporting case law.[215] According to HQE management, only 22 subpoena enforcement actions were brought by HQE on MBC's behalf in fiscal year 2001–02, and 17 such actions were brought in 2002–03. Similarly, HQE brought three actions for sanctions for delay in records production pursuant to section 2225.5 in 2001–02, and about ten such actions in 2002–03 — only two of which successfully obtained monetary sanctions.[216] No other section 2225.5 sanction motions have been granted in recent years. Largely as a result of the infrequent use of these enforcement tools, doctors and their lawyers pay little attention to section 2225.5 sanctions because they are generally aware of the infrequent enforcement of these sanctions, and further because even at $1,000 per day, the potential sanctions exposure is comparatively modest in light of most doctors' incomes.

Serious delays in medical records procurement are pervasive in the 1800-plus investigations handled each year, making it difficult to understand how 19 subpoena enforcement actions and a half dozen sanction actions (most without sanction orders) are sufficient to address this problem each year.

An additional component of this issue from the prosecutor's perspective is the concern over obtaining certified medical records for use in anticipated administrative hearings in MBC matters. Many DAGs we interviewed indicated that administrative law judges often demand such certified records, notwithstanding the fact that there is no requirement in the law for certification of these medical records as a prerequisite for their admissibility. MBC investigators occasionally balk at insisting on certification during the field investigative process, and HQE attorneys cite this as an example of the disconnect between the two staffs. To complicate the matter, MBC investigators and HQE attorneys report that certain defense counsel routinely refuse to allow their clients to produce certified records, and then refuse to stipulate to their admission at hearing because the records are not certified. Such gamesmanship has no place in an ordered legal process, and clarification of this issue may be necessary to eliminate yet another HQE burden and source of delay.

5. HQE and MBC make inadequate use of their ISO/TRO powers and the Penal Code section 23 authority.

MBC periodically identifies subject physicians who may be an imminent danger to the public if they continue to practice. These circumstances call for the immediate application of the statutory

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[215] *See generally* Gov't Code § 11180 *et seq*.; Bus. & Prof. Code § 2225.5; *Arnett v. Dal Cielo* (1996) 14 Cal.4th 4.

[216] Source: HQE management memo (May 3, 2004). Only one enforcement proceeding (against a podiatrist in northern California) is familiar to most investigators; HQE management is aware of two such cases.

authority in California for interim remedies to protect the public. MBC and HQE are empowered to seek such emergency preliminary relief in two forms: (1) an interim suspension order (ISO) under Government Code section 11529, where MBC and HQE may obtain a court order under which a physician's right to practice may be partially or entirely suspended during the pendency of disciplinary proceedings; and (2) a temporary restraining order (TRO) under Business and Professions Code section 125.7, through which HQE representing MBC may obtain a court's temporary order restraining further wrongdoing or medical practice pending adjudication of the matter at issue. These powerful emergency remedies have obvious and special importance in the context of physicians on whose competence and sound decisionmaking depend the lives of patients in California.

A somewhat related enforcement authority is found in Penal Code section 23, which permits HQE to appear in any criminal proceeding against an MBC licensee "to furnish pertinent information, make recommendations regarding specific conditions of probation, or provide any other assistance necessary to promote the interests of justice and protect the interests of the public." In practice, HQE attorneys representing the Medical Board appear in criminal matters involving physicians to recommend orders barring the physicians from practice, or other terms, as conditions of probation or other components of the defendants' sentences.[217]

The enforcement output statistics in Exhibits IX-A and IX-D above indicate a troubling decline in the efforts to use the powerful ISO/TRO authority in MBC cases in the recent past. ISOs/TROs sought by HQE on behalf of the Medical Board diminished from a high of 40 in 2001–2002 to 26 in the 2003–04 fiscal year (a decline of 40%). Given the importance of these public safety circumstances, a decline in the use of this tool is a source of concern to the Monitor.

Of similar concern is the comparatively infrequent use by HQE and MBC of the resource-efficient appearances in superior court criminal proceedings under Penal Code section 23. The agencies' track record of success is excellent, with 15 orders obtained in 16 appearances, but the overall number of appearances statewide (16) suggests that many other appropriate uses of this authority pass unrecognized. In part this is attributable to prosecutors' and judges' unfamiliarity with this process. However, MBC and HQE should be taking the lead in efforts to improve the system of inter-agency communications and to promote better utilization of this important mechanism.

6. Needed improvements in HQE case tracking and management information systems have begun and must be properly implemented.

As described above, HQE and the Attorney General's Office as a whole have long been subject to criticism for the outdated and antiquated management information system which they have

[217] *See* Penal Code § 23.

operated in recent years. To address these concerns, the Attorney General has installed the long-awaited ProLaw management information system. Implementation of ProLaw is still in its gestational stage, and at this early point even the staff of the Attorney General's Office is unclear as to what kind of management reports it can produce and/or what kind of information they must input in order to generate those reports.

This new system holds substantial promise for improved case tracking, accurate client billing, and management analysis, but this promise has not been fully realized yet. The Monitor will continue to evaluate this new system during the balance of the Monitor's term. At the very least, there is a clear consensus that this long-overdue update to the AG's management information system is necessary and must be fully implemented.

7. HQE has no formal policy and procedure manual to ensure uniformity and assist in training.

HQE presently has no formal policy and procedure or operations manual in place regarding its functions and process. Our interviewees indicate that, while memoranda and other written materials are distributed periodically (and there is a short 20-page "handbook" for DIDO DAGs[218]), HQE has not yet organized its policies and procedures into a single comprehensive written manual. This leads to diverging policies and inconsistencies among HQE offices. For example, different SDAGs in HQE report differing policies on periodic case reviews — a common feature of most law office management systems — with some supervisors employing monthly or quarterly formal review sessions with each trial DAG, and other supervisors simply handling case review informally on an "as needed" basis.

Related to the concern about an HQE operations manual, most training in HQE for new DAGs appears to be infrequent and informal, with the majority of the guidance provided by SDAGs and more experienced HQE staff on an *ad hoc* and verbal basis as questions arise. This observation is consistent with a more general observation by this project and others concerning the need for improved and standardized training at the Attorney General's Office generally.[219] This informal word-of-mouth system of training will likely prove increasingly unworkable because many of today's HQE prosecutors are in their fifties and likely to retire in the relatively near term. Loss of institutional memory and practical trial experience could be compensated for, to at least some extent, by a properly drafted policy and procedure manual which preserves the benefits of that experience.

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[218] Health Quality Enforcement Section, *Deputy in District Office Handbook* (undated).

[219] *See, e.g.*, PriceWaterhouseCoopers, *Organizational Assessment – State of California, Office of the Attorney General – Legal Divisions* (2001) at III-20.

8. The current venue statute for adjudicative hearings results in substantial and unnecessary costs for HQE, OAH, MBC, and — ultimately — disciplined physicians and the physician population generally.

Government Code section 11508 governs the venue for adjudicative hearings under the Administrative Procedure Act — including MBC hearings at which the HQE DAG, the respondent and his/her counsel, and the OAH ALJ must appear. Subsection (a) of that statute generally designates hearing location based on the appellate district in which the transaction occurred or the respondent resides. It does not limit hearing location to cities in which HQE and OAH have offices. For example, if the transaction occurred or the respondent resides in the Fourth Appellate District (San Diego and Imperial counties), the hearing must be held in "San Diego County." If the transaction occurred or the respondent resides within the Second or Fourth Appellate Districts other than San Diego and Imperial Counties, the hearings must be held in "Los Angeles County." Subsections (b) and (c) then make exceptions to subsection (a), and permit the agency to select a different venue under certain circumstances, and the respondent to seek a change in the venue selected by the agency.

Under this statute, hearings may be held anywhere in the state — frequently causing HQE, OAH, and/or respondent's counsel to incur significant costs. If the respondent resides in San Bernardino (in which neither HQE or OAH has an office), the respondent may insist that the hearing be held in San Bernardino — requiring HQE to find and pay for a hearing room. Additionally, the HQE DAG, the OAH ALJ, and often respondent's counsel will be required to drive long distances to San Bernardino for the hearing. If the hearing lasts more than one day, hotel costs will be incurred by all involved. All parties often pay additional costs because of this statute. Some of these costs may even find their way into cost recovery ordered against a disciplined respondent under section 125.3. However, these costs fall disproportionately on HQE — and ultimately MBC — because HQE handles all physician discipline cases.

The recent hiring freeze and budget cuts have exacerbated the problems posed by this statute. As noted above, HQE's Los Angeles office has been devastated by the loss of six attorney positions, and two other attorneys are out on extended medical leave. This shortage has resulted in HQE's decision to require San Diego DAGs to handle many cases arising out of Orange County. This requirement has resulted in additional costs to HQE, OAH, and MBC, and significant unproductive travel time and inconvenience for the deputies and judges involved. And when hearings in those matters are held in Orange County for the "convenience" of the respondent, the respondent will bear the additional costs incurred by his/her counsel (who is usually from Los Angeles).

Section 11508 was originally enacted in 1945 and has only been amended when additional appellate districts have been created. It does not conform to today's extraordinary state budget

dilemma or to the physical location of HQE and OAH offices. Requiring adjudicative hearings to be held in cities in which HQE and OAH already have office facilities will substantially lessen costs for MBC, and in many cases for the respondent as well.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #33: MBC and HQE should fully implement the vertical prosecution model. As described above in Chapter VII.C. and Recommendation #22, full implementation of the vertical prosecution model — in which an attorney/investigator team is formed at the inception of an investigation and works together to the case's conclusion — would greatly improve the efficiency and effectiveness of HQE's prosecution efforts and MBC's enforcement process as a whole. The Monitor believes the vertical prosecution system could best be implemented by merging existing MBC investigators and supervisors into HQE. However, this system could also be effectuated through coordinated assignments to case teams by the respective agencies.

Recommendation #34: MBC and HQE must revise their medical records procurement and enforcement policy to ensure prompt and full compliance with existing laws, and the role of HQE attorneys in medical records procurement issues should be expanded. HQE and MBC should adopt and strictly enforce a comprehensive medical records procurement policy which is consistently applied in all MBC enforcement cases, as more fully described above in Chapter VII.B.3. and Recommendations #7 and #23. HQE might consider the formation of a small "strike team" of prosecutors familiar with and skilled in subpoena preparation and enforcement actions.

Recommendation #35: The Attorney General's Office should come into full compliance with Government Code section 12529 *et seq.* by adequately staffing HQE to restore lost attorney positions and to fulfill all missions required by these statutes. The Attorney General's Office should take all necessary steps to comply with the staffing mandates of section 12529 *et seq*. by restoring HQE's prosecutor positions lost in recent years (at least six DAG positions) and by assigning sufficient additional DAG staff to fulfill the CCU assistance function and improve on HQE's current track record of moving MBC cases forward rapidly to conclusion. As appropriate, the Attorney General's Office should consider transfers of DAGs from non-fee-generating units to HQE to satisfy pressing HQE personnel needs in Los Angeles, CCU, and elsewhere.

Recommendation #36: MBC and HQE should improve their cooperation with state and local prosecutors, including increased use of Penal Code section 23. As addressed in Recommendation #25 in Chapter VII.C., HQE personnel should join with MBC staff in strengthening existing communications and working relationships with state and local prosecutors to ensure increased coordination of efforts, and in particular to promote increased use of the resource-efficient and highly effective Penal Code section 23 mechanism which is underutilized today.

Recommendation #37: MBC and HQE should make better and more extensive use of the powerful interim suspension order and temporary restraining order tools. Additional resources and training should be directed to reverse the downward trend and to promote increased HQE use of the powerful ISO and TRO interim remedies. Consideration should be given to establishing a rapid response team within HQE to handle these pressing public safety matters on an expedited basis statewide.

Recommendation #38: HQE should develop a formal policy and procedure manual to improve consistency and assist in prosecutor training. HQE must develop and use a policy and procedure manual which adequately covers all the key operations and functions in HQE. The manual should be updated periodically by appropriate management staff and experienced trial personnel. This manual would free HQE from reliance on oral history and verbal training from veteran staff, and would facilitate continuing on-the-job training of new HQE prosecutors.

Recommendation #39: Government Code section 11508 should be amended to locate venue for HQE administrative hearings in the cities of Sacramento, Oakland, Los Angeles, and San Diego. This recommendation would enable the Attorney General to require that adjudicative hearings be held at the hearing facilities maintained by OAH in Sacramento, Oakland, Los Angeles, or San Diego. HQE has offices in all of these cities. In addition, most defense counsel who regularly represent physicians in MBC disciplinary matters are based in one of these cities. The convenience to the respondent afforded by this statute is surely outweighed by the extraordinary costs it imposes on the system — and ultimately MBC and California physicians who pay MBC's licensing fees. The statute currently permits the parties to agree to other hearing locations in unusual circumstances (for example, if the respondent physician is in poor health and unable to travel), and that provision should remain to ameliorate any special respondent hardships. However, the statutory presumption should be that these hearings are to take place in large-city locations in which HQE and OAH already have offices.

Chapter X

HEARINGS: MEDICAL QUALITY HEARING PANEL

A. General Description of Functions

Housed within the Department of General Services, the Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state agency adjudicative hearings in a variety of areas. OAH is headed by a director (also called the chief administrative law judge) appointed by the Governor. The Office currently employs the director, four presiding judges, and 34.4 ALJs based in four California cities (Sacramento, Oakland, Los Angeles, and San Diego).

As noted in Chapter IV, a special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH in 1990's SB 2375 and refined in 1993's SB 916.[220] The purpose of the creation of the MQHP is to enhance the expertise and independence of the ALJs who preside over physician discipline hearings. First, the statute enables the MQHP ALJs to specialize in physician discipline matters; it limits the number of ALJs who may be appointed to the MQHP by the OAH executive director,[221] and requires an MQHP ALJ to preside over MBC adjudicative hearings.[222] The statute also declares that the MQHP ALJs "shall have medical training as recommended by the Division of Medical Quality . . . and approved by the Director of the Office of

[220] *See supra* Ch. IV.C. and Ch. IV.D.

[221] Gov't Code § 11371(a)-(b). As enacted in 1990 in SB 2375 (Presley), these sections granted wide discretion to the OAH Director in determining which and how many ALJs to appoint to the MQHP. Opposed to the provision creating the MQHP because it violates OAH's tradition of providing a "pool" of judges available to hear all types of hearings, and armed with the broad language in SB 2375, the OAH Director in 1991 appointed all 27 ALJs in OAH to the MQHP, defeating the "specialization" intent of the statute. *See supra* Ch. IV.C. SB 916 (Presley) added the specific limit on the number of ALJs who may be appointed to the MQHP. These sections provide that the OAH Director must appoint at least five full-time ALJs but not more than 25% of the total number of ALJs in OAH to the MQHP. Currently, 13 full-time ALJs are on the MQHP — 33% of the ALJs at OAH (including the presiding ALJs and the chief ALJ).

[222] Gov't Code § 11372. SB 916 (Presley) (Chapter 1267, Statutes of 1993) abolished the Board's physician-dominated Medical Quality Review Committees, which had been authorized to preside over MBC disciplinary hearings, and directed MQHP ALJs to preside over all hearings. According to a legislative analysis of SB 916, "supporters argue that the shift is necessary to provide fair hearings and eliminate the appearance of doctors protecting colleagues." Assembly Health Committee, *Bill Analysis of SB 916 (Presley)* (Aug. 25, 1993).

Administrative Hearings."[223] Additionally, the statute requires the OAH director, with the advice of MBC, to appoint "panels of experts" to provide assistance to ALJs who may have difficulty with the expert witnesses paid by the parties. "These panels of experts may be called as witnesses by the administrative law judges of the panel to testify on the record about any matter relevant to a proceeding and subject to cross-examination by all parties."[224] With the creation of the specialized ALJ panel, the Legislature — for the first time — felt comfortable authorizing those judges to entertain motions for and issue interim suspension orders restricting or suspending the license of a physician pending the conclusion of the disciplinary matter, as an alternative to the temporary restraining order remedy in superior court.[225]

Once an accusation has been filed by HQE and the respondent files a notice of defense, the parties approach OAH for a hearing date; the procedure for securing a hearing date varies from northern to southern California.[226] Effective July 1, 2004, OAH adopted a new policy requiring it to calendar hearings to start within 90 days of the date both parties are available; in no event will the first day of the hearing be scheduled more than 210 days from the date OAH receives the request for hearing.[227] Prior to the evidentiary hearing, the assigned ALJ may entertain and rule on discovery disputes[228] and hold prehearing conferences to clarify issues, make rulings on witnesses and objections to proffers of evidence, establish the order of presentation of evidence and witnesses, require the exchange of witness lists and exhibits or documents to be offered in evidence at the hearing, and explore the possibility of settlement.[229] OAH may also conduct formal settlement conferences prior to the hearing in an effort to avoid litigation.[230]

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[223] *Id*. at § 11371(a).

[224] *Id*. at § 11371(d).

[225] *Id*. at §§ 11372(b), 11529.

[226] In southern California, OAH usually conducts an immediate telephonic trial-setting conference with the parties in order to schedule a hearing date, which is preceded by one or two scheduled settlement conferences. In northern California, OAH permits the parties to explore settlement opportunities first; only if settlement negotiations fail does OAH schedule a hearing date.

[227] OAH's July 1, 2004 policy replaced a prior policy requiring it to calendar hearings to start within 120 days of the date that both parties are available; there was no outer limit.

[228] *See* Gov't Code § 11507.7.

[229] *See id*. at § 11511.5.

[230] *See id*. at § 11511.7. The ALJ who is assigned to the matter may not conduct the settlement conference unless the parties so stipulate.

Evidentiary hearings on accusations filed by MBC are presided over by an MQHP ALJ. During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument.[231] Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline.[232] At the Board's request, the ALJ may also recommend that the licensee pay "cost recovery" to reimburse the Board for its investigative and enforcement costs incurred up to the first day of the evidentiary hearing.[233] The ALJ's ruling is a "proposed decision"[234] which is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision (see Chapter XI).

In recommending discipline, the MQHP ALJ is guided by a set of "disciplinary guidelines" approved by DMQ; these guidelines set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[235]

Exhibit IX-A above reflects the "throughput" of MBC investigations into HQE, and HQE accusations into OAH. In the past five years, HQE has filed an annual average of 270 accusations and 22 petitions to revoke probation. Due to the large number of post-filing settlements, the MQHP has presided over an average of 44 MBC disciplinary hearings annually for the past five years. Government Code section 11517(c)(1) requires ALJs to submit a proposed decision to DMQ within 30 days of submission of all the evidence. Exhibit X-A below indicates that — over the past three years — it took MQHP ALJs an average of 35 days to submit proposed decisions. Although this is slightly longer than the statute permits, it is much better than OAH's 120-day average in 1994. However, HQE DAGs have expressed concern that some decisions take over 90 days; in one egregious case seeking revocation, seven months elapsed between case submission and completion of the proposed decision.

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[231] *Id*. at § 11513.

[232] *Id*. at § 11425.50.

[233] Bus. & Prof. Code § 125.3.

[234] Gov't Code § 11517.

[235] Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board's disciplinary guidelines.

Ex. X-A. HQE/OAH/DMQ Average Cycle Times

	Activity	FY 2001–02	FY 2002–03	FY 2003–04
HQE	MBC transmittal ➜ HQE filing of accusation	103 days	91 days	107 days
HQE/ OAH	Estimated time from filing of accusation ➜ conclusion of hearing/ submission of stipulation[236]	351 days	379 days	443 days
OAH	Case submission to ALJ ➜ submission of proposed decision to DMQ	35 days[237]	36 days[238]	35 days[239]
DMQ	Receipt of proposed decision ➜ DMQ final decision	51 days[240]	56 days[241]	30 days[242]

Source: Medical Board of California

B. Initial Concerns of the MBC Enforcement Monitor

Due in part to the 2003 Administration change (and an April 1, 2004 change in leadership at OAH) and in part to the press of other issues that we were required to address in this report, the Monitor did not examine OAH's performance in-depth during the first year of this project. During the second year, we plan to look at the following issues.

1. OAH was impacted by the hiring freeze and budget cuts.

OAH was not immune from the October 2001 hiring freeze or the subsequent position "sweeps" and budget cuts. OAH lost two ALJ positions and a number of support staff positions. The OAH Director has stated that these losses have not directly impacted the MQHP, but they have affected the office as a whole. OAH has requested eight new ALJ positions and four support staff positions.

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[236] We generated this estimated figure by subtracting average ALJ proposed decision drafting time (presented above) and average DMQ decision time (presented above) from the *MBC Annual Report*'s calculation of the average length of time from accusation filing to final case disposition.

[237] This figure includes 7 cases that exceeded 90 days.

[238] This figure includes 4 cases that exceeded 90 days.

[239] This figure includes 6 cases that exceeded 90 days.

[240] This figure includes 16 nonadoptions.

[241] This figure includes 12 nonadoptions.

[242] This figure includes 5 nonadoptions.

2. The time it takes to schedule and conduct evidentiary hearings is lengthy.

Exhibit X-A above indicates an estimated average 443-day period between filing of the accusation and conclusion of the evidentiary hearing — over 14 months. Some of these hearings are one- or two-day matters; others should last weeks but — due to the schedules of the attorneys, respondent, and judge — must be conducted in many non-contiguous blocks over the course of many months. Based on a limited review, it seems that the delay in scheduling and conducting MBC hearings is not due to a shortage of judges or bureaucratic limitations on OAH's part. Instead, it appears that the understaffing in HQE's Los Angeles office[243] (which normally files approximately 60% of all accusations in California) and the limited number of defense counsel who regularly defend physicians in MBC disciplinary matters account for much of the delay in scheduling and holding hearings. In short, there are too few attorneys on both the prosecution and defense sides, and all of these attorneys are "booked" many months in advance. OAH believes that it is setting hearings well within the timelines established in its July 1, 2004 policy, but is forced to postpone scheduled hearings because the parties request continuances. In OAH's view, it has sufficient MQHP ALJs to hear cases more rapidly than they are being heard — but they can't, due to a shortage of attorneys in HQE and the limited number of defense attorneys who handle MBC cases.

3. DMQ members perceive that MQHP ALJs are not following MBC disciplinary guidelines.

Exhibit XI-A below indicates that, during 2001–02 and 2002–03, DMQ nonadopted an unusually high number of proposed ALJ decisions: 25% in 2001–02 and 28% in 2002–03. An October 2002 memo from one DMQ member expresses concern that "some [ALJs] do not follow the Board's Disciplinary Guidelines when imposing discipline in physician cases."[244] Although the percentage of nonadoptions declined to 16% in 2003–04, the Monitor will attempt to examine whether ALJs are adhering to MBC's disciplinary guidelines.

4. Whether ALJs are receiving medical training as authorized by Government Code section 11371 is unclear.

As noted above, one of the ways in which SB 2375 (Presley) and SB 916 (Presley) sought to enhance the expertise of MQHP ALJs was to provide them with medical training "as

[243] *See supra* Ch. IX.B.2.

[244] Ronald H. Wender, MD, Chair, MBC Enforcement Committee, *New Proposal for Reorganization of the Enforcement Program* (Oct. 7, 2002).

recommended by the Division of Medical Quality . . . and approved by the Director of the Office of Administrative Hearings."[245] It is unclear whether ALJs are receiving medical training.

5. ALJs rarely make use of their authority to call their own expert witnesses.

Another way in which SB 2375 (Presley) sought to enhance both the expertise and independence of the MQHP ALJs was to provide them with a panel of expert witnesses. If confronted with diametrically opposed expert witnesses paid by the parties, this mechanism enables the ALJ to call his/her own expert to the stand "to testify on the record about any matter relevant to a proceeding and subject to cross-examination by all parties."[246] We asked dozens of HQE prosecutors and investigators whether any MQHP ALJ had ever utilized this mechanism; one prosecutor remember one ALJ in the past 14 years who has called an expert from that panel.

6. Should ALJs be authorized to enforce administrative subpoenas?

As noted throughout this report, medical records procurement is one of the most serious issues confronting MBC and HQE. MBC and HQE must agree on a new strategy for expediting the prompt production of medical records by physicians and health care institutions. One time-consuming aspect of the existing process is that subpoena enforcement is available only in superior court. Research and inquiry should be performed as to whether MQHP ALJs should be authorized to enforce subpoenas issued by MBC, as a means of expediting medical records procurement.

C. Initial Recommendations of the MBC Enforcement Monitor

As noted above, the Monitor did not examine OAH extensively during the first year of this project. The Monitor intends to look into the above-described issues and others during the second year of the project, and report on OAH in the next report.

[245] Gov't Code at § 11371(a).

[246] *Id*. at § 11371(d).

Chapter XI

DECISIONS: DIVISION OF MEDICAL QUALITY

A. General Description of Functions

The Medical Board's Division of Medical Quality (DMQ), which consists of fourteen of MBC's 21 members (eight physicians and six public members), is the Board's enforcement arm. As described in prior chapters, it oversees a large enforcement staff and adopts final adjudicative decisions in disciplinary matters against its licensees.

Adjudicative or "quasijudicial" decisionmaking is generally governed by the Administrative Procedure Act (APA).[247] It differs fundamentally from all other types of agency decisionmaking, and the courts and Legislature have adopted special rules to ensure that the due process rights of the respondent — who stands to lose a vested constitutional property right — are preserved. Of import, the burden is on the agency to prove a disciplinable violation by "clear and convincing evidence to a reasonable certainty."[248] Under the APA and constitutional law, the respondent has a right to a written statement of the charges (the "accusation") that sets forth the acts or omissions with which she has been charged with sufficient specificity to enable her to prepare a defense.[249] Thereafter, the respondent is entitled to some discovery rights,[250] a noticed and public hearing[251] at which the respondent may be represented by counsel (at his/her expense), testimony under oath,[252] the right to

[247] Gov't Code § 11370 *et seq*.

[248] *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

[249] Gov't Code § 11503.

[250] *Id*. at § 11507.6. APA discovery is not as expansive as civil discovery, in that interrogatories and depositions are generally not allowed.

[251] *Id*. at §§ 11425.10(a)(3), 11509.

[252] *Id*. at § 11513(a).

cross-examine and confront witnesses,[253] the issuance of a formal decision,[254] and judicial review of the agency's decision.[255] Of critical importance, the respondent is also entitled to a decisionmaker who is neutral and unbiased,[256] and who decides the matter based upon evidence that has been lawfully gathered and admitted at a public hearing.[257]

Another mechanism utilized by DMQ and other adjudicative bodies attempts to protect the constitutional rights of the respondent. In imposing disciplinary sanctions, the DMQ panel must consider the Division's "disciplinary guidelines," which set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[258] While not binding standards, these disciplinary guidelines attempt to ensure consistency in DMQ decisionmaking — an important component of equal protection.

DMQ is the final decisionmaker in all MBC disciplinary matters in which an accusation has been filed. However, as described above, DMQ does not personally preside over or even attend APA evidentiary hearings; that responsibility is delegated to an administrative law judge (ALJ) from the Office of Administrative Hearings' Medical Quality Hearing Panel (MQHP), who prepares a proposed decision (PD) for DMQ's review. Nor does DMQ negotiate the terms of stipulated settlements that avoid an evidentiary hearing; that responsibility is delegated to its counsel (HQE) and its staff, who negotiate proposed settlements with the respondent and his/her counsel and present them to DMQ for review. DMQ reviews all proposed case dispositions that follow the filing of an accusation — including all PDs (including ALJ recommendations that an accusation be dismissed),

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[253] *Id.* at § 11513(b).

[254] *Id.* at §§ 11425.10(a)(6), 11425.50, 11517, 11518.

[255] *Id.* at § 11523; *see also* Civ. Proc. Code § 1094.5.

[256] Gov't Code §§ 11425.10(a)(5), 11425.40. *See also Gibson v. Berryhill* (1973) 411 U.S. 564; *State Board of Dry Cleaners v. Thrift-D-Lux Cleaners, Inc.* (1953) 40 Cal. 2d 436; *Allen v. California Board of Barber Examiners* (1972) 25 Cal. App. 3d 1014; and the long series of cases involving the New Motor Vehicle Board, including *American Motor Sales Corp. v. New Motor Vehicle Board* (1977) 69 Cal. App. 3d 983; *Chevrolet Motor Division v. New Motor Vehicle Board* (1983) 146 Cal. App. 3d 353; *Nissan Motor Corp. v. New Motor Vehicle Board* (1984) 153 Cal. App. 3d 109; *University Ford Chrysler-Plymouth v. New Motor Vehicle Board* (1986) 179 Cal. App. 3d 796.

[257] Decisions must be made based on evidence lawfully admitted at the public hearing, and not on off-the-record "ex parte" communications with either the presiding officer at the hearing, Gov't Code § 11430.10, or the governmental official or body entrusted with making the ultimate decision, Gov't Code § 11430.70. *See also* Bus. & Prof. Code § 2335(c)(2).

[258] Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board's disciplinary guidelines.

stipulated settlements, license surrenders, and default judgments.[259] In APA jargon, DMQ is authorized to "adopt" or "nonadopt" proposed case dispositions; in so doing, it is the final judge in the disciplinary matter. It makes the final agency decision which is then subject to judicial review.

For purposes of reviewing PDs, stipulated settlements, and other proposed case dispositions, DMQ divides into two seven-member panels (called "Panel A" and "Panel B"); a proposed case disposition is randomly assigned to one of the panels for review.[260] As presented in Exhibit XI-A below, DMQ panels review and act upon an average total of 54 PDs and 195 stipulated settlements each year.

Generally, Government Code section 11517 — part of the APA — governs a board's review of a PD. However, special rules apply to a DMQ panel's review of a proposed decision:

(1) A DMQ panel must give "great weight to the findings of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence."[261] This "great weight" requirement was added by SB 609 (Rosenthal) in 1995,[262] and is based on the fundamental premise of American jurisprudence that the "trier of fact" should be the one who sees and hears the witnesses, has an opportunity to observe how they say what they say, and observe their credibility and demeanor.[263]

(2) Once MBC receives the PD, it must be assigned to a DMQ panel and sent by mail to each panel member within ten calendar days of receipt. Each member must vote whether to "approve the decision, approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel . . . as a whole, or to nonadopt the decision."[264] Four votes are needed to adopt a decision, approve a decision with an altered penalty, refer the case back to the ALJ for the taking of

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[259] DMQ does not review interim suspension orders issued by MQHP ALJs; those are final when issued, Bus. & Prof. Code § 2335(b), subject to judicial review, Gov't Code § 11529(h). DMQ also does not review pre-filing public letters of reprimand, license surrenders while on probation, or withdrawn accusations (unless they are part of a stipulated settlement).

[260] Bus. & Prof. Code § 2230(b). This provision has not been updated to conform to SB 1950's addition of two new members to DMQ.

[261] *Id*. at § 2335(c)(1).

[262] *See supra* Ch. IV.E.

[263] The "great weight" provision in the enacted version of Business and Professions Code section 2335(c)(1) was a fallback position from an earlier version (August 21, 1995) which would have provided that DMQ is "bound by" the findings of fact of the ALJ.

[264] Gov't Code § 2335(c)(2).

additional evidence, or nonadopt the decision. Two votes will effectively "hold" the proposed decision for discussion of the case at the panel's next meeting. DMQ panel members must return their votes by mail to the Board within 30 days from receipt of the proposed decision.[265]

(3) The DMQ panel must take action on the proposed decision — that is, adopt it or nonadopt it — within 90 calendar days of the date it was received by the Board.[266] If two panel members vote to "hold" a proposed decision for discussion at the panel's next meeting (see above), that meeting must take place within the 90-calendar-day period.[267] If the panel takes no action on the PD within the 90-calendar-day period, the PD becomes final and subject to judicial review.[268]

(4) If the panel believes that the penalty should be more harsh than that recommended by the ALJ, the panel must nonadopt the decision within the 90-calendar-day period. Thereafter, it must order a record of the entire administrative proceeding (including a transcript of the hearing and all the documentary evidence), make it available to both parties,[269] and afford the parties an opportunity for oral argument before the panel prior to deciding the case.[270] Following oral argument, four votes are required to increase the penalty proposed by the ALJ, and "no member of the . . . panel may vote to increase the penalty except after reading the entire record and personally hearing any additional oral argument and evidence presented to the panel . . .."[271]

Once a DMQ panel has adopted a final decision and mailed it to the parties, that decision is subject to reconsideration "on its own motion or on petition of any party," within specified time limits prior to the effective date of the decision. Thereafter, the decision may be reconsidered by the panel itself or may be assigned to an ALJ.[272]

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[265] Bus. & Prof. Code § 2335(c)(3).

[266] *Id*.

[267] *Id*. at § 2335(c)(2).

[268] *Id*. at § 2335(c)(3).

[269] Gov't Code § 11517(c)(2)(E).

[270] Bus. & Prof. Code § 2335(c)(4). Under the APA, an agency that considers the penalty proposed by the ALJ too harsh may simply lower it and adopt the decision with the lowered penalty. Gov't Code § 11517(c)(2)(B). An agency that nonadopts a proposed decision because it does not believe the penalty recommended by the ALJ is sufficiently harsh must afford the parties "the opportunity to present either oral *or written* argument before the agency itself." Gov't Code § 11517(c)(2)(E)(ii) (emphasis added). However, a DMQ panel that is nonadopting a proposed decision must afford the respondent an opportunity for oral argument. Bus. & Prof Code § 2335(c)(4).

[271] *Id*. at § 2335(c)(5).

[272] Gov't Code § 11521.

Exhibit XI-A below presents recent DMQ activity in two areas — DMQ panel review of proposed decisions and stipulated settlements. It reveals that DMQ adopts most PDs (84% in 2003–04) and approves most stipulations (95% in 2003–04). When it nonadopts a decision, it generally increases the penalty recommended by the ALJ. Recall, however, that increasing the penalty is the only reason a panel must nonadopt a proposed decision — such that a harsher penalty after nonadoption is the expectable result. If the panel believes the recommended penalty is too harsh, it can simply reduce the penalty and approve the decision.[273]

EX. XI-A. Division of Medical Quality Review of ALJ Proposed Decisions and Stipulations

Activity	FY 1999–2000	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04
Total ALJ decisions	53	60	52	57	50
ALJ decisions adopted	45 (85%)	49 (82%)	39 (75%)	41 (72%)	42 (84%)
ALJ decisions nonadopted	8 (15%)	11 (18%)	13 (25%)	16 (28%)	8 (16%)
Subsequent disposition of nonadoptions	7 increased 1 upheld	8 increased 2 upheld 1 decreased	11 increased 2 upheld	13 increased 2 upheld	6 increased 2 pending
Total stipulations submitted	198	182	162	218	214
Stipulations approved	184 (93%)	171 (94%)	145 (90%)	205 (94%)	203 (95%)
Stipulations rejected	14 (7%)	11 (6%)	17 (10%)	13 (6%)	11 (5%)

Source: Medical Board of California

Exhibit XI-B below presents recent DMQ decisions on petitions for reconsideration under Government Code section 11521.

XI-B. Rulings on Petitions for Reconsideration

	FY 1999–2000	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04
Petitions filed by Respondent	18	17	9	17	14
Petitions Granted	1	1	1	1	1
Petitions Denied	17	16	8	16	13
Petitions filed by DAG	2	4	4	4	5
Petitions Granted	1	3	1	1	4
Petitions Denied	1	1	3	3	1

Source: Medical Board of California

Finally, Exhibit X-A above presents DMQ's average cycle time from receipt of a PD to DMQ decision. In 2003–04, DMQ reviewed and reached a final decision on most PDs within 30 days (with the exception of the cases it nonadopted).

[273] *See supra* note 270. DMQ rarely reduces a proposed penalty.

B. Initial Concerns of the MBC Enforcement Monitor

Due to the press of other issues that we were required to address in this report, our examination of DMQ's performance during the first year of this project was limited to the data-gathering displayed above. To our knowledge, these data have not been gathered and/or presented in any way in recent memory, and may be valuable to Board members as they consider the following issues, which will be examined during the second year of this project.

1. The added value of DMQ review of proposed decisions is unclear.

As described in Chapter IV, *Code Blue* argued in 1989 that DMQ review of proposed decisions should be eliminated in favor of permitting the ALJ to make the final agency decision based on the agency's disciplinary guidelines and subject to a petition for judicial review by either side.[274] Legislation to implement this concept was unsuccessfully attempted in 1989, 1990, and 1993.[275] Although we find little support for that concept today among MBC and HQE staff, it resonates with defense counsel and the California Medical Association. While making no specific recommendation at this time, the Monitor will describe the reasons underlying the concept in hopes of promoting a constructive public dialogue on the issue during 2005.

Members of occupational licensing boards — which consist of "volunteers" who have full-time jobs in cities all over the state, convene for meetings once every three months, and who may be members of the profession regulated by the board on which they sit — may be well-suited to making certain kinds of decisions and less well-suited to making other kinds of decisions. For example, volunteer board members are capable of adopting regulations to guide the practice of a trade or profession and making other kinds of "quasilegislative" or policy decisions to guide the profession or board staff. However, in the view of the Monitor and others, volunteer board members are less well-suited to making decisions in quasijudicial proceedings on the rights of an individual licensee — which is of momentous importance to that licensee and to the Board's public protection mandate, calls for intense exposure to and knowledge of the evidence in the specific matter, and may require subject matter expertise in the intricacies and complexities of the particular specialty at issue.

When DMQ panel members receive a proposed decision in an adjudicative matter, that is all they have. They have had no prior involvement in the case as it has worked its way through the system — no knowledge of the facts or details of the investigation, prosecution, or hearing. They are not permitted any involvement in the pre-PD process. Because they are the final judges and their

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[274] *See supra* Ch. IV.B.

[275] *See supra* Ch. IV.C. and IV. D.

decision must be based on the evidence that has been admitted by the ALJ, they are permitted to have no external knowledge of the case. So they work from the proposed decision alone, and have no access to the record of the hearing before the ALJ. They were not present at the hearing and had no opportunity to observe the witnesses, their credibility and demeanor, or the evidence. They are not judges and generally have no familiarity with the rules of evidence or administrative procedure. They may not have any familiarity with the subject matter of the particular case, usually have no idea how similar cases have been decided, and usually consist in majority of people in the same profession or trade as the accused licensee.

Are those decisionmakers in the best position to make a high-quality decision in that particular matter? Are they the "neutral and unbiased tribunal" to which the respondent has a constitutional right? Are they the "neutral and unbiased tribunal" best suited to make a decision that serves the Board's "paramount" priority of public protection?[276] These are important issues. Some DMQ members may have medical expertise, but not "on point" expertise due to the specialization of the profession. They also lack optimum information about the specific matter. At the same time, they may have the expected general "bias" or empathy with colleagues — or be perceived by the public to be so influenced. They are members of the same profession.

The prior attempts to eliminate DMQ review of proposed decisions were intended to achieve two goals: (1) streamline the decisionmaking process to expedite it for the benefit of both the respondent and the public; and (2) create a limited number of decisionmakers who have both subject matter expertise and independence from the profession — as opposed to perpetuating a time-consuming and expensive system with layer after layer after layer of decisionmakers who are sequentially required to learn the details of a disciplinary matter. These twin touchstones — subject matter expertise and independence — have formed the foundation of prior proposals to permit the administrative judge who has presided over the hearing to make the final agency decision (subject to a petition for judicial review by either side). The judge was at the hearing and has seen and heard the witnesses, received all the documentary evidence, and heard the expert testimony submitted by both sides. The judge specializes in physician discipline matters and is familiar with the rules of procedure and evidence in administrative proceedings. The judge has both knowledge of the evidence and is independent of the profession — the twin touchstones that are most important in making a decision that is consistently fair and in the public interest. And if the judge makes a mistake — as judges sometimes do — that case will go to court more quickly and at less cost for both the agency and the respondent.

The data presented above are instructive. Historically, DMQ nonadopts very few proposed decisions, and rejects very few stipulations. Other factors also lead some to support elimination of

[276] Bus. & Prof. Code § 2229(a) and (c); *see also id.* at § 2001.1.

DMQ review. DMQ members have full-time jobs and busy lives; the burden of having to read multiple proposed decisions and boxes of hearing transcripts and evidence for each quarterly meeting may be too much to realistically ask of these volunteers. As such, there is no guarantee that all DMQ members read and/or fully understand the proposed decisions or hearing transcripts before voting on disciplinary action. And the time DMQ must spend on fact-finding in individual disciplinary matters leaves less time for other kinds of decisionmaking that is vitally needed and to which the members are better suited, such as rulemaking, policymaking, and oversight of important mechanisms such as the Diversion Program (see Chapter XV). The cost of the current system — including time, money, and lost opportunity costs — seems to outweigh the system's output: the nonadoption of very few proposed decisions and the rejection of very few stipulations.

Over the years, the Board and others who support DMQ review have advanced two arguments:

(1) "We nonadopt to impose a harsher penalty. We are harsher on our own than are the ALJs." That may be true. However, such harshness by members of a profession against one of their competitors or colleagues may be unfair to respondents, especially if it is inconsistent. The goal should not be harshness, but consistency — and some dispute the overall consistency of DMQ decisionmaking (see below).

(2) "DMQ review brings medical expertise to the process, because many DMQ members are physicians." DMQ review may bring generalized medical expertise to the decisionmaking process, but it is unclear how a psychiatrist on DMQ could bring subject matter expertise to a decision involving neurosurgery. It is unclear why that DMQ member with generalized medical expertise and specialized knowledge of psychiatry should be permitted to second-guess the opinions of the physicians who have reviewed the medical records and specific evidence in the particular matter[277] — to which the psychiatrist on DMQ has no access — or the judge who has immersed herself in the facts, law, and expert medical opinion peculiar to that particular matter.

In sum, due to the structure of the process, DMQ members generally lack the twin touchstones — maximum information and independence from the profession — necessary to engage in adjudicative decisionmaking in the public interest. Their talents and skills might be better directed to other kinds of decisionmaking.

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[277] As described in prior chapters, MBC's enforcement program incorporates and requires extensive physician review of the medical records, other evidence, and testimony in each individual case — from the "specialty reviewer" in the Central Complaint Unit, to the medical consultant in the district office, to the expert reviewer with on-point medical expertise who reviews the entire investigative report and all the evidence, and opines as to the standard of care applicable in the particular matter and whether the subject physician's conduct conformed to those standards.

2. The consistency of DMQ decisionmaking is unclear.

The fragmented structure of MBC's enforcement program makes it difficult to evaluate the consistency of decisionmaking at any point in the process, including DMQ review. Investigations are handled from twelve different offices; they are funneled into one of six HQE offices and thereafter into one of four OAH offices. Decisionmaking occurs at each of these steps — decisions to close cases, to move them further in the process, to seek disciplinary action, to impose disciplinary action. An evaluation of the overall consistency of this decisionmaking is almost impossible within the confines and resources of this project.

DMQ decisionmaking is superimposed on all the decisionmaking that occurs below, and it is also plagued with fragmentation. After all, DMQ is split into two panels, neither of which knows of the other's decisionmaking in similar cases. DMQ membership is constantly shifting and changing. There is little or no *stare decisis* — the legal doctrine under which courts adhere to precedent (prior decisionmaking in similar cases) on questions of law in order to ensure certainty, consistency, and stability in the administration of justice — in administrative agency proceedings. To promote *stare decisis* and consistent decisionmaking over time and across the shifting membership of DMQ panels, SB 916 (Presley) in 1993 required the Office of Administrative Hearings to publish the decisions of the Medical Quality Hearing Panel, "together with court decisions reviewing those decisions, and any court decisions relevant to medical quality adjudications" in a quarterly *Medical Discipline Report*.[278] The intent of the journal was to inform all parties — including licensees, HQE, respondent's counsel, and DMQ itself — of prior DMQ disciplinary decisionmaking in order to promote consistency and encourage settlements. A similar journal instituted at the State Bar in the early 1990s has accomplished precisely that.[279] Although the law enacted in SB 916 remains on the books today, the *Medical Discipline Report* has never been published. And it has been effectively superseded by the Legislature's enactment of Government Code section 11425.60 in 1995, which precludes a party from relying on or citing to a prior DMQ decision unless the Division has designated it as a "precedent decision." Although the "precedent decision" mechanism is intended to promote consistency in decisionmaking, encourage settlements, and avoid costly litigation, DMQ has made no use of its "precedent decision" authority under section 11425.60.

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[278] *See* Ch. IV.D. This requirement is now codified in Government Code section 11371(c).

[279] Rule 310 of the State Bar's Rules of Procedure requires the Bar to compile final disciplinary decisions of the Bar's Review Department (an appellate review body within the Bar) into a *California State Bar Court Reporter*; these decisions are binding on the Bar's hearing judges who preside over evidentiary hearings in attorney discipline matters. Note that the State Bar is not subject to the APA and does not use OAH ALJs at attorney discipline hearings; the Bar has its own staff of hearing and appellate judges who specialize in attorney discipline matters. Note also that the State Bar Board of Governors does not review final disciplinary decisions made by the appellate Review Department; those are reviewable only by the California Supreme Court.

3. The procedure utilized at DMQ oral arguments is flawed.

Since 1986, the Monitor has personally attended literally hundreds of DMQ oral arguments on nonadoptions. The procedure employed is quite unusual. And if the Monitor — an attorney — thinks it is unusual, one can only wonder about the impressions of the public and the respondents whose licenses and livelihoods are potentially at stake.

The scenario is as follows: A DMQ panel has nonadopted a proposed decision. The only reason a DMQ panel needs to nonadopt a PD is to consider a harsher penalty than that recommended by the ALJ. So the respondent physician turns into a petitioner — pleading with the panel to either leave the ALJ's proposed penalty alone or lower it, but certainly not to increase it. That respondent must be mystified when he arrives at the hearing to find that the Board is represented by its own counsel — HQE. In effect, the "client" hears argument from its own counsel, with which it frequently interacts and upon whom it depends for legal advice on a myriad of matters. The Monitor would not be surprised to learn that respondents feel disadvantaged, as if there is a level of unfairness built into the process.

Procedurally, the respondent is usually permitted to argue first. The HQE DAG is given equal time to respond, and each side is afforded a brief rebuttal. In making oral argument, the lawyers are required to confine themselves to evidence that is "in the record" — that is, evidence that has been presented at the evidentiary hearing and admitted by the ALJ. The DMQ members have all of this evidence, because in nonadoption cases the entire transcript and record of the evidentiary hearing are ordered and delivered to all panel members, and by law all of them are required to "read . . . the entire record and personally hear . . . any additional oral argument and evidence presented to the panel" before voting on the nonadoption.[280] However, counsel do not always confine themselves to the record, and an objection to the argument may be voiced — requiring a ruling on the objection.

Historically, the chair of the DMQ panel — usually a physician, usually (and understandably) not well-versed in litigation procedures and responding instantly to evidentiary challenges — presided at these oral arguments and was expected to rule on objections. On those occasions, in-house MBC lawyers would attempt to assist the panel chair in ruling on objections; inasmuch as those individuals generally report to the "prosecutor" in the matter (MBC's executive director), that procedure left something to be desired. Due to these problems and the considerable mischief that resulted, 1995's SB 609 (Rosenthal) required MBC to adopt regulations governing the procedure at

[280] *See supra* note 271.

oral arguments,[281] and those regulations now require an ALJ to preside at oral argument.[282] Of course, this cannot be the same ALJ who presided over the hearing and whose decision was nonadopted in the matter at issue, so the ALJ presiding at oral argument necessarily has little or no knowledge of the sometimes voluminous record in the underlying matter. As opposed to the panel chair, this judge might be somewhat more successful in controlling the proceeding, ruling on objections, and requiring counsel to cite to the record when there is a question as to whether argument is based on the record. However, the required presence of the ALJ adds more expense to this process, and interrupts the hearing schedule of that MQHP ALJ.

Then, in what is by far the most unusual aspect of the proceeding, the respondent himself must be given an opportunity to personally address the panel,[283] and members of the DMQ panel are permitted to question either counsel or the respondent. Neither the statute nor the regulations require that the respondent be put under oath when he makes this statement or answers questions. Respondents sometimes stray from the record and/or the topic at hand, and are subject to objections. Well-meaning DMQ panel members often ask questions outside the record, and are subject to more objections.

Suffice it to say that the process — both in substance and in appearance — leaves a dissatisfied taste in the mouths of most members of the audience, especially lawyers. This entire process and its attendant costs could be obviated if the original ALJ's decision were designated as the final decision.

4. DMQ's procedures on motions for a stay in order to seek reconsideration appear unfair.

The defense counsel we interviewed raised two procedural issues related to petitions for reconsideration of a final DMQ decision. As described above, Government Code section 11521 permits either party to seek reconsideration of a final DMQ decision prior to its effective date (which is usually 30 days after DMQ adoption of the decision). Defense counsel assert that defense petitions for reconsideration are almost always denied, while HQE petitions for reconsideration are often granted.

Exhibit XI-B above presents data on the number and outcome of petitions for reconsideration filed in the past five years. Defense counsel are correct. In the past five years, defense counsel filed

[281] Bus. & Prof. Code § 2336.

[282] 16 CAL. CODE REGS. § 1364.30.

[283] *Id*. at § 1364.30(e).

75 petitions for reconsideration and five were granted; HQE filed 19 petitions for reconsideration and 10 were granted. While these results appear unfair, they are also somewhat expectable and unsurprising. One expects the prosecution to win most of the time a case goes to hearing; an experienced prosecutor with a weak case will settle prior to hearing, while a respondent with a weak case may decide to "roll the dice," go to hearing, and hope for the best rather than stipulating to discipline. One also expects a respondent to "exhaust his administrative remedies" by challenging every order adverse to his interests (which is why respondents petitioned for reconsideration four times more than did HQE). Finally, one does not expect DMQ to revisit these matters often — the DMQ panel has already reviewed the PD, perhaps held oral argument on it, and ruled on it. In the absence of serious procedural or substantive error, DMQ will be content to let the matter proceed to court.

Section 11521(a) also permits either side to request a short stay of the effective date of the final decision to enable counsel to prepare a petition for reconsideration. Defense counsel contend that whenever HQE files a motion for a stay in order to prepare a petition for reconsideration, it is "always granted." Yet whenever the defense counsel asks for a stay, the request is "always denied." Regrettably, the Monitor did not have an opportunity to request data on that particular component of the process, but anecdotal evidence provided by MBC staff who collect this information indicates that defense counsel are probably correct (just as they were correct about the outcomes of petitions for reconsideration). Defense counsel further charge that MBC's Enforcement Chief (and not the DMQ panel) rules on motions for stay — which is why HQE motions for stay are "always granted" and defense motions for stay are "always denied." According to one defense lawyer, "the Board's staff and enforcement personnel, represented by the Attorney General, are the prosecutors and are adversaries against the physicians. The fox guards the chicken coop when our adversaries can grant themselves stays for purposes of reconsideration. There are no standards which guide the granting of stays. . . . Government Code section 11521 requires the agency itself to hear and deliberate petitions for reconsideration. The agency itself, with a member of the Board signing a formal order, should be the way a stay is acted upon by the Board." That attorney provided the Monitor with an example of a motion for stay filed by HQE that had been approved and signed by the Enforcement Chief. Additionally, the subsequent petition for reconsideration was granted. That order was also signed by the Enforcement Chief, making it unclear to the attorney whether the Enforcement Chief or the DMQ panel actually ruled on the petition for reconsideration.

MBC's *Discipline Coordination Unit Procedure Manual* states that "agency staff are authorized to grant or deny a stay request and need not be elevated to the Chair or President of the voting body. Agency staff includes the Executive Director or his/her designee (*i.e.*, Enforcement Chief or Deputy Chief)."[284] The manual also sets forth three criteria to be used in determining

[284] Medical Board of California, *Discipline Coordination Unit Procedure Manual*, Ch. 30 (revised 12/03).

whether to grant a stay: "good cause, whether or not an opposition will be submitted, [and] the amount time before the decision effective date."[285] Whether or not the stay is granted, the manual goes on to set forth a procedure that clearly indicates that the panel members — not the Enforcement Chief or other MBC staff — decide whether to grant or deny the petition for reconsideration.

Section 11521 is unsatisfactorily unclear about who is required to make the stay decision. It requires the "agency" to rule on motions for stay. The term "agency" is defined as "a board, bureau, commission, department, division, office, officer, or other administrative unit, including the agency head, and one or more members of the agency head *or agency employees or other persons directly or indirectly purporting to act on behalf of or under the authority of the agency head*."[286] The term "agency head" is defined as "a person or body in which the ultimate legal authority of an agency is vested, and *includes a person or body to which the power to act is delegated pursuant to authority to delegate the agency's power to hear and decide*."[287] Had the drafters of section 11521 intended the DMQ panel to rule on motions for stay, they probably should have used the term "agency head." Instead, they used the term "agency." Thus, it appears MBC is within the law in permitting its Enforcement Chief to rule on motions for stay. However, the Monitor agrees with defense counsel that this appears to be a rather one-sided procedure wherein a representative of the prosecutor is able to make decisions affecting the final outcome of a disciplinary matter.

5. DMQ should notify both parties if it rejects a stipulated settlement.

Defense counsel also complain that when DMQ rejects a stipulated settlement, it notifies only the HQE DAG and not the defense attorney. Sometimes it takes a lengthy period of time for the HQE DAG to contact the respondent's counsel to convey the information that a stipulation has been rejected — during which time respondent's counsel has no information on the fate of his client. Defense counsel assert that "the staff and the DAGs are made privy to the reasons for the rejection of the settlement. OAH and the defense bar should have the benefits of those reasons as well." The Monitor does not agree that defense counsel are necessarily entitled to the reasons for the rejection — those reasons are often communicated by DMQ to HQE in the context of the attorney-client privilege, and are accompanied by instructions to negotiate a "counter-stipulation" that is acceptable

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[285] *Id*.

[286] Gov't Code § 11405.30 (emphasis added). This statute was enacted as part of a wide-ranging effort to reform the adjudication provisions of the Administrative Procedure Act conducted by the California Law Revision Commission in the mid-1990s. The Law Revision Commission's background document on the provision that eventually became Government Code section 11405.30 indicates that its definition of the term "agency" "explicitly includes the agency head *and those others who would act for an agency*, so as to effect the broadest possible coverage" (emphasis added). California Law Revision Commission, *Revised Tentative Recommendation: Administrative Adjudication by State Agencies* (July 1994), at 2.

[287] *Id*. at § 11405.40 (emphasis added).

to the DMQ panel But the fact of the rejection should be communicated to defense counsel at the same time it is communicated to HQE.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #40: DMQ should engage in a public dialogue on the value and costs of DMQ review of proposed decisions and stipulated settlements. We reiterate that little support exists within MBC and HQE for eliminating DMQ review of proposed decisions, but the defense bar and the California Medical Association are concerned about the fairness and consistency of both DMQ decisionmaking and the procedures that result in DMQ decisionmaking.

Recommendation #41: MBC should explore its "precedent decision" authority under Government Code section 11425.60 and begin to make use of it. DMQ in fact commenced a discussion of this issue at its July 2004 meeting, but could not readily identify a "benefit" to the procedure. The benefit is that a well-written legal ruling that represents the will of the Division will become binding on future divisions; should future divisions disagree with the precedent decision, they can un-adopt it as a precedent decision. In the meantime, however, licensees, HQE, respondent's counsel, and OAH can be guided by it as a standard of conduct and it will serve to encourage consistency in subsequent decisionmaking, promote settlements in similar cases, and avoid the time and cost of litigation.

Recommendation #42: DMQ should address the procedural issues raised by defense counsel related to motions for a stay of the effective date of a disciplinary decision in order to file a petition for reconsideration. To preserve both the appearance and actuality of fairness to all parties, MBC enforcement staff should not rule on these motions.

Recommendation #43: Government Code section 11371(c) should be repealed. This subsection, which has never been implemented by MBC or OAH, requires the publication of MQHP decisions and court decisions reviewing those decisions in a *Medical Discipline Report* publication. It has been superseded by Government Code section 11425.60.

Recommendation #44: DMQ should notify counsel for both HQE and the respondent when it rejects a stipulated settlement.

Recommendation #45: Business and Professions Code section 2230(b) should be amended to reflect SB 1950's addition of two new members to DMQ.

Chapter XII

JUDICIAL REVIEW OF DMQ DECISIONS

A. General Description of Functions

A physician whose license has been disciplined may seek judicial review of MBC's decision by filing a petition for writ of mandate (also called a "writ of administrative mandamus") in superior court under Code of Civil Procedure (CCP) section 1094.5.[288] The physician may also seek a court order staying MBC's decision pending the conclusion of the superior court's review. Under MBC's unique venue statute, a writ challenging DMQ's disciplinary decision may be filed in any city in which the Board has an office.[289]

In conducting its review of the agency's decision, the superior court sits alone, without a jury, and reviews the record of the administrative hearing (including the transcripts of the testimony that was presented at the hearing and the exhibits that were introduced). The court does not call witnesses, nor does it consider new evidence that was not introduced at the administrative hearing (except under very narrow statutory circumstances). Generally, the focus of the court's review is to determine whether the agency's findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency's discretion or constitutes an abuse of that discretion.[290] The court exercises its independent judgment and reviews the administrative record as a whole in determining these issues. There is a presumption the agency's decision is correct,[291] and the petitioner (the disciplined licensee or applicant denied a license) has the burden of demonstrating how the decision is invalid.

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[288] Gov't Code § 11523.

[289] Business and Professions Code section 2019 requires the Board to have an office in Sacramento, authorizes it to have offices in Los Angeles, San Diego, and San Francisco, and states that "legal proceedings against the board shall be instituted in any one of these four cities."

[290] Civ. Proc. Code § 1094.5(b).

[291] *Fukuda v. City of Angels* (1999) 20 Cal. 4th 805, 812.

If the court determines that the findings and conclusions are supported by the weight of the evidence and that the Board acted within its discretion, the court will uphold MBC's decision and deny the petition. If not, the court can grant the petition in part (with respect to those findings it does not find supported) and deny the petition in part (affirming those portions of the decision which it concludes are supported by the weight of the evidence). The court can also grant the petition altogether, explaining how the findings are not supported by the evidence, the conclusions are not supported by the findings, or how — in its opinion — the penalty constitutes an abuse of discretion. Whenever a petition is granted in whole or in part, the matter is remanded to the Board for further proceedings (the issuance of a new decision) consistent with the court's ruling. The court may not tell the Board how to exercise its discretion (in other words, it cannot specify a penalty it prefers).

Either side may challenge the superior court's decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal.[292] Unlike a direct appeal, this procedure requires the party filing the petition to promptly file papers supporting the claim, and file the entire administrative and superior court record with the court. The appellate court has three options. If it concludes the petition lacks merit on its face and does not believe additional briefing would be helpful, it may summarily deny the writ on the merits, thus obviating the need for oral argument and a written opinion. In most instances, however, the court issues an alternative writ. When an alternate writ is issued, the parties engage in full briefing, the court entertains oral argument, and it issues a written decision. The court also has the option of summarily granting the writ (reversing the lower court's decision without further input from the parties), but this has not been yet been done by a court reviewing a superior court's decision concerning physician discipline. Although the procedure for judicial review of physician discipline has been expedited by this "extraordinary writ" process, the appellate court still uses the same standard of review it does for direct appeals: It determines whether the superior court's findings are supported by substantial evidence and are correct on matters of law.[293]

The appellate court's decision may be appealed to the California Supreme Court. Such review is entirely discretionary and is rarely attempted or granted.

Exhibit XII-A below presents the number of DMQ disciplinary decisions appealed to a court in the year indicated. It also reveals the number of decisions issued in those years in which either MBC prevailed or the respondent prevailed.[294]

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[292] Bus. & Prof. Code § 2337.

[293] The constitutionality of the "extraordinary writ" mechanism, which was added by SB 609 (Rosenthal) in 1995, was upheld by the California Supreme Court in *Leone v. Medical Board of California* (2000) 22 Cal. 4th 660.

[294] Note that the number of decisions upholding DMQ orders or reversing/remanding them in a given year does not match the number appealed during that year. The number of court orders on DMQ decisions applies to a different universe of cases that were appealed in prior years. We present these figures only to give the reader an idea of how MBC fares when its disciplinary decisions are reviewed by the courts.

Ex. XII-A. Judicial Review of DMQ Decisions

	FY 2001-02	FY 2002-03	FY 2003-04
DMQ decisions appealed to:			
Superior Court	23	24	19
Court of Appeal	5	8	6
Supreme Court	2	3	2
DMQ decisions upheld by:			
Superior Court	16	16	5
Court of Appeal	5	4	5
Supreme Court	1	2	2
DMQ decisions reversed/remanded/vacated by:			
Superior Court	16	13	12
Court of Appeal	1	1	0
Supreme Court	0	0	1

Source: Medical Board of California

Exhibit XII-B below presents the average days from the filing of a petition for writ of mandate in a superior court until the superior court's decision; it also indicates the number of DMQ decisions that were stayed by the superior court — that is, their effective date was postponed — pending the conclusion of superior court review.

Ex. XII-B. Cycle Time and Stay Rate: Superior Court Review of DMQ Decisions

	FY 2001–02	FY 2002–03	FY 2003–04
Percentage of writ cases in which superior court stayed DMQ decision	34.7%	37.5%	47.3%
Average days from filing of petition ➜ superior court ruling	357 days	375 days	409 days

Source: Medical Board of California

B. Initial Concerns of the MBC Enforcement Monitor

1. MBC's venue statute is encouraging "forum-shopping" and inefficient use of judicial resources, and is unnecessarily costing HQE and MBC substantial amounts of money every year.

As noted above, under Business and Professions Code section 2019 (which is unique to MBC), a respondent unhappy with a DMQ disciplinary decision may file a petition for writ of mandate in San Diego, Los Angeles, Sacramento, or San Francisco — regardless of where the administrative hearing was held and regardless of where the HQE DAG who prosecuted the case works. This has led to apparent "forum-shopping" on the part of defense counsel in search of a

Note also that the source of these figures is the Medical Board, whose Discipline Coordination Unit (DCU) closely tracks the status and disposition of every matter transmitted from MBC to HQE. DCU must undertake this tracking function because the computer systems of MBC and HQE are separate. Further, HQE just began utilizing its new ProLaw case management system in July 2004; prior to that time, HQE data tracking was not comprehensive. Because of the separate computer systems, DCU depends on the HQE DAG handling a writ matter to inform DCU that a writ has been filed and its subsequent disposition. These data represent the number and disposition of writs transmitted to DCU.

sympathetic judge. The Monitor's research reveals that, of 24 writs filed in 2002–03, only eight were filed in the same city where the administrative hearing was held and the HQE DAG works; the remaining 16 (66%) of them were filed in different cities. Eleven of those 16 cases were filed in Sacramento. During 2003–04, of 19 writs filed, only five were filed in the same city where the administrative hearing was held and the HQE DAG works; the remaining 14 (74%) were filed in different cities. Once again, Sacramento appears to be the "venue *du jour*" — ten of those 14 writ cases were filed in Sacramento.

This practice is resulting in the inefficient use of judicial resources — overburdening one court disproportionately while other courts are relatively unused by MBC petitioners. Additionally, it is costing MBC and HQE thousands of additional dollars to fly HQE DAGs all over the state for writ hearings.

2. MBC is inappropriately subsidizing the cost of the preparation of administrative hearing transcripts for writ proceedings.

When a licensee files a CCP section 1094.5 petition for writ of mandate challenging a DMQ disciplinary decision, that petitioner must request the record of the administrative proceeding from the Office of Administrating Hearings. Under section 1094.5, "[e]xcept when otherwise prescribed by statute, the cost of preparing the transcript shall be borne by petitioner."[295] OAH must prepare the record and deliver it to the petitioner "upon the payment of the fee specified in [Government Code] Section 69950 for the transcript, the cost of preparation of other portions of the record and for certification thereof. Thereafter, the remaining balance of any costs or charges for the preparation of the record shall be assessed against the petitioner whenever the agency prevails on judicial review following trial of the cause."[296]

Thus, through the interaction of CCP section 1094.5 and Government Code section 69950, the petitioner pays up front a specific amount per page, which tends to be only about one-half of the actual cost of the preparation of the transcript, and the agency is billed for the rest. Although the agency is permitted to recoup the amount it has been charged if it prevails in the writ proceeding, the recoupment process is long and complex, and requires OAH's cooperation in preparing billing paperwork. Further, according to MBC, "many cases for which the transcript is prepared pursuant to this section never result in the pursuit of a petition for writ of mandate once the petitioner reviews the record. Thus, for the majority of these cases, the Board is precluded from recovering its costs."[297]

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[295] Civ. Proc. Code § 1094.5(a).

[296] Gov't Code § 11523.

[297] Medical Board of California, *Request for Approval of Proposed Legislation: Redirection of Office of Administrative Hearings Transcript Costs From the Agency to the Requestor* (circulated for the November 7, 1997 meeting of the Board's Committee on Attorney General Services).

MBC's underwriting or cross-subsidization of the cost of the preparation of the record in writ of mandate proceedings — to the tune of thousands of dollars per transcript and many more thousands of dollars each year — is unnecessary and particularly inappropriate in light of its current financial plight. Legally, the cost of transcript preparation in writ cases must be borne by the petitioner; if petitioner prevails, MBC is required to reimburse those costs. It is unfair for MBC to be required to cross-subsidize the petitioner's costs and then be unable to recoup them.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #46: Business and Professions Code section 2019 should be amended to require legal proceedings challenging the Board's decision following an administrative hearing to be instituted in Sacramento, San Francisco, Los Angeles, or San Diego — whichever is closest to where the administrative hearing was held. Consistent with the Monitor's Recommendation #39 regarding venue for administrative hearings, the venue for writ proceedings should lie in the city closest to where the administrative hearing was held.

Recommendation #47: Government Code section 11523 should be amended to eliminate the reference to Government Code section 69950 and instead require the petitioner to pay the actual cost of the transcript up front. If the petitioner prevails, he or she will be reimbursed by the Board. And those litigants who cannot afford to pay for the transcript up front are able to receive a free copy under a separate provision of law.[298]

[298] Gov't Code § 68511.3; *see also Board of Medical Quality Assurance v. Superior Court (Dean, Real Party in Interest)* (1988) 203 Cal. App. 3d 691.

Chapter XIII

PUBLIC DISCLOSURE

A. General Description of Functions

In addition to removing incompetent, negligent, dishonest, and impaired physicians from the marketplace through its enforcement program, another way in which MBC implements its "paramount" public protection priority[299] is by disclosing licensee information to the public, to enable consumers to make informed choices when selecting a health care practitioner.

The Board's public disclosure policy is an important complement to its enforcement program. The preceding chapters have described many limitations on the Board's ability to protect the public through its enforcement program — including limitations that are within its control (for example, lengthy delays due in part to its failure to demand compliance with medical records procurement laws[300]) and others that are beyond its control (for example, its limited resources,[301] the recent staffing losses at both MBC and HQE,[302] and the failure of many of its most important sources of information to report physician misconduct as required by law[303]). As a result of these flaws, it is unreasonable to expect that MBC will be able to promptly remove all dangerous physicians from the marketplace. Even assuming these flaws are addressed and resolved, consumers are entitled to information about the people to whom they are entrusting their lives and health. It is thus reasonable to expect MBC, as a complement to its enforcement program, to provide consumers with true, accurate, and complete information about its licensees so they can make informed choices and protect themselves from physicians with whom they would prefer not to deal.

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[299] Bus. & Prof. Code §§ 2001.1, 2229(a) and (c).

[300] *See supra* Ch. VI.B.2, Ch. VII.B.3, Ch. IX.B.4.

[301] *See supra* Ch. V.B.2.

[302] *Id*.

[303] *See supra* Ch. VI.B.5.

Further, and as astutely noted by the Joint Legislative Sunset Review Committee in 2002, "poor public disclosure is worse than no public disclosure." In its final report and recommendations on MBC's 2001–02 sunset review, the JLSRC stated: "A public program of disclosure that purports to provide information a patient might find relevant about the history and record of a physician, but which for whatever reason falls short, is worse than no disclosure program at all. An inadequate program leads a diligent patient into erroneously believing that their physician was trouble-free, when the physician may in fact have an extensive record of problems. An inadequate program of public disclosure leads a patient into an incorrect belief that no further investigation of their physician is warranted."[304]

The Board's evolving public disclosure policy. As described in Chapter IV, MBC disclosed nothing about its licensees except its own disciplinary actions prior to 1993. In response to criticism of its public disclosure policy in the 1989 *Code Blue* report[305] and the 1992 "Sixty Minutes" exposé,[306] and as a result of discussions at the March 1993 Medical Summit that followed release of the CHP report,[307] MBC liberalized its public disclosure policy in May 1993, and that policy was codified (for the most part) in SB 916 (Presley) in 1993. Under SB 916 and regulations implementing that bill, the Board disclosed (in addition to its own disciplinary actions) felony convictions, medical malpractice judgments in excess of $30,000, temporary restraining orders and interim suspension orders, Board-ordered limitations on practice, public letters of reprimand, citations, fines, and disciplinary actions taken by medical boards in other states. From 1993 through 1997, the Board disclosed this information in writing upon the request of a consumer.

By 1997, the Internet had become a widely-used means of communication. Effective January 1, 1998, AB 103 (Figueroa) added section 2027 to the Business and Professions Code. Section 2027 required the Board to create a Web site and to post the "public information" described above on the Web site so consumers could quickly and easily access information about their physicians' histories. AB 103 also required the Internet posting of new information not previously disclosed by MBC: It required the disclosure of *all* medical malpractice judgments and arbitration awards (thus removing the $30,000 threshold), and — for the first time — permitted MBC to disclose (from section 805 reports) adverse peer review actions resulting in the termination or revocation of a physician's privileges by a hospital or HMO.[308]

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[304] Joint Legislative Sunset Review Committee, *Final Recommendations of the Joint Legislative Sunset Review Committee on the Medical Board of California* (May 2002) at 4.

[305] *See supra* Ch. IV.B.

[306] *See supra* Ch. IV.D.

[307] *Id*.

[308] *See supra* Ch. IV.E.

By 2002, dissatisfaction with MBC's public disclosure policy was reflected in numerous news articles revealing the many ways in which physicians and their counsel exploited loopholes in MBC's reporting statutes and otherwise manipulated the legal system in order to avoid reporting to the Board and — therefore — to avoid disclosure by the Board of otherwise disclosable events.[309] In addition, injured patients and consumer advocates questioned why the public is deprived of information on medical malpractice settlements and other adverse events relevant to medical practice when every other societal institution which deals with physicians — including state medical boards, medical malpractice insurers, hospitals, and HMOs — is able to acquire and use their entire professional history before choosing to deal with them.[310] These issues were predominant at MBC's 2001–02 sunset review proceeding and the resulting legislation — SB 1950 (Figueroa) — addressed some of them. Specifically, SB 1950 closed loopholes in MBC's reporting statutes by clarifying that a medical malpractice judgment in any amount must be reported to MBC "whether or not vacated by a settlement after entry of the judgment, that was not reversed on appeal . . . ."[311] It also requires the reporting of settlements over $30,000 "if the settlement is based on the licensee's negligence, error, or omission in practice, or by the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee."[312] Finally, SB 1950 permitted MBC — for the first time — to disclose some civil malpractice settlements.[313]

Statutory framework. MBC's public disclosure policy is codified in a complex and tangled web of statutes and regulations — primarily sections 803.1 and 2027 of the Business and Professions Code. Superimposed over those MBC-specific statutes[314] are the California Public Records Act[315]

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[309] *See, e.g.*, Todd Wallack, *Patients Don't Get Full Story on Doctors*, S.F. CHRON., Jan. 6, 2002, at A1 (malpractice judgments settled on appeal considered nondisclosable "settlements" by MBC rather than judgments; MBC's policy to disclose judgments but not settlements has resulted in high settlement rate to avoid disclosure); Cheryl Clark, *Loophole Leaves Some Medical Suits Off Web Site*, S.D. UNION-TRIB., Apr. 29, 2002 (malpractice judgments settled on appeal considered nondisclosable "settlements" by MBC rather than judgments; Board's failure to disclose misdemeanor criminal convictions deprives consumers of public information about criminal history of physicians); William Heisel and Mayrav Saar, *Doctors Without Discipline*, O.C. REGISTER, Apr. 7, 2002 ($53.5 million judgment entered against physician's medical group instead of physician not disclosed by MBC).

[310] *See, e.g.*, William Heisel and Hanh Kim Quach, *Family Pleads for Reform*, O.C. REGISTER, May 2, 2002.

[311] Bus. & Prof. Code § 801(b).

[312] *Id.*; *see also id.* at §§ 801.1(b), 802(b).

[313] *Id.* at § 803.1(b)(2). *See supra* Ch. IV.G.

[314] Sections 803.1 is also applicable to the Board of Podiatric Medicine and the Osteopathic Medical Board of California.

[315] Gov't Code § 6250 *et seq*.

(which specifies that most agency records are public information unless they fall within narrow enumerated exemptions), the Information Practices Act[316] (which limits public disclosure of "personal information" held by government agencies), and Article I, section 1 of the California Constitution (which was enacted to preclude unnecessary "government snooping" and the overbroad collection, retention, and misuse of personal information by government and business interests).

As a result of the interaction of all of these provisions, there are essentially four categories of "information" on physicians and three ways to obtain some (but not all) of it — and one will receive different information depending on how and who one asks:

■ **"Public information" available on the Internet**. The Medical Board maintains a Web site at www.medbd.ca.gov or www.caldocinfo.com. At the right side of the home page is a link entitled "Check Your Doctor Online." Clicking on that link brings up an information page listing the information that is — and is not — available from MBC about its licensees. Entering the name or license number of a California physician will bring up that physician's "screen," which reveals her license status, address of record, original issue date of the license, its expiration date, and any "public record actions" — meaning enforcement-related actions that may be posted on the Web site. Section 2027 details the categories of information that the Legislature has determined is "public information" that MBC must post on its Web site — and is thus available to the public with a click of a mouse:

(1) with regard to the status of the license, whether or not the licensee is in good standing, subject to a TRO or ISO, or subject to any of the enforcement actions set forth in section 803.1;[317]

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[316] Civil Code § 1798 *et seq*.

[317] The "enforcement actions" set forth in section 803.1 include "enforcement actions taken against a licensee by [MBC] or by another state or jurisdiction, including all of the following": TROs/ISOs; revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement; public letters of reprimand; and infractions, citations, or fines.

One defense attorney we interviewed alleged that MBC posts notices of disciplinary action on its Web site before they have become effective. According to the attorney, "this premature posting publishes to the world that this is a bad doctor even though he or she may be seeking a petition for reconsideration from the Medical Board or judicial review in superior court." MBC posts a disciplinary action on the Internet on the date it is ordered and mailed to the respondent; if the decision has a delayed effective date (for example, 30 days hence), that effective date is also posted. If the physician files a timely petition for reconsideration that MBC grants, the Internet posting is changed to read "decision stayed" or "stay order granted" pending the conclusion of DMQ's reconsideration. If a petition for writ challenging a DMQ decision is filed and a stay is granted, MBC usually notes on the Internet that a stay has been granted and an appeal is pending. This is accurate information. The Medical Board has taken disciplinary action after affording the physician a panoply of due process rights, it has temporarily stayed that decision in order to reconsider it, and/or a court has temporarily stayed that decision to afford it time to meaningfully review the matter, and an appeal is pending. Because of MBC's paramount public protection priority, the Monitor is not prepared to recommend a change in that policy. Public Citizen's Health Research Group, which evaluates and rates the Web sites of state medical boards for content and user-friendliness, agrees: "If a court overrules or vacates a board action and exonerates the physician and the court decision is final, information on that action should be removed from the database. While an appeal is pending, or while a remanded action is being considered, information on the action and the court's decision should continue to

(2) prior discipline by the board of another state or jurisdiction;

(3) felony convictions reported to the Board after January 3, 1991;

(4) current accusations filed by the Attorney General, including those accusations that are on appeal;[318]

(5) any malpractice judgment or arbitration award reported to the board after January 1, 1993;

(6) any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason;

(7) a description of categories of information that are not disclosed; and

(8) any information required to be disclosed pursuant to section 803.1.[319]

Section 2027(b) limits the amount of time that certain information may be posted on MBC's Web site. While felony convictions and section 805 reports of hospital disciplinary action resulting in termination or revocation of privileges may be disclosed on the Internet indefinitely, the remaining categories of information described in section 2027 may be posted only for a ten-year period "and after the end of that period shall be removed from being posted on the board's Internet Web site."[320]

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be reported in the database." Public Citizen Health Research Group, *Survey of Doctor Disciplinary Information on State Web Sites* (Apr. 9, 2002) at 4.

[318] The term "current accusation" means an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the Medical Board of California unless an appeal of that decision is pending. Bus. & Prof. Code § 2027(a)(4).

[319] The information "required to be disclosed by section 803.1" includes: (a) the "enforcement actions" described in footnote 317 above; (b) civil judgments in any amount, "whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal and arbitration awards in any amount of a claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services"; (c) some civil malpractice settlements, as described in Chapter XIII.B. below, and whose disclosure must be accompanied by a lengthy statement prescribed in section 803.1(c); (d) current specialty certification by a national board recognized by MBC; (e) approved postgraduate training completed; (f) the "status of the license of a licensee"; and (g) summaries of hospital disciplinary actions that have resulted in the termination or revocation of a physician's staff privileges for medical disciplinary cause or reason.

[320] Bus. & Prof. Code § 2027(b)(2). As interpreted and implemented by the Medical Board, the ten-year period specified in section 2027(b) started on January 1, 2003 — the effective date of SB 1950 (Figueroa). Thus, all information on the Board's Web site as of that date will remain on its Web site until January 1, 2013 — at which time information that is (a) over ten years old, and (b) not exempted from the ten-year requirement will be removed from the Board's Web site.

■ **"Public information" that is disclosed but is not posted on MBC's Web site**. Accessible via a Public Records Act request or a letter or telephone call to MBC, this category includes public information of an enforcement nature that is maintained by MBC but is not permitted to be posted on the Board's Web site under section 2027. Examples of this kind of information include the following:

(1) items of information that would be permitted to be disclosed on the Web site but — as of January 1, 2013 — are over ten years old and are thus prohibited from Web posting under section 2027(b);

(2) MBC disciplinary actions that were taken before 1990 (the year MBC began to use the CAS computer system) — actions taken before that date and recorded on the Board's prior computer system could not be "imported" onto its Web site created in 1998;[321] and

(3) filed accusations that have been withdrawn, dismissed, settled, and/or are no longer "current" pursuant to the definition of that word in section 2027(a)(4) and thus may not be posted on the Web site. This category includes about 300 so-called "enforcement agreements" negotiated by the Board in the mid-1990s, in which MBC filed an accusation but subsequently agreed to withdraw it on the condition that the physician take and pass an oral competency exam or successfully complete a Board-directed educational program. If and when the physician completed the requirement, MBC would "withdraw" the accusation and drop the matter entirely. Because filed accusations and their subsequent disposition have historically been considered public information,[322] MBC is required to disclose this information if requested in a Public Records Act request.

If MBC has disciplinary information about a physician which is not permitted to be posted on the Web under section 2027, it states — next to the "Public Record Actions" line — "none available on Web site" and invites the inquirer to click on a link that states: "California law does not permit all of a physician's records to be posted on the Board's Web site. Additional information that you may or may not find relevant about your doctor is available if you contact us directly at: Central File Room, (916) 263-2525. The Board encourages you to discuss with your physician any information the Board provides to you."

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[321] For example, the Monitor knows of a physician whose license was revoked by MBC at least four times prior to 1990; on most of those occasions, the revocation was stayed and the physician's license was put on five years' probation on numerous terms and conditions. He completed his last probation in 1994. MBC filed another accusation against him in April 2004, and his hearing is pending. His MBC Web site screen reveals only the 2004 accusation and the completion of probation in 1994. None of the pre-1990 disciplinary actions are revealed on MBC's Web site, but they are all public information which MBC is required to reveal in response to a request under the Public Records Act.

[322] See 16 CAL. CODE REGS. § 1354.5(b) (MBC's public disclosure regulation requiring disclosure of "any public document filed against any physician and surgeon, and any disposition thereof").

■ **"Public information" that is known to MBC but not disclosed at all**. This category includes information that is technically "public information," is known to the Medical Board, but is not disclosed by MBC because it is not disclosable under either section 803.1 or section 2027. Examples of this kind of information include the following:

(1) criminal arrests of physicians. MBC receives information on arrests of physicians because all physicians are fingerprinted at point of licensure. Those fingerprints are entered into the Department of Justice's Criminal Identification and Information (CII) system. If a physician is subsequently arrested, the CII system's "subsequent arrest notification" mechanism notifies MBC of the arrest. Although arrest information is considered public information under the Public Records Act,[323] MBC does not disclose criminal arrests of physicians to the public in any way. Arrest information is available through local law enforcement agencies and is often published in local newspapers.

(2) misdemeanor criminal convictions of physicians. All criminal convictions are public information. Theoretically, MBC receives criminal conviction information — including misdemeanor criminal conviction information — because court clerks are required to report convictions to MBC.[324] However, MBC does not disclose any misdemeanor criminal convictions. This information is public information and is available at county courthouses.

(3) civil malpractice settlements that do not qualify for disclosure under section 803.1(b)(2) — these are discussed below in Chapter XIII.B. If these settlements are over $30,000, MBC must be notified of them by malpractice insurance companies or the physician licensee. Information on civil malpractice settlements that have not been sealed is public information and is available at county courthouses. MBC's Web site contains a link to superior court information, but online availability of civil malpractice settlement information varies widely by county.

■ **"Non-public information" known to MBC that is not disclosed**. This category includes enforcement-related information that is known to MBC but is not disclosed because no statute expressly permits it to be disclosed. Thus, a Public Records Act request would not yield this information, and it is not publicly available anywhere else. Examples of this kind of information include the following:

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[323] Gov't Code § 6254(f)(1).

[324] Business and Professions Code section 2236(c) requires the clerk of the court "in which a licensee is convicted of a crime" to "within 48 hours after the conviction, transmit a certified copy of the conviction to the board." As noted in Chapter VI, court clerks do not always comply with this requirement, because they do not know about the reporting requirement and many do not know that a defendant in their courtroom is a physician whose criminal conviction must be reported to the Medical Board. *See infra* Ch. VI.B.5 and Recommendation #15.

(1) complaints;[325]

(2) investigations — including completed investigations that have been referred to HQE for the filing of an accusation;[326] and

(3) hospital disciplinary actions that have not resulted in termination or revocation of a physician's privileges, including suspensions, restrictions, resignations while under investigation and/or with charges pending, and extended leaves of absence to enter drug/alcohol rehabilitation programs. The vast majority of peer review actions fall into this category and are not disclosed. Of 157 peer review actions reported to MBC in 2003–04, only six (6) were disclosable; the rest — including resignations with charges pending and drug/alcohol-related leaves of absences — may not be disclosed by MBC.

B. Initial Concerns of the MBC Enforcement Monitor

1. The fragmented tangle of overlapping statutes — including drafting errors and inconsistencies — frustrates the purpose of MBC's Web site, unnecessarily exposes MBC to litigation, and results in the disclosure of different information depending on the mode of inquiry.

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[325] Courts have held that complaints — even complaints that are not referred for investigation — fall within the "investigatory files" exemption to the Public Records Act in Government Code section 6254(f). *See*, *e.g.*, *Black Panther Party v. Kehoe* (1974) 42 Cal. App. 3d 645.

However, some Department of Consumer Affairs agencies disclose complaints prior to the filing of an accusation. The Board of Podiatric Medicine, whose policy is "to permit the maximum public access to information in its possession consistent with the requirements of the California Public Records Act . . . , the Information Practices Act . . . , section 803.1 of the Business and Professions Code, and the individual's right of privacy guaranteed by the California Constitution," (16 CAL. CODE REGS. § 1399.700), discloses "the nature of all complaints on file which have been investigated by the Board and referred for legal action to the Attorney General . . ."; this information is accompanied by a disclaimer set forth in Board regulation. 16 CAL. CODE REGS. § 1399.704(a).

Going even further, the Contractors State License Board (CSLB) is required by statute to "make available to members of the public the date, nature, and status of all complaints on file against a licensee that do either of the following: (1) Have been referred for accusation. (2) Have been referred for investigation after a determination by board enforcement staff that a probable violation has occurred, and have been reviewed by a supervisor, and regard allegations that if proven would present a risk of harm to the public and would be appropriate for suspension or revocation of the contractor's license or criminal prosecution." Bus. & Prof. Code § 7124.6(a). In other words, CSLB discloses not only complaints referred to the Attorney General's Office for legal action, but also complaints in which sufficient investigation has been performed to indicate a "probable violation" that, if proven, would justify suspension or revocation of the license or criminal prosecution.

[326] Generally, pending investigations fall within the "investigatory files" exemption to the Public Records Act in Government Code section 6254(f).

One important purpose of MBC's Web site was to provide the public with easy access to all public information about California physicians.[327] By implication, another purpose might have been to relieve MBC of the costly and time-consuming pre-AB 103 duty of responding to thousands of written or telephonic requests for physician-specific information.[328] The idea was to load the Medical Board's repository of public information about its licensees onto the Internet to provide consumers with quick and easy access to that information so they can make better-informed health care choices.

Over the years, that intent has been frustrated by the language of the laws themselves. Under the laws as they exist today, consumers who check MBC's Web site will be given only information specifically authorized by section 2027. Consumers who call the Board's Central File Room or submit a Public Records Act request will be given a different set of information. And consumers who consult their county courthouses — or perhaps many of them in large communities such as Los Angeles and the Bay Area — may receive even more information. Although most of this information is technically "public information," is known to the Medical Board, and could easily be loaded onto the Web site, the complexities of the statutes and the unwillingness of MBC to expose itself to more expensive litigation[329] over its public disclosure policy means that disclosure varies based on how (and who) the consumer asks for information.

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[327] According to many legislative analyses of AB 103 (Figueroa), "allowing the public easy access to important information about physicians, particularly in the area of medical negligence, and putting that information into proper context is an essential element of genuine health care reform. The author states a shroud of secrecy exists around medical malpractice information and doctor disciplinary reports from hospitals. The author states this issue has received national attention due to the enactment of a Massachusetts law which provides for the release of detailed information about physician disciplinary actions and malpractice suits; according to the author, this bill mirrors the key provisions of the Massachusetts law. The author concludes this bill will help consumers make better-informed choices about their health care."

[328] Public Citizen's Health Research Group, which evaluates and rates the Web sites of state medical boards for content and user-friendliness, recognizes this concept: "Unless a board Web site provides adequate information about actions, patients will be unable to use the site to make an informed choice in selecting a physician. For these patients, contacting the board by phone or mail will still be necessary. This represents a lost opportunity for the board to enhance consumer access to doctor disciplinary data and reduce its own workload." Public Citizen Health Research Group, *Survey of Doctor Disciplinary Information on State Web Sites* (Apr. 9, 2002) at 4.

[329] MBC has had to defend its public disclosure policy in a number of lawsuits, including the California Medical Association's November 1993 challenge to MBC's May 1993 decision to disclose felony convictions, malpractice judgments over $30,000, other-state discipline decisions, and completed investigations at point of referral to HQE. Additionally, in 2002, the insurance industry sued MBC to stop it from disclosing section 801 reports of civil settlements to the *San Francisco Chronicle* in response to a Public Records Act request. After a flurry of briefing by MBC, the insurance industry, the *Chronicle* (which intervened in the action), and the California Medical Association, the court preliminarily enjoined MBC from disclosing the settlement information on March 8, 2002. *California Association of Professional Liability Insurers, et al. v. Joseph*, No. 02-CS-00231 (Sacramento County Superior Court). Subsequent to the filing of the lawsuit, SB 1950 (Figueroa) was enacted and, effective January 1, 2003, substantially changed the statutes pertaining to the disclosure of medical malpractice settlement information by MBC. In July 2004, the plaintiffs voluntarily dismissed the action.

As described above, section 803.1 and the Public Records Act set forth the "public information" that MBC must disclose. Section 2027 sets forth the "public information" that MBC must disclose *on the Internet*. Inconsistencies between sections 803.1 and 2027 have resulted in concealment of some information from the public, confusion, and litigation. For example:

■ On its face, section 2027 — as added by AB 103 Figueroa in 1998 — does not permit MBC to disclose its own prior disciplinary actions on the Internet. This makes little policy sense and is surely a drafting error;[330] MBC has always disclosed its own disciplinary actions, and one goal of AB 103 was to require MBC to post on the Internet the information it was already disclosing. However, to this day, section 2027 limits MBC's disclosure of prior discipline to "discipline by the board **of** another state or jurisdiction, as described in Section 803.1" (emphasis added). Contrary to section 2027, section 803.1 states that "the Medical Board of California . . . shall disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee by [the] board **or** by another state or jurisdiction . . . (emphasis added). Although section 2027 was amended in 2002 to require the Internet disclosure of "any information required to be disclosed pursuant to Section 803.1," MBC is being sued right now by a physician who contends that — because of the use of the word "of" in section 2027 — MBC is not permitted to disclose its own prior disciplinary action against him on the Internet.[331]

■ As noted above, section 2027 was amended in 2002 to require MBC to post on the Internet not only the information specified in section 2027 but also the information specified in section 803.1.[332] Section 2027 was also amended to place time limits on MBC's Internet disclosure of many of the information categories in section 2027.[333] However, no time limit was specified for the cut-off of disclosure of "any information required to be disclosed pursuant to Section 803.1."

■ Finally, the 2002 amendment to section 2027(a)(4), which restricts MBC's authority to disclose accusations that have been "dismissed, withdrawn, *or settled*" on the Internet, appears to conflict with section 803.1's mandate that MBC disclose (on the Internet, pursuant to section

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[330] As introduced on January 9, 1997, AB 103 would have required MBC to post on the Internet "with regard to prior discipline, whether or not the licensee has ever been subject to discipline by the board **or** another state or jurisdiction" (emphasis added). Without explanation, the "or" was changed to "of" on April 9, 1997. However, every single legislative analysis of AB 103 on and after April 9, 1997 continued to state that AB 103 requires MBC to post all prior discipline — whether imposed by MBC or an out-of-state medical board. Thus, it appears the change from "or" to "of" was not intended, and was a drafting error.

[331] *Szold v. Medical Board of California*, 4 Civil No. D04448 (petition for writ of mandate denied by San Diego County Superior Court; appeal pending in Fourth District Court of Appeal).

[332] Bus. & Prof. Code § 2027(a)(8).

[333] *Id*. at § 2027(b).

2027(a)(8)) "[r]evocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order *or stipulated agreement*."[334]

Some of these problems may stem from hurried legislative drafting; others may stem from the Board's overly cautious interpretation of the language and its unwillingness to risk litigation it can ill afford at this juncture. The Monitor is acutely aware that knowledgeable and reasonable people have spent many hours debating the impact of the language in these overlapping statutes; perhaps the better approach — and certainly one more consistent with the Board's public protection mandate — would be to draft "clean-up" amendments that combine and harmonize sections 803.1 and 2027, eliminate obvious drafting errors and inconsistencies, and ensure that all "public information" known to the Medical Board is posted on its Web site.

2. SB 1950's civil settlement disclosure provision has had minimal effect.

As noted above, MBC's 2001–02 sunset review took account of a series of media articles illuminating flaws in the Board's enforcement program and its loopholed public disclosure policy.[335] In its May 1, 2002 background paper for MBC's sunset hearing, JLSRC staff called for "a publicly credible disclosure program that — by definition — does not conceal from patient-consumers information they might consider important, that is available to multiple other stakeholders, and that will also permit market forces to favor quality medical care providers."[336]

In its final report and recommendations, the JLSRC itself stated that "the Board's current disclosure policy, including the information available on its web site, does not accurately reflect whether an individual physician has a past history that could very well influence the decision a person may make regarding which physician they choose for their health care. For example, the Board's current web site does not disclose to the public categories of information available, and considered important, by the Board, medical malpractice insurers, HMOs and hospitals for investigation and disciplinary purposes, underwriting purposes, and liability exposure purposes, respectively." In particular, the JLSRC noted that at least ten other states (at that time) disclosed medical malpractice settlements and called for a similar statute requiring their disclosure in California.[337]

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[334] *Id*. at § 803.1(a)(3).

[335] *See supra* note 309; *see also* Ch. IV.G.

[336] Joint Legislative Sunset Review Committee, *Medical Board of California: Background Paper for May 1, 2002 Hearing* (May 1, 2002) at 2.

[337] Joint Legislative Sunset Review Committee, *Final Recommendations of the Joint Legislative Sunset Review Committee on the Medical Board of California* (May 2002) at 2. JLSRC staff's May 1, 2002 background paper included a National Conference of State Legislatures study revealing that ten other states (Arizona, Connecticut, Florida, Georgia,

Prior to its sunset review hearing, MBC's Public Information Disclosure Committee had commenced a series of hearings on the Board's public disclosure policy in January 2002. After much public testimony and debate, the Public Information Disclosure Committee, Division of Medical Quality, and the full Board all approved a proposal to disclose all medical malpractice settlements over $30,000 at their May 2002 meetings. Although they had initially considered proposals to disclose only multiple and/or very large malpractice settlements, the Board and its committees discarded those ideas in favor of disclosing all settlements with a strong disclaimer — with the idea of letting the consumer be the judge. Early versions of SB 1950 incorporated MBC's proposal, with the following rationale: "As detailed in recent news articles, physicians with repeated histories of even multi-million dollar malpractice settlements could misleadingly get a 'clean bill of health' from the Board's Web site. This is because medical malpractice settlement information is not disclosed to the public — even though every other stakeholder insists upon the same information. The Board obtains it for enforcement purposes. Hospitals, medical groups, and medical malpractice insurers all insist upon it to weigh the potential risk of associating with particular physicians . . . ."[338]

The California Medical Association and the insurance industry persuaded several key legislators to oppose civil settlements, arguing that (1) the number of malpractice claims against physicians is determined by many factors, including the inherent risks of some specialties and the number of high-risk patients in a physician's practice; (2) cases are often settled not because they are meritorious but because they will cost more to try than to settle, and settlement decisions are influenced by many factors, including the availability of witnesses, the complexity of the medical issue, the relative sympathy for the plaintiff, and the emotional consequences to the physician in going to trial; (3) settlement disclosure is likely to drive up malpractice premiums because physicians will more frequently refuse to settle, thus increasing malpractice insurance costs and delaying resolution for all concerned; and (4) the assurance of confidentiality is an overriding factor facilitating settlement of a case, which is especially true when the physician believes the case against him or her is without merit. Without the assurance of confidentiality, physicians — who have the right to refuse to settle[339] — will go to trial much more often, thereby driving up the cost of malpractice insurance.

Idaho, Rhode Island, Tennessee, New York, Virginia, and Massachusetts) all disclose medical malpractice settlement information. JLSRC staff conducted interviews with officials from the states' medical boards, and those interviews had a common theme. "While many physicians opposed the disclosure of such information initially, once implemented it appears as though none of these states received a noteworthy number of complaints about the disclosure from physicians. It should be underscored that each of these states reveals medical malpractice settlement information accompanied by certain disclosures and explanatory disclaimers to place the information in an appropriate and useful context . . . . Current California law already permits the Board to craft appropriate disclaimers or explanatory statements included with any information released." Joint Legislative Sunset Review Committee, *Medical Board of California: Background Paper for May 1, 2002 Hearing* (May 1, 2002) at 11.

[338] Senate Business and Professions Committee, *Analysis of SB 1950 (Figueroa)* (May 7, 2002).

[339] *See* Bus. & Prof. Code § 801(f).

As the summer of 2002 wore on, numerous amendments diluted the settlement disclosure provision. In the end, SB 1950's settlement disclosure provision authorizes MBC to disclose civil malpractice settlements according to the following procedure:

(1) First, the Board must adopt regulations classifying each physician specialty as "high risk" or "low risk." In adopting those regulations, the Board must consult with and convene public meetings of commercial underwriters of medical malpractice insurance companies, health care systems that self-insure physicians, and representatives of California medical specialty societies; further, it "shall utilize" the carriers' data to establish the two risk categories.[340]

(2) MBC may disclose the civil settlements of a physician in a "low risk" specialty only if the physician has three or more settlements in the past ten years. MBC may disclose the civil settlements of a physician in a "high risk" specialty only if the physician has four or more settlements in the past ten years.[341] The Board may disclose only settlements occurring and reported to the Board after SB 1950's effective date — January 1, 2003.

(3) When it discloses civil settlements, the Board is not permitted to disclose the actual dollar amount of a settlement. Instead, the Board must "put the number and amount of the settlement in context by doing the following": (a) compare the settlement amount to the experience of other licensees within the same specialty or subspecialty, and indicate if it is below average, average, or above average for the most recent ten-year period; (b) report the number of years the licensee has been in practice; and (c) report the total number of licensees in that specialty or subspecialty, the number of those who have entered into a settlement agreement, and the percentage that number represents of the total number of licensees in the specialty or subspecialty.[342]

(4) When it discloses civil settlements, the Board is required to attach a lengthy disclaimer mandated in section 803.1(c).

Commencing in July 2003, MBC began its effort to implement the procedures described above. As required by the statute, it consulted with insurers, self-insurers, and specialty societies to obtain input on which specialties should be classified as "high risk" vs. "low risk." According to Board staff, the insurers provided data that was not usable; thus, staff performed its own analysis of other insurance carrier data available to it — settlements reported to the Board under section 801 for the prior ten-year period of 1993–2003. Based on this analysis, staff recommended the

[340] *Id*. at § 803.1(e).

[341] *Id*. at § 803.1(b)(2)(A).

[342] *Id*. at § 803.1(b)(2)(B).

identification of neurological surgery, orthopedic surgery, obstetrics, and plastic surgery as the "high risk" specialties requiring four or more settlements in a ten-year period before any of them will be disclosed; all other specialties are considered "low risk." DMQ adopted this proposal in section 1355.31, Title 16 of the California Code of Regulations, at its November 7, 2003 meeting; that regulation was approved by the Office of Administrative Law on October 4, 2004.

In its analysis of settlements reported in 1993–2003, MBC staff found that only 375 physicians settled three or more malpractice claims during that ten-year period, and only 121 physicians settled more than four. As a result, staff predicted that disclosure of settlements under SB 1950 would occur very rarely. Staff was correct. In almost two years since SB 1950 became effective, the Medical Board has disclosed civil malpractice settlements on a grand total of seven (7) physicians — all of whom have agreed to four or more settlements since January 1, 2003.

In the Monitor's view, this is not the "publicly credible disclosure program" demanded by the Medical Board, the JLSRC, and its staff in 2002. Civil malpractice settlements are increasingly public information since the Judicial Council adopted rules prohibiting the sealing of court records in 2001[343] — and MBC (which publicly voted to disclose all malpractice settlements over $30,000) may appear overly protective and solicitous of the medical profession with its "three-in-ten" and "four-in-ten" limitations on the disclosure of public information that a consumer can obtain at the local county courthouse. Civil malpractice settlements are reached in the context of a public judicial proceeding financed with taxpayer money in which the physician has every opportunity to be represented by counsel and to reject the settlement[344] — and the proceeding pertains to the physician's professional performance (and not to his personal life); secreting this information is offensive both to taxpayers and to the judicial system. Insurers, hospitals and HMOs, and the Board itself demand, obtain, and rely upon a physician's complete malpractice history before determining whether to ensure, grant privileges to, or license that physician. Only consumers are left in the dark.

The medical profession consistently argues that if a physician with multiple settlements is truly a danger to the public, the Medical Board should take disciplinary action against that physician

[343] The routine sealing of court records is a thing of the past under recent rule changes adopted by the Judicial Council. Effective January 1, 2001, the Judicial Council adopted new rules 12.5 and 243.1–243.4, California Rules of Court, which expressly prohibit courts from sealing court records (including settlements) simply because the parties agree to their sealing, and permit courts to seal court records only if they make the following findings: (1) there exists an overriding interest that overcomes the right of public access to the record; (2) the overriding interest supports sealing the record; (3) a substantial probability exists that the overriding interest will be prejudiced if the record is not sealed; (4) the proposed sealing is narrowly tailored; and (5) no less restrictive means exist to achieve the overriding interest. These rules apply statewide to courts across California. However, some large California counties have prohibited routine sealing of otherwise-public court documents for many years. Effective July 1, 1990, the San Diego County Superior Court adopted local rule 6.9 (now numbered as rule 2.48), which prohibits the sealing of court records except to protect a legitimate trade secret or privileged information.

[344] *See* Bus. & Prof. Code § 801(f).

and publicize that — not the settlements. The response to that argument is twofold: (1) MBC cannot be reasonably expected to take prompt and decisive disciplinary action against all dangerous physicians under current resource constraints; and (2) the Medical Board does in fact take disciplinary action against most physicians with multiple settlements. Exhibit XIII-A below reveals the results of MBC staff's analysis of physicians with the most settlements as of June 24, 2003.

Exhibit XIII-A. MBC Disciplinary Action Against Physicians with Seven or More Malpractice Settlements as of June 24, 2003

Physician's Specialty	# of Settlements	Investigation/Discipline
Urology	80	Stipulation: license surrendered following the filing of Accusation.
Plastic Surgery	35	Stipulation: suspension, probation following the filing of Accusation; Petition to Revoke Probation filed.
Neurosurgery	27	Accusation filed; hearing scheduled.
Urology	15	Disciplined twice; suspension & probation: At present, physician has not met terms of probation and is not able to practice.
Plastic Surgery	14	ISO issued; Stipulation: license surrendered.
Neurosurgery	12	7 years probation; physician was denied Petition for Early Termination.
Ophthalmology	12	Stipulation; license surrendered.
Ophthalmology	10	Revoked; criminally convicted; discipline and felony conviction on appeal.
Orthopedic Surgery	9	Accusation filed and withdrawn.
Neurosurgery	8	Investigation of several cases resulted in "closed with merit," but there was insufficient evidence for findings of gross negligence.
Orthopedic Surgery	8	Accusation filed; three years probation granted and completed.
General Surgery	8	Investigation of cases resulted in citation and fine for giving false information, but there was insufficient evidence for finding of gross negligence.
Obstetrics/ Gynecology	8	Accusation filed and probation granted, which was followed by a Petition to Terminate Probation. As a result of petition, physician stipulated to surrender license.
Obstetrics/ Gynecology	8	Physician died while under investigation, and therefore no action was taken (although it was likely that an Accusation would have been filed).
Ophthalmology	8	Accusation filed, awaiting hearing. Physician is also convicted of a felony.
Plastic Surgery	7	Physician died after Accusation was filed, and therefore no disciplinary action was taken.
Plastic Surgery	7	Physician died while under investigation, and therefore no action was taken (although it was likely that an Accusation would have been filed).
Plastic Surgery	7	Stipulation: Surrender of License, after ISO and Accusation were filed.
Neurosurgery	7	Under investigation; several cases already "closed with merit" with insufficient evidence for findings of gross negligence.
Orthopedic Surgery	7	Investigation conducted and there was insufficient evidence for finding of gross negligence. Several cases were "closed with merit."
Orthopedic Surgery	7	AG's Office denied request for Accusation to be filed and requested more evidence. While under further investigation, physician died, and no action was taken.
General Surgery	7	Currently under investigation for some cases; other cases were "closed with merit" as investigation was unable to obtain sufficient evidence for finding of gross negligence.

Source: Medical Board of California

Of the 22 physicians listed (all of whom had agreed to seven or more settlements since their licensure as physicians), MBC investigated all 22 of them and attempted disciplinary action against at least 17 of them; five of these physicians died while their cases were in the accusation phase or under investigation. Of the 17 cases in which MBC attempted disciplinary action, it succeeded in ten, and two others are pending. Cases against the other five physicians were closed "with merit" or for insufficient evidence of gross negligence. Obviously, multiple settlements are a major predictor of future MBC disciplinary action. Why must consumers — and only consumers — be forced to wallow in ignorance while these physicians are injuring patients and racking up the requisite number of settlements prior to disclosure of those settlements and eventual MBC disciplinary action?

Those who oppose broader disclosure of medical malpractice settlements on the Internet argue that, in every profession, people make mistakes. Happily, in most jobs, a mistake does not mean that someone dies or is disabled. But, they say, in medicine, mistakes that will inevitably be made by even highly capable, highly trained, highly talented physicians could have devastating human consequences. Similarly, those doctors who choose to treat the most difficult cases logically may be sued more because the inevitable greater number of sad outcomes increases the risk of someone suing.

They argue that disclosure of these consequences — especially on the easy-to-access Internet — is so inflammatory that the public may be dissuaded from seeing physicians who are truly excellent healers. They point out — correctly — that, unlike some other states, California does not permit MBC to take disciplinary action against a physician for a single act of negligence, no matter how tragic the consequences. This, they correctly observe, is recognition in California law that simple errors are not ipso facto related to a physician's competence to treat patients. They are instead matters where the issue is compensation for the harm done, not punishment for, in essence, being human. Based on these arguments, opponents of the Board's proposed disclosure policy succeeded in persuading members of the Legislature that only those doctors at the far ends of the medical malpractice settlement spectrum ought to have their settlements disclosed on the Internet. Confronted with such arguments, the author amended the bill to ensure disclosure of at least some medical malpractice settlements and, in all likelihood, to show by practice that many of the forecast fears expressed by opponents would not occur, just as they had not in other states.

The Monitor believes that these arguments miss an important point. At the heart of the MICRA bargain is the assumption that the public will and should accept the Board's enforcement and disclosure program as a credible and trustworthy substitute for having ready access to quality lawyers willing to seek compensation that is artificially limited. As the 2002 JSLRC background paper points out, the credibility of the Board and its enforcement program cannot long endure if it keeps secret from the public information that every other stakeholder deems absolutely necessary

— namely, complete and unedited medical malpractice settlement information. If medical malpractice insurers and hospitals themselves demand this information before dealing with a physician, why should consumers be deprived of it?

3. MBC is not authorized to disclose misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician.

Since 1993, MBC has disclosed felony criminal convictions against physicians. However, it has never disclosed misdemeanor criminal convictions — including those convictions which were originally charged as felonies and/or "wobblers"[345] but were pled down to misdemeanors.

Conviction of a misdemeanor that is substantially related to the qualifications, functions, and duties of a physician is grounds for disciplinary action.[346] Under existing law, a conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any controlled substance, dangerous drug, or alcohol constitutes conclusive evidence of unprofessional conduct.[347] MBC is entitled to receive information about misdemeanor criminal convictions against physicians.[348] In 2002, the Joint Legislative Sunset Review Committee recommended that MBC disclose "all physician misdemeanor criminal convictions that have a substantial relationship to the practice of medicine . . . ."[349] The Medical Board itself agreed to disclose all substantially related misdemeanor convictions at its May 2002 meeting.[350]

A misdemeanor criminal conviction is just that — a *crime*. And it is not a mere allegation — it is a *conviction*. A misdemeanor criminal conviction is either an admission or a finding by a jury or court — beyond a reasonable doubt — of the commission of an act which has been categorized as a *crime* by the Legislature. A misdemeanor criminal conviction is public information. In an April 2000 report, even the Federation of State Medical Boards expressed support for the disclosure of substantially related misdemeanor criminal convictions — which the Federation

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[345] A "wobbler" is a crime that may be charged as either a felony or misdemeanor based on the facts of the case and in the discretion of the public prosecutor. *See* Penal Code § 17.

[346] Bus. & Prof. Code §§ 490 *et seq*., 2236.

[347] *Id*. at § 2239(a); *see also Griffiths v. Superior Court of Los Angeles County (Medical Board of California, Real Party in Interest)* (2002) 96 Cal. App. 4th 757.

[348] Bus. & Prof. Code § 2236(b)–(c).

[349] Joint Legislative Sunset Review Committee, *Final Recommendations of the Joint Legislative Sunset Review Committee on the Medical Board of California* (May 2002) at 3.

[350] *See supra* Ch. IV.G.

defined to include "misdemeanors involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol, and violations of public health and safety codes."[351]

4. MBC is not disclosing all significant terms and conditions of probation on its Web site.

Section 2027(a)(1) requires MBC to post on the Internet ". . . whether or not the licensee is in good standing, subject to a temporary restraining order, subject to an interim suspension order, or subject to any of the enforcement actions set forth in section 803.1." Section 803.1 directs MBC to "disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee by [the] board or by another state or jurisdiction, including all of the following: . . . (3) revocations, suspensions, *probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement*" (emphasis added).

Taken together, these sections require MBC to post significant terms and conditions of probation on the Web. MBC's *Manual of Model Disciplinary Orders and Disciplinary Guidelines* sets forth 13 standard terms of probation and 23 optional terms of probation. Some of these optional terms and conditions of probation — including restrictions on practice or prescribing, a requirement to have a third-party chaperone present when examining or treating patients, and requirements to participate in the Board's Diversion Program and to abstain from the use of controlled substances and/or alcohol — are significant and would influence patient choice. These terms and conditions of probation are part of a public Board disciplinary order and must be disclosed to the public under sections 2027 and 803.1.

Due in part to limitations imposed by its CAS computer system, MBC does not consistently disclose all significant terms and conditions of probation on the Internet.[352] As described in Chapter V, CAS data are largely "imported" onto the Board's Web site, so limitations on CAS' data fields result in limitations on the amount and type of information that MBC can disclose to the public via its Web site. Having looked at literally hundreds of MBC Web site screens on California physicians, the Monitor can say that a few screens of physicians whose licenses are on probation disclose significant terms of probation. For example, one physician's screen states "six years probation with

[351] Federation of State Medical Boards, *Report of the Special Committee on Physician Profiling*, 87:2 JOURNAL OF MEDICAL LICENSURE AND DISCIPLINE (2001) at 53.

[352] When section 2027 was amended in 2002 to require MBC to disclose "limitations on practice" ordered by the Board, MBC staff searched the records of all physicians on probation for restrictions or limitations on practice, to enter those onto the Internet. It has not been completely successful in this effort. Additionally, section 803.1 requires the Board to disclose information on "probations" — and it does not consistently post all significant terms and conditions of probation.

various terms and conditions; restrictions: during probation, Dr. [X] is prohibited from providing anesthesia for laser ENT surgeries and supervising physician assistants." However, the screens of most physicians whose licenses are on probation simply state "seven years probation with various terms and conditions." That disclosure does not comply with the law.

MBC is moving toward resolution of this issue. First, its *Action Report* licensee newsletter is now including complete summaries of Board orders issued to disciplined physicians. More importantly, MBC is in the process of implementing a revamped Web site that will afford online access to public documents. Thus, when a physician is disciplined, his or her screen will eventually contain a link to the actual disciplinary order, including any terms and conditions of probation imposed.[353]

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #48: Sections 2027 and 803.1 should be consolidated and harmonized to implement the purposes behind the creation of MBC's Web site in AB 103 (Figueroa): "allowing the public easy access to important information about physicians, particularly in the area of medical negligence . . . ." The fine-tuning of these two sections would also eliminate drafting errors and inconsistencies between the two statutes that have caused confusion and expensive litigation; save MBC time and money by ensuring that most public information is posted on the Board's Web site; and ensure that information disclosed to consumers by MBC is consistent and accurate regardless of the way in which the consumer asks for it.

Recommendation #49: All medical malpractice settlements exceeding $30,000 should be disclosed on MBC's Web site with the disclaimer currently required in section 803.1(c). Subsequent experience has now shown that the compromise reached in 2002 — which has resulted in the disclosure of the settlements of seven (7) physicians — is not a "publicly credible program of public disclosure" as demanded by the Board and the JLSRC in 2002. Medical malpractice settlements are public information reached in the context of a public judicial proceeding financed with taxpayer money in which the physician is represented by counsel and may reject the settlement. Every other stakeholder has a physician's complete malpractice history; only consumers are left in the dark. Consumers are entitled to that same information in making decisions affecting the lives and health of themselves and their families.

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[353] As noted above, Public Citizen's Health Research Group (HRG) rates the Web sites of state medical boards for both content and user-friendliness. In 2002, MBC's Web site earned a "B" in both areas — up considerably from its overall "D" grade in 2000. Public Citizen Health Research Group, *Survey of Doctor Disciplinary Information on State Web Sites* (Apr. 9, 2002) at 2–3. The addition of a link to actual Board orders and other public documents, along with a designation of each physician's specialty (which is now being collected by MBC) may result in a higher ranking for MBC's Web site.

Recommendation #50: All misdemeanor criminal convictions substantially related to the qualifications, functions, and duties of a physician should be disclosed on MBC's Web site. As recommended by the Federation of State Medical Boards, these "substantially related" criminal convictions should include "misdemeanors involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol, and violations of public health and safety codes."

Recommendation #51: MBC should disclose all significant terms and conditions of public probation orders on its Web site. MBC should continue in its efforts to revise its Web site so that consumers can access public documents — including complete Board disciplinary decisions and stipulations that set forth all significant terms and conditions of probations.

Recommendation #52: Section 2027 should be amended to permit MBC to disclose the resignation or surrender of hospital privileges after the hospital has notified the physician of an impending investigation under section 805(c). The number of disclosable section 805 reports has dwindled significantly to six (6) in 2003–04, such that the intent behind section 2027(a)(6) — public disclosure of serious peer review actions — is being defeated.

Chapter XIV

PUBLIC EDUCATION AND OUTREACH

A. General Description of Functions

MBC uses a number of methods to educate and communicate with consumers, licensees, and other stakeholders regarding the Board's enforcement program. Through its Public Education Committee (PEC) created in 2002, the Board works to improve communications between MBC and the public. The Committee's goals are to (1) increase the number of Californians who know of the existence of the Board and its enforcement program by bringing together representatives of organizations to develop better ways of communication, and (2) encourage officials and entities that are required to report certain information to the Board to do so.[354]

Beginning in 2002, the PEC began a targeted effort to increase the Board's visibility and to educate consumers on the role of the Board in licensing and disciplining physicians. It reviewed the various materials that the Board makes available to consumers, and engaged in outreach to the media, other state agencies that regulate health care professionals, consumer groups, and mandated reporters under Business and Professions Code section 800 *et seq*. — inviting representatives of these groups to attend PEC meetings, make presentations, and exchange information about how MBC can better serve its various constituencies and carry out its public protection mandate. In November 2002, the Committee prepared a draft strategic communications plan identifying specific goals and objectives, strategies for achieving those goals and objectives, target audiences for MBC communications, key messages that should be communicated, and measurable outcomes to monitor the Board's success. Due to budget and staffing constraints, the Board has yet to formally adopt the strategic communications plan. However, the PEC voted in May 2003 to approve the plan in concept, review it quarterly, and implement it as resources become available.

Under the general guidance of the PEC, Medical Board staff communicate with the public about the Board's enforcement program on two levels. First, MBC's public information officer

[354] Medical Board of California Public Education Committee, *Medical Board of California Communications Plan* (working draft Nov. 5, 2002).

(PIO) and her staff provide information to consumers and the profession through various media, and respond to press inquiries regarding the Board's enforcement actions. The PIO provides general information about the Board's enforcement program and specific disciplinary actions through the publication of MBC's *Action Report* licensee newsletter, its monthly *Hot Sheet* of recent disciplinary actions taken, other Board publications and brochures, and the Board's Web site. Second, the enforcement program itself is responsible for communicating with complainants and with physicians who are the subject of complaints.

The Board's outreach to consumers and patients. The Board conducts public outreach and education to the general public in an effort to ensure that consumers know of the existence of the Board and how they can access the Board's services. The Board maintains a toll-free phone line for complaints,[355] but not for general Board information or questions.[356] Subject to budget and staffing limitations, the Board engages in public outreach at consumer or healthcare events, and provides presentations about the Board to physician groups and other healthcare entities. The Board has created and distributed public service announcement (PSAs) in English and Spanish for both radio and television. The PSAs, which advise consumers to choose only licensed physicians and to contact MBC if they have questions about the healthcare they have received, are available on the Board's Web site. The Board also created a simple one-page brochure describing the Medical Board and how and when a consumer should contact MBC.[357] Finally, the Board engages in outreach to consumers via the media; MBC routinely issues press releases to notify media of disciplinary actions taken by the Board, and these disciplinary actions are often reprinted in newspapers in the locality of the disciplined physician.

MBC's Web site is a helpful tool for consumers seeking more information about their physician or the Board. In addition to allowing patients to access information about an individual physician,[358] the Web site provides information on (1) how to file a complaint; (2) the types of complaints over which the Board has jurisdiction; (3) phone numbers for contacting the Board regarding a complaint; (4) links to MBC brochures on complaint handling, investigations, and medical consultants; and (5) a downloadable complaint form that the consumer may complete, print, and mail to the Board.[359] The Web site refers patients who have problems with a health plan or their

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[355] MBC's toll-free complaint line is (800) 633-2322.

[356] To ask about a physician's record or obtain general information about the Medical Board, the public must call (916) 263-2382. MBC staff and the Public Education Committee have advocated a toll-free information line for consumers and licensees; due to budget constraints, that proposal has never been adopted or implemented.

[357] *Medical Board of California: Information and Services for Consumers* (rev. 7/04).

[358] *See supra* Chapter XIII.A.

[359] At this time, consumers are unable to submit the complaint form online.

insurance company to the Department of Managed Health Care or the Department of Insurance. By clicking on "Services for Consumers," one can also access fact sheets related to California physicians and medical marijuana, guidelines for prescribing controlled substances for pain, patient privacy protection, tips on choosing a doctor, Internet prescribing, how to order public documents from the Board, patient access to medical records, resources available for reduced-cost mammograms, specialty board advertising, and links to other MBC forms and publications.

The Board's outreach to its licensees. The Board's primary vehicle for communicating with its licensees is the *Action Report*, a quarterly licensee newsletter. The *Action Report* — which is posted on MBC's Web site so anyone can access it — includes articles on medical issues of interest to physicians, updates on recent legislation, enforcement-related articles (including information on the Board's Diversion Program for substance-abusing physicians and outreach to licensees who would like to serve as expert medical reviewers for the enforcement program), and a summary of MBC disciplinary actions (including a fairly comprehensive description of terms and conditions of probation that have been imposed — which is frequently missing from MBC's Web site[360]). MBC also publishes the *Hot Sheet*, a monthly summary of disciplinary actions taken by the Medical Board.

MBC's Web site also provides information directed towards its physician licensees. Under "Services for Licensees," a physician may find information related to the enforcement process in general, California physicians and medical marijuana, the Expert Reviewer Program, fictitious name permits, guidelines for prescribing controlled substances for pain, patient privacy, patient activity reports from the California Department of Justice, MBC's Diversion Program, and links to various forms, fact sheets, and other MBC publications (including a list of publications that physicians are required by law to provide to patients under certain circumstances).

The Board's outreach to mandated reporters. Business and Professions Code section 800 *et seq*. requires many entities — including malpractice insurers, court clerks, coroners, hospitals, and physicians — to report certain information about physicians to the Board. As described in Chapter VI above, these mandated reporters are particularly valuable sources of information to MBC in detecting physician misconduct warranting discipline — including section 2220.05 priority cases.[361] Although MBC has posted easily-downloadable reporting forms for all mandated reporters on its Web site, some mandated reporters do not always file required reports with the Board, and/or do not fully comply with their reporting responsibilities.[362]

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[360] *See supra* Ch. XIII.B.4.

[361] *See supra* Ex. VI-B, Ex. VI-F.

[362] *See supra* Ch. VI.B.5.

In 2002, the PEC began to examine the various mandated reporters and the current methods used by MBC to inform and remind these reporters about their reporting responsibilities, and explore new ways in which MBC can stimulate greater compliance with the reporting laws. The Board sends a letter each year to coroners and court clerks in each county explaining the relevant reporting requirement and including a copy of the MBC form to be used in submitting such reports.[363] A similar letter is sent to over 70 malpractice insurers.

Court clerk compliance with the reporting statutes is particularly low, and the PEC invited several court clerks to attend its meetings in 2003. As a result of their helpful input and testimony, it became clear that most court clerks (and the thousands of courtroom clerks across the state who support each individual judge in each courtroom in each county) are entirely unaware of the existence of the reporting requirements, and that the Board's annual letter to each of the state's 58 county court clerks does not "trickle down" to each of the many courtroom clerks who must file the reports. A related problem is that many courtroom clerks are often unaware that a defendant in their courtroom is a physician whose civil judgment or criminal conviction must be reported to MBC. This problem is only partly ameliorated by section 803.5(a), which requires public prosecutors who are prosecuting a physician to notify the court clerk that the defendant is a physician, because many prosecutors are also unaware of that notification duty or the court clerk's reporting requirement.

Because MBC is but one of many DCA agencies with court clerk reporting requirements, the Department of Consumer Affairs initiated communications with the Judicial Council in November 2002 to explore ways to improve court clerk compliance with all DCA agency reporting statutes. The Department agreed to draft an article outlining the various reporting requirements for all of its agencies for publication in various Judicial Council newsletters and for posting on Web sites to which court clerks, prosecutors, and/or judges have access. The same article would be shared with the California District Attorneys Association to make prosecutors aware of their responsibilities under the reporting statutes. In order to make reporting easier for court clerks, DCA also agreed to create a standardized reporting form for courts and make the form accessible through DCA's Web site. Due to the change in administrations in November 2003, this project is not yet complete. As its implementation is critically important to the success of the reporting requirements, this issue is already the subject of Recommendation #15 in Chapter VI.

The Board's outreach to prospective expert reviewers. As noted above in Chapter VIII, the Board has difficulty hiring and retaining adequate numbers of physicians to serve as expert reviewers for MBC enforcement cases. Outreach to physicians who may be willing to serve as expert reviewers is handled primarily through notices in the *Action Report* newsletter and information regarding these positions is posted on the MBC Web site. Additionally, Board members

[363] According to the Board, the letter to county clerks was not sent in 2003 or 2004 due to budget concerns.

and enforcement program representatives occasionally make presentations to hospital staffs, local and specialty medical societies, and other physician organizations to recruit prospective experts. In Recommendation #31 above, the Monitor has already commented on the need for trained, experienced expert reviewers, and has suggested ways in which MBC might expand its pool of experts.

The enforcement program's outreach to complainants and complained-of physicians. In the past, MBC conducted consumer satisfaction surveys to measure its effectiveness in communicating with complainants to its enforcement program. In 1997, the Board conducted a consumer satisfaction survey as part of its first sunset review process. The results were "alarmingly poor," showing that most of those filing complaints were highly dissatisfied with the outcome of their case (about 75%) and the overall service provided by the Board (about 60%).[364]

In an effort to improve its communications with those who file complaints, the Board changed its procedures to ensure regular communication with complainants about the status of their complaints, and developed three brochures which now accompany those communications. MBC now sends an acknowledgment letter when a complaint is received, and includes a brochure entitled *How Complaints Are Handled*, an overview of the steps taken in processing complaints. MBC next notifies the complainant when medical records are being reviewed by a medical consultant, and includes its brochure entitled *Most Asked Questions About Medical Consultants* to explain that part of the process. When that consultant makes findings, MBC mails a letter to the complainant explaining those findings. If the complainant is referred for investigation, the complainant is again notified and mailed another brochure entitled *Questions and Answers About Investigations*. Thereafter, the complainant is notified if an accusation is filed. If the case is closed, the consumer is informed of the reasons for closure and the manner in which that decision may be appealed.

During its 2001–02 sunset review of MBC, the JLSRC noted that surveys conducted in 1998, 1999, and 2000 indicated significant improvement in consumer satisfaction with MBC's communications about its enforcement process, although most consumers continued to be dissatisfied with the overall outcome of their case.[365] The JLSRC and Department of Consumer Affairs recommended that MBC continue its efforts to improve communications with consumers who file complaints with the Board. The Board has continued its efforts, but has had insufficient funding to conduct consumer satisfaction surveys since 2000.

As discussed in Chapter VI above, MBC's procedure manuals set forth the points at which CCU and/or district offices should apprize complained-of physicians of the pendency of a complaint

[364] Joint Legislative Sunset Review Committee, *2002 Sunset Review Report on Medical Board of California* (December 2001) at 63–64.

[365] *Id.* at 64.

and/or investigation. Essentially, CCU contacts a subject physician if it needs medical records, and informs the physician that the matter has been closed only if it has previously contacted the physician in the matter. Similarly, field offices contact the physician if they need medical records and/or want to schedule a subject interview; otherwise, there is no strict policy that all physicians under investigation must be told of the pendency of an investigation. As the Monitor commented in Chapter VI, it would be inappropriate to establish a blanket rule requiring MBC to contact all physicians against whom a complaint has been filed or an investigation is commenced, because such contact might stifle undercover operations or encourage medical records alteration or destruction.

B. Initial Concerns of the MBC Enforcement Monitor

1. Physicians are not required to provide patients with information about the existence of the Board and its disciplinary jurisdiction.

Effective January 1, 1999, SB 2238 (Committee on Business and Professions) (Chapter 879, Statutes of 1998) added section 138 to the Business and Professions Code. That section requires each DCA board to adopt regulations by June 30, 1999 to require each licensee to "provide notice to their clients or customers that the practitioner is licensed by this state. A board shall be exempt from the requirement to adopt regulations if the board has in place, in statute or regulation, a requirement that provides for consumer notice of a practitioner's status as a licensee of this state." It is unclear whether MBC has complied with section 138.

The PEC began a discussion on whether physicians should be required to provide patients with information about the Medical Board in January 2003. Many agencies — including health care-related agencies — require their licensees to provide customers or clients with information about their licensing board, its regulatory authority, and its contact information. Depending on the agency, this notice may be provided in a variety of ways — through brochures, posted notices, or statements on invoices and/or other documents that are given to the customer or client. For example, the Department of Managed Health Care recently adopted a regulation requiring managed care providers to post a notice in their waiting room areas informing subscribers and enrollees how to contact their health plan, file a complaint with their plan, obtain assistance from the Department, and seek independent medical review of a health plan's decision. The notice must be displayed in English and in other languages commonly used in the community.[366] Other California agencies require their licensees to provide some type of information to consumers, clients, or patients about the agency and

[366] 28 CAL. CODE REGS. § 1300.67.8. The Department of Managed Health Care's waiting room notice and translations can be found at www.dmhc.ca.gov and are available for downloading, printing, and posting.

its regulatory authority, including those regulating accountants,[367] architects,[368] engineers,[369] optometrists,[370] structural pest control operators,[371] geologists and geophysicists,[372] automotive repair dealers,[373] contractors,[374] and automobile insurers.[375]

Some Board members have expressed concern about the capability of MBC's enforcement program to handle the surge of patient complaints which may result if MBC imposes a similar requirement on physicians. To a certain extent, these Board members have a point. Although Exhibit VI-A indicates that patients are the source of the vast majority of MBC complaints, Exhibit VI-B indicates that few patient complaints are referred for investigation and/or result in disciplinary action.

On the other hand, Exhibit VI-F indicates that — in raw numbers — patients were the top source of section 2220.05 priority complaints resulting in disciplinary action taken between January 1, 2003 and June 30, 2004. Exhibit VI-F and its explanatory notes also indicate that MBC itself is the "source" of a large number of priority complaints resulting in disciplinary action; in many of those complaints, a Board investigator looking into a particular matter checked the Civil Index and found civil malpractice lawsuits filed against the subject physician by patients who had not filed a complaint with MBC. It seems clear that many California citizens do not know of the existence of the Medical Board, and that MBC is not educating patients sufficiently enough on the kinds of matters they should bring to MBC's attention.

The reality of patient ignorance of the MBC regulatory process cannot be ignored, nor is reducing that ignorance likely to overwhelm MBC's enforcement program. The many California agencies listed above manage their caseloads while still meeting their obligation to help the public seek redress of legitimate grievances. The Monitor believes that, as a matter of sound public policy, the Medical Board should likewise make better efforts to meet its obligation to assist victims of medical wrongdoing in understanding how to be involved with its enforcement program.

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[367] 16 CAL. CODE REGS. § 50.

[368] *Id*. at. § 140.

[369] *Id*. at § 463.5.

[370] *Id*. at § 1566.1.

[371] *Id*. at § 1937.17.

[372] *Id*. at § 3066.

[373] *Id*. at §§ 3351.3, 3351.4.

[374] Bus. & Prof. Code § 7030.

[375] 10 CAL. CODE REGS. § 2695.85.

2. The Board does not communicate consistently with physicians during the complaint review and investigative process.

The Board has made a concerted and apparently successful effort to improve its communications with complainants throughout the complaint handling process. Its communications with subject physicians seem less consistent. Several defense counsel we interviewed stated that their clients were contacted for medical records by CCU but were never notified whether the complaint had been closed or referred for investigation. This appears to violate CCU's policy.[376] Absent exigent circumstances in which the Board may be contemplating undercover operations, CCU and the district offices should make every effort to communicate case closures and other dispositions to subject physicians (see Recommendation #20).

3. MBC should communicate with local county medical societies about their obligations under Civil Code section 43.96.

SB 916 (Presley) enacted Civil Code section 43.96, which requires medical societies, hospitals, and local government agencies that receive a written complaint against a physician to affirmatively notify the complainant that they have no jurisdiction over the physician's license and that only MBC may discipline a physician's license. Further, the local entity must "provide to the complainant the address and toll-free telephone number" of the Board. The Monitor checked a number of Web sites of county medical societies. A few of them that offer "complaint processes" — including the San Diego County Medical Society and the Ventura County Medical Association — state in bold print that the medical society has no authority to require a physician to follow its recommendation or to take action against a physician's license; those sites provide MBC's address and toll-free number. Others — including the Los Angeles County Medical Association and the Orange County Medical Association — make no such statement. Because some of these organizations with the word "county" in their name offer "complaint processes," consumers sometimes confuse them with the Medical Board and fail to file a complaint with the only entity that can protect the public from a dangerous physician.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #53: Physicians should be required to inform patients about the Medical Board's existence, disciplinary jurisdiction, address, and toll-free complaint number. MBC should implement a system to ensure that its licensees inform the patient public about its existence and enforcement role. Physicians could be given a variety of options to accomplish this

[376] Medical Board of California, *CCICU Procedure Manual* at § 9.2; see also Medical Board of California, *Enforcement Operations Manual*, at Ch. 7, § 7.1. See supra Ch. VI.B.8. and Recommendation #20.

consumer education — for example, a fact sheet, a posted waiting room notice, or a disclosure on a discharge summary, invoice, or other document routinely given to patients.

Recommendation #54: As suggested in related Recommendation #20, MBC's enforcement program should ensure that complained-of physicians are appropriately notified of complaint dispositions.

Recommendation #55: MBC should periodically communicate with local county medical societies and remind them of their obligations under Civil Code section 43.96, to ensure that those private organizations are properly referring complainants to the Medical Board.

Chapter XV

MBC'S DIVERSION PROGRAM

A. General Description of Functions

This chapter addresses the Medical Board's Diversion Program, which "diverts" substance-abusing physicians out of the enforcement program described in the preceding fourteen chapters and into a program that is intended to monitor them while they attempt to recover from the disease of addiction.[377] The Diversion Program designs a contract that includes terms and conditions of participation for a five-year monitoring period, including random bodily fluids testing, required group meeting attendance, required worksite monitoring, and often substance abuse treatment and/or psychotherapy. Those who comply with the terms and conditions of their Diversion Program contract may be "successfully terminated" from the Program after three years of continuous sobriety. Those who violate the terms and conditions of their Diversion Program contract may be "unsuccessfully terminated" from the Program and referred to the enforcement program for disciplinary action. During their participation in the Program, these physicians generally retain their full and unrestricted license to practice medicine, and many of them are in fact permitted to practice medicine subject to the terms and conditions of their contracts. Many of them participate in absolute confidentiality — their participation in the Diversion Program is secreted from the Board's enforcement program, their patients, and the public.

It is important to understand that the Diversion Program is a *monitoring* program, not a treatment program. It does not provide substance abuse treatment; its staff are not authorized or trained to do so. Instead, it evaluates the needs of its participants; provides a rehabilitative plan that directs them to treatment — including inpatient detoxification, medical and psychiatric evaluation, and psychotherapy, as appropriate; monitors their compliance with the terms and conditions of their

[377] The enabling act of the Diversion Program also refers to physicians with "impairment due to . . . mental illness or physical illness." Bus. & Prof. Code § 2340. However, the Diversion Program has historically and primarily been structured to monitor substance-abusing physicians (or physicians who are "dually diagnosed" with both chemical dependency and mental illness). Despite the inclusion of the terms "mental illness and physical illness" in its enabling act, the Diversion Program was not authorized to "divert" singly-diagnosed mentally ill physicians until January 1, 2003, when an amendment included in SB 1950 (Figueroa) became effective. Thus, for most of its history, the Diversion Program has been structured primarily to monitor chemically dependent physicians, and this chapter focuses on that function.

contract with the Program; and is authorized to terminate them from the Program (and refer them to the enforcement program) if they do not comply.

Supporters argue that the Diversion Program protects the public by providing impaired physicians with access to appropriate intervention programs and treatment services, and monitoring them for several years to ensure they have recovered and are consistently capable of safe practice. According to Dr. Gene Feldman, who was president of the Medical Board during 1980 when the Program was created, "the Diversion Program was enacted because a lot of doctors who came before us in discipline had hurt no one but themselves through the disease of substance abuse/chemical dependency. They were being disciplined at an average cost of $30,000 per case, and most had already gone into rehabilitation programs and were clean and sober. But we were required to discipline them and ruin their lives."[378] Dr. Feldman and others envisioned the Program as being cheaper than discipline and more protective of the public, in that it could immediately remove an impaired physician from practice if necessary (whereas the discipline system at that time lacked any meaningful interim remedies).

As discussed briefly in Chapter V,[379] the Diversion Program is a "stand-alone" program that is relatively isolated within the structure and management of the Medical Board. Because it is so distinct and separate from the enforcement program described in the prior chapters, this chapter is structured differently to provide the reader with an in-depth understanding of the Program and its purpose, history, structure, personnel, participants, and problems.

B. Authority and Methodology of the MBC Enforcement Monitor

Enforcement Monitor's duty to evaluate the diversion program. Business and Professions Code section 2220.1(c)(2) requires that, as part of its evaluation of MBC's overall enforcement program, "[t]he enforcement program monitor shall also evaluate the effectiveness and efficiency of the board's diversion program and make recommendations regarding the continuation of the program and any changes or reforms required to assure that physicians and surgeons participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired due to alcohol or drug abuse or mental or physical illness."

This assignment is timely and overdue. Despite the critical importance of the proper functioning of the Diversion Program in protecting the public from impaired physicians who retain their licenses to practice medicine, the Diversion Program has not been externally audited since 1986.

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[378] Presentation by Dr. Gene Feldman at DMQ's July 27, 1994 meeting, recorded in 14:4 CAL. REG. L. REP. (Fall 1994) at 65.

[379] *See* Ch. V.B.3.

Enforcement Monitor's methodology in evaluating the Diversion Program. The Enforcement Monitor team read and studied both the current and prior versions of the Diversion Program's statutes (Business and Professions Code section 2340 *et seq*.) and regulations (section 1357.1 *et seq*., Title 16 of the California Code of Regulations). In addition, the Monitor studied two internal policy and procedure manuals that guide the day-to-day operation of the Program: (1) the *Diversion Program Manual*, which — at the time of its provision to the Monitor in November 2003 — had not been comprehensively updated since 1998; and (2) the *Diversion Program Policy, Guidelines, and Procedures*, a supplemental compilation of policies and procedures implemented by Diversion Program staff since the *Diversion Program Manual*'s last comprehensive update in 1998, and prepared especially for the Monitor.

The Monitor also read and summarized all prior available audits and evaluations of the Diversion Program, including three Auditor General audits, the CHP report released in January 1993, and the State Auditor's 1995 report; all of these critiques are described below. In addition, the Monitor team reviewed the Medical Board's *Annual Report* for the past 15 years for its data on Diversion Program participation and cost; the Diversion Program's own annual reports from 1994 through 2000; and the Center for Public Interest Law's vast library of Diversion Program documents that have been distributed to the Medical Board, its Division of Medical Quality, and/or its various diversion committees and collected by CPIL as part of its monitoring function since at least 1993.

In an attempt to determine whether the Program is functioning in compliance with its statutes, regulations, and the policies and procedures set forth in its internal manuals, the Monitor team analyzed a sample of participant files[380] in three major areas:

- ***Intakes***: Commencing in March 2004, we analyzed the files of the twenty (20) most recent Diversion Program "intakes," physicians who have (a) self-referred into the Program, or (b) are participating via a statement of understanding (SOU) because a complaint was pending against them at the time they sought admission, or (c) because they were ordered by the Division of Medical Quality to participate in the Program as a term of probation.

[380] Diversion Program participant files are accorded extraordinary confidentiality: Only Diversion Program staff and members of the DECs know the identity of participants in the Diversion Program. Other MBC staff (including Enforcement Program staff) have no access to the identities or files of Diversion Program participants; nor do members of the Medical Board or the Liaison Committee to the Diversion Program. However, both state and federal law waive the confidentiality normally accorded Diversion Program files (and treatment records possibly contained therein) for "qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation," so long as those personnel do not "identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner." *See* 42 U.S.C. § 290dd-2(b)(2)(B); 42 C.F.R. § 2.1(b)(2)(B); Health and Safety Code § 11977(c)(3).

- ***Relapses***: We also looked at the files of twenty (20) participants who relapsed into drug or alcohol use during the past few years. We identified these cases from the "Quarterly Quality Review" reports that are distributed to the Board's Diversion Committee at each quarterly committee meetings, and analyzed these participants' pre-relapse history and the Program's response to the relapse.

- ***Imminent completions***: Finally, we looked at the files of twenty (20) participants who have been in the Program for approximately five years and who are on the verge of achieving three years of sobriety such that they will soon "successfully complete" the Program.

In addition to reviewing these case files and collecting data from them, we have extensively interviewed the Diversion Program Administrator and other staff of the Program. We also interviewed the Liaison Committee to the Diversion Program.

As a result of this review, the Monitor has detected numerous significant problems in the functioning of the Diversion Program. These issues are discussed below in Chapter XV.G. To put those concerns into perspective, however, it is instructive to review the statutory purpose of the Diversion Program; its structure, staffing, and funding; the actual functioning of the Program; and prior critiques of the Program.

C. Statutory Purpose of the Diversion Program

The Medical Board's Diversion Program was created in 1980 legislation that enacted Business and Professions Code section 2340 *et seq*. In the enabling legislation, the Legislature stated its intent "that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety."[381] This language thus requires the Board to "identify and rehabilitate" impaired physicians and "return" them to the practice of medicine, but only if this can be done "in a manner which will not endanger the public health and safety."

Subsequent legislative actions confirm this interpretation. Business and Professions Code section 2229 was amended in SB 2375 (Presley) (Chapter 1597, Statutes of 1990), extensive reform

[381] Bus. & Prof. Code § 2340.

legislation that followed the release of *Code Blue* and the *Klvana* prosecution.[382] SB 2375 amended section 2229(a) to clarify that "protection of the public shall be the highest priority" for the Medical Board of California in exercising its disciplinary authority. SB 2375 also addressed the relative role of "rehabilitation," which is one goal of the Diversion Program. The bill amended section 2229(c) to unambiguously state: "Where rehabilitation and protection are inconsistent, protection shall be paramount." Finally, AB 269 (Correa) (Chapter 107, Statutes of 2002) added section 2001.1 to the Business and Professions Code, which reiterates that "[p]rotection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

D. The Structure, Staffing, and Funding of the Diversion Program

The Medical Board of California's Diversion Program is one of the few state-sanctioned impaired physician programs to be run from within a state medical licensing board by employees of that board. Most other state medical boards contract out all functions of their impaired physician programs to the private sector.[383] And most other California occupational licensing agencies whose statutes provide for a diversion program contract with a private company to administer those programs.[384] As described below, MBC's Diversion Program contracts out some components of its program, including its drug testing, laboratory, and group meeting components. But the critical case management component and all aspects of the Diversion Program's management and administration are performed by employees of the Medical Board — and have been since the Program's inception in 1981.

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[382] *See supra* Ch. IV.B. and VI.C.

[383] According to the Federation of State Physician Health Programs, only four state physician diversion programs are operated solely by the state medical board. Most state medical boards contract the operation of their diversion programs to state medical societies or independent corporations. Information on the operation of state physician diversion programs is found at www.ama-assn.org/ama/pub/category/5705.html.

[384] We found eight other California agencies with diversion programs for their licensees. Seven of the eight (including the Dental Board of California, the Board of Registered Nursing, the Board of Pharmacy, the Physical Therapy Board of California, the Physician Assistant Committee, the Veterinary Medical Board of California, and the Osteopathic Medical Board of California) arrange for all operations of their diversion programs to be administered by a private company that is under contract with the Department of Consumer Affairs. Only the State Bar — which recently created a new diversion program for substance-abusing and mentally ill attorneys called the "Lawyer Assistance Program," which is modeled after the Medical Board's operational structure — operates its attorney diversion program in-house. See SB 479 (Burton), Cal.Stats.2001 c.129, enacting Bus. & Prof. Code § 6230 *et seq*.

The Program is staffed by ten MBC employees: (1) a Diversion Program Administrator[385] based in Sacramento; (2) five "case managers" (CMs)[386] based in Sacramento, Bakersfield, Fresno, the Bay Area, and Orange County; and (3) four support staff based in Sacramento, including a Collection System Manager (CSM) with responsibility for overseeing the Program's urine collection and testing system — the Program's major objective measure of compliance with Diversion contracts. The CSM is required to generate a monthly list of random dates on which each participant will be tested; forward that list to local urine collectors (see below); ensure that samples are collected pursuant to the random schedule; ensure that samples are sent promptly to an approved laboratory for testing; ensure that results are received from the lab and forwarded to the CMs of tested participants; and ensure that results are appended to participants' files in the Program's Diversion Tracking System.

These ten Board employees are assisted by thirteen "group facilitators" (GFs) based throughout the state.[387] GFs facilitate biweekly group meetings of Diversion Program participants in their localities. They are expected to conduct group meetings, record attendance, observe each participant for any sign of substance abuse or pre-relapse behavior, take random urine tests if noncompliance is suspected, and report problems to the CMs and to Program management. GFs are not state employees, such that there is no formal duty statement or minimum qualifications for them.[388] They sign a "memorandum of understanding" with the Diversion Program, and they are paid directly by Program participants for the meeting facilitation services they provide.

The Program is also assisted by approximately 30 local businesses throughout the state that serve as urine specimen collectors for the Diversion Program. Pursuant to a random schedule generated by the Collection System Manager, these collectors are expected to conduct observed urine collections on the dates specified and to immediately transmit urine samples to a Program-approved laboratory for testing (following chain of custody procedures), submit a monthly report of all tests

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[385] The State Personnel Board's minimum qualifications for the Diversion Program Administrator position do not require a college degree, certification as a drug/alcohol counselor, or a license to practice counseling, social work, therapy, or medicine. They do require at least one year of responsible experience in "substance abuse treatment or prevention, rehabilitation, or education."

[386] The State Personnel Board's title for a Diversion Program case manager is "Diversion Program Compliance Specialist I." The minimum qualifications for this position do not require a college degree, certification as a drug/alcohol counselor, or a license to practice counseling, social work, therapy, or medicine. They do require at least two years of experience "performing analytical staff work and/or clinical counseling work in a substance abuse treatment or prevention program."

[387] Currently, GFs conduct group meetings of Diversion Program participants in Culver City, Fresno, Sacramento, Santa Barbara, Santa Cruz, Eureka, Modesto, Santa Rosa, the Bay Area, San Diego, Chico, Huntington Beach, and San Bernardino.

[388] Although there are no required minimum qualifications for GFs, the Program seeks licensed therapists or certified drug/alcohol abuse counselors. Most Diversion Program GFs in fact have a license.

taken, and document any problems or incidents in the taking of a sample. These collectors are not state employees, such that there is no formal duty statement or minimum qualifications for them. There is no contract, memorandum of understanding, or any other type of formal agreement between the Diversion Program and these independent businesses. They are recruited by the GFs and CMs and approved by the Program Administrator, and Program participants are required to utilize their services. They are paid directly by Program participants.

As described in Chapter V, the Diversion Program maintains the Diversion Tracking System (DTS), its own separate database of information on its participants that is unavailable to Board management or the enforcement program. DTS is supposed to contain a file on each participant that includes all information on the participant, the terms and conditions of his/her Diversion Program contract (including restrictions on medical practice), and his/her participation in the Diversion Program, including results of all bodily fluids testing (which are downloaded directly into DTS from the laboratory that tests participants' urine samples), absences from required group meetings, and dates of worksite monitor and treating therapist reports.

As of June 30, 2004, 258 physicians were admitted to and participating in the Diversion Program.[389] In fiscal year 2003–04, the Diversion Program cost over $1 million. That cost was subsidized entirely through license fees paid by all California physicians. Participants in MBC's Diversion Program pay nothing toward the overhead costs of the Program.[390] They are required to pay the costs of their own drug testing (approximately $220 per month during the first two years[391]) and group meetings (as of May 2004, $322 per month for two meetings per week[392]), for a total of $542 per month. Additionally, if they are required to undergo substance abuse treatment as a condition of Diversion Program participation, they must pay for that treatment.[393]

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[389] In addition to its 258 active participants, the Program was also monitoring 29 prospective participants who had signed an "interim agreement" (see below) but had not yet seen a DEC or signed a formal Diversion Program Agreement; and 17 California physicians participating in other-state diversion programs.

[390] Dentists and dental auxiliaries in the Dental Board's "Impaired Licentiates Program" pay $72.50 per month toward the overhead costs of the Program. Pharmacists in the Board of Pharmacy's "Pharmacists Recovery Program" pay $75.00 per month toward the overhead costs of the Program. Nurses in the Board of Registered Nursing's Diversion Program pay $25.00 month in overhead costs. Both the State Bar and the Veterinary Medical Board are authorized to charge overhead fees to program participants; they have not done so.

[391] Participants currently pay $20 to the collector for each observed collection, and $35 for laboratory testing of the sample, for a total of $55 per test. During the first two years of participation, participants are generally tested four times per month; thus, participants pay approximately $220 per month for drug testing during the first two years.

[392] At its May 2004 meeting, the Diversion Committee and DMQ approved an increase in group facilitator fees, from $315 per month for two meetings per week (or $220 per month for one meeting per week) to $322 per month for two meetings per week (or $225 for one meeting per week).

[393] According to Program staff, inpatient substance abuse treatment ranges from $8,000–$20,000, and is not always covered by insurance.

E. Overview of Participation in the Diversion Program

A physician makes contact with the Diversion Program in one of three ways: (1) he may telephone the Diversion Program at its Sacramento headquarters office seeking information and/or admission into the Program (a so-called "self-referral"); (2) impaired physicians are sometimes detected through complaints or reports made to the enforcement program, and enforcement permits the physician to enter Diversion under a "statement of understanding" (SOU)[394] (these physicians are called "diverted" or "Board-referred" participants); or (3) the Board may order a physician to participate in Diversion as a term of probation in a public disciplinary order ("Board-ordered participants").

Regardless of why the physician is entering the Program, a Program analyst conducts a telephone interview to record basic information about the physician's situation. The analyst checks the enforcement program's CAS computer system to determine whether any complaints are pending against the physician; if not,[395] the analyst relays the information on the prospective participant to the CM with responsibility for covering the geographical area of the state in which the physician lives. Within the next four days, the CM telephones the physician, assesses the situation, and schedules an in-person "intake interview" which should occur within seven days of the physician's initial contact with the Program.[396] At the intake interview, the physician must sign an "interim agreement" with the Program.[397] At this point, the CM is required to do three things: (1) arrange for a comprehensive multidisciplinary physical and mental evaluation of the prospective participant by

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[394] *See* Bus. & Prof. Code § 2350(b).

[395] If there is a complaint pending against a physician who seeks admission into the Diversion Program, the Program asks the Deputy Chief of Enforcement to "divert" the physician into Diversion. If the complaint is based primarily on "the self-administration of drugs or alcohol under Section 2239, or the illegal possession, prescription, or nonviolent procurement of drugs for self-administration, and does not involve actual harm to the public or [the physician's] patients," the Deputy Chief "shall refer" the physician to Diversion for an evaluation of eligibility. However, before making the referral, enforcement may require the physician to sign a "statement of understanding" (SOU) in which the physician agrees that "violations of this chapter or other statutes that would otherwise be the basis for discipline may nevertheless be prosecuted should the physician . . . be terminated from the program for failure to comply with program requirements." Bus. & Prof. Code § 2350(b).

[396] These timeframe goals are not stated in any statute, regulation, or procedure manual. They are set forth in the Diversion Program's "Quarterly Quality Review" reports that are reviewed by the Diversion Committee at its quarterly meetings.

[397] In the interim agreement, the physician acknowledges that he is applying for admission into the Diversion Program, recognizes that he may have a substance abuse disorder, and agrees to restrict or cease practice if so instructed by the Diversion Program; enter a treatment program if so instructed by the Diversion Program; undergo a minimum of four observed urine tests per month; attend facilitated group meetings with other Diversion Program participants; attend additional group meetings of Alcoholics Anonymous or Narcotics Anonymous, as instructed by the Diversion Program; abstain from the use of alcohol and drugs except those that have been prescribed by another physician and approved by the Diversion Program; refrain from self-prescribing any medications that require a prescription; and immediately report to the Program any relapse or use of alcohol or unauthorized drugs.

a physician who specializes in addiction medicine and is competent to recommend the type of treatment and monitoring needed by the prospective participant;[398] (2) refer the physician to a local GF who conducts weekly group therapy meetings attended by other impaired physicians who are participating in the Diversion Program, so that the physician may begin to attend meetings pending his formal admission into the Program; and (3) arrange for random urine testing of the physician commencing immediately.

Once the physician's comprehensive evaluation has been completed, the results and recommendations are forwarded to the CM, who then refers the physician's file to a local Diversion Evaluation Committee (DEC) and schedules the physician for an in-person appointment with the DEC. The Diversion Program maintains five DECs throughout the state; by statute,[399] each DEC consists of five individuals (three physicians and two non-physicians) who have expertise in substance abuse detection and treatment. DEC members are private parties appointed by DMQ.[400] DECs meet quarterly and in private.[401] The DEC reviews the file, meets with the physician, and makes a recommendation to the Diversion Program Administrator whether the physician should be accepted into the Program, whether the physician should be permitted to continue practicing medicine, and the terms and conditions of the physician's Diversion Program contract (including proposed treatment requirements). The DEC acts in an advisory role to the Program Administrator.[402] The Program Administrator prepares a formal Diversion Program contract, and — if the physician signs it — he is formally accepted into the Program.

The time period from the initial contact by the physician with the Program to the DEC meeting and signature on the formal contract generally exceeds three months. In the meantime, the participant is expected to attend two group meetings per week and is subject to four random urine tests per month during the first 24 months of participation.[403] If the participant is permitted to

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[398] Business and Profession Code section 2350(h) requires DMQ to "establish criteria for the selection of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion . . . ." In 1981, DMQ adopted the following regulation: "A physician selected by the program manager or his/her designee to conduct medical and psychiatric evaluations of an applicant shall be a licensed physician who is competent in his/her field of specialty." 16 CAL. CODE REGS. § 1357.3.

[399] Bus. & Prof. Code § 2342.

[400] *Id*.

[401] *Id*. at § 2353.

[402] *Id*. at § 2344.

[403] These rules governing random urine testing and group meeting attendance do not appear in any statute, regulation, or even the *Diversion Program Manual*. The Program's policy regarding the frequency of random urine testing is contained in a June 30, 2000 memo from the Diversion Program Administrator, which was then clarified in a March 26, 2001 memo from the Diversion Program Administrator. These memos are contained in an undated

practice medicine, he must secure a "worksite monitor" who must file quarterly written reports on the participant.[404] In addition, if the participant has hospital privileges, the participant must also secure a "hospital monitor" and notify the well-being committee at each hospital at which the participant has privileges. The hospital monitor must also file quarterly written reports on the participant with the Program.[405] If the Program requires a participant to undergo psychotherapy, the treating therapist is also required to file quarterly written reports on the participant's progress.[406] The CM is responsible for ensuring that all of these quarterly reports are received, recorded, and forwarded to headquarters for placement in the participant's file.[407]

Assuming no relapses or other noncompliance, the Program's monitoring continues for at least five years. Participants are expected to file a semi-annual report assessing their own progress toward recovery;[408] these reports are reviewed by the DEC on an annual basis, along with all of the other documentation that is required to be gathered by the case manager, including quarterly worksite and hospital monitor reports, treating therapist reports, and the participant's drug testing history.[409] After two years of continuous sobriety, urine testing may be decreased to three times per month; after three years, it may be decreased to twice per month. Similarly, required group meeting attendance may be reduced to once per week.[410] After three years of sobriety, compliance with the terms of the contract, and adoption of a "lifestyle to maintain a state of sobriety," a participant may be "successfully terminated " from the Diversion Program.[411] At that point, a physician who entered the Program under an SOU is immune from discipline for the alleged violation that resulted in his

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supplemental compilation of Diversion Program policies prepared for the Monitor entitled *Diversion Program Policy, Guidelines, and Procedures*. The rule concerning frequency of required group meeting attendance appears nowhere — not in any statute, regulation, or procedure manual. The closest the Program comes to defining its expectations regarding required group meeting attendance is Appendix D to its *Diversion Program Manual*, which contains a compilation of materials given to new participants. Appendix D states: "During the first eighteen months of participation in the Diversion Program, most participants are expected to attend two Diversion Group meetings a week. At the end of this period, the participant may request a reduction in meeting attendance from two to one a week. Your request should also be discussed with your facilitator and case manager."

[404] Medical Board of California, *Diversion Program Manual*, Ch. 1 at 7.

[405] *Id*. at 7–8.

[406] *Id*. at 8.

[407] *Id*., Ch. 2 at 8.

[408] *Id*. at Appendix D ("semi-annual reports").

[409] *Id*., Ch. 4 at 1, 3.

[410] *See supra* note 403.

[411] Bus. & Prof. Code § 2350(g)(1).

referral to Diversion.[412] Most Diversion Program records of "successfully terminated" participants — including treatment records — are destroyed.[413] Thereafter, the Program does not inquire into or track the sobriety or performance of its graduates in any way.

Due to relapses, however, it takes most participants five to seven years to "successfully terminate" from the Program. Addiction to alcohol or drugs is a chronic, lifelong disease in which relapse and recidivism are expected.[414] Under Diversion Program policy, the consequences for a relapse depend on the facts of the situation, the level of breach, and the way in which it is detected. A January 2000 policy entitled "Response to Relapse" in the *Diversion Program Policy, Guidelines, and Procedures* manual states: "Three factors are considered in evaluating the severity of use and level of impairment. They are: 1) frequency of use (single, multiple, continuous), 2) duration of use, and 3) level of risk (self-report, on/off duty)." The manual also refers to a "Relapse Response Matrix" contained in the same manual, which may be used as "guidelines for Diversion Program staff to assess the appropriate level of treatment for Program participants who have relapsed or are entering the Program."[415] If the physician is practicing medicine at the time of the relapse, he is usually directed to cease practice until he can meet with the DEC, and is placed on the DEC's calendar for the next available meeting. Depending on the circumstances, the Program may also direct the physician to enter treatment, increase the frequency of required urine testing or group meeting attendance, or undergo psychiatric evaluation and/or psychotherapy. According to the Diversion Program Manual, "a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program."[416]

In an average of 13 cases per year for the past five years, the Program has "unsuccessfully terminated" a participant. A participant who repeatedly fails to comply with his Diversion Agreement is referred to a DEC at its next available meeting. The DEC makes a recommendation

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[412] *Id*. at § 2350(g).

[413] *Id*. at § 2355(a). A DMQ regulation specifies a few types of Diversion Program records that must be retained in confidence by the Diversion Program. 16 CAL. CODE REGS. § 1357.9.

[414] G. Douglas Talbott, MD and Carolyn Anne Martin, Ph.D., Talbott Recovery Campus, *Relapse and Recovery* (Atlanta, GA 1999) (on file at CPIL); *see also* American Society of Addiction Medicine and National Council on Alcoholism and Drug Dependence, *The Definition of Alcoholism* (policy statement approved by NCADD on Feb. 3, 1990; approved by ASAM's Board of Directors on Feb. 25, 1990) (on file at CPIL).

[415] Neither the "Response to Relapse" document nor the "Relapse Response Matrix" has ever been considered, discussed, or approved by the Board's Diversion Committee, any of its predecessor task forces, or the Division of Medical Quality.

[416] Medical Board of California, *Diversion Program Manual*, Ch. 1 at 4; see also Medical Board of California, *Diversion Program Policy, Guidelines, and Procedures* ("Guidelines for Maximum Relapses While in the Diversion Program") ("a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program").

to the Program Administrator, who makes a final decision on whether the participant should be terminated. The consequences of "unsuccessful termination" depend on the type of participant who has unsuccessfully terminated. Participants who are in the Diversion Program under an SOU or as a condition of Board-ordered probation are referred to enforcement, which can then file an accusation for the alleged violation that resulted in the referral to Diversion,[417] or a petition to revoke probation based on the unsuccessful termination. "Self-referred" participants who are "unsuccessfully terminated" will not be referred to enforcement unless the DEC "determines that he or she presents a threat to the public health or safety."[418] According to the Program Manager, DECs do not generally make such a finding unless the participant is actively using drugs or alcohol. Even if the participant is referred to enforcement, only the fact of "unsuccessful termination" is communicated; enforcement does not receive an explanation of the reasons for "unsuccessful termination." Thereafter, the Program does not inquire into or track the sobriety or performance of participants it has unsuccessfully terminated in any way.

F. History of the Diversion Program

As noted above, the Diversion Program's enabling statute was enacted in 1980; the Program was formally created in 1981. The statute expressly requires the Board's Division of Medical Quality to administer the Diversion Program.[419] Specifically, DMQ is charged with the following duties: (1) ensuring that protection of the public is the Program's highest priority ("where rehabilitation and protection are inconsistent, protection shall be paramount");[420] (2) establishing regional DECs and appointing their members;[421] (3) establishing criteria for "the acceptance, denial, or termination of physicians" from the Diversion Program;[422] (4) establishing criteria for the selection of "administrative physicians" who examine physicians requesting admission into the Diversion Program;[423] (5) requiring each DEC to submit a biannual report including information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance,

[417] Bus. & Prof. Code § 2350(e).

[418] *Id*. at § 2350(j)(3).

[419] *Id*. at § 2346.

[420] *Id*. at § 2229(c).

[421] *Id*. at § 2342.

[422] *Id*. at § 2350(a). In 1981, DMQ adopted regulations establishing these criteria; see 16 CAL. CODE REGS. §§ 1357.1, 1357.4, 1357.5.

[423] Bus. & Prof. Code § 2350(h).

and a cost analysis of the program";[424] and (6) "administering the provisions" of the statutes creating the Diversion Program.[425]

Despite this clear delegation of oversight responsibility to DMQ, in 1982, DMQ and the California Medical Association decided to form an external "Liaison Committee to the Diversion Program" (LCD), consisting of representatives of CMA and the California Society of Addition Medicine (CSAM),[426] the chairperson of each DEC, and staff of MBC, the Diversion Program, and CMA. Most of the LCD members are physicians and other licensed professionals whose careers are dedicated to substance abuse detection, treatment, and rehabilitation. The LCD was intended to be an advisory body that brings clinical expertise and external information to DMQ and the Medical Board staff who administer the Diversion Program. According to the minutes of the LCD's first meeting on April 12, 1982, "the Liaison Committee would serve as a place where information and suggestions can be analyzed, providing for different points of view to be represented in the discussion. The Liaison Committee could then bring recommendations to the attention of the Division of Medical Quality where the responsibility and authority for the program operation and policies rests." Notwithstanding the language of the statute and the stated function of the LCD, for all intents and purposes, DMQ effectively delegated its policymaking and oversight role to the LCD in 1982.

In 1982, the Auditor General released the first in a series of audits on the Diversion Program.[427] As described in Chapter IV above, the Auditor General criticized DMQ for failing to establish any formal policies governing surveillance of participant compliance with the terms and conditions of their contracts. Specifically, the Auditor General found wide variability in the case managers' frequency of contact with participants, inadequate monitoring of participant compliance with specific terms of their contracts, inadequate verification of participant attendance at required support group meetings, failure to ensure that treating psychotherapist reports are submitted to the Program, and failure to ensure that participants obtained "worksite monitors" to oversee their medical practice. Additionally, the Auditor General criticized the Diversion Program for inadequate recordkeeping (noting that "records on each participant are scattered among three separate files" across the state) and for failure to terminate participants who do not comply with the terms of their contract. This latter deficiency was attributed to DMQ's failure to establish clear standards and

[424] *Id*. at § 2350(I).

[425] *Id*. at § 2346.

[426] Since then, the composition of the LCD has been expanded to include a representative of the California Psychiatric Association (CPA) and CPA staff.

[427] Auditor General of California, *Review of the Board of Medical Quality Assurance* (No. P-035) (August 1982) (hereinafter "1982 Auditor General Report").

guidelines for terminating participants. In response, DMQ promised to hire a deputy program manager to better supervise the case managers, draft formal guidelines for practice monitoring (to include a requirement that the participant submit a plan of employment to the case manager, who would then inspect the work environment, interview the prospective supervisor, and ensure the supervisor understands his or her responsibilities), and formulate standards for terminating participants from the Program.

In January 1985, the Auditor General released a follow-up report.[428] The Auditor General found continuing problems with the case managers. Although Program policy required CMs to visit participants on a monthly basis, the Auditor General determined that the CMs were not meeting this requirement and some were substituting telephone contacts for personal visits. One of the CMs had not personally visited any of the participants in his portfolio for the prior year. At that time, CMs were responsible for collecting urine specimens at least once per month; the Auditor General found deficiencies in this function as well. In one case, the CM either did not collect required urine samples or collected and discarded them without testing. As it had in 1982, the Auditor General found deficiencies in the Program's worksite monitoring system, including the Program's failure to provide worksite monitors with copies of the participant's treatment plan, participants' failure to obtain a monitor within required timeframes (or obtaining a monitor who was also a participant in the Diversion Program), failure by monitors to fulfill their monitoring responsibilities, and failure by monitors to file quarterly written reports. Once again, the Auditor General found that the Program failed to provide worksite monitors with a detailed description of their duties, including the level, degree, and frequency of supervision and observation expected by the Program. The Auditor General found that the Program Administrator had failed to suspend several participants who should have been suspended, and failed to refer several participants to the DEC for termination from the Program where they had repeatedly failed to comply with the terms and conditions of their treatment plan.[429] Concerning the management of the Program, the Auditor General stated that "the medical board's staff has not developed adequate procedures for supervising the diversion program and for ensuring that the diversion program is protecting the public." Specifically, the monthly reports filed by CMs and the Program Administrator contained insufficient information to enable the Chief Medical Consultant (who was supposed to be responsible for supervising the Diversion Program) to assess the performance of the CMs, Program Administrator, or the Program generally. The Auditor General noted that there was no tracking of the frequency of CM visits to participants or

[428] Auditor General of California, *The State's Diversion Programs Do Not Adequately Protect the Public from Health Professionals Who Suffer from Alcoholism or Drug Abuse* (No. P-425) (January 1985) (hereinafter "1985 Auditor General Report").

[429] The Auditor General described an astounding example of this critical failure: "On four separate occasions over a three-month period, urine samples collected from the participant during his office hours revealed that he was under the influence of alcohol." Yet the Program Manager failed to require the physician to cease practicing, and he failed to terminate him from the Program. *Id*. at 23.

urine sample collections, and no comparison of compliance reports with the participant's treatment plan.

The Auditor General concluded that these persistent and systemic problem exist because the Medical Board "has not adequately supervised the diversion program." The Auditor General recommended that the Diversion Program provide CMs with training in their duties, improve its system for tracking the CMs' activities in monitoring participants, and develop new guidelines for worksite monitors "that describe the observations they must make of participants, how frequently they must observe the participants, how often they must collect urine samples, and what information they should include in their quarterly reports." The Auditor General stated that the Medical Board must "specify . . . the kinds of noncompliance that warrant suspension or termination, develop a system to ensure that the program manager consults with [DECs] when participants violate significant terms and conditions of their treatment plans, . . . [and] develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly." Once again, MBC promised to address the issues identified by the Auditor General.

In 1986, the Auditor General released another report,[430] again finding deficiencies with the CMs' personal visits to participants. Of the 21 participants examined, 17 (81%) were not visited for periods ranging from three to seven months. Over 70% of participants that were required to undergo monthly urine screening did not have samples collected as frequently as required. The Auditor General found continuing problems with worksite monitors as well — 86% of worksite monitors were not contacted by CMs as frequently as required, and 71% of worksite monitors had not signed and returned their letter of acknowledgment. The Auditor General criticized the CMs' recordkeeping and the Program Administrator's failure to check the adequacy and accuracy of records submitted by the CMs. The Board agreed to implement a computerized participant profile and tracking system to enable the Program to identify participants who were not being adequately monitored by the CMs, and to continue its training of CMs on its expectations regarding their monitoring of Diversion Program participants.

In 1993, the California Highway Patrol released its report on MBC's enforcement program.[431] As part of its investigation, the CHP examined several allegations of misconduct and corruption within the Diversion Program. Although the CHP made no definitive findings, it expressed concern that group facilitators characterized as "volunteers" were in fact making up to $7,000 per month for

[430] Auditor General of California, *The Board of Medical Quality Assurance Has Made Progress in Improving its Diversion Program; Some Problems Remain* (No. P-576) (June 1986) (hereinafter "1986 Auditor General Report").

[431] California Highway Patrol, Bureau of Internal Affairs, *Administrative Proceedings of the Medical Board of California (Preliminary Report)* (Jan. 11, 1993).

holding two meetings per week; one case manager was not collecting urine samples from participants as frequently as required; some Diversion staff made "threatening" comments to participants; and the Program Manager improperly accepted expensive gifts from participants in the Program. Following the Medical Summit in March 1993, MBC appointed a task force to examine the CHP's concerns. After meeting for about six months, the task force disbanded without recommending any substantive changes to any aspect of the Diversion Program.[432]

In March 1995, the State Auditor (formerly the Auditor General) released its audit of MBC's enforcement program as required by SB 916 (Presley). The Auditor noted that effective January 1, 1993, AB 2743 (Frazee) (Chapter 1289, Statutes of 1992) added section 125.3 to the Business and Professions Code, enabling MBC to create a cost recovery mechanism (such as that recommended in *Code Blue* six years earlier) to recoup some of its investigative and enforcement costs from disciplined licensees. The Auditor found that MBC spent over $25 million on enforcement during 1993–94, could have recovered $6.3 million in cost recovery, but recovered only $94,000 because of its failure to properly implement its cost recovery authority. The Auditor pointed specifically to MBC's failure to seek recovery of its costs to administer the Diversion Program as against physicians who are ordered to participate in it as an alternative to disciplinary action or pursuant to a stipulated settlement. According to the Auditor, "as of June 25, 1992, 118 (46 percent) of the 256 participants were ordered to participate in the diversion program as an alternative to other disciplinary actions. Similarly as of July 31, 1993, 82 (38 percent) of the 213 active participants in the diversion program were ordered to participate. The law does not prohibit the medical board from seeking recovery of the proportion of the diversion program's administrative costs relating to those individuals ordered to participate in the program as an alternative to facing other disciplinary action. Using the numbers of participants ordered into the program for the two years we reviewed, we determined that the medical board could have sought recovery of approximately $332,500 for fiscal year 1992–93 and $284,600 for fiscal year 1993–94."[433]

In 1996, the Legislature enacted AB 1974 (Friedman) (Chapter 644, Statutes of 1996) to give the Diversion Program a new responsibility unrelated to substance abuse. Under Business and Professions Code section 821.5, hospital peer review bodies that are investigating a physician's ability to practice medicine "based on information that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care" must file a confidential report with the Diversion Program Administrator. The Administrator must contact the peer review body within 60 days and "periodically thereafter to monitor the progress of the investigation. At any time, if the diversion program administrator determines that the progress of

[432] *See supra* Ch. IV.D.

[433] State Auditor of California, *The Medical Board Needs to Maximize Its Recovery of Costs* (No. 93032) (March 1995) at 14–15.

the investigation is not adequate to protect the public, the diversion program administrator shall notify the chief of enforcement of the Division of Medical Quality of the Medical Board of California, who shall promptly conduct an investigation of the matter."[434]

During this time period, the Diversion Program Administrator would make brief reports at each quarterly DMQ meeting. Division members knew little about the functioning of the Program other than what it was told by staff, which would present a five-minute oral report and a one-page written report containing minimal statistics dating back to the inception of the Program in 1981 — including total number of intakes, participants, releases, and some information about the "primary drugs of choice" among Diversion Program participants. No DMQ members fully understood how the Program worked; their questions to staff generally went unanswered. With the exception of the CHP report in 1993 and a 1994 effort to craft legislation to supersede a troublesome court decision applicable to the authority of MBC to discipline a physician in the Diversion Program,[435] it is fair to say that DMQ paid little serious attention to the Diversion Program until 1997.

In 1997, the Center for Public Interest Law raised questions about the Diversion Program in testimony to the Joint Legislative Sunset Review Committee at the Board's first sunset review. CPIL expressed concern about DMQ's failure to properly oversee the Diversion Program; specifically, CPIL alleged that DMQ had delegated its oversight role to the LCD, and had failed to discuss or adopt standards for urine test frequency and the handling of relapses, criteria governing a physician's readiness to return to practice and justifying termination from the Program, and qualifications for the "evaluating physicians" who examine applicants to the Diversion Program. CPIL noted that the DECs were making decisions (not recommendations) about whether and under what terms and conditions a participant may practice medicine — decisions that were not reviewed or ratified by any Medical Board staff or Board member, and decisions that are properly made by government officials and not private parties. CPIL questioned the effectiveness of the Diversion Program — noting that the Program had "graduated" only 590 physicians and unsuccessfully terminated 267 physicians since its inception in 1981. CPIL also expressed concern over the infrequency of required urine testing (twice per month); the Program's inability to monitor participants who had agreed to cease practice; its lack of standards, policy, or expectations when handling relapses; its failure to demand practice cessation during the initial comprehensive evaluation; and its constant advertisement of a

[434] MBC has adopted regulations to implement section 821.5; *see* 16 CAL. CODE REGS. § 1362 *et seq*. In 2004, the Diversion Program Administrator estimated that she receives approximately one section 821.5 report per month.

[435] In *Kees v. Medical Board of California* (1992) 7 Cal. App. 4th 1801, the Fourth District Court of Appeal stated that "once a physician enters the . . . [diversion] program . . . , the Board halts all action against the physician, whether it is investigatory or disciplinary." This language led the enforcement program to insist on completing all investigations on physicians seeking admission into the Diversion Program before formally admitting a physician with a complaint pending into the Program. MBC and CMA negotiations led to the enactment of SB 779 (Lewis) (Chapter 252, Statutes of 1995) to repeal the language in *Kees* and clarify the procedures to be followed when a physician against whom a complaint is pending seeks admission into the Diversion Program.

"69% success rate" when it wholly failed to track the post-termination activities of any of its participants. CPIL recommended that the Legislature require DMQ to engage in substantive rulemaking and oversight of the Diversion Program ("DMQ should be required to adopt protocols, procedures, and reporting requirements about the decisionmaking of the Diversion Program which staff must follow, and to develop intrusive monitoring mechanisms to enable the Division to ensure that staff is in fact following them"), amend the statutes creating the DECs to ensure they act in an advisory capacity only, require Diversion Program participants to cease practice during the initial evaluative stage of participation, and ask the State Auditor to undertake another independent look at the Diversion Program to ensure that the problems first identified in 1982 had been corrected.

In response to CPIL's testimony, MBC created a Task Force in 1998 to comprehensively study the Program; examine the precise functioning of the Program; and determine who was making decisions, whether they are qualified to make those decisions, and whether they should be allowed to make those decisions. In May 2000, the Task Force reviewed the issue of urine test frequency and decided to increase the frequency of urine testing for participants permitted to practice medicine — one of the few Diversion-related policy decisions made by MBC members.[436] The work of the Task Force also led to 2000 legislation clarifying that the Program Administrator makes Diversion Program decisions and the DECs serve in an advisory capacity to the Administrator, extending the minimum period of sobriety from two years to three years (for purposes of successful completion of the program), and making a number of other important changes to the Diversion Program's statutes.[437]

In July 2000, the Task Force began to require Diversion Program staff to compile and present "Quarterly Quality Review" (QQR) reports containing data on three important performance measures: (1) total intakes during the quarter — that is, the number of physicians who contacted the Program; the time it took the Program to respond with a face-to-face meeting with the CM, group meeting attendance, a complete mental and physical evaluation by a competent evaluating physician, a DEC meeting, and formal admission into the Program; and the status of all physicians who contacted the Program during that quarter; (2) total relapses during the quarter — including the method and details of the Program's detection of reuse, the timeliness and substance of the Program's response to the relapse, how long the participant had been in the Program at the time of relapse, whether the participant was a self-referral or Board referral, and the participant's current status; and (3) total releases during the quarter — both "successful completions" and "unsuccessful completions" with factual details on each. The information presented in these reports is anonymous, and tended to be about six months old by the time the Task Force reviewed it, but it was the Board's first meaningful attempt to supervise and oversee the Program's functioning as required by law.

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[436] This policy decision was reflected not in statute or regulation, but in a June 30, 2000 memo from the Diversion Program Administrator to the Diversion Task Force.

[437] SB 1554 (Figueroa), Cal.Stats.2000, c. 836.

In November 2000, the Board converted the Task Force to a standing Committee on the Diversion Program, to ensure that some members of the Board are familiar with the Diversion Program, its statutes and regulations, and its policies and procedures. The Committee meets quarterly in public, reviews the QQR reports, receives a report from the LCD, and occasionally studies and/or decides a policy issue related to the Diversion Program.

In 2002, SB 1950 (Figueroa) amended section 2350 to permit the "diversion" of singly-diagnosed mentally ill physicians from enforcement into the Diversion Program. The Program was then confronted with integrating singly-diagnosed mentally ill physicians into a program that — for twenty years — had been primarily structured to monitor chemically dependent physicians. A 2001 memo from Medical Board staff anticipated no serious problems in accommodating mentally ill physicians; the memo stated that they could be reviewed by existing DECs or that the Program could create a special DEC specifically for mentally ill physicians. Staff noted that the Program would probably need one additional case manager — "not including support staff or administrative services, the fiscal impact would be near $80,000 per year (some of which would be offset by the savings to Enforcement)." Based on this estimate, CMA and MBC agreed to the inclusion of the provision in SB 1950 (Figueroa). In February 2003, however, the Diversion Program Administrator wrote a memo anticipating a 30% increase in Program participation over the following five years due to the inclusion of mentally ill physicians. Of greater import, the memo described the burdens imposed by the addition of mentally ill physicians to the Diversion Program: "Physicians with mental illness are expected to have reoccurring symptoms of their disease that will require intervention and treatment at a much greater frequency than those with chemical dependency that relapse into substance abuse. As such, the singly diagnosed mentally ill are expected to significantly compound the workload of the program's case managers by increasing the time involved with monitoring and providing referrals for these physicians." The Administrator opined that if the anticipated number of singly-diagnosed mentally ill physicians enters the Diversion Program over the next five years, it will need eight new case managers at a cost of an additional $600,000 per year (a 60% increase in the Diversion Program's budget).

Even without the addition of mentally ill physicians, the Program's staffing has been stretched to its breaking point. At the end of fiscal year 1994–95, a total of 212 physicians were participating in the Diversion Program,[438] which was staffed by ten people (including five CMs). During 1994–95, the average caseload of the case managers was 49 cases[439] — which is the maximum believed prudent by the Program Administrator. At the end of fiscal year 2003–04, a total

[438] Medical Board of California, *1994–95 Annual Report* (October 1995) at vii.

[439] Diversion Program, Medical Board of California, *Second Annual Report* (1995) at 8.

of 258 physicians were participating in the Program,[440] which was still staffed by ten people (including five CMs). During early 2002, the caseloads of at least three CMs soared to above 80 cases each, causing the Program to impose "dampening activities" to stifle the number of participants in these "impacted" regions of the state. The Program "delayed entry" to applicants in these areas of the state until the CMs' caseloads decreased to a somewhat more manageable level,[441] and also relieved those CMs of some of the monitoring activities which they would otherwise be required to perform.[442] In other words, between 1994–95 and 2003–04, the Program's participation rate increased by 22% with no increase in staffing, and — in some areas of the state — participants are not monitored as comprehensively as called for by Program policy.

Additionally, on at least two occasions during the past three years, the Program Administrator has had to abandon her position in Sacramento in order to temporarily fill in for a case manager in the field who resigned. On these occasions, the Program Administrator has become a case manager for several months (until the hiring freeze waiver could be secured and the position could be filled), requiring the Deputy Executive Director to assume the duties of Acting Diversion Program Administrator. It is unclear what happens when these critical case managers — who are the "nerve center" for information exchange regarding potentially dangerous physicians — go on vacation for even a day.

G. Initial Concerns of the MBC Enforcement Monitor

The Monitor's review of the Diversion Program's statute and regulations, its policy and procedure manuals, its computer tracking system, its participant files, and its oversight have revealed fundamental flaws in its operation that are described below. However, the following critique does not imply that the Diversion Program has never helped a physician recover from addiction. Our review of the files on twenty "imminent completion" participants tells us that it has. Similarly, the

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[440] Medical Board of California, *2003–04 Annual Report* (October 2003) at v.

[441] According to the Program Administrator, the "goal" maximum caseload for case managers is 50 cases. When a CM reaches 65 cases, the Administrator declares the area of the state served by that case manager to be "impacted" and "delays entry" to prospective participants in that area until the case manager's caseload drops below 65. As of July 26, 2004, one CM had 70 cases (so was "impacted") and another's caseload had dropped to 62 cases so that CM could accept new participants. Interview with Diversion Program Administrator (July 26, 2004).

[442] In memos dated March 11, 2002 and March 29, 2002, Diversion Program management lengthened the time within which intake interviews must be conducted by case managers from the usual one week from the date the physician contacts the Program to an unspecified time "within the discretion of the case manager." The Program also suspended the usually-required use of the "Intake Interview Guide Sheet" and left it up to the discretion of the case manager as to what information should be collected in the intake interview. Finally, the Program changed the monthly group meeting attendance requirement for case managers to "the Case Manager is to use discretion in determining the frequency of attendance at Diversion Group meetings." In 2004 interviews with the Diversion Program Administrator, she stated that those memos are directed only at case managers with caseloads in excess of 65 cases (two of the five CMs had caseloads in excess of 75 cases); other CMs should abide by the usual rules.

Monitor has nothing but respect for the people who are employed by and who volunteer their time, skills, and expertise to the Diversion Program. However, this Program operates in an area of extraordinary sensitivity and patient risk. If the Program or its monitoring mechanisms fail for whatever reason, both the public and its participants are subject to grave harm.

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are random urine screening requirements, case manager attendance at required group meetings, required worksite monitoring, and regular reporting by treating psychotherapists. Most of these monitoring mechanisms are failing the Program and the public, and — as described below — the Program lacks internal quality controls that would otherwise enable staff to detect these failures. As a result, Program staff and oversight authorities are unaware of the deficiencies that exist in the Program and falsely assume that the Program is effectively monitoring participants when it is not. A comprehensive overhaul of the Diversion Program is urgently needed to correct longstanding deficiencies that limit the Program's effectiveness both in terms of assisting participant recovery and in terms of protecting the public.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means for monitoring participants' sobriety and detecting relapses. Available data suggest that more than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major objective measure of participant compliance with the terms of the contract and with the Program's requirements. However, the results of our review suggest that the confluence of various deficiencies in the current system delays the Program's detection of participant relapses (in some cases for an extended period of time) or prevents that detection entirely. In our view, these deficiencies seriously undermine the integrity of the major objective measurement of participant compliance, and may expose the public to unacceptable risk.

As described above, at least three levels of Diversion Program staff are supposed to play a "gatekeeper" role in implementing and monitoring the urine collection system: (1) the Collection

System Manager (CSM), a Sacramento-based staff employee who provides oversight and coordination of the urine collection system; (2) regional case managers (CMs) who monitor a caseload of participants in their region; and (3) local urine collectors who are supposed to collect specimens from participants according to a random schedule of monthly dates generated by the CSM. Each of these "gatekeepers" is in a position to monitor participant compliance with the Program's urine collection requirements; however, excessive caseloads and a lack of internal controls on the system have combined to prevent any of these people from detecting the problems that we have documented.

Diversion Program policy requires participants who are practicing medicine to be tested four times per month for the first two years of participation. These collections are supposed to be randomly scheduled by the CSM and observed by the local urine collector. After 24 months of participation (which must include a similar period of sobriety), scheduled collections may be reduced to three collections per month. After 36 months of participation (which must include a similar period of sobriety), scheduled collections may be further reduced to two collections per month. Non-practicing participants are usually scheduled for two collections per month irrespective of how long they have been in the Diversion Program.

On a monthly basis, the CSM generates a master list of randomly-generated urine collection dates for various groups of participants in different geographical regions of the state. Individualized listings are then prepared for each case manager, group facilitator, and collector.

In preparing the list of random dates, the CSM is highly dependent on the CMs to provide updated information regarding the Program's participants. If the case managers do not notify the CSM of changes to the list of participants for whom collections are needed, changes in the number of needed collections per month, or changes in participants' practice status or unavailability for testing due to treatment or other circumstance, then the monthly master schedules prepared by the CSM will necessarily be out of alignment with actual collection requirements. Further, the system used to prepare the monthly collection schedules does not permit the CSM to block out dates for individual participants in order to avoid scheduling collections on dates when it is known that they will be unavailable due to vacations or other approved absences. The case managers and collectors are responsible for making any changes to the schedules prepared by the CSM as needed to accommodate requests that have been submitted by participants for vacations or other approved absences. The CSM does not oversee, control, or monitor changes made to the collection schedules after they are generated and distributed.

On the date randomly generated by the computer — and that date can be a weekday, a weekend day (Friday, Saturday, or Sunday), Christmas Day, Easter Sunday, or Super Bowl Sunday (whatever date the computer generates), the collector is supposed to call the participant and instruct

the participant where and by when he must present himself for a collection. According to the *Diversion Program Manual*, the physician is required to provide a sample within six hours of the call. The participant shows up and submits to an observed urine collection, and pays the collector both the collection fee and the lab fee. The collector prepares paperwork for the laboratory that will analyze the specimen. The paperwork prepared by the collector does not indicate the participant's name; instead, all participants are given a "Donor ID" number, and that number is entered onto the chain of custody form prepared by the collector.

The collector then overnight-mails the specimen to the laboratory used by the Program. The Program's arrangement with the lab gives it an outside window of 12 hours to return a result if the result is negative. The lab is allowed up to 72 hours to return a positive result. Sometimes (most of the time) a positive result will come earlier than that outside window; sometimes it does not.

The results of all urine tests come to the Diversion Program in two ways:

(1) All positive results are communicated to the CSM. The CSM identifies the participant who tested positive from the Donor ID, and emails the case manager of that participant so that the CM can begin a fairly complex chain of events to determine whether the positive result is in fact evidence of a relapse. Not all positive tests indicate relapse; some participants are taking prescription drugs that have been approved by the Program, and those drugs show up in the test. Other physicians test positive because they say they have eaten poppy seeds, or taken cough medicine with codeine, or used mouthwash containing alcohol.

(2) All results of all urine tests — both positive and negative — are electronically forwarded to the Program by the lab via a "data dump." These test results are then "appended" to the electronic file of the tested participant in the Program's Diversion Tracking System. Theoretically, the DTS contains detailed information regarding the date and result of each urine test completed.

The CSM and case managers review and respond only to reports of positive tests. Reports of negative tests are reviewed only superficially, or not at all. If positive test reports are not received, all Program staff assume that the collections were completed as scheduled and that the test results were negative. They also assume that the results of all completed tests are correctly downloaded and appended to each participant's record in the DTS. However, these assumptions are frequently erroneous, and there are very few control mechanisms to detect those errors. Specifically, there are not sufficient positive controls on the current collection system to provide assurance of six major components:

- All active participants are included in the master collection schedule.
- The participant is scheduled for the required number of tests, per the Diversion Program "frequency of testing" policy described above.

- Collections are actually completed on the random date assigned by the CSM.
- The same number of collections is completed as is scheduled for each participant.
- Collected specimens are received at and processed by the laboratory.
- Test results are correctly downloaded and appended to each participant's record in the DTS.

Due to the absence of sufficient positive controls over the scheduling and collection process, participants can be tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there is a problem. Also, test results may be inadvertently appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there is a problem. All of these events have occurred. We found significant defects in four areas of the Diversion Program's urine collection system: (A) collection scheduling process deficiencies; (B) specimen collection process deficiencies; (C) reporting and recordkeeping deficiencies; and (D) urine collection system oversight deficiencies.

A. Collection Scheduling Process Deficiencies

1. New participants are not always promptly scheduled for urine collections. Diversion Program policy requires new participants to be scheduled for collections immediately following completion of their intake interview. If the participant will be immediately entering or is already in treatment, the collections are usually supposed to begin immediately following completion of treatment. In most cases, the case manager initially needs to schedule the collections directly with a collector for a period of several weeks until the participant can be incorporated into the CSM's master scheduling system.

Although the Program assures the public of "immediate drug testing," our review of 20 recently completed intakes identified one participant who was not scheduled for any collections (or tested) for the first three months following completion of his intake interview. Four other participants were not scheduled for any collections (or tested) for at least the first month following completion of their intake interview. These data suggest that about 25% of new participants are not promptly scheduled for any collections (or tested) for a period of at least a month following completion of their intake interview — and most of these participants are permitted to practice medicine. During the transitional period following initial intake and, if applicable, completion of inpatient treatment, it is particularly important to assure that urine testing is completed on a regular basis.

2. Urine collections are not always promptly restarted when a participant completes treatment following a relapse. Participants are usually required to obtain treatment after a relapse.

Generally, inpatient treatment is recommended and, during the treatment period, Diversion Program urine collections are suspended. Urine collections are supposed to be restarted immediately following a participant's release from treatment. In most cases, the case manager needs to initially schedule the collections directly with a collector for a period of several weeks until the participant can be incorporated into the CSM's master scheduling system.

However, our review of 20 recent relapse cases identified four cases where urine collections were not promptly restarted following completion of treatment. Following release from treatment, these four participants were not tested for periods of time ranging from 3 to 4½ months. Although participants are not usually permitted to immediately return to practice following release from treatment, this is not always the case. During the transitional period following release from treatment, it is particularly important to assure that urine testing is completed on a regular basis.

3. The CSM is not always promptly notified by the case managers of the need to add new participants to the random urine collection scheduling system. New participants should be included in the CSM's random urine collection scheduling system within one month of completion of their intake interview. If the individual is already in an inpatient treatment program at the time the intake interview is completed, or will be entering treatment in the near future, then his inclusion in the CSM's collection scheduling system is deferred until treatment is completed.

However, our review of 20 recently completed intake cases identified nine cases — almost 50% of the cases we reviewed — where the participants were not randomly scheduled for collections through the CSM for periods ranging from one month to as many as four months following completion of their intake interview or, if applicable, release from treatment. In some cases, rather than scheduling collections through the CSM, the case managers continued to schedule the participant's collections directly with the collectors on an ad hoc basis.

4. The CSM is not always promptly notified of changes to participants' testing frequency. Participants oftentimes are scheduled by the CSM for four collections per month when a lesser number of collections is required due to the participant's practice status or length of time in the Diversion Program without a relapse. In these circumstances, the case manager and/or collector unilaterally determine which dates to delete from the list of random collection dates generated by the CSM. In some cases, this practice continues for a period of several months before the CSM is alerted to the need to adjust the participant's collection schedule. The practice of repeatedly overriding the random collection schedule generated by the CSM, rather than notifying the CSM of needed changes to a participant's collection requirements, undermines the integrity of the random collection scheduling system.

B. Specimen Collection Process Deficiencies

1. Collectors do not usually obtain urine specimens on the dates specified in the CSM's master collection schedule. We compared scheduled collections with actual collections for periods ranging from four to eleven months for each of 20 recently completed intake cases. A total of 378 collections were scheduled. Collections were actually completed on the date that had been scheduled only 40% of the time. In addition to scheduling changes resulting from needs to accommodate participant unavailability due to vacations, meetings, etc., schedules were sometimes changed for the convenience of or due to the unavailability of the collector.

There are no controls over many of the changes to the random collection schedule that are made and, in most cases, the reasons for the changes are not documented. The systemic rescheduling of collections by case managers and/or collectors raises serious questions about the integrity of the Diversion Program's random collection scheduling system.

2. Collectors disproportionately shift collections from weekends to weekdays. Collectors disproportionately shift collections from weekend days (Friday, Saturday, and Sunday) to weekdays, particularly Tuesday and Thursday. Among the 20 recently completed intake cases that we reviewed, 22% fewer collections were completed on weekends compared to the number that were scheduled for those days. Significantly more collections were completed on both Tuesdays and Thursdays than were scheduled. The reduced frequency of testing on weekends and increased frequency of testing on Tuesdays and Thursdays potentially enables participants to "game" the system by anticipating when they are least likely to be tested.[443]

3. Collectors do not always make up for skipped collections. When a collector decides to skip a collection on a scheduled day due to his own vacation, meeting, scheduling conflict, or other circumstance, a make-up collection is not always scheduled. As a result, many participants complete fewer collections than are scheduled. Additionally, some collections are skipped when the participant is unavailable due to meetings or other circumstances. Skipped collections due to participant unavailability may be symptomatic of a relapse and, because of this, should be of particular concern — especially when they are not made up.

C. Reporting and Recordkeeping Deficiencies

1. Reporting of test results is sometimes delayed. As noted above, the Diversion Program's arrangement with the lab calls for positive results to be reported to the Program within

[443] Participants are able to "game" the system in other ways. For example, most participants are aware of the general requirement of four urine tests per month during the first two years of participation. If a participant is tested four times by the tenth of the month, that participant knows the odds are he will not be tested again until the following month.

72 hours. Our review of 20 recent relapse cases identified four cases where positive test results were not reported for timeframes ranging 10 to 14 days after the sample was obtained. In another case, test results were not reported for as long as 3 to 4 weeks after the sample was obtained. In most cases, reporting delays are attributable to failure by the collector to submit the specimen to the laboratory on a timely basis. The problem is exacerbated by the fact that Diversion Program staff do not identify these problems when they occur, or do not immediately initiate corrective action to prevent the problems from recurring in the future.

2. There are gaps in the collection records maintained in the DTS. The DTS is used to maintain a record of urine test results for all participants from late 2001 to the present. However, the Diversion Program does not have positive controls to assure that test results are actually received from the laboratory and downloaded to the DTS. It also is possible that data can be inadvertently erased or purged from the system without being detected. For example: (1) there are no records in the DTS of any urine tests during June 2002 for any of 60 participants that we checked. Diversion Program staff are unable to explain what may have caused this gap; (2) there are no records in the DTS for any urine tests for most of May 2003. This is the same time that the Program switched to a new laboratory service. It appears that several weeks' worth of records from the former laboratory were never downloaded to the DTS. It is unlikely that these records can be recovered; and (3) a set of records covering testing during a two-week period in late January and early February 2004 also was missing in the DTS. After the Monitor brought this problem to the attention of the Diversion Program Administrator, the missing records were identified, located, and appended to the DTS.

3. Test results are not always appended to the correct participant's DTS file. Our reviews of 60 Diversion Program files identified numerous inconsistencies between the dates of completed tests shown in the database maintained by the laboratory service and the dates shown in the Program's DTS. These problems often occur because the Donor ID number is not entered onto the chain of custody form by the collector, or the Donor ID number entered is incorrect. In cooperation with the Diversion Program Administrator, we determined that more than 300 lab reports received during the past year did not contain a Donor ID and therefore had not been appended to the appropriate participant's record in the DTS. These records have since been corrected and appended to the appropriate files in the DTS. However, there are still a number of records with incorrect (versus missing) Donor IDs that may, or may not, already be appended to the correct participant's record in the DTS. MBC's Information Technology Services Division staff have indicated that there are no records that have been downloaded but not appended, so it is unclear what happened to records that had incorrect Donor IDs when they were downloaded.

One of the cases that we reviewed involved a non-practicing participant who appeared not to have been tested for the past full year after several years of participation in the Program. We subsequently determined that the participant's collector had been using the wrong Donor ID for this

participant's specimens. Consequently, the test results for this participant were posted to another participant's record in the DTS. After reviewing all of the past year's test results for the other participant, the incorrectly posted records were able to be identified. It was then learned that, during six of the past twelve months, this participant was tested only one time per month. None of the Diversion Program's "gatekeepers" detected any of these problems.

Finally, our review of 20 recent relapse cases identified a practicing participant who appeared not to have been tested for an eight-month period extending from mid-April 2003 through January 2004. Program staff are unable to determine whether the participant was actually tested during this period and the results were posted to another participant's file, or whether the participant wasn't tested. During this period the participant relapsed. The relapse was detected not by the Diversion Program but by the participant's employer.

4. Incorrect data have sometimes been reported. Primarily as a result of data entry errors, some of the data reported by the lab to the Diversion Program are incorrect. For example, we completed our reviews during April and May 2004, but saw several laboratory reports with collection or reporting dates during late 2004 or 2005. We also saw examples of obvious inconsistencies between the dates shown for urine collection, lab receipt of the specimen, and reporting of the results (*e.g.*, a subsequent event, such as a report, occurring before the preceding event, such as a collection). The laboratory recently reinstituted double-key data entry procedures that should help to reduce the magnitude of these types of problems in the future.

5. Most local collectors fail to file a required monthly report. The Diversion Program Manual requires local urine collectors to file a monthly report detailing the dates of all urine collections on all participants, including the specimen chain of custody number. This monthly report could help Program staff in detecting errors. The Manual also requires local collectors to "cite reasons for adjusting a collection date." However, the majority of collectors fail to file monthly reports, and Program staff do not insist on compliance with this requirement. We randomly looked at the CSM's binder for the month of December 2003. Out of 30 collectors collecting from 60 different groups of participants, only five (5) collectors (covering 9 groups) submitted the required monthly report for that month. It is unclear whether the Program has a standardized form for this report; we looked but could not find one.

D. Urine Collection System Oversight Deficiencies

1. Program staff do not adequately monitor the collectors. As discussed previously, collectors appear to have broad discretion to unilaterally modify the collection schedules prepared by the CSM or, in some cases, skip collections altogether. As a result, many participants are not tested on the dates scheduled or are not tested as frequently as required. We are aware that the

Program has terminated several collectors for egregious and longstanding lapses. However, routine modification of random schedules without explanation, skipped collections, and collector failure to file a monthly report of all collections appear to be tolerated without discussion or sanction. It is unclear whether Program staff even know these events are occurring.

2. Program staff do not periodically review individual participant collection histories. Diversion Program staff do not routinely, or even periodically, review individual participant urine collection records. If a positive test is reported for a participant, the case manager initiates consultations with all concerned parties in response to that specific report. However, if no positive test results are reported, Diversion Program staff assume that all required collections have been completed as scheduled, submitted to the laboratory for testing, and reported as negative results.

The above assumptions are sometimes false. In most cases, specimens are not collected on the dates scheduled and, in many cases, specimens are not collected as frequently as required. In some cases, specimens are not collected at all for extended periods of time and nobody, other than the participant, is aware that this is occurring.

The results of our review suggest that at least several dozen of the Diversion Program's current participants have, at some point, not been tested for an extended period of time when they should have been. The results of our review also suggest that many more participants are not being consistently tested as often as they should be. Nobody currently makes any effort to track or monitor actual collections on a proactive basis for purposes of (1) controlling unapproved changes to the collection schedule that otherwise might be made for the convenience of the collectors or participants, (2) assuring that the required number of tests is actually completed for each participant, and (3) detecting relapse behaviors in advance or in lieu of actually receiving a positive test result.

3. Diversion Program staff have not usually responded to negative-dilute test results. Sometimes, participants who have resumed use of drugs or alcohol attempt to "dilute" their urine by ingesting large quantities of liquid. A "positive-dilute" result means that the specimen has registered over the threshold for a specific drug and is also diluted. A "negative-dilute" result means that the specimen registered under the threshold and is diluted. During April 2004, the Monitor pointed out to the Diversion Program Administrator several instances where a pattern of negative-dilute specimens was followed by a relapse. The Monitor also pointed out two cases where there was a recent pattern of negative-dilutes which suggested that the participant may have relapsed. Program staff subsequently determined that both of these participants had relapsed.

In many cases, negative-dilute test results clearly reflect a participant's efforts to disguise his relapse. Therefore, negative-dilutes should be recognized and addressed immediately. However, the Program had no policy regarding appropriate reaction to negative-dilute tests prior to April 2004.

In response to the Monitor's concerns, the Diversion Program Administrator recently established a new policy to require that case managers review and initiate appropriate responses in cases where negative-dilute specimens are obtained (for example, by immediately ordering a replacement collection and, in some cases, using alternative testing protocols).

To summarize, the Diversion Program today in 2004 is plagued by the same problem found by the Auditor General in 1985[444]and again in 1986[445]: The Diversion Program cannot guarantee the public that its participants are being tested as frequently as it requires. Focusing specifically on Diversion Program participants who are permitted to practice medicine, about one-half of recent intakes were not tested as often as required during the first one to four months of participation. About 25% of new participants were not tested at all for at least one month following completion of the intake interview. The relapse cases we reviewed indicated that five of the 20 participants who relapsed — all of whom were practicing medicine — were not tested as often as required. The public is exposed to unnecessary risk.

And consumers are not the only ones at risk. In one case, a physician was ordered to participate in the Diversion Program as a term of probation. However, he was not tested at all for the first three months of participation. The Diversion Program thought the Probation Unit was testing him, and the Probation Unit thought the Diversion Program was testing him. Nobody was testing him — and nobody knew that except the participant. Diversion assumed that Probation was testing him and that — because it received no positive tests — there were no problems. Then the Diversion Program received a telephone call from an emergency room attending physician who told Diversion that the participant had been brought into the ER passed out due to acute intoxication. At the time of this incident, that participant was permitted to practice medicine. He almost died because nobody was testing him, and nobody knew that nobody was testing him.

Even when the required minimum levels of testing are completed, in some circumstances these requirements are insufficient for purposes of detecting a participant's substance abuse. The human body can flush alcohol from the system fairly quickly, such that — in the words of one knowledgeable interviewee — "you can drink a six-pack on Sunday night and test clean on Monday." Some powerful drugs dissipate quickly from the system and are generally not detected. There are simply no (or inadequate) tests capable of detecting other drugs of choice. We found the following examples in Diversion Program files:

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[444] *See* 1985 Auditor General Report, *supra* note 428, at 17 ("[case managers] are not collecting urine samples in accordance with the diversion program's policies").

[445] *See* 1986 Auditor General Report, *supra* note 430, at 7 ("[case managers] did not collect all the urine samples for 71 percent of the participants in our sample").

■ A participant's admitted self-use of prescription drugs obtained from a hospital pharmacy over a five-month period extending from November 2002 to March 2003 and also during July and August 2003 was not detected even though the participant was consistently tested four times per month during both of these periods.

■ An employer detected a participant's diversions of Fentanyl during a routine hospital audit and then tested the participant positive. A Diversion Program specimen collected the next day did not test positive. Subsequently, about one year later, this same participant was arrested for driving while under the influence of alcohol. A Diversion Program specimen collected the next day did not test positive.

■ An employer investigation identified evidence of a participant's self-reported diversions of prescription drugs over a ten-month period that went undetected by the Diversion Program even though the participant was usually tested four times per month throughout this period. In one of these months, specimens were collected from the participant on the 14th, 17th, 24th, and 27th. The participant diverted IV-Demerol on the 25th and 30th. During the next month, the participant's four specimens were all collected by the 17th day of the month. The participant diverted IV-Demerol three times during the next ten days.

These examples illustrate the critical importance of testing *at least* the minimum number of times required pursuant to current Diversion Program policy. In contrast to these policies, current practices of the Diversion Program generally result in a frequency of testing that rarely exceeds these minimum requirements and, oftentimes, falls far short.

Even in cases where participants are being tested the required number of times, the above-described problems of flawed recordkeeping, delays in receiving test results, and absence of sufficient positive controls over the Diversion Program's urine collection system cast doubt on the integrity of the system. At the very least, the Program is unable to demonstrate that participants are complying with the terms of their contracts. At worst, the public is being exposed to physicians who may be practicing medicine while impaired due to undetected relapse into drug and/or alcohol use — a clear violation of Business and Professions Code sections 2001.1, 2229, and 2340.

The Monitor alerted Diversion Program and MBC management to the confluence of these problems within the Program's urine collection system in June 2004, and management immediately convened a small working group consisting of two Board members, MBC and Diversion staff, and representatives of the Monitor team. The working group has met three times and is working toward resolution of these problems.

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The Program's case managers represent another "monitoring"

mechanism of the Diversion Program.[446] The *Diversion Program Manual* requires case managers to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants.[447] Case managers are required to report their group meeting attendance in monthly reports to the Program Administrator.[448] However, few case managers file monthly reports as required. In August 2004, we looked at the Program Administrator's binders of CM monthly reports for 2003 and 2004. One case manager submitted one monthly report in 2003 and none in 2004, and another submitted no monthly reports in 2003 and two in 2004 — so there is no documentation as to whether they have attended group meetings as required by Program policy. Three other case managers submitted monthly reports fairly regularly during both years; two of those CMs reported attending the meetings of only one or two groups in their locale per month, while the other attended the meetings of five to seven groups per month. And, for long periods during 2003 and 2004, the policy requiring case managers to attend group meetings of each group in his/her locale at least monthly was suspended for case managers in "impacted" areas of the state — those with 70 or more cases.

The Program constantly states that its case managers — one of the few components of the Diversion Program that has not been performed by the private sector — are one of its key monitoring mechanisms. Yet the problem of inconsistent or inadequate contact by case managers with participants was identified by the Auditor General as far back as 1982,[449] 1985,[450] and 1986.[451] The problem of inadequate reporting by case managers and inadequate supervision of the case managers

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[446] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[t]he role of the case managers is to ensure that the participants who are assigned to them comply with the provisions of their Diversion Agreements and are solidly in the recovery process. The Case Manager has direct contact with each participant every 4–8 weeks").

[447] Medical Board of California, *Diversion Program Manual* (undated) at Ch. 2, p. 5 ("CMs attend the facilitators' group meetings once a month to observe the facilitators and participants"). Actually, the Manual is inconsistent on this point. On another page, the Manual states: "The CM is to attend each group meeting in his geographic area at least every two months." *Id*. at Ch. 1, p. 6 When questioned about this inconsistency, the Program Administrator clarified that the statement in Chapter 1 at page 6 is an error. Her expectation is that case managers must attend a meeting of every group in his/her locale once every month; however, case managers in "impacted" areas of the state must attend meetings of a group of each facilitator once every two months. Interview with Diversion Program Administrator (Mar. 4, 2004).

[448] Medical Board of California, *Diversion Program Manual* (undated) at Ch. 1, p. 12.

[449] *See* 1982 Auditor General Report, *supra* note 427, at 36 ("the frequency of the [case managers'] contacts with physicians varies . . . . [F]requency of contact varies widely").

[450] *See* 1985 Auditor General Report, *supra* note 428, at 9 (for 24 participants studied, case managers made only 150 (57%) of the 262 visits required).

[451] *See* 1986 Auditor General Report, *supra* note 430, at 7 (case managers "did not visit 81% of the participants in our sample for periods ranging from approximately three months to seven months").

by the Program Administrator was identified by the Auditor General in 1985[452] and 1986.[453] Little has changed.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are "monitored" by non-impaired physicians.[454] However, the Program has set forth no workable definition of the duties, qualifications, or expectations of a "worksite monitor." Although some Diversion Program materials convey the idea that participants are "supervised" while practicing medicine, that is not the case. The *Diversion Program Manual* contains a semblance of the duties of a "hospital monitor," but it is hardly specific or reassuring. According to the *Manual*, "the hospital monitor's responsibility is to observe the participant as frequently as possible and to assess to the best of his/her ability whether the participant is impaired as a result of drugs, alcohol and/or mental difficulties; to provide written reports on preprinted forms regarding the progress of the participant every three months and to assess if there are any changes in attitudes and behavior. Both positive and negative changes should be reported. The monitor is to notify the case manager if he feels a urine specimen is needed or he may collect the urine specimen himself." The statement contains no requirements that the worksite monitor actually be onsite at the same time as the participant, supervise the participant in any way, or even meet with or talk to the participant. The statement also sets forth no qualifications or criteria for someone functioning as a "worksite monitor"; it does not even require the monitor to be a physician. In fact, the Program Administrator stated that, on occasion, the Program is required to approve a physician's office manager — someone who is hired and fired by the participant — as the worksite monitor.

Additionally, people functioning as worksite monitors are not consistently filing quarterly reports as required by the Program. A complete, or nearly complete, set of quarterly worksite monitoring reports was present in the central file for only seven of the twenty imminent completion cases that we reviewed. In most of the other thirteen cases, there are only a few quarterly worksite monitoring reports in the central file. In many cases, participants have been allowed to increase their practice hours or — in one case — resume practice on a full-time basis notwithstanding continuing deficiencies related to the submission of quarterly worksite monitoring reports.

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[452] *See* 1985 Auditor General Report, *supra* note 428, at 18 ("[case managers'] reports are not always complete or accurate"; "while the diversion program's [case managers] have been deficient in monitoring participants, the program's management has been similarly deficient in monitoring the performance of the [case managers]").

[453] *See* 1986 Auditor General Report, *supra* note 430, at 19–20 ("[d]eficiencies persist in [case managers'] performance because supervision of the monitoring activities of [case managers] has been limited. For example, the program manager does not check the accuracy of [case managers'] recordkeeping . . . . The program manager also does not ensure that visits to participants recorded by [case managers] on their monthly logs are documented in writing").

[454] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including "worksite monitor(s)" and "hospital monitor(s)"] is used in order to ensure patient safety and provide strong support for the physician's recovery").

It is possible that these participants' worksite monitors have submitted quarterly reports more often, but that the Diversion Program's case managers have not always forwarded copies of the reports to the central file. In an effort to determine the extent to which this has occurred, in May 2004 we asked the case managers to provide us with a listing for each of these participants showing the dates of all reports contained in their personal files. To date, none of the case managers has responded to this request.

The quarterly worksite monitoring reports constitute a promise made by the Diversion Program to the public, and are a key mechanism for communication between the worksite monitors and the case managers. It is our understanding that the case managers may sometimes telephone worksite monitors and obtain verbal reports when written reports are not submitted. In addition to asking the case managers to provide us with a listing of the dates of all reports contained in their personal files, we also asked them to list the dates of any verbal reports that they received in lieu of the written reports. To date, none of the case managers has responded to this request.

Nothing came to our attention during the course of our review of the twenty imminent completion files to indicate that participants have been practicing without appointment of an approved worksite monitor. However, it does not appear that Diversion Program staff pay much attention to participant noncompliance with the associated quarterly reporting requirement. When continuing noncompliance with the quarterly reporting requirement is detected, the only corrective action usually taken is to remind the participant that they are supposed to comply with the requirement. It does not appear that participants are ever sanctioned or penalized in any way for failure to comply with this provision of their Diversion Agreement. For example, we found no instances where restrictions were placed on the number of hours per week a participant was permitted to practice due to deficiencies related to the submission of quarterly worksite monitoring reports. Conversely, we found several cases were participants were permitted to increase their practice hours notwithstanding continuing compliance deficiencies related to submission of quarterly monitoring reports as well as deficiencies related to fulfillment of other administrative requirements (for example, submission of quarterly therapist reports (see below) and participant semi-annual reports).

Although Appendix C to the *Diversion Program Manual* displays a form letter sent to hospital well-being committee chairs and a document entitled "Worksite Monitor Responsibilities," neither of those documents sets forth any required qualifications, criteria, or standards for the worksite "monitoring" that is promised to the public by the Diversion Program. The Program's failure to adequately define the duties, qualifications, and functions of "worksite monitors" and the

failure of worksite monitors to submit quarterly reports were identified by the Auditor General in 1982,[455] 1985,[456] and 1986.[457] Little has changed.

(4) Treating psychotherapist reporting is deficient. The Diversion Program assures the public that impaired physicians are also monitored by treating psychotherapists who are required to file quarterly written reports with the Program.[458] However, this monitoring requirement is not being satisfied. Neither the case managers, the Program Administrator, nor the DECs (which annually review all Program participants) are ensuring that quarterly treating psychotherapist reports are filed.

Of the twenty imminent completion cases that we reviewed, eleven participants were required to receive individual therapy. In most cases, this requirement was imposed immediately upon the participant's acceptance into the Program and has continued in force since that time. In a few cases, this requirement was not imposed until some time after the participant was accepted into the Program or the requirement was deleted prior to the participant's completion of the Program. The quarterly reports help to assure that the participant actually fulfills his individual therapy requirements and is progressing in treatment. The treating therapist also helps program staff to detect pre-relapse behavior and relapses.

As shown in Exhibit XV-A below, the central file records available to us indicate that participants with this requirement have actually complied with the quarterly therapist reporting

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[455] *See* 1982 Auditor General Report, *supra* note 427, at 38–39 (Program policy requires participants to "work in an environment that permits his or her practice to be overseen by another physician. The purpose of this restriction is to reduce the opportunity for the physician to repeat incompetent acts or to return to alcohol or drug abuse . . . . [However,] supervisors were not submitting required reports on the physicians' performance in 17 of the 18 cases, 94 percent").

[456] *See* 1985 Auditor General Report, *supra* note 428, at 20–21 ("[t]he practice monitors told us that they do not know what their responsibilities are. They said that they do not receive a copy of the participants' treatment plans, which outline the duties of practice monitors. Furthermore, the [case managers] are not routinely contacting practice monitors to inform them of their responsibilities . . . . These problems regarding the responsibilities of practice monitors result, in part, because the diversion program does not have a detailed description of the duties of a practice monitor").

[457] *See* 1986 Auditor General Report, *supra* note 430, at 3–4 and 15–18. Here, the Auditor General discussed "condition monitors," defined as "physicians or supervisors who work in the same building as the participants, and . . . are responsible for observing the participants' condition while the participants practice medicine." The Auditor General found that the case managers "are not contacting participants' condition monitors often enough . . . 12 (86%) of the 14 condition monitors assigned to participants were not contacted by [case managers] as often as policy requires." Also, "[case managers] are not ensuring that condition monitors sign and submit the letters that explain the condition monitors' responsibilities."

[458] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including "ongoing psychotherapy" and "progress reports: therapists, monitors, treating physicians"] is used in order to ensure patient safety and provide strong support for the physician's recovery"). *See also* Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at p. 8 (treating psychotherapist quarterly report requirement).

requirement on only a minimal basis, or not at all. For example, there are no treating therapist quarterly reports in the central file for four of the participants. In all of the remaining cases, the central file contains fewer than one-half of the required number of reports.

Ex. XV-A. Treating Therapist Quarterly Report Submissions — Imminent Completion Cases

Speciality	Accepted Into the Diversion Program	Required Number of Quarterly Reports	Actual Number of Quarterly Reports
Emergency Medicine	September 1999	18	8
Internal Medicine	September 1999	13	3
Family Practice	September 1999	11	5
Anesthesiology	September 1999	14	6
Anesthesiology	October 1999	18	None
Pediatrics	October 1999	18	3
OB/GYN	November 1999	11	None
Radiology	April 2000	16	None
Surgery	May 2001	11	2
Psychiatry	April 2000	16	4
Otolaryngology	January 2000	13	None

It is possible that these participants' therapists have been submitting quarterly reports more often than indicated above, but the Diversion Program's case managers have not always forwarded copies of the reports to the central file. In an effort to determine the extent to which this has occurred, in May 2004 we asked the case managers to provide us a listing for each of these participants showing the dates of all reports contained in their personal files. None of the case managers responded to this request.

We were unable to determine, within the scope of this review, the extent to which participants were actually completing individual therapy as required by their Diversion Program Agreements. The presence of some quarterly reports in cases where they are not regularly submitted suggests that most of the participants are probably complying with the treatment requirements. Of concern, however, are those cases where there are no quarterly reports for the participant. In these cases, it is possible that the participant is not complying with the treatment requirements.

Again, in most cases, it does not appear that Diversion Program staff pay attention to participant noncompliance with the quarterly therapist reporting requirement. When continuing

noncompliance with the reporting requirement is detected, the only corrective action usually taken is to remind the participant that he is supposed to comply with the requirement. Given the limited extent to which participants comply with this reporting requirement, it is unclear how Diversion Program staff monitor and track participant compliance with the underlying treatment requirements. It does not appear that participants are ever sanctioned or penalized in any way for failure to comply with this provision of their Diversion agreement.

b. The Program is so understaffed that staff could not correct the failures in its monitoring mechanisms even if they knew about them.

As described above, the Diversion Program has suffered a 22% increase in participation with no increase in staff over the past ten years. Beginning in March 2002, the caseloads of several case managers in certain parts of the state were deemed so excessive that Program management curtailed entry into the Program by participants who would be served by those case managers and simultaneously lessened the participant monitoring expected of those case managers.[459]

Excessive caseloads for the case managers is only one symptom of the understaffing of the Diversion Program. In the Monitor's view, there is significant understaffing at all levels of the Diversion Program. As described above, the Board — as a result of the Auditor General's 1982 report — acknowledged that it is not possible for one administrator to (1) supervise the case managers and support staff, (2) make Program decisions, and (3) engage in overall program oversight. Thus, the Board agreed to hire a deputy program manager to supervise the case managers. That deputy program manager was hired at the time of the Auditor General's 1985 report, but that person was apparently ineffective because the Auditor General found significant deficiencies with the performance of the case managers in both the 1985 and 1986 reports. That deputy manager position was reclassified to a lower-level position in the early 1990s, and the Program Administrator is back to handling functional supervision, program oversight, and program development — a burdensome combination of duties which one person cannot competently handle alone. Many issues referred by the Diversion Committee to staff for study — or to the Liaison Committee to be assisted by staff — simply fall through the cracks and are never resolved because of the paucity of analytical staff.[460]

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[459] *See supra* notes 441–42 and accompanying text.

[460] Over the past three years, the Monitor has observed the Diversion Committee refer — either to staff or to the Liaison Committee — the following issues: (1) how to protect the public from self-referred participants who contact the Diversion Program, admit to a serious problem, and then walk away; (2) the Program's failure to track "graduates" in any way to determine whether the Program is effective; (3) the criteria and qualifications for "evaluating physicians" who examine prospective participants in the Diversion Program; (4) the development of regulations providing guidelines for when the Program may order a participant to undergo a competency exam; and (5) ironically enough, whether the Diversion Program is sufficiently staffed. None of these issues has ever been resolved.

In our observation and based on our reviews of Diversion Program files, the case managers and the Program Administrator are so overloaded that all they are able to do is react to relapses. The case managers do not adequately monitor their caseloads — as evidenced by missing documentation described above that should be in participants' files but is not. CMs do not enter all required data in the DTS, nor do they forward all required materials to Sacramento. Neither the case managers nor the Program Administrator were aware of any of the problems we found with the urine collection system described above. The four Sacramento-based support staff cannot possibly keep up with their Program-related work responsibilities (including the calendaring and staffing of all DEC meetings all over the state) plus the work necessary to accommodate the needs of the Diversion Committee, the Liaison Committee, and the Division of Medical Quality.

Of particular importance, the Collection System Manager position is significantly understaffed. Although the *Diversion Program Manual* promises a dedicated CSM position responsible for the generation of random testing dates for all participants and the communication of that list to all collectors, GFs, and CMs, "oversight and coordination for the collection system process," and "the integrity of the collection system,"[461] the individual currently serving as the CSM is able to spend only about two hours per month on CSM duties. All the CSM is able to do is generate the list of dates and send it out. As described above, no one ensures that all active participants are included in the master collection schedule; all participants are scheduled for the required number of tests, per the Diversion Program "frequency of testing" policy; collections are actually completed on the random date assigned by the CSM; the same number of collections is completed as is scheduled for each participant; collected specimens are received at and processed by the laboratory; test results are correctly downloaded and appended to each participant's record in the DTS; and collectors submit a monthly report of all collections as required by Program policy.

Because of the Program's significant understaffing and the imposition of the hiring freeze, the Program Administrator admitted that she is hesitant to discipline or even warn case managers who do not adequately monitor their caseloads, enter information onto the DTS, and/or forward important documentation of Program requirements to Sacramento for filing in the participant's master file. Having looked at over 60 Diversion Program participant files (which is about one-fourth of the entire population of participants), the Monitor can state without hesitation that the Auditor General's 1982 criticism of Diversion Program recordkeeping — "records on each participant are scattered among three separate files"[462] — is still true in 2004. And that recordkeeping is essential

[461] Medical Board of California, *Diversion Program Manual* (undated), Ch. 5 at 3.

[462] *See* 1982 Auditor General Report, *supra* note 427, at 40.

to informed decisionmaking that must occur very quickly to protect the public in the event of relapse.[463]

The Diversion Program must be adequately staffed with persons of adequate qualifications. The Program Administrator should be supported by two administrative positions — one to supervise the case managers to ensure that programmatic policies and procedures are followed, and to assist the Administrator in making critical decisions regarding participation, treatment, and the practice of medicine by participants; and another to supervise the support staff and to ensure that the needs of CMs, GFs, DECs, the Diversion Committee, and DMQ are met. Case managers should have no more than 50 cases each; each case manager should be required to ensure that all participants comply with all requirements of their Diversion Program contracts, and that all required information is both entered onto the DTS and forwarded to headquarters for filing in participants' master files. The CSM function must be staffed on a full-time basis. The Program should have a sufficient number of support staff to accommodate the needs of the CMs, GFs, DECs, the Diversion Committee, and DMQ.

Having said that, the Monitor must emphasize that the mere addition of staff alone will not solve the Diversion Program's problems. As described above, the Program lacks significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. If those monitoring mechanisms fail (as they have), and if there are inadequate internal quality controls to detect that failure (as there are), both the physicians in the Diversion Program and the public whose safety is the "paramount" priority of the Medical Board are exposed to serious risk. It is abundantly clear that the Program has functioned without adequate internal controls for 24 years. These controls must be designed, installed, and adequately staffed.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held.

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[463] Our review of the records in Diversion Program participants' files revealed a number of other defects attributable to inadequate recordkeeping practices and/or the failure of Program staff to insist on compliance with Program policies. For example, we found numerous files in which Diversion Program agreements were inaccurate, incomplete, or unsigned by both the participant and the Program. We also found wide variability in the use of Diversion Agreement amendments. Diversion Agreements are frequently amended when the Program changes a participant's practice restrictions, frequency of required attendance at Diversion Program group or AA meetings, frequency of urine collections, etc. There was no consistency in the types of Agreement changes that were documented in formal "amendments" to the Agreement vs. a "note to the file." Additionally, it was quite unclear who was approving these changes — a DEC, the Program Administrator, or other Program staff. The end result of these deficiencies is confusion about which terms and conditions are in force at any particular point in time. Additionally, and as noted above, we found numerous errors and inconsistencies in the Program's DTS computerized database; some of these are due to human error, while others are due to the failure of CMs to consistently enter all data they are required to enter into the DTS. Finally, because the Program's files are so incomplete, the Quarterly Quality Review reports discussed at each quarterly meeting of the Diversion Committee contain errors and omissions which prevent the Committee from adequately supervising the performance of the Program.

Compounding the failure of its monitoring mechanisms and understaffing problems described above, the Diversion Program is plagued by an almost complete lack of hard-and-fast, enforceable rules, standards, or expectations to which participants are held. The Diversion Program's decisionmaking is characterized by an unacceptable "case-by-case basis" mentality which promotes inconsistent decisionmaking and serves the interests of neither the participants nor the public.

a. The Diversion Program's statutes and regulations are skeletal at best, and set forth few enforceable rules, standards, or expectations for either the Program or its participants. The Diversion Program's statute was enacted in 1980 and has been rarely amended since then; DMQ's regulations implementing that statute are — for the most part — nonsubstantive restatements of the statute. None of the monitoring mechanisms described above — not the urine testing, nor the requirement that case managers regularly and personally observe both the group facilitators and the participants, nor the requirement of group meeting attendance, nor the worksite monitor requirements, nor the treating psychotherapy reporting — are mentioned in, much less governed by, statute or regulation. All of these monitoring mechanisms are contained in an unenforceable "procedure manual" that has rarely if ever been scrutinized by DMQ — which is statutorily responsible for administration of the Program — or even the Diversion Committee.

b. The *Diversion Program Manual* — which is unenforceable — sets forth no clear rules and no mechanisms to ensure standardized and consistent decisionmaking about potentially dangerous physicians. As described above, Diversion Program decisionmaking is excessively fragmented. If and when a relapse occurs — a relapse into drug or alcohol use by a physician who is practicing medicine with a full and unrestricted license and who may see dozens of patients each day, that event (which is detected by the Program days or even weeks after the test) sets in motion a complex and time-consuming chain of communications between various Program personnel (the CM, GF, the DEC consultant assigned to the participant, and perhaps the entire DEC which may be polled by telephone) and the participant, the lab, the participant's worksite monitor and/or hospital monitor, and the hospital well-being committee. As described above, these contributors to the ultimate Program decision are hampered by "records on each participant . . . scattered among three separate files" — participant files maintained at headquarters which lack critical documentation, a Diversion Tracking System that is used inconsistently by case managers and fails to capture all relevant information, and documentation of Program requirements that is either on location with the case managers or does not exist at all because it has not been submitted.

These individuals have no clear standards to guide their decisionmaking — a dynamic which can lead to inconsistent decisionmaking. The "rules" that are set forth in the *Diversion Program Manual* and purport to govern day-to-day operational procedures have been developed by prior staff with little or no input from the Division of Medical Quality, the Diversion Committee, or any of the Committee's predecessor task forces. Several of those "rules" are in fact "underground regulations" that should be adopted as regulations pursuant to the Administrative Procedure Act.

Each DEC operates in a vacuum; no standards exist to guide their consideration of individual participant matters to ensure that their recommendations are fair, consistent, and protective of the public interest. No DEC knows how another DEC has acted in a similar matter. No caselaw, precedent, or standards exist anywhere to guide them. In fact, no minutes of DEC meetings are ever taken.[464] The minutes of Liaison Committee meetings indicate an occasional concern that the various DECs are treating similar substantive issues differently, or procedurally functioning differently from each other. Under current law, the Program Administrator (not the DEC) is supposed to make final decisions and is thus in a position to impose consistency on various DEC recommendations — but the Program Administrator rarely if ever overrules a DEC recommendation.[465]

c. There is no consistently applied and enforceable rule regarding consequences for relapse. The Diversion Program's statute sets forth no consequences for relapse; instead, it directs the Division of Medical Quality to "establish criteria for the . . . termination of physicians" from the Program.[466] In turn, the Division has adopted a regulation authorizing the Program Administrator to terminate a physician's participation "for any of the following reasons: (a) [t]he physician has failed to comply with the diversion agreement, including but not limited to, failure to comply with the prescribed monitoring or treatment regimen, use of alcohol or other unauthorized drug; or refusal to stop practice when directed to do so . . . ."[467] This regulation is close to meaningless in practice. Participants relapse every day and are not terminated. Participants routinely fail to comply with their Diversion Program agreements in all sorts of ways — both significant and insignificant — and are not terminated. Of most critical importance, however, is the Division's failure to address the consequences for relapse. As noted above, relapse is expected during recovery, and it may not be reasonable to fashion a "one-strike-you're-out" policy. However, the Diversion Program has unilaterally fashioned (without input from DMQ) a "three-strikes-and-you-may-be-out" policy which is unenforceable.[468] Further, this "rule" is not consistently applied. In our review of twenty recent

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[464] Counsel to the Board have advised the Program not to take or retain "minutes" of DEC meetings which might be subpoenaed. Instead, the Program Administrator and analyst take notes on each case, which notes are then destroyed after staff implements the directives recorded in those notes.

[465] Interview with Diversion Program Administrator (July 26, 2004). Program staff note that the Program Administrator attends every DEC meeting and is in a position to inform one DEC how another DEC has treated a similar case. This may be true, but — for purposes of consistent decisionmaking across DECs and over time — it assumes that the Program Administrator serves for a lengthy tenure and has perfect memory. The Diversion Program has had two Administrators and one Acting Administrator in the past four years.

[466] Bus. & Prof. Code § 2350(a).

[467] 16 CAL. CODE REGS. § 1357.5.

[468] As noted above, both Diversion Program manuals include a "rule" stating that "a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program." *See supra* text at note 416 and note 416. This is one example of arguable "underground rulemaking" contained in the Diversion Program's policy and procedure manuals.

relapse cases, we found at least six cases in which the participants had relapsed at least four times before even being considered for termination, including the following examples:

- A participant was referred to the Diversion Program during mid-1998 pursuant to an SOU. The participant was permitted to remain in the Diversion Program following three relapses during November 1998 (collection tested positive for cocaine), December 1999 (collection tested positive for cocaine and alcohol), and December 2000 (self-reported using alcohol after missing work and group meetings). The participant subsequently relapsed a fourth time during April 2003 (collection tested positive for methamphetamine) and concurrently quit providing specimens and attending group meetings. The participant was not formally terminated from the Program until more than two months after the fourth relapse was detected.

- A participant was ordered into the Diversion Program during November 2000 as a condition of probation. At that time, the participant had already been involved with the Diversion Program for nearly two years. The participant missed several urine tests during the evaluation phase and also was noncompliant with Program requirements for a 2.5-year period following acceptance into the program (for example, the participant provided only two urine specimens over a 24-month period due to an inability to pay associated fees, failed to submit quarterly therapist reports, failed to submit semi-annual reports, and was out of compliance with continuing education requirements). Notwithstanding these continuing compliance deficiencies, during April 2003 the participant was authorized to return to work on a part-time basis. Following this, the participant continued to be out of compliance with Program requirements. In November 2003, the participant tested positive for cocaine, but was allowed to continue participating in the Program. In February 2004, the participant tested positive for Vicodin. Three months later, during May 2004, the participant was terminated from the Diversion Program. In total, this participant was involved with the Diversion Program for nearly six years and, as best we can determine, never achieved monitored sobriety for a sustained period or otherwise complied with Program participation requirements.

- A participant was referred to the Diversion Program during June 2001 pursuant to an SOU. The participant was permitted to remain in the Diversion Program after four relapses during October 2001 (tested positive for alcohol), February/March 2003 (tested positive for alcohol on two different occasions), December 2003 (tested positive for alcohol), and March 2004 (tested positive for alcohol). The participant also missed a scheduled collection during June 2001, was unavailable to be monitored for an extended period of time during mid-2003 due to participation in an unauthorized activity, and submitted a diluted specimen during January 2004. The participant was terminated from the Diversion Program one month after the fourth relapse was detected. The stated basis for the termination was the participant's failure to begin recommended inpatient treatment, suggesting that the participant otherwise would have been permitted to continue in the Program.

■ A participant self-referred to the Diversion Program during November 2002. The participant relapsed during August/September 2003 (tested positive for Meperidine and Fentanyl), ceased taking Naltrexone without notifying the case manager, overmedicated a patient, was observed carrying unnecessary medications on his cart, missed urine collections and, after mid-October 2003, stopped attending group meetings. The participant was not formally terminated until early January 2004 (more than three months after he had stopped complying with Program requirements).

In 1982, the Auditor General detailed six cases in which participants egregiously violated the terms of their Diversion contracts but were not terminated from the Program; according to the Auditor General, "[t]hese deficiencies result from a lack of established standards and guidelines for terminating participants. In particular, the Board has not clarified the requirement that a physician be terminated from the program when that physician is deemed too great a risk to public health, safety, or welfare, especially when the physician is either under the influence of alcohol or drugs or mentally or physically disabled while caring for patients."[469] In 1985, the Auditor General detailed three matters where the participant repeatedly violated significant terms and conditions of the contract and should have been suspended from the practice of medicine and/or terminated from the Program but was not; the Auditor General concluded that the Medical Board must "[s]pecify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination," and "develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly."[470]

Over 20 years later, DMQ has still failed to establish meaningful and enforceable standards for the handling of relapse by Diversion Program participants and for termination from the Program — apparently preferring to delegate to DECs and the Program Administrator a "case-by-case" approach. The Monitor appreciates the difficulty of fashioning a "one-size-fits-all" rule regarding relapse, but it seems patently unfair to both physicians and consumers that chronic relapsers who repeatedly and egregiously violate the terms of their Diversion contracts remain in the Program while other physicians genuinely seeking help are denied admission because of resource constraints and the Program's unwillingness to terminate the chronic relapsers.

d. The Diversion Program's statutes permit repeat offenders "too many bites of the apple." Related to the concern expressed above about DMQ's failure to establish meaningful standards for relapse and termination from the Program is another dynamic that we found in our review of Diversion Program files — and that remains unaddressed by statute, regulation, or policy. This dynamic involves a participant's repeated entry into, withdrawal or termination from, and

[469] *See* 1982 Auditor General Report, *supra* note 427, at 43.

[470] *See* 1985 Auditor General Report, *supra* note 428, at 22–32.

reentry back into the Diversion Program. This "too many bites of the apple" syndrome works as follows:

Bite #1: A physician self-refers into the Diversion Program, then withdraws or is terminated for noncompliance. The Program can do nothing unless a DEC makes a finding that the physician constitutes a "threat to the public health or safety" under section 2350(j)(3).

Bite #2: MBC receives a complaint, a DUI arrest or conviction, or section 805 report against that same physician. Enforcement investigates the matter and diverts the physician into the Diversion Program under a statement of understanding (SOU) under section 2350(b). The physician is again in the Diversion Program; this time, his participation is known to enforcement but it is still concealed from the public because SOUs are not disclosed on MBC's Web site or in any other way. The physician withdraws or is terminated from noncompliance. This time, there is no "threat" assessment because the physician is in Diversion under an SOU, so he is referred to enforcement.

Bite #3: This time, enforcement likely files an accusation, which fact is disclosed on MBC's Web site. The physician stipulates to probation, including required participation in the Diversion Program. That term of probation is not included on MBC's Web site because of CAS limitations (see Chapters V and XIII). The physician withdraws or is terminated for noncompliance.

Bite #4: HQE files a petition to revoke probation (and possibly a petition for ISO if HQE can prove the physician is currently using drugs or alcohol). After hearing, the ALJ recommends revocation of the license. DMQ revokes, stays the revocation, and places him on probation — one term of which is (again) required participation in Diversion. The physician withdraws or is terminated for noncompliance.

Bite #5: This "bite" will be a repeat of Bite #4 unless DMQ finally revokes the license or the DEC and the Program Administrator refuses to admit him into the Diversion Program (both events are somewhat rare).

This is not a hypothetical issue. We have found a number of cases in which chronic relapsers who repeatedly enter and are repeatedly terminated from the Program are repeatedly readmitted to the Program. Two examples are illustrative:

- While undergoing inpatient substance abuse treatment in 1997, 1998, and 1999, a physician was ordered by the Board to participate in Diversion in July 1998; the physician was unsuccessfully terminated in June 1999. In September 1999, HQE filed an accusation and a petition

for ISO after the physician collapsed on duty as a result of abuse of Vicodin, Demerol, and Xanax. A partial ISO imposing therapy and practice restrictions (not a suspension) was granted on September 19, 1999. Following the filing of a supplemental accusation in November 2000, DMQ placed the physician's license on probation and ordered the physician to return to Diversion. In February 2002, a DEC denied admission to Diversion because of noncompliance during the evaluation phase; Probation was not notified of the DEC's decision, and assumed the physician was in the Diversion Program. In July 2003, HQE filed a petition to revoke probation (because the physician was not in Diversion), and the physician reapplied for admission to Diversion. This time, the DEC accepted the physician's application and admitted the physician into the Program. HQE's petition to revoke probation is pending.

■ After undergoing inpatient treatment in 1997, 1998, and 1999, this physician was unsuccessfully terminated from the Diversion Program in April 2000. As the result of a complaint to enforcement, the physician was referred back into Diversion under an SOU in July 2000. The physician resumed practice without authorization and, in December 2000, the physician's application for admission into Diversion was denied. During September 2001, the participant was ordered into Diversion under the terms of a DMQ-approved stipulation. Although the physician relapsed on alcohol on July 17, 2003, the Program permitted the physician to continue practicing medicine. On July 28, 2003, the physician tested positive for Demerol, and was terminated from Diversion on August 8, 2003.

Nothing in the Diversion Program's statutes, regulations, or policy manual addresses this issue or prevents this waste of the Program's limited resources. In light of the Program's budget constraints, understaffing, and the significant absence of internal controls described above, it is unfair to subject the public to a repeat offender who is able to manipulate the system and remain licensed. That physician's space in the Diversion Program would be better used by someone more committed to recovery.

DMQ must shoulder its statutory duty and establish clear standards for several aspects of the Program. It is fair to say that DMQ has never meaningfully implemented the Legislature's directive to "establish criteria for the acceptance, denial, or termination of physicians" from the Diversion Program.[471] The Division has adopted some regulations, but they are merely restatements of the statute and/or commonsense, circular, and fairly nonsubstantive prescriptions.[472] The Division has never meaningfully implemented the Legislature's directive to "establish criteria for the selection

[471] Bus. & Prof. Code § 2350(a).

[472] For example, a physician can be terminated from Diversion under section 1357.5, Title 16 of the California Code of Regulations, if he has done anything to warrant denial of his application for admission under section 1357.4, Title 16 of the California Code of Regulations.

of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion . . . ."[473] This leads the Monitor to the next major concern.

3. Contrary to statute, the Division of Medical Quality has never taken "ownership" of or responsibility for the Diversion Program.

As noted above, state law requires DMQ to administer the Diversion Program and oversee its functioning.[474] MBC's Diversion Program is one of only four in the nation to be housed directly within a state medical board — subject to its direct supervision and oversight. One must assume that the purpose of this in-house structure is to enable members of the Medical Board to affirmatively oversee the Diversion Program to ensure that the public is protected from impaired physicians. However, this has not happened. Instead, in 1982, the Division of Medical Quality effectively delegated its authority over the Diversion Program to the Liaison Committee — which has no statutory existence or authority — and to the staff of the Diversion Program, which in the past has interpreted Liaison Committee directives and recommendations as orders, and has implemented them without DMQ or Diversion Committee review.[475]

The Auditor General reports of the 1980s universally found that the Division has failed to adequately supervise and oversee the Diversion Program.[476] The 1985 report could not be more

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[473] Bus. & Prof. Code § 2350(h). *See supra* note 398. Instead, the Division punted this duty to the Liaison Committee, which presented some draft criteria to the Diversion Committee at its February 2001 meeting. The Chair of the Diversion Committee strongly objected to some of the exceptions to the requirements, and sent the criteria back to LCD for more work. The LCD did not come back with an amended version until the Committee's January 2002 meeting, when legal counsel objected to them and LCD withdrew them for "further work." These criteria have never again appeared on any agenda of the Diversion Committee or the Division of Medical Quality.

[474] Bus. & Prof. Code § 2346.

[475] In 1999 documents, the Liaison Committee noted that it had engaged in numerous activities and made many recommendations regarding the functioning of the Diversion Program over the prior five years. These activities include a report and recommendation on the Program's urine testing program (Oct.16, 1998); a recommendation on elements which should be included in the clinical evaluations of physicians applying for or participating in the Program (Feb. 25, 1998); a report specifying the role and responsibilities of the DEC member who is serving as a case consultant, plus two measures for identifying whether a case consultant is carrying out the intended function (Aug. 21, 1996); and the adoption of a policy in 1994 requiring group facilitators to maintain a current file on each participant. Liaison Committee to the Medical Board's Diversion Program, *Testimony before the Medical Board's Diversion Task Force* (Jan. 20, 1999) (on file at CPIL); *see also* Liaison Committee to the Medical Board's Diversion Program, *Agenda Packet for May 27, 1998 Meeting* (Agenda Item V.F. regarding Facilitator Records) (on file at CPIL). None of these recommendations were ever discussed, reviewed, or ratified by DMQ at any public meeting.

[476] *See* 1982 Auditor General Report, *supra* note 427, at 36 ("the board has not established policies governing frequency of contact with participants"), 40 ("the board has not established policies for approving and monitoring supervised, structured environments for Diversion Program participants"), 43 (the board has failed to establish "standards and guidelines for terminating participants"). *See also* 1986 Auditor General Report, supra note 430, at 21 ("[t]he Board of Medical Quality Assurance has improved some elements of its diversion program for physicians; however, further improvement is needed. . . . [T]he board still does not routinely monitor physicians in the diversion program

clear: "The diversion program of the Board of Medical Quality Assurance does not protect the public while it rehabilitates physicians who suffer from alcoholism or drug abuse. . . . The medical board has allowed these problems to develop because it has not adequately supervised the diversion program."[477]

As described above, DMQ made an effort beginning in 1998 to reclaim its jurisdiction over the Diversion Program, and in 2000 established a standing Committee on the Diversion Program to meet quarterly to discuss Diversion-related issues. The Committee has done its best to fashion procedures to enable it to oversee the Program, including its review of "Quarterly Quality Review" reports on the Program's responses to intakes, relapses, and releases. However, the Committee remains at the mercy of staff in terms of the information that it receives — and at no time has staff apprized the Committee of any of the serious issues described above by the Monitor. The Committee has attempted to address a number of major issues, including the criteria for "evaluating physicians" (described above), the issue of "postgraduate tracking" of Diversion Program participants to determine the effectiveness of the Program (described below), and an important issue that has been raised at nearly every Committee meeting in the past four years but never addressed — what to do about self-referred physicians who clearly have serious addiction problems but are "not interested" and walk away. These issues — raised again and again, and referred to staff or the LCD for discussion — remained unresolved due to the volunteer nature of LCD, its infrequent meeting schedule and unclear agenda, and the Diversion Program's lack of staff.

The governance of the Diversion Program must be transformed into an accountable structure with a sufficient number of staff who are able and willing to implement DMQ's instructions, with monitoring mechanisms that provide DMQ with an ability to meaningfully oversee both staff and participant compliance with policies and procedures (preferably statutes and regulations) that it has approved and the Program's response to specific cases. If this structure is not possible, or if DMQ is unwilling to fully design and participate in it, then the Diversion Program should be abolished and the licenses of impaired physicians should be suspended until they prove that they are capable of safe medical practice.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC management.

As described in Chapter V above, the management of the Diversion Program is not well-integrated into overall MBC management. For many years, the Medical Board — both the Board

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adequately").

[477] *See* 1985 Auditor General Report, *supra* note 428, at 29.

and its staff — has permitted Diversion to effectively function in a vacuum. Considering the current confidentiality under which the Diversion Program operates, it is not unreasonable that the identities of self-referred Diversion Program participants be concealed from the enforcement program and from MBC management. However, the entire operation of the Diversion Program has been walled off from the rest of MBC management. This separation has resulted in breakdowns in key Diversion Program monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which have not been communicated to MBC management so that management might address it. The Monitor has found several examples that illustrate this failure:

■ Our interviews with Diversion Program staff revealed that another "monitoring mechanism" utilized by the Diversion Program is the confiscation of drug prescribing permits issued by the U.S. Drug Enforcement Administration (DEA); these permits enable physicians to prescribe controlled substances. Program staff told us that when a Diversion Program participant is addicted to a controlled substance, the Program confiscates his DEA permit to preclude self-prescription of that drug; the physician turns the permit over to Diversion, which files it in a special file. Our review of twenty recent intakes revealed that three physicians had been required to turn their DEA permits over to Diversion; however, none of those permits were in the special file.

This is irrelevant, however, because the mere confiscation of a DEA permit does not prevent a physician from prescribing controlled substances. DEA permits are good for three years. Pharmacists continue to dispense controlled substances on the prescription of a DEA-permitted physician until the three-year term expires or until DEA revokes or restricts the permit and communicates that fact to pharmacies. Internet prescribing sites continue to dispense upon the physician's entry of a DEA permit number (for which the actual permit is unnecessary). And physicians may continue to order controlled substances in bulk directly from drug wholesalers. DEA issues the permit, and only DEA can revoke or restrict the permit. Unless DEA takes action against the prescriber's privileges, the physician can and will continue to self-prescribe controlled substances, purchase them on the Internet, or purchase them in bulk from drug wholesalers.

When MBC's enforcement program takes disciplinary action against a physician and, as one term of probation, restricts the physician's prescribing privileges, enforcement requires the physician to surrender the DEA permit *to DEA*, and to provide proof to MBC that DEA has accepted the surrender and cancelled or restricted the physician's prescribing privileges. However, the Diversion Program merely confiscates — or purports to confiscate — the DEA permit. That practice is inconsistent with MBC's *Disciplinary Guidelines* and its *Probation Operations Manual*; is probably unlawful in that it infringes on the authority of DEA and (in the absence of a Medical Board disciplinary order) only DEA can revoke or restrict DEA prescribing privileges; and is ineffective in preventing the physician from self-prescribing or purchasing controlled substances. However, the

Diversion Program does not know this because the Diversion Program is not sufficiently integrated into enforcement management or overall MBC management. This is unacceptable. For many Diversion participants, Diversion is a Board-ordered alternative to discipline. Diversion Program management should be well-versed in MBC's disciplinary program and procedures.

■ The *Diversion Program Manual* requires case managers to periodically check the enforcement program's CAS database for new complaints against Diversion Program participants.[478] However, the case managers have no access to CAS. Nor do they have access to the Department of Justice's CURES database to assess whether Program participants are prescribing medications in violation of their Diversion Agreements. The case managers are not investigators, the Program lacks investigative assistance, and sometimes the Program needs investigative assistance. This assistance is neither requested nor forthcoming because of the "firewall" between enforcement and the Diversion Program.

■ The Diversion Program has allowed its *Diversion Program Manual* to become almost completely obsolete. Most of its pages are dated in 1998. It fails to incorporate changes in Diversion Program statutes made by SB 2239 (Committee on Business and Professions) (Chapter 878, Statutes of 1998),[479] SB 1554 (Committee on Business and Professions) (Chapter 836, Statutes

[478] Medical Board of California, *Diversion Program Policy, Guidelines, and Procedures* (undated) ("Protocol for Checking the CAS System for Current Diversion Participants").

[479] SB 2239, which the *Manual* refers to as "pending" (page 9) amended section 2350 to require physicians participating in the Diversion Program to sign an agreement that Diversion Program records may be used in disciplinary or criminal proceedings if the participating is terminated from the Program and one of the following conditions exist: (1) his/her participation in the program is a condition of probation; (2) he/she has disciplinary action pending or was under investigation at the time of entering the Program; or (3) a DEC determines that he/she presents a threat to the public health or safety. The agreement must also authorize the Diversion Program to exchange information about the participant's recovery with a hospital well-being committee or monitor and with MBC's licensing program, where appropriate, and to acknowledge, with the participant's approval, that he/she is participating in the Diversion Program. SB 2239 also amended section 2355 to clarify that, if a Diversion Program participant successfully completes the Program, the Program will purge and destroy all treatment records pertaining to the physician's participation; however, the Program may retain any other information and records that it specifies by regulation. Although the Diversion Program has not amended its procedure manual to reflect the changes made by SB 2239, it has incorporated SB 2239's requirements into its standard participant agreement.

of 2000),[480] and SB 1950 (Figueroa) (Chapter 1085, Statutes of 2002).[481] As noted in Chapter V, the Diversion Program's manual is not alone in being out-of-date; however, it is the worst offender. Clearly, the Diversion Program has not been required — as have other MBC units — to regularly revise and update its policy and procedure manual. This is a critical management function that must be recognized, resourced, and regularly performed.

5. The Program's claim of a "74% success rate" is misleading.

The Diversion Program periodically calculates the total number of admissions into the Program, the total number of "successful completions," and the total number of "unsuccessful terminations." Based on this calculation, the Program advertises a "success rate." For example, in its March 2000 brochure, the Program announced that "[f]rom the inception of the Diversion Program in 1980 to March 1, 2000, there have been 981 participants. Six hundred sixty-three (663) of these have completed the program successfully. After factoring out physicians who did not complete for reasons unrelated to their disorders, this results in a 74 percent success rate."

This is misleading. While it appears to convey effectiveness in assisting participants to recover from substance abuse, it means only that 663 physicians completed the program and were "successfully terminated." The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Program has no idea whether it is successful in rehabilitating physicians over the long term. In fact, of the twenty recent intake cases we reviewed, three had previously "successfully completed" the Diversion Program. At the very least, Diversion

[480] SB 1554, an outgrowth of the work of the 1998 Diversion Task Force, amended numerous sections of the Diversion Program's statutes to clarify that DECs act in an advisory capacity only to the Diversion Program Manager. Significantly, the manual has not been updated to reflect the law's clarification that DECs act in an advisory capacity only. In Chapter 1 alone, there are 11 references to the DECs' "decisions" or "determinations." SB 1554 also amended section 2350(g) to extend the minimum period of time a physician must remain free from the use of drugs/alcohol from two to three years in order to successfully complete the Diversion Program; repealed a requirement that DECs hold public meetings twice a year (with which the DECs were noncompliant) and instead requires them to provide specified information to the Board; and requires the Board to hold a public meeting at least annually for the purposes of reviewing the data provided by the DECs.

[481] SB 1950 amended section § 2350(b) to permit mentally ill physicians to be "diverted" into the Diversion Program; added section 2350(g)(2) to establish criteria for successful completion of the Diversion Program by mentally ill physicians; amended section 2350(h) to require DMQ to establish criteria for selecting "evaluating physicians or psychologists" who evaluate prospective Diversion Program participants upon application to the Program; and added a new paragraph to section 2350(j)(3) that allows the Diversion Program, upon recommendation by a DEC, to order a participant to undergo a clinical competency exam. Failure of the participant to comply with this order is grounds for license suspension/revocation. The amendment also requires "the board" to "develop regulations that provide guidelines for determining when this examination should be ordered." The Diversion Committee and Liaison Committee are in the process of drafting these regulations.

Program claims should contain careful explanations of terms like "success" to avoid misleading the public.

The Monitor has occasionally heard Program staff and supporters make statements to the effect that "no patient has ever been injured by a physician in the Diversion Program." This is similarly misleading. Injury to patients is not a type of information that the Program captures or publicizes. As demonstrated above, the Program does not even know whether its participants are being drug-tested as frequently as its own policies require, or whether they have adequate worksite supervision, or whether their treating psychotherapists are properly reporting on their patients' progress. As described above, at least one participant almost died due to the failure of the Program's urine testing program. Published news articles prove that injury to patients — if it has not already occurred — is a tragedy waiting to happen.[482] The Program should be less concerned with "spin" about its effectiveness and more concerned about real-time monitoring of impaired physicians to protect the public.

H. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #56: Based on the information contained in this and prior reports on the Diversion Program, the Medical Board must reevaluate whether the "diversion" concept is feasible, possible, and protective of the public interest. The Medical Board's paramount priority is public protection. It is unclear why a board charged with public protection as its paramount priority would permit physicians who are addicted to drugs or alcohol to practice medicine before they have recovered from that addiction. If such a board believes that impaired but recovering physicians should be permitted to practice medicine while they are in recovery and susceptible to relapse, that board must insist on comprehensive monitoring mechanisms which are demonstrably effective in detecting both relapse and pre-relapse behaviors, to protect both the participant and the public at large. According to the clear findings in three Auditor General reports and this report, this Board's Diversion Program has never consistently — if ever — had those monitoring mechanisms in place in all cases and at all times, thus exposing the public to unacceptable risk in violation of Business and Professions Code sections 2001.1, 2229, and 2340. The Medical Board must determine whether it is possible to develop, resource, and ensure the effective monitoring mechanisms demanded by state law, or whether the public interest demands that the licenses of impaired physicians be suspended during periods of impairment.

Recommendation #57: If the Board determines that it is possible to implement the "diversion" concept consistent with the public interest (which is presently demanded by

[482] *See, e.g.*, David Washburn and David Hasemyer, *Substance Abuse Program Criticized as Full of Loopholes*, S.D. UNION-TRIB., Mar. 11, 2002.

sections 2001.1, 2229, and 2340), the Board must then determine whether to house that diversion program within the Medical Board or contract it out to a private entity. This Board has evaluated that question on several occasions (most recently during its 2002 strategic planning session), and has determined to preserve the Program within the Medical Board. However, the Board did not have access to the findings in this report at that time. Nor did it have full and objective information on the alternative structures currently used by other California regulatory agencies — because it has insufficient staff to research that question and present that information to the Board. The Board must undertake an informed and objective study of all other models used by other state medical boards and other California agencies with diversion programs.[483]

Presumably, the current location of the Diversion Program within the Medical Board was intended to enable the Board — and specifically, its Division of Medical Quality — to comprehensively oversee and supervise the functioning of the Program. As demonstrated above, that goal has not been realized thus far. Undeniably, the location of the Diversion Program within the Medical Board may discourage some physicians from self-referring into Diversion because they are afraid of possible referral to enforcement if they fail. The location of the Diversion Program within the Medical Board may be deterring physicians who would otherwise seek help from seeking help — the antithesis of the purpose of the Program. On the other hand, contracting out the administration of the Program would give the Board less access to and control over the precise details of its operations. This is a decision that the Board must make — fully informed by the findings in this report, the reports of the Auditor General, and a complete study of the diversion program models used by other state medical boards and other California agencies.

Recommendation #58: If the Medical Board decides that "diversion" is feasible and that administration of the Diversion Program should remain within the Medical Board, the Division of Medical Quality must spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that limit the Program's effectiveness both in terms of assisting participant recovery and in terms of protecting the public. This overhaul must include an influx of staff resources (including — at the very least — the addition of a manager to supervise the case managers, a sufficient number of case managers so their caseloads never exceed 50 cases, and a full-time Collection System Manager whose entire job is devoted to ensuring the integrity of the Program's urine collection system) and the installation and staffing of internal quality

[483] For example, the Board of Pharmacy — in addition to contracting out the administration of its diversion program — does not use regional DECs to make recommendations on individual cases. Information on applicants and participants who have relapsed is forwarded to one single "Pharmacy Review Committee" consisting of a manager from the private company which administers the Board's Diversion Program, a supervising inspector, and the Board's Diversion Program Manager. That one committee makes all decisions, rather than farming them out to five different regional DECs which meet only quarterly. Throughout this chapter, the Monitor has identified other mechanisms utilized by other state medical boards and their Diversion Programs of which this Board should take note. Those mechanisms have never been studied or debated by DMQ or the Diversion Committee.

controls to assure the Division, Program participants, and the public that the Program's monitoring mechanisms are effective in detecting relapse into drug/alcohol use. The restructuring must also include the long-overdue adoption by DMQ of meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse (see Recommendation #62 below). If the Division adopts clear standards applicable to relapse and termination from the Program, it may be that significant staffing additions are unnecessary because noncompliant participants will be terminated from the Program more quickly.

Recommendation #59: The Division of Medical Quality must reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it is currently structured. Consistent with its comprehensive restructuring of the Diversion Program in Recommendation #58 above, the Division must determine whether there is a need for external clinical expertise and — if so — convert the Liaison Committee into a workable advisory panel that serves the needs of DMQ as determined by DMQ. The LCD has evolved into an unwieldy 19-member committee whose members have not been chosen by DMQ, whose purpose is unclear, and whose output is modest and excessively delayed. Over the years, the Liaison Committee has taken, or has been delegated, responsibility for addressing important issues which have not been promptly (or ever) resolved. The skills, expertise, and time of Liaison Committee members could be better directed to a different function as determined by the Division of Medical Quality.

Recommendation #60: The Division of Medical Quality must determine whether Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Diversion Program. This report has outlined the staffing constraints that currently plague the Diversion Program, and the impacts of those staffing constraints on its ability to monitor participants and protect the public. Even the Program has recognized that it cannot simply keep accepting more participants. DMQ must decide how the Program is to be structured and funded. If Program participation must be capped, the Division must further consider who should have priority — Board-ordered participants, Board-referred participants who enter under a statement of understanding with the enforcement program, or self-referred physicians.

Recommendation #61: Regardless of whether Diversion Program participation is deemed an entitlement or is capped to accommodate staffing and protect the public, the Diversion Program's budget should be earmarked and separated from other MBC program budgets. The Diversion Program should be funded by a specified and identifiable portion of MBC license fees paid by all California physicians, and by participation fees paid by participants (as is done at the Dental Board, the Pharmacy Board, and the Board of Registered Nursing). The Monitor believes that all Program participants who can afford to pay participation fees — including all participants who are practicing medicine — should pay them. In particular, the Monitor agrees with

the Auditor General's 1995 recommendation that physicians who are ordered to participate in the Diversion Program as a term of probation should pay their proportionate share of the overhead costs of the Program — as do MBC probationers who are currently required to pay $2,800 per year for their probation monitoring costs. Indigent physicians who are so impaired that they are unable to work should not have to pay participation fees. In 32 states, physician diversion programs are funded by a combination of physician license fees, monthly participation fees paid by participants, and contributions from the state medical society. Other states require contributions from malpractice carriers and hospitals as well. DMQ should research and evaluate the feasibility of supplementing the budget of its Diversion Program through these sources.

Recommendation #62: DMQ must establish enforceable standards and consistent expectations of participants and Diversion Program staff through legislation or the rulemaking process, oversee a comprehensive revision of the Diversion Program's policy manual, and ensure that Diversion Program management is integrated into overall MBC management. The Monitor recommends that DMQ consider enforceable standards in a number of areas:

- First, to address the repeated "bites of the apple" problem and prevent chronic relapsers from consuming Program resources, DMQ should consider adopting a "deferred entry of judgment" mechanism similar to that in Penal Code 1000. Under that type of mechanism, an applicant for admission to Diversion would sign an agreement in which he admits to a violation of section 2239 (self-abuse of drugs or alcohol) and stipulates to the revocation of his license. That judgment would be "deferred" during participation in the Diversion Program. If the participant successfully completes the Program, that admission would be destroyed. If the participant is unsuccessfully terminated, that admission could be used against him in subsequent disciplinary proceedings. Pennsylvania uses this type of mechanism.[484]

- Alternatively, the Division should consider banning Diversion Program participation to anyone who was previously a participant in the Program pursuant to an SOU, a stipulation, or Board-ordered probation within a specified number of years and who failed to successfully complete the Program.

- In adopting criteria for termination from the Program, the Division should consider adopting in regulation the Program's current "three-strikes-and-you-may-be-out" policy (which is arguably underground rulemaking). If such a policy is adopted, the participant could be referred to the DEC for consideration of termination or, if the Division believes faster action is necessary to protect the public, it could delegate the decision to the Program Administrator without DEC consideration.

[484] 63 P.S. § 422.4(c).

■ The Monitor also recommends that the Division consider a required (or at least presumed) "cease practice" period at the commencement of Program participation to enable a full-scale interdisciplinary evaluation of the extent of the physician's addiction, afford time for necessary treatment, and encourage the physician to focus on recovery. New York requires a physician participant to temporarily surrender his/her license upon entry into its diversion program.[485] Similarly, the California Board of Registered Nursing requires a cease practice period at the beginning of participation in its Diversion Program; DEC approval is required before the nurse may return to work.

Additionally, DMQ must ensure that the *Diversion Program Manual* is completely rewritten to incorporate the impact of all relevant statutory and regulatory changes. And MBC management must effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management, to ensure that Diversion staff are knowledgeable of enforcement procedures which impact its Board-ordered participants.

Recommendation #63: DMQ should explore various methods of assessing the long-term effectiveness of the Diversion Program in assisting physicians in recovering from substance abuse. Such an assessment would provide invaluable information and enable informed decisionmaking to guide future Diversion Program structure and operations.

Recommendation #64: The Medical Board should continue its efforts to replace and upgrade the Diversion Tracking System. As discussed in Chapter V.A., Program staff believe the DTS is obsolete even though it is only three years old. The Monitor found numerous errors and gaps in the DTS which were unknown to Program staff, mostly stemming from the lab's download of incorrect urine testing information and DTS' failure to post lab test information to the correct participant's file.

Recommendation #65: The Medical Board's Diversion Program should undergo a full performance audit by the Bureau of State Audits every five years. Under no circumstances should 18 years pass between external performance audits of this critically important program which is permitted to operate in secrecy.

[485] N.Y. PUB. HEALTH LAW § 230(13)(a).

Chapter XVI

ISSUES FOR FINAL REPORT

The Monitor's final report is due on November 1, 2005. During 2005, the Monitor will continue to evaluate the components of the Medical Board's enforcement program that were highlighted in this Initial Report, compile and analyze MBC's 2004–05 enforcement data, and evaluate the impact of changes made by the Board as suggested by the Monitor. Also during 2005, the Monitor will present the findings and recommendations in this Initial Report to the Joint Committee on Boards, Commissions and Consumer Protection at the Board's sunset review proceeding, draft and advocate 2005 legislation to implement Monitor recommendations that require legislative approval, and study several components of the Board's enforcement program that we were not able to cover in depth this year. Those components include:

- MBC's Citation and Fine Unit;

- the Medical Quality Hearing Panel of the Office of Administrative Hearings (see Chapter X above for a list of issues the Monitor expects to explore);

- the Board's Probation Unit, which is intended to ensure that physicians whose licenses have been placed on probation are adhering to all terms and conditions of probation; and

- the Physician Assessment and Clinical Education (PACE) program at the University of California at San Diego School of Medicine, an assessment and skills remediation program in which many physicians disciplined by MBC are required to participate.

Additionally, time permitting, we may explore other enforcement-related issues during 2005, including the following:

- the extent to which continuing medical education ensures continuing competency throughout the career of a physician or whether physicians should have to periodically demonstrate continuing competency in some affirmative fashion, as is required of doctors of podiatric medicine under Business and Professions Code section 2496;

- the Medical Board's competency examination statutes; and

- the quality of service provided by MBC's enforcement program to other agencies that utilize it (for example, the Board of Podiatric Medicine and the Physician Assistant Committee), and MBC's overall interaction and cooperation with other agencies charged with enforcing laws and regulations related to physicians (for example, the Department of Managed Health Care, the Department of Health Services, and the Board of Pharmacy).

Chapter XVII

CONCLUSION

As mandated by Business and Professions Code section 2220.1, this Initial Report has presented a critical analysis of the enforcement and diversion programs of the Medical Board of California for the purpose of improving those programs, and has offered 65 initial recommendations for improvement. There is much to be done to improve these important systems, and the Monitor stands ready to assist in that process.

To be effective, a report such as this must focus for the most part on the shortcomings in the system under scrutiny. However, the Monitor also notes that there is much that is good at the Medical Board of California and the Health Quality Enforcement Section of the Attorney General's Office, and that the Monitor has consistently encountered a spirit of cooperation and a commitment to progress among the public servants who undertake this important duty.

In particular, the Monitor has found:

■ **A dedicated and hardworking MBC staff** who have diligently maintained their mission in the face of substantial resource reductions;

■ **An equally dedicated and skilled staff of attorneys** in the Health Quality Enforcement Section, who have also labored to do more with less;

■ **New Executive Director David Thornton**, who brings in-depth knowledge of enforcement processes and impressive experience and management skill to this post, and who is rapidly responding to the organizational problems facing MBC, including many of those described in this Initial Report;

■ **Experienced senior managers with extensive system knowledge** and a highly constructive attitude toward institutional change and improvement;

■ **A conscientious and public-spirited Board** with outstanding professional credentials and demonstrated commitment to public protection; and

■ **A substantial volume of good disciplinary work done every day** by these dedicated public servants.

MBC, HQE, and associated organizations must continue to address substantial concerns to better meet their statutory obligation to protect the California public. If given adequate resources and an improved structure and process, MBC and HQE should be expected and required to achieve significant improvements in:

■ **Prompt and efficient handling of complaints and reports of physician misconduct** by a well-trained staff utilizing consistent criteria and procedures;

■ **Timely and effective enforcement action,** facilitated by close coordination and teamwork, and appropriately tailored to the circumstances of each case;

■ **Educating and communicating with the medical community and the public** these agencies serve; and

■ **An effective Diversion Program** that demonstrably protects the public while monitoring and assisting troubled physicians.

To help promote and document such improvements, the MBC Enforcement Monitor will continue to work closely for the statutory term with the Legislature, the Department of Consumer Affairs, MBC and HQE and their respective managements and staffs, the medical community, and the public whose protection is the agency's central mandate.

APPENDICES

APPENDIX A

Business and Professions Code § 2220.1

as amended by SB 136 (Figueroa) (Chapter 909, Statutes of 2004)

(a) (1) The [Department of Consumer Affairs] director shall appoint a Medical Board of California Enforcement Program Monitor prior to March 31, 2003. The director may retain a person for this position by a personal services contract, the Legislature finding, pursuant to Section 19130 of the Government Code, that this is a new state function.

(2) The director shall supervise the enforcement program monitor and may terminate or dismiss him or her from this position.

(b) The director shall advertise the availability of this position. The requirements for this position include experience in conducting investigations and familiarity with state laws, rules, and procedures pertaining to the board and with relevant administrative procedures.

(c) (1) The enforcement program monitor shall monitor and evaluate the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system.

(2) This monitoring duty shall be performed on a continuing basis for a period not exceeding two years from the date of the enforcement program monitor's appointment and shall include, but not be limited to, improving the quality and consistency of complaint processing and investigation, reducing the timeframes for completing complaint processing and investigation, reducing any complaint backlog, assessing the relative value to the board of various sources of complaints or information available to the board about licensees in identifying licensees who practice substandard care causing serious patient harm, assuring consistency in the application of sanctions or discipline imposed on licensees, and shall include the following areas: the accurate and consistent implementation of the laws and rules affecting discipline, appropriate application of investigation and prosecution priorities, particularly with respect to priority cases, as defined in Section 2220.05, board and Attorney General staff, defense bar, licensee, and patients' concerns regarding disciplinary matters or procedures, and the board's cooperation with other governmental entities charged with enforcing related laws and regulations regarding physicians and surgeons. The enforcement program monitor shall also evaluate the method used by investigators in the regional offices for selecting experts to review cases to determine if the experts are selected on an impartial basis and to recommend methods of improving the selection process. The enforcement program monitor shall also evaluate the effectiveness and efficiency of the board's diversion

program and make recommendations regarding the continuation of the program and any changes or reforms required to assure that physicians and surgeons participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired due to alcohol or drug abuse or mental or physical illness.

(3) The enforcement program monitor shall exercise no authority over the board's discipline operations or staff; however, the board and its staff shall cooperate with him or her, and the board shall provide data, information, and case files as requested by the enforcement program monitor to perform all of his or her duties. The provision of confidential data, information, and case files by the board to the enforcement program monitor at any time after the appointment of the monitor shall not constitute a waiver of any exemption from disclosure or discovery or of any confidentiality protection or privilege otherwise provided by law that is applicable to the data, information, or case files.

(4) The director shall assist the enforcement program monitor in the performance of his or her duties, and the enforcement program monitor shall have the same investigative authority as the director.

(d) The enforcement program monitor shall submit an initial written report of his or her findings and conclusions to the board, the department, and the Legislature no later than November 1, 2004, and be available to make oral reports if requested to do so. The initial report shall include an analysis of the sources of information that resulted in each disciplinary action imposed since January 1, 2003, involving priority cases, as defined in Section 2220.05. The enforcement program monitor may also provide additional information to either the department or the Legislature at his or her discretion or at the request of either the department or the Legislature. The enforcement program monitor shall make his or her reports available to the public or the media. The enforcement program monitor shall make every effort to provide the board with an opportunity to reply to any facts, findings, issues, or conclusions in his or her reports with which the board may disagree.

(e) The board shall reimburse the department for all of the costs associated with the employment of an enforcement program monitor.

(f) The enforcement program monitor shall issue a final report prior to November 1, 2005. The final report shall include final findings and conclusions on the topics addressed in the initial report submitted by the monitor pursuant to subdivision (d).

(g) This section shall become inoperative on January 1, 2006, and as of January 1, 2006, shall be repealed, unless a later enacted statute, which is enacted before January 1, 2006, deletes or extends the dates on which it becomes inoperative and is repealed.

APPENDIX B

Previous Studies relevant to MBC's Enforcement and Diversion Programs
(in chronological order)

California Medical Association and California Hospital Association, *Report on the Medical Insurance Feasibility Study* (1977).

David G. Warren and Richard Merritt (editors), *A Legislator's Guide to the Medical Malpractice Issue* (1976).

Auditor General of California, *Review of the Board of Medical Quality Assurance* (August 1982).

Auditor General of California, *The State's Diversion Programs Do Not Adequately Protect The Public From Health Professionals Who Suffer From Alcoholism or Drug Abuse* (January 1985).

Auditor General of California, *The Board of Medical Quality Assurance Has Made Progress in Improving Its Diversion Program; Some Problems Remain* (June 1986).

Arthur Young, *Board of Medical Quality Assurance: Final Report on a Management and Staffing Study of the BMQA Enforcement Program* (September 1986).

Assembly Office of Research, *"No Such Listing": Consumer Access to the Board of Medical Quality Assurance* (July 1988).

Legislative Analyst's Office, *Analysis of the 1989–90 Budget Bill* (February 22, 1989) at 97–99.

Commission on California State Government Organization and Economy ("Little Hoover Commission"), *Report on the Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight* (February 1989).

Center for Public Interest Law, *Physician Discipline in California: A Code Blue Emergency—An Initial Report on the Physician Discipline System of the Board of Medical Quality Assurance* (April 1989).

Legislative Analyst's Office, *Analysis of the 1990–91 Budget Bill* (February 21, 1990) at 121–23.

Auditor General of California, *A Review of the Processing of Complaints Made to the Medical Board of California* (April 1991).

California Highway Patrol, Bureau of Internal Affairs, *Administrative Investigation of the Medical Board of California (Preliminary Report)* (January 11, 1993).

Schubert Associates, *Development of Complaint Classification and Risk Ranking System: Final Report to the Medical Board of California* (February 28, 1994).

State Auditor of California, *The Medical Board Needs to Maximize Its Recovery of Costs* (March 1995).

Medical Board of California, *Sunset Review Report* (October 1, 1997).

Joint Legislative Sunset Review Committee, *Review and Evaluation of the Medical Board of California* (April 1998).

Julianne D'Angelo Fellmeth, *Rehabilitating the Medical Board's Diversion Program*, 16:1 CAL. REG. L. REP. (Winter 1999) at 3.

Medical Board of California, *Sunset Review Report* (September 1, 2001).

Joint Legislative Sunset Review Committee, *Background Paper for the May 2002 Public Hearing and Final Recommendations of the Joint Committee* (May 2002).

Public Citizen, *Survey of Doctor Disciplinary Information on State Web Sites* (2002).

Public Citizen, *Ranking of State Medical Board Serious Disciplinary Actions in 2002* (2003).

APPENDIX C

MBC Enforcement Program Policy/Procedure Manuals and MBC-Generated Information Reviewed by the Monitor

Enforcement Program General Operations Manual (November 2001)

Safety and Security Manual (April 2000)

Central File Room Procedure Manual (undated)

Enforcement Operations Manual (July 2002; revised throughout 2003–04)

Discipline Coordination Unit Procedure Manual Volumes I and II (undated)

Diversion Program Manual (undated)

Diversion Program Policy, Guidelines & Procedures (undated)

Individual Study Program for Expert Reviewers (October 2002)

Central Complaint & Investigative Control Unit Procedure Manual (September 2003; revised throughout 2003–04)

Citation & Fine Program Procedure Manual (undated)

Field Training Officer Program (Proposed) (undated)

Deputy in the District Office Program Handbook (undated)

Manual of Model Disciplinary Orders and Disciplinary Guidelines (9th Ed. 2003)

Central Complaint Unit Medical Consultant Procedure Manual (November 2000; revised July 2002; revised September 2004)

Probation Operations Manual (November 2003)

Investigation Activity Report (IAR) Intranet Users' Guide (January 2004)

Search Warrants (California District Attorneys Association publication dated 1995)

Medical Consultants' Reference Book (September 1996)

Medical Consultant Information Booklet (1999)

Medical Board of California 1990–91 Annual Report

Medical Board of California 1991–92 Annual Report

Medical Board of California 1992–93 Annual Report

Medical Board of California 1993–94 Annual Report

Medical Board of California 1994–95 Annual Report

Medical Board of California 1995–96 Annual Report

Medical Board of California 1996–97 Annual Report

Medical Board of California 1997–98 Annual Report

Medical Board of California 1998–99 Annual Report

Medical Board of California 1999–2000 Annual Report

Medical Board of California 2000–01 Annual Report

Medical Board of California 2001–02 Annual Report

Medical Board of California 2002–03 Annual Report

Medical Board of California 2003–04 Annual Report

Department of Consumer Affairs Statistical Profile - Fiscal Year 1998/99 (excerpt)

Department of Consumer Affairs Annual Report 1992–93 (excerpt)

Department of Consumer Affairs Annual Report 1993–94 (excerpt)

Medical Board of California Strategic Plan 2002

Medical Board of California Performance Measurement / Indicator Report (Jan–Feb 2003)

Medical Board of California Performance Measurement / Indicator Report (May 2003)

Medical Board of California Performance Measurement / Indicator Report (Jul–Aug 2003)

Medical Board of California Performance Measurement / Indicator Report (Nov 2003)

Medical Board of California Performance Measurement / Indicator Report (Jan. 2004)

Medical Board of California Performance Measurement / Indicator Report (May 2004)

Medical Board of California Performance Measurement / Indicator Report (July 2004)