State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

January 27-28, 2011

Licensing Committee	January 27	8:30 a.m. - 9:00 a.m.
Enforcement Committee	January 27	9:00 a.m. -10:00 a.m.
Education Committee	January 27	10:00 a.m - 10:30 a.m.
Advisory Committee on Physician Supervision of Affiliated Health Care Professionals	January 27	10:30 a.m - 12:00 p.m.
Panel A	January 27	1:00 p.m. - 4:30 p.m.
Panel B	January 27	1:00 p.m. - 4:30 p.m.
Full Board	January 28	9:00 a.m - 4:00 p.m.

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Embassy Suites
San Francisco Airport
150 Anza Blvd.
Burlingame, CA 94010

January 27-28, 2011

Thursday, January 27

- **8:30 a.m. – 9:00 a.m.** — **Licensing Committee - Mendocino / Burlingame Room**
  (Members: Salomonson, Carreon, Chang, Diego, Duruisseau, Esrailian, Schipske)

- **9:00 a.m. – 10:00 a.m.** — **Enforcement Committee – Mendocino / Burlingame Room**
  (Members: Low, Chin, Levine, Moran, Schipske, Zerunyan)

- **10:00 a.m. – 10:30 a.m.** — **Education Committee – Mendocino / Burlingame Room**
  (Members: Yaroslavsky, Carreon, Chang, Esrailian, Levine, Moran, Salomonson, Schipske)

- **10:30 a.m. – 12:00 p.m.** — **Advisory Committee on Physician Responsibility in Supervision of Affiliated Health Care Professionals – Mendocino / Burlingame Room**
  (Moran, Salomonson, Schipske, Barnard, Bruner, Grivett, Kilmer, Newman, Phinney, Robbins)

- **1:00 p.m. – 4:30 p.m.** — **Panel A – Santa Cruz Room**
  (Members: Duruisseau, Carreon, Chin, Diego, Salomonson, Yaroslavsky, Zerunyan)

- **1:00 p.m. – 4:30 p.m.** — **Panel B – Mendocino / Burlingame Room**
  (Members: Chang, Esrailian, Levine, Low, Moran, Schipske)

Friday, January 28

- **9:00 a.m. – 4:00 p.m.** — **Full Board Meeting – Mendocino / Burlingame Room**
  (All Members)

MEDICAL BOARD OF CALIFORNIA
Executive Office

MEMBERS OF THE BOARD
Barbara Yaroslavsky, President
Frank V. Zerunyan, J.D., Vice President
Hedy Chang, Secretary
Jorge Carreon, M.D.
John Chin, M.D.
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Eric Esrailian, M.D.
Jennifer Kent
Sharon Levine, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

QUARTERLY BOARD MEETING

January 28, 2011

Embassy Suites – San Francisco Airport
Mendocino / Burlingame Room
150 Anza Blvd.
Burlingame, CA 94010
650-342-4600

Action may be taken on any item listed on the agenda.

AGENDA

Friday, January 28, 2011
9:00 a.m. – 4:00 p.m.

While the board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

ORDER OF ITEMS IS SUBJECT TO CHANGE

1. Call to Order / Roll Call

2. Introduction and Swearing in of New Board Member

3. Public Comment on Items not on the Agenda
   Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]

4. Approval of Minutes from the November 5, 2010 meeting

5. Licensing Committee Update – Dr. Salomonson

6. Enforcement Committee Update and Consideration of Possible Action on Committee Recommendations – Dr. Low

7. Education Committee Update and Consideration of Possible Action on Committee Recommendations – Ms. Yaroslavsky

8. Physician Responsibility in the Supervision of Affiliated Health Care Professionals Advisory Committee Update – Dr. Moran

9. Physician Recognition Committee Update / Announcement – Dr. Moran

10. Physician Assistant Committee Update – Dr. Low

11. Federation of State Medical Boards Update - Ms. Chang

12. Nominations to Federation of State Medical Boards Update - Ms. Yaroslavsky

13. Health Professions Education Foundation Update – Ms. Yaroslavsky

14. Board Member Communications with Interested Parties – Ms. Yaroslavsky

15. President's Report - Ms. Yaroslavsky

16. Executive Director's Report – Ms. Whitney
    A. Budget Overview
    B. Staffing Update
    C. Strategic Plan / On-going Board Evaluations

17. Legislation/ Regulation – Ms. Simoes
    A. AB 2699 Implementation Update
    B. 2011 Legislative Proposals
        i. Approved Legislative Proposals
        ii. New Legislative Proposals
    C. 2011 Legislation – Other
    D. Status of Regulatory Action

18. City of Hope -- Petition to Modify 16 CCR 1327(a)(3) – Mr. Heppler

19. 12:00 p.m. (noon) Presentation on the Universidad Autónoma de Guadalajara and the University of California, Davis Collaborative Partnership for Medical Training – Dr. Duruisseau and Dr. Leon

20. Update on Special Task Force on International Medical School Recognition– Dr. Low
    A. Status of Schools Being Reviewed
    B. Update on Pending Site Visit to American University of Antigua – Mr. Worden
    C. Status / Timeline for Periodic Compliance Requirements

21. Consideration of Request for Recognition of Medical University of Silesia (English Language Program) – Dr. Silva

22. Consideration of Request for Recognition of Technion–Israel Institute of Technology (American Program) – Dr. Servis

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23. Licensing Chief's Report – Mr. Worden
    A. Licensing Program Update
    B. Status of Implementation of AB 2386

24. Consideration of Proposed Changes to Title 16, California Code of Regulations Section 1378.1--Polysomnography Program – Mr. Worden and Mr. Heppler

25. Licensing Outreach Report – Mr. Schunke

26. Telemedicine Pilot Program Status Report – Mr. Schunke

27. Midwifery Advisory Council Update – Ms. Ehrlich

28. Consideration of Proposed Changes to Title 16 California Code Of Regulations Section 1361--the Manual of Disciplinary Guidelines and Model Disciplinary Orders – Ms. Cady and Ms. Scuri

29. Enforcement Chief's Report – Ms. Threadgill
    A. Approval of Orders Following Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation
    B. Expert Utilization Report
    C. Enforcement Program Update
    D. Status of Implementation of SB 700

30. Vertical Enforcement Program Report – Ms. Threadgill and Mr. Ramirez

31. Request to Designate a Precedent Decision – *Jill Siren Meoni* – Ms. Scuri

32. Update on Board's Mechanism for Impaired Physicians – Ms. Whitney
    A. Law
    B. Probation: Terms and Conditions
    C. Wellness Committee

33. Department of Consumer Affairs Update – Ms. Kirchmeyer
    A. Budget / Hiring Freeze/ Other Administrative Updates
    B. Consumer Protection Enforcement Initiative (CPEI)
    C. BreEZe Update - Brandon Rutschmann

34. Agenda Items for May 5-6, 2011 Meeting in Los Angeles, CA

35. Adjournment

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

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For additional information call (916) 263-2389.

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Cheryl Thompson at (916) 263-2389 or cheryl.thompson@mbc.ca.gov or send a written request to Ms. Thompson. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

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STATE AND CONSUMER SERVICES AGENCY - *Department of Consumer Affairs* EMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA
Executive Office

Long Beach Memorial Medical Center
Miller Children's Hospital
Long Beach, CA 90806

November 4-5, 2010

MINUTES

Due to timing for invited guests to provide their presentations, the agenda items below are listed in the order they were presented.

Thursday, November 4, 2010

Agenda Item 1 Call to Order/ Roll Call
Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on November 4, 2010 at 2:43 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Barbara Yaroslavsky, President
Hedy Chang, Secretary
Frank V. Zerunyan, J.D., Vice President
Jorge Carreon, M.D.
John Chin, M.D.
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Eric Esrailian, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

Members Absent:
Sharon Levine, M.D.
Reginald Low, M.D.

Staff Present:
Fayne Boyd, Licensing Manager
Ken Buscarino, Enforcement Investigator
Susan Cady, Enforcement Program Manager
Dianna Gharibian, Inspector
Catherine Hayes, Probation Manager
Kurt Heppler, Legal Counsel
Breanne Humphreys, Licensing Manager

DRAFT

Teri Hunley, Business Services Manager
Arlene Krysinski, Enforcement Analyst
Rachel LaSota, Inspector
Ross Locke, Business Services Staff
Natalie Lowe, Enforcement Analyst
Armando Melendez, Business Services Staff
Valerie Moore, Enforcement Manager
Regina Rao, Business Services Staff
Kevin Schunke, Committee Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief, Enforcement
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Laura Alipoon, Loma Linda University
Hilma Balaian, Kaiser Permanente GME Office
Michele Benedict, Kaiser Northern California GME Office
Mary Con Tryba, Member of the Public
Julie D'Angelo Fellmuth, Center for Public Interest Law
Neil Desai, Arizona College of Osteopathic Medicine
Karen Ehrlich, L.M., Midwifery Advisory Council
Mary Elizarraras, UCI GME Office
Janis Fodran, RadNet, Inc.
Stan Furmanski, M.D., Member of the Public
Carolyn Ginno, California Medical Association
Beth Grivett, CAPA
Paul Hawkins, Hemet Radiology Medical Group
Jim Hay, California Medical Association
Dr. Will Kirby, Member of the Public
Arjun Maker, Arizona College of Osteopathic Medicine
Jack McGee, California Society for Repiratory Care
Joy Mobley, Member of the Public
Michele Monserratt-Ramos, Consumers Union Safe Patient Campaign
Margaret Montgomery, Kaiser Permanente
Elisa Nicholas, M.D., Miller Children's Hospital
Joseph Otonichar, Midwestern University
Erich Pollak, M.D., Medical Consultant
Carlos Ramirez, Office of the Attorney General
Katie Scholl, Center for Public Interest Law
Mark Serves, M.D., UC Davis
Rehan Sheik, Member of the Public
Bob Siemer, Member of the Public
Monica Weisbrich, RN, ANA

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Agenda Item 6 Enforcement Committee Update
Dr. Chin reported the Enforcement Committee met as a subcommittee on November 4, 2010. A presentation was made on the Probation Monitoring Program, including challenges within the practice monitor conditions. The Committee also heard information on the Controlled Substance Utilization Review and Evaluation System (CURES) enforcement. There were no action items from the meeting.

Agenda Item 2 Introduction and Swearing in of New Board Member
Ms. Yaroslavsky introduced and administered the Oath of Office to new Board Member, Dr. Silvia Diego, a physician and chief medical officer from the Central Valley who was appointed by the Governor on July 30, 2010.

Agenda Item 3 Public Comment on Items Not on the Agenda
Dr. Stan Furmanski addressed the Board regarding the Physician Assessment and Clinical Education program (PACE), noting, per Business and Professions Code (B&P) Section 2228, training must be completed before an assessment is given in a clinical training program. He stated that PACE gives the assessment *before* training has occurred, making it out of compliance with this section of law. He stated B&P Sections 2292, 2293, and 2294 must also be complied with. Dr. Furmanski referenced information provided by a "whistleblower" indicating PACE does not have assessment material for post-doctoral specialists and subspecialists, such as neuroradiologists, making it impossible to test in these areas. He claimed the tests PACE uses to assess these specialties are, therefore, inappropriate. He requested that the Board address these deficiencies.

Michele Monserratt-Ramos, Consumers Union, California Safe Patient Campaign, requested that the Board research, discuss and implement alternative methods for consumers to participate in Medical Board meetings. She requested that this be added as an agenda item for its next Los Angeles meeting. She expressed her appreciation for the webcasting of meetings, but would like to be able to participate via public comment, as well.

Agenda Item 4 Approval of Minutes from the July 30, 2010 Meeting
Dr. Moran moved to approve the minutes from the July 30, 2010 meeting; s/Esrailian; motion carried.

Agenda Item 5 Review of Selected Discipline Processes
Ms. Scuri reminded the Members, per B&P Code Section 2001.1, public protection is the Board's highest mandate. She provided an overview of the differences between license and discipline cases. In licensure cases, if the Board establishes grounds for denial by a preponderance of the evidence, more likely than not (the civil standard), the burden of proof to show fitness is on the applicant. In discipline cases, the burden is on the Board to show a violation or unprofessional conduct by clear and convincing evidence to a reasonable certainty. It only takes one Member vote to hold a license application, but two Member votes to hold a discipline case for discussion.

Mr. Heppler reviewed the purpose and use of the Disciplinary Guidelines, which are incorporated by reference in regulation and assist the panels when they deliberate on disciplinary matters. In

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addition, the guidelines assist administrative law judges, deputy attorney generals and defense counsels in matters involving administrative discipline to promote consistency, certainty and fairness. The guidelines also establish expectations of what a respondent may face if charged and found to have violated certain provisions of the Medical Practice Act or attendant terms and regulations. Ms. Scuri noted that if a decision or stipulation deviates from the Disciplinary Guidelines, the administrative law judge or deputy attorney general should explain the reason for the deviation.

Members with questions about stipulated decisions should contact enforcement staff. Questions about proposed decisions from an administrative law judge should be directed to the staff counsel assigned to their panel.

Once Members have voted on decisions or a stipulation, they cannot decide at a later date to hold the decision. Delayed voting by Members can impact public protection (in discipline cases) or access to care (in licensure cases). Members are asked to notify staff if they will be unavailable for voting due to access issues.

Mr. Heppler concluded by reviewing out of state discipline. These are reciprocal actions that occur when a licensee has had action taken by another licensing jurisdiction; the Board then follows with its own action if the offense would be a basis for discipline in California. If the matter were to go to hearing, the underlying basis is not re-litigated or reinvestigated. The Board attempts to institute parallel discipline to the other licensing jurisdiction.

Dr. Moran asked about differences in the appeal process for licensure and discipline cases. Ms. Scuri offered to provide additional information on the differences to her. Mr. Heppler noted that an applicant who is denied a license based on qualifications may request a court hearing without delay.

Rehan Sheikh, member of the public, questioned why, when the basis for an accusation and statement of issues is often the same for both licensure and discipline cases (e.g., incompetence, unprofessional conduct), the burden of proof lies with the applicant and not the Board in licensure cases. Mr. Heppler noted the basis for a statement of issues can be found in B&P Code Sections 480 and 2221 of the Medical Practice Act.

Agenda Item 7 Wellness Committee Update

Dr. Duruisseau reported the Wellness Committee heard a presentation on Kaiser Permanente's Get Fit Program and discussed best practices. At the conclusion of the Committee meeting, an Interested Parties Workgroup discussion, led by Dr. Laurie Gregg, took place. The Workgroup agreed to pursue further discussion of best practices and a review of successful programs through additional interested parties meetings.

Agenda Item 8 Licensing Committee Update

Dr. Salomonson reported the Licensing Committee received an update on application processing times and progress on the Business Process Re-engineering Report recommendations by Curt Worden, Chief of Licensing. Fayne Boyd, Licensing Manager, provided updates on streamlining the application process, updates to the Board's website related to applicants, and a study of the

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Post Graduate Training Authorization Letter process. Breanne Humphreys, Licensing Manager, delivered an update on the implementation of new management reports and the development of the Policies and Procedures Manual. Mr. Schunke reviewed proposed alternatives to traditional US and IMG medical education. A subcommittee is being formed and an interested parties meeting is planned to further explore alternatives to traditional training. Dr. Diego and Dr. Carreon will serve on this subcommittee.

Agenda Item 9 Physician Responsibility in the Supervision of Affiliated Health Care Professionals Advisory Committee Update and Consideration of Committee Recommendations

Dr. Moran reported the Committee met on October 20, 2010 in Sacramento. Mr. Heppler provided an overview of the relevant laws and regulations within the Medical Practice Act regarding what constitutes the practice of medicine, the unlicensed practice of medicine and the corporate practice of medicine. Representatives from the Board of Registered Nursing and the Physician Assistant Committee also participated in the meeting to address specific scope of practice questions regarding midlevel practitioners and the relative oversight of physicians. A date has not yet been set for the next Committee meeting.

The Committee passed the following motion for the Board's consideration:
The Board should consider in its outreach program, including board newsletter articles and other actions, informing physicians of their responsibilities regarding supervision and delegation issues regarding affiliated healing arts professionals and educating the public about basic laws in this area. Dr. Moran made a motion for the Board to adopt the Committee's recommendation; s/ Salomonson.

During public comment, Dr. Will Kirby, member of the public, voiced his support for the motion and requested that a Doctor of Osteopathic Medicine be included on the Committee. Ms. Whitney noted that only those professionals who the Medical Board has jurisdiction over were included on the Committee, but she invited all nurses, nurse practitioners, osteopathic doctors, and others were invited to participate in the meetings.

Ms. Yaroslavsky called for the vote; motion carried.

Agenda Item 15 Presentation on and Tour of Miller Children's Hospital

Dr. Elisa Nicholas, Chief Executive Officer, provided an overview of the of The Children's Clinic, a dynamic system of non-profit community health centers in Long Beach dedicated to caring and advocating for underserved children and their families. Over 70,000 visits are provided per year. There a currently six centers, three of which are medical homes located on school sites; two of these locations also provide health care to families. In addition, one of the centers is located in a homeless center run by the City of Long Beach. The program is heavily involved in the promoting health within the community.

Ms. Yaroslavsky recessed the meeting until 9:00 a.m. Friday, November 5, 2010.

Dr. Lupe Padilla, Acting Medical Officer, conducted a tour of the Miller Children's Hospital for Board Members and attendees.

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Friday, November 5, 2010

Agenda Item 16 Call to Order/ Roll Call
Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on November 5, 2010 at 9:03 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Barbara Yaroslavsky, President
Hedy Chang, Secretary
Frank V. Zerunyan, J.D., Vice President
Jorge Carreon, M.D.
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Eric Esrailian, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

Members Absent:
John Chin, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.

Staff Present:
Susan Cady, Enforcement Program Manager
Irene Bisson, Inspector
Maksim Degtyar, Enforcement Investigator
Catherine Hayes, Probation Manager
Kurt Heppler, Legal Counsel
Teri Hunley, Business Services Manager
Ross Locke, Business Services Staff
Natalie Lowe, Enforcement Analyst
Armando Melendez, Business Services Staff
Kathleen Nicholls, Supervising Investigator
Regina Rao, Business Services Staff
James Sandoval, Investigator
Sylvia Salcedo, Senior Investigator
Kevin Schunke, Committee Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief, Enforcement
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

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Members of the Audience:

Ryan Alexander, Midwestern University
Hilma Balaian, Kaiser Permanente GME Office
Claudia Breglia, California Association of Midwives
Stephen E. Brown, Long Beach Memorial Medical Center
Kristen Brumleve, Midwestern University
Gina Castro, Long Beach Memorial Medical Center
Kathy Cavendar, Glendale Adventist Medical Center
Janice Sams Cespedes, RPA Society
Julie Christiansen, Pomona Valley Hospital
Marcelene Compton, Radiology Practitioner Assistant Society
Kelly Cook, Good Samaritan Hospital
Bruce Docherty, ASRT
Julie D'Angelo Fellmuth, Center for Public Interest Law
Stephanie Doan, Long Beach Memorial Medical Center
Karen Ehrlich, L.M., Midwifery Advisory Council
Ben Frank, Consultant
Stan Furmanski, M.D., Member of the Public
Beth Grivett, CAPA
Ali Hamadani, Midwestern University
Kimberly Kirchmeyer, Department of Consumer Affairs
Pega Mashayekhi, Midwestern University
Jesse Mejia, RPA Society
Pam Michael, Torrance Memorial Medical Center
Joy Mobley, Member of the Public
Don Monroe, Radiology Practitioner Assistant Society
M. Monserratt-Ramos, CU Safe Patient Campaign
Chris Mullin, Midwestern University
Dennis Nicholson, Pomona Valley Hospital
Thanh Nso, Midwestern University
Stephanie Nunez, RCB
Nancy Perri, Ross University
Tammy Pham, Midwestern University
Carlos Ramirez, Office of the Attorney General
Leonard Sclafani, American University of Antigua
Katie Scholl, Center for Public Interest Law
Herb Schultz, U.S. Dept. of Health and Human Services Region IX
Paul Selecky, CA Sleep Society
Rehan Sheik, Member of the Public
Thomas C. Shepherd, Ross University
Stephanie Smith, Midwestern University
David Solomon, Midwestern University
Trish Stiger, Hoag Hospital
Marion Watson, Glendale Adventist Medical Center
Ronald Wender, M.D., Consultant
Qi Yu, Midwestern University

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Agenda Item 17 Public Comment on Items Not on the Agenda
Dr. Stan Furmanski stated the PACE Program is unable to validly assess physicians in specialty or subspecialty areas due to a lack of content validation in the testing procedures and tools. In the absence of valid tests for the specialty, he claimed that inappropriate tests are used in assessing these physicians, particularly in the area of neuroradiology.

Agenda Item 10 Physician Assistant Committee Update
Ms. Yaroslavsky reported the Physician Assistant Committee (PAC) has not met since the Board's last meeting in July 2010. The PAC will meet on November 18, 2010 in Sacramento.

Agenda Item 11 Federation of State Medical Boards Update
Ms. Chang reported FSMB's improvements to the Federation Credentials Verification Service (FCVS) program have been completed and are currently in the testing phase. A telemedicine committee was recently formed to work on the development of a national telemedicine model. Maintenance of License (MOL) issues continue to be a priority for FSMB. Ms. Chang reported a committee has also been formed to examine the re-entry of physicians who have been out of practice but who desire to return to active practice. A Physician Impairment Committee has been created; Dr. Bolton and Dr. Fantozzi, former Board Members, both serve on this committee. Dr. Salomonson has agreed to participate in writing questions for the newest United States Medical Licensing Examination (USMLE).

Ms. Chang serves on the FSMB Foundation which undertakes various educational and scientific research projects. She has been involved in a project to explore the best ways to educate public members on medical boards' roles and functions, and a project that examines violent threats to state medical board members and staff. In addition, Ms. Chang is participating in a project to evaluate all state medical boards. This project is currently in the process of developing criteria for the evaluation.

Agenda Item 12 Nomination(s) to Federation of State Medical Boards
The FSMB is seeking nominations for a variety of items and positions, including its Board of Directors. These include resolutions to the Federation's House of Delegates, nominations for distinguished service, leadership awards, and nominations for associate members. With the exception of entertaining a nomination to the FSMB Board of Directors, Ms. Yaroslavsky recommended that the Board not pursue any of these at this time since there has not been an opportunity for discussion.

Dr. Salomonson nominated Ms. Chang to continue in her role on the Board of Directors; s/Esrailian; motion carried.

Agenda Item 13 Telemedicine Pilot Program Status Report
Mr. Schunke reported Dr. Nuovo presented a summary of the telemedicine pilot at the July 2010 meeting. He directed Members to page 101 in their packets for an overview of more recent activities and outreach efforts.

Agenda Item 14 Licensing Outreach Report
Outreach activities continue to be successfully received. Mr. Schunke thanked Ms. Yaroslavsky and other Members who have participated in some of the licensing outreach efforts throughout

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the state. Outreach events were conducted for the first time at LAC + USC Teaching Hospital, Huntington Hospital in Pasadena, and Children's Hospital in Los Angeles. In addition, a first time licensing workshop is scheduled for Loma Linda Medical University. During 2010, Mr. Schunke has had direct contact or made group presentations to approximately 2,000 applicants.

In the next two weeks, the Board will be hosting two outreach meetings with Graduate Medical Education (GME) staff throughout California. Invitations have been sent to 200 GME directors and deans from California teaching hospitals. Additional outreach has been made to California Association of Physician Groups (CAPG), California Hospital Association (CHA), California Primary Care Association and California Medical Association (CMA).

Approximately 1,100 letters were sent out in November 2010 to the 200 GME directors and deans, as well as to 900 Program Directors in California asking for their cooperation in providing to the Board the names of individuals who will require licensure by July 1, 2011. Last year approximately 1,800 individuals were added to the Board's master matrix, which helps the Licensing Program successfully conduct workload planning and tracking.

Dr. Salomonson and Ms. Yaroslavsky thanked Mr. Schunke for his excellent outreach efforts and encouraged other Members to attending future licensing fairs and other outreach events as their schedules allow.

Agenda Item 23 Health Care Reform Presentation

Herb Schultz, recently appointed by President Obama to serve as Regional Director at the U.S. Department of Health and Human Services (HHS) Region IX, delivered a presentation on plans to implement the Patient Protection and Affordable Care Act. He stressed the many opportunities for collaboration and partnership with the Board in areas such as physician education and outreach, policy level discussions, troubleshooting, and potential grant opportunities. HHS would like to engage the Board and other state government, regional and local organizations in early discussions on the development of regulations. Mr. Schultz mentioned the possibility of co-hosting workshops throughout the state on key issues of mutual interest, assisting HHs and the Attorney General's Office in addressing medical fraud, and publicizing community based prevention events and health programs.

Ms. Chang asked about the projected 30% physician shortage that will result from the influx of newly insured individuals into the health care system as the Act is implemented. Mr. Schultz noted $500 million has been allotted the first year to strengthen the primary care system; over $168 million will go to programs for physician education training, loan repayment, the growth of the National Health Service Corp, and other programs. Additional investment will be made in developing nurse practitioners, physician assistants, school-based health centers, nurse-managed clinics and other provider options.

Mr. Schultz responded to questions and comments from Members on a variety of issues including successful models of coordinated and collaborative care, liability coverage issues that impede physician service, reimbursement issues, and opportunities for individual physicians to partner with larger programs or accountable care organizations.

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Ms. Yaroslavsky expressed the Board's willingness to collaborate with HHS. She suggested a possible link on the Board's website to items that might be of interest to its licensees and best practices that HHS uncovers.

Agenda Item 18 REGULATIONS – PUBLIC HEARING

Ms. Yaroslavsky opened the public hearing on the proposed regulations to adopt Sections 1315.50, 1315.53, and 1315.55 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. For the record, Ms. Yaroslavsky stated the date was November 5, 2010; the hearing began at approximately 10:40 a.m.

The regulations would establish the procedures for the issuance of a limited physician's and surgeon's certificate to an applicant who is otherwise eligible for medical licensure in California but is unable to practice all aspects of medicine safely due to a disability, including the requirements for an independent clinical evaluation. In preparing the regulatory language, staff also considered current licensees who wish to go into this status due to a disability affecting their ability to practice some aspects of medicine safely. Parallel language also was prepared to ensure the limited practice license is consistent with the criteria for the current disability license.

No written comments were received by the October 25, 2010 deadline. No oral testimony was offered during the public hearing. Ms. Yaroslavsky closed the hearing.

Dr. Moran made a motion to adopt the proposed regulations; s/Chang; motion carried.

Agenda Item 19 REGULATIONS – PUBLIC HEARING

Ms. Yaroslavsky opened the public hearing on the proposed regulations to adopt Chapter 3.5, Articles 1 through 6, of Title 16 of the California Code of Regulations regarding the requirements for the registration and supervision of polysomnographic technologists, technicians, and trainees as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. For the record, Ms. Yaroslavsky stated the date was November 5, 2010; the hearing began at approximately 10:50 a.m.

Among other things, this regulatory proposal sets the qualifications for certified polysomnographic technologists, including requiring those technologists to: be credentialed by a board-approved national accrediting agency; have graduated from a board-approved educational program; and, have passed a board-approved national certifying examination (with a specified exception for that examination requirement for a three-year period).

Seven written comments were received before the October 25, 2010 deadline and were provided to the Board Members for their review before the meeting.

Mr. Heppler noted that he and Ms. Scuri have reviewed the public comments and believe there are four revisions that appear warranted from a legal perspective.

During public comment, David Gonzales and Dr. Paul Selecky, California Sleep Society, provided additional written comments on the proposed regulations. They thanked the Board for their work on the regulations and expressed California Sleep Society's desire to continue to work with the Board on implementing SB 132.

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Stephanie Nunez, California Respiratory Care Board (RCB), requested that Article 3, Section 1378.9 be eliminated. This section allows an applicant, in lieu of successful completion of the BRPT certification exam, to be "grandfathered" in by submitting a declaration from a physician that he/she has been practicing polysomnography safely for at least 5 years. The RCB requests that the certification examination be required for *all* applicants in order to establish competency. Further, the RCB requests that Article 4, Section 1378.13 be amended to allow only properly licensed physicians and respiratory care practitioners to provide supervision based on the propensity for respiratory-related emergencies to arise in a sleep lab.

Ms. Yaroslavsky closed the hearing.

Mr. Heppler noted the "grandfathering" provision in lieu of examination is already established in law. He proposed a 15-day notice to effect the legal clarification changes previously mentioned. Ms. Scuri stated the law requires regulations to be drafted within one year from the effective date, which was in October 2009.

Ms. Chang made a motion to authorize the Executive Director to adopt the regulations as modified at the expiration of the comment period if there are no adverse comments; s/Duruisseau; motion carried.

Agenda Item 20 REGULATIONS – PUBLIC HEARING

Ms. Yaroslavsky opened the public hearing on the proposed regulation to amend Section 1361 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. This proposal would amend the regulations that incorporate by reference the disciplinary guidelines entitled "Manual of Disciplinary Guidelines and Disciplinary Orders." These amendments are being made to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment. For the record, Ms. Yaroslavsky stated the date was November 5, 2010; the hearing began at approximately 11:00 a.m.

The Board received written comments from the California Medical Association prior to the November 1, 2010 deadline. A copy of this letter was provided to the Board Members for their review prior to this meeting.

Ms. Scuri noted a proposed change to Condition 33 of the Guidelines that deals with non-practice while on probation. The change would combine former Conditions 33 and 34, and clarify non-practice regardless of physician location. In addition, the change would allow time spent in an intensive training program not to be considered non-practice.

During public comment, Julie D'Angelo Fellmeth, CPIL, expressed concern that some of the Disciplinary Guidelines that deal with substance abusing physicians are not consistent with the Uniform Standards developed for all healing arts boards by the Substance Abuse Coordination Committee (convened by the Department of Consumer Affairs in 2009 as directed by SB 1441). Uniform Standard 10 requires a licensee to immediately cease practice upon a positive drug test result; the Board's proposed guidelines require the licensee to cease practice within 3 days of a positive test. Ms. Fellmeth stated this 3 day delay did not provide adequate public protection.

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Uniform Standard 4 requires a substance abusing probationer to be tested 104 times during the first year of probation (twice a week). The Board's Disciplinary Guidelines previously required drug testing once a week; however, the specification for the required frequency of testing has been removed from the proposed guidelines. Ms. Fellmeth stated this was a concern. Proposed Disciplinary Guideline 11 requires substance abusing licensees to arrange for drug testing within 30 days of the decision placing them on probation. Ms. Fellmeth felt this 30 day delay does not provide adequate patient protection. She proposed that the drug testing arrangements be a precedent condition to returning to practice.

Kimberly Kirchmeyer, Department of Consumer Affairs, reported a subcommittee of the Substance Abuse Coordination Committee was formed to review the frequency of required drug testing. To date, a meeting of this subcommittee has not been scheduled. For now, the recommended frequency of 104 drug tests during the first year stands.

Ms. Whitney indicated at the April 2010 Substance Abuse Coordination Committee meeting, a number of the members were concerned with requiring 104 tests and expressed the need to review and validate this number. This remains an outstanding issue that has not yet been fully resolved.

Ms. Scuri recommended *not* including a specific number of required tests in the Disciplinary Guidelines at this time since the issue is not yet resolved. As written, the guidelines would allow the Board to test to comply with the Uniform Standard's specifications.

Ms. Kirchmeyer said the Department is asking all healing arts boards to come into compliance with the SB 1441 Uniform Standards.

Stan Furmanski, M.D., suggested, in order to protect a physician's ex post facto rights, the regulations specify that it is the Board's intent that no change in the guidelines or model orders be used to detrimentally affect any licensee who has an order or stipulation issued prior to the effective date. He also expressed the need for a grievance procedure to be included in the proposed regulations.

Ms. Scuri clarified that regulations are never applied retroactively.

Ms. Yaroslavsky closed the hearing. She suggested that the regulations be tabled until the January 2011 meeting to allow staff to resolve the conflicts with SB 1441 standards in order to receive approval from the Office of Administrative Law.

Dr. Duruisseau made a motion to table the regulations until the January 2011 meeting; s/Chang; motion carried.

Agenda Item 21 Board Member Communications with Interested Parties
No Members reported any communications.

During public comment, Leonard Sclafani, legal counsel for the American University of Antigua, expressed his concern that specific notice was not sent to the school with regard to the meeting agenda.

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Ms. Yaroslavsky clarified that the agenda item dealing with international medical school recognition is only an update and no action is being considered. She suggested that the school and all other interested parties sign up for automatic updates from the Board's website.

Agenda Item 22 President's Report

Ms. Yaroslavsky participated in three monthly conference calls with the Department Director, his deputies, healing arts board presidents and executive directors. Updates were given on the budget, personnel, CPEI and an exemption request, drug testing by Maximus, meeting protocols, healthcare workforce statistics, and a roundtable discussion on best practices by boards. She attended the Midwifery Advisory Council meeting in August 2010, toured the Licensing Section at the Board's offices, and attended the Physician Responsibility Committee meeting on October 20, 2010 to hear presentations by the Nursing Board and Physician Assistant Committee. Ms. Yaroslavsky announced she had made some new committee assignments for Members.

Agenda Item 24 Executive Director's Report

A. Budget Overview

Ms. Whitney directed Members to the Analysis of Fund Condition of the Board located on page 199 in their packets. She noted FY 2010-11 is projected to have a 5.3 month balance in reserve at the end of the year; this is slightly higher than the 4 month reserve permitted by law. This amount may increase depending upon the outcome of labor union agreements with regard to the 3-day per month furlough program. In addition, there will be a 5% salary savings cap that will be incorporated. This could offset proposed augmentations that the Board is seeking in a spring 2011 finance letter from the new administration. She expressed disappointment that the previous augmentation requests did not go forward with the current administration. At this time, the Board is not seeking any reduction in the fund condition until more information about operating costs and changes to be made by the incoming administration is available.

The Board implemented a potential long term savings program by emailing the most recent newsletter to 96,900 licensees, thus reducing printing and postage costs by two-thirds. Approximately 1,100 emails were returned as undeliverable and 900 requests were received for printed versions of the newsletter. As the Board continues to pursue this "green" approach to communications, staff will survey major medical associations and groups to determine if this delivery method is satisfactory. In addition, for the January 2011 meeting, Members may elect to receive their Board materials via thumb drive.

B. Staffing Update

The Board's Public Information Officer, Candis Cohen, retired on October 29, 2010. Due to the hiring freeze, her position cannot be filled at this time. Jennifer Simoes, Chief of Legislation, will serve as the Acting Public Information Officer. Although job announcements are out for various vacancies, the hiring freeze only permits transfers within the Department of Consumer Affairs. This will make it difficult to fill any of the vacant positions. In addition, no promotions or new employee hires are permitted. Other agencies are not subject to the freeze, so it is possible that some staff may be lost to these agencies. In the meantime, current staff is working to cover vacant positions.

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The Federation of State Medical Boards is currently holding its Attorney Workshop; however, due to the Board meeting, Ms. Scuri and Mr. Heppler are unable to attend. Attorneys from other Department healing arts boards are attending in their absence and will report back to the Board's legal counsel.

C. Strategic Plan: Consideration of 2011 Update

Ms. Whitney reported the Strategic Plan Subcommittee will meet in early January 2011 to discuss a time table for a revised strategic plan. She anticipates the plan will be ready by the end of 2011. The subcommittee is comprised of Ms. Yaroslavsky and Dr. Levine. The Department's SOLID division may provide assistance.

D. Confirm Board Meeting Dates and Locations for 2011

Ms. Whitney directed Members to the meeting dates and locations for 2011 located on page 207 of their packets. The originally scheduled April 2010 meeting has been moved to May 5-6, 2011 to avoid a conflict with the FSMB Annual Meeting.

E. On-going Board Evaluations

On-going Board evaluations will be discussed with the Strategic Plan Subcommittee and incorporated into the planning process. The Board's major sunset review will take place in 2013, thus, this review will be considered in the plan for on-going evaluations.

Agenda Item 25 Board Evaluation Presentation and Discussion

Mr. Zerunyan reported that he and Dr. Salomonson have met with Ben Frank, an independent consultant retained by the Board to conduct an evaluation of its programs and operations, and have reviewed the report. The full report and an executive summary of the report were sent to Members and were posted on-line. Mr. Frank presented his study's major findings. The majority of his comments focused on the Vertical Enforcement Program and the differences in implementation strategies and costs from region to region.

Mr. Frank recommended that some of the funding currently being spent on Vertical Enforcement be redirected in order to hire additional medical consultants and medical experts for the Enforcement Program. He noted that delays in the processing of investigations were often due to the unavailability of these professionals, a finding that is consistent with Enforcement Monitor's report from 5 years ago.

Mr. Zerunyan suggested that the Board Evaluation Subcommittee continue to review the report recommendations and work with the Attorney General's Office to examine various policies and efficiencies in order to develop concrete, workable strategies. Ms. Yaroslavsky concurred.

Carlos Ramirez, Attorney General's Office, Health Quality Enforcement Section, expressed his interest in working with the Board in implementing some of the recommendations contained in the report.

Ms. Kirchmeyer stated the Department is still reviewing the report and, as such, has no comments at this time. She indicated the Department will respond to the Board once their review has been completed.

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Ms. Yaroslavsky directed the Evaluation Subcommittee to work with staff and the AG's Office in the development of recommendations for the Board to take action on.

During public comment, Ms. D'Angelo-Fellmeth offered her services as the Board works to refine the implementation of the Vertical Enforcement Program.

Agenda Item 26 Legislation

A. 2010 Legislation Wrap Up and Implementation

Ms. Simoes provided a brief overview of the legislative process. She then referred Members to the Legislative Packet for a listing of dead, vetoed, and chaptered bills.

Chaptered bills:

- **AB 583 (Hayashi) – Disclosure of Education and Office Hours**
  This bill requires physicians to communicate to their patients their license types, highest level of educational degree and board certification. For implementation, the Board staff proposes to include an article in the newsletter, notify and train staff, and add this item to the Cite and Fine Table via regulations.
- **AB 1767 (Hill) – Expert Reviewers & HPEF Sunset Extension**
  This Board-sponsored bill requires the Board to provide representation to a licensed physician who provides expert reviewer services to the Board. The bill also extends the sunset date for the two Board Members appointed to the Health Professions Education Foundation. For implementation, staff plans to add an article in the newsletter, notify and train Board staff, notify and work with HPEF staff, notify the AG's Office, and to inform expert reviewers and provide information during their training.
- **AB 2386 (Gilmore) – Armed Forces: Medical Personnel**
  The bill allows a hospital to enter into an agreement with the Armed Forces of the United States to authorize a physician and surgeon, physician assistant, or a registered nurse to provide medical care in a hospital under specified conditions. The Board took a neutral position on the bill. For implementation, staff proposes to include an article in the newsletter, notify and train Board staff, revise the existing military form and create a new form with added fields, and post the new form on the Board's website. In addition, staff will work with a military contact provided by author's office in order to provide outreach.
- **AB 2699 (Bass) – Healing Arts: Licensure Exemption**
  This bill exempts specified health care practitioners, who are licensed and certified in other states, from California state licensure for the purpose of providing voluntary health care services to uninsured and underinsured Californians on a short-term basis and in association with a sponsoring entity that complies with specified requirements. Practitioners would be required to register with the respective board in advance of these events.

  Since the last Board meeting, the bill was amended to apply to all healing arts licensees and to limit the sponsored events to 10 days (although there is no limit on the number of events that can take place in a year). The bill also now requires practitioners to provide a copy of his/her license in each state in which they are licensed, the license must be in good standing, and each board must prescribe a form for the individual to fill out and set

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a fee in regulations for processing the request for authorization for practicing without a license. Each board must also specify the appropriate education and experience in regulations. The bill also includes a termination process and will sunset January 1, 2014.

The bill does have a fiscal impact on the Board. For implementation, the Board has submitted a legislative Budget Change Proposal (BCP) to DCA for the ½ position needed to accomplish the extra workload. At this time, it is not known if DCA has approved this BCP. In addition to including a newsletter article and notifying and training Board staff, staff resources to manage the program will need to be identified. Staff is working with DCA and other healing arts boards to discuss implementation strategies. DCA committed to drafting model regulations that the boards can use as a template for their regulations to ensure consistency. DCA also committed to being the responsible party to approve the sponsoring entities.

Dr. Salomonson suggested that the regulations should require participating physicians to post or notify consumers receiving care that complaints about the quality of care should be made to the Board. Liability insurance should also be verified.

Ms. Yaroslavsky suggested the regulations would also need to address the requirement to maintain records, make follow up care recommendations, and provide a mechanism for DCA to be made aware of complaints.

- **SB 294 (Negrete McLeod) – DCA: Regulatory Boards – Sunset Dates**
  This bill changes the sunset review date for the Board from 2013 to 2014. For implementation, staff proposed to add an article in the newsletter, notify Board staff, and prepare for performing a sunset evaluation report in late 2012 in anticipation of legislation in 2013.
- **SB 700 (Negrete McLeod) – Peer Review**
  This bill adds a definition of peer review, adds that the peer review minutes and reports may be obtained by the Board, and requires the Board to post a fact sheet on the internet that explains and provides information on 805 reporting. The Board took a support position on this bill. For implementation, staff proposes to include an article in the newsletter, notify and train Board staff, and develop and post the fact sheet on our website by January 1, 2010, and revise the 805.01 reporting process as necessary.
- **SB 1069 (Pavley) – Physician Assistants**
  The bill authorizes physician assistants (PAs) to perform physical examinations and order durable medical equipment. A previous provision allowing PAs to certify disability for the purposes of unemployment insurance eligibility was removed from the bill. For implementation, staff recommends including an article in the newsletter.
- **SB 1172 (Negrete McLeod) – Diversion Programs**
  This bill codifies many of the standards established by the Substance Abuse Uniform Standards Committee. It requires all healing arts boards under DCA to order a licensee to cease practice if the licensee tests positive for any substance prohibited under the terms of their probation or diversion program. The bill also allows healing arts boards to adopt regulations authorizing the board to order a licensee cease practice for major violations or in order to undergo a clinical diagnostic evaluation. For implementation, staff proposes to include an article in the newsletter, notify and train Board staff, and continue to work on developing regulations.

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- **SB 1489 (B&P Committee) – Omnibus (Board sponsored)**
  This bill includes amendments that are technical in nature, including deleting and correcting obsolete references with regard to the Board's licensing exams, reinstating postgraduate training requirements for licensure, and clarifying provisions related to the reporting requirements for midwives. For implementation, staff proposes including an article in the newsletter and informing and training Board staff.

Vetoed Bills:

- **SB 933 (Fong) - Worker's Compensation: Utilization Review**
- **AB 2566 (Carter) – Cosmetic Surgery: Employment of Physicians**
- **SB 1410 (Cedillo) – Medicine: Licensure Examinations**

B. 2011 Legislative Proposals

Staff has identified the following proposals for 2011:

- Require physicians to cooperate/attend physician interviews with the Board and consider non-compliance unprofessional conduct. This will expedite the closure of cases and no longer require the Board to subpoena physicians who do not cooperate.

  Ms. Scuri noted this would not remove the requirement for a subpoena if records are requested. It does add another item that can be added to the accusation if the physician does not comply.

  Dr. Duruisseau made a motion to authorize staff to move forward with this proposal and seek legislation; the motion was seconded; motion carried.

- Authorize staff to seek legislation to automatically temporarily suspend a physician and surgeon's certificate when a physician is incarcerated after a misdemeanor conviction during the period of incarceration. This would prevent incarcerated physicians from treating or prescribing to patients, including other inmates. The authorization currently exists for felony convictions but staff would like to include misdemeanor convictions, as well.

  A motion was made to authorize staff to move forward with this proposal and seek legislation; s/Chan; motion carried.

- Omnibus – Authorize staff to develop proposed technical "fixes" to licensing laws (including midwifery) and place as many as possible in an omnibus bill. Changes must be non-controversial.

  Ms. Chang made a motion to authorize staff to move forward with an omnibus proposal and seek legislation; motion was seconded and carried.

The following proposals are drawn from recommendations made in the Board Evaluation Report:

- Per the Board Evaluation Report, authorize staff to seek legislation to amend the statutes governing Vertical Enforcement (VE) to clarify the Medical Board's sole authority to determine whether to continue an investigation. Per the report, this will promote efficiency in the Enforcement Program by clarifying the Board and AG's Offices roles.

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Staff believes legislative clarification will most likely not make a practical difference and instead recommends revising the VE Manual which will allow the Board and AG to work together to implement VE.

Ms. Schipske made a motion to move forward with staff's recommendation to revise the VE Manual; the motion was seconded; motion carried.

- Per the Board Evaluation Report, authorize staff to seek legislation to amend current law to no longer require the Medical Board Investigators and HQES Attorneys to be permanently co-located. Co-location has been found to be impractical; repealing existing law would legislatively mirror current practice.

  Since co-location is not in existence in current practice, legislation is not needed. As an option, staff recommends that this language be included in an omnibus bill (if it is considered non-controversial).

  Ms. Schipske and other Members did not see this legislation as necessary; no action was taken.

- Per the Board Evaluation Report, authorize staff to seek legislation to amend current law to no longer require the Medical Board to invest in the Complaint Tracking System (CAS) to make it more compatible with HQES's ProLaw System. However, with the approval of DCA's BreEZe computer system, this legislative change is no longer needed. BreEZe will completely replace CAS and the Board's Application Tracking System. No action was taken.

C. 2011 Legislation - Other

Ms. Simoes asked Members if there was any other legislation they would like to propose.

Ms. Schipske asked, in light of the Governor's veto of AB 2566, if the medical spa issue would be revisited. She believed the issue needs to be addressed legislatively and a placeholder bill established.

Ms. Yaroslavsky stated it would be better to wait for the Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals to develop recommendations.

Ms. Whitney indicated, in light of AB 2566 sponsors continuing interest in this legislation, it might be best to direct staff to work with the sponsors to develop placeholder legislation in case any recommendations or conclusions are reached.

Ms. Schipske suggested examining whether any of the medi-spa concerns could be addressed in regulation alongside the physician supervision of mid-level practitioners; this would eliminate the need to single out cosmetic procedures.

As the Legislature is currently in recess, Ms. Simoes is only aware of one legislative proposal of interest to the Board at this time. The proposal is jointly sponsored by the Radiology Practitioner

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Assistant Society (RPAS) and the American Society of Radiologic Technologists (ASRT). The proposal would create the Radiologist Assistant Committee of the Medical Board, similar to the Physician Assistant Committee. The Radiologist Assistant Committee would license radiologist assistants. The licensing category would include two current mid-level radiology technician classifications: radiologist assistant and radiology practitioner assistant, which are both trained advanced technologists with separate educational backgrounds. Both technicians provide radiology services by assisting the radiologists with less invasive procedures, allowing the radiologist to focus on less routine patients and studies. The bill has not yet been introduced, so no action is necessary at this time.

Bryce Docherty, ASRT, Sal Martino, ASRT, Robert Thomas, M.D., California Radiological Society, and Marcelene Compton, RPAS, spoke on behalf of the proposed legislation and asked the Board for their support and guidance.

Agenda Item 27 Status of Regulatory Action

Ms. Yaroslavsky directed Members to page 223 of their packets for information on the Status of Pending Regulations.

Agenda Item 28 Update on Special Task Force on International Medical School Recognition

A. Status of Schools Being Reviewed

Dr. Esrailian directed Members to page 224 in their packets. As of November 1, 2010, the Board has 3 consultants to review medical school applications. Two to four additional consultants are being sought to review medical school applications, however the hiring freeze prohibits additional hiring or extension of current appointments terms at this time.

Ms. Chang noted the Educational Commission for Foreign Medical Graduates (ECFMG) has a new goal to certify international medical schools by the year 2020. She hoped this might relieve the Board of some of this work.

Ms. Whitney noted, upon hearing of their goal, the Board immediately contacted ECFMG and offered assistance.

Curt Worden, Chief of Licensing, reported the University of Silesia is currently being reviewed. Additional information was requested from the university which, the Board has been informed, is on its way. Additional information was also requested from the Medical University of Warsaw; it has informed the Board it is working on gathering this information for submission. Staff has transmitted information on the Universidad IberoAmericana to the medical consultant for review. Additional information requested from Technion-Israel Institute of Technology arrived at the Board today.

B. American University of Antigua

Mr. Worden reported the medical consultant has reviewed the information that was provided to the Board at the end of July 2010. The consultant requested additional clarifying information from the school on October 14, 2010. Staff has been working on the preliminary request for out

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of country travel from the Governor's Office for the authorized site visit once the medical consultant determines the proper locations and times.

Mr. Sclafani expressed dissatisfaction over the delay in scheduling the site visit. He stated the response to the October 14, 2010 request for additional information has already been provided.

C. Discussion of Periodic Compliance Requirements

Dr. Esrailian stated CCR 1314.1 lays the foundation for the periodic compliance requirements for previously recognized international medical schools. Staff recommends that the Board delegate these duties to the Special Task Force on International Medical School Recognition with final recommendations on the reevaluations coming to the Board. A list of items the Task Force would need to consider is included in the October 27, 2010 staff memo to Board Members. These items include conducting a review of the current Self-Assessment Report for changes and to determine if there is a need for two different reports: one for initial evaluations and one for reevaluations. In addition, the Task Force will need to determine the order in which medical schools are to be reevaluated and to develop a new timeline for these reevaluations. Further, it will need to consider the costs associated with site visits for reevaluations and the difficulty in obtaining out of country travel authorizations. Ms. Yaroslavsky delegated these responsibilities to the Task Force.

Agenda Item 29 Consideration of Request for Recognition of Ross University

Dr. Mark Servis, UC Davis School of Medicine and medical consultant to the Board, reported the Board currently recognizes Ross University's main campus located in Dominica, West Indies. In January 2009, Ross opened a branch campus in the Bahamas to provide medical education for the third and fourth semesters of medical school. Dr. Servis and staff have reviewed the Ross Grand Bahama's application and determined that it meets the criteria pursuant to Section 1314.1 (a)(2) of Title 16 of the California code of Regulations. As such, they recommended that the Board approve Ross University's Freeport, Grand Bahama campus to provide medical school education for semesters 3 and 4 only at this time. He recommends retroactive recognition to January 2009.

Dr. Servis noted an unsolicited complaint was received from a student that made a number of allegations about the main campus program in Dominica. He and staff recommend site visits to Ross University's main campus, the Bahamas campus and several representative teaching hospitals in the United States where students receive clinical training as part of Ross University's reevaluation by the Board.

Ms. Chang made a motion to approve Ross University's Freeport, Grand Bahama campus to provide medical education for semesters 3 and 4 with retroactivity to its inception in January 2009; s/Duruisseau.

During public comment, Mr. Sclafani, AUA, expressed concern over conflict of interest issues for one of the medical consultants the Board used in conducting Caribbean medical school evaluations. In addition, he stated there are over 1,300 schools on the list of approved medical schools. Of these, the Board has reviewed and approved (via Self-Assessment Reports) only 14 schools, most without site visits. He felt it was wrong that the Board put schools that have already been reviewed through the reevaluation process when so many other schools have never received an initial review. He claimed staff added schools to the approved list based only on a

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telephone conversation with the school's staff, without any review taking place. He felt the Board was unfairly singling out these 14 schools and needs to reexamine its policies.

Ms. Yaroslavsky called for the vote; motion carried (1 abstention).

Dr. Esrailian made a motion to conduct a site visit(s) to Ross University's main campus, the Bahama campus, and several representative teaching hospitals where student receive clinical training as part of Ross University' reevaluation by the Board; s/Salomonson; motion carried.

Agenda Item 30 Licensing Chief's Report

A. Licensing Program Update

Mr. Worden directed Members to page 234 of the packet for workload data for the first quarter of the fiscal year and briefly reviewed the results. He reported Special Faculty Permit meetings have been scheduled for March 24, 2011, June 16, 2011, and September 15, 2011; these meetings will take place only if there are applications for review. With the approval of Ross University's Grand Bahama campus, there are now 5 international medical school applications pending.

B. Application Review Process for Probationary Licenses

Mr. Worden reviewed the application process for probationary licenses. Staff must conduct a thorough review of each application to determine if an applicant meets the education, examination, and training required by statute and regulations. This review includes determining if the applicant failed to disclose required information. Substance abuse is usually self-disclosed by the applicant or indicated from a criminal conviction or other documentation received by the Board in its investigation. All these steps are taken to fulfill the Board's statutory requirement to protect the public.

Applications with identified concerns are submitted to management for a Senior Review Level 1 (SR1), a collaborative review by the licensing managers and Licensing Chief. If the SR1 determines that issuing a free and clear license is inappropriate, additional information and documentation is obtained and the application is sent to Senior Review Level 2 (SR2) which is conducted by Executive Management and legal staff. During this process, it is determined if a denial is warranted and if sufficient grounds exist to deny the application.

The SR2 determines whether an applicant's actions justify an outright denial or the offer of a stipulated agreement for a probationary license with appropriate terms and conditions. If a probationary license is offered, the applicant has 60 days to agree and return the signed stipulated agreement or request an Administrative Hearing. Signed stipulated agreements are reviewed and signed by the Licensing Chief and then forwarded to the Enforcement Program for processing and then sent to the Members for a vote. The burden of proof for licensing cases lies with the applicant, not the Board.

Mr. Worden concluded by requesting Members to vote in a timely manner, as most of the applicants require their license to continue in post graduate training or have pending employment offers.

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During public comment, Mr. Sheikh noted when the Program Director signs the L3 Certificate of Post Graduate Training, he/she is certifying that the individual has successfully completed the training and acquired the skills and qualifications necessary to safely practice medicine. He questioned whether the Board has the authority to challenge the qualifications of a physician if the signed L3 form indicates the applicant is qualified and if the Board staff have the authority to require additional documentation from the post graduate training program.

Agenda Item 31 Midwifery Advisory Council Update

Karen Ehrlich, Chair, Midwifery Advisory Council (MAC), reported the MAC met on August 11, 2010 in Sacramento. She reported the physician supervision requirement for licensed midwives (LMs), which is essentially unavailable in California, prevents midwives from having the tools they need to adequately safeguard women and babies. She'd like to place the issue of supervision on the December MAC agenda to develop strategies for making this requirement work. She mentioned that no other state requires physician supervision of midwives.

Ms. Ehrlich indicated the data collected in the Licensed Midwife Annual Report (LMAR) is unreliable since it depends upon retrospective rather than prospective reporting and the verification of questionable data is not possible due to staffing and budget limitations. It might be possible to contract with other organizations that are collecting, validating and verifying prospective data from midwives throughout the country. This would also allow a comparison of California midwives with other states. She also noted that when a midwife reports a death in the LMAR, OSHPD (which hosts the LMAR on their website and collects the data) will no longer be able to validate this data. Ms. Ehrlich would like to expand the survey so that when a midwife reports a death she will then be asked to answer a whole new set of questions regarding the circumstances of the death. She reported that she and Faith Gibson, MAC Member, had developed a preliminary set of supplemental questions.

The Comprehensive Perinatal Services Program, which was established to serve low income pregnant women in California, does not have licensed midwives on the list of providers. She would like the MAC to discuss how to obtain CPSP authorization for licensed midwives.

Ms. Ehrlich was concerned that former Section 2514 of the Business and Professions, Code, which was a section of the enabling legislation for midwives authorizing educational standards, was sunsetted in 1998. She would like to discuss how to put this section back into law.

By law, at least half the seats on the MAC are to be midwives. When the MAC was established, the Board determined the categories of individuals who would comprise the other half (two obstetricians and a Member of the Board). Ms. Ehrlich stated the California midwives always envisioned at least one of the public member spots would be assigned to a parent who had been served by a midwife. She requested, should a public member seat open up, that the Board consider renaming the position and develop a selection process whereby a parent is placed on the MAC.

Ms. Erhlich reminded that Board that most LMs also hold the Certified Professional Midwife (CPM) credential, a national and sometimes international certification by the North American Registry of Midwives (NARM). The credential has been psychometrically designed and

continues to be constantly updated. In the recently passed Health Care Reform, CPMs are now on the authorized list for Medicaid reimbursement in free standing, licensed birth centers. Due to the supervision requirement, LMs do not have Medicaid availability in California.

Ms. Ehrlich asked the Board to include an article in its newsletter informing physicians that it is the Midwifery Standard of Care to refer women that have had a prior cesarean for medical care. However, the midwife's scope of practice stipulates that, if a woman refuses to be medicalized, the midwife may continue to provide care. Physicians need to know that performing VBACs is within a midwife's scope of practice and within a woman's right to choose.

Ms. Chang made a motion to allow MAC to place the issues of supervision, prospective versus retrospective reporting for the LMAR, CPSP authorization, B&P Section 2514, and barriers to care as an on-going agenda item on its agenda; s/Schipske; motion carried.

During public comment, Claudia Breglia, California Association of Midwives (CAM), provided information to Members on midwifery barriers to care. She noted that the physician supervision requirement is the major issue that needs to be addressed, as it creates a host of problems for midwives. Ms. Breglia reported that California has already made a move to incorporate collaborative care in addressing health care disparities in obstetrics. LMs, nurse midwives (NMs) and physicians have come together to create federally qualified health centers that provide community based prenatal care and family planning to low income women. The problem is LMs were never added to the list of providers of obstetric care for neither the CPSP nor the Family Planning Access Care and Treatment Program (Family PACT). LMs are designated Medi-Cal providers in section 51051 of Title 22 of the CCR and are covered to the extent that federal financial participation is available in section 14132.39 of the Welfare and Institutions Code. These clinics provide services within the LM's scope of practice and are also under physician supervision. However, since LMs have been left off the lists, LMs are being fired, even though, in many cases, they were instrumental in creating the clinics. The clinics' lawyers are telling the clinics not to hire LMs because they can't bill for their services and can't be reimbursed.

Similarly, Ms. Breglia stated the Affordable Care Act allows for the reimbursement of CPMs when working in state licensed birth centers. California birth center law requires accreditation by the American Association of Childbirth Centers which includes a physician medical director and strict practice guidelines in their accrediting requirements. California law requires that 2 people be present at all times when a woman is in the birth center in labor, and that one of those people be a CPM or physician. Until LMs are added to the list of authorized providers, LMs cannot be hired by licensed birth centers since they are not legally authorized to provide midwifery services within our scope of practice under the supervision of a licensed physician.

Agenda Item 32 Enforcement Chief's Report

A. Approval of Orders Restoring License Following Satisfactory Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation.

Ms. Threadgill requested approval of 17 orders to restore licenses following satisfactory completion of probation and 3 orders for surrender of license during probation or administrative action .

Ms. Chang made the motion to approve the orders; s/Schipske; motion carried.

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B. Expert Utilization Report

Ms. Threadgill directed Members to page 237 of the packets for a chart reflecting the use of 556 experts by specialty during the past quarter. The number of experts in the Board's database has increased to 1,207 since the last quarter. The program received over 120 applications following the advertisement in the July 2010 newsletter. Staff is busy processing these applications and working to develop a training program for the expert reviewers. Ms. Sweet will provide information on the training program at the January 2011 meeting.

C. Enforcement Program Update

The Enforcement Program has a vacancy rate of approximately 10 percent for supervisors and 7 percent for investigators; this equates to an overall vacancy rate of approximately 7 percent. Staff conducted an informal inquiry of vacancy rates from 12 other state agencies and learned that rates varied from as low as 4 percent to as high as 56 percent. Ms. Threadgill reported the Enforcement Program normally recruits and hires from an open list of field investigator positions and a promotional list to fill the supervisor positions. Currently, as a result of the hiring freeze, they are only able to hire via transfers from within the Department and they cannot promote individuals to backfill supervisor positions. The authorized Consumer Protection Enforcement Initiative (CPEI) positions will not be filled due to the current hiring freeze. The pending retirement of several supervisors is an additional point of concern for the Enforcement Program.

In an effort to remove perceived obstacles in investigations and improve communications, the Enforcement Program management team and HQES held a meeting with Kaiser-South earlier this year. On September 20, 2010, a similar meeting was held with Kaiser-North. Both meetings were extremely productive; it is hoped the new resolutions that were reached will improve investigative timelines.

The Program continues to utilize the Aged Case Council to move forward cases that appear to be "stuck". Experience has shown that the mere identification of cases to be subject to the Council produces movement.

Ms. Threadgill reported a number of training projects are in process. The Mini Academy (investigator training) will be held over a period of three weeks in November, December and January. Board Members are invited to drop by during any of the sessions. The statewide Investigator Training Conference should be held in April 2011 in San Diego.

Agenda Item 25 Vertical Enforcement Program Report

Carlos Ramirez, Senior Assistant Attorney General, reported he met with Mr. Zerunyan, Ms. Whitney, and Ms. Threadgill on October 19, 2010 to discuss the findings from the Board Evaluation Report. One of the items discussed were the costs associated with Vertical Enforcement (VE). Mr. Zerunyan requested data, which has since been provided. Discussion will continue after the new administration is in place. Mr. Ramirez indicated that, although HQES disagreed with parts of the Report, there were sections that caused them to reevaluate how they conduct business statewide. Some measures have already been taken to address areas of concern. He will work with Ms. Threadgill to revise portions of the VE Manual to reflect best practices that are used throughout the state and to move toward more consistent implementation across regions.

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Mr. Ramirez noted there are 22 Deputy Attorney Generals (DAGs) located at the Los Angeles Office with only 2 Supervising DAGs. He believes this supervisor to deputy ratio is too high and has received permission to hire an additional supervisor to lower the ratio.

Ms. Threadgill referred Members to page 245 of their packets for the VE statistics. She reported that several of the recommendations made in the Board Evaluation Report were already being implemented. These include video conferencing (which was temporarily halted but is hoped to be reinstated soon), re-submitting a request for a medical consultants, and on-going improvements to the Expert Reviewer Program.

Ms. Threadgill reported that she is continuing to work with Mr. Ramirez and the SDAGs. A conference call is scheduled next week to discuss improvements to default decision processing. Areas of concerns and best practices are being explored to reduce timelines.

Mr. Zerunyan thanked Mr. Ramirez and Ms. Threadgill for their openness and willingness to address identified issues.

Agenda Item 34 Update on Board's Mechanism for Impaired Physicians
This item was tabled until the January 2011 meeting.

Agenda Item 35 Department of Consumer Affairs Update

A. Budget / Hiring Freeze Update
Ms. Kirchmeyer reported that on August 31, 2010, the Department received a directive from the Governor's Office to cease the hiring of employees. The directive stated there may be limited circumstances where exceptions may be necessary, including the protection of mission critical functions. The exception approval process is very stringent and must go through the Department, the State and Consumer Services Agency (SCSA), and the Governor's Office. Only the most critical exemption requests are being approved. DCA has submitted several requests but, to date, only 5 exceptions have been approved; these were primarily exemptions for overtime and the hiring of limited staff for the Bureau for Private Post-Secondary Education which was recently re-established. The next exception request the Department will put forward will be for overtime for existing staff to perform CPEI functions since these recently authorized positions cannot be filled due to the hiring freeze.

Ms. Whitney stated it was her understanding that the overtime could only be requested for the "front end" of the enforcement process to cover the duties CPEI staff would have performed. Ms. Kirchmeyer recommended that overtime exemptions be requested for investigative staff as well in order to bring timelines down.

Ms. Yaroslavsky asked that Ms. Whitney be allowed to submit an overtime exception for the entire staff for a specific period of time.

As they receive information from the Department of Finance, the Department has communicated changes to the budget so the boards will know how these changes will affect their current budgets for FY 2010/11.

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B. Consumer Protection Enforcement Initiative (CPEI)

The Department encourages the Board to continue to move forward with any regulations that will allow the Executive Director the ability to expedite the Board's investigation and prosecution processes as identified in the drafting of SB 1111. Although many of the recommended regulations were drawn from existing Medical Board regulations, there were 3 other regulations that the Board could move forward to implement. One of these involves requiring physician cooperation in Board interviews / conferences, which the Board has just put forward as proposed legislation. The other suggested regulations deal with the psychological or medical evaluation of an applicant and the failure to report an arrest to be considered unprofessional conduct (currently the Board only requires that licensees report felony or misdemeanor convictions or felony indictments, not arrests).

The Department is preparing the duty statements and other paperwork for the CPEI positions that the boards may use in order to be able to move quickly once the hiring freeze is lifted.

Ms. Kirchmeyer reported the collection of information on board performance measurements has begun. These include data on cycle times, volumes of complaints, costs, customer service, and probation monitoring. This information will be posted on both the Medical Board's website and the Department's website for the public's use. These reports should be posted by mid-November 2010. The time from complaint initiation to disciplinary action has been the information considered most important to the public.

C. Board Meeting Protocol

DCA Director Brian Stiger has been holding monthly phone conferences with board chairs and presidents and executive directors/officers. During one of the calls, there was discussion on protocols for board meetings. Board meeting protocols were developed by the Department's Deputy Director for Legal Affairs and are included in the packets on page 247.

D. BreEZe Update

Ms. Kirchmeyer reported the Department's project to replace the antiquated CAS and ATS systems for enforcement and licensing is on target and moving forward. The Department will provide a presentation to the Board on the new program at the January 2011 meeting. Two vendors were pre-qualified to bid for the project and have been meeting with staff and subject matter experts for the past three weeks to review the requirements for this system. The Request for Proposal will go out at the end of December 2010. The completed BreEZe system is expected to roll out in December 2012. This will be a business-driven project, rather than an IT-driven project. Three workgroups have been identified as necessary for the project: Forms Revision Workgroup, Data Conversion Workgroup, and Reports Workgroup. These workgroups will be drawn from the boards.

Ms. Kirchmeyer thanked the Board for webcasting the meeting and for including a speaker on Health Care Reform on its agenda.

Agenda Item 36 Agenda Items for January 27-28, 2011 Meeting in Burlingame, CA

The update on the Board's mechanism for impaired physicians, which was tabled until the January meeting, will be on the agenda. Disciplinary guidelines regulations will also appear on the agenda.

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During public comment, Michele Monserratt-Ramos, Consumers Union, California Safe Patient Campaign, expressed her support for requiring licensees to report arrests to the Board in addition to convictions.

Agenda Item 37 Adjournment

There being no further business, Dr. Duruisseau made a motion to adjourn. The meeting was adjourned at 3:05 p.m.

_____

Barbara Yaroslavsky, President

_____

Hedy Chang, Secretary

_____

Linda K. Whitney, Executive Director

DRAFT

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0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

FY 2011-12 Governor's Proposed Budget	Actual 2009-10	Budget Act CY 2010-11	Governor's Budget BY 2011-12	BY+1 2012-13	BY+2 2013-14
BEGINNING BALANCE	$ 24,380	$ 27,903	$ 26,743	$ 23,413	$ 19,633
Prior Year Adjustment	$ 32	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 24,412	$ 27,903	$ 26,743	$ 23,413	$ 19,633
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 271	$ 314	$ 313	$ 313	$ 313
125700 Other regulatory licenses and permits	$ 5,321	$ 5,533	$ 5,533	$ 5,533	$ 5,533
125800 Renewal fees	$ 44,670	$ 43,357	$ 44,838	$ 45,226	$ 45,621
125900 Delinquent fees	$ 94	$ 96	$ 96	$ 96	$ 96
142500 Miscellaneous services to the public	$ 37	$ 25	$ 25	$ 25	$ 25
150300 Income from surplus money investments	$ 178	$ 173	$ 151	$ 125	$ 95
160400 Sale of fixed assets	$ 20	$ -	$ -	$ -	$ -
161000 Escheat of unclaimed checks and warrants	$ 23	$ -	$ -	$ -	$ -
161400 Miscellaneous revenues	$ 1	$ 20	$ 20	$ 20	$ 20
164300 Penalty assessments - Probation Monitoring		$ 1,100	$ 1,100	$ 1,100	$ 1,100
Totals, Revenues	$ 50,615	$ 50,618	$ 52,076	$ 52,438	$ 52,803
Transfers:					
TOTALS, REVENUES AND TRANSFERS	$ 50,615	$ 50,618	$ 52,076	$ 52,438	$ 52,803
TOTAL RESOURCES	$ 75,027	$ 78,521	$ 78,819	$ 75,851	$ 72,435
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 33	$ 80	$ 58	$ -	$ -
8880 FSCU (State Operations)		$ 31	$ 232		
1110 Program Expenditures (State Operations)	$ 47,091	$ 51,708	$ 55,116	$ 56,218	$ 57,343
2010-11 Approved BCPs:					
License Application Processing		$ -	$ -	$ -	$ -
Cal-Licensing System-BCP 1111-04: BreEZe		$ (41)			
Proposed 2011-12 Augmentations (Board):					
Operation Safe Medicine			Disapproved		
Staff Programmer			Disapproved		
Temp Help (District Medical Consultant $)			Disapproved		
WAAZ/Scanning			Disapproved		
AB 2699: Exemption from Licensure (Volunteer Physicians)			Disapproved		
Totals, Disbursements	$ 47,124	$ 51,778	$ 55,406	$ 56,218	$ 57,343
FUND BALANCE					
Reserve for economic uncertainties	$ 27,903	$ 26,743	$ 23,413	$ 19,633	$ 15,093
Months in Reserve	6.5	5.8	5.0	4.1	3.1

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2010-11 AND BEYOND.

B. INTEREST ON FUND ESTIMATED AT .68% in FY 09/10 and beyond.

C. MED BOARD'S 2009-2010 PROB MONITORING AND OSM BCPs APPROVED WITH NO FUNDING (Prob Mon = $294,000; OSM = $510,000); OSM APPROVED FOR 2 YEARS; CONTINUATION OF OSM BEYOND 2 YEARS MUST BE AUTHORIZED VIA SUBMISSION/APPROVAL OF A BCP FOR FY 2011/12.

D. FY 10-11 RENEWAL FEE REVENUE INCLUDES A ONE-TIME CREDIT OF $22 FOR EACH PHYSICIAN RENEWING (ELIMINATION OF THE DIVERSION PROGRAM)

E. OSM ($567,000, 6.0 PY); ISB ($106,000, 1.0 PY); Temp Help-MCs ($196,000); WAAZ/Scanning ($116,000, 2.0 PY); AB 2699 ($43,000, 0.5 PY)

1/12/2011

Medical Board of California

FY 10/11
Budget Expenditure Report
(As of November 30, 2010)
(41.6% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	15,038,145	5,460,912	36.3	9,577,233
Board Members	31,500	10,500	33.3	21,000
Phy Fitness Incentive Pay	29,623	9,555	32.3	20,068
Temp Help	1,144,410	689,319	60.2	455,091
Overtime	12,143	12,163	100.2	(20)
Staff Benefits	6,986,548	2,450,644	35.1	4,535,904
Salary Savings	(1,588,105)			(1,588,105)
TOTALS, PERS SERVICES	21,654,264	8,633,093	39.9	13,021,171
OPERATING EXP & EQUIP				
General Expense	795,533	51,722	6.5	743,811
Fingerprint Reports	333,448	105,510	31.6	227,938
Minor Equipment	253,500	11,176	4.4	242,324
Printing	483,755	257,063	53.1	226,692
Communications	287,780	97,429	33.9	190,351
Postage	280,511	72,968	26.0	207,543
Insurance	41,053	12,992	31.6	28,061
Travel In-State	494,298	52,918	10.7	441,380
Travel Out-of-State	1,000	0	0.0	1,000
Training	76,895	4,651	6.0	72,244
Facilities Operation (Rent)	2,758,140	2,258,685	81.9	499,455
Consult/Prof Services	982,594	888,435	90.4	94,159
Departmental Prorata	4,045,307	1,586,504	39.2	2,458,803
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	646,809	172,386	26.7	474,423
Data Processing	128,492	3,800	3.0	124,692
Central Admin Svcs (Statewide Prorata)	1,718,857	859,429	50.0	859,428
Attorney General Services	13,347,280	5,046,235	37.8	8,301,045
Office of Administrative Hearings	1,862,591	254,865	13.7	1,607,726
Evidence/Witness	1,893,439	470,636	24.9	1,422,803
Court Reporter Services	175,000	16,507	9.4	158,493
Major Equipment	563,000	0	0.0	563,000
Other Items of Expense	81	31,835	39,302.5	(31,754)
Vehicle Operations	261,925	82,731	31.6	179,194
TOTALS, OE&E	31,436,430	12,338,477	39.2	19,097,953
TOTALS, EXPENDITURES	53,090,694	20,971,570	39.5	32,119,124
Scheduled Reimbursements	(384,000)	(138,611)	36.1	(245,389)
Distributed Costs	(999,000)	(348,645)	34.9	(650,355)
NET TOTAL, EXPENDITURES	51,707,694	20,484,314	39.6	31,223,380
Unscheduled Reimbursements		(308,246)		
		20,176,068		

Budget Expenditure Report.xls
Date: December 28, 2010

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2010 - NOVEMBER 30, 2010

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	8,980,637	3,666,012	current
Staff Benefits	4,115,706	1,442,743	current
TOTAL PERSONAL SERVICES	13,096,343	5,108,755	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	389,731	37,692	1-2
Printing	214,944	210,130	1-2
Communications	140,780	59,308	1-2
Postage	50,000	22,999	1-2
Insurance	38,235	10,976	current
Travel In-State	282,139	27,750	1-2
Training	35,209	2,571	1-2
Facililties Operations	2,056,940	1,596,249	current
Consultant/Professional Services	300,000	115,019	1-2
Departmental Services	2,945,506	1,161,003	current
Interagency Services	3,744	0	1-2
Data Processing	18,000	0	1-2
Statewide Pro Rata	1,251,500	625,750	current
Attorney General 1/	13,197,280	4,975,522	current
OAH	1,862,591	254,865	1
Evidence/Witness Fees	1,820,939	459,830	1-2
Court Reporter Services	174,750	16,507	1-2
Major Equipment	503,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	31,448	1-2
Vehicle Operations	210,925	69,925	1-2
Minor Equipment	1,600	8,272	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	25,497,894	9,685,816	
DISTRIBUTED COSTS	(945,405)	(335,246)	
TOTAL BUDGET/EXPENDITURES	**37,648,832**	**14,459,325**	
Unscheduled Reimbursements		(37,251)	
		14,422,074	

1/See next page for monthly billing detail

12/29/2010
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MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 10/11
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	5,877.25	170.00	999,132.50
	Paralegal Services	442.75	120.00	53,130.00
	Auditor/Analyst Services	92.25	99.00	9,132.75
	Cost of Suit			
				1,061,395.25
August	Attorney Services	5,896.00	170.00	1,002,320.00
	Paralegal Services	376.00	120.00	45,120.00
	Auditor/Analyst Services	87.50	99.00	8,662.50
	Cost of Suit			
				1,056,102.50
September	Attorney Services	5,613.00	170.00	954,210.00
	Paralegal Services	318.75	120.00	38,250.00
	Auditor/Analyst Services	92.50	99.00	9,157.50
	Cost of Suit			
				1,001,617.50
October	Attorney Services	5,597.00	170.00	951,490.00
	Paralegal Services	245.50	120.00	29,460.00
	Auditor/Analyst Services	83.25	99.00	8,241.75
	Cost of Suit			8,879.53
				998,071.28
November	Attorney Services	4,829.00	170.00	820,930.00
	Paralegal Services	237.75	120.00	28,530.00
	Auditor/Analyst	83.00	99.00	8,217.00
	Cost of Suit			658.72
				858,335.72
December	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst		99.00	0.00
	Cost of Suit			
				0.00
			FYTD Total =	**4,975,522.25**
			FY 10/11 Budget =	**13,197,280.00**

Revised 12/7/10

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2008 - NOVEMBER 2010

	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Total
Invest Cost Recovery	18,069	1,850	2,935	6,569	3,616	4,564	8,445	14,535	2,716	5,585	3,650	5,200	77,734
Criminal Cost Recovery	0	5,694	0	0	0	0	3,500	0	0	0	0	0	9,194
Probation Monitoring	56,999	17,107	28,739	109,603	53,626	75,517	218,781	232,169	82,153	52,220	44,309	37,530	1,008,753
Exam	825	75	50	3,495	50	2,150	125	5,740	100	75	75	50	12,810
Cite/Fine	3,050	3,200	9,050	2,400	1,500	5,650	4,300	10,400	9,415	5,375	5,700	8,300	68,340
MONTHLY TOTAL	78,943	27,926	40,774	122,067	58,792	87,881	235,151	262,844	94,384	63,255	53,734	51,080	1,176,831
FYTD TOTAL	78,943	106,869	147,643	269,710	328,502	416,383	651,534	914,378	1,008,762	1,072,017	1,125,751	1,176,831	

	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	FYTD Total
Invest Cost Recovery	4,486	1,050	1,250	740	67	1,161	7,409	11,613	0	2,186	11,388	1,500	42,850
Criminal Cost Recovery	0	0	0	0	0	0	0	0	0	0	0	0	0
Probation Monitoring	46,225	21,354	22,836	34,983	22,419	186,279	345,366	200,249	60,048	59,731	29,879	42,043	1,071,412
Exam	150	250	105	330	3,480	1,658	292	200	1,500	300	325	500	9,090
Cite/Fine	3,500	3,025	2,425	3,225	3,055	5,320	475	4,723	4,600	5,200	3,261	5,340	44,149
MONTHLY TOTAL	54,361	25,679	26,616	39,278	29,021	194,418	353,542	216,785	66,148	67,417	44,853	49,383	1,167,501
FYTD TOTAL	54,361	80,040	106,656	145,934	174,955	369,373	722,915	939,700	1,005,848	1,073,265	1,118,118	1,167,501	

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	FYTD Total
Invest Cost Recovery	3,981	971	871	846	996								7,665
Criminal Cost Recovery	0	0	0	0	0								0
Probation Monitoring	43,697	74,202	31,474	35,029	120,104								304,506
Exam	2,475	3,730	1,750	9,456	4,031								21,442
Cite/Fine	5,500	8,250	10,075	4,000	2,600								30,425
MONTHLY TOTAL	55,653	87,153	44,170	49,331	127,731	0	0	0	0	0	0	0	364,038
FYTD TOTAL	55,653	142,807	186,977	236,308	364,038	364,038	364,038	364,038	364,038	364,038	364,038	364,038	

excel:enfreceiptsmonthlyprofile.xls revised 12/21/2010

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2010 - NOVEMBER 30, 2010

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,213,962	938,994	current
Staff Benefits	1,116,520	396,104	current
TOTAL PERSONAL SERVICES	3,330,482	1,335,098	
OPERATING EXPENSES & EQUIPMENT			
General Expense	85,000	4,425	1-2
Fingerprint Reports*	329,248	100,441	1-2
Printing	30,000	12,323	1-2
Communications	50,000	14,753	1-2
Postage	73,511	48,882	1-2
Travel In-State	25,000	342	1-2
Training	3,500	1,800	1-2
Facilities Operation	225,000	222,912	current
Consult/Professional Services	506,873	366,562	1-2
Departmental Services	393,204	154,050	current
Interagency Services	499	0	current
Data Processing	3,000	3,800	1-2
Statewide Pro Rata	167,073	83,536	current
Attorney General	150,000	70,713	current
Evidence/Witness Fees	7,500	0	1-2
Court Reporter Services	250	0	1-2
Major Equipment	12,000	0	1-2
Minor Equipment	67,500	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,129,158	1,084,539	
SCHEDULED REIMBURSEMENTS	(384,000)	(138,611)	
DISTRIBUTED COSTS	(49,282)	(12,321)	
TOTAL BUDGET/EXPENDITURES	**5,026,358**	**2,268,705**	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports

g/admin/licensn2.xls
12/29/2010

Medical Board of California
Board Members' Expense Report
July 1, 2010 - November 30, 2010

	*Per Diem**				*Travel Expenses**	*Total Sept-Nov*	***Total FYTD***
	SEPT	OCT	NOV	TOTAL			
Dr. Carreon	1,000	1,100	1,200	3,300	0.00	3,300.00	4,700.00
Ms. Chang	0	0	0	0	0.00	0.00	0.00
Dr. Chin	0	0	0	0	0.00	0.00	0.00
Dr. Diego	0	0	200	200	0.00	200.00	381.50
Dr. Duruisseau	300	800	800	1,900	762.66	2,662.66	4,472.66
Dr. Esrailian	400	0	0	400	0.00	400.00	2,179.76
Dr. Levine	0	0	0	0	0.00	0.00	747.33
Dr. Low	0	0	0	0	0.00	0.00	0.00
Dr. Moran	700	1,200	600	2,500	0.00	2,500.00	2,500.00
Dr. Salomonson	0	0	0	0	0.00	0.00	1,403.09
Ms. Schipske	100	100	600	800	0.00	800.00	800.00
Ms. Yaroslavsky	1,000	1,500	1,500	4,000	396.26	4,396.26	4,396.26
Mr. Zerunyan	1,300	1,500	1,600	4,400	109.00	4,509.00	7,517.66
BOARD TOTAL	4,800	6,200	6,500	17,500	1,267.92	18,767.92	**29,098.26**

*includes claims paid/submitted through January 4, 2011

Board Members Expense Report.xls
Date: January 5, 2011

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	DIVERSION	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 08/09									
$ Budgeted	2,158,000	36,659,000		4,599,000	2,048,000		3,370,000	1,914,000	50,748,000
$ Spent *	1,875,000	34,026,000		4,522,000	1,697,000		2,668,000	625,000	45,413,000 *
Positions Authorized	8.8	146.6		45.5	15.0		16.0	20.0	251.9
FY 09/10									
$ Budgeted	2,030,000	36,539,000	567,000	4,262,000	1,558,000		2,953,000	1,589,000	49,498,000
$ Spent *	2,920,000	34,130,000	494,000	4,772,000	1,547,000		2,728,000	500,000	47,091,000 *
Positions Authorized	8.8	146.6	6.0	45.5	15.0		16.0	25.0	262.9
FY 10/11									
$ Budgeted	1,939,000	37,649,000	574,000	5,026,000	1,682,000		3,110,000	1,728,000	51,708,000
$ Spent thru 11/30*	1,018,000	14,422,000	314,000	2,269,000	624,000		1,029,000	500,000	20,176,000 *
Positions Authorized	8.8	165.0	6.0	53.3	15.0		17.0	24.0	289.1
FY 11/12									
$ Budgeted									55,116,000
Positions Authorized	8.8	167.6		53.3	15.0		17.0	24.0	285.7

* net expenditures (includes unscheduled reimbursements)

1/4/2011
Budget Overview by Program.xls

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

JANUARY 28, 2011
SAN FRANCISCO, CA

2011 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Deadlines based on custom and usage; pending adoption of the Joint Rules.

11-17-10

JANUARY							
	S	M	T	W	TH	F	S
							1
Wk. 1	2	3	4	5	6	7	8
Wk. 2	9	10	11	12	13	14	15
Wk. 3	16	17	18	19	20	21	22
Wk. 4	23	24	25	26	27	28	29
Wk. 1	30	31					

FEBRUARY							
	S	M	T	W	TH	F	S
Wk. 1			1	2	3	4	5
Wk. 2	6	7	8	9	10	11	12
Wk. 3	13	14	15	16	17	18	19
Wk. 4	20	21	22	23	24	25	26
Wk. 1	27	28					

MARCH							
	S	M	T	W	TH	F	S
Wk. 1			1	2	3	4	5
Wk. 2	6	7	8	9	10	11	12
Wk. 3	13	14	15	16	17	18	19
Wk. 4	20	21	22	23	24	25	26
Wk. 1	27	28	29	30	31		

APRIL							
	S	M	T	W	TH	F	S
Wk. 1						1	2
Wk. 2	3	4	5	6	7	8	9
Wk. 3	10	11	12	13	14	15	16
Spring Recess	17	18	19	20	21	22	23
Wk. 4	24	25	26	27	28	29	30

MAY							
	S	M	T	W	TH	F	S
Wk. 1	1	2	3	4	5	6	7
Wk. 2	8	9	10	11	12	13	14
Wk. 3	15	16	17	18	19	20	21
Wk. 4	22	23	24	25	26	27	28
No Hrgs.	29	30	31				

Holiday schedule subject to final approval by Rules Committee.

DEADLINES

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 3 Legislature reconvenes (J.R. 51(a)(1)).

Jan. 10 Budget must be submitted by Governor on or before this date (Art. IV, Sec. 12(a)).

Jan. 17 Martin Luther King, Jr. Day.

Jan. 21 Last day to submit bill requests to the Office of Legislative Counsel.

Feb. 18 Last day for bills to be introduced (J.R. 61(a)(1)) (J.R. 54(a)).

Feb. 21 President's Day.

Mar. 28 Cesar Chavez Day observed.

Apr. 14 Spring Recess begins upon adjournment (J.R. 51(a)(2)).

Apr. 25 Legislature reconvenes (J.R. 51(a)(2)).

May 6 Last day for policy committees to hear and report to fiscal committees fiscal bills introduced in their house (J.R. 61(a)(2)).

May 13 Last day for policy committees to hear and report to the floor nonfiscal bills introduced in their house (J.R. 61(a)(3)).

May 20 Last day for policy committees to meet prior to June 6 (J.R. 61 (a)(4)).

May 27 Last day for fiscal committees to hear and report to the floor bills introduced in their house (J.R. 61 (a)(5)). Last day for fiscal committees to meet prior to June 6 (J.R. 61 (a)(6)).

May 30 Memorial Day.

May 31 - June 3 Floor session only. No committee may meet for any purpose (J.R. 61(a)(7)).

OVER

AB 2699 (Bass, Chapter 270) Healing Arts: Licensure Exemption
This bill exempts all healing arts practitioners who are licensed and certified in other states from California state licensure, for the purposes of providing voluntary health care services to uninsured and underinsured Californians on a short-term basis. The services being provided must be part of a sponsored event (which is limited to 10 days), and the event must be put on by an approved sponsored entity. The health care practitioner must submit a request for authorization to practice without a license on a form prescribed by each board and pay a fee determined by each board through regulation.

The practitioner must also provide each board a copy of his or her license in each state where the individual is licensed, and each license must be in good standing. This bill will sunset on January 1, 2014.

The Medical Board, along with all other healing arts boards, must do regulations in order to implement this bill. The Department of Consumer Affairs (DCA) has drafted model regulations and a standardized authorization form for all boards to use as a starting point. The text of these model regulations and the draft authorization form is included in your legislative packet.

The major elements of the model regulations are:

- Definitions of "community-based organization" and out-of-state practitioner".
- Sponsoring entity registration and recordkeeping requirements.
- Out-of-state practitioner authorization to participate in a sponsored event. In this Section, the Medical Board will need to input additional information in the model regulations to require the following:
    - The processing fee for the request for authorization to practice. *Staff proposes to cover basic review and processing.*
    - Any additional educational and experience requirements that should be included. *Staff proposes to require that physicians must have graduated from a Medical Board recognized school, and must have nothing on the DOJ record that would otherwise disqualify them from licensure. The bill already requires the license to be in good standing in other states where the physician is licensed.*
    - *Staff proposes to require participating physicians to post or notify consumers receiving care that complaints about quality of care should be made to Medical Board.*
    - Any additional criteria for reasons to deny a request for authorization to participate.
- Termination of authorization and appeal.

Time Line for Regulations
In order for these regulations to have a hearing date at the next board meeting on May 6, 2011, they will need to be submitted to the Office of Administrative Law by March 1, 2011; published and mailed out by March 11, 2011; and the public comment period would then close on April 25, 2011. Staff will work on drafting the regulations to meet these deadlines.

Staff requests authorization to move forward with setting the model regulations for hearing with those items identified and approved by the Board included in these regulations so they can be set in May. Alternatively, the Board could request more staff development and these regulations could be taken to the Board for approval in May to be set for hearing in July.

_____

[Board Name]

Proposed Regulations

Article X.
Sponsored Free Health Care Events—Requirements for Exemption.

§1. Definitions.

For the purposes of section 901 of the code:

(a) "Community-based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

(b) "Out-of-state practitioner" means a person who is not licensed in California to engage in the practice of _____ but who holds a current valid license or certificate in good standing in another state, district, or territory of the United States to practice _____.

NOTE: Authority cited: Business and Professions Code §§ _____, 901. Reference: Business and Professions Code § 901.

§2. Sponsoring Entity Registration and Recordkeeping Requirements.

(a) Registration. A sponsoring entity that wishes to provide, or arrange for the provision of, health care services at a sponsored event under section 901 of the code shall register with the board not later than 90 calendar days prior to the date on which the sponsored event is scheduled to begin. A sponsoring entity shall register with the board by submitting to the board a completed Form 901-A (xx/xxxx), which is hereby incorporated by reference.

(b) Determination of Completeness of Form. The board may, by resolution, delegate to the [Identify unit] in the Department of Consumer Affairs the authority to receive and process Form 901-A on behalf of the board. The board or its delegatee shall inform the sponsoring entity within 15 calendar days of receipt of Form 901-A in writing that the form is either complete and the sponsoring entity is registered or that the form is deficient and what specific information or documentation is required to complete the form and be registered. The board or its delegatee shall reject the registration if all of the identified

deficiencies have not been corrected at least 30 days prior to the commencement of the sponsored event.

(c) Recordkeeping Requirements. Regardless of where it is located, a sponsoring entity shall maintain at a physical location in California a copy of all records required by section 901 as well as a copy of the authorization for participation issued by the board to an out-of-state practitioner. The sponsoring entity shall maintain these records for a period of at least five years after the date on which a sponsored event ended. The records may be maintained in either paper or electronic form. The sponsoring entity shall notify the board at the time of registration as to the form in which it will maintain the records. In addition, the sponsoring entity shall keep a copy of all records required by section 901(g) of the code at the physical location of the sponsored event until that event has ended. These records shall be available for inspection and copying during the operating hours of the sponsored event upon request of any representative of the board.

(d) Requirement for Prior Board Approval of Out-of-State Practitioner. A sponsoring entity shall not permit an out-of-state practitioner to participate in a sponsored event unless and until the sponsoring entity has received written approval from the board.

(e) Report. Within 15 calendar days after a sponsored event has concluded, the sponsoring entity shall file a report with the board summarizing the details of the sponsored event. This report may be in a form of the sponsoring entity's choosing, but shall include, at a minimum, the following information:

(1) The date(s) of the sponsored event;

(2) The location(s) of the sponsored event;

(3) The type(s) and general description of all health care services provided at the sponsored event; and

(4) A list of each out-of-state practitioner granted authorization pursuant to this article who participated in the sponsored event, along with the license number of that practitioner.

NOTE: Authority cited: Business and Professions Code §§ ____, 901. Reference: Business and Professions Code § 901.

§3. Out-of-State Practitioner Authorization to Participate in Sponsored Event

(a) Request for Authorization to Participate. An out-of-state practitioner ("applicant") may request authorization from the board to participate in a sponsored event and provide such health care services at the sponsored event as would be permitted if the applicant were licensed by the board to provide those services. An applicant shall request authorization by submitting to the board a completed Form 901-B (xx/xxxx), which is hereby incorporated by reference, accompanied by a non-refundable processing fee of $_____. The applicant shall also furnish either a full set of fingerprints or submit a Live Scan inquiry to establish the identity of the applicant and to permit the board to conduct a criminal history record check.

(b) Response to Request for Authorization to Participate. Within 20 calendar days of receiving a completed request for authorization, the board shall notify the sponsoring entity whether that request is approved or denied.

(c) Denial of Request for Authorization to Participate.

(1) The board shall deny a request for authorization to participate if:

(A) The submitted Form 901-B is incomplete and the applicant has not responded within 7 calendar days to the board's request for additional information.

[(B) The applicant has not met the following educational and experience requirements:

(i) ***
(ii) ***

(C) ***]

(D) The applicant has failed to comply with a requirement of this article or has committed any act that would constitute grounds for denial of an application for licensure by the board.

(E) The applicant does not possess a current valid license in good standing. The term "good standing" means the applicant:

(i) Has not been charged with an offense for any act substantially related to the practice for which the applicant is licensed by any public agency;

(ii) Has not entered into any consent agreement or been subject to an administrative decision that contains conditions placed upon the applicant's professional conduct or practice, including any voluntary surrender of license;

(iii) Has not been the subject of an adverse judgment resulting from the practice for which the applicant is licensed that

the board determines constitutes evidence of a pattern or negligence or incompetence.

(2) The board may deny a request for authorization to participate if:

(A) The request is received less than 20 calendars days before the date on which the sponsored event will begin.

(B) The applicant has been previously denied a request for authorization by the board to participate in a sponsored event.

(C) The applicant has previously had an authorization to participate in a sponsored event terminated by the board.

(D) The applicant has participated in [insert a number here] or more sponsored events during the 12 month period immediately preceding the current application.

[(E) ***]

(d) Appeal of Denial. An applicant requesting authorization to participate in a sponsored event may appeal the denial of such request by following the procedures set forth in section 4.

NOTE: Authority cited: Business and Professions Code §§144, _____, 901. Reference: Business and Professions Code § 901

§4. Termination of Authorization and Appeal.

(a) Grounds for Termination. The Board may terminate an out-of-state practitioner's authorization to participate in a sponsored event for any of the following reasons:

(1) The out-of-state practitioner has failed to comply with any applicable provision of this article, or any applicable practice requirement or regulation of the board.

(2) The out-of-state practitioner has committed an act that would constitute grounds for discipline if done by a licensee of the board.

(3) The board has received a credible complaint indicating that the out-of-state practitioner is unfit to practice at the sponsored event or has otherwise endangered consumers of the practitioner's services.

(b) Notice of Termination. The board shall provide both the sponsoring entity and the out-of-state practitioner with a written notice of the termination, including the basis for the termination. If the written notice is provided during a sponsored event, the board may provide the notice to any representative of the sponsored event on the premises of the event.

(c) Consequences of Termination. An out-of-state practitioner shall immediately cease his or her participation in a sponsored event upon receipt of the written notice of termination.

Termination of authority to participate in a sponsored event shall be deemed a disciplinary measure reportable to the national practitioner data banks. In addition, the board shall provide a copy of the written notice of termination to the licensing authority of each jurisdiction in which the out-of-state practitioner is licensed.

(d) Appeal of Termination. An out-of-state practitioner may appeal the board's decision to terminate an authorization in the manner provided by section 901(j)(2) of the code. The request for an appeal shall be considered a request for an informal hearing under the Administrative Procedure Act.

(e) Informal Conference Option. In addition to requesting a hearing, the out-of-state practitioner may request an informal conference with the executive officer regarding the reasons for the termination of authorization to participate. The executive officer shall, within 30 days from receipt of the request, hold an informal conference with the out-of-state practitioner. At the conclusion of the informal conference, the executive officer may affirm or dismiss the termination of authorization to participate. The executive officer shall state in writing the reasons for his or her action and mail a copy of his or her findings and decision to the out-of-state practitioner within ten days from the date of the informal conference. The out-of-state practitioner does not waive his or her request for a hearing to contest a termination of authorization by requesting an informal conference. If the termination is dismissed after the informal conference, the request for a hearing shall be deemed to be withdrawn.

NOTE: Authority cited: Business and Professions Code §§ _____, 901.
Reference: Business and Professions Code § 901.

REQUEST FOR AUTHORIZATION TO PRACTICE WITHOUT A LICENSE AT A REGISTERED FREE HEALTH CARE EVENT

In accordance with California Business and Professions Code Section 901 any *[profession]* licensed/certified and in good standing in another state, district, or territory in the United States may request authorization from the *[board/committee name]* (Board) to participate in a free health care event offered by a sponsoring entity, registered with the Board pursuant to Section 901, for a period not to exceed ten (10) days.

PART 1 - APPLICATION INSTRUCTIONS

An application must be complete and must be accompanied by all of the following:

- A processing fee of $_____, made payable to the board.
- A copy of each valid and current license and/or certificate authorizing the applicant to engage in the practice of [profession] issued by any state, district, or territory of the United States.
- A copy of a valid photo identification of the applicant issued by one of the jurisdictions in which the applicant holds a license or certificate to practice.
- [Boards shall list here any additional information required to be submitted with the application – this may include fingerprinting information, educational records, letter(s) of reference, list of work experience, etc.]

The board will not grant authorization until this form has been completed in its entirety, all required enclosures have been received by the board, and any additional information requested by the Board has been provided by the applicant and reviewed by the board, and a determination made to grant authorization.

The board shall process this request and notify the sponsoring entity listed in this form if the request is approved or denied within 20 calendar days of receipt. If the board requires additional or clarifying information, the board will contact you directly, but **written approval or denial of requests will be provided directly to the sponsoring entity**. It is the applicant's responsibility to maintain contact with the sponsoring entity.

PART 2 – NAME AND CONTACT INFORMATION

1. Applicant Name: _____
First Middle Last

2. Social Security Number: ____ - ___ - _____ Date of Birth: _____

3. Applicant's Contact Information:

Address Line 1 _____ Phone _____

Address Line 2 _____ Alternate Phone _____

City, State, Zip _____ E-mail address _____

4. Applicant's Employer : _____

Employer's Contact Information:

Address Line 1 _____ Phone _____

Address Line 2 _____ Facsimile _____

City, State, Zip _____ E-mail address (if available) _____

PART 3 – LICENSURE INFORMATION

1. Do you hold a current license, certification, or registration issued by a state, district, or territory of the United States authorizing the unrestricted practice of [profession] in your jurisdiction(s)?

No ☐ If no, you are not eligible to participate as an out-of-state practitioner in the sponsored event.

Yes ☐ If yes, list every license, certificate, and registration authorizing you to engage in the practice of [profession] in the following table. If there are not enough boxes to include all the relevant information please attach an addendum to this form. Please also attach a copy of each of your current licenses, certificates, and registrations.

State/ Jurisdiction	Issuing Agency/Authority	License Number	Expiration Date

2. Have you ever had a license or certification to practice [profession] revoked or suspended?
___ Yes ___ No

3. Have you ever been subject to any disciplinary action or proceeding by a licensing body?
___ Yes ___ No

4. Have you ever allowed any license or certification to practice [profession] to cancel or to remain in expired status without renewal?
___ Yes ___ No

5. If you answered "Yes" to any of questions 2-3, please explain (*attach additional page(s) if necessary*): _____

PART 4 – SPONSORED EVENT

1. Name of non-profit or community-based organization hosting the free healthcare event (the "sponsoring entity"): _____

2. Name of event: _____

3. Date(s) & location(s) of the event: _____

4. Date(s) & location(s) applicant will be performing healthcare services (if different): _____

5. Please specify the healthcare services you intend to provide: _____

6. Name and phone number of contact person with sponsoring entity: _____

PART 5 – ACKNOWLEDGMENT/CERTIFICATION

I, the undersigned, declare under penalty of perjury under the laws of the State of California and acknowledge that:

- I have not committed any act or been convicted of a crime constituting grounds for denial of licensure by the board.
- I am in good standing with the licensing authority or authorities of all jurisdictions in which I hold licensure and/or certification to practice [profession].
- I will comply with all applicable practice requirements required of licensed [profession]s and all regulations of the Board.
- In accordance with Business and Professions Code Section 901(i), I will only practice within the scope of my licensure and/or certification and within the scope of practice for California-licensed [profession]s.
- I will provide the services authorized by this request and Business and Professions Code Section 901 to uninsured and underinsured persons only and shall receive no compensation for such services.
- I will provide the services authorized by this request and Business and Professions Code Section 901 only in association with the sponsoring entity listed herein and only on the dates and at the locations listed herein for a period not to exceed 10 calendar days.
- I am responsible for knowing and complying with California law and practice standards while participating in a sponsored event located in California.
- Practice of a regulated profession in California without proper licensure and/or authorization may subject me to potential administrative, civil and/or criminal penalties.
- The Board may notify the licensing authority of my home jurisdiction and/or other appropriate law enforcement authorities of any potential grounds for discipline associated with my participation in the sponsored event.
- All information provided by me in this application is true and complete to the best of my knowledge. By submitting this application and signing below, I am granting permission to the Board to verify the information provided and to perform any investigation pertaining to the information I have provided as the board deems necessary.

_____ _____

Signature Date

Name Printed: _____

Medical Board Legislative Proposals

1. Language proposes to require physicians to attend scheduled physician interviews with the Board and to consider non-compliance unprofessional conduct.

   Reason: Similar and consistent with the State Bar of California requirements for attorneys and requirements for licensees of other healing arts boards, this proposal would require physicians to cooperate with the Medical Board, which will expedite the closure of cases.

   Pro:

   - Will help to expedite the closure of cases and no longer require the Medical Board to subpoena physicians who do not cooperate, which adds time to the cases.

   Con:

   - Will impose a new legal requirement on physicians.

Background: Over the last three years, 338 subpoenas have been issued for the purpose of requiring a subject physician to appear at a physician interview with the Medical Board. This has related in case delays anywhere from 60 days, to over a year. This issue was noted in the Final Report done by the Medical Board of California's Enforcement Monitor, released November 1, 2005.

Further, many other healing arts boards are in the process of putting this requirement in regulations. Refusal of some health care practitioners to cooperate with an investigation of the Board is a significant factor preventing the timely completion of investigations. The Medical Board believes that the enactment of a statutory requirement in California would significantly reduce the delays that result of a practitioner's failure to cooperate during a board's investigation.

2. Language proposes to automatically temporarily suspend a physician and surgeon's certificate when a physician is incarcerated after a misdemeanor conviction during the period of incarceration.

   Reason: Incarcerated physicians should not be treating or prescribing to patients, including other inmates.

   Pro:

   - This proposal would prohibit incarcerated physicians from treating and prescribing to patients, including other inmates. There is a similar provision for felony incarceration (B&P Code Section 2236.1).

   Con:

   - Incarcerated physicians would not be allowed to prescribe to patients, even those that were patients before the time of incarceration.

Background: There have been cases where physicians incarcerated for a misdemeanor have continued to practice while incarcerated, including prescribing for fellow inmates. This proposed legislative change will prevent this from happening in the future.

The following is a new legislative proposal staff would like to develop for 2011 Legislation.

Authorize staff to seek legislation to allow the Medical Board to continue to utilize expert reviewers as is currently being done, without going through formal contracting process in order to utilize the services of each expert reviewer.

Background

The Department of Consumer Affairs (DCA) issued a memo on November 10, 2010, which stated that all healing arts boards must enter into a formal consulting services contract with each consultant (reviewer) they use to provide an opinion in an enforcement matter (from the initial review through testifying at a hearing). The memo further stated that each board would need to go through the required contracting process for each reviewer utilized. At a meeting held on this matter, DCA stated that it would take a minimum of 60 days to get each contract processed.

The Board already has the authority to hire consultants and contract with reviewers, but the state has determined that the way it allowed DCA to contract individually with reviewers did not meet the letter of the contracting codes in the Public Contract Code.

Issues

The Board referred approximately 2,900 cases to reviewers performing the initial or triage review to determine the need to move the case forward for investigation. It utilized 281 expert reviewers in one quarter to review completed investigations, which translates to 457 cases. Under the new DCA policy, the Board would be required to go through the contracting process for each reviewer, even if the reviewer only reviews one case. The contract would need to be approved before the Board can utilize the reviewer's services and the Board would have to encumber the funding for the reviewer once the contract is approved (again, before the reviewer's services are utilized).

Going through the formal contracting process in order to utilize a reviewer would create an enormous backlog for both DCA and the Board and would significantly impact the time required to complete the initial review and investigate complaints filed with the Board. In addition, this would severely limit the Board's ability to take disciplinary actions against physicians and result in tremendous case delays. This could mean cases would be lost due to the statute of limitations expiring.

Staff recommends that a motion be made to authorize staff go forward with this proposal and seek legislation to exempt expert reviewer utilization from the formal contracting process.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
OFFICE OF ADMINISTRATIVE AND INFORMATION SERVICES-
BUSINESS SERVICES OFFICE
1625 North Market Blvd, Suite S-103
P (916) 574-7292 F (916) 574-8656 | www.dca.ca.gov

MEMORANDUM

DATE	November 10, 2010
TO	ALL BOARDS, BUREAUS, PROGRAMS, DIVISIONS, OFFICES
FROM	Judy Masuda, Business Services Officer
SUBJECT	CONTRACTS FOR SUBJECT MATTER EXPERT CONSULTANTS

Purpose

This memorandum announces changes to existing processes related to acquiring the services of a Subject Matter Expert Consultant (Expert Consultant).

Definition

An Expert Consultant is defined as an individual, business firm, or corporation whose services are retained for any one of the following services:

- Provide an expert opinion in an enforcement matter from the initial review through testifying at a hearing;
- Evaluate applications for applicant licensure;
- Evaluate curriculum content and other requirements for school or program approval;
- Develop (but not proctor) professional licensing exams.

New requirement

All Expert Consultants shall enter into a formal consulting services contract that will follow all guidelines, procedures, and rules governed by the:

- State Contracting Manual (SCM) and
- the California Public Contract Code.

This change may impact the time required for boards, bureaus, and programs to secure Expert Consultant services through the required contracting process.

Transition	The DCA recognizes this potential impact. To facilitate this transition, the Business Services Office will schedule a meeting with your office to better understand your Expert Consultant processes and business requirements. The Business Services Office will use the information gathered at the meeting to prioritize and develop a rollout plan for each board. The rollout plan will allow the boards, bureaus, and programs to plan, adjust resources to adhere to these changes, and minimize the impact to your licensing and enforcement efforts.
Questions	If you have any questions, please contact: Mike Melliza, Contract Operations Manager Department of Consumer Affairs Business Services Office- Non-IT Contracts Unit Email: michael.melliza@dca.ca.gov Phone: (916) 574-7292
Attachment 1, Expert Consultant Authority	Public Contract Code Sections 10335.5, 10340, 10371, 10410, 10411; Government Code Section 19130, 19131; State Contracting Manual Chapter 7.10

Attachment 1
Expert Consultant Authority

AUTHORITY PERTAINING TO CONTRACTING FOR CONSULTING SERVICES CONTRACTS

The following sections of California law require state agencies to meet certain conditions before entering into a consulting services contract, also referred to as a personal services contract. These sections of law also contain exemptions to these requirements that may or may not apply to all consulting services contracts executed by DCA. Also, some boards have exemptions from these requirements in their practice acts.

Public Contract Code section 10335.5

(a) "Consulting services contract," as used in this article, means services that do all of the of the following:

(1) Are of an advisory nature.

(2) Provide a recommended course of action or personal expertise.

(3) Have an end product that is basically a transmittal of information either written or verbal and that is related to the governmental functions of state agency administration and management and program management or innovation.

(4) Are obtained by awarding a contract, a grant, or any other payment of funds for services of the above type.

(5) The product may include anything from answers to specific questions to design of a system or plan, and includes workshops, seminars, retreats, and conferences for which paid expertise is retained by contract.

(b) "Consulting services contract" does not include any of the following:

(1) Contracts between a state agency and the federal government.

(2) Contracts with local agencies, as defined in Section 2211 of the Revenue and Taxation Code, to subvene federal funds for which no matching state funds are required.

(c) The following consultant services contracts are exempt from the advertising and bidding requirements of this article:

(1) Contract that are temporary or time-limited appointments to a nontesting civil service classification for the purpose of meeting a time-limited employment need. Selection and compensation for these appointments shall be made in accordance with state civil service requirements. Payment under a consulting service contract may be on the basis of each hour or day devoted to the task or in one lump sum for the end product.

(2) Contracts that can only be performed by a public entity as defined in subdivision (b) of Section 605 of the Unemployment Insurance Code.

(3) Contracts solely for the purpose of obtaining expert witnesses for litigation.

(4) Contract for legal defense, legal advice, or legal services.

(5) Contracts in an amount of less than five thousand dollars ($5,000).

(6) Contracts entered into pursuant to Section 14838.5 of the Government Code. (Emphasis added.)

Public Contract Code section 10340

(a) Except as provided by subdivision (b), state agencies shall secure at least three competitive bids or proposals for each contract.
(b) Three competitive bids or proposals are not required in any of the following cases:

***

(7) Contracts for the development, maintenance, administration, or use of licensing or proficiency testing examinations. (Emphasis added.)

***

Public Contract Code 10371

The following provisions shall apply to all consulting services contracts:
(a) Each state agency shall, regardless of the fiscal amount involved, use available private resource only when the quality of work of private resources is of at least equal quality compared with the state agency operated resources.
(b) Any state agency that enters into or expects to enter into more than one consulting services contract with the same individual, business firm, or corporation within a 12-month period for an aggregate amount of twelve thousand five hundred dollars ($12,500) or more, shall notify, in writing, the department and shall have each contract that exceeds an aggregate amount of twelve thousand five hundred dollars ($12,500) approved by the department.
(c) Each state agency shall, prior to signing a consulting services contract totaling five thousand dollars ($5,000) or more, prepare a detailed criteria and a mandatory progress schedule for the performance of the contract and shall require each selected contractor to provide a detailed analysis of the costs of performing the contract.
(d) Except in an emergency, no consulting services contract shall be commenced prior to formal approval by the department or, if the department's approval is not otherwise required, by the director of the state agency. No payments for any consulting services contract shall be made prior to this approval of the award.

For purposes of this subdivision an "emergency" means an instance, as determined by the department, where the use of contracted services appeared to be reasonably necessary but time did not permit the obtaining of prior formal approval of the contract.

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Government Code section 19130

The purpose of this article is to establish standards for the use of personal services contracts.

(a) Personal services contracting is permissible to achieve cost savings when all the following conditions are met:

***

(b) Personal services contracting also shall be permissible when **any of the following conditions can be met:**

***

(3) The services contracted are not available within civil service, cannot be performed satisfactorily by civil service employees, or are of such a highly specialized or technical nature that the necessary expert knowledge, experience, and ability are not available through the civil service system.

***

(5) The legislative, administrative, or legal goals and purposes cannot be accomplished through the utilization of persons selected pursuant to the regular civil service system. Contracts are permissible under this criterion to protect against a conflict of interest or to insure independent and unbiased findings in cases where there is a clear need for a different, outside perspective. These contracts shall include, but not be limited to, obtaining expert witnesses in litigation.

***

(10) The services are of such an urgent, temporary, or occasional nature that the delay incumbent in their implementation under civil service would frustrate their very purpose.

(Emphasis added)

Government Code section 19131

Any state agency proposing to execute a contract pursuant to subdivision (a) of Section 19130 shall notify the State Personnel Board of its intention. All organizations that represent state employees who perform the type of work to be contracted, and any person or organization which has filed with the board a request for notice, shall be contacted immediately by the State Personnel Board upon receipt of this notice so that they may be given a reasonable opportunity to comment on the proposed contract. Departments or agencies submitting proposed contracts shall retain and provide all data and other information relevant to the contracts and necessary for a specific application of the standards set forth in subdivision (a) of Section 19130. Any employee organization may request, within 10 days notification, the State Personnel Board to review any contract proposed or executed pursuant to subdivision (a) of Section 19130. The review shall be conducted in accordance with subdivision (b) of Section 10337 of the Public Contract Code. Upon such a request, the State Personnel Board shall review the contract for compliance with the standards specified in subdivision (a) of Section 19130. (Emphasis added.)

AUTHORITY PERTAINING TO PROHIBITIONS AGAINST CONTRACTING WITH CURRENT OR FORMER STATE EMPLOYEES INCLUDING THOSE EXEMPT FROM CIVIL SERVICE

Public Contract Code section 10410

The Public Contract Code (PCC) mandates that "no officer or employee in the state civil service shall contract on his or her own individual behalf as an independent contractor with any state agency to provide services or goods."

Public Contract Code section 10411

The PCC also requires an employee to wait a period of twelve months before he or she contracts with his or her prior employer. Specifically, PCC 10411 forbids a former state employee, for a "period of 12 months following the date of his or her retirement, dismissal, or separation from state service, no person employed under state civil service or otherwise appointed to serve in state government may enter into a contract with any state agency, if he or she was employed by that state agency in a policymaking position in the same general subject area as the proposed contract within the 12-month period prior to his or her retirement, dismissal, or separation."

A. *Current State Employees* (PCC § 10410)

1. No officer or employee shall engage in any employment, activity, or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency unless the employment, activity, or enterprise is required as a condition of regular state employment.

2. No officer or employee shall contract on that person's own behalf as an independent contractor with any state agency to provide goods or services.

B. *Former State Employees* (PCC § 10411)

1. For the two-year period from the date of leaving state employment, no former state officer or employee may enter into a contract in which that person was engaged in any of the negotiations, transactions, planning, arrangements, or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2. For the twelve-month period from the date of leaving state employment, no former state officer or employee may enter into a contract with any state agency if that person was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the twelve-month period prior to that person leaving state service. This does not apply to contracts with former employees as an expert witness, or continuation of attorney services the former employee was involved with prior to leaving state service.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 100
Author: Price
Bill Date: January 11, 2011, introduced
Subject: Healing Arts
Sponsor: Author

STATUS OF BILL:

This bill has just been introduced.

DESCRIPTION OF CURRENT LEGISLATION:

This bill covers a variety of subjects. This bill will allow outpatient settings to be licensed by the California Department of Public Health (CDPH) or accredited by an accreditation agency approved by the Medical Board of California (the Board). This bill also contains new requirements for outpatient setting accreditation and licensing and for information sharing between CDPH and the Board. In addition, this bill includes requirements on the supervision of laser and intense pulse laser device procedures, advertising, and disclosing outpatient setting information to the public.

ANALYSIS:

This bill makes some significant changes to sections of the Business and Professions (B&P) Code and the Health and Safety (H&S) Code that may benefit the public.

This bill states the intent of the Legislature to:

- Clarify *Capen v. Shewry* (2007) and give surgical clinics with any percentage of physician ownership the option to be licensed by the California Department of Public Health (CDPH).
- Continue to give physicians the option to obtain licensure through CDPH, or accreditation through an accreditation agency approved by the Medical Board of California (the Board).
- Provide appropriate oversight by CDPH and allow corrective action to be taken against any outpatient setting if there is reason to believe that there may be a risk to patient safety, in order to ensure patient protection.
- Deem an outpatient setting that is accredited to be licensed by CDPH.

Amends B&P Code section 651:

This section requires, effective January 1, 2011, advertising to include the license designation following the licensee's name:

- Chiropractors -"DC"
- Dentists - "DDS" or "DMD"
- Physicians - "MD" or "DO", as appropriate;
- Podiatrists – "DPM"

- Registered Nurses – "RN"
- Vocational Nurses – "LVN"
- Psychologists – "Ph.D."
- Optometrists – "OD"
- Physician Assistants – "PA"
- Naturopathic doctor – "ND"

This bill also defines advertising as virtually any promotional communications, including direct mail, television, radio, motion picture, newspaper, book, Internet, or any other form of communication. It does not include insurance provider directories, billing statements, or appointment reminders.

Amends B&P Code section 2023.5:
This section would require that the Board adopt regulations on or before January 1, 2013, regarding the "appropriate level of physician availability" needed within clinics or other settings for use of prescriptive lasers or intense pulse light devices for elective cosmetic procedures.

The Board and the Board of Registered Nursing held three public forums to study this subject as mandated by B&P Code section 2023.5 (added to statutes by SB 1423; Figueroa, Chap 873, Statutes of 2006). As a result of that study, it was determined that current law and regulations were sufficient related to supervision --- it was lack of enforcement that was contributing to the problems occurring in the use of lasers and IPL devices, among other cosmetic procedures. These forums did not address physician availability.

Adds B&P Code section 2027.5:
This new section requires the Board to post on its Web site a comprehensive fact sheet on cosmetic surgery, which must include a comprehensive list of questions for patients to ask their physician regarding cosmetic surgery.

This will enhance consumer awareness and protection.

Amends H&S Code section 1204:
This section adds to the definition of "surgical clinic" that it includes a surgical clinic owned in whole or in part by a physician.

This will clarify the Capen decision and allow CDPH to license physician owned surgical clinics.

Adds H&S Code section 1204.6:
This section allows CDPH, until regulations are developed for the licensing standards for surgical clinics, to use the federal conditions of coverage as the basis for licensure for surgical clinics.

This will allow the bill to be implemented now; there will be no delay in implementation due to development of regulations.

Adds H&S Code section 1204.7:
This section states that an outpatient setting that is accredited by an accreditation agency approved by the Board, is deemed to be licensed by CDPH, and requires the outpatient setting to pay an annual licensing fee to CDPH. This section also requires CDPH to notify the Board of any action taken against an outpatient setting. This section also requires any outpatient setting whose license is revoked or suspended by CDPH, to also have their accreditation be void.

This allows for regulation of outpatient settings by both the accreditation agency and CDPH, which will help to ensure patient protection. However, this could be costly for the outpatient setting, as they will be required to pay fees to the accreditation agency and CDPH.

Adds H&S Code section 1204.8:
This section makes outpatient settings subject to adverse event reporting requirements and associated penalties.

This will help to ensure public protection.

Amends H&S Code section 1248:
This section adds in vitro fertilization facilities or other assisted reproduction technology services to the definition of "Outpatient setting." This section also clarifies that any references to Division of Licensing are deemed to refer to the Medical Board.

Amends H&S Code section 1248.15:
This section makes technical changes and adds the requirement for accreditation agencies that they not only require of the settings emergency plans for outpatient settings, but also require the inclusion of standardized procedures and protocols to be followed in the event of emergencies or complications that place patients at risk of injury or harm.

This language has been added to address concerns that detailed procedures were not in place at these settings. This section also allows the Board to adopt standards for outpatient settings that offer in vitro fertilization or assisted reproduction technology. Facilities providing these services would be required to meet accreditation standards that the board deems necessary, different than existing standards for current outpatient settings.

Amends H&S Code section 1248.2:
This section requires the Medical Board to disclose to the public if an outpatient setting has been suspended, placed on probation, or received a reprimand by the approved accreditation agency. This section also requires the Board to notify CDPH within 10 days if an outpatient setting's accreditation has been revoked, suspended, or placed on probation. CDPH must notify the Board within 10 days if a surgical clinic's license has been revoked.

This section also requires the Medical Board, on or before February 1, 2012 to provide CDPH with a listing of all outpatient settings that are accredited as of January 1, 2012. Beginning April 1, 2010, the Board must provide CDPH a listing every three months, which must include the following:

- Name, address, and telephone number of the owner.
- Name and address of the facility.
- The name and telephone number of the accreditation agency.

- The effective and expiration dates of the accreditation.

This list and information must also be provided by the Board to CDPH within 10 days of the accreditation of an outpatient setting.

This section also requires the Board to also provide CDPH with the accreditation standards approved by the Board, free of charge. This section states that these standards are not subject to public disclosure.

This will allow the public access to the status of all outpatient settings and give useful information to a sister regulatory agency. However, amendments are needed as this bill does not require the accreditation agencies to give the Board the required detailed information, or to inform the Board within 10 days that an outpatient setting has been accredited. In order for the Board to comply with this bill, a requirement that the accreditation agencies supply the required information to the Board in the set time frames will need to be added to the bill.

Amends H&S Code section 1248.25:

This section requires an accreditation agency to immediately report to the Board if the outpatient settings accreditation has been denied.

This will give the Board up-to-date information on the status of an outpatient settings accreditation.

Amends H&S Code section 1248.35

This section does the following:

- Requires the Board or the Board's approved accreditation agencies to periodically inspect accredited outpatient settings. Inspections must be performed no less than once every three years. The Board must ensure that accreditation agencies inspect outpatient settings.

  This will help the settings remain in compliance with the law, thus providing enhanced consumer protection. However, it is not clear who will pay for these inspections.
- Current law requires accreditation agencies to provide outpatient settings a notice of deficiencies and a reasonable time to remedy them before revoking accreditation. This legislation would require the outpatient setting to agree with the accreditation agency on a plan of correction and conspicuously post the list of deficiencies and the plan of correction in a location accessible to public view.

  This will allow the public access to issues that the settings may have and the suggested remedy.
- Requires the accreditation agency within 10 days after adoption of the plan of correction to send a list of deficiencies and the corrective action to be taken to the Board and CDPH.

  This will make both regulatory bodies aware of the deficiency and remedy of the outpatient setting.
- Upon receipt of a notice of corrective action, allows CDPH to inspect an outpatient setting if the department believes there is a risk to patient safety, health, or welfare.

This oversight by CDPH will help to ensure public protection.

- Requires an outpatient setting that does not comply with the plan of correction to pay penalties to CDPH and allows CDPH to suspend or revoke their license. Also gives outpatient settings appeal/due process rights.
- Allows CDPH to take action if an outpatient setting violates a standard of the accreditation agency or a CDPH licensing standard, or for failure to pay licensing fees or administrative penalties.
- Requires that reports on the results of outpatient setting inspections be kept on file by the Board or accrediting agency, along with proposed corrective action, outpatient setting comments, and recommendations for re-inspection.

  These reports will be public information, which will help to ensure public protection and will encourage transparency.
- Requires the approved accrediting agencies to inform the Board within 24 hours of issuing a reprimand, suspending or revoking accreditation, or placing an outpatient setting on probation.

  This will alert the Board of an issue that may need action.
- Provides that if one accrediting agency denies, revokes, or suspends accreditation of an outpatient setting, this action applies to all other accrediting agencies.

This will prevent outpatient settings from accreditation agency "shopping", and will ensure that actions taken by one agency will stand for that outpatient setting, regardless of which accreditation agency issues the accreditation.

Amends H&S Code section 1248.5:

This section requires, instead of allows, the Board to:

- Evaluate the accreditation agencies every three years.
- Evaluate responses to complaints against an agency.
- Evaluate complaints against the accreditation of outpatient settings.

This will be a new workload requirement for the Board. However, these evaluations will help to ensure public protection.

Amends H&S Code section 1248.55:

This section clarifies and adds to the process for the Board to terminate the approval of an accreditation agency. In addition allowing the Board to terminate approval, this section allows the Board to issue a citation. This section also allows the Board to establish, by regulation, a system for issuing citations to accreditation agencies not meeting the Board criteria. The system must include the following requirements:

- Failure of an accreditation agency to pay any fine associated with a citation within 30 days (unless the citation is being appealed), may result in termination of the accreditation agency's approval.
- When a citation is not contested and a fine is not paid, the fine must be added to the agency's renewal fee. The approval of the agency shall not be renewed until the renewal fee and fine is paid.
- Specified that administrative fines collected must be deposited into the Outpatient Setting Fund of the Medical Board of California.

By allowing the Board to issue citations and fines to accreditation agencies, it will help to provide incentives to the accreditation agencies to meet board criteria and help to ensure public protection.

This section also requires the Board to notify CDPH of any action taken against an accreditation agency or accreditation agency.

This will allow for information sharing between sister agencies, which will help to ensure public protection.

Amends H&S Code section 1279:

This section requires CDPH, while conducting regular period state inspections of acute care hospitals, to inspect the peer review process in that hospital as well.

FISCAL: Unknown, but could be substantial if the Board does the inspections, although they are not required to be performed by the Board. The newly required evaluations that must be performed by the Board every three years will result in additional workload for the Board.

POSITION: Support if Amended – In order for the Board to comply with this bill, a requirement that the accreditation agencies supply the required information to the Board in the set time frames will need to be added to the bill. In addition, it is not clear in the bill how the required inspections that are not done by the accreditation agency will be paid for. An amendment may be needed to clarify this issue.

January 20, 2011

SENATE BILL No. 100

Introduced by Senator Price

January 11, 2011

An act to amend Sections 651 and 2023.5 of, and to add Section 2027.5 to, the Business and Professions Code, and to amend Sections 1204, 1248, 1248.15, 1248.2, 1248.25, 1248.35, 1248.5, 1248.55, and 1279 of, and to add Sections 1204.6, 1204.7, and 1204.8 to, the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 100, as introduced, Price. Healing arts.

(1) Existing law provides for the licensure and regulation of various healing arts practitioners and requires certain of those practitioners to use particular designations following their names in specified instances. Existing law provides that it is unlawful for healing arts licensees to disseminate or cause to be disseminated any form of public communication, as defined, containing a false, fraudulent, misleading, or deceptive statement, claim, or image to induce the rendering of services or the furnishing of products relating to a professional practice or business for which they are licensed. Existing law authorizes advertising by these healing arts licensees to include certain general information. A violation of these provisions is a misdemeanor.

This bill would require certain healing arts licensees to include in advertisements, as defined, certain words or designations following their names indicating the particular educational degree they hold or healing art they practice, as specified. By changing the definition of a crime, this bill would impose a state-mandated local program.

(2) Existing law requires the Medical Board of California, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field,

to review issues and problems relating to the use of laser or intense light pulse devices for elective cosmetic procedures by their respective licensees.

This bill would require the board to adopt regulations by January 1, 2013, regarding the appropriate level of physician availability needed within clinics or other settings using certain laser or intense pulse light devices for elective cosmetic procedures.

(3) Existing law requires the Medical Board of California to post on the Internet specified information regarding licensed physicians and surgeons.

This bill would require the board to post on its Internet Web site an easy-to-understand factsheet to educate the public about cosmetic surgery and procedures, as specified.

(4) Under existing law, the State Department of Public Health licenses and regulates clinics, including surgical clinics, as defined.

This bill would expand the definition of surgical clinics to include a surgical clinic owned in whole or in part by a physician and would require, until the department promulgates regulations for the licensing of surgical clinics, the department to use specified federal conditions of coverage.

(5) Existing law requires the Medical Board of California, as successor to the Division of Licensing of the Medical Board of California, to adopt standards for accreditation of outpatient settings, as defined, and, in approving accreditation agencies to perform this accreditation, to ensure that the certification program shall, at a minimum, include standards for specified aspects of the settings' operations. Existing law makes a willful violation of these and other provisions relating to outpatient settings a crime.

This bill would include, among those specified aspects, the submission for approval by an accreditation agency at the time of accreditation, a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery. The bill would also modify the definition of "outpatient setting" to include facilities that offer in vitro fertilization, as defined. By changing the definition of a crime, this bill would impose a state-mandated local program.

Existing law also requires the Medical Board of California to obtain and maintain a list of all accredited, certified, and licensed outpatient settings, and to notify the public, upon inquiry, whether a setting is

accredited, certified, or licensed, or whether the setting's accreditation, certification, or license has been revoked.

This bill would require the board, absent inquiry, to notify the public whether a setting is accredited, certified, or licensed, or the setting's accreditation, certification, or license has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency. The bill would also require the board to give the department notice of all accredited, certified, and licensed outpatient settings and to notify the department of accreditation standards, changes in the accreditation of an outpatient setting, or any disciplinary actions and corrective actions.

Existing law requires accreditation of an outpatient setting to be denied if the setting does not meet specified standards. Existing law authorizes an outpatient setting to reapply for accreditation at any time after receiving notification of the denial.

This bill would require the accreditation agency to immediately report to the Medical Board of California if the outpatient setting's certificate for accreditation has been denied. Because a willful violation of this requirement would be a crime, the bill would impose a state-mandated local program. The bill would also apply the denial of accreditation, or the revocation or suspension of accreditation by one accrediting agency to all other accrediting agencies.

Existing law authorizes the Medical Board of California, as successor to the Division of Medical Quality of the Medical Board of California, or an accreditation agency to, upon reasonable prior notice and presentation of proper identification, enter and inspect any accredited outpatient setting to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of the specified law.

This bill would delete the notice and identification requirements. The bill would require that every outpatient setting that is accredited be inspected by the accreditation agency, as specified, and would specify that it may also be inspected by the board and the department, as specified. The bill would require the board to ensure that accreditation agencies inspect outpatient settings.

Existing law authorizes the Medical Board of California to terminate approval of an accreditation agency if the agency is not meeting the criteria set by the board.

This bill would also authorize the board to issue a citation to the agency, including an administrative fine, in accordance with a specified system established by the board.

Existing law authorizes the Medical Board of California to evaluate the performance of an approved accreditation agency no less than every 3 years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the board.

This bill would make that evaluation mandatory.

(5) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health and requires the department to periodically inspect those facilities, as specified.

This bill would state the intent of the Legislature that the department, as part of its periodic inspections of acute care hospitals, inspect the peer review process utilized by those hospitals.

(6) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. (a) It is the intent of the Legislature to clarify
2 Capen v. Shewry (2007) 147 Cal.App.4th 680 and give surgical
3 clinics that are owned in whole or in part by physicians the option
4 to be licensed by the State Department of Public Health. It is further
5 the intent of the Legislature that this clarification shall not be
6 construed to permit the practice of medicine in prohibition of the
7 corporate practice of medicine pursuant to Section 2400 of the
8 Business and Professions Code.
9 (b) It is the further intent of the Legislature to continue to give
10 physicians and surgeons the option to obtain licensure from the
11 State Department of Public Health if they are operating surgical
12 clinics, or an accreditation through an accrediting agency approved
13 by the Medical Board of California pursuant to Chapter 1.3

(commencing with Section 1248) of Division 2 of the Health and Safety Code.

(c) It is the further intent of the Legislature, in order to ensure patient protection, to provide appropriate oversight by the State Department of Public Health, and to allow corrective action to be taken against an outpatient setting if there is reason to believe that there may be risk to patient safety, health, or welfare, that an outpatient setting shall be deemed licensed by the State Department of Public Health.

SEC. 2. Section 651 of the Business and Professions Code is amended to read:

651. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure

being advertised, of the licensee who is advertising for his or her services.

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

(4) Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.

(7) Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.

(8) Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional

services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5) (A) A statement that the practitioner is certified by a private or public board or agency or a statement that the practitioner limits his or her practice to specific fields.

(i) For the purposes of this section, a dentist licensed under Chapter 4 (commencing with Section 1600) may not hold himself or herself out as a specialist, or advertise membership in or specialty recognition by an accrediting organization, unless the practitioner has completed a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation, is eligible for examination by a national specialty board recognized by the American Dental Association, or is a

1 diplomate of a national specialty board recognized by the American
2 Dental Association.
3 (ii) A dentist licensed under Chapter 4 (commencing with
4 Section 1600) shall not represent to the public or advertise
5 accreditation either in a specialty area of practice or by a board
6 not meeting the requirements of clause (i) unless the dentist has
7 attained membership in or otherwise been credentialed by an
8 accrediting organization that is recognized by the board as a bona
9 fide organization for that area of dental practice. In order to be
10 recognized by the board as a bona fide accrediting organization
11 for a specific area of dental practice other than a specialty area of
12 dentistry authorized under clause (i), the organization shall
13 condition membership or credentialing of its members upon all of
14 the following:
15 (I) Successful completion of a formal, full-time advanced
16 education program that is affiliated with or sponsored by a
17 university based dental school and is beyond the dental degree at
18 a graduate or postgraduate level.
19 (II) Prior didactic training and clinical experience in the specific
20 area of dentistry that is greater than that of other dentists.
21 (III) Successful completion of oral and written examinations
22 based on psychometric principles.
23 (iii) Notwithstanding the requirements of clauses (i) and (ii), a
24 dentist who lacks membership in or certification, diplomate status,
25 other similar credentials, or completed advanced training approved
26 as bona fide either by an American Dental Association recognized
27 accrediting organization or by the board, may announce a practice
28 emphasis in any other area of dental practice only if the dentist
29 incorporates in capital letters or some other manner clearly
30 distinguishable from the rest of the announcement, solicitation, or
31 advertisement that he or she is a general dentist.
32 (iv) A statement of certification by a practitioner licensed under
33 Chapter 7 (commencing with Section 3000) shall only include a
34 statement that he or she is certified or eligible for certification by
35 a private or public board or parent association recognized by that
36 practitioner's licensing board.
37 (B) A physician and surgeon licensed under Chapter 5
38 (commencing with Section 2000) by the Medical Board of
39 California may include a statement that he or she limits his or her
40 practice to specific fields, but shall not include a statement that he

1 or she is certified or eligible for certification by a private or public
2 board or parent association, including, but not limited to, a
3 multidisciplinary board or association, unless that board or
4 association is (i) an American Board of Medical Specialties
5 member board, (ii) a board or association with equivalent
6 requirements approved by that physician and surgeon's licensing
7 board, or (iii) a board or association with an Accreditation Council
8 for Graduate Medical Education approved postgraduate training
9 program that provides complete training in that specialty or
10 subspecialty. A physician and surgeon licensed under Chapter 5
11 (commencing with Section 2000) by the Medical Board of
12 California who is certified by an organization other than a board
13 or association referred to in clause (i), (ii), or (iii) shall not use the
14 term "board certified" in reference to that certification, unless the
15 physician and surgeon is also licensed under Chapter 4
16 (commencing with Section 1600) and the use of the term "board
17 certified" in reference to that certification is in accordance with
18 subparagraph (A). A physician and surgeon licensed under Chapter
19 5 (commencing with Section 2000) by the Medical Board of
20 California who is certified by a board or association referred to in
21 clause (i), (ii), or (iii) shall not use the term "board certified" unless
22 the full name of the certifying board is also used and given
23 comparable prominence with the term "board certified" in the
24 statement.
25 For purposes of this subparagraph, a "multidisciplinary board
26 or association" means an educational certifying body that has a
27 psychometrically valid testing process, as determined by the
28 Medical Board of California, for certifying medical doctors and
29 other health care professionals that is based on the applicant's
30 education, training, and experience.
31 For purposes of the term "board certified," as used in this
32 subparagraph, the terms "board" and "association" mean an
33 organization that is an American Board of Medical Specialties
34 member board, an organization with equivalent requirements
35 approved by a physician and surgeon's licensing board, or an
36 organization with an Accreditation Council for Graduate Medical
37 Education approved postgraduate training program that provides
38 complete training in a specialty or subspecialty.
39 The Medical Board of California shall adopt regulations to
40 establish and collect a reasonable fee from each board or

association applying for recognition pursuant to this subparagraph. The fee shall not exceed the cost of administering this subparagraph. Notwithstanding Section 2 of Chapter 1660 of the Statutes of 1990, this subparagraph shall become operative July 1, 1993. However, an administrative agency or accrediting organization may take any action contemplated by this subparagraph relating to the establishment or approval of specialist requirements on and after January 1, 1991.

(C) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical

1 Education approved board, an organization with equivalent
2 requirements approved by the California Board of Podiatric
3 Medicine, or an organization with a Council on Podiatric Medical
4 Education approved postgraduate training program that provides
5 training in podiatric medicine and podiatric surgery.
6 The California Board of Podiatric Medicine shall adopt
7 regulations to establish and collect a reasonable fee from each
8 board or association applying for recognition pursuant to this
9 subparagraph, to be deposited in the State Treasury in the Podiatry
10 Fund, pursuant to Section 2499. The fee shall not exceed the cost
11 of administering this subparagraph.
12 (6) A statement that the practitioner provides services under a
13 specified private or public insurance plan or health care plan.
14 (7) A statement of names of schools and postgraduate clinical
15 training programs from which the practitioner has graduated,
16 together with the degrees received.
17 (8) A statement of publications authored by the practitioner.
18 (9) A statement of teaching positions currently or formerly held
19 by the practitioner, together with pertinent dates.
20 (10) A statement of his or her affiliations with hospitals or
21 clinics.
22 (11) A statement of the charges or fees for services or
23 commodities offered by the practitioner.
24 (12) A statement that the practitioner regularly accepts
25 installment payments of fees.
26 (13) Otherwise lawful images of a practitioner, his or her
27 physical facilities, or of a commodity to be advertised.
28 (14) A statement of the manufacturer, designer, style, make,
29 trade name, brand name, color, size, or type of commodities
30 advertised.
31 (15) An advertisement of a registered dispensing optician may
32 include statements in addition to those specified in paragraphs (1)
33 to (14), inclusive, provided that any statement shall not violate
34 subdivision (a), (b), (c), or (e) or any other section of this code.
35 (16) A statement, or statements, providing public health
36 information encouraging preventative or corrective care.
37 (17) Any other item of factual information that is not false,
38 fraudulent, misleading, or likely to deceive.
39 *(i) (1) Advertising by the following licensees shall include the*
40 *designations as follows:*

(A) Advertising by a chiropractor licensed under Chapter 2 (commencing with Section 1000) shall include the designation "DC" or the word "chiropractor" immediately following the chiropractor's name.

(B) Advertising by a dentist licensed under Chapter 4 (commencing with Section 1600) shall include the designation "DDS" or "DMD" immediately following the dentist's name.

(C) Advertising by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) shall include the designation "MD" immediately following the physician and surgeon's name.

(D) Advertising by an osteopathic physician and surgeon certified under Article 21 (commencing with Section 2450) shall include the designation "DO" immediately following the osteopathic physician and surgeon's name.

(E) Advertising by a podiatrist certified under Article 22 (commencing with Section 2460) of Chapter 5 shall include the designation "DPM" immediately following the podiatrist's name.

(F) Advertising by a registered nurse licensed under Chapter 6 (commencing with Section 2700) shall include the designation "RN" immediately following the registered nurse's name.

(G) Advertising by a licensed vocational nurse under Chapter 6.5 (commencing with Section 2840) shall include the designation "LVN" immediately following the licensed vocational nurse's name.

(H) Advertising by a psychologist licensed under Chapter 6.6 (commencing with Section 2900) shall include the designation "Ph.D." immediately following the psychologist's name.

(I) Advertising by an optometrist licensed under Chapter 7 (commencing with Section 3000) shall include the applicable designation or word described in Section 3098 immediately following the optometrist's name.

(J) Advertising by a physician assistant licensed under Chapter 7.7 (commencing with Section 3500) shall include the designation "PA" immediately following the physician assistant's name.

(K) Advertising by a naturopathic doctor licensed under Chapter 8.2 (commencing with Section 3610) shall include the designation "ND" immediately following the naturopathic doctor's name. However, if the naturopathic doctor uses the term or designation

"Dr." in an advertisement, he or she shall further identify himself by any of the terms listed in Section 3661.

(2) For purposes of this subdivision, "advertisement" includes communication by means of mail, television, radio, motion picture, newspaper, book, directory, Internet, or other electronic communication.

(3) Advertisements do not include any of the following:

(A) A medical directory released by a health care service plan or a health insurer.

(B) A billing statement from a health care practitioner to a patient.

(C) An appointment reminder from a health care practitioner to a patient.

(4) This subdivision shall not apply until January 1, 2013, to any advertisement that is published annually and prior to July 1, 2012.

(5) This subdivision shall not apply to any advertisement or business card disseminated by a health care service plan that is subject to the requirements of Section 1367.26 of the Health and Safety Code.

~~(i)~~

(j) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not,

by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

~~(j)~~

(k) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

~~(k)~~

(l) A physician and surgeon or doctor of podiatric medicine licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars ($10,000) per event. Section 125.9 shall govern the issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

SEC. 3. Section 2023.5 of the Business and Professions Code is amended to read:

2023.5. (a) The board, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

(1) The appropriate level of physician supervision needed.

(2) The appropriate level of training to ensure competency.

(3) Guidelines for standardized procedures and protocols that address, at a minimum, all of the following:

(A) Patient selection.

(B) Patient education, instruction, and informed consent.

(C) Use of topical agents.

(D) Procedures to be followed in the event of complications or side effects from the treatment.

(E) Procedures governing emergency and urgent care situations.

(b) On or before January 1, 2009, the board and the Board of Registered Nursing shall promulgate regulations to implement changes determined to be necessary with regard to the use of laser or intense pulse light devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.

(c) On or before January 1, 2013, the board shall adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures. However, these regulations shall not apply to laser or intense pulse light devices approved by the federal Food and Drug Administration for over-the-counter use by a health care practitioner or by an unlicensed person on himself or herself.

(d) Nothing in this section shall be construed to modify the prohibition against the unlicensed practice of medicine.

SEC. 4. Section 2027.5 is added to the Business and Professions Code, to read:

2027.5. The board shall post on its Internet Web site an easy-to-understand factsheet to educate the public about cosmetic surgery and procedures, including their risks. Included with the factsheet shall be a comprehensive list of questions for patients to ask their physician and surgeon regarding cosmetic surgery.

SEC. 5. Section 1204 of the Health and Safety Code is amended to read:

1204. Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics.

(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure:

(A) A "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods,

1 or services. In a community clinic, any charges to the patient shall
2 be based on the patient's ability to pay, utilizing a sliding fee scale.
3 No corporation other than a nonprofit corporation, exempt from
4 federal income taxation under paragraph (3) of subsection (c) of
5 Section 501 of the Internal Revenue Code of 1954 as amended, or
6 a statutory successor thereof, shall operate a community clinic;
7 provided, that the licensee of any community clinic so licensed on
8 the effective date of this section shall not be required to obtain
9 tax-exempt status under either federal or state law in order to be
10 eligible for, or as a condition of, renewal of its license. No natural
11 person or persons shall operate a community clinic.
12 (B) A "free clinic" means a clinic operated by a tax-exempt,
13 nonprofit corporation supported in whole or in part by voluntary
14 donations, bequests, gifts, grants, government funds or
15 contributions, that may be in the form of money, goods, or services.
16 In a free clinic there shall be no charges directly to the patient for
17 services rendered or for drugs, medicines, appliances, or
18 apparatuses furnished. No corporation other than a nonprofit
19 corporation exempt from federal income taxation under paragraph
20 (3) of subsection (c) of Section 501 of the Internal Revenue Code
21 of 1954 as amended, or a statutory successor thereof, shall operate
22 a free clinic; provided, that the licensee of any free clinic so
23 licensed on the effective date of this section shall not be required
24 to obtain tax-exempt status under either federal or state law in
25 order to be eligible for, or as a condition of, renewal of its license.
26 No natural person or persons shall operate a free clinic.
27 (2) Nothing in this subdivision shall prohibit a community clinic
28 or a free clinic from providing services to patients whose services
29 are reimbursed by third-party payers, or from entering into
30 managed care contracts for services provided to private or public
31 health plan subscribers, as long as the clinic meets the requirements
32 identified in subparagraphs (A) and (B). For purposes of this
33 subdivision, any payments made to a community clinic by a
34 third-party payer, including, but not limited to, a health care service
35 plan, shall not constitute a charge to the patient. This paragraph is
36 a clarification of existing law.
37 (b) The following types of specialty clinics shall be eligible for
38 licensure as specialty clinics pursuant to this chapter:
39 (1) A "surgical clinic" means a clinic that is not part of a hospital
40 and that provides ambulatory surgical care for patients who remain

less than 24 hours, *including a surgical clinic that is owned in whole or in part by a physician.* A surgical clinic does not include any place or establishment owned or leased and operated as a clinic or office by one or more physicians or dentists in individual or group practice, regardless of the name used publicly to identify the place or establishment, provided, however, that physicians or dentists may, at their option, apply for licensure.

(2) A "chronic dialysis clinic" means a clinic that provides less than 24-hour care for the treatment of patients with end-stage renal disease, including renal dialysis services.

(3) A "rehabilitation clinic" means a clinic that, in addition to providing medical services directly, also provides physical rehabilitation services for patients who remain less than 24 hours. Rehabilitation clinics shall provide at least two of the following rehabilitation services: physical therapy, occupational therapy, social, speech pathology, and audiology services. A rehabilitation clinic does not include the offices of a private physician in individual or group practice.

(4) An "alternative birth center" means a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility.

SEC. 6. Section 1204.6 is added to the Health and Safety Code, to read:

1204.6. Until the department promulgates regulations for the licensing of surgical clinics, the department shall use the federal conditions of coverage, as set forth in Subpart C of Part 416 of Title 42 of the Code of Federal Regulations, as those conditions existed on May 18, 2009, as the basis for licensure for facilities licensed pursuant to paragraph (1) of subdivision (b) of Section 1204.

SEC. 7. Section 1204.7 is added to the Health and Safety Code, to read:

1204.7. (a) An outpatient setting, as defined in subdivision (a) of Section 1248, that is accredited by an accrediting agency approved by the Medical Board of California, shall be deemed licensed by the department and shall be required to pay an annual licensing fee as established pursuant to Section 1266.

(b) The department shall have only that authority over outpatient settings specified in Chapter 3.1 (commencing with Section 1248).

(c) The department shall notify the Medical Board of California of any action taken against an outpatient setting and, if licensure of an outpatient setting is revoked or suspended by the department for any reason, then accreditation shall be void by operation of law. Notwithstanding Sections 1241 and 131071, proceedings shall not be required to void the accreditation of an outpatient setting under these circumstances.

SEC. 8. Section 1204.8 is added to the Health and Safety Code, to read:

1204.8. A clinic licensed pursuant to paragraph (1) of subdivision (b) of Section 1204 or an outpatient setting, as defined in Section 1248, shall be subject to the reporting requirements in Section 1279.1 and the penalties for failure to report specified in Section 1280.4.

SEC. 9. Section 1248 of the Health and Safety Code is amended to read:

1248. For purposes of this chapter, the following definitions shall apply:

(a) "Division" means the *Medical Board of California. All references in this chapter to the division, the* Division of Licensing of the Medical Board of ~~California.~~ *California, or the Division of Medical Quality shall be deemed to refer to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.*

~~(b) "Division of Medical Quality" means the Division of Medical Quality of the Medical Board of California.~~

~~(c)~~

(b) (1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of

practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

~~(d)~~

(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the ~~division~~ *board* pursuant to Sections 1248.15 and 1248.4.

SEC. 10. Section 1248.15 of the Health and Safety Code is amended to read:

1248.15. (a) The ~~division~~ *board* shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings' operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

~~(iii) Submit~~

(D) The outpatient setting shall submit for approval by an accrediting agency a detailed procedural plan for handling medical

emergencies that shall be reviewed at the time of accreditation. No reasonable plan shall be disapproved by the accrediting agency.

(E) The outpatient setting shall submit for approval by an accreditation agency at the time accreditation of a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergency and urgent care situations.

~~(D)~~

(F) All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process on the transferred case, the results of which shall be referred back to the outpatient setting, if deemed appropriate by the medical staff peer review committee. If the medical staff of the acute care facility determines that inappropriate care was delivered at the outpatient setting, the acute care facility's peer review outcome shall be reported, as appropriate, to the accrediting body, the Health Care Financing Administration, the State Department of ~~Health Services,~~ *Public Health,* and the appropriate licensing authority.

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of *Division 2 of* the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under Chapter 5 (commencing with Section 2000) of *Division 2 of* the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of *Division 2 of* the Business and Professions Code.

(4) Outpatient settings shall have a system for maintaining clinical records.

(5) Outpatient settings shall have a system for patient care and monitoring procedures.

(6) (A) Outpatient settings shall have a system for quality assessment and improvement.

(B) Members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and

appropriately credentialed for the performance of privileges granted. The outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.

(C) Clinical privileges shall be periodically reappraised by the outpatient setting. The scope of procedures performed in the outpatient setting shall be periodically reviewed and amended as appropriate.

(7) Outpatient settings regulated by this chapter that have multiple service locations governed by the same standards may elect to have all service sites surveyed on any accreditation survey. Organizations that do not elect to have all sites surveyed shall have a sample, not to exceed 20 percent of all service sites, surveyed. The actual sample size shall be determined by the ~~division.~~ *board.* The accreditation agency shall determine the location of the sites to be surveyed. Outpatient settings that have five or fewer sites shall have at least one site surveyed. When an organization that elects to have a sample of sites surveyed is approved for accreditation, all of the organizations' sites shall be automatically accredited.

(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.

(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.

(10) Outpatient settings shall have a written discharge criteria.

(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the ~~division~~ *board* to protect the public health and safety.

(d) No accreditation standard adopted or approved by the ~~division,~~ *board,* and no standard included in any certification

program of any accreditation agency approved by the ~~division,~~ *board,* shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.

(e) The board shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

SEC. 11. Section 1248.2 of the Health and Safety Code is amended to read:

1248.2. (a) Any outpatient setting may apply to an accreditation agency for a certificate of accreditation. Accreditation shall be issued by the accreditation agency solely on the basis of compliance with its standards as approved by the ~~division~~ *board* under this chapter.

(b) The board shall submit to the State Department of Public Health the information required pursuant to paragraph (3) of subdivision (d) within 10 days of the accreditation of an outpatient setting.

~~(b)~~

(c) The ~~division~~ *board* shall obtain and maintain a list of all accredited, certified, and licensed outpatient settings from the information provided by the accreditation, certification, and licensing agencies approved by the ~~division,~~ *board,* and shall notify the ~~public, upon inquiry,~~ *public* whether a setting is accredited, certified, or licensed, or ~~whether~~ the setting's accreditation, certification, or license has been ~~revoked.~~ *revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency. The board shall provide notice to the department within 10 days when an outpatient setting's accreditation has been revoked, suspended, or placed on probation. The department shall notify the board within 10 days if the license of a surgical clinic, as defined in paragraph (1) of subdivision (b) of Section 1204, has been revoked.*

(d) (1) The board shall, on or before February 1, 2012, provide the department with a list of all outpatient settings that are accredited as of January 1, 2012.

(2) Beginning April 1, 2012, the board shall provide the department with an updated list of outpatient settings every three months.

(3) The list of outpatient settings shall include all of the following:

(A) Name, address, and telephone number of the owner.

(B) Name and address of the facility.

(C) The name and telephone number of the accreditation agency.

(D) The effective and expiration dates of the accreditation.

(e) The board shall provide the department with all accreditation standards approved by the board, free of charge. Accreditation standards provided to the department by the board shall not be subject to public disclosure provisions of the California Public Records Act (Chapter 3.5 commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

SEC. 12. Section 1248.25 of the Health and Safety Code is amended to read:

1248.25. If an outpatient setting does not meet the standards approved by the ~~division,~~ *board,* accreditation shall be denied by the accreditation agency, which shall provide the outpatient setting notification of the reasons for the denial. An outpatient setting may reapply for accreditation at any time after receiving notification of the denial. *The accreditation agency shall immediately report to the board if the outpatient setting's certificate for accreditation has been denied.*

SEC. 13. Section 1248.35 of the Health and Safety Code is amended to read:

1248.35. *(a) Every outpatient setting which is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings.*

(b) Unless otherwise specified, the following requirements apply to inspections described in subdivision (a).

(1) The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided.

~~(a)~~

(3) The ~~Division of~~ Medical ~~Quality~~ *Board of California* or ~~an~~ *the* accreditation agency ~~may, upon reasonable prior notice and presentation of proper identification,~~ *may* enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of this chapter.

~~(b)~~

(c) If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:

(1) Issue a reprimand.

(2) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the ~~division~~ *board* or the accreditation agency, to correct the deficiencies.

(3) Suspend or revoke the outpatient setting's certification of accreditation.

~~(c)~~

(d) Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice of any deficiencies and *the outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting* reasonable time to supply information demonstrating compliance with the standards of the accreditation agency in compliance with this chapter, as well as the opportunity for a hearing on the matter upon the request of the outpatient center. *During that allotted time, a list of deficiencies and the plan of correction shall be conspicuously posted in a clinic location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting agency shall send a list of deficiencies and the corrective action to be taken to both the board and the department.* The accreditation agency may

immediately suspend the certificate of accreditation before providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual. In such cases, the accreditation agency shall provide subsequent notice and an opportunity to be heard.

~~(d) If the division determines that deficiencies found during an inspection suggests that the accreditation agency does not comply with the standards approved by the division, the division may conduct inspections, as described in this section, of other settings accredited by the accreditation agency to determine if the agency is accrediting settings in accordance with Section 1248.15.~~

(e) The department may enter and inspect an outpatient setting upon receipt of a notice of corrective action or if it has reason to believe that there may be risk to patient safety, health, or welfare.

(f) An outpatient setting that does not comply with a corrective action may be required by the department to pay similar penalties assessed against a surgical clinic licensed pursuant to paragraph (1) of subdivision (b) of Section 1204, and may have its license suspended or revoked pursuant to Article 5 (commencing with Section 1240) of Chapter 1.

(g) If the licensee disputes a determination by the department regarding the alleged deficiency, the alleged failure to correct a deficiency, the reasonableness of the proposed deadline for correction, or the amount of the penalty, the licensee may, within 10 days, request a hearing pursuant to Section 130171. Penalties shall be paid when appeals have been exhausted and the department's position has been upheld.

(h) Moneys collected by the department as a result of administrative penalties imposed under this section shall be deposited into the Internal Departmental Quality Improvement Account established pursuant to Section 1280.15. These moneys shall be tracked and available for expenditure, upon appropriation by the Legislature, to support internal departmental quality improvement activities.

(i) If, after an inspection authorized pursuant to this section, the department finds a violation of a standard of the facility's accrediting agency or any provision of this chapter or the regulations promulgated thereunder, or if the facility fails to pay a licensing fee or an administrative penalty assessed under this chapter, the department may take any action pursuant to Article

5 (commencing with Section 1240) of Chapter 1 and shall report the violation to the board and may recommend that accreditation be revoked, canceled, or not renewed.

(j) Reports on the results of any inspection conducted pursuant to subdivision (a) shall be kept on file with the board or the accreditation agency along with the plan of correction and the outpatient setting comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies, and plans of correction shall be public records open to public inspection.

(k) The accreditation agency shall, within 24 hours, report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation.

(l) If one accrediting agency denies accreditation, or revokes or suspends the accreditation of an outpatient setting, this action shall apply to all other accrediting agencies.

SEC. 14. Section 1248.5 of the Health and Safety Code is amended to read:

1248.5. The ~~division may~~ *board shall* evaluate the performance of an approved accreditation agency no less than every three years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the ~~division.~~ *board.*

SEC. 15. Section 1248.55 of the Health and Safety Code is amended to read:

1248.55. (a) If the accreditation agency is not meeting the criteria set by the ~~division,~~ *board,* the ~~division~~ *board* may terminate approval of the ~~agency.~~ *agency or may issue a citation to the agency in accordance with the system established under subdivision (b).*

(b) The board may establish, by regulation, a system for the issuance of a citation to an accreditation agency that is not meeting the criteria set by the board. This system shall meet the requirements of Section 125.9 of the Business and Professions Code, as applicable, except that both of the following shall apply:

(1) Failure of an agency to pay an administrative fine assessed pursuant to a citation within 30 days of the date of the assessment,

unless the citation is being appealed, may result in the board's termination of approval of the agency. Where a citation is not contested and a fine is not paid, the full amount of the assessed fine shall be added to the renewal fee established under Section 1248.6. Approval of an agency shall not be renewed without payment of the renewal fee and fine.

(2) Administrative fines collected pursuant to the system shall be deposited in the Outpatient Setting Fund of the Medical Board of California established under Section 1248.6.

~~(b)~~

(c) Before terminating approval of an accreditation agency, the ~~division~~ *board* shall provide the accreditation agency with notice of any deficiencies and reasonable time to supply information demonstrating compliance with the requirements of this chapter, as well as the opportunity for a hearing on the matter in compliance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

~~(c)~~

(d) (1) If approval of the accreditation agency is terminated by the ~~division,~~ *board,* outpatient settings accredited by that agency shall be notified by the ~~division~~ *board* and, except as provided in paragraph (2), shall be authorized to continue to operate for a period of 12 months in order to seek accreditation through an approved accreditation agency, unless the time is extended by the ~~division~~ *board* for good cause.

(2) The ~~division~~ *board* may require that an outpatient setting, that has been accredited by an accreditation agency whose approval has been terminated by the ~~division,~~ *board,* cease operations immediately ~~in~~ *if* the ~~event that the division~~ *board* is in possession of information indicating that continued operation poses an imminent risk of harm to the health of an individual. In such cases, the ~~division~~ *board* shall provide the outpatient setting with notice of its action, the reason underlying it, and a subsequent opportunity for a hearing on the matter. An outpatient setting that is ordered to cease operations under this paragraph may reapply for a certificate of accreditation after six months and shall notify the ~~division~~ *board* promptly of its reapplication. *The board shall notify the department of any action taken pursuant to this section for an outpatient setting. Upon cancellation, revocation, nonrenewal, or any other loss of accreditation, an outpatient setting's license shall*

be void by operation of law. Notwithstanding Sections 1241 and 131071, no proceedings shall be required to void the license of an outpatient setting.

SEC. 16. Section 1279 of the Health and Safety Code is amended to read:

1279. (a) Every health facility for which a license or special permit has been issued shall be periodically inspected by the department, or by another governmental entity under contract with the department. The frequency of inspections shall vary, depending upon the type and complexity of the health facility or special service to be inspected, unless otherwise specified by state or federal law or regulation. The inspection shall include participation by the California Medical Association consistent with the manner in which it participated in inspections, as provided in Section 1282 prior to September 15, 1992.

(b) Except as provided in subdivision (c), inspections shall be conducted no less than once every two years and as often as necessary to ensure the quality of care being provided.

(c) For a health facility specified in subdivision (a), (b), or (f) of Section 1250, inspections shall be conducted no less than once every three years, and as often as necessary to ensure the quality of care being provided.

(d) During the inspection, the representative or representatives shall offer such advice and assistance to the health facility as they deem appropriate.

(e) For acute care hospitals of 100 beds or more, the inspection team shall include at least a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections. During the inspection, the team shall offer advice and assistance to the hospital as it deems appropriate.

(f) The department shall ensure that a periodic inspection conducted pursuant to this section is not announced in advance of the date of inspection. An inspection may be conducted jointly with inspections by entities specified in Section 1282. However, if the department conducts an inspection jointly with an entity specified in Section 1282 that provides notice in advance of the periodic inspection, the department shall conduct an additional periodic inspection that is not announced or noticed to the health facility.

(g) Notwithstanding any other ~~provision~~ of law, the department shall inspect for compliance with provisions of state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection, including, but not limited to, an inspection required under this section. If the department inspects for compliance with state law and regulations at the same time as a federal periodic inspection, the inspection shall be done consistent with the guidance of the federal Centers for Medicare and Medicaid Services for the federal portion of the inspection.

(h) The department shall emphasize consistency across the state and *in* its district offices when conducting licensing and certification surveys and complaint investigations, including the selection of state or federal enforcement remedies in accordance with Section 1423. The department may issue federal deficiencies and recommend federal enforcement actions in those circumstances where they provide more rigorous enforcement action.

(i) It is the intent of the Legislature that the department, pursuant to its existing regulations, inspect the peer review process utilized by acute care hospitals as part of its periodic inspection of those hospitals pursuant to this section.

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Board	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption	Date to DCA (and other control agencies) for Review *	Date to OAL for Review **	Date to Sec. of State***
Written Exam for Physician licensure	At DCA for review and approval; then still has to go to DOF and Agency	1/29/10	3/12/10	4/30/10	4/30/10	To DCA 12/8/10		
Abandonment of Application Files	At DCA for review and approval; then still has to go to DOF and Agency	4/30/10	6/4/10	7/30/10	7/30/10	To DCA 12/27/10		
Polysomno-graphy Program	Hearing held 11/5/2010; amendments being considered by staff	7/30/10	9/10/10	11/5/10				
Limited Practice License	Hearing held 11/5/2010; no comments; file being completed by staff	7/30/10	9/10/10	11/5/10	11/5/10			
Disciplinary Guidelines - 2010	Hearing held 11/5/2010; interested parties meeting held 1/6/11; modified text sent out on 1/7/11; comment period 1/24/11	7/30/10	9/17/10	11/5/10				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Summer 2011							

* - DCA is allowed 30 calendar days for review
** - OAL is allowed 30 working days for review
*** - Regs usually take effect 30 days after filing with Sec. of State

Prepared by Kevin A. Schunke
Updated January 11, 2011
For questions, call (916) 263-2368

AGENDA ITEM 17D

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 10, 2011
ATTENTION:	Medical Board of California
SUBJECT:	City of Hope – Petition for Regulatory Amendment of California Code of Regulations Section1327
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

Direct staff on how to proceed with City of Hope's petition for regulatory amendment of California Code of Regulations, Title 16, Division 13, Section 1327.

STAFF RECOMMENDATION:

Direct staff to proceed with City of Hope's petition and start the regulatory process to make amendments to add a national accreditation agency for continuing medical education to 1327(a)(3) and to make a clarification to 1327(a).

BACKGROUND:

This memo provides Board members with information regarding the petition for regulatory amendment submitted by the City of Hope. City of Hope's petition (attached) requests that the Medical Board of California (Board) add another continuing education accreditation agency to subdivision (a)(3) of section 1327 of the California Code of Regulations as follows:

> "The health facility shall be accredited for continuing education programs by the California Medical Association <u>or the Accreditation Council for Continuing Medical Education.</u>"

This change would allow the City of Hope to apply to the Board for approval to administer clinical training programs in which medical students enrolled in a recognized international medical school may participate. Currently, the City of Hope cannot enroll foreign medical students in its clinical training programs because it is not accredited by the California Medical Association but it is accredited by the Accreditation Council for Continuing Medical Education (ACCME). The ACCME's bylaws prohibit a Continuing Medical Education (CME) provider from obtaining or holding accreditation from a state medical society. When the regulation was first promulgated ACCME did not exist. Please note that if this proposed regulatory amendment is ultimately adopted, the City of Hope cannot automatically enroll foreign medical students but rather it could then seek approval from the Board to do so provided the requirements set forth in section 1327 are satisfied.

OPTIONS:

Pursuant to section 11340.7 of the Government Code, the Board may grant or deny the request in whole or in part or may grant other relief.

Other relief could include referring the petition to the Licensing Committee for additional research and fact-finding. For example, there may be value in determining if other healthcare facilities or institutions are similarly situated and have an interest in this subject matter. There may be other relevant accreditation agencies as well.

If the petition is granted, the Board would commence the rulemaking process.

In addition if the Board decides to proceed with City of Hope petition to amend 1327(a)(3) this would be a good time for the Board to amend the language in 1327(a) for clarification purposes as follows:

(a) Pursuant to Section 2064 of the code a medical student enrolled in a foreign medical school recognized by the Board may practice medicine in a clinical training program approved by the division. A clinical training program shall submit a written application for such approval and shall meet the following criteria:

City of Hope

1500 East Duarte Road
Duarte, CA 91010-3000
Phone 626-256-HOPE (4673)
www.cityofhope.org

December 7, 2010

CERTIFIED US MAIL, RETURN RECEIPT REQUESTED

Ms. Linda Whiney
Executive Director
The Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, California 95815

RE: Petition to Amend California Code of Regulations, Title 16, Sec. 1327 (3) s 1317. Criteria for Approval of Clinical Training Programs for Foreign Medical Students

We are writing this letter on behalf of City of Hope and City of Hope's Graduate Medical Education Committee to formally request a change to Title 16, Section 1327 (a)(3) of the California Code of Regulations to broaden the accreditation requirements for continuing education programs for foreign medical students and graduates.

REQUEST

Existing California Code of Regulations Title 16, chapter 1, Article 7, Section 1327, subdivision (a)(3) reads as follows:

> "The health facility shall be accredited for continuing education programs by the California Medical Association."

We propose this section be amended to read:

> "The health facility shall be accredited for continuing education programs by the California Medical Association *or the Accreditation Council for Continuing Medical Education.*"

BACKGROUND

City of Hope has a strong interest in applying to the Medical Board's Division of Licensing for approval to train foreign medical students.

Currently our institution is fully accredited, with commendation, for continuing education programs by the Accreditation Council for Continuing Medical Education, known as ACCME. Since its establishment in 1981, the ACCME has been the national authority on accreditation for medical schools, state medical societies and national physician membership organizations and specialty societies. In fact, the California Medical Association, which currently accredits continuing education programs in accordance with the regulation, must hold an accreditation from ACCME to serve as the state's accrediting body.

ACCME accreditation allows the CMA to authorize, review and accredit hospitals and health care organizations within their state. But organizations of "national influence" such as the City of Hope, which is a National Cancer Institute-designated Comprehensive Cancer Center, are required to obtain national accreditation directly from the ACCME.

However, ACCME policy forbids institutions from holding both ACCME accreditation as well accreditation from a state medical society.

ACCME bylaws state:

> "...a CME provider may not maintain both ACCME accreditation and accreditation by a state medical society at the same time."

Existing regulation, in combination with the ACCME bylaws, preclude City of Hope from obtaining a state license to train foreign medical students.

City of Hope is recognized worldwide for its compassionate patient care, innovative science and translational research, which rapidly turns laboratory breakthroughs into promising new therapies. City of Hope strives to promote medical education by supporting educational opportunities in research, and clinical fields for our ACGME accredited residency programs in radiation oncology, hematopathlogy, hematology and medical oncology, and diabetes/endocrinology: in addition to have an active program of continuing medical education on our campus. However, these goals cannot be fully realized unless the current regulations are amended to recognize ACCME accreditation.

An amendment to California Code of Regulations, Title 16, Section 1327 (3) to include ACCME as an additional accrediting body for continuing medical education would recognize those organizations of national influence that are required to obtain their accreditation from ACCME. This requested change would allow City of Hope and other institutions of national influence to fully qualify to submit an application for approval by the Medical Board of California to train foreign medical students in the same manner that we currently offer training to medical students enrolled in medical schools in the United States. Such a change would benefit patient care, innovative science and translational research by permitting City of Hope, and other similarly situated academic medical institutions, to expand the reach of training opportunities to include well-qualified medical students whose only impediment to participation is that they are enrolled in a foreign medical school.

We would be happy to provide more information concerning our training programs, and to explain City of Hope's situation in more detail at the request of the Medical Board of California.

Thank you for your consideration of City of Hope's request for a change in regulation. We look forward to your reply.

Sincerely,

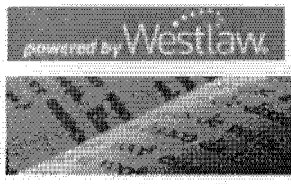
Alexandra M. Levine, M.D.
Chief Medical Officer

Robert J. Morgan, M.D.
Chair, CME Committee

Joshua D. Ellenhorn, M.D.
Chair, GME Committee

Jonathan R. Espenschied, M.D.
Director, GME & Clinical Training

AML: RJM: JDE: JRE/arr



16 CA ADC § 1327

16 CCR § 1327

Cal. Admin. Code tit. 16, § 1327

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California (Refs & Annos)[FNA1]
Chapter 1. Division of Licensing
Article 7. Foreign Medical Students and Graduates

➡§ 1327. Criteria for Approval of Clinical Training Programs for Foreign Medical Students.

(a) Pursuant to Section 2064 of the code a medical student enrolled in a foreign medical school may practice medicine in a clinical training program approved by the division. A clinical training program shall submit a written application for such approval and shall meet the following criteria:

(1) Programs shall be conducted in health facilities accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

(2) Programs shall be under the direction of the director of a residency program approved pursuant to Section 1321 above or an active staff member who holds a faculty appointment from the clinical department of a California medical school approved by the division.

(3) The health facility shall be accredited for continuing education programs by the California Medical Association.

(4) The health facility shall have appropriate liability insurance for those medical students participating in the clinical training program approved under this section.

(5) The program shall have a ratio of one (1) student per physician supervisor or one (1) student per two (2) residents in the training program. Such physician supervisor or resident shall participate directly in the training of and provision of medical services by the medical student.

(6) The health facility shall not remunerate students for medical services rendered, but may provide room and board for students in the program.

(7) The health facility may require a fee to cover necessary administrative costs.

(8) A clinical training program in a specialty area shall not exceed twelve (12) weeks.

(9) The division determines on a case-by-case basis that a health facility has sufficient beds and occupancy by patients to provide medical students with clinical experience in the specialty area of the clinical training program.

(b) The application shall include the curriculum vitae of all individual preceptors and/or physician supervisors in the program.

(c) The health facility shall file with the division the names of those students accepted for training in the program. All students accepted shall have completed at least two (2) years of medical education and shall be in good academic standing.

(d) The approval of each clinical training program shall be for a period of one (1) year and may be renewed annually.

(e) Approval under this section shall not be required for clinical training to be taken in health facilities which are the site of a residency program approved under Section 1321, subs. (a), which is in family practice or the same clinical area as the student's training program, or in health facilities which have a major affiliation with a medical school which is approved under Section 1314, subs. (a).

[FNa1] For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2005 and 2064, Business and Professions Code.

HISTORY

1. New section filed 6-17-77; effective thirtieth day thereafter (Register 77, No. 25).

2. Amendment of subsection (a) filed 8-5-81; effective thirtieth day thereafter (Register 81, No. 32).

3. Amendment of subsection (a) and new subsection (d) filed 8-6-86; effective thirtieth day thereafter (Register 86, No. 32).

4. Amendment of subsections (a), (a)(1), (a)(3)-(4), (a)(6)-(7), (a)(9), (c) and new subsection (e) filed 4-22-92; operative 5-22-92 (Register 92, No. 18).

16 CCR § 1327, 16 CA ADC § 1327
This database is current through 12/24/10 Register 2010, No. 52
END OF DOCUMENT

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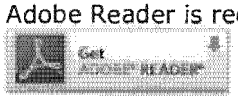

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Agenda Item 19

Presentation on the Universidad Autonoma de Guadalajara and the University of California Davis Collaborative Partnership for Medical Training

Information will be provided at the Board Meeting.

State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: January 10, 2011

To: Members of the Board

From: Reginald Low, M.D.

Subject: Status Update of International Medical School Recognition

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International Medical Schools are subject to review pursuant to Title 16, Section 1314.1 (a)(2), of the California Code of Regulations (CCR).

Attached for your information is the list of the six International Medical Schools that have submitted applications for recognition by the Board. This list provides both the timelines and the current status of the application.

In summary, two of the six schools are scheduled to be reviewed by the Board at the January 2011 Board meeting. Three of the schools have submitted additional information that is currently being reviewed by the medical consultants and one school is just starting the process.

International Medical School Review
Per CCR Section 1314.1(a)(2)

Last Update: 01/10/2011

AMERICAN UNIVERSITY OF ANTIGUA	
DATE	DISCRIPTION/COMMENT
3/23/2008	Received application
6/30/2008	Staff transmitted application to Medical Consultant
11/26/2008	Staff mailed Medical Consultant deficiency letter to school
8/20/2009	Staff mailed "due diligence" letter to school
9/24/2009	Staff received information from school
10/22/2009	Staff transmitted school's reply to Medical Consultant
1/4/2010	Medical Consultant requested additional information
2/3/2010	Staff mailed Medical Consultant deficiency letter to school
4/30/2010	Staff received information from school
6/4/2010	Staff transmitted school's reply to Medical Consultant
6/21/2010	Staff mailed staff deficiency letter to school
6/22/2010	Staff and Medical Consultant discussed questions, obtained information and clarified additional informational needs with school officials from AUA via teleconference
7/12/2010	Staff e-mailed school a summary of questions from June 22, 2010 discussion
7/15/2010	Staff e-mailed school a copy of Consultant's preliminary report
7/21/2010	Staff received information from school dated July 20, 2010
7/29/2010	Staff received information from school dated July 28, 2010
7/30/2010	Board voted to begin site visit process after school submits all requested information
8/11/2010	Staff e-mailed analysis of AUA's July 28, 2010 binder to management and Medical Consultant
8/12/2010	Staff e-mailed Medical Consultant's reply to management
9/16/2010	Meeting with Medical Consultant at MBC -update on status of review
10/12/2010	Draft out of state/country travel request to management
10/14/2010	Staff mailed and e-mail letter to school requesting additional information
11/3/2010	Staff received information from school dated November 2, 2010
11/22/2010	Staff forwarded out of state travel request to DCA

International Medical School Review
Per CCR Section 1314.1(a)(2)

AMERICAN UNIVERSITY OF ANTIGUA	
DATE	DISCRIPTION/COMMENT
11/18/2010	Staff mailed and e-mail letter to school requesting clarification of regarding schools information dated November 2, 2010
12/6/2010	Staff received clarification from school dated November 30,2010
12/8/2010	Governor approved out of state travel
12/10/2010	Staff delivered November 2, 2010 and November 30, 2010 information to Medical Consultant
12/31/2010	Staff mailed and e-mail letter to school advising out state travel for site visit was approved
1/4/2011	Staff received check from school for site visit

International Medical School Review
Per CCR Section 1314.1(a)(2)

UNIVERSIDAD IBEROAMERICANA (UNIBE), DOMINICAN REPUBLIC	
DATE	DISCRIPTION/COMMENT
8/22/2008	Staff received application
1/4/2010	Staff transmitted application to Medical Consultant
4/5/2010	Medical Consultant requested additional information
4/21/2010	Staff mailed Medical Consultant deficiency letter to school
8/18/2010	Staff received information from school
9/7/2010	Staff transmitted information to Medical Consultant

International Medical School Review
Per CCR Section 1314.1(a)(2)

Last Update: 01/10/2011

MEDICAL UNIVERSITY OF SILESIA (ENGLISH-LANGUAGE PROGRAM), POLAND	
DATE	DISCRIPTION/COMMENT
1/6/2009	Staff received application
2/10/2010	Staff transmitted application to Medical Consultant
4/9/2010	Medical Consultant requested additional information
5/24/2010	Staff mailed Medical Consultant deficiency letter to medical school
10/1/2010	Staff mailed reminder letter to medical school
10/20/2010	Staff received information from school
12/14/2010	Staff delivered school information to Medical Consultant

International Medical School Review
Per CCR Section 1314.1(a)(2)

Last Update: 01/10/2011

MEDICAL UNIVERSITY OF WARSAW (ENGLISH-LANGUAGE PROGRAM), POLAND	
DATE	DISCRIPTION/COMMENT
4/15/2010	Staff received application
6/30/2010	Staff transmitted application to Medical Consultant
6/30/2010	Staff mailed staff deficiency letter to medical school
9/17/2010	Meeting with Medical Consultant and management - update on review status
10/1/2010	Staff mailed reminder letter to medical school
10/27/2010	Staff received letter from medical school requesting an extension of time to November 19, 2010
10/30/2010	Staff notified medical school that request for extension is approved
11/18/2010	Staff received information from medical school
12/14/2010	Staff provided medical school information to Medical Consultant

International Medical School Review
Per CCR Section 1314.1(a)(2)

Last Update: 01/10/2011

TECHNION-ISRAEL INSTITUTE OF TECHNOLOGY (US/CAN PROGRAM), ISRAEL	
DATE	DISCRIPTION/COMMENT
6/10/2010	Staff received application
9/16/2010	Staff mailed staff deficiency letter to medical school
10/1/2010	Staff transmitted application to Medical Consultant
11/2/2010	Staff received information from medical school
11/10/2010	Staff delivered medical school information to Medical Consultant

International Medical School Review
Per CCR Section 1314.1(a)(2)

THE QUEENSLAND UNIVERISTY - AUSTRALIA - U.S. BRANCH CAMPUS	
DATE	DISCRIPTION/COMMENT
10/29/2010	Received letter by e-mail from Queensland advising Board of new branch campus
10/30/2010	E-mail to Queensland advising will review letter with legal counsel
12/9/2010	Reviewed letter - determined we need further information inorder to be evaluated
12/10/2010	E-mail to Queensland providing a copy of CCR 1314 and advising Queensland additional documentation will be needed.

AGENDA ITEM 20C

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 10, 2011
ATTENTION:	Medical Board of California
SUBJECT:	Special Task Force – International Medical Schools Status / Time Line for Periodic Compliance Requirements for International Medical Schools Previously Recognized by the Board
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

STAFF RECOMMENDATION:

Staff recommends proceeding with the proposed timeline and authorizing the Special Task Force to revise the timeline should it be deemed necessary at a later date.

BACKGROUND:

At the November 2010, Board meeting the Board delegated to the Special Task Force on International Medical Recognition to review the current Self-Assessment Report for changes and to determine if there should be two different Self-Assessment Reports: one for initial evaluations and one for reevaluations. In addition, the Task Force will need to determine the order in which the medical schools are to be reevaluated and develop a new timeline for these evaluations. The Board also determined it needed to conduct site visits to Ross University's main campus, Bahamas campus and several representative teaching hospitals where students receive clinical training as part of Ross University's reevaluation by the Board.

The Task Force members Dr. Low and Dr. Esrailian, met with Linda Whitney, Executive Director and me regarding the above referenced issues. It was determined that there will only be one Self-Assessment Report for both initial and reevaluation. It was also determined to have staff proceed with updating the current Self-Assessment Report and to develop a proposed timeline for reevaluation of the previously recognized schools.

Please see the attached proposed timeline for the reevaluations of international medical schools previously recognized by the Board. This timeline is based upon the availability of medical consultants and being able to maintain full staffing. If the Board is not able to maintain full staffing the timeline will mostly need to be revised at a future date.

Reevaluations of Previously Reviewed International Medical Schools Mandated pursuant to CCR Section 1314.1 (f)(2)

Name of School	Recognition Date*	7-Year Reevaluation Date	Proposed Reevaluation Timeline
Ross University (Dominica)	6/30/1990**	December 2010**	Summer 2011 - Proposed site visit Fall 2011
American Univ. of Caribbean (St. Maarten, N.A.)	9/15/1989**	December 2010**	Fall 2011
St. George's University (Grenada)	9/15/1989**	December 2010**	Fall 2011
Semmelweis University (Hungary)	5/30/2002	December 2010**	Summer 2012
Szeged University (Hungary)	9/22/2003	December 2010**	Summer 2012
Charles University (Czech. Republic)	12/29/2003	December 2010	Summer 2012
Saba University (Saba, N.A.)	11/5/2004***	November 2011	Fall 2012
Debrecen University (Hungary)	4/28/2005	April 2012	Fall 2012
Pecs Univ. (Hungary)	5/3/2005	May 2012	Fall 2012
Jagiellonian Univ. (Hungary)	7/27/2007	July 2014	Summer 2012
Med. Univ. of Poznan (Poland)	7/27/2007	July 2014	Summer 2012
ELAM (Cuba)	7/27/2007	July 2014	Summer 2012
Med. Univ. of Lublin (Poland)	7/25/2008	July 2015	Winter 2014
St. George's UK campus	7/24/2009	July 2016	Winter 2015
Ross University (Bahamas - Semesters 3-4 Only)	11/4/2010	November 2017****	****Proposed site visit Fall 2011

*This is the date used to calculate the seven-year reevaluation period.

**The recognition date of these schools predated December 13, 2003, the effective date of Section 1314.1. Therefore, their reevaluation date is calculated as seven years after December 13, 2003.

*** Recognition extended only to those students who matriculate at Saba on or after January 1, 2002.

**** Site visit at same time as Ross Dominica 2011 reevaluation site visit.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 10, 2011
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of International Medical School Medical University of Silesia – English Language Program Self Assessment Report
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Approve Medical Board of California recognition of the medical education from the Medical University of Silesia's English Language Program retroactive to the start of the English Language Program, and that a site visit of the school is not necessary for this action.

BACKGROUND AND ANALYSIS:

The Board already recognizes the Medical University of Silesia (MSU) pursuant to Section 1314.1 (a)(1) of Title 16, California Code of Regulations. MSU is a well establish medical school in Poland with the primary mission of training citizens of Poland to practice medicine in Poland. MSU started an English language program for medical students designed students that speak English with the goal of practicing medicine in the U.S., Canada and other European countries. MUS's English language program meets the criteria for the Board's review pursuant to Section 1314.1 (a)(2) of Title 16, California Code of Regulations.

In January 2009, MSU officials submitted a Self Assessment Report to commence the Board's review process of their medical school. Medical Consultant Joseph Silva, M.D., M.S.C.P., has been reviewing the school's application. Staff and Dr. Silva requested additional information from MSU and the medical school officials provided the requested information. The additional information was reviewed by Dr. Silva.

Staff requests that Board members review Dr. Silva's report and determine whether to recognize the medical education provided to students by MUS's English language program.

Alternatively, if the Board requires further information regarding the school's educational resources before a decision is reached, staff will request MUS officials to submit the information for your review during a future meeting. If the Board determines site inspections are necessary prior to making a determination, staff will prepare the necessary documents.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code Section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs include all team members' air and ground travel costs within the guidelines allowed by the State, the consultant's daily per diem expense, and the consultant's travel expenses to and from any Board meetings where the team presents its report. Subsection (e) of Section 1314.1 of the regulations requires the medical school to reimburse the Board for the team's estimated travel expenses in advance of the site visit.

If you have any questions concerning this memorandum, please telephone me at (916) 263-2382.

Agenda Item 21

January 10, 2011

To: Curtis J. Worden, Chief of Licensing
Medical Board of California

From: Joseph Silva, M.D., M.A.C.P.
Medical Consultant

Subject: Medical University of Silesia – Request for Recognition of English – Language Program – Amended Response

I have reviewed the materials listed above which you provided on December 14, 2010. The response involves answers to 27 questions framed by the Medical Board of California to Rector Ewa Malecka-Tendera. The document involves 21 pages and 8 backup exhibits. Overall, all questions are directly and succinctly answered and fills in gaps so their compliance with California laws and statutes can be ascertained (Business Professions Code Sections 2089 [Section 2089] and 2089.5 [Section 2089.5] and section 1314.1 of title 16 of the California Code of regulations [Section 1314.1]). The document is well written and includes responses to several new amendments to section 1314.1 which took place on January 8, 2010, after the date the original application for recognition was submitted. I will critique them in order as presented in their response document of October 11, 2010.

This amended response has more description and content concerning the above responses. Incorporated are changes made to date by the MBC in the preceding paragraph.

Section 1314.1

b(2) Organization: MUS has clarified that there was overlap for one Registrar in the third year course (i.e. dual responsibilities for the Polish and English programs). This is acceptable.

b(4) Clinical Oversight: In the submission of answers in the MUS letter of 12/14/10 this section was extensively addressed. They provide for central oversight to assure that their faculty define the types of patients and clinical conditions that students must encounter. Faculty clearly monitor and verify student experiences. Student diaries of experiences in clinical training are regularly reviewed.

Exhibit V11-10a lists administrative changes in number of departments, configurations, and leadership are delineated. These seem appropriate and are similar to many schools of medicine where hybridizations of departments are related to the scientific advances and trends. Compliant.

(3) Subsection (b)(5) Professionalism: MUS documents that there are three threads for educating medical students in Professionalism. The first is its mission statements, academic traditions, and every student studies the rules and regulations governing this area (exhibit provided) and the Hippocratic oath. The second are is devotion of time to this area in the basic sciences (Psychology and Physical Diagnosis) and even more extensively in the clinical settings and performance in professionalism are one of five determinants for setting the final grade.

(4) Subsection (b)(8) Admission and Promotion: Extensive documentation is provided as to documents and materials that are examined before a student is admitted, including background checks. As to the

latter, if a student has committed a crime, the severity is examined by the admissions committee of MUS.

(5) Subsection (b)(9) Financial Resources: Extracted from the 12/14/10 MUS response:
"As a state institution, school is financed by the Polish Ministry of Health and Ministry of Science and Higher Education. There is no pressure for institutional self financing that could compromise the education mission. Each academic year the total number of admitted students, both for Polish and English language programs, cannot exceed the limits set by the Senate of the Medical University of Silesia and approved by the Ministry of Health."

(6) Subsection (b)(13) Branch Campuses: None exist for MUS in terms of the MD degree.

(7) Subsection (b)(14) Program Effectiveness: MUS has experience in collection of data related to student education and effectiveness. As to this area, outcome data are collected for every credit and examination taken by their students. These data are then assessed against mission objectives.

These data are segregated by department and include many features of performance such as attitude, punctuality, behavior, leadership, and other characteristics including bedside manner and skill sets. A grading system exists (A-F). While the Polish ministry regulations do not require NBME/USMLE test score/results, these results are being collected from ECFMG materials as of Fall 2010.

Evidence for modification of the curriculum was provided based on evaluations from academic year 2009/2010. Curriculum is annually approved by the faculty (exhibit 7).

(8) Subsection (f): No major changes are anticipated nor have occurred since original submission of the Silesnian application to our Board. This area involves locations, missions, name change, shifts in organizational control, and increases in enrollment beyond stipulated levels. Compliant.

VII. FACULTY

9. Faculty do not have joint appointments. New chairmen and chairwomen of preclinical and clinical departments was updated and all positions are filled.

VIII. ADMISSION AND PROMOTION STANDARDS

10. Numbers of students enrolled in 3 different programs have clarified the size of classes. For the Medical Board there are three distinct programs:

(1) 6-year Polish language program for Polish citizens
(2) 6-year English language program for non-Polish citizens
(3) 4-year English language program

In exhibit Q11 in response to MBC queries (Question 11) are delineated the size of the program. Courses and facilities appear adequate to satisfactorily train these students.

X. FACILITIES

MBC questioned the number of autopsy tables and they were adequate for the number of students in the Polish and English programs. Their response was that they scheduled students in shifts and had assigned 10 students/cadaver and used subdivided tables. This can be adequate but are these prosected bodies with the anatomy well laid out or do students perform "fresh" dissection. The trend in anatomy in medical schools is to use more models, web based programs, and extensive three dimensional materials so that actual dissection time is limited. I viewed this facility years ago with the

previous director (Prof. Jerszy Gilecki) and his students were achieving satisfactory scores on standardized tests.

XI. MEDICAL STUDENTS

MBC queried as to the location of a hospital. MUS clarified the names were different but the location was the same. No problem with answer.

XIV. AFFILIATION AGREEMENTS

MBC presented a number of questions related to this important area. MUS has clarified what sites are currently being employed to train students outside Poland. Response to question 23 indicates that a number of English Program students train in 3 countries: Poland (63), USA (51) and Taiwan (4).

MBC raised questions about agreements for Polish institutions (Center for Treatment of Burns and Scalds Victims and Center of Oncology) which MUS state are existent MUS also clarified that two re-duplications exist for names of (2) affiliations in New York, NY and incongruities have been resolved.

MBC also offered concern as to affiliation agreements with Hope Medical Institute (see exhibit 17). This document was reviewed and presents no problems to this reviewer.

MUS provided in Question 21 as to USMLE requirements that exist at MUS. Their answer is contained in this communication under subsection (b)(14).

Subsection (8) of Section 2089.5: Provisions of adequate patients for training.

MUS has responded that their overview is adequate and monitoring occurs every quarter (see response in this document (Subsection (b)(14)).

CONCLUSIONS

I believe all queries from our Board have been answered and provide no cause for me to raise any other queries.

I recommend that the Board recognize the program retroactive to January 1, 1996 as the school has been around since the late 1940s and is governed by a number of Polish Ministers with their own codes and regulations. In addition, this recommendation is based on my visit to MUS in May 200 to review some of the programs, particularly Microbiology (as the Chairman spent some time in my laboratory) and briefly reviewed the English program (including a few discussions with students in this program). The programs looked "sound" and the students in the second year were pleased with their training and accommodations. In addition, our intrinsic processes of review have been glacial. I look forward to appear before the Board in January.

Sincerely,

Joseph Silva, M.D., M.A.C.P.
UC Davis, School of Medicine
Professor of Internal Medicine
Dean Emeritus
Medical Consultant (MBC)

Attention: Kathryn Taylor, Licensing Manager
Patricia Park, Licensing Program

From: Joseph Silva, M.D., M.A.C.P.
Medical Consultant and Professor of Internal Medicine, Dean Emeritus
University of California, Davis School of Medicine

Subject: Recognition of International Medical School Program at the Medical University of Silesia (School of Medicine in Katowice, Poland)

BACKGROUND

The Medical Board of California (Board) requested a review of materials provided by the Medical University of Silesia (MUS) in Katowice, Poland for their English Language Program. These materials were submitted to the Board on December 23, 2008. The content is divided into two areas: content related to MUS self assessment (92 pages) and 18 exhibit category with 4 sub-exhibit categories (ie: ba, bb, bc – 7a of over 150 pages). Assessments will be in two articles contained under title 16 Professional and Vocational Regulations and Article 4, Schools and Colleges of Medicine: Section 1314.1 International Medical Schools and Section 2089.

Section 1314.1

a(1) MUS was founded by special charter of the Polish government in 1948 and is under the Ministry of Health and Ministry of Higher Education. In 2008, MUS is one of the largest medical universities in Poland and is comprised of five schools: School of Medicine in Katowice, School of Medicine and Dentistry in Zabrze, School of Pharmacy and Laboratory Medicine in Sosnowiec, School of Health Care in Katowice, and School of Public Health in Bytom.

Since its founding, MUS has trained 26,036 physicians and dentists, 3646 pharmacists, medical analysts and cosmetologists, 2172 nurses and physiotherapists, and 241 public health specialists. The Rektor Malecka-Tendera touts that in the past 50+ years, MUS is in "the forefront for medical research, treatment, and health care for the vast population

of Silesia region". It was also the first to provide heart and lung transplant surgery and has maintained leadership in areas like cardiology, cardiac surgery, transplantology, nephrology, and public health. They have trained students from 90 countries.

b(1) Mission and Objectives (pages 1-12)

(A) The School has a tripartite mission of teaching, research and patient care. In Exhibits 1(a), 1(b) and 1(c) are the statues that codify these activities. There is a strong Academic Senate which acts autonomously in all specified activities. Concomitantly, there are statues which allow for self-governance of University staff members, undergraduate and graduate students, and doctoral and masters students. Faculty are charged with implementing curriculum (according to the European Union directive –see Exhibit 2), and self assessment of the curriculum is requested of faculty and students alike.

(B) MUS faculty are mindful that there has to be appropriate overview of students schedules for lecture and didactics, research, laboratory time and self study. Students rights are published as are requirements for research (over 100 departmental groups are available). Articles are published in two periodicals of MUS: Annales Academiae Medicaen Silesiensis and Annales Socretatis Doctrinae Studentium.

(C) Availability of clinical facilities are codified under law and access to research activities are appropriately fostered. In addition, in statue is language to address education in human rights, beneficence in practice for community, regional and national communities. Educational objectives are spelled out in detail for the pre-clinical and clinical education programs by course (38 pre-clinical and 23 clinical courses). These courses are very much like the curriculum in US medical schools.

b(2) Organization (pages 13-15)

MUS is organized and run through three levels of authority which is codified and is graphically presented in Exhibits ba, bb, and bc. Under the overall Rector (Professor Ewa Malecka-Tendera, M.D., Ph.D.) are four vice-rectors – Scientific Affairs, Clinical Affairs, Student Affairs and Post-Graduate Studies. At level two are all five schools in the health sciences that report to the former group and which has their respective Deans and at least one Vice Dean. Within the MUS School of Medicine are the two broad divisions of medical studies in Polish and English. Appropriately so there are separate Deans and their functions as follows:

Polish Language	English
First Year	Financial Aid
Second and Third Years	First and Second Years
Fourth and Fifth Years	Third, Fourth, Fifth and Sixth Years
Sixth Year	Administrative Financial Affairs

There are some administrative functions which serve both language schools, however why are there two financial units for the English Language school? Do they have overlapping functions?

b(3) Curriculum (pages 16-39, Exhibit 2)

MUS indicates they are compliant with curricular requirements for education related to article 23 of European Community Directive 93/16 EEC and also endorsed by Program Minimum accepted by the Polish Ministry of Health. These two documents were reviewed for content and MUS is in compliance by in large.

The best place to analyze the curriculum is on page 18 where it is divided into preclinical and clinical. There are no overlapping clinical courses by and large in the first 4 years of the 6 year program, as is the trend in US medical schools. Thus for the 6 year program (primarily for Polish high school graduates) consists of 12 semesters being divided in 8 for pre-clinical and 4 semesters for clinical training. The other track is the advanced six year program (for college graduates from accredited universities or those with 90 hours of transferable credits in the biological sciences). This track is called both programs. Their curriculum is for 8 semesters split evenly between preclinical advanced courses and 4 semesters of clinical training. It is the latter program to which English language students are admitted.

Total number of hours for the 6 year courses (so called "Program Minimum") is 5700 hours and 5974 hours for the English language program/both programs. Attendance is mandatory for all classes, laboratories and clinical rotations with make-up sessions expected. Faculty monitor absences which is quite in contrast to US medical schools. Various components of the curriculum will be discussed in detail under Section 2089 of this report (California Business and Professions Code). They are listed in detail from pages 17 (item 10 in self assessment report) to page 38 and Exhibit 2. There are

discrepancies for time listed for Family Medicine and Psychiatry which will be discussed under 2089 where length of time is codified.

New Standards in Section 1314.1

One critical question to which we need an explanation is how MUS assesses and demonstrates comparably of educational experiences for all students at the numerous institutional sites. All following inquires were developed with assistance of the Medical Board Staff (ie. Ms. Pat Parks).

b(4) Clinical oversight is not well addressed. The MUS faculty must better define this area.

b(5) Professionalism. Please explain how the school's learning environment promotes the development of appropriate professional attributes in medical students.

The school's response should encompass how professionalism attributes are taught and monitored both in the basic sciences and clinical sciences settings, to promote the safe practice of medicine. This is an important new area for instructional programs being developed in US medical schools.

b(8) Admissions and Promotion Standards. Please document how the school's admitted students generally meet entrance requirements equivalent to those utilized by US and Canadian medical schools, including an appropriate background check of all applicants admitted to the institution. How does the school make decisions regarding applications from individuals with prior criminal convictions? How does the school address students who commit criminal acts while in medical school?

b(9) Financial Resources. Please explain what steps the school takes to ensure that pressure for institution self-financing does not compromise the educational mission of the institution or cause the school to enroll more students than its total resources can accommodate.

b(13) Branch Campuses. Please disclose any affiliation or other relationship that the school has with another institution in which either institution agrees to grant a doctor of medicine degree or its equivalent to students of the other institution who complete coursework at the affiliated institution.

(This question does not pertain to the school's affiliations with hospitals at which only clinical instruction is provided).

b(14) Evaluation of Program Effectiveness. Please explain what outcome data the school collects to assess whether students are meeting the school's educational program objectives and how it uses that outcome data.

For purposes of this question, "outcome data" means specific and measurable outcome – based performance measures of knowledge, skills, attributes, and values (for example, measures of academic progress, program completion rates, performance of graduates in residency training and on licensing and certification examinations).

(f) Subsequent Notifications to the Board. Subsection (f) lists various changes to a school's program that schools are required to report to the Board while a school's application for recognition is pending before the Board.

Subsection (f) (2) (D) now requires schools to notify the Board of any major change in curriculum, including but not limited to, a change that would affect its focus, design, requirements for completion, or mode of delivery, or other circumstance that would affect the institution's compliance with subsections (a) and (b). Subsection (f) (2) (F) requires schools to notify the Board of an increase in their entering enrollment about 10% of the current enrollment or 15 students in one year, whichever is less, or 20% or more in three years.

After the school submitted its Self Assessment Report to the Board, did the school take any of the above actions or does the school plan to take any such actions in the future? This needs to be answered.

4 Governance (pages 41-46)

Structure of governance is very similar to that of California universities within medical schools. Dean's Administration is responsible for budget, academic calendar, space management and administrative personnel hiring/firing and work policies. Faculty are responsible for curricular design and faculty admission to the Senate and their promotion. Faculty and Administration communicate with one another, hold transparent meetings and mutually consult with students. Due processes are published for hiring/dismissals and faculty promotions. Appeal processes are stipulated for adverse decisions. Students do not serve as instructors, administrators, officers or director of school.

Members of the college ruling body (known as the "faculty council") are delineated as is election of new Deans and evaluation of faculty and administrators.

5 Faculty (pages 47-58, Exhibits 8a (teaching staff) and 8b (non-teaching staff)

As of September 24, 2008, MUS School of Medicine teaching faculty number 369 and non-teaching staff were 133. On pages 47-49 faculty are listed by pre-clinical versus clinical departments. No mention is made of joint appointees which often is not allowable in many European faculties. On page 54 are listed the criteria for professional titles. Do such joint appointments exist and if so how many? A large proportion of chairman/chairwoman of Academic departments or Clinical departments in hospitals have been granted at least one professional degree or holder of a postdoctoral degree (dr hab-"habilitation doctor"). On pages 55 and 56 are detailed faculty expectations for promotion and tenure and also their annual reviews which is a very metric assessment. Some faculty appointments are extended to clinical teachers at US affiliated hospitals (+Canada?). Assignment of duties for the faculty are discussed on pages 56-58. Faculty numbers appear adequate to meet the three missions of MUS, as does the non-teaching support staff who appear qualified.

6. Admission and Promotion Standards (pages 59-64 and Exhibit 9)

Admission criteria are well spelled out for 3 separate programs:

(a) basic 6 year program after high school and primarily for Polish citizens

(b) 6 year program in English for transfer applicants; curriculum very similar to (a) but recruitment appeal is to non-Polish enrollees.

(c) advanced 6 year program in English

It is interesting that 1 semester of calculus is required whereas almost all US schools of medicine have eliminated this course requirement. Requirements for entry and promotion are consistent with MUS mission and objectives. Commentary is rendered as to remediation course and/or examinations, informing students of study rules and regulations, career guidance (page 60), examinations to be taken (page 62) by year of study. We need to know three metrics for this section from academic year 2008: 1) total number of students enrolled in a, b, c; 2) number of graduates for a, b, c; and 3) what countries are the enrolling students from in a, b, and c.

7. Financial Resources (pages 65-66 and Exhibits 10, 11, 12)

There are two areas to comment here for the Medical Board – tuition and overall operating budget. Tuition and fees (after a $500 US one-time registering fee) is $17,500 (US) for basic sciences years and either $17,082 (US) or $27,300 (US) for clinical year and whether it occurs in Polish or US hospitals. The individual student decides where to

obtain clinical training. Allied costs for books and equipment and living expenses are reasonable and almost 50% less than in the US. These tuition charges are much les than US private/public charges for medical students.

The operating budgets are significant and for 2008, 187,262,916 PLN with research receiving 52,704,000 PLN which is sizeable for this part of the world (although there are less funds (91%) devoted to this pot in 2008 from 2007). Audits of this operating budget have been completed with no error and growth is projected at a 1-6-7% increase for all costs when comparing 2007 vs 2008 budgets. This is commiserate with the increasing Polish GDP. Some of the greatest increases are for minor renovations, energy costs, and salaries. The 2008 budget will support their missions and objectives, and since this 2010 we should inquire what over expenditures occurred in 2008

8 Facilities (pages 67-73 and Exhibits 14 and 15 which contain affiliation agreements)

There is mention of only space for 6 lecture halls that can accommodate 400 seats in one hall and between 110-157 seats in the others. Each department has seminar halls for 30 seats. Total area of space in Basic Science Departments is 4 033, 82 m^2 but no detail is given as to the space devoted to teaching laboratories other than the student seats or bench spaces. In addition, there are only 3 cadaver tables. Does this mean that students get access by shifts or what other accommodations are made? How much conflict occurs for space accession between the Polish vs. English Language students? These questions should be answered before adequacy of facilities (number, modern or antiquated) can be determined.

Libraries are many, active, and have a full array of teaching materials including computers with WEB access. A visit to their website (www.sum.edu.pl) reveals a large University with modern, electronic interconnects to areas outside Poland.

9 Clinical Facilities (pages 68-69)

Six hospital affiliations are listed for the US. MUS indicates emphatically on page 69 that they take "full responsibility for the conduct and quality of the educational program at the hospitals." These facilities have approval by ACGME, LCME, JCAHO and close supervision is supplied by the Office of the Dean at MUS.

Polish hospitals are listed for obtaining clinical training. Polish hospitals (pages 50-53) are as follows: 1) Main Clinical Hospital (Katowice, 14 Medykow St); 2) 6th Public

Clinical Hospital, Child and Mother Health Care Center of Upper Silesia (Katowice, 14 Medykow St); 3) Mielecki Public Clinical Hospital (Katowice, 20/24 Fracuska St); 4) 5th Region Specialist Hospital (Sosnowiec, 1 Pl. Medykow); 5) 7th Public Clinical Hospital Upper Silesia Medical Center (Katowice, 45/47 Ziolowa St); 6) The Professor Michalowski Public Health Care Center (Katowice, 35 Ceglana St); 7) The Dr. Urhanowiz and Dr. Kosny Public Hospital (Chorzow, 10 Zjednoczenia St). Summary of teaching space is listed on pages 68 and 69 and appears adequate. These hospitals are all in the Katowice District (ie. 5-40 miles).

Affiliated facilities in the US (page 87) are: 1) Baptist Hospital, Nashville, TN; 2) LaGrange Hospital and Hinsdale Hospital, Hinsdale, IL; 3) MacNeal Hosptial, Berwyn, IL; 4) Metrohealth Medical Center, Cleveland, OH; 5) St. John Hospital, New York City, NY; and 6) Wyckoff Hospital, New York City (Brooklyn), NY.

Another set of documents (pages 78-79) involve partnerships between MUS with other universities allowing exchange programs and summer clerkships up to 12 weeks in accordance with the European Union's Socrates/Erasmus program. This is a well documented program under EU sponsorship so examination of affiliation agreements is not necessary and exists for student exchanges between 10 countries and a total of 14 universities. Erasmus codes are listed. Also listed as University affiliations not under Erasmus aegis are 5 universities in four countries. No affiliation agreements for these European Union Universities were submitted but are probably not necessary unless the Medical Board desires such. I have visited 3 of the 5 centers and they have academic missions and objectives.

Affiliation agreements with the 7 Polish hospitals use the same boiler plate agreement and assures that MUS can fulfill its teaching and care missions. Polish hospital #6 agreement appears to have two names but the address is the same; "Katowice, 35 Ceglana St." In the document it is called "The Professor Michalowski Public Health Care Center" and in exhibit 14 it is listed as "No.5 Clinical Hospital of the MUS in Katowice." We should ask MUS to clarify if my assumption is correct. Also under exhibit 14 for Polish hospital affiliations are listed two hospitals that were not included in their overall self-study document: 1) Center for the Treatment of Burns and Scalds Victims in Siemianowice, Slaski and 2) Center of Oncology-M. Sklodowska-Curie Institute in Gliwice. We should ask for further clarification why they were not listed in the self-study, although the heritage of the Center of Oncology is legendary.

Scrutiny of affiliation agreements with US and Canadian hospitals is greater because they become the surrogate "University" for MUS. Two hospitals had no affiliation agreements with my packet: 1) Metrohealth Center in Cleveland and 2) St. John Hospital in New York City. We need to obtain these agreements. With the assistance of Pat Parks (licensing program) we have noted their accreditations by ACGME and in what specialties/subspecialties.

Baptist Hospital, Nashvile, TN. This is a MAJOR teaching hospital for the University of Tennessee Health Sciences Center College of Medicine. The hospital has five ACGME-accredited residency programs. Because of its MAJOR teaching hospital status the hospital complies with Section 2089.5 (d)(3). Silesia students may complete any core or electives in this hospital.

Adventist Hinsdale Hospital, Hinsdale, IL. This hospital is a limited-level affiliate teaching hospital for Rush Medical School and has an ACGME-accredited residency in family practice. Because of its ACGME-accredited family practice residency, this hospital complies with Section 2089.5 (d)(2). Silesia students may complete any core or elective in this hospital.

The same is true of Adventist LaGrange Memorial Hospital in LaGrange, IL. The affiliation agreement in Exhibit 15 mentions the names of both hospitals but does not confirm the address of either hospital.

MacNeal Hospital, Berwyn, IL. This hospital has ACGME-accredited residency programs in family practice, sports medicine/family medicine and transitional year. Because of its ACGME-accredited family medicine residency, the hospital complies with Section 2089.5 (d)(2). Silesia students may complete any core or elective in this hospital.

Metrohealth Medical Center, Cleveland, OH. This hospital is a MAJOR affiliate teaching hospital for Case Western Reserve medical school. It has 22 ACGME-accredited residency programs, including family practice. Because of its MAJOR teaching hospital status and ACGME-accredited family practice residency, the hospital complies with Section 2089.5 (d)(2) and (d)(3). Silesia students may complete any core or elective in this hospital.

St. John's Hospital, NYC. (The school may have meant to state "St. John's Episcopal Hospital, Far Rockaway, NY." The coordinator's telephone number and website are for St. John's Episcopal in Far Rockaway). St. John's Episcopal has a graduate-level affiliation with SUNY-Downstate medical school. It has one ACGME-accredited

residency program in internal medicine and is a sponsoring institution for cardiovascular disease, gastroenterology, pulmonary disease/critical care and PM&R.

Because the hospital has a limited affiliation with its medical school and no family practice residency, Section 2089.5 (d)(3) limits students to receiving credit for rotations in the five indicated areas. However, Section 2089.5 (d)(4) allows international schools to execute affiliation agreements with US hospitals to train students in clinical areas in which the hospital does not otherwise comply with subsections (d)(1), (2), or (3). The affiliation agreement needs to comply with the provisions of subsection (e).

Note: The school omitted this hospital's affiliation agreement in Exhibit 15. This school should be required to submit this affiliation agreement?

Wyckoff Heights Medical Center, Brooklyn, NY. This hospital has a limited affiliation with Weill Cornell Medical College. The hospital has ACGME-accredited residency programs in family practice and internal medicine and is a sponsoring institution for gastroenterology, hematology/oncology, pediatrics and pulmonary diseases. Because of its ACGME-accredited family practice residency, this hospital complies with Section 2089.5 (d)(2). Silesia students may complete any core or elective in this hospital.

University of Saskatchewan, Canada. Although the school did not list this affiliation on Page 68 or 69, in Exhibit 15 the school provided a copy of its affiliation agreement with this Canadian medical school. The agreement provides for two Silesia students to rotate through the medical school's affiliated teaching hospitals (the hospitals are not named) in internal medicine, surgery, ob/gyn, pediatrics, psychiatry and subspecialty electives. This affiliation agreement needs to comply with Section 2089.5 (e)(1-10).

Note: The above hospital affiliation agreements were executed by Mahendra Patel of Hope Medical Institute (HMI) rather than a medical school official in Silesia. HMI is a private company in Virginia. On Page 5 of Exhibit 17, the school refers to a Memorandum of Understanding (MOU) between the school and HMI. MUS should provide a copy of its MOU with HMI delegating to Mr. Patel the authority to execute affiliation agreements and perform other functions.

Please also note in Exhibit 17, Page 3, that the school will allow students to train in their "homeland" including India and other European countries. In these instances, Section 2089.5 (d)(4) will require the school to execute an affiliation agreement with the foreign hospital that satisfies Section 2089.5 (e)(1-10). If not, students will be limited to 18 weeks of elective training credit.

Among international medical schools that purport to train US citizens to practice in the United States, a commonly accepted standard is to require students to pass USMLE Step1 before they begin clinical rotations in US hospitals. None of the affiliation agreements in Exhibit 15 requires Silesia students to pass USMLE Step 1 prior to beginning their clinical training. While the agreement with Baptist Hospital requires students to have a "C" average in their courses, an increasing national and international practice is not to give letter grades.

MUS should explain how the faculty determines that students in the English program have demonstrated their readiness to begin clinical training in US hospitals. The Medical Board should also be provided data on the number of students who train in Poland versus the United States and other foreign countries.

In past instances, the Medical Consultant and the Board members have focused on the integration of the basic sciences and clinical sciences programs when these two programs are geographically separated. Exhibit 17 outlines the process by which the school monitors the quality of its overseas affiliate teaching sites. We need to review the tools that MUS employs to monitor and integrate its geographically-separated programs. In Exhibit 17a, the school provided a blank copy of its Off Campus Clinical Training Site Visitation Report form. MSU should also provide copies of completed site visit report forms for recent inspections of US hospitals. If provided these assessments and data, then we can review if the educational experiences outside Poland allow for quality education and the missions and objectives of MUS are being met in providing a medical doctorate diploma.

10 Quality Assurance System (page 80 and Exhibit 17)

None of the submitted documents in the assessments directly address this activity. However, it can be inferred to occur under the wrap-around reviews. For US hospitals, certification is by JCAHO, LCME and ACGME and for Polish hospitals, two entities provide accreditation: Panstwowa Komisja Aredytacyjna (PKA), Konfercja Akredytacyjna Ucelnia Medycznych (KAUM). The latter is equivalent to the US LCME. The clinical volumes of Polish hospitals affiliated with MUS for inpatient beds, ER visits, and outpatient visits are all substantial. Medical students are only assigned to services with a daily census of 15 patients. This latter objective is probably being met but we should as for confirmation.

11 Medical Records

MUS meets this section and even spells out what the continuity for passage of records will be if the institution ceases to exist. I have seen several transcripts of Polish students rotating to UCD SOM and they are very complete and meticulous (and rival the exactitude of German medical schools).

12 Branch Campuses (pages 80-82 and Exhibit 17)

MUS is meeting the requirements stated in this section which is discussed on pages 80-82. In addition, Exhibit 17 describes some of the mechanics whereby quality in education is insured. As indicated under Section 8 (Facilities), a sample form, presumably employed for a site visit report, was included. The metrics appear appropriate and I believe the Medical Board should consider obtaining any site visits to the 6 US affiliated hospitals and the one Canadian hospital.

Clinical Instruction of the Article 2089 California Business and Professions Code

a) Annual hours – on page 17 is testament that total number of hours of all six year courses is 5700 hours (also dictated by the Polish Ministry of Health under the document entitled "Program Minimum") and in English both programs equal 5974 hours. This standard is met.

b) Curriculum in list of the 26 subject areas - on pages 17-32, are the courses required to meet this code and all topics under 2089(b) are taught thus meeting this guideline. Quantitative metrics for several critical courses as outlined in 2089.5 will be covered in that section (pages 32-39 and Exhibit 2). As a note of interest, there are also unique courses which MUS offers such as dentistry and Latin (Exhibit 8).

Article 2089.5

a) Meets requirements.

b) Meets requirements.

c) Instruction in care clinical courses – minimum requirements are met for surgery and medicine (8 weeks), pediatrics and obstetrics/gynecology (6 weeks), and family medicine (page 38). Psychiatry hours have to be searched for and are not listed on pages 34-39. However, on page 33 180 hours is mentioned in year VI and Behavioral Sciences is listed on page 35 for 1st semester in the third year.

The Medical Board should ask for sustention that 180 hours do occur. In a list of Psychiatry faculty most are junior faculty so this may be a discipline that is "beefing up." Classically under the old Soviet block, the field of Psychiatry was not established as a legitimate discipline except of KGB operatives.

d) Hospital requirements for instructor criteria (1), (2), (3), (4) – guidelines met.

e) For institutions specified under (d), criteria (1), (2), (3), (4), (5), (6), (7), (8), (9) (10) – guidelines met for hospitals MUS has affiliation agreements.

Overall Summary

Documents need some reworking and about 18+ questions need to be answered prior to final recommendations.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 10, 2011
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of International Medical School Technion-Israel Institute of Technology, Ruth and Bruce Rappaport Faculty of Medicine, Technion American Medical Students Program (TeAMS), Self Assessment Report
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Approve Medical Board of California recognition of the medical education provided by Technion-Israel Institute of Technology, Ruth and Bruce Rappaport Faculty of Medicine, Technion American Medical Students Program (TeAMS) retroactive to the start of the TeAMS program, and that a site visit of the school is not necessary for this action.

BACKGROUND AND ANALYSIS:

The Board already recognizes Technion-Israel Institute of Technology, Ruth and Bruce Rappaport Faculty of Medicine (Technion – Faculty of Medicine) pursuant to Section 1314.1 (a)(1) of Title 16, California Code of Regulations. Technion – Faculty of Medicine is a well establish medical school in Israel with the primary mission of training citizens of Israel to practice medicine in Israel. Technion-Faculty of Medicine started an American medical students program (English language) designed for U.S. and Canadian citizens with the goal of practicing medicine in the U.S. or Canada. TeAMS meets the criteria for the Board's review pursuant to Section 1314.1 (a)(2) of Title 16, California Code of Regulations.

In June 2010, TeAMS officials submitted a Self Assessment Report to commence the Board's review process of their medical school. Medical Consultant Mark Servis, M.D., has been reviewing the school's application. Staff and Dr. Servis requested additional information from TeAMS in August 2010 and the medical school officials provided the requested information. The additional information was reviewed by Dr. Servis.

Staff requests that Board members review Dr. Servis' report and determine whether to recognize the medical education provided to students by TeAMS.

Alternatively, if the Board requires further information regarding the school's educational resources before a decision is reached, staff will request TeAMS officials to submit the information for your review during a future meeting. If the Board determines site inspections are necessary prior to making a determination, staff will prepare the necessary documents.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code Section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs include all team members' air and ground travel costs within the guidelines allowed by the State, the consultant's daily per diem expense, and the consultant's travel expenses to and from any Board meetings where the team presents its report. Subsection (e) of Section 1314.1 of the regulations requires the medical school to reimburse the Board for the team's estimated travel expenses in advance of the site visit.

If you have any questions concerning this memorandum, please telephone me at (916) 263-2382.

December 27, 2010

To: Linda Whitney
Executive Director
Medical Board of California

From: Mark Servis, MD
Professor and Associate Dean of Curriculum and Competency Development
UC Davis School of Medicine
2230 Stockton Blvd.
Sacramento, CA 95817

Re: Evaluation of the Technion-Israel Institute of Technology, Faculty of Medicine "American Program" or Technion American Medical Students Program (TeAMS) Self Assessment Report; Application for Recognition in California.

BACKGROUND

The Medical Board of California requested a review of the Self Assessment Report submitted by the Technion-Israel Institute of Technology, Faculty of Medicine in June 2010 for its TeAMS or English-language "American Program", whose mission is to prepare U.S. and Canadian citizens to practice medicine in the United States and Canada. The originally submitted Self Assessment Report from Technion did not closely follow the format of the Board's Self Assessment Report and was missing information in some areas. It also contained some information that was not requested. Board staff subsequently requested missing and clarifying information from Technion, which was provided for review on Novermber 10, 2010. The additional information provided by Technion addressed all areas and was sufficient to complete the evaluation.

Technion-Israel Institute of Technology, Ruth and Bruce Rappaport Faculty of Medicine, is a state sponsored medical school in Haifa that has graduated over 4,000 physicians in the past 40 years. They have a long established six year medical education program in the Hebrew language for Israeli citizens, and began a five year joint English language medical education program with Touro College in New York in 1983 for students who wanted to pursue residency training in the United States. They discontinued their joint program with Touro College in 2006 and began their own independent four year English language program based entirely in Haifa in 2006. The mission of this new program is to prepare students for residency training in the United States and Canada. The TeAMS program is small and is limited to 32 students per year, with a maximum of 35, to "allow more personal teaching." Since this new program is independent of the Touro program that is already recognized by the Medical Board of California, and is different from their standard six year Hebrew language program for Israeli citizens, it comes under the purview of subsection (a)(2) of Section 1314.1, Title 16 of the California Code of Regulations, and requires the Board's individual review.

This report is based on my review of the documents submitted by Technion. The goal of the review was to determine if the medical education received in the new Technion American Medical Students Program (TeAMS) meets the requirements of current California statutes and regulations for recognition by the Medical Board of California.

RECOMMENDATIONS

The Technion American Medical Students Program (TeAMS) has provided sufficient documentation to satisfy the criteria in Sections 2089 and 2089.5 of the Business and Professions Code and Section 1314.1 of Title 16, California Code of Regulations. The program takes full advantage of the resources of an excellent larger medical school for Israeli citizens, with strong faculty and established clinical training sites throughout northern Israel. The connection to a strong research faculty and graduate students in the Technion-Israel Institute of Technology provides students the opportunity to participate in research and encourages use of state of the art knowledge and teaching in medicine by the faculty.

REVIEW

The following is a detailed assessment of TeAMS based on the relevant California statutes and regulations and on Technion's responses to the Self-Assessment Report.

Business and Professions Code Section 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. TeAMS is a full four year program that consists of 4750 hours of formal instruction. TeAMS therefore meets the Section 2089 requirement for a minimum of 4,000 hours of course instruction. Students are required to attend 80% of classes in the first two years and full attendance is mandatory for students in the third and fourth clinical years. Attendance is monitored by students signing into classes in the preclinical years and is part of the evaluation of students in the clinical years. This meets the Section 2089 requirement for 80% actual attendance in all courses. Instruction in pain management and end-of-life care is included in the Introduction to Clinical Medicine course in the second year, and the internal medicine and anesthesiology clerkships in the third and fourth year.

Business and Professions Code Section 2089.5

The documents provided by Technion for the TeAMS program demonstrate that instruction in the clinical courses meets or exceeds the minimum requirements of Section 2089.5. For example, Section 2089.5 requires a minimum of 72 weeks of clinical coursework. TeAMS requires 80 hours and includes all of the required minimums of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry stipulated in Section 2089.5.

Clinical rotations are in established teaching hospitals with Technion faculty in Haifa and other regional hospitals in northern Israel. Technion has sufficient numbers of clinical faculty in its teaching hospitals to provide experiences in all specialties. Technion has also established two "exchange" agreements with USC and UC Irvine in the United States to allow TeAMS students in their fourth year to do required clinical rotations at these California schools.

California Code of Regulations, Title 16, Division 13, Section 1314.1

The stated mission of the TeAMS program is to "produce a quality physician, placing professionalism at the center of teaching while fostering research abilities and scientific know-how." The mission and goals have been systematically reviewed by the faculty and administration over a series of four "Vision and Mission" retreats from 1997 to 2010, with comprehensive review of the school's strengths, weaknesses, and opportunities for improvement. As a result the school does have a clearly defined mission statement with educational goals and objectives.

As required in Section 1314.1, the administration and governance system allows the institution to accomplish its objectives and the faculty have a formal role in curriculum oversight and evaluation of student progress. There is an adequate number of faculty available for the TeAMS program with 420 faculty in the Technion-Israel Institute of Technology, Ruth and Bruce Rappaport Faculty of Medicine, who also teach in the larger Hebrew language six year program. The six year Hebrew language program has 110 students per year. The faculty include 45 full time pre-clinical researchers and 375 clinical faculty. The faculty credentials that Technion provided demonstrate they are qualified to teach their respective courses and fulfill their roles, and include two Nobel Prize winners in Chemistry. Research has a prominent role in the education of students in TeAMS and is an area of emphasis for the school given its connection to the Technion Institute of Technology and its active research programs.

The structure and content of the educational program provides an adequate foundation in the basic and clinical sciences and enables students to learn the fundamental principles of medicine, to acquire critical judgment skills, and to use those principles and skills to provide competent medical care. TeAMS curriculum makes extensive use of active learning methods such as problem-based learning and small group teaching in the preclinical years given the small class size, and promotes self-directed learning in its students consistent with its stated mission. Efforts are made to standardize the clerkship experiences across the eight regional teaching hospitals.

Technion has organized central oversight of the curriculum. Courses and faculty are systematically and regularly evaluated by students to ensure they are meeting objectives and to ensure quality. Faculty define the types of patients and clinical conditions that students must encounter and the expected level of student responsibility in clinical courses. The student's experiences in courses can be modified to ensure that the objectives are being met. Students are comprehensively evaluated in all courses and a broad range of evaluation instruments are used including OSCEs and the USMLE.

Students were just recently required to pass USMLE Step 1 and Step 2 CS and CK, but past performance by students who voluntarily took the UMSLE is anecdotally good.

TeAMS has clear admission and promotion standards. There is a description of the admissions criteria, student selection and promotion criteria, and admissions oversight provided from an Admissions Committee. These standards are consistent with those utilized by U.S. and Canadian medical schools. Students having difficulty are comprehensively assessed and remediation plans are determined by a "Student Advisory and Monitoring Committee" chaired by the Deputy Dean of the Faculty of Medicine with key teaching and advising faculty as members of the committee. The school has not kept track of its graduates placement in residency training programs, a curious omission given the usual attention in medical schools to annual NRMP results, particularly for a school whose mission is placement in US residency training programs. The school does however plan to track these results in the future, which would be an important part of assuring compliance with (14) Evaluation of Program Effectiveness.

There are no branch campuses. Records and student transcripts are kept indefinitely. There is an established quality assurance program for patient care in the main teaching hospital, Rambam Medical Center, and affiliated regional hospitals. Facilities at Technion are state of the art and include all needed physical, laboratory, library and academic resources, classroom space, and technology needed to fulfill its mission and objectives.

Technion presented information on its financial resources in the form of the entire school's Financial Statement from September 30, 2009. The funds for TeAMS were not separated out. Tuition for TeAMS students is $25,000 annually. Technion is a state school with government support and a long history, so the school appears to have more than adequate financial resources to carry out its stated mission.

SUMMARY

In summary, I believe there is sufficient documentation to support the application for recognition of the TeAMS or English-language "American Program" of Technion-Israel Institute of Technology, Ruth and Bruce Rappaport Faculty of Medicine retroactive to the beginning of the Haifa-based program that was no longer affiliated with Touro College in 2006. Information about the Touro College affiliated program was not provided in their documentation and therefore is not addressed in this review. This TeAMS program of 32 students per year exists within the larger, well established medical education program at Technion and is compliant with the requirements of current California statutes and regulations for recognition by the Medical Board of California.

Thank you for the opportunity to review the materials from Technion-Israel Institute of Technology, Ruth and Bruce Rappaport Faculty of Medicine.

WORKLOAD REPORT

as of December 31, 2010

CONSUMER INFORMATION UNIT FY 10/11					
	FY 10/11	*Q1	Q2	Q3	Q4
Total Calls Answered	***49,458***	26,974	22,484		
Calls Requesting Call Back	***6,255***	3,792	2,463		
Calls Abandoned	***8,397***	5,544	2,853		
Address Changes Completed	***5,397***	3,120	2,277		

* 1.5 days phone outage; technical issues w/dropped calls.

CONSUMER INFORMATION UNIT FY 9/10					
	FY 09/10	Q1	Q2	Q3	Q4
Total Calls Answered	***97,450***	27,117	22,049	23,579	24,705
Calls Requesting Call Back	***16,318***	4,951	3,021	4,491	3,855
Calls Abandoned	***17,248***	4,967	3,336	4,834	4,111
Address Changes Completed	***9,700***	3,346	2,302	2,217	1,835

PHYSICIAN & SURGEON DATA FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
Applications Received	***3,105***	1,568	1,537		
Initial Reviews Completed	***3,100***	1,208	1,892		
Total Pending	***N/A***	5,291	5,038		
Reviewed	***N/A***	4,460	4,532		
Not Reviewed	***N/A***	831	506		
(SR2s Pending)	***N/A***	98	83		
Licenses Issued	***2,695***	1,447	1,248		
Renewals Issued	***31,545***	16,168	15,377		

PHYSICIAN & SURGEON DATA FY 09/10					
	FY 09/10	Q1	Q2	Q3	*Q4*
Applications Received	***5,822***	1,651	1,555	1,274	1,342
Initial Reviews Completed	***3,530***	n/a	n/a	1,658	1,872
Total Pending	***N/A***	n/a	n/a	6,716	5,772
Reviewed	***N/A***	n/a	n/a	n/a	5,386
Not Reviewed	***N/A***	n/a	n/a	n/a	386
(SR2s Pending)	***N/A***	n/a	n/a	73	65
Licenses Issued	***5,111***	1,107	1,132	1,425	1,447
Renewals Issued	***60,814***	14,883	15,668	15,447	14,816

WORKLOAD REPORT

as of December 31, 2010

SPECIAL PROGRAMS FY 10/11																				
Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	19	9			18	4			16	4			13	7			4	14		
2112	0	1			0				0				0				0	1		
2113	7	1			5	3			4	4			20	15			6	3		
2168	0				0				0				3	1			1			
2072	0				0				0				0				0			
1327	1				1				0				0				1			

SPECIAL PROGRAMS FY 09/10																				
Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	12	4	3	16	12	4	3	16	17	10	3	7	17	11	6	8	6	0	0	0
2112	1	0	0	1	1	0	0	1	1	1	0	0	1	0	0	0	0	1	0	0
2113	5	1	3	11	5	1	0	11	13	4	1	9	13	18	18	22	8	0	3	0
2168	1	0	0	0	1	0	0	0	0	0	2	0	0	1	1	1	1	1	0	0
2072	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1327	1	0	0	0	1	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0

2111 - Visiting Fellow (doesn't satisfy postgraduate training required for licensure)

2112 - Hospital Fellowship Program Non-Citizen (does not satisfy postgraduate training required for licensure)

2113 - Medical School Faculty Member (may satisfy postgraduate training required for licensure)

2168 - Special Faculty Permit (academically eminent; unrestricted practice within sponsoring medical school - not eligible for licensure)

2072 - Special Faculty Permit - Correctional Facility

1327 - Special Faculty Permit - Hospital

WORKLOAD REPORT

as of December 31, 2010

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 10/11					
	FY 10/11	Q1	Q2	Q3	Q4
New Applications Received	*1*	0	1		
Total Pending Applications	*N/A*	0	6		

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 09/10					
	FY 09/10	Q1	Q2	Q3	Q4
New Applications Received	*3*	0	1	0	2
Total Pending Applications	*6*	3	4	4	6

LICENSED MIDWIVES FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
Applications Received	*23*	12	11		
Applications Pending	*N/A*	4	1		
Licenses Issued	*22*	9	13		
Licenses Renewed	*47*	30	17		

LICENSED MIDWIVES FY 09/10					
	FY 09/10	Q1	Q2	Q3	*Q4*
Applications Received	*16*	2	0	10	4
Applications Pending	*N/A*	N/A	1	0	2
Licenses Issued	*19*	2	2	10	5
Licenses Renewed	*74*	18	4	29	23

RESEARCH PSYCHOANALYST FY 10/11					
	FY 10/11	Q1	Q2	Q3	Q4
RP Applications Received	*6*	3	3		
RP Licenses Issued	*6*	2	4		

RESEARCH PSYCHOANALYST FY 09/10					
	FY 09/10	Q1	Q2	Q3	Q4
RP Applications Received	*4*	0	0	0	4
RP Licenses Issued	*3*	0	1	0	2

WORKLOAD REPORT
as of December 31, 2010

FICTITIOUS NAME PERMITS FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
P&S - FNP Issued	***627***	310	317		
P&S - FNP Pending	***N/A***	66	62		
Podiatric FNP Issued	***9***	7	2		
Podiatric FNP Pending	***N/A***	1	0		

FICTITIOUS NAME PERMITS FY 09/10					
	FY 09/10	Q1	Q2	Q3	*Q4*
P&S - FNP Issued	***1,100***	276	227	210	387
P&S - FNP Pending	***N/A***	N/A	N/A	242	86
Podiatric FNP Issued	***18***	6	6	1	5
Podiatric FNP Pending	1	0	0	1	1

SPECIALTY BOARD APPLICATIONS FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
Applications Received	***0***	0	0		
Applications Pending	***2***	1	1		

SPECIALTY BOARD APPLICATIONS FY 09/10					
	FY 09/10	Q1	Q2	Q3	*Q4*
Applications Received	***0***	0	0	0	0
Applications Pending	***N/A***	1	1	1	1

OPTICAL REGISTRATIONS FY 10/11					
	FY 010/11	Q1	Q2	Q3	Q4
Business Registrations Issued	***37***	16	21		
Pending Applications Business	***N/A***	25	21		
Out-of-State Business Registrations Issued	***0***	0	0		
Pending Applications Out of State Bus.	***N/A***	0	0		
Spectacle Lens Registrations Issued	***97***	42	55		
Pending Applications-Spectacle Lens	***N/A***	62	37		
Contact Lens Registrations Issued	***36***	19	17		
Pending Applications-Contact Lens	***N/A***	20	11		
Spectacle Lens Registrations Renewed	***438***	200	238		
Contact Lens Registrations Renewed	***197***	81	116		

OPTICAL REGISTRATIONS FY 09/10					
	FY 09/10	Q1	Q2	Q3	Q4
Business Registrations Issued	***142***	19	60	8	55
Pending Applications Business	***N/A***	N/A	N/A	82	30
Out-of-State Business Registrations Issued	***1***	1	0	0	0
Pending Applications Out of State Bus.	***N/A***	N/A	N/A	0	0
Spectacle Lens Registrations Issued	***221***	56	18	71	76
Pending Applications-Spectacle Lens	***N/A***	N/A	N/A	47	38
Contact Lens Registrations Issued	***98***	36	11	26	25
Pending Applications-Contact Lens	***N/A***	N/A	N/A	22	7
Spectacle Lens Registrations Renewed	***906***	214	200	242	250
Contact Lens Registrations Renewed	***366***	82	93	77	114

Licensing Program

Weekly Application Production

Week Ending -->	16-Oct	23-Oct	30-Oct	6-Nov	13-Nov	20-Nov	27-Nov	4-Dec	11-Dec	18-Dec	25-Dec	1-Jan	8-Jan
Number of Workdays -->	4	4	5	5	4	5	3	5	5	5	5	5	5
Applications Received													
US/CAN	61	55	62	131	105	109	5	159	54	74	77	63	52
IMG - License	13	6	6	25	12	24	3	26	14	17	19	18	17
IMG - PTAL	31	28	17	33	6	20	6	23	13	20	12	11	12
Total	***105***	***89***	***85***	***189***	***123***	***153***	***14***	***208***	***81***	***111***	***108***	***92***	***81***
Applications Completed (License or PTAL Issued)													
US/CAN - Licensed	48	60	39	118	39	81	49	125	41	55	43	57	166
IMG - Licensed	15	18	21	35	31	33	20	43	29	23	16	14	36
Total - Licensed	**63**	**78**	**60**	**153**	**70**	**114**	**69**	**168**	**70**	**78**	**59**	**71**	**202**
Total - PTAL's Issued	***27***	***19***	***44***	***42***	***35***	***47***	***19***	***33***	***34***	***25***	***25***	***23***	***15***
Applications Processed (Initial Review Completed)													
Application Complete Upon Initial Review (ready for licensure)													
US/CAN	14	8	10	4	6	10	2	14	18	11	8	18	16
IMG - License	0	0	0	0	0	0	0	0	0	0	0	0	0
IMG - PTAL	0	0	0	1	0	1	1	1	0	0	0	0	0
Subtotal	***14***	***8***	***10***	***5***	***6***	***11***	***3***	***15***	***18***	***11***	***8***	***18***	***16***
Initial Review (Application Deficient)													
US/CAN	81	59	106	86	67	76	21	57	96	103	90	81	91
IMG - License	20	14	15	18	20	36	8	20	33	27	13	19	19
IMG - PTAL	37	29	24	43	36	30	24	30	40	16	21	6	14
Subtotal	***138***	***102***	***145***	***147***	***123***	***142***	***53***	***107***	***169***	***146***	***124***	***106***	***124***
Total	***152***	***110***	***155***	***152***	***129***	***153***	***56***	***122***	***187***	***157***	***132***	***124***	***140***
*Inventory Awaiting Initial Review - Current as of: -->	19-Oct	26-Oct	2-Nov	9-Nov	16-Nov	23-Nov	30-Nov	7-Dec	14-Dec	21-Dec	28-Dec	4-Jan	11-Jan
NEW: 0-30 days	494	449	425	483	519	558	489	500	460	421	*	410	384
AGING: 31-60 days	190	201	163	142	130	76	109	167	108	87	*	86	16
AGING: 61-90 days	0	0	0	0	0	0	0	0	0	0	*	0	0
BACKLOG: Over 90 days	0	0	0	0	0	0	0	0	0	0	*	0	0
Total	***684***	***650***	***588***	***625***	***649***	***634***	***598***	***667***	***568***	***508***	*	***496***	***400***
Date of Oldest US Appl Awaiting Initial Review--->	*09/13/10*	*09/20/10*	*09/27/10*	*10/04/10*	*10/11/10*	*10/18/10*	*10/25/10*	*11/01/10*	*11/08/10*	*11/16/10*	*	*12/01/10*	*12/13/10*
Number of calendar days for US Initial Reviews	*37*	*37*	*37*	*37*	*37*	*37*	*37*	*37*	*37*	*36*	*	*35*	*30*
Date of Oldest IMG Appl Awaiting Initial Review--->	*09/01/10*	*09/07/10*	*09/14/10*	*09/22/10*	*09/29/10*	*10/12/10*	*10/18/10*	*10/25/10*	*11/10/10*	*11/18/10*	*	*12/01/10*	*12/06/10*
Number of calendar days for IMG Initial Reviews	*49*	*50*	*50*	*49*	*49*	*43*	*44*	*44*	*35*	*34*	*	*35*	*37*
Date of Oldest US Pending Mail Awaiting Review--->	*10/13/10*	*10/20/10*	*10/27/10*	*11/03/10*	*11/10/10*	*11/15/10*	*11/24/10*	*12/02/10*	*12/08/10*	*12/14/10*	*12/22/10*	*12/29/10*	*01/05/11*
Number of calendar days for US Pending Mail	*7*	*7*	*7*	*7*	*7*	*9*	*7*	*6*	*7*	*8*	*7*	*7*	*7*
Date of Oldest IMG Pending Mail Awaiting Review--->	*10/04/10*	*10/12/10*	*10/18/10*	*10/25/10*	*11/01/10*	*11/12/10*	*11/17/10*	*11/29/10*	*12/06/10*	*12/13/10*	*12/21/10*	*12/28/10*	*01/05/11*
Number of calendar days for IMG Pending Mail	16	15	16	16	16	12	14	9	9	9	8	8	7

***Note:** Live data numbers are subject to change depending on the date that they are ran. All data on the report is ran weekly reflecting a Sunday through Saturday reporting period with the exception of the *Inventory Awaiting Initial Review* section. The data in the *Inventory Awaiting Initial Review section* reflects current data when the report is ran on the following Tuesday.

***AdHoc Database required maintenance was performed 12/20/10 - 1/3/11, therefore, live data numbers were not available on 12/28.**

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 Main
(916) 263-2487 Facsimile

TRAINING REGISTRATION OF U.S. ARMED FORCES MILITARY MEDICAL PHYSICIAN & SURGEON PERSONNEL IN CALIFORNIA HOSPITAL FACILITIES

(PER SECTION 714, BUSINESS AND PROFESSIONS CODE)

The following trainee(s) will be receiving combat ready medical training, per Section 714 of the Business and Professions Code, at the following hospital training site.

Name	DOB	Rank	Service Branch	State Licensed & License Number	Medical School of Graduation	Area of Training	Dates of Training

Hospital Name: _____

Address: _____

City/State/Zip: _____

Program Director Name: _____

SIGNATURE & DATE: _____

Telephone Number: _____

Stationed Federal Facility: _____

Address: _____

City/State/Zip: _____

Branch of Service: _____

Commanding Officer: _____

SIGNATURE & DATE: _____

Telephone Number: _____

DRAFT

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 10, 2011
ATTENTION:	Medical Board of California
SUBJECT:	Polysomonographic Technologist Regulations (CCR, Title 16, Division 13, Chapter 3.5, Articles 1 through 6) Second Modified Text
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

Direct staff on how to proceed with the Polysomonographic Technologist Regulations (CCR, Title 16, Division 13, Chapter 3.5, Articles 1 through 6) Second Modified Text.

STAFF RECOMMENDATION:

Staff recommends posting the Second Modified Text for a 15 day comment period and authorizing the Executive Director in the absence of any adverse comments to proceed with filing the Second Modified Text with the Office of Administrative Law.

BACKGROUND:

This memo provides you information regarding the Board's attempt to adopt regulations to implement the registration of polysomnographic technologists, technicians and trainees, as required by Senate Bill 132. As you may recall, the Board, at its November 15, 2010, meeting, decided to make some revisions to the proposed polysomnographic regulations and then circulate those revisions for a comment period of fifteen days. The Board received comments on the reviewed proposal.

As a result, after the meeting, interested parties met with Board staff and legal counsel to discuss additional revisions to the regulations. Of particular interest to the interested parties are the following:

1) Approval of Educational Polysomnographic Programs. Staff and legal counsel agree that this revision is necessary to recognize those applicants who have completed an educational program designated by the Board of Registered Polysomnographic Technicians.

2) Potential Grandfathering of the Examination Requirement. One of the more controversial issues is the qualifications to become a registered technologist. One of the *statutory* requirements for registration as a technologist is the successful completion of a national certifying examination. In lieu of the examination, however, SB 132 allows an applicant for registration to provide the Board with sufficient evidence that he or she has been

practicing polysomnography for at least five years. In other words, some technologists – those who have been practicing for five years safely – would be grandfathered in and passage of the examination would not be required as a prerequisite to registration.

In discussions with the interested parties, Board staff and legal counsel have learned that the supposed intent of the grandfather clause was to essentially allow an applicant who has practiced safely for five years to register as a technologist without reference to the completion of an educational program or successful passage of an examination.

From a legal perspective, this new, broader interpretation is inconsistent with the statute. The test for regulatory sufficiency is a two-part test: The regulation must be 1) consistent and not in conflict with the statute; and 2) reasonably necessary to effectuate the purpose of the statute. Additionally, a regulation cannot enlarge or restrict the scope of a statute. (See *Home Depot U.S.A. v. Contractors' State Licensing Board* (1996) 49 Cal.Rptr.2d 302, 306.) Here, the enlarged grandfather clause would expand the scope of the statute from the examination only exemption to an exception from the requirements for graduation from an approved program as well as the examination.

3) Level of Services and Supervision to be Provided. As part of the resolution to the grandfathering issue described above, the interested parties propose to significantly revise the Board's regulation to create three levels of polysomnographic technicians and to expand the level of services that these technicians can provide. In essence, while the Board has proposed three classes of licensure, the interested parties suggest five: trainee, three classes of technicians, and technologist, all at program startup. This new regimen is unnecessarily complex, potentially confusing and may not be prudent public policy as it tends to blur the lines and distinctions among the classifications. Two of the technician classifications would be identical to the technologist classification in scope and ability to supervise. The Board may want to consider have the underlying statutory issues resolved before moving forward with expanding these regulations. Additionally, the Board may want to set an effective date for these regulations.

4) The Board also received the following comment: "I thought I should bring to your attention that subdivision (a) of section 1378.13 references section 1378.1 (e) and I believe it was meant to reference section 1378.1(f).

   "1378.13. Employment and Supervision of Registrants.

   (a) A physician and surgeon who does not meet one of the requirements set forth in section 1378.1(e) shall not supervise polysomnography registrants…"

   Section 1378.1(e) references the definition for a "polysomnographic registrant" whereas 1378.1(f) references the definition for "Supervising physician and surgeon."

   This change is appropriate and has been made to the second modified text.

MEDICAL BOARD OF CALIFORNIA

Proposed Second Modified Text

Changes to the first modified text are shown in italics with double underline for new text and italics with double strikeout for deleted text.

Add Chapter 3.5 to Division 13 of Title 16, California Code of Regulations, to read as follows:

Chapter 3.5. Polysomnography

Article 1. General Provisions

1378.1. Definitions.

For the purposes of the regulations contained in this chapter and for purposes of Chapter 7.8 of Division 2 (commencing with section 3575) of the code:

(a)"Approved polysomnographic education program" means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs ("CAAHEP") or by the Commission on Accreditation for Respiratory Care; ~~or~~ (2) a sleep technologist program accredited by the American Academy of Sleep Medicine*; and (3) a sleep technologist program approved by the Board of Registered Polysomnographic Technologists*.

(b) "Board" means the Medical Board of California.

(c) "Code" means the Business and Professions Code.

(d) "National certifying examination" means the technologist credentialing examination given by the Board of Registered Polysomnographic Technologists.

(e) "Polysomnography registrant" includes any person registered as a trainee, technician or technologist under this chapter.

(f) "Supervising physician and surgeon" means physician and surgeon who holds a valid license in California and who (1) possesses a current certification or subspecialty certification or is eligible for such a certification in sleep medicine by a member board of the American Board of Medical Specialties ("ABMS") or the American Board of Sleep Medicine ("ABSM"); or (2) holds active staff membership at a sleep center or laboratory accredited by the American Academy of Sleep Medicine or by the Joint Commission.

(g) "Valid, current credentials as a polysomnographic technologist issued by a national accrediting agency approved by the board" means current valid registration as a polysomnographic technologist issued by the Board of Registered Polysomnographic Technologists.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575, Business and Professions Code.

1378.3. Delegation of Functions.

Except for those powers reserved exclusively to the "agency itself" or for the adoption of stipulated settlements under the Administrative Procedure Act (Section 11500 et seq. of the Government Code), the board delegates and confers upon the executive director of the board, or his/her designee, all functions necessary to the dispatch of business of the board in connection with investigative and administrative proceedings under the jurisdiction of the board.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

Article 2. Applications

1378.5. Application for Registration as a Polysomnographic Technologist, Technician or Trainee.

An application for registration as a polysomnographic technologist, technician, or trainee shall be filed with the board at its principal office on the prescribed application form [PST – 1A (8/10)], which is incorporated by reference. The application shall be accompanied by such evidence, statements or documents as therein required and filed with the fee required by section 1378.35.

NOTE: Authority cited: Sections 2018 and 3577, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.7. Abandonment of Applications.

An applicant shall be deemed to have abandoned an application if he or she does not complete the requirements for registration within one year from the date on which the application was filed. An application submitted subsequent to an abandoned application shall be treated as a new application.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

Article 3. Qualifications for Registration

1378.9. Examination

(a) The certification examination offered by the Board of Registered Polysomnographic Technologists is approved by the board for purposes of qualifying for registration pursuant to Chapter 7.8 of Division 2 of the code:

(b) An applicant who applies for registration as a polysomnographic technologist on or before October 22, 2012, may, in lieu of successful completion of the examination

approved by the board, submit any of the following as proof that the applicant has been practicing polysomnography safely for at least five years:

(1) One or more declarations under penalty of perjury by a supervising physician attesting to the period of time the physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely.

(2) A letter of good standing from each state in which the applicant is registered or licensed.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.11. Registration Requirements.

(a) Polysomnographic Trainee. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic trainee shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have either (A) a high school diploma or GED and six months of supervised direct polysomnographic patient care experience; or (B) be currently enrolled in an approved polysomnographic education program; and

(3) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

(b) Polysomnographic Technician. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic technician shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have successfully completed an approved polysomnographic education program; and

(3) Possess a minimum of six months experience as a registered polysomnographic trainee; and

(4) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

(c) Polysomnographic Technologist. An applicant for registration as a polysomnographic technologist shall meet the requirements set forth in Sections 3575 and 3576 of the code and shall possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

Article 4. Polysomnography Practice

1378.13. Employment and Supervision of Registrants.

(a) A physician and surgeon who does not meet one of the requirements set forth in section 1378.1~~(e)~~ *(f)* shall not supervise polysomnography registrants . No physician and surgeon shall supervise more than eight polysomnographic technologists at any one time. A physician and surgeon shall comply with the supervision requirement of Section 3575(a) of the code.

(b) A supervising physician and surgeon, supervising polysomnographic technologist or other licensed health care professional shall not supervise more than a total of eight polysomnographic technicians and/or trainees at any one time. If a supervising

physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist or other licensed health care professional shall be physically present on the premises and available to the polysomnographic technicians and/or trainees under his/her supervision. For purposes of this ~~section~~ article, "other licensed health care professional" means a registered nurse, physician assistant ~~and~~ or respiratory care practitioner who possesses a current California license.

(c) A supervising polysomnographic technologist and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision by the technologist of polysomnographic technicians and trainees. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the technicians and trainees. Protocols shall be signed and dated by the supervising physician and surgeon and the polysomnographic technologist.

(d) The delegation of procedures to a registrant or other licensed health care professional shall not relieve the supervising physician of primary continued responsibility for the welfare of the patient.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.15. Scope of Services—Polysomnographic Trainee.

Under the direct supervision of a supervising physician and surgeon, polysomnographic technologist or other licensed health care professional, a polysomnographic trainee may provide basic supportive services as part of the trainee's educational program, including but not limited to gathering and verifying patient information, testing preparation and

monitoring, documenting routine observations, data acquisition and scoring, and assisting with appropriate interventions for patient safety.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.17. Scope of Services—Polysomnographic Technician.

A polysomnographic technician may perform the services described in section 1378.15 under general supervision and may implement appropriate interventions necessary for patient safety.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.19 . Notice to Consumers.

(a) A polysomnography registrant shall provide notice to each patient of the fact that the person is registered and regulated by the board. The notice shall include the following statement and information:

NOTICE TO CONSUMERS

Medical doctors and polysomnographic technologists,

technicians, and trainees are licensed and regulated

by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

(b) The notice required by this section shall be provided by one of the following methods:

(1) Prominently posting the notice in an area visible to patients on the premises where the registrant provides the services for which registration is required, in which case the notice shall be in at least 48-point type in Arial font.

(2) Including the notice in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the polysomnographic registrant is registered and regulated by the board.

(3) Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

NOTE: Authority cited: Section 2018, Business and Professions Code; Reference: Sections 138 and 680, Business and Professions Code.

Article 5. Enforcement

1378.25. Substantial Relationship Criteria.

For the purpose of denial, suspension, or revocation of the registration of a polysomnography registrant pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered substantially related to the qualifications, functions, and duties of a polysomnographic registrant if to a substantial degree it evidences present or potential unfitness of a polysomnographic registrant to perform the functions authorized by his or her registration in a manner consistent with the public health, safety, or welfare. Such crimes or acts shall include, but not be limited to, those involving the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting or abetting the violation of or conspiring to violate any provision or term of Chapter 7.8 of Division 2 of

the code.

(b) Conviction of a crime involving fiscal dishonesty, or theft.

(c) Battery or assault

(d) Sexual misconduct or abuse.

(e) Conviction of a crime involving lewd conduct, prostitution or solicitation thereof, or pandering and/or indecent exposure, as defined by the Penal Code.

Note: Authority cited: Sections 481 and 2558, Business and Professions Code. Reference: Sections 481, 2555.1 and 2556, Business and Professions Code.

1378.27. Criteria for Rehabilitation for Denial and Reinstatement

When considering the denial of a registration under Section 480 of the code, or a petition for reinstatement under Section 11522 of the code, the board in evaluating the rehabilitation of the applicant and his or her present eligibility for registration, shall consider the following criteria:

(a) The nature and severity of the act(s) or crime(s) under consideration.

(b) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration which also could be considered as grounds for denial under Section 480 of the Business and Professions Code.

(c) The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (a) or (b).

(d) The extent to which the applicant or petitioner has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against him or her.

(e) Evidence, if any, of rehabilitation submitted by the applicant or petitioner.

Curt Worden - Polysomnographic Program Regs

From: Gail Blanchard-Saiger <gblanchard@calhospital.org>
To: "'curt.worden@mbc.ca.gov'" <curt.worden@mbc.ca.gov>
Date: 1/3/2011 10:24 AM
Subject: Polysomnographic Program Regs
CC: Dorel Harms <dharms@calhospital.org>, "'dlgonzalez@cs.com'" <dlgonzalez@...
Attachments: Draft language for Tech 2.doc

Mr. Worden,

Happy New Year. Attached please find the language we discussed-creating a polysomnographic technician II classification. After our meeting, one of our group members pointed out there is a third category of individuals who should qualify for grandfathering—those individuals who have the RPSGT certification but did not graduate from an approved program. The reason these individuals did not graduate from an approved program is that there were no such programs when the RPSGT certification was created. Of note, many of these individuals helped to develop the current educational program and may be currently administering that program.

Many of these Technologists are currently administering clinical Sleep Medicine programs in California acute care hospitals and/or supervising the staff of those programs. If the new California Regulations do not recognize these Sleep Technologists and allow them to continue their supervisory duties the care of California sleep disorder patients may be compromised.

After meeting with the California Sleep Society representatives, we now understand the intent of intent of SB 132- B&P Code 3575(b) was to grandfather these individuals as well as individuals who have been working for at least 5 years. If you agree with that interpretation, it should resolve these issues. If not, we believe there are two options.

One option would be to expand the Technician II category (reflected on the attached) to include both individuals who have been working for at least 5 years as well as those who have RPSGT certification (who would necessarily have been working at least 5 years) Under this option, the Technicians II would be authorized to provide the full scope of services as a technologist as well as supervise staff.

Another alternative would be to leave the Technician II category as reflected on the attached (authorized to perform full scope of services but no supervisory responsibility) and create a Technician III category. The technician III category would be reserved for those individuals who have passed the RPSGT certification but who have not graduated from an approved program (because they did not exist). These individuals would be authorized to perform the same scope of services as a Technologist as well as supervise other staff.

Thank you for your consideration of these issues. Please feel free to contact me with any questions or concerns.

Gail

Gail M. Blanchard-Saiger
VP Labor & Employment
California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
Tel: (916)552-7620
Fax: (916)554-2220
gblanchard@calhospital.org

Technician II proposal (full scope of services but no supervisory authority)

Modify 1378.11
(b) Polysomnographic Technician I

Add new
(c) Polysomnographic Technician II. In addition to the requirements set forth in Section 3575(c) of the Code, an applicant for registration as a polysomnographic technician II shall meet the following requirements:
(1) not be subject to denial under Section 3576 of the code; and
(2) submit the following as proof that the applicant has been practicing polysomnography safely for at least five years, as of January 1, 2012:
    (a) one or more declarations under penalty of perjury by a supervising physician attesting to the period of time they physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely; and
    (b) a letter of good standing from each state in which the applicant is registered or licensed, if the individual is registered or licensed in another state; and
(3) possess at the time of application a current certificate in Basis Life Support issued by the American Heart Association.

Modify 1378.13
(a) A physician and surgeon who does not meet one of the requirements set forth in section 1378.1(e) shall not supervise polysomnographic registrants. No physician and surgeon shall supervise more than eight polysomnographic technologists and/or polysomnographic technician IIs at any one time. A physician and surgeon shall comply with the supervision requirement of Section 3575(a) of the code.
(b) A supervising physician and surgeon, supervising polysomnographic technologist, or other licensed health care professional shall not supervise more than a total of eight polysomnographic technician Is and/or trainees at any one time. If a supervising physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist, or other licensed health care professional shall be physically present on the premises and available to the polysomnographic technicians I or trainees under his/her supervision.

Modify 1378.17.
Scope of Services – Polysomnographic Technician I
A polysomnographic technician I may perform the services described in section 1378.15.....

Add new 1378.19
Scope of Services Polysomnographic Technician II
A polysomnographic technician II may perform the services described in Section 3575(a)(2).

Technician III Proposal:

Add new 1378.11
(c) Polysomnographic Technician III. In addition to the requirements set forth in Section 3575(c) of the Code, an applicant for registration as a polysomnographic technician III shall meet the following requirements:
(1) not be subject to denial under Section 3576 of the code; and
(2) submit the following as proof that the applicant has been practicing polysomnography safely for at least five years, as of January 1, 2012:
    (a) one or more declarations under penalty of perjury by a supervising physician attesting to the period of time they physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely; and
    (b) a letter of good standing from each state in which the applicant is registered or licensed, if the individual is registered or licensed in another state; and
(3) have passed the national certifying examination; and
(4) possess at the time of application a current certificate in Basis Life Support issued by the American Heart Association.

Modify 1378.13
(a) A physician and surgeon who does not meet one of the requirements set forth in section 1378.1(e) shall not supervise polysomnographic registrants. No physician and surgeon shall supervise more than eight polysomnographic technologists and/or polysomnographic technicians II or III at any one time. A physician and surgeon shall comply with the supervision requirement of Section 3575(a) of the code.
(b) A supervising physician and surgeon, supervising polysomnographic technologist, supervising polysomnographic technician III or other licensed health care professional shall not supervise more than a total of eight polysomnographic technicians I and/or trainees at any one time. If a supervising physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist, supervising polysomnographic technician III or other licensed health care professional shall be physically present on the premises and available to the polysomnographic technician I or trainees under his/her supervision.
(c) A supervising polysomnographic technologist or supervising polysomnographic technician III and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervising by the technologist or polysomnographic technician III of polysomnographic technician I and trainees. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the technician I and trainees. Protocols shall be signed and dated by the supervising physician and surgeon and the polysomnographic technologist or polysomnographic technician III.

Curt Worden - FW: Medical Board of California - - Polysomnography Registration Program - - REGULATIONS - - Modified TEXT

From: Stephanie Nunez <Stephanie.Nunez@dca.ca.gov>
To: Curt Worden <Curt.Worden@dca.ca.gov>, "fboyd@mbc.ca.gov" <fboyd@mbc.ca.g...
Date: 11/22/2010 3:55 PM
Subject: FW: Medical Board of California - - Polysomnography Registration Program - - REGULATIONS - - Modified TEXT
Attachments: Polysom Availability - Modified Text - Combined 11-2010.pdf

This is NOT an official comment, but I thought I should bring to your attention that subdivision (a) of section 1378.13 references section 1378.1**(e)** and I believe it was meant to reference section 1378.1**(f).**

"1378.13. Employment and Supervision of Registrants.
(a) A physician and surgeon who does not meet one of the requirements set forth in section 1378.1 (e) shall not supervise polysomnography registrants..."

Section 1378.1(e) references the definition for a "polysomnographic registrant" whereas 1378.1(f) references the definition for "Supervising physician and surgeon."

Stephanie

916.323.9983

-----Original Message-----
From: rcbinfo
Sent: Monday, November 22, 2010 2:23 PM
To: Stephanie Nunez; Christine Molina
Subject: FW: Medical Board of California - - Polysomnography Registration Program - - REGULATIONS - - Modified TEXT

From: Rhonda Baldo [Rhonda.Baldo@mbc.ca.gov]
Sent: Monday, November 22, 2010 2:05 PM
To: Rhonda Baldo
Cc: Curt Worden; Fayne Boyd
Subject: Medical Board of California - - Polysomnography Registration Program - - REGULATIONS - - Modified TEXT

To All Interested Parties:

A copy of the Polysomnography Program proposed modified text is attached.

If you wish to comment on the proposed modifications, you may do so by submitting written comments on or before December 3, 2010 to the following:

Fayne Boyd, Licensing Manager
Medical Board of California
Sacramento, CA 95815
Telephone: (916) 274-5983
Fax: (916) 263-2487
E-Mail Address: regulations@mbc.ca.gov

You may also obtain a copy of the proposed modified text on the Medical Board Website:
http://www.mbc.ca.gov/laws/regs_polysomnography_avail.pdf

If you have any questions or problems downloading the attached information, please contact me at (916) 263-2605.

Thank you,

Rhonda Baldo
Medical Board of California
Polysomnographic Registration Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2605

Note: My E-Mail address has changed to Rhonda.Baldo@mbc.ca.gov Please update your address book to reflect this change. Thanks.

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California Sleep Society

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Hoag Hospital Sleep Disorders Center

Kimberly Trotter, M.A., RPSGT
UCSF Sleep Disorders Center

December 3, 2010

Ms. Fayne Boyd, Licensing Manager
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Proposed Regulations for Certified Polysomnographic Technologist

Dear Ms. Boyd:

The California Sleep Society (CSS) is pleased to submit comments to the Medical Board of California (Board) regarding the proposed regulations outlining the educational and training requirements a sleep technologist must complete to obtain the designation of "certified polysomnographic technologist" by the Board. The CSS promotes and provides education in polysomnography and sleep medicine as well as increased public awareness of the field. The CSS encourages and assists in the advancement of scientific and technical standards of sleep technology, and promotes the highest standards of training and qualifications for sleep medicine physicians and sleep technologists.

We have attached a copy of our letter dated November 3, 2010 and hereby incorporate by reference the attached previously submitted comments in that letter.

(1) Amend section 1378.1 (2)

We have on several occasions requested that the Board modify the language in 1378.1 (2) and must again underscore importance of this modification and the serious consequences associated with maintaining the current language. CSS respectfully requests that the following amendments are incorporated into the regulatory language:

> **Current language:**
> *(a)—Approved polysomnographic education program means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or by the Commission on Accreditation for Respiratory Care; or (2) a sleep technologist program accredited by the American Academy of Sleep Medicine.*
>
> We remain concerned with the use of the American Academy of Sleep Medicine (AASM) as the body that accredits polysomnographic training programs when it is the Board of Registered Polysomnographic Technologists (BRPT) that governs the national credentialing exam. <u>If the proposed language is not amended there will be significant disparity between California law and the regulations that qualify sleep technicians for the national certifying examination</u>.
>
> The BRPT has approved sixteen training programs that satisfy the training requirement for the board exam. Two of these training programs are offered on line and are an important option to have ready access to qualified training programs. A-STEP is only one training option and there is no reason to question the judgment of the BRPT on setting the standards for its own exam. A-STEP is a trademark of the AASM and their

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'accreditation" of training programs is subject to BRPT's approval of the A-STEP curriculum. Although it is highly unlikely, it is important to recognize that BRPT could one day not recognize A-STEP as a qualified training program for the RPSGT exam. If this were to happen there would be no educational program that would qualify trainees and technicians for both California certification and the BRPT Exam.

Proposed Language:
(a)—Approved polysomnographic education program// means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or by the Commission on Accreditation for Respiratory Care; or (2) a sleep technologist program approved by the Board of Registered Polysomnographic Technologists.

We have enclosed a statement from BRPT Executive Director John Ganoe that explains the standards for A-Step equivalent training programs and the rationale behind the creation of this classification for training programs that satisfy the requirements for the RPSGT exam.

(2) The important issues of polysomnographic (PSG) technician scope of practice and grandfathering of PSG technicians in California are commendably described and discussed in the California Hospital Association (CHA) letter of December 3 to Fayne Boyd of the Medical Board of California (MBC). We are in agreement and support of the CHA letter including their concern over the possibility that the MBC may have modeled its technologist and technician scope of services after the Board of Registered Polysomnographic Technologists (BRPT) classifications. And we agree; "...the BRPT does not define technician and technologist scope of services." However, the American Academy of Sleep Technologists (AAST) does provide job descriptions with scope of services.

The AAST is the original professional organization of PSG technologists and technicians established in 1978. The BRPT originated as a committee of the AAST (at that time known as the APT) and in 2000 became the independent authority on PSG technologist and technician credentialing and professional conduct that it is today. In addition to a common history the AAST and BRPT share the same commitment to upholding the highest standards of conduct and professional achievement in Polysomnography Technology.

The AAST website (http://www.aastweb.org/) provides detailed scope of service descriptions for; Sleep Trainee, Sleep Technician, and Sleep Technologist (http://www.aastweb.org/JobDescriptions.aspx).

The pertinent aspect of the AAST Sleep Technician job description is:

A Sleep Technician performs comprehensive polysomnographic testing and analysis, and associated interventions under the general oversight of a Sleep Technologist (RPSGT) and/or the clinical director (MD, PhD, DO) or designee. A Sleep Technician can provide supervision of a Sleep Trainee.

The California Sleep Society agrees with the CHA that the Polysomnographic Technician scope of services in the current regulations proposal is unduly restrictive,

and we propose that the regulations be amended to reflect the Technician scope of services described by the AAST. In addition, it is imperative that grandfather provisions for Technicians be included in the regulations to minimize disruption of vital medical services to patients in California.

Again, thank you for allowing the CSS to submit comments on these important regulations. We urge the Medical Board to reconsider this language and trust that you will recognize the importance of this issue for polysomnography clinicians and sleep centers throughout the State of California.

If you have any questions or would like to discuss these issues further, please feel free to contact the CSS President, Al Reichert, MA, RPSGT at 650-367-5188 or CSS Secretary-Treasurer, Michael Salemi, RPSGT at 510-703-3906.

Sincerely,

California Sleep Society Board of Directors

President:	Al Reichert, M.A., RPSGT
Past President:	Clete A. Kushida, MD, PhD, RPSGT
Secretary-Treasurer:	Michael Salemi, RPSGT
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	Glenn Roldan, RPSGT
	Paul Selecky, M.D.
	Kimberly Trotter, M.A., RPSGT

December 3, 2011
Michael Salemi, RPSGT
Secretary / Treasurer
California Sleep Society

Dear Michael:

We're pleased to hear that the regulatory phase of the legislative process in which the California Sleep Society has been actively engaged over the course of the past two years is proceeding.

In response to your request for additional information regarding the BPRT-designated alternative educational programs – programs which may be used to establish Pathway #1 or Pathway #4 eligibility to sit for the Registered Polysomnographic Technologist (RPSGT) exam in lieu of the A-STEP online module curriculum -- I would like to offer some background on the BRPT decision to designate alternative educational pathways, as well as some information on how those programs are reviewed prior to designation.

The development and delivery of the AASM A-STEP curriculum – both the didactic / clinical component and the online modules – was a significant development for our field and moved the discipline closer to the establishment of a basic, common curriculum for individuals preparing for a career in sleep technology. Completion of the A-STEP curriculum is solidly integrated into the pathways for establishing eligibility for the RPSGT exam. The decision to designate alternative educational programs for establishing Pathway #1 or Pathway #4 eligibility was based both on a concern that educational offerings be as widely available as possible, and a belief that the field would be well-served by the availability of more than one educational option for establishing exam eligibility.

The application and review process leading to designation as an alternative educational pathway is rigorous. The application process requires that a program demonstrate that curriculum mirrors the content outline of the A-STEP modules. In effect, each applying program is required to demonstrate how each element of the program's curriculum is aligned against a corresponding A-STEP online module. Documentation is submitted electronically and accompanied by detailed information regarding program faculty and reference texts. Application materials are forwarded to the BRPT Education Advisory Committee (EAC) for review. The EAC includes Subject Matter Experts with extensive professional experience and a broadbased knowledge of both the field of polysomnography and the BRPT exam blueprint. Again, the review process is rigorous and thorough, and carries a requirement for periodic review and recertification. As new A-STEP modules have become available and been incorporated into the RPSGT exam eligibility requirements existing designated alternative programs have been required to demonstrate that their curriculum corresponds to any newly developed A-STEP modules.
Our collaboration with AASM in establishing and maintaining an increasingly strong educational pathway to the BPRT exams is enormously valuable, Michael, and we look forward to continuing that collaboration. We do believe that the availability of alternative, strong educational pathways to establishing RPSGT exam eligibility has served our candidates and our field well.

Please be in touch if I can provide further information.

Best personal regards,

John H. Ganoe, CAE
Executive Director
Board of Registered Polysomnographic Technologists
8400 Westpark Drive, Second Floor
McLean, VA 22102
Telephone: 703-610-0263 (Direct)
Email: jganoe@brpt.org

Website: www.brpt.org

California Sleep Society

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Paul Selecky, M.D.
Hoag Hospital Sleep Disorders Center

Kimberly Trotter, M.A., RPSGT
UCSF Sleep Disorders Center

November 3, 2010

Ms. Fayne Boyd, Licensing Manager
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Proposed Regulations for Certified Polysomnographic Technologist

Dear Ms. Boyd:

The California Sleep Society (CSS) is pleased to submit comments to the Medical Board of California (Board) regarding the proposed regulations outlining the educational and training requirements a sleep technologist must complete to obtain the designation of "certified polysomnographic technologist" by the Board. The CSS promotes and provides education in polysomnography and sleep medicine as well as increased public awareness of the field. The CSS encourages and assists in the advancement of scientific and technical standards of sleep technology, and promotes the highest standards of training and qualifications for sleep medicine physicians and sleep technologists.

After reviewing the proposed language, the CSS respectfully requests that the following amendments are incorporated into the regulatory language:

(1) Amend section 1378.1 to ensure that the regulations do not unduly restrict the education opportunities for registrants.

Current language:
(a)—Approved polysomnographic education program means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or by the Commission on Accreditation for Respiratory Care; or (2) a sleep technologist program accredited by the American Academy of Sleep Medicine.

We remain concerned with the use of the American Academy of Sleep Medicine (AASM) as the body that accredits polysomnographic training programs when it is the Board of Registered Polysomnographic Technologists (BRPT) that governs the national credentialing exam. If the proposed language is not amended there will be significant disparity between California law and the regulations that qualify sleep technicians for the national certifying examination.

The BRPT has approved sixteen training programs that satisfy the training requirement for the board exam. Two of these training programs are offered on line and are an important option to have ready access to qualified training programs. A-STEP is only one training option and there is no reason to question the judgment of the BRPT on setting the standards for its own exam. A-STEP is a trademark of the AASM and their 'accreditation" of training programs is subject to BRPT's approval of the A-STEP curriculum.

Proposed Language:
(a)—Approved polysomnographic education program// means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or by the Commission on Accreditation for Respiratory Care; or (2) a sleep technologist program ***approved by the Board of Registered Polysomnographic Technologists.***

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From the Board of Registered Polysomnographic Technologists:

RPSGT Exam Requirements

- *Pathway #1 - 18 months of experience*
- *Pathway #2 - 6 months of experience*
- *Pathway #3 - CAAHEP/CoARC graduate*
- *Pathway #4 - 9 months of experience*

Pathway #1 - for candidates with 18-months of PSG experience (on-the-job training)

1. *Candidates must complete a minimum of 18 months of paid clinical experience where at least 21 hours per week per calendar year of on-the-job duties performed are Polysomnography direct patient recording and/or scoring. Duties must be within a 3-year period prior to the exam.*
2. *Candidates must complete the AASM A-STEP Self-Study (online) Modules or a BRPT-designated alternate educational program. Proof of completing the modules must be submitted with the application. Acceptable forms of proof are:*
    1. *Copies of the 14 certificates of completion from each module, or*
    2. *An official transcript from the AASM.*
3. *Candidates must include proof of completing secondary education. Acceptable forms of proof are copies of transcripts or diplomas from high school, GED or equivalent, or college or university education.*

BRPT-Designated Alternate Educational Programs:

Please note: A-STEP programs are not required for RPSGT recertification.

The programs listed below have been reviewed by the BRPT Education Advisory Committee and are BRPT-designated alternate educational programs. These programs have not been reviewed or endorsed in any way by the American Academy of Sleep Medicine (AASM) and are not recognized as meeting any criteria for AASM accreditation.

American Sleep and Breathing Academy - BRPT Exam Modules *Online*

Beaumont Hospitals Sleep Evaluation Services - Berkely Center *Berkely, MI*

Bluegrass Community & Technical College (Polysomnography Program) *Lexington, KY*

Community College of Baltimore County *Baltimore, MD*

Erwin Technical Center *Tampa, Florida*

Harrisburg Area Community College PSG Program *Harrisburg, PA*

Linn Benton Community College *Albany, OR*

London Health Sciences Centre - Sleep Lab *London, Ontario, Canada*

Madison Area Technical College PSG Program *Madison, WI*

Piedmont Virginia Community College with Keswick Sleep Center *Charlottesville, Virginia*

Sleep Evaluation Services - Berkley Center *William Beaumont Hospitals - Berkely, MI*

Sleep Multimedia *Online*

Southeast Technical Institute, ENDT Program *Sioux Falls, SD*

Southern Maine Community College *South Portland, Maine*

Toronto Sleep Institute *Toronto, ON, Canada*

University of Western Australia *Nedlands WA, Australia*

(2) Eliminate the language requiring a sleep technologist or other licensed health care professional to directly supervise a sleep technician.

Current Language:
Section 1378.13 (b) "Employment and Supervision of Registrants"
"If a supervising physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist or other licensed health care professional shall be physically present on the premises and available to the polysomnographic technicians and/or trainees under his/her supervision."

Proposed Language:
"If a supervising physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist or other licensed health care professional shall be physically present on the premises and available to the polysomnographic ~~technicians and/or~~ trainees under his/her supervision."

The AASM job description for a polsomnographic technician states:

> *A Polysomnographic Technician performs comprehensive polysomnographic testing and analysis, and associated interventions* ***under the general supervision of a Polysomnographic Technologist (RPSGT) and/or the clinical director (MD, PhD, DO) or designee.*** *A Polysomnographic Technician can provide supervision of a Polysomnographic Trainee.*

A sleep technician is an individual who has: successfully completed an approved polysomnographic education program; possesses a minimum of six months experience as a registered polysomnographic trainee; and possesses a current certificate in Basic Life Support issued by the American Heart Association. The CSS requests that the language is amended to allow the sleep technician to work under general supervision of a RPSGT, clinical director or other appropriately qualified licensed health care professional.

(3) Eliminate or modify use of the phrase 'registered' when referring to technicians and trainees covered under the certification requirements of SB 132.

Sleep technologists that have passed the national credentialing exam receive the title "Registered Polysomnographic Technologist" and may use credential RPSGT. In the profession of polysomnography the word 'registered' confers specific status. Similarly the word 'technologist' is reserved for those who have passed the exam.

SB 132 and the related regulations use the term 'technologist' appropriately. However the terms 'registered', 'registration' and 'registrant' are used to describe technicians and trainees throughout the regulation. Here are two examples:

> 1378.1 (e) Polysomnography registrant includes any person registered as a trainee, technician or technologist under this chapter…
>
> and
>
> 1378.11. (a) Polysomnographic Trainee. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic trainee shall meet the following …

We believe that use of the term 'registered' should be modified or its use clarified to ensure that technicians and trainees do not inappropriately use the term in ways that would confuse the public or other members of the profession. Possible solution would include the following:

1. Substitute the terms 'certified' and 'certification' for 'registered' and 'registrant' when referring to trainees and technicians
   or;
2. Place a disclaimer in the regulations stating that use of the terms "registered' and 'registration' when used in relation to polysomnographic trainees and technicians does not confer the right to use these terms in job descriptions or credentials. Further it should be clarified that the use of these terms when used to describe individuals that have satisfied certain provisions within SB 132 and its associated regulations does not indicate that they have met the requirements of any national certifying examination.

(4) Clarify that the national certifying exam means the RPSGT examination.

During the enactment of SB 132, the BRPT was administering the RPSGT examination. However, in 2009 the BRPT introduced the Certified Polysomnographic Technician (CPSGT) exam and credential. Although we believe that this is a good step toward further refinement of practice parameters in polysomnography, it is too early to adopt this credential as a requirement to meet the definition of 'technician' under SB 132.

We recommend that the Medical Board not consider the adoption of the CPSGT credential and examination until its usefulness is more fully explored within the sleep medicine community both nationally and within California. Therefore we respectfully request that the regulations specify that the national certifying examination is the **RPSGT** examination until more information is available regarding the CPSGT credential and examination.

Proposed Language:

*1378.1 (d) National certifying examination means the **RPSGT** examination given by the Board of Registered Polysomnographic Technologists.*

(5) Clarify the scope of services permitted to be provided by technologists, technicians, and trainees.

The draft regulation proposes to adopt sections 1378.15 and 137817 relating to "scope of services." However, these provisions appear to relate more to the level of supervision that may be required. Also, they create confusion as to what the exact scope of services are that may be provided by technologists, technicians, and trainees. We respectfully request that the regulations be amended to clarify the scope of services that may be offered by each of these three categories in order to eliminate any confusion that may be created by the draft regulation. Further, we respectfully request that the regulations be clarified to reflect the levels of supervision that are generally accepted within the practice of sleep medicine.

(6) Clarify the "grandfathering provisions contained in Senate Bill 132.

Business and Professions Code Section 3575, subdivision (b) contains provisions relating to the "grandfathering" of certain practitioners who have been practicing polysomnography for at least five years in a manner acceptable to the Board. We respectfully request that the proposed regulations be amended to clarify the manner in which existing practitioners may be grandfathered into the program.

Again, thank you for allowing the CSS to submit comments on these important regulations. If you have any questions or would like to discuss these issues further, please feel free to contact the CSS President, Al Reichert, MA, RPSGT at 650-367-5188.

Sincerely,

California Sleep Society Board of Directors

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Past President:	Clete A. Kushida, MD, PhD, RPSGT
Secretary-Treasurer:	Michael Salemi, RPSGT
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	Glenn Roldan, RPSGT
	Paul Selecky, M.D.
	Kimberly Trotter, M.A., RPSGT

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 11, 2011
ATTENTION: Board Members
SUBJECT: Disciplinary Guidelines – Modified Text
STAFF CONTACT: Susan Cady, Enforcement Manager

REQUESTED ACTION: Adopt modified text and request the Executive Director to complete the rulemaking file to be submitted to the Office of Administrative Law for review and approval.

STAFF RECOMMENDATION:
Staff recommends that the Board consider the proposed revisions, discussed at the Board's January 6, 2011, Interested Parties Meeting, which relates to the Manual of Disciplinary Guidelines and Model Disciplinary Orders.

EXECUTIVE SUMMARY:

At the November 5, 2010, Board meeting, a hearing was held to discuss a rulemaking that proposed amendments to the Manual of Disciplinary Guidelines and Model Disciplinary Orders. The proposed amendments are being made to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment.

The Board received written comments before the meeting and public comments were given regarding the proposed regulations.

At the end of the hearing, it was suggested that any action on the rulemaking be tabled until the January 28, 2011, meeting so that staff could further review the comments provided and the Uniform Standards being developed for all healing arts boards by the Substance Abuse Coordination Committee (convened by the Department of Consumer Affairs in 2009 as directed by SB 1441). Further, it was suggested that a meeting of interested parties be held.

A meeting of interested parties was held on January 6, 2011, in Sacramento. Several written comments were received and discussed at that meeting.

Attached, please see:
- Letter from California Medical Association, dated October 18, 2010
- Letter from California Society of Addiction Medicine, dated January 6, 2011
- E-mail from Julie D'Angelo Fellmuth, CPIL, dated January 6, 2011

Based on these written comments, which also were discussed at the January 6, 2011 Interested Parties meeting, the following modifications were made to the proposed text:

Conditions 9 and 10 -- Controlled Substances/Alcohol-- Abstain from Use

In response to the comments and testimony received during the 45-day comment period, the regulation hearing and interested parties meeting, the board modified the text to eliminate the 3-day advance notice before the cease practice order is issued following a positive test result. This modification makes the board's guidelines consistent with the DCA uniform standard and the provisions of Business and Professions Code Section 315.2 requiring an immediate "cease practice"

order based on a positive test. In addition, Business and Professions Code Section 315.2 became effective January 1, 2011, which provides specific authority to impose the immediate cease practice order and addresses CMA's concerns regarding the board's authority to impose this requirement.

No modification was made to address the testimony from CSAM to combine the conditions requiring that the licensee "abstain from use" for controlled substance and/or alcohol. Under the current "recommended range of penalties", violations related to excessive use of either alcohol or controlled substances suggest including both Condition 9 and 10, which is consistent with the testimony provided. Therefore, no modification of text was necessary.

The board did modify the text to add that the biological fluid test must be "confirmed" before pursuing a "cease practice" order in response to CSAM's testimony regarding this issue. The text was also modified in response to the issue identified by a representative from the Office of Attorney General to address the failure by a licensee to promptly report a new prescription to the Board, which triggered a positive test result.

Condition 11 – Biological Fluid Testing

The board modified the text to eliminate the 3-day advance notice before the cease practice order is issued for failing to cooperate with biological fluid testing. This modification makes the board's guidelines consistent with the DCA uniform standard. In response to comments received, the proposed text "Within 30 calendar days of the decision" has been removed and the condition will require that an acceptable lab contract must be in place "prior to practicing medicine".

Staff did not propose a modification to the proposed language regarding the testing frequency. The testing frequency standard proposed by the DCA SB 1441 Substance Abuse Coordination Committee is not finalized. The subcommittee meeting scheduled on September 27, 2010 to further discuss this standard was cancelled and has not been rescheduled. The condition as proposed requires the licensee to submit to random, unannounced testing. The Board believes that by not identifying a specific testing frequency in this condition, the frequency can be determined by board policy and modified when a standard is finalized.

Other technical, non-substantive changes were made to the proposed language.

The modified text is attached. It was mailed out to all interested parties on January 7, 2011. The close of the public comment period will be January 24, 2011. This meets the 15-day notice requirement allowing the Board to adopt the modified text at the Board meeting on January 28, 2011.

If any written comments are received during the public comment period, copies will be brought to the Board meeting. As always, public comment also may be received during the meeting. In the mean time, if you have any questions, please contact me at (916) 263-2644 or at susan.cady@mbc.ca.gov
.

California Medical Association
Physicians dedicated to the health of Californians

October 18, 2010

Susan Cady
Enforcement Manager
Medical Board of California
2005 Evergreen St, Suite 1200
Sacramento, CA 95815

Subject: Comments on
"Manual of Model Disciplinary Orders and Disciplinary Guidelines (11th Edition/2010)"

Dear Ms. Cady:

The California Medical Association (CMA) respectfully submits the following comments for consideration related to the proposed amendments to the "Manual of Model Disciplinary Orders and Disciplinary Guidelines (11th Edition/2010)". The comments are in response to the solicitation for comments in a notice of proposed rulemaking posted on September 13, 2010 for Division 13 of Title 16 of the California Code of Regulations.

The California Medical Association is an advocacy organization that represents 35,000 California physicians. Dedicated to the health of Californians, CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

I. Background

We understand that the purpose of the proposed amendments to the Manual of Model Disciplinary Orders and Disciplinary Guidelines is to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment. CMA would like to offer additional revisions for your consideration.

II. CMA's Comments

CMA has several concerns regarding the proposed disciplinary guidelines as follows:

A. Section 9. Controlled Substances - Abstain From Use
Section 10. Alcohol - Abstain From Use
Section 11. Biological Fluid Testing

These sections essentially provide for an automatic suspension of a license in the event the respondent has a positive biological fluid test for certain substances or fails to cooperate in a random biological fluid testing program. While we acknowledge that such events are a violation of probation, as was the case with the diversion program, we have serious reservations that the Medical Board may lawfully order the cessation of medical practice under these circumstances.

First, the Legislature, in its detailed statutory scheme governing Medical Board disciplinary powers, has not authorized an automatic suspension in these cases, as it has where a licensee has been convicted of a felony. See Business & Professions Code §2236.1. Accordingly, the Medical Board lacks the statutory authority to issue such suspensions. See *Medical Board of California v. Superior Court* (2003) 111 Cal.App.4th 163 (Business & Professions Code provision governing a physician's participation in the diversion program did not permit disciplinary action against a physician solely on his failure to complete the program).

Further, there are serious questions as to the constitutionality of the proposed guidelines purporting to authorize automatic suspension of the license. For example, in *Ralph Williams Ford v. New Car Dealers policy and Appeals Board* (1973) 30 Cal.App.3d 494, at issue was whether the Director of Motor Vehicles could lawfully suspend a license in the event the licensee violated a condition of probation. Recognizing the constitutional infirmity of the activity, the court stated:

> The Fourteenth Amendment protects the pursuit of one's profession from abridgment by arbitrary state action, and a state cannot exclude a person from any occupation in a manner or for reasons that contravene due process of law. (*Endler v. Schutzbank*, 68 Cal.2d 162, 169-170, 65 Cal.Rptr. 297, 436 P.2d 297.) Here, the revocation of probation, and therefore the revocation of Williams' dealer's license, is left to the discretion of the Director of Motor Vehicles. But "an individual must be afforded notice and an opportunity for a hearing before he is deprived of any significant property interest, ..." (*Randone v. Appellate Department*, 5 Cal.3d 536, 541, 96 Cal.Rptr. 709, 488 P.2d 13.) Although Williams received notice and a hearing on its past violations, the conditions of probation dispense with notice and hearing on any future violations that may bring about a revocation of its license.
>
> In criminal law "fundamental principles of due process and fair play demand, ... that after a summary revocation of probation and before sentencing a hearing is required at which the defendant is entitled to be represented by counsel, to be advised of the alleged violation and given an opportunity to deny or explain it, and, if necessary, present witnesses on his own behalf." (*People v. Youngs*, 23 Cal.App.3d 180, 188, 99 Cal.Rptr. 101; *People v. Vickers*, 8 Cal.3d 451, 458-461, 105 Cal.Rptr. 305, 503 P.2d 313; see also, *Morrissey v. Brewer*, 408 U.S. 471, 33 L.Ed.2d 484, 92 S.Ct. 2593.) Due process requires a comparable opportunity for notice and hearing on the revocation of an occupational license. (Cf. *Goldberg v. Kelly*, 397 U.S. 254, 25 L.Ed.2d 287, 90 S.Ct. 1011.)

Accordingly, CMA believes licensees under probation should be accorded a pre-deprivation hearing on the issue to determine whether the licensee in fact imposes a danger to patients. If the Medical Board truly believes the licensee poses a threat to patient care, the Board can certainly take steps to prevent harm by seeking a temporary restraining order or interim suspension.

B. Section 16. Professionalism Program (Ethics Course)

This section requires respondents to enroll in a professionalism program that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. To be consistent with the other sections of the guidelines that require respondents to participate in educational courses and specify that the courses must be "equivalent to the ... Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program)," we recommend that this section be amended to state that the professionalism program must be "equivalent to the Professionalism Program offered by the Institute for Medical Quality (IMQ)." Providing more information regarding the content of a recognized professionalism program will clarify the type of professionalism program that meets the Medical Board's standards.

The IMQ Professionalism Program was developed to comply with the requirements established by the Medical Board of California. The program centers on both the legal and ethical dimensions of the practice of medicine in California, and it introduces participants to a range of resources to address present or future problems. Full participation and completion of all assignments are required for completion of the program. The Program is divided into three components.

The pre-course component consists of a background assessment application, a baseline knowledge test and pre course reading. The purpose of this component is to determine the participant's knowledge/awareness of ethical/legal issues related to the practice of medicine in California, as well as information about the participant's knowledge of the legal and ethical issues related to the specific case(s) for which the participant has been referred to the program. Participants prepare an assessment of their expectations of the program, recognition of need for change and commitment to change.

The second component is the two-day ethics course. It includes a series of components that move from demonstration to practice and application. Issues covered include: what are ethical issues and when they arise, clarification of legal issues, resources to analyze situations and a decision making model. The course is very interactive, and it is designed to provide participants with a full understanding of the ethical and legal aspects of their own violations and knowledge about how to access resources to deal with future issues.

The third component is required assessments over a one-year period following the course. It consists of the post-course test on California law and ethics given at the end of the two-day course, and 6 month and 12 month follow-up assessments. At 6 months, participants submit information regarding their practice during the period since the course and complete a skills review exercise. At 12 months they provide a final report on changes in their practice profile and

a self-assessment status report. On completion of the course, a report is sent to the Medical Board.

III. Conclusion

In conclusion, the CMA believes that the recommended changes will improve the disciplinary guidelines making it a more useful document for those involved in the physician disciplinary process.

Sincerely,

Yvonne Choong
Associate Director, Center for Medical and Regulatory Policy
California Medical Association

Cc: Lisa Folberg, CMA Vice-President, Center for Medical and Regulatory Policy

California Society of Addiction Medicine
575 Market Street, Ste 2125 — San Francisco, CA 94105 — 415/764-4855 — Fax 415/764-4915 — www.csam-asam.org

A specialty society of physicians founded in 1973. Since 1989, a State Chapter of the American Society of Addiction Medicine

January 6, 2011

TO: Medical Board of California
Susan Cady, Enforcement Manager
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

CC: Linda Whitney, Executive Director
Medical Board of California

FROM: David Pating, MD and Stephanie Shaner, MD
CSAM Committee on the Well-being of Physicians

RE: Changes proposed to the 11th Edition/2010 of the Manual of Model Disciplinary Orders and Disciplinary Guidelines

California Society of Addiction Medicine is the specialty society of physicians who have clinical experience and expertise in the full spectrum of diagnosis and treatment of alcoholism and other drug dependencies. CSAM has a longstanding interest in the promotion and maintenance of physician health and the relationship of physician health to patient safety. CSAM has always reinforced physician health activities and provided information and education for those in positions of responsibility for maintenance of patient safety. CSAM contributed to the MBC Diversion Program for Physicians during its development in 1978 and 1979 and from the time it began operations on January 1, 1980.

CSAM is interested in these disciplinary guidelines because physicians who would previously have gone into the Diversion Program for Physicians are now going into probation governed by these guidelines.

CSAM offers these statements of concern and suggests these specific changes.

Conditions 9 and 10 *– abstain from use of controlled substances and from alcohol*
CSAM recommends that these two should be applied together so that a respondent with a substance use or alcohol use disorder is required to abstain from both alcohol and drugs not lawfully prescribed.

REASONS: Our recommendation is in line with the clinical evidence that, for a person with a substance use disorder (alcoholism or drug dependence), alcohol and any other mind-altering substance represent the same risk. Because clinical experience has shown that individuals most often use several substances—both alcohol and other drugs—and use one when another is not available, and because alcohol and other drugs have similar effects on the brain and on behavior, abstinence from both alcohol and illegal or not-legally-prescribed drugs is indicated.

Condition 9 *-- "If respondent has a positive biological fluid test for any substance ... , respondent shall receive a notification from the Board ... to cease the practice of medicine within three ... days ... . The respondent will not resume ... until final decision on an accusation and/or a petition to revoke probation."*
CSAM recommends that this guideline specify a requirement for confirmation of a positive screening test result before the respondent is required to cease practice and wait for a decision of the Board.

REASON: False positives from initial screening tests are not unusual, due to the simplified techniques

employed in the testing methods used for screening tests. Confirmation of a positive screening test by another, more sophisticated testing method has always been the industry standard.

Further, CSAM recommends that the guideline specify that MRO review shall be available to the respondent if the respondent contests any confirmed positive test.

Condition 20 *– psychiatric exam*
CSAM recommends these added requirements
-- add an additional qualification of the Board-approved psychiatrist: participation in a 4-hour orientation to relevant clinical principles conducted by the recognized specialty societies in the psychiatric disorders and substance abuse disorders, CPA and CSAM, together with the MBC.
-- add a requirement that an orientation must be repeated every four years
-- add a requirement that the evaluating psychiatrist must complete the evaluation of the respondent and submit the report to the Board within sixty days
-- add a requirement that the MBC or the evaluating psychiatrist must provide the respondent with a copy of the report of the evaluation

REASONS: The evaluations of high functioning professionals in safety sensitive situations require specialized experience and skill beyond most psychiatric evaluations. The psychiatrists performing these examinations and preparing the reports for the Medical Board should be required to participate in orientations to clinical issues to assure a baseline competence, and continuing currency and competence, in this specialized area.

The timeliness of the evaluation, and thus the action of the Medical Board to bring the respondent under [therapeutic] terms and conditions, is important to the clinical outcome for the respondent.

Condition 21 – psychotherapy
"Note: this condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients."
CSAM recommends these added requirements
-- add to the qualifications required of the psychiatrist or psychologist so that they include ...
"experience in the diagnosis and treatment of emotional and mental disorders <u>and/or substance use disorders."</u>
-- add a definition of "psychotherapy treatment" to insure that it includes treatment approaches that have been demonstrated effective for substance use disorders.

REASON: Diagnosis and effective treatment of alcohol/substance use disorders require treatment approaches not commonly used within traditional psychotherapy; such experience should be required.

"The psychotherapist ... shall furnish a written evaluation report to the Board..."
CSAM asks for a clarification of how this evaluation is different from the evaluation required in condition in condition 20.

Condition 22 – medical evaluation and treatment
"Note: this condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations."
CSAM recommends these added requirements
-- add a requirement that physicians who are appointed by the Medical Board to conduct medical evaluations must complete an orientation about the use of validated screening instruments for diagnosis of substance use disorders and mood disorders
-- add a requirement that the medical report furnished to the Medical Board include documentation of which screening instruments were used and the scores or response of the respondent

REASON: Harmful alcohol use and substance use/abuse have significant medical effects that are

factors in a number of medical illnesses or conditions. Harmful alcohol use and drug use should always be ruled out. There are well-validated screening instruments designed to be used by primary care physicians and others for this purpose, and the Medical Board should insure that those tests are employed and the results are included in the reports of these comprehensive examinations and evaluations.

Simple, short, validated screening instruments are used routinely in history and physical examinations. Examples of the instruments are the single question test for alcohol abuse, the MAST, ASSIST, the AUDIT, the CAGE and the CAGE adapted for drug use. They are available from more than one government website, such as http://drugabuse.gov/NIDAMED/screening/ http://www.dhs.state.il.us/page.aspx?item=38488

A new section

CSAM recommends the addition of a guideline designed to be followed when the Medical Board becomes aware that a resident applying for a license may be required to enter probation.
CSAM recommends adding a requirement that the MBC provide a decision within a specified time, requiring that a Board-approved evaluator conduct the evaluation and submit the evaluation report within a specified time.

##

>>> Linda Whitney 1/6/2011 11:29 AM >>>
fyi

>>> Julianne Fellmeth <julied@sandiego.edu> 1/6/2011 11:28 AM >>>
Dear Linda:

I am trying to get to Sac for the meeting today at 1:00, but my plane is delayed due to mechanical problems.

FYI: CPIL has concerns about Conditions 9, 10, and 11 for the same reasons as I stated in November: the 3-day practice period is not consistent with the SB 1441 Committee's Stds #8 and 10, which require immediate removal from practice upon notice of a positive test. This is a PROBATIONER who has been disciplined w/full procedural due process. Additionally, Condits 9-11 are not consistent w/new BPC section 31.2, as added by SB 1172.

Also, CPIL has concerns about the absence of any required drug testing frequency standard. The SB 1441 Committee's std requires 104 tests (2x per week) duriing the first year.

Finally, CPIL is concerned about Condit #11 -- it allows a substance-abusing probationer to practice medicine for 30 days w/ no testing. This is not acceptable. Drug testing arrangements acceptable to MBC should be a condition precedent to practicing medicine.

If you are not attending the meeting today, could you please forward this to the staff person who is? I'm trying to get there as soon as I can! We are being put on a different plane!

Julie D. F.
Sent from my HTC Touch Pro2 on the Now Network from Sprint®.

California Society of Addiction Medicine
575 Market Street, Ste 2125 — San Francisco, CA 94105 — 415/764-4855 — Fax 415/764-4915 www.csam-asam.org

A specialty society of physicians founded in 1973. Since 1989, a State Chapter of the American Society of Addiction Medicine

January 7, 2011

Ms. Linda Whitney
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Dear Linda:

We understand that many or most of CSAM's comments made in response to the proposed changes in the Disciplinary Guidelines should be addressed by MBC policy and procedures, and thus we are writing to ask that the Board take them up now as recommendations. They are all included in the letter attached here.

We look forward to discussing them with you and members of the Board's committees and staff.

Sincerely,

Kerry Parker, CAE
Executive Director

cc : Ms. Barbara Yaroslavsky
Ms. Gail Jara
Stephanie Shaner, MD
David Pating, MD

Rehan Sheikh
PO Box 869 French Camp CA 95231
Phone (209) 982 9039; Facsimile (209) 468 6392
Email: rehansheikh@yahoo.com

Date: Jul 24, 2009

Respectable Board Members
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento California 95815

Subject: A few Considerations on Disciplinary Actions against Physician(s)

Reference: Quarterly Board Meeting – May 2009

Respectable Board Member(s),

If I had the opportunity to speak at the Quarterly Board Meeting, I would have suggested that the Members of the Board must not ignore a suggestion by a very respectable member Ms. Gerrie Schipske, Esq. Ms. Schipske had suggested that the Medical Board demand 'truthfulness'.

As I recall, her suggestion was for the experts and the institutions that provide certain information to the Medical Board. Intent or Bad Intent for the peer review was another relevant issue. I am writing to second her suggestion.

The Executive Director of this Board acts as a Judge with Unequivocal Authority

The Respectable members of the Medical Board must understand that the Executive Director of the Medical Board serves as a 'Judge' in such a unique and powerful way that there is no appeal available after the decision. There is an Administrative Review of the decisions; however, generally the Courts have relied on the Medical Board to determine credibility and truthfulness of a witness. The Executive Director, acting as a Judge, **must** assure truthfulness of facts.

A humble Suggestion for Oversight of the Decision making

A key oversight on the actions of 'the Executive Director of the Medical Board acting as a Judge', are the members of this Medical Board. This is requested that the Members of the Medical Board consider a process that monitors the quality of decision making for the accusations brought by the Medical Board **before** the accusations are brought. The Board can bring accusations only if the accusations are supported by the evidence such as verified information and appropriate expert reports.

The 'well known meeting of Board Members' where a proposed decision by an ALJ is adopted or otherwise, appears to be too little too late in the disciplinary process. Further, there is no reliable information available in the public domain whether that meeting considers the truthfulness of the evidence or **only** the severity of the punishment.

Incompetence of a Physician (Accusation of)

This is requested that the Medical Board reconsider if this is appropriate (whether legal or ethical) for this Board to bring accusations of incompetence against a physician who has successfully

completed his/her residency training. This is also requested that the Medical Board reconsider the definition of incompetency **if** this Board has a legal authority and qualification to bring accusations of incompetence against physician(s).

Severity of Disciplinary 'Punishment'

Clearly a section of the B&P Code states that the Board can discipline a physician by taking actions such as to suspend/revoke a license, place on probation and issuing a letter of reprimand etc. While this may or may not be a legally obligation, the respectable members of this Board can make it obligatory for the Board to propose **only appropriate and proportionate** 'punishment' in consistent with the intent of this Board and the final report of the Enforcement Monitor.

Enforcement Monitor Report

The final report of the Enforcement Monitor submitted to California State Legislature states:

> *In this era of managed care, the impact of MBC investigative and disciplinary activity can have momentous ramifications for a physician's ability to practice medicine. Thus, the **fairness, consistency, and quality** of MBC disciplinary decision making are of significant importance to California's physician population.*

While taking disciplinary actions against physician(s), the respectable members of this Board are hereby requested to kindly consider a process that is not adverse to physicians.

Respectfully Submitted,

Rehan Sheikh
Engineer

The Office of Rehan Sheikh
PO Box 869 French Camp CA 95231
Phone (209) 982 9039
Email: rehansheikh@yahoo.com

Date: January 17, 2011

Ms. Barbara Yaroslavsky
President, Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento California 95815

Subject: Rehan's Suggestion on Disciplinary Guidelines
Ref: MBC Meeting on Disciplinary Guidelines (Sacramento, Jan 6, 2011)

Dear Madam President,

I attended the above referenced meeting and I have some reservations on the Disciplinary Guidelines primarily because;

1) The Disciplinary guidelines are not binding on the Board
2) The Board has unlimited discretion to propose any punishment to a physician

As I understand, our legal system generally demands that punishment be appropriate to the offense (or negligence). For example; punishment of individuals who is guilty of a minor infraction such as a traffic violation may not be the same as punishment of someone who is guilty of an act of felony.

In my letter dated July 24, 2009, I had requested the Board to adopt a guideline to propose "appropriate" disciplinary punishment. I have not received any response. For your convenience I am resending a copy of my previous letter for your kind consideration. After the Board approves a guideline to propose "appropriate" disciplinary punishment, only then, the disciplinary guidelines can begin to gain acceptance.

I propose that, in order to standardize the discipline of physicians with other professionals, your office consider adding an additional paragraph at end of disciplinary guidelines. The new paragraph may state;

"In lieu of any or all of the disciplinary terms, a physician who is found guilty of unprofessional conduct may settle all disciplinary punishment by paying $400 fine".

Respectfully Submitted,

/s/
Rehan Sheikh
Representative for Dr. Sheikh

Via Email:

- Executive Staff, Medical Board of California
- Members, Medical Board of California
- Immediate Past President (IMPP) of Medical Board of California
- MBC Advisory Committee on Physicians Responsibility
- U. C. Davis Family Medicine Residency Program(s)

Lodi-area senators [name Redacted], Lois Wolk admit to gifts;

By The Associated Press and News-Sentinel Staff
Wednesday, February 3, 2010 6:08 AM PST

Here is the list of California lawmakers who have acknowledged they failed to report gifts, all in 2008. Seven other lawmakers, listed at the end, have outstanding cases with the commission:

A state senator *.... Sen. Lois Wolk, D-Davis, who represents parts of Stockton and the Delta.*

Wolk ***failed*** *to list two $151.51 hotel stays paid for by the Consumer Attorneys of California and the Northern California Regional Council SCC at Wine & Roses in Lodi for a Democratic retreat.* ***She agreed to pay a $400 penalty.***

==========

Political Gravy Train Rolls in Sacramento: Free Gifts go unreported by 35 California lawmakers,

— Sen. Lois Wolk, D-Davis, failed to list a $151.51 stay at the Wine and Roses hotel in Lodi from the Consumer Attorneys of California.

http://economy4abc.blogspot.com/2010/01/political-gravy-train-rolls-in.html

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
DIVISION OF LEGAL AFFAIRS
1625 N. Market Blvd., Suite S 309, Sacramento, CA 95834
P (916) 574-8220 F (916) 574-8623

MEMORANDUM

DATE: **October 7, 2010**

TO: **Executive Officers**
Board Presidents/Chairs

Doreathea Johnson

FROM: **DOREATHEA JOHNSON**
Deputy Director
Legal Affairs

SUBJECT: **Board Meeting Protocols**

Three Duties for Board Meetings

1. Give adequate notice of meetings that will be held and agenda items.
2. Conduct meetings in open session.
3. Provide the public an opportunity to comment.

First Duty
Adequate Notice of Meetings and Agenda Items

1. Timely – Law requires 10 days notice to those on a mailing list and posting notice and agenda on your website.
2. Specific Notice – Detailed, itemized agenda, identifying all items of business to be conducted at the meeting.
   - Items not on agenda cannot be discussed nor can they be acted on.
   - Can't discuss items under the heading of "New or Old Business" unless they are specifically identified.
   - Test for Specific Notice --Is an item specific enough for a member of the public to reasonably ascertain the nature of the business to occur at the meeting?

Second Duty
Conduct Meetings

Open Session

General rule: Meetings must be conducted in Open Session and all discussion and actions must take place in the public, unless specifically authorized by law to go into closed session, with regard to that item of business.

Vote in public – Votes must be publically taken. Secret votes or votes by proxy are not permitted.

Closed Session

Business statutorily authorized to be conducted in closed session:

- Disciplinary matters;
- Preparing, approving or grading examinations;
- Pending litigation;
- Matters affecting personal privacy;
- Executive officer appointment, employment or dismissal.

Once in closed session, you can only discuss those matters that were identified as closed session on your agenda.

Third Duty
Public Comment At The Meeting

General Rule

Must allow public comment on each open session agenda item.

Suggested script to be read at the beginning of the meeting:

The Board Chair will allow public comment on agenda items, as those items are taken up by the Board, during the meeting. Under the Open Meetings Act, the Board may not take any action on items raised by public comment that are not on the Agenda, other than to decide whether to schedule that item for a future meeting.

If any person desires to address the Board, it will be appreciated if he or she will stand or come forward and give his or her name, and if he or she represents an organization, the name of such organization, so that we will have a record of all those who appear. Please note that a person wishing to provide comment is not

required to identify him or herself when making public comment, but it is appreciated.

In order to allow the Board sufficient time to conduct its scheduled business, public comment will be limited to ___ minutes. Please make your comments focused and relevant to the duties of the Board. It is not necessary to repeat statements or views of a previous speaker, it is sufficient to state that you agree. Written statements should be summarized and submitted to the Board. They should not be read.

If as chairperson/president, I forget to ask for public comment on an agenda item, it is not because I intend to limit comment but just because I forgot. So in that situation, please raise your hand and I will recognize you.

Suggested script to be used for each item on the agenda:

1. Call the Agenda Item
2. Committee Presents the agenda item
3. Ask for a motion
4. Ask for a second, unless the motion is made by the committee (second is not needed)
5. Ask for board discussion.
6. Ask if there is public comment. [You may reverse the order of these 2.]
7. Ask if there is further board discussion.
8. Repeat the Motion
9. Take the vote

Suggested script for public comment on items not on the agenda:

The board values input from the public as part of its consumer protection mission. It invites and welcomes public comment during this section of the agenda. However, board members cannot engage in dialogue with those who testify during this section of the agenda due to constraints imposed on the board and its members by law. The law prohibits the board from substantively discussing or voting on any matter brought up during public comment. A member of the public who would like the board to discuss a general topic not related to a specific case involving one of its licensees can ask the board to consider placing the issue on the board's agenda for a future meeting.

If you have an application or disciplinary charges pending before the board, we ask that you not discuss the details of your case or pending complaint since the board members will be the "judges" and by law are not permitted to receive evidence or information that is not part of the administrative record in the case.

Disruptive persons:

The public has the right to express its disapproval, and may sometimes make emotional presentations. It is the board's duty and obligation to allow that public comment. Since the purpose of the meeting is for the agency to conduct its business, commenters shouldn't be permitted to thwart that purpose and may be

removed from the meeting if disruptive behavior continues after a request that it stop.

Suggested script to use when there is a disruptive person:

Under the Open Meetings Act (Government Code Section 11126.5), if you continue in this manner, I will ask you to leave the meeting and if you do not leave the meeting, you will be removed. Accordingly, I am asking you to discontinue your disruptive conduct so that all participants can be heard in an orderly fashion.

Miscellaneous

Wording of Motions

- Motions must be clearly worded.
- The test: Could a reasonable person reading the motion understand what the board meant to accomplish?
- Chair should restate the motion before the discussion and just before the vote is taken

Improper Disclosure of Information

- Improper for information received during closed session to be publicly disclosed without authorization of the body as a whole.

Role of the Attorney

The attorney's role during board meetings is to advise the agency of its obligations and authority under the law when it appears that the agency may be deviating from it, e.g. Open Meetings Act, quorum requirements, practice acts, regulations. In some cases, it may be necessary for the attorney to assist the agency in identifying an issue, framing a motion that accurately reflects the agency's deliberations and intent or seeking clarification from a speaker or board member.

When a problem is identified, the attorney is expected to assist the board in developing a lawful alternative method of accomplishing the board's goal.

It is not the attorney's responsibility or role to chair the meetings or direct the discussion. And the attorney should refrain from doing so even if requested to take on that role.

AVAILABILITY OF MODIFIED TEXT

NOTICE IS HEREBY GIVEN that the Medical Board of California has proposed modifications to the text of CCR Section 1361 in Article 4 of Chapter 2, Division 13, in Title 16 relating to the *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, that were the subject of a regulatory hearing on November 5, 2010. A copy of only the text being modified is enclosed. Any person who wishes to comment on the proposed modifications may do so by submitting written comments by the close of business on January 24, 2011 to the following:

Name:	Susan Cady, Enforcement Manager Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

DATED: January 7, 2011

/ signed by /

Kevin A. Schunke
Regulations Coordinator

Medical Board of California

Modified Text

Changes to the originally proposed language are shown by double underline for the new text and underline with strikeout for the deleted text.
(For ease of locating the modified text, it also has been shaded.)

1. Amend section 1361 in Article 4 of Chapter 2, Division 13, to read as follows:

1361. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Disciplinary Guidelines and Model Disciplinary Orders" (~~10th Edition/2008~~ 11th Edition/~~2010~~ 2011) which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Medical Board of California in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation -- for example: the presence of mitigating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Sections 2018, Business and Professions Code; and ~~Sections~~ Section 11400.20 ~~and 11400.21~~, Government Code. Reference: Sections 2227, 2228, 2229, and 2234, Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

Modifications have been made to probationary conditions:

Title Page – non-substantive change to year

- #9
- #10
- #11
- Recommended Range of Penalties for Violations of Probation

State of California
State and Consumer Services Agency
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
11~~10~~th Edition
~~2008~~~~2010~~ 2011
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

~~Richard Fantozzi, M.D.~~
Barbara Yaroslavsky,
President
~~Cesar Aristeiguita, M.D.~~
Frank Zerunyan,
Vice President
Hedy Chang,
Secretary

The Board produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11~~10~~th Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physicians-respondents, trial attorneys from the Office of the Attorney General, and the Board's disciplinary panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

For additional copies of this manual, please write to the address below or visit http://www.medbd.ca.gov/publications/disciplinary_guide.pdf:

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Phone (916) 263-2466

Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines~~,~~ are made periodically. Listed below are the most recent changes included in the 11~~10~~th edition approved by the Board following open discussion at a public meeting.

Summary of Changes
The former "Disciplinary Guidelines – Index" printed after the last "Standard Conditions" has been moved to the Table of Contents (a formatting change only) and has been renamed the "Recommended Range of Penalties for Violations" for clarity.

Model Condition Number:

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed ~~lawful prescription~~ medications, respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, ~~and~~ strength, and quantity; and issuing pharmacy name, address, and telephone number.

If respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the Board or its designee, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine ~~within three (3) calendar days after being so notified~~. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

If respondent has a confirmed positive biological fluid test for alcohol, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine ~~within three (3) calendar days after being so notified~~. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be

filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

11. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. ~~Within 30 calendar days of this Decision, Prior to practicing medicine,~~ Prior to practicing medicine, respondent shall~~, at respondent's expense,~~ contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, ~~urine~~ biological fluid testing~~ a minimum of four times each month~~. The contract shall require results of the ~~urine~~ tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall ~~Failure to~~ maintain this laboratory or service contract during the period of probation ~~is a violation of probation~~.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent. ~~Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation."~~

If respondent fails to cooperate in a random biological fluid testing program within the specified time frame, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine ~~within three (3) calendar days after being so notified~~. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board

within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

VIOLATION OF PROBATION

Minimum penalty: 30 day suspension
Maximum penalty: Revocation
The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]
3. Professional Boundaries Program [17]

~~4. Clinical Training Program [18]~~

4 ~~5.~~ Psychiatric Evaluation [20]
5 ~~6.~~ Psychotherapy [21]
6 ~~7.~~ Medical Evaluation and Treatment [22]
7 ~~8.~~ Third Party Chaperone [25]

It is the expectation of the Medical Board of California that the appropriate penalty for a physician who did not successfully complete a clinical training program ordered as part of his or her probation is revocation.

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

Calendar Year 2010

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Total=1,289↑
ADDICTION	9	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	17 ↑
ALLERGY & IMMUNOLOGY (A&I)	2	2 LIST EXPERTS REVIEWED 1 CASE	10
ANESTHESIOLOGY (Anes)	10	8 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	102 ↑
COLON & RECTAL SURGERY (CRS)	3	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	5
COMPLEMENTARY/ALTERNATIVE MEDICINE	5	1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	26 ↑
CORRECTIONAL MEDICINE	13	8 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	41 ↑
DERMATOLOGY (D)	10	2 LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIWED 2 CASES	16
EMERGENCY (EM)	14	9 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	61
ETHICS	3	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6
FAMILY (FM)	94	23 LIST EXPERTS REVIEWED 1 CASE 11 LIST EXPERTS REVIEWED 2CASES 3 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 6 CASES * 2 LIST EXPERTS REVIEWED 7CASES* 1 LIST EXPERT REVIEWED 8 CASES *	110 ↑
HOSPICE & PALLIATIVE MEDICINE	1	LIST EXPERT	9

*Flagged Expert (reviewed over 5 cases for calendar year 2010 - requires prior approval before using to review new cases for 2011)

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2010

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Total=1,289↑
INTERNAL (General Internal Med)	88	21 LIST EXPERTS REVIEWED 1 CASE 9 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES 3 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 10CASES*	250 ↑
Cardiovascular Disease (Cv)	28	5 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 7 CASES*	37
[Interventional Cardiology (Intv Cd)]	[21]		[24]
[Non-Interventional Cardiology]	[7]		[23]
Endocrinology, Diabetes and Metabolism (EDM)	5	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	9 ↑
Gastroenterology (Ge)	7	4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	23
Hematology (Hem)	1	1 LIST EXPERT	7
Infectious Disease (Inf)	-		12
Medical Oncology (Onc)	10	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	16
Nephrology (Nep)	2	2 LIST EXPERTS REVIEWED 1 CASE	11 ↑
Pulmonary Disease (Pul)	6	6 LIST EXPERTS REVIEWED 1 CASE	23
Rheumatology (Rhu)	-		10
MIDWIFE REVIEWER	3	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	10
MEDICAL GENETICS (MG)	-		2
NEUROLOGICAL SURGERY (NS)	7	4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	15 ↓
NEUROLOGY (N)	8	6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	32 ↑

*Flagged Expert (reviewed over 5 cases for calendar year 2010 - requires prior approval before using to review new cases for 2018)

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2010

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Total=1,289↑
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)	-		5
NUCLEAR MEDICINE (NuM)	-		6
OBSTETRICS & GYNECOLOGY (ObG)	80	1 OFF LIST EXPERT REVIEWED 1 CASE 14 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 5 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 2 LIST EXPERTS REVIEWED 6 CASES * 1 LIST EXPERT REVIEWED 11 CASES *	104 ↑
Gynecologic Oncology (GO)	2	2 LIST EXPERTS REVIEWED 1 CASE	7
Maternal & Fetal Medicine (MF)	5	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	11
Reproductive Endocrinology/ Infertility (RE)	2	1 LIST EXPERT REVIEWED 2 CASES	10
OPHTHALMOLOGY (Oph)	28	5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 5 CASES	43 ↑
ORAL & MAXILLOFACIAL SURGERY	-		1
ORTHOPAEDIC SURGERY (OrS)	19	8 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	47 ↑
Surgery of the Hand (HS)	2	1 LIST EXPERT REVIEWED 2 CASES	23
Orthopaedic Sports Medicine (OSM)			22
OTOLARYNGOLOGY (Oto)	6	2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	32 ↑
Neurotology (ON)	1	LIST EXPERT	6
Pediatric Otolaryngology (PO)	-		3

*Flagged Expert (reviewed over 5 cases for calendar year 2010 - requires prior approval before using to review new cases for 2011)

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2010

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Total=1,289↑
Undersea & Hyperbaric Medicine (UM; UHM)			0
PSYCHIATRY (Psyc)	83	26 LIST EXPERTS REVIEWED 1 CASE 10 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 3 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 8 CASES *(7 WERE MENTAL EVALUATIONS)*	123 ↑
Addiction Psychiatry (AdP)	7	3 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	30 ↑
Child & Adolescent Psychiatry (ChAP)			26 ↑
Forensic Psychiatry (FPsy)	3	3 LIST EXPERTS REVIEWED 1 CASE	61 ↑
Geriatric Psychiatry (GPsyc)			31 ↑
Pain Medicine (PM)	1	LIST EXPERT	16 ↑
Psychosomatic Medicine (PsychoMed)			23 ↑
Sleep Medicine (SLP)			1
RADIOLOGY (Rad)/Diagnostic Radiology (Rad DR)	11	5 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	40 ↑
Radiation Oncology (Rad RO)	3	3 LIST EXPERTS REVIEWED 1 CASE	6
Neuroradiology (NRad)			18
Nuclear Radiology (NR)			2
Pediatric Radiology (PR)			9
Vascular/Interventional Radiology (VIR)			3
SLEEP MEDICINE (S)	1	1 LIST EXPERT	9
SPINE SURGERY (SS)			1

*Flagged Expert (reviewed over 5 cases for calendar year 2010 - requires prior approval before using to review new cases for 2018)

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2010

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Total=1,289↑
SURGERY (S)	25	7 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES	64 ↑
Pediatric Surgery (PdS)			4 ↓
Vascular Surgery (VascS)	3	3 LIST EXPERTS REVIEWED 1 CASE	16
THORACIC SURGERY (TS)	3	3 LIST EXPERTS REVIEWED 1 CASE	19
(MEDICAL) TOXICOLOGY			4
UROLOGY (U)	21	1 OFF LIST EXPERT REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERT REVIEWED 4 CASES	20 ↑
WORKERS' COMP/QME/IME	1	LIST EXPERT	29

/susan (12/31/10)

*Flagged Expert (reviewed over 5 cases for calendar year 2010 - requires prior approval before using to review new cases for 2011)

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2441 FAX (916) 263-2435
www.mbc.ca.gov

AGENDA ITEM 29D

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805.01 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason. .

******PLEASE PRINT OR TYPE******

REPORTING ENTITY

Please check type of Reporting Entity: ☐ Health Care Facility or Clinic - §805(a)(1)(A) ☐ Health Care Service Plan - §805(a)(1)(B)

☐ Professional Society - §805(a)(1)(C) ☐ Medical Group or Employer - §805(a)(1)(D)

☐ Ambulatory Surgical Center - §805(a)(1)(A)

Name	Telephone #:
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report:	Telephone #
street address city state zip code	

LICENTIATE

Name (Last) (First) License # _____

Physician ☐

Podiatrist ☐

REASON FOR FORMAL INVESTIGATION

Reason for formal investigation that resulted in recommended action::

_____ Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, To the extent or in such a manner as to be dangerous or injurious to any person or the public.

_____ The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other Persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

_____ 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 effort prior examination of the patient and medical reason therefor.

_____ Sexual misconduct with one or more patients during a course of treatment or an examination.

RECOMMENDED ACTION

_____ Termination or revocation of staff privileges, membership or employment

_____ Restriction of staff privileges, membership or employment

_____ Summary suspension of staff privileges, membership or employment

If staff privilege restriction is recommended, list proposed specific restrictions:

_____

_____

Date final decision/recommendation made: _____

_____ _____

Signature Date Signature Date

Chief Executive Officer/Medical Director/Administrator Chief of Medical Staff

805 Fact Sheet

- An 805 report is the mechanism in which peer review bodies, most commonly found in hospitals, are required to report specific information regarding physicians to the Medical Board. ***It is important to note that 805 reports are not public documents and are not available to consumers.***

- SB 700 (Negrete McLeod, Chapter 505, Statutes of 2010) requires the Medical Board to post an 805 fact sheet that explains and provides information on the 805 reporting requirements. More information on the requirements related to 805 reporting can be found in Business and Professions Code Section 805: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=800-809.9

Who must file:

Any peer review body from:

- ✓ A health care facility or clinic licensed under Division 2 of the Health and Safety Code or a facility certified to participate in the federal Medicare Program as an ambulatory surgical center
- ✓ A health care service plan licensed under Chapter 2.2 of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates
- ✓ A medical or podiatric professional society having as members at least 25% of the eligible licentiates in the area in which it functions, which is not organized for profit and which has been determined to be exempt from taxes
- ✓ A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of care provided by members or employees

The 805 report can be signed by:

- ✓ The chief of staff of a medical or professional staff
- ✓ Other chief executive officer
- ✓ Medical director, or administrator of any peer review body
- ✓ Chief executive officer or administrator of any licensed health care facility or clinic

What must be reported:

- ✓ Name of licensee (the physician)
- ✓ Physician's license number
- ✓ Description of the facts and circumstances of the medical disciplinary cause or reason and any other relevant information deemed appropriate by the reporter

When a report must be filed:

An 805 Report must be filed within 15 days from the date:

- ✓ A peer review body denies or rejects a licensee's applications for staff privileges or membership for a medical disciplinary cause or reason
- ✓ A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason
- ✓ Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons
- ✓ An 805 report must be filed if the resignation, leave of absence, withdrawal or abandonment of application or for renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason
- ✓ A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days

Failure to File:

Intentional failure to report may result in a $100,000 fine.
Any failure to report may result in a $50,000 fine.

A blank 805 report form can be obtained at the following link:

http://www.mbc.ca.gov/forms/enf-805.pdf

Medical Board of California

Investigation & Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010	
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution											
Average	271	299	138	330	268	374	358	383	381	333	333
Median	252	285	134	304	269	335	324	346	346	298	297
Record Count	827	703	192	648	539	609	588	673	672	664	663
Calendar Day Age from Request to Suspension Order Granted											
Average	51	44	4	34	38	19	19	52	39	40	40
Median	17	3	2	22	23	10	10	23	23	1	1
Record Count	24	21	11	17	13	21	17	17	16	27	27
Calendar Day Age from Request to Receipt of Medical Records											
Average	58	53	37	59	57	63	58	73	73	64	64
Median	32	31	26	31	31	28	28	32	32	29	29
Record Count	475	376	228	264	259	256	252	243	243	257	257
Calendar Day Age from Request to Physician Interview Completed											
Average	48	51	43	52	50	63	63	52	52	46	46
Median	36	42	38	37	36	41	42	37	37	34	34
Record Count	597	453	172	406	371	473	466	696	696	582	582
Calendar Day Age from Request to Receipt of Expert Opinion											
Average	51	47	35	51	43	50	50	48	48	47	47
Median	41	35	31	36	35	39	38	36	35	37	37
Record Count	519	424	82	344	270	374	359	426	424	415	415
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed											
Average	556	554	140	543	340	565	493	584	578	589	588
Median	525	504	120	523	339	541	486	575	569	616	616
Record Count	187	149	17	198	95	157	131	189	186	200	199
Calendar Day Age from Accusation Filed to Disciplinary Outcome**											
Average	608	602	85	576	188	561	243	473	339	426	340
Median	526	466	99	426	182	384	238	351	309	326	304
Record Count	212	195	3	226	29	203	80	198	145	171	156

*Excludes Out of State and Headquarters Cases
**Excludes Outcomes where no Accusation Filed

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

LEGAL AFFAIRS
1625 North Market Blvd., Suite S 309
P (916) 574-8220 F (916) 574-8623

MEMORANDUM

DATE	December 15, 2010
TO	Members Medical Board of California
FROM	Anita L. Scuri Supervising Sr. Counsel Department of Consumer Affairs
SUBJECT	**PROPOSED PRECEDENTIAL DECISION – *In the Matter of the Accusation Against Jill Siren Meoni, M.D.*; Case No. 10-2007-185857; OAH No. 2008100753**

In accordance with the procedure adopted by the Division of Medical Quality in July 2004 (Exhibit 1), the Office of the Attorney General has recommended that one portion of the above-captioned decision be designated as precedential. The executive director, chief of enforcement and I all agree with this recommendation.

Procedural Background

Dr. Meoni ("respondent") was the recipient of an Accusation. The matter was heard before Administrative Law Judge Donald P. Cole, who submitted a Proposed Decision to the Medical Board of California ("Board") on July 7, 2009. A panel of the board non-adopted that decision and later granted reconsideration to change several footnotes to ensure consistency in all parts of the decision.

Facts/Findings of the Case

The facts of the case are not themselves relevant to the current request since the portion of the decision sought to be designated as precedential relates to the interpretation of Business and Professions Code Section 2334. Section 2334 governs the exchange of information regarding expert witnesses and provides as follows:

"(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

(1) A curriculum vitae setting forth the qualifications of the expert.

(2) A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.
(3) A representation that the expert has agreed to testify at the hearing.
(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.
(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.
(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.

The key issue relates to a motion by complainant (the Board's executive director) to exclude expert testimony for violation of section 2334. The administrative law judge found that respondent had violated the requirements of section 2334 by failing to provide the expert witness disclosure within 30 calendar days prior to the commencement of the hearing and by failing to provide "a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis." Nonetheless, the administrative law judge declined to apply the statutory remedy of excluding the expert testimony. The administrative law judge construed section 2334 as affording both OAH and the administrative law judge a measure of discretion with regard to the remedy for noncompliance to be applied in a given case, depending on the totality of the circumstances.

Portions of Decision to be Designated as Precedential

The recommendation is that only the following portion of the decision be designated as precedential:

Motion in Limine to Exclude Expert Testimony (Conclusions of Law Nos. 5 through 14, inclusive)—pages 36 to 45.

If the Board approves the request to designate the above portion of the decision as precedential, those portions not accepted for publication will be redacted and replaced with asterisks. Exhibit 2 is the redacted version of the decision and is what those viewing the precedent decision would see. Exhibit 3 is the decision in its entirety.

Rationale

16 Cal. Code Regs. 1364.40(a) authorizes the division to designate, as a precedent decision, "any decision or part of any decision that contains a significant legal or policy determination of general application that is likely to recur."

Expert witnesses are necessary in every quality of care case; therefore the issue presented in this case is very likely to be a recurring issue. In its decision (Conclusion of Law No. 9,

page 39), the board agreed with both the administrative law judge and with complainant about the critical need for guidance in interpreting section 2334 in order to carry out the purpose for which that section was enacted. The board further stated that it "intends to convey its interpretation of that section in this decision." That interpretation is not binding on administrative law judges unless it is designated as a precedential decision.

The portion of the decision proposed to be designated as precedent contain significant legal determinations and would provide guidance to counsel for respondent and complainant as well as guidance to the Office of Administrative Hearings.

Attachments

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	OAH No. 2008100753
JILL SIREN MEONI, M.D.	MBC Case No. 10-2007-185857
Physician's and Surgeon's Certificate No. A 55229	PRECEDENTIAL DECISION No. MBC-2011-01 DMQ

DESIGNATION AS PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Medical Board of California hereby designates as precedential that portion of the decision listed below in the Matter of the Accusation against Jill Siren Meoni:

> *Motion in Limine to Exclude Expert Testimony* (Conclusions of Law Nos. 5 through 14, inclusive)—pages 36 to 45

This precedential designation shall be effective January 28, 2011.

IT IS SO ORDERED this 28th day of January, 2011.

BARBARA YAROSLAVSKY, President
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 10-2007-185857
JILL SIREN MEONI, M.D.,	OAH No. 2008100753
Physician's and Surgeon's Certificate No. A 55229,	
Respondent.	

DECISION AFTER RECONSIDERATION

****

Motion in Limine to Exclude Expert Testimony

5. On May 7, 2009, complainant filed a motion in limine seeking "to exclude the expert testimony of each of respondent's six expert witnesses, on the grounds that respondent has violated the mandatory expert witness disclosure requirements of [Business and Professions Code] section 2334." The motion was based primarily on the following arguments: (i) Contrary to the requirements of section 2334, respondent's expert witness disclosure did not occur at least 30 calendar days before the commencement of the hearing; and (ii) the mandatory penalty for the failure to comply on a timely basis with the requirements of section 2334 is the automatic exclusion of the offending party's expert testimony. Complainant also contended that: (iii) Respondent's expert disclosures failed to comply with the requirements of section 2334 in other respects than timeliness (e.g., the description of the expected testimony of respondent's experts); and (iv) respondent's various failures to comply with the requirements of section 2334 were highly prejudicial to complainant's ability to prepare for the hearing.

6. Respondent has violated the requirements of section 2334 in two respects. First, respondent failed to provide its expert witness disclosure within 30 calendar days prior to the commencement of the hearing. On March 5, 2009, OAH granted respondent's motion to continue the hearing, and set the hearing to commence on May 14, 2009. Based on that hearing date, and pursuant to section 2334, subdivision (a), expert witness disclosure was to be made no later than April 14, 2009. Respondent did not, however, make her formal disclosure until April 30, 2009. [1] For purposes of the motion in limine, respondent's disclosure is deemed to have been

[1] The analysis that follows focuses on respondent's formal expert witness disclosure of

16 days late.[2] It is thus concluded that respondent's disclosure was untimely.

Second, respondent failed, as to two of its experts, to provide "a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis." Complainant argued essentially that the descriptions provided in respondent's disclosure were not adequate to meaningfully inform complainant of the actual substance of the expected testimony of respondent's experts, including the experts' actual opinions and the bases therefor. Complainant's argument is rejected with regard to William Umansky and Luis Becerra. The description of the expected testimony of these individuals as set forth in respondent's disclosure did not constitute the kind of testimony that is typically considered "expert testimony," i.e., as described, it did not consist of formal expert opinions, but instead involved the physician's course of care of respondent.[3] As such, such testimony is properly characterized as percipient witness testimony, not expert testimony per se.[4] On the other hand, the description of the expected testimony of Frank Tiffany and David Sheffner clearly involved, at least in part, the rendering of genuine expert opinions. The description of their testimony adequately set forth the general substance of the testimony, including opinion testimony,[5] but did not set forth any "basis" for such opinion testimony, and thus fails to comply with section 2334.[6]

April 30, 2009. On April 16, 2009, respondent served a Final Witness and Exhibit List. This list may be viewed as constituting respondent's initial expert witness disclosure. Under either view, based on the reasoning set forth below, violations of section 2334 would be found, though the violations would differ to a certain extent. For example, respondent did not disclose the fee to be charged by all of her experts until April 30.

[2] On April 16, 2009, Presiding Administrative Law Judge Alan R. Alvord issued a prehearing conference order, in which the parties were ordered to exchange the information required by section 2334 by April 30, 2009. Complainant objected to that portion of the order and contended in her in limine motion that OAH lacked the authority to grant additional time within which to make a section 2334 disclosure after the 30-day deadline had already passed. For the purposes of ruling on the in limine motion, it is assumed arguendo that the disclosure was to be made on April 14, 2009, notwithstanding the prehearing conference order.

[3] Indeed, the testimony of these two physicians, as described above, was limited to issues directly relating to the course of care, and did not constitute expert opinion testimony.

[4] In the absence of any statutory, regulatory or judicial guidance as to the meaning of "expert testimony," recourse is taken to the somewhat analogous use of expert testimony in civil cases pursuant to Code of Civil Procedure section 2034.

[5] Complainant's contention that the disclosures provide insufficient detail to permit complainant to prepare to meet the testimony of respondent's experts at the hearing was unpersuasive. Absent any guidance—both for respondent and for the administrative law judge—as to how "brief" the required narrative statement may be, it is not appropriate to construe that adjective in an unduly narrow fashion that would in effect constitute a trap for the unwary.

[6] Since respondent's other two experts, Christine Baser and Steven Rudolph, did not testify at the hearing, it is not necessary to address the adequacy of respondent's disclosures of their testimony.

7. In light of the conclusion that respondent has violated section 2334, the remedy for respondent's violations must now be addressed. The Administrative Law Judge denied the motion in limine and rejected exclusion of the expert testimony on the grounds that section 2334 affords both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

8. The administrative law judge determined that exclusion of respondent's expert witness testimony would not further the apparent legislative purpose of the statute, but would instead undermine the interests of justice, and based this conclusion on the following considerations.

First, with regard to the timeliness of disclosure, even though formal disclosure did not occur until April 30, the identity of respondent's six experts, and at least a short description of the subject matter of their expected testimony, was provided on April 16, 2009, i.e., just two days after the April 14 deadline.

Second, in the absence of clear guidance as to what level of detail satisfies the "brief narrative statement" requirement of section 2334, great caution and restraint is appropriate before excluding expert testimony based on a finding that a proffered description did not constitute an adequate "brief narrative statement."

Third—and closely related to the preceding point—complainant did not place respondent on notice prior to filing the motion in limine of the alleged inadequacy of respondent's disclosure.

Fourth, complainant did not establish prejudice by virtue of either the untimeliness or the inadequacy of respondent's disclosures.

Fifth, no evidence was presented that respondent's failure fully to comply with section 2334 was in bad faith, i.e., constituted a conscious attempt to "hide the ball" or otherwise circumvent proper disclosure.

Sixth, the administrative law judge presumed that the ultimate decision maker in this case, the Medical Board of California, would desire to have all relevant evidence available for its consideration, so that it can make the most well-informed and appropriate decision possible in this very important matter.

9. In her written argument and during oral argument, complainant asked the board to reverse the decision denying the motion in limine, exclude expert testimony as a result of that reversal, and, in the decision itself, designate its decision as a precedent decision. The board denies these requests for the following reasons.

First, as required by law, the board has read all of the expert testimony in question as part of its review of the record and therefore does not believe it is appropriate, fair or equitable at this

stage of the proceedings to attempt to "unring the bell."

Second, there is a process set out in regulation (Title 16 CCR section 1364.40) for designating precedent decisions and complainant's request is inconsistent with that process. Complainant may certainly renew her request in the manner prescribed in that regulation.

The board does agree with both the administrative law judge and with complainant about the critical need for guidance in interpreting Business and Professions Code Section 2334, in order to carry out the purpose for which that section was enacted, and intends to convey its interpretation of that section in this decision.

10. Business and Professions Code section 2334 provides as follows:

"(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

"(1) A curriculum vitae setting forth the qualifications of the expert.

"(2) A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.

"(3) A representation that the expert has agreed to testify at the hearing.

"(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

"(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.

"(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section."
(Stats. 2005, c. 674 (S.B. 231), § 14.)

11. The board finds that Section 2334 governs the entire subject of expert witness disclosures in Medical Board cases, including the penalty to be imposed for failure to comply with the disclosure requirements by the statutory production deadline and therefore Section 2334 prevails over any other provision of law, including provisions of the Administrative Procedure Act (APA). Evidence of this is found in the first sentence of section 2334, subdivision (a), which begins with the phrase: "Notwithstanding any other provision of law . . ." This phrase is indicative of the Legislature's intent to have the provisions of section 2334 control notwithstanding the existence of other laws that might otherwise govern the subject. (See *People*

v. DeLaCruz (1993) 20 Cal.App.4th 955, 963 [phrase "has been read as an express legislative intent to have the specific statute control despite the existence of other law which might otherwise govern."].)

12. A review of the legislative history of section 2334 confirms both the problem section 2334 was specifically enacted to address, as well as the legislative intent to place a mandatory obligation on the parties to make the required disclosures by the statutory deadline in order to promote, rather than defeat, its underlying public policy. In her Initial Report to the Legislature, the Medical Board's Enforcement Monitor[7] described the problems that result from defense counsel's failure to disclose the opinions of their experts as follows:

> "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."

(Initial Report, Medical Board of California Enforcement Program Monitor, prepared by Julianne D'Angelo Fellmeth and Thomas A. Papageorge, dated November 1, 2004, at pp. 160-161.)

In the wake of the Enforcement Monitor's Initial Report, Senate Bill 231, as amended, included a new statute specifically designed to address this problem. That statute, as originally introduced, provided that:

> "2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert

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[7]. Business and Professions Code section 2220.1 provided for the appointment of a "Medical Board Enforcement Program Monitor" to 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." (Added by Stats. 2002, c. 1085, (Sen. Bill No. 1950), § 18; repealed by Stats. 2004, c. 909 (Sen. Bill No. 136), § 3, operative Jan. 1, 2006.)

testimony shall be permitted by any party unless a detailed written report by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings." (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on June 13, 2005.)

Thus, as original introduced, the Legislature only required that the disclosure be made "in advance of the hearing." As the bill moved through the legislative process, the Legislature amended section 2334, never losing sight of its objective to compel the timely production of information regarding expert witnesses. For example, the Legislature eliminated the requirement that "a detailed written report" be produced and, instead, required only that the expert testimony be "reduced to writing by the expert witness, including findings and conclusions of the expert witness, . . ." Thus, as later amended in the Assembly, section 2334 then provided:

"2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless ~~a detailed written report~~ *it is reduced to writing* by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings." (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on July 11, 2005.)

Then, on August 30, 2005, the Legislature abandoned the requirement that the disclosure simply be made "in advance of the hearing" and, instead, established a <u>specific statutory deadline</u> for the production. In this regard, section 2334, as amended, stated:

"2334. *(a)* Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless ~~it is reduced to writing by the expert witness, including findings and conclusions of the expert witness, and it is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings.~~ *the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:*

(1) A curriculum vitae setting forth the qualifications of the expert.

(2) A brief narrative statement of the general substance of the testimony the expert is expected to give, including any opinion testimony and its basis.

(3) A representation that the expert has agreed to testify at the hearing.

(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party how retained his or her services.

(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.

(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section."
(Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 12, as amended in Assembly on August 30, 2005.)

This would remain the statutory production deadline throughout the remainder of the legislative process (see Sen. Bill No. 235 (2005-2006 Reg. Sess.) § 11, as amended on September 2, 2005) and ultimate approval by the Governor on October 7, 2005 (see Bus. & Prof. Code, § 2334). Thus, subsequent amendments to Senate Bill 231 confirm the Legislature's explicit rejection of the requirement that the expert witness disclosures be made simply "in advance of the hearing" and, instead, its intention that such disclosures shall be made "at least 30 calendar days prior to the commencement date of the hearing." (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"]; see also *Martin v. Szeto* (2004) 32 Cal.4th 445, 450 [subsequent amendments to bill cited as clarifying legislative intent].)

Permitting OAH to order the required expert witness disclosures to be made *less than* 30 calendar days prior to commencement of the hearing was included in an earlier version of Senate Bill 231 that was explicitly rejected by the Legislature and, thus, to permit it now would be entirely inconsistent with legislative intent. (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"].)

13. The board finds that the obligation of both parties to make the required exchange of expert witness information by the statutory deadline set by the Legislature in section 2334 (b), is mandatory, not merely directory. (Business and Professions Code Sections 8, 19) This is also consistent with case law:

> ". . . 'Time limits are usually deemed to be directory unless the Legislature clearly expresses a contrary intent.' (*Id.* at p. 1145.) For example, if the statute attaches consequences or penalties to the failure to observe time limits, the statute is construed as mandatory. (*County of Sacramento v. Insurance Co. of the West* (1983) 139 Cal.App.3d 561, 565-566; see also *Edwards v. Steele, supra*, 25 Cal.3d at p.410.)" (*Matus v. Board of Administration* (2009) 177 Cal.App.4th 597, 608-609.)

14. In the proposed decision, the administrative law judge construed section 2334 as

affording both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

(a) The board finds, using well-settled rules of statutory construction, that an interpretation granting discretion as to whether to impose the statutory remedy of exclusion is inconsistent with the legislative intent underlying the statute, would defeat (rather than promote) the statute's general purpose and would lead to absurd consequences.

> "In construing a statute, our fundamental task is to ascertain the Legislature's intent so as to effectuate the purpose of the statute. (*Day v. City of Fontana* (2001) 25 Cal.4th 268, 272.) We begin with the language of the statute, giving the words their usual and ordinary meaning. (*Ibid.*) The language must be construed 'in the context of the statute as a whole and the overall statutory scheme, and we give 'significance to every word, phrase, sentence, and part of an act in pursuance of the legislative purpose." ' (*People v. Canty* (2004) 32 Cal.4th 1266, 1276.) In other words, ' "we do not construe statutes in isolation, but rather read every statute 'with reference to the entire scheme of law of which it is part so that the whole may be harmonized and retain effectiveness.' [Citation.]" ' (*In re Marriage of Harris* (2004) 34 Cal.4th 210, 222.) If the statutory terms are ambiguous, we may examine extrinsic sources, including the ostensible objects to be achieved and the legislative history. (*Day, supra*, 25 Cal.4th at p. 272.) In such circumstances, we choose the construction that comports most closely with the Legislature's apparent intent, endeavoring to promote rather than defeat the statute's general purpose, and avoiding a construction that would lead to absurd consequences. (*Ibid.*)" (*Smith v. Superior Court* (2006) 39 Cal.4th 77, 83.)
>
> Section 2334, subdivision (a), states that:
>
> "(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, *as ordered by the Office of Administrative Hearings*: . . ." (Italics added.)

The board finds that section 2334 is a self-executing statute in the sense that it applies in all Medical Board cases, regardless of whether OAH orders the parties to comply with its provisions or not.[8] In this regard, section 2334 is similar to a statute of limitations (see, e.g., Bus. & Prof. Code, § 2230.5) which applies whether or not the parties are ordered to comply with its provisions.

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[8]. While OAH has reportedly begun the practice of routinely issuing orders requiring the parties to comply with the provisions of section 2334, issuance of such orders are not required since section 2334 is otherwise applicable in Medical Board cases, regardless of whether OAH orders the parties to comply or not. Such orders do, however, serve a useful purpose by helping to ensure that section 2334 does not become a trap for the unwary.

To interpret the phrase "as ordered by the Office of Administrative Hearings" as requiring an OAH order before the statute could apply in Medical Board cases would violate the general rules of statutory construction cited above. It would also lead to the absurd consequence of section 2334 applying in those Medical Board cases where OAH has issued an order requiring compliance with its provisions but not to those cases where OAH has not issued such an order.

Here, the phrase "as ordered by the Office of Administrative Hearings" is more appropriately read as referring to an order from OAH prohibiting expert testimony offered by a party whenever it has been determined that the party has failed to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline. Without such an order from OAH, the statutory penalty fixed by the Legislature for violation of section 2334 could never be imposed. This reading is also consistent with other prescribed duties and responsibilities of administrative law judges under the APA, including those provisions requiring an administrative law judge to issue orders and decisions. (See, e.g., Gov. Code, §§ 11511.5, subd. (e) ["The administrative law judge shall issue a prehearing conference order incorporating the matters determined at the prehearing conference."]; and 11517 ["If a contested case is originally heard by an administrative law judge alone, he or she shall prepare . . . a proposed decision in a form that may be adopted by the agency as the final decision in the case."].) The Legislature was presumed to be aware of existing law (here, the authority of an administrative law judge to issue orders) when it required an order from OAH to impose the statutorily required penalty for failure to comply with the requirements of section 2334. (*People v. Cruz* (1996) 13 Cal.4th 764, 775)

(b) "The most basic principle of statutory construction is that courts must give effect to statutes according to the ordinary import of the language used in framing them." (*People v. Herman* (2002) 97 Cal.App.4th 1369, 1380-1381, internal quotes and citation omitted.) "If there is no ambiguity in the language of the statute, then the Legislature is presumed to have meant what it said, and the plain meaning of the language governs." (*Id.*, at p. 1381, internal quotes and citations omitted.) Here, there is no ambiguity regarding the penalty to be imposed for a violation of section 2334. The Legislature has made a policy choice to fix that penalty as exclusion of the expert testimony.

The board finds that OAH lacks the authority to refuse to impose the legislatively mandated penalty of exclusion where a party has failed to comply with the requirements of section 2334. Whenever it has been determined that a party in a Medical Board case has violated the expert witness disclosure requirements of section 2334, either by failing to disclose the information specified in section 2334, subdivision (b), and/or failing to make the required disclosures by the statutory deadline contained in section 2334(c), section 2334(a) requires that an order be issued prohibiting that party from presenting the proffered expert testimony in the case.[9]

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[9]. Administrative disciplinary proceedings that are commenced by the issuance of an interim order of suspension (ISO) under Government Code section 11529 constitute an exception to the otherwise applicable provisions of section 2334. In ISO cases, the filing of the accusation and subsequent hearing are necessarily expedited (Gov. Code, § 11529, subd. (f)) and, as a result, the hearing may be scheduled such that is impossible for the parties to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline set

The board notes that the conclusion expressed above applies equally to both complainant and respondent. Based upon its review of the record (Exh. 29 in particular), the board urges both parties in future cases to be diligent in fully complying with Section 2334 in order to fulfill the purposes of the statute.

What constitutes compliance with Section 2334(a)(2)? Merely listing topics or subjects that the expert witness will testify about, without disclosing the general substance of the expert's anticipated testimony, the actual expert opinions he/she will testify to, and the basis for each of those opinions, is plainly insufficient and would clearly violate the statutory requirements of section 2334. A "brief narrative statement" of the "general substance" of the expert's testimony means a short narrative statement that provides the main features of the testimony—the essential nature of the testimony to be proffered. The statement must include any opinion to be presented and the basis for that opinion. By way of example as to what is not acceptable, taken from the record in this matter: A party merely states (see Exh. 29) that an expert will testify "whether Respondent can practice medicine safely, and whether the circumstances surrounding Respondent's use of medication constituted general unprofessional conduct as alleged." This narrative does not state what expert opinion will actually be proffered (i.e. that respondent can practice medicine safely and that respondent's use of medication is not general unprofessional conduct). Nor does it describe whatsoever the basis for that opinion. This is simply insufficient.

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This decision shall become effective at 5 p.m. on June 7, 2010.

IT IS SO ORDERED this 6th day of May, 2010.

HEDY CHANG, Chairperson
Panel B, Medical Board of
California

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by section 2334, subdivision (c). Compliance with section 2234 is excused when it is impossible to comply. (See e.g., *McKenzie v. City of Thousand Oaks* (1973) 36 Cal.App.3d 426, 430 [compliance with procedural statute may be excused when it is "impracticable, impossible or futile" to comply].)

State of California Department of Consumer Affairs

Memorandum

To : Carlos Ramirez, Asst. DAG
Tom Reilly, DAG
Mary Agnes Matyszewski, DAG
Health Quality Enforcement Section
Office of the Attorney General

Date: July 28, 2004

From : Joan M. Jerzak
Chief, Enforcement Program

Subject: Precedential Decisions Revised Procedures

As a follow-up to our meeting on July 21, 2004, with DCA Legal Counsel Anita Scuri, Board Counsel Nancy Vedera, Interim Executive Director Dave Thornton and me, the attached Precedent Decision Procedure was revised. I believe it incorporates all the offered suggestions and will serve as a guide for Board staff as decisions are selected for precedential designation.

Thank you all for your assistance.

Exhibit 1

PRECEDENT DECISION PROCEDURE

July 2004

Introduction

The purpose of this policy is to establish a procedure for identifying potential precedential decisions and reviewing and acting upon recommendations to designate decisions as precedential. Under the Administrative Procedure Act (APA) a decision that contains a significant legal or policy determination of general application that is likely to recur may be designated as precedential. (See Government Code (GC) Section 11425.60; Attachment 1) Once a decision is designated as precedential, the Division of Medical Quality (hereinafter "Division") may rely on it, and parties may cite to such decision in their argument to the Division and courts. Furthermore, it helps ensure consistency in decision-making by institutionalizing rulings that the Board feels reflects its position on various issues. The Division has adopted section 1364.40, Title 16, California Code of Regulations, to implement its authority to designate decisions as precedential.

Step 1: Identifying Potential Precedential Decisions

A decision or part of a decision that contains significant legal or policy determination of general application that is likely to recur may be recommended for designation as a precedential decision. Section 11425.60 does not preclude the Board from designating as precedential a decision that is already in effect. The recommendation shall be made to Board Counsel, giving the reasons why the person believes the decision meets the criteria to be designated as a precedential decision. Their recommendation shall be accompanied by a copy of the decision.

Step 2: Review of Recommendation

If the Executive Director, after consultation with the Chief of Enforcement and the Board Counsel, concludes that the Division should consider the decision for precedential designation, the matter will be placed on the Division's agenda for action. The agenda serves as public notice that the Division will consider the decision as a precedential decision.

Step 3: Preparation for Board Review

Board Counsel will then prepare or will arrange with the appropriate staff to prepare the precedential designation proposal for presentation to the Division for review and consideration.

The Board's Discipline Coordination Unit shall maintain a log of the decisions proposed to the Division for precedential designation. The log shall show the date of the Board meeting, decision number, respondent's name, a general description of the legal or policy issue, and whether the precedential decision was approved or not. A copy of the Board Counsel memorandum and minutes of the Board meeting (when the decision was discussed) will be maintained with the log.

If the Division adopts a decision as precedential, it will be assigned a precedential designation number. The precedential designation number shall begin with "MBC" and uses the calendar year and sequential numbering beginning with "01" for each year, followed by lettering for the Division designating the decision, DMQ (Division of Medical Quality) and DOL (Division of Licensing), (i.e., MBC-2004-01-DMQ for year 2004).

Step 4: Designation of a Precedential Decision

Board Counsel will prepare an order designating the decision, or portion(s) of the decision, as precedential for signature by the Division President. The effective date is the date the date the decision was designated as a precedential decision. (See Attachment 2 for an example of a Designation as Precedential Decision.)

Board Counsel will send a copy of the signed Designation as a Precedential Decision, including a copy of the decision, to the Office of Administrative Hearings. (The Office of Administrative Hearings maintains a file of precedential designations for reference by Administrative Law Judges.)

Step 5: Indexing

Under Government Code section 11425.60(c), the Division is required to maintain an index of significant legal and policy determinations made in precedential decisions. The Board's Discipline Coordination Unit will maintain the index.

The index shall be divided into three sections (Attachment 3) :

1) Decisions by fiscal year, including: the precedential designation number, the respondent's name, the MBC case number, the OAH case number and the precedential designation date (effective date).

2) Subject matter, followed by a general description of legal and/or policy issue, the precedential designation number and the respondent's name.

3) Code section number, followed by a general description of the section, the precedential designation number and the respondent's name.

NOTE: As decisions are added to the index, an asterisk will be entered after the cases, showing if they were appealed to the Superior Court, Court of Appeals or Supreme Court. Two asterisks following the case, will reflect the case was reversed as a precedential decision by the Board.

A copy of each precedential designation shall be maintained with the index and on the Board's website. The index shall be updated every time a decision is designated as precedential. The index is a public record, available for public inspection and copying. It shall be made available to the public by subscription and its availability shall be published annually in the California Regulatory Notice Register. Each January, Board staff will submit the index to the Office of Administrative Law for publication in the California Regulatory Notice Register.

Step 6: Reversal of Precedential Designation

The Executive Director, after consultation with the Chief of Enforcement and Board Counsel, may recommend that the Division reverse its designation of all or portion(s) of the precedential designation on a decision. The matter will then be placed on the agenda for action. Board Counsel will prepare or arrange with the appropriate staff to prepare the order, "Reversal of Precedential Designation," (Attachment 4). Board Counsel will then send a copy of the signed Reversal of Precedential Designation, including a copy of the decision to the Office of Administrative Hearings.

§ 11425.60. Decisions relied on as precedents

(a) A decision may not be expressly relied on as precedent unless it is designated as a precedent decision by the agency.

(b) An agency may designate as a precedent decision a decision or part of a decision that contains a significant legal or policy determination of general application that is likely to recur. Designation of a decision or part of a decision as a precedent decision is not rulemaking and need not be done under Chapter 3.5 (commencing with Section 11340). An agency's designation of a decision or part of a decision, or failure to designate a decision or part of a decision, as a precedent decision is not subject to judicial review.

(c) An agency shall maintain an index of significant legal and policy determinations made in precedent decisions. The index shall be updated not less frequently than annually, unless no precedent decision has been designated since the last preceding update. The index shall be made available to the public by subscription, and its availability shall be publicized annually in the California Regulatory Notice Register.

(d) This section applies to decisions issued on or after July 1, 1997. Nothing in this section precludes an agency from designating and indexing as a precedent decision a decision issued before July 1, 1997.

HISTORY:

Added Stats 1995 ch 938 §21 (SB 523), operative July 1, 1997; Amended by Stats 1996 ch 390 §8 (SB 794), operative July 1, 1997.

Added "and indexing" in subd (d).

Law Revision Commission Comments:

1995_Section 11425.60 limits the authority of an agency to rely on previous decisions unless the decisions have been publicly announced as precedential.

The first sentence of subdivision (b) recognizes the need of agencies to be able to make law and policy through adjudication as well as through rulemaking. It codifies the practice of a number of agencies to designate important decisions as precedential. See Sections 12935(h) (Fair Employment and Housing Commission), 19582.5 (State Personnel Board); Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Section 11425.60 is intended to encourage agencies to articulate what they are doing when they make new law or policy in an adjudicative decision. An agency may not by precedent decision revise or amend an existing regulation or adopt a rule that has no adequate legislative basis.

Under the second sentence of subdivision (b), this section applies notwithstanding Section 11340.5 ("underground regulations"). See 1993 OAL Det. No. 1 (determination by Office of Administrative Law that agency designation of decision as precedential violates former Government Code Section 11347.5 [now 11340.5] unless made pursuant to rulemaking procedures). The provision is drawn from Government Code Section 19582.5 (expressly exempting the State Personnel Board's precedent decision designations from rulemaking procedures). See also Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Nonetheless, agencies are encouraged to express precedent decisions in the form of regulations, to the extent practicable.

The index required by subdivision (c) is a public record, available for public inspection and copying.

Subdivision (d) minimizes the potential burden on agencies by making the precedent decision requirements prospective only.

Attachment 1

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

DESIGNATION AS A PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby designates as precedential Decision No. MBC-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

This precedential designation shall be effective July 30, 2004.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 2

SAMPLE

2004

Medical Board of California
Precedential Decisions

Index

MBC-2004-01-DMQ ***Ridgill, Edward***, MBC Case No. 06-1997-78021, OAH Number E-123545, July 30, 2004

Attachment 3
1 of 2 pages

SAMPLE

Medical Board of California
Precedential Decisions

Index 2004

by Subject Matter

Petition for Penalty Relief
Evidence of rehabilitation, or lack of, 2004-01-DMQ

Rehabilitation
Petitioner's burden, 2004-01-DMQ

by Code Section

Business and Professions Code

Section 2307 - Modification or Termination of Probation –
2004-01-DMQ, *Ridgill*

2 of 2 pages

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

WITHDRAWAL OF PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby orders the withdrawal of precedential Decision No. DMQ-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

The withdrawal of this precedential designation shall be effective July 30, 2005.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 4

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 10-2007-185857
JILL SIREN MEONI, M.D.,	OAH No. 2008100753
Physician's and Surgeon's Certificate No. A 55229,	
Respondent.	

DECISION AFTER RECONSIDERATION

Donald P. Cole, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on May 14, 18, 19, 20, 26, 27, 28, 29 and June 1, 2009, in San Diego, California.

Michael S. Cochrane, Deputy Attorney General, Department of Justice, State of California, represented complainant Barbara Johnston, Executive Director, Medical Board of California (board or medical board), Department of Consumer Affairs, State of California.

Steven H. Zeigen, Esq., Rosenberg, Shpall & Associates, APLC, represented respondent Jill Siren Meoni, M.D., who was present throughout the hearing.

The matter was submitted on June 10, 2009.[1]

The proposed decision of the Administrative Law Judge was submitted to the Medical Board of California on July 7, 2009. After due consideration thereof, Panel B of the Board (hereafter "Board") declined to adopt the proposed decision and thereafter on October 5, 2009, issued an Order of Nonadoption and subsequently issued an Order Fixing Date for Submission of Written Argument. On December 29, 2009, the Board issued a Notice of Hearing for Oral Argument. Oral argument was heard on January 28, 2010, and the Board voted on the matter that same day.

The Board issued its Decision After Nonadoption on February 17, 2010, to become effective March 22, 2010. On March 12, 2010, complainant filed a Petition for Reconsideration seeking a change to several footnotes to ensure consistency in all parts of the decision. An order staying the decision until April 1, 2010, was issued. A Nunc Pro Tunc Order was issued granting reconsideration and staying the effective date of the decision until the board issues its Decision

[1] See footnote to Finding 3.

After Reconsideration. Neither party requested oral argument. The time for filing written argument in this matter having expired, written argument having been filed by complainant and such written argument, together with the entire record, including the transcript of said hearing, having been read and considered, pursuant to Government Code Section 11517, the board hereby makes the following decision and order:

FACTUAL FINDINGS

Jurisdictional Matters

1. On November 15, 1995, the board issued to respondent Physician's and Surgeon's Certificate No. A 55229. The certificate is renewed and current, with an expiration date of October 31, 2009.

2. On September 15, 2008, complainant signed the accusation in her official capacity. The accusation and other required jurisdictional documents were served on respondent. On September 24, 2008, respondent executed and thereafter filed a notice of defense.

3. On May 14, 2009, the record was opened and jurisdictional documents were received. On May 14, 18, 19, 20, 26, 27, 28, 29, and June 1, 2009, sworn testimony was given and documentary evidence was introduced. On June 1, 2009, closing arguments were presented. On June 10, 2009, the record was closed and the matter was deemed submitted. [2]

Introductory Matters

4. Respondent served in the United States Navy Medical Corps from July 1990 to August 2003. She received several honors during her service. Respondent was discharged from the Navy in 2003, under circumstances set forth below.

Respondent received her medical degree in 1994 from the Uniformed Services University of the Health Sciences in Bethesda, Maryland. She completed her internship at the Naval Hospital, Camp Pendleton, California in family practice in 1995, and her residency in radiology at the Naval Medical Center, San Diego, California, in 2002, where she served as Chief Resident in 2001 to 2002 and was an annual instructor of Radiology for the General Practitioner. Respondent was certified by the American Board of Radiology in 2002.

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[2] During the hearing, the ALJ requested the parties to meet and confer in an effort to reach a written stipulation on certain specified matters. The record was left open at the conclusion of the hearing to permit the parties additional time to reach the requested stipulation. By letter dated June 10, 2009, counsel for complainant advised the administrative law judge that the parties were unable to reach any factual stipulations. Based on the parties' asserted inability to reach such stipulations, the record was closed and the matter deemed submitted on June 10, 2009.

In the fall of 2003, after her discharge from the Navy, respondent began working part-time at Promise Hospital in San Diego as a contract physician. In June 2005, she was promoted to Director of Radiology, a position she held until August 2008, when she left Promise due to the facility's emerging practice of diverting work to an outside radiology company.

In March 2004, respondent began working at Sharp Rees-Stealy in San Diego on a per diem basis. By the time the accusation was filed (September 2008), respondent was working at Sharp two days per week on a regular basis, and also covered for other radiologists when they were unable to work due to illness or for other reasons. Respondent now works at Sharp on an irregular, as-needed basis.

As a radiologist, respondent is engaged primarily in the review and interpretation of medical radiological images, produced by such processes as radiography and magnetic resonance imaging. At times, she also performs "semi-invasive procedures," such as anthrograms and superficial biopsies.

5. The accusation set forth one cause for action and two causes for discipline. The cause for action alleged pursuant to Business and Professions Code section 822[3] that respondent has a mental illness and/or physical illness affecting her ability to practice medicine safely. The first cause for discipline alleged pursuant to section 2239, subdivision (a) that respondent used prescription medication and/or alcohol to the extent, or in such a manner, as to be dangerous to herself, to others, or to the public, or to the extent that such use impaired her ability to practice medicine safely. The second cause for discipline alleged pursuant to section 2234 that respondent engaged in unprofessional conduct by breaching the rules or ethical code of the medical profession, or by engaging in conduct unbecoming to a member in good standing of the profession, so as to demonstrate her unfitness to practice medicine.

All allegations arose out of events occurring primarily in the periods from December 2002 to April 2003 and from January to August 2007, and related to physical and mental conditions of respondent (in particular migraine headaches, anxiety, and depression), and the prescription medications respondent used in an effort to alleviate the symptoms of those physical and mental conditions.

December 2002 to April 2003

6. During the period from December 2002 to April 2003, when the events described below took place, respondent was not practicing as a physician.

7. Kathleen Flanigan, L.C.S.W., has been a California licensed clinical social worker for about 25 years. Since 2000, she has worked at Sharp Mesa Vista Hospital (Mesa Vista) in that facility's Cognitive Intensive Outpatient Program (CIOP), as either a staff therapist or on a part-time per diem basis.

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[3] All statutory references are to the Business and Professions Code, unless otherwise noted.

The CIOP is a program for persons with mood disorders (primarily anxiety and depression), and includes both a group therapeutic and an educational component. The focus of the program is to help people learn cognitive behavior techniques to help them control their moods. During the time period in question, Flanigan worked with Dr. Michael Ricciardi, a Mesa Vista staff psychiatrist.

Respondent was in the CIOP for about three months, attending on 62 dates from January 5 to April 11, 2003.[4] As far as Flanigan could recall at the hearing, respondent's diagnosis was major depression.

During the course of respondent's participation in the CIOP, Flanigan at times observed respondent to sleep through class sessions.[5] On January 29, 2003, respondent appeared "somnolent & appeared sedated. She denied (when screened) taking any extra or unprescribed meds. [She was] minimally participative." Respondent stated, "I had another bad night last night." Flanigan, together with the nurse (RN), determined that respondent should not be permitted to drive home that day. On February 3, 2003, respondent was "alternately attentive & drowsy." On February 19, 2003, respondent "explored her catastrophic thinking the day prior, after beginning to ruminate on elements of the diversion program for impaired physicians." As of February 12, 2003, it was Flanigan's overall evaluation that "Jill's progress in program has been quite rocky."[6] On March 18, 2003, respondent "presented as somewhat sedated" and stated that she did not sleep well the previous night. Flanigan did not know whether respondent's sedation was the result of medication.

8. Flanigan was aware that respondent's outpatient psychiatrist, Dr. Howard Hicks, believed that respondent was abusing her pain medication, and that respondent did not agree with Dr. Hicks' assessment. Flanigan did not offer an opinion as to whether respondent did or did not abuse her medication. She testified that if she had had concerns about respondent's ability to practice medicine, she would have recorded that in her chart notes. No such concern is there recorded.

9. Flanigan testified in a professional, direct, objective, and careful manner. She did not appear to have any bias, or to overstate any of the matters about which she testified.

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[4] Respondent was admitted to the CIOP several times in December 2002; on each such occasion, she was discharged from the program upon her inpatient admission to the hospital in connection with the episodes discussed below in this Proposed Decision.

[5] This paragraph is based on both Flanigan's testimony at the hearing and her therapy notes and other medical records she prepared.

[6] Flanigan referred in connection with respondent's December 2002 inpatient hospitalizations to "the context of intense suicidal ideation and [that] patient at points took excessive medication." Flanigan testified that she did not recall what she meant by "excessive medication," and that nothing more may have been involved than the taking of one pill in excess of what was prescribed.

10. Howard Hicks, M.D., has been a psychiatrist since 1981. He is not Board certified. Respondent was his patient from September 29, 1998 to April 10, 2003.

Dr. Hicks testified that respondent first came to him with a diagnosis of general anxiety disorder, which Dr. Hicks confirmed. Later, it became apparent to him that she had a major depressive disorder as well.

In March 2003, Dr. Hicks diagnosed respondent with "polysubstance abuse."[7] He made this diagnosis on the basis of a series of events occurring during the period from December 2002 to March (and, eventually, April) 2003, including: (i) that respondent came to his office impaired on two or three occasions,[8] i.e., with slurred speech, unsteady gait, forgetfulness, needing to have questions repeated, and appearing to fall asleep; (ii) her reporting of a couple of minor automobile accidents; (iii) her lack of truthfulness about what medications she was prescribed and taking, which Dr. Hicks viewed as a desperate attempt to cling to narcotics and benzodiazepines, her "drugs of choice";[9] (iv) her husband's phone call to Dr. Hicks, which Dr. Hicks understood to reflect her husband's concern that respondent was impaired at home, and his related concern for the safety of their son; (v) that her family planned an intervention on her behalf relating to her drug and alcohol problems; and (vi) respondent's several hospital admissions, one of which, in late December 2000, resulted from an incident when she phoned him and expressed a concern she may have taken too much Xanax.[10]

Because of the events described above and Dr. Hicks' polysubstance abuse diagnosis, Dr. Hicks told respondent that she would have to address her chemical dependency before she could address other problems (i.e., anxiety, depression). Respondent disagreed with Dr. Hicks, who then told her that he could not treat her if they had such a fundamental difference in approach. As a result, their therapeutic relationship was terminated in April 2003.

11. Dr. Hicks testified that respondent's above-described impairment could but was unlikely to have resulted from taking her medications as prescribed.[11] He added that under the

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[7] "Polysubstance Abuse" is not identified as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Instead, substance abuse mental disorders are identified by categories, e.g., Cannabis Abuse, Hallucinogen Abuse, Opioid Abuse. Additionally, the disorder of "Polysubstance Dependence" is recognized.

[8] Respondent had 17 sessions with Dr. Hicks during this period.

[9] Dr. Hicks also testified that at one point he suggested that respondent stop taking Xanax, and she protested "vociferously." This caused Dr. Hicks to believe that Xanax was a drug of choice and was hurting her.

[10] Xanax is a benzodiazepine used to treat anxiety and panic attacks.

Dr. Hicks testified about what was possibly a distinct incident, when, on December 16, 2002, respondent called and told him that she had taken over 50 Xanax tablets, as well as two Vicodin tablets and two wine coolers to "knock her out."

[11] In addition to Xanax and narcotics, which Dr. Hicks was aware that respondent was

totality of the described circumstances, he did not believe that her impairment could reasonably be explained in that way.

Dr. Hicks testified that once an individual is diagnosed with polysubstance abuse, the diagnosis in some sense follows or remains with the patient, even during periods when the patient is not using the drugs in question, and even though the patient is not impaired during periods of non-use. This is especially the case if a chemical dependence is "primary," i.e., genetic. If, on the other hand, the dependence is "secondary," i.e., arises out of an attempt to address a particular primary problem such as depression, migraine headaches or anxiety, and if the primary issue is successfully addressed, the likelihood of relapse into drug abuse is substantially less, though not "zero." He added that if respondent did not undergo a "downward spiral" within the past six years, he would think that she had managed to get "clean and sober."

12. Since respondent left Dr. Hicks' care in April 2003, Dr. Hicks has had no contact with respondent's other health care providers or colleagues.

13. During his testimony, Dr. Hicks exhibited a palpable degree of hostility toward respondent and toward members of her family who were present at the hearing. At times he seemed inclined to assume the worst about respondent. For example, he did not contact her colleagues because he "knew" that she would not have given him permission to do so.

14. Michael Ricciardi, M.D., is a staff psychiatrist at the Naval Medical Center of San Diego. From 2001 to 2006, he practiced at Mesa Vista. Respondent came under Dr. Ricciardi's care in late November 2002, on referral from Dr. Hicks, and remained under Dr. Ricciardi's care until mid April 2003.[12] Dr. Ricciardi testified with regard to some of his medical records, but he had practically no independent recollection of respondent or his treatment of her. Mesa Vista (and other) records reflected that respondent underwent four acute psychiatric inpatient hospitalizations in December 2002 and early January 2003, precipitated by a crisis relating to her employment with the Navy.

a. *December 11, 2002.* In a Mesa Vista admission history dated December 11, 2002, Dr. Ricciardi referred to respondent's problems with the Navy, and in particular to the recent issuance of a 1,000 page EEO report, which essentially exonerated everyone but her in connection with a sexual harassment claim she had filed against a fellow radiology resident.[13] On the evening of December 11, 2002, respondent "began to have thoughts of suicide and of self-injury. She was uncomfortable with remaining at home, fearing that to do so would allow opportunity for her to hurt herself or her children. She sought counsel with . . . Dr. Hicks, who

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taking, respondent at some point advised him that she was taking pursuant to prescription Neurontin, another pain medication, initially 900 mg, but later 1,200 mg. Dr. Hicks testified that at the 1,200 mg level, Neurontin can also cause impairment.

[12] Respondent was under Dr. Ricciardi's care in connection with her several admissions into the CIOP and one or more of her inpatient admissions at Mesa Vista.

[13] This incident is described below.

recommended referral to the inpatient unit."[14] Dr. Ricciardi described respondent as "awake, tired, alert, and oriented to person, place, time, and situation," and also "depressed and dejected." Her speech was described as "spontaneous and regular in rate, rhythm, modulation, and volume. Thought processing is logical, linear, and goal directed." Respondent expressed "concern for her own safety at home given the frequency of the suicidal ideas and the safety of her children as well. When she considers suicide she is burdened with guilt of leaving her children and has commented more than once that she would have to take the children with her."[15] Dr. Ricciardi's "psychiatric impression" included major depression, chronic, severe, without psychosis and anxiety disorder not otherwise specified. He referred as well to respondent's migraine headaches. He made no reference to substance abuse. Respondent was discharged on December 13, 2002.

b. *December 16, 2002.* In a Mesa Vista CIOG discharge summary dictated on February 3, 2003, Dr. Ricciardi stated that respondent was discharged from the CIOP on December 17, 2002,[16] and admitted to the inpatient unit, because she "was expressing suicidal ideas." From there, respondent was referred to the Naval Medical Center San Diego (NMCSD).[17]

According to NMCSD records, respondent stated that at about 6:00 p.m. on December 16, 2002, she took 45 Xanax tablets,[18] two Vicodin,[19] and three wine coolers, explaining that she felt "very stressed" and "wanted to go to sleep" or "take a break."[20] She later corrected herself, stating she had taken "closer to 10 mg" Xanax. Respondent denied suicidal intent. After taking the medication, respondent called her psychiatrist, Dr. Hicks, who told her to go to the hospital. She went to the Sharp Coronado Hospital emergency room, and, after she was medically cleared from her Xanax overdose, she was transferred to NMCSD. Respondent related to NMCSD staff some of the details concerning her sexual harassment complainant, as well as several other Navy-related "stressors" with which she was trying to cope. She described semi-weekly panic attacks, which she treated with Xanax. She stated that she had been diagnosed with major

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[14] Dr. Ricciardi testified that the information recited here came from respondent herself.

[15] Dr. Ricciardi testified that he thought respondent meant by this last comment that if she killed herself, she would kill her children as well. He did not explain the basis for his opinion. Respondent testified that she did not make this comment at all.

[16] Respondent's inpatient admission was the prior evening, December 16. She was discharged from the CIOP on December 17, after program staff called respondent's home and learned from respondent's husband of her inpatient admission the night before.

[17] NMCSD was respondent's duty station, and her transfer there caused her substantial additional anxiety and embarrassment. It was not claimed, however, and the evidence did not suggest, that the transfer to NMCSD was other than coincidental.

[18] NMCSD documents variously record respondent claiming to have ingested 45, 50, or 60 Xanax.

[19] Vicodin is an opioid used to treat pain.

[20] As set forth below, respondent denied that she ingested any alcohol or Vicodin. Lab test results from later in the evening of December 16 were negative for opiates and alcohol, thus supporting her testimony.

depression, general anxiety disorder, and post-traumatic stress disorder. Respondent was given a mental status exam. Her level of consciousness "was alert and nonfluctuating and the patient was oriented in four spheres." Her speech "was characterized by normal rate and rhythm." Her memory "appeared intact," and her "[a]ttention and concentration skills appeared unimpaired." Respondent's discharge diagnoses included major depressive disorder, panic disorder, general anxiety disorder, migraines, and occupational problems. Respondent was discharged on December 17, 2002.[21]

c. *December 27, 2002.* In an admission history dated December 31, 2002, Dr. Ricciardi referred again to the EEO report. He stated that after returning home earlier that day from the CIOP, respondent "found herself becoming more agitated, anxious and depressed" and went to her parent's home. "There she continued to experience worsening of her depressed mood and emergence of suicidal ideas in the form of taking an overdose of medications with the hope of sleeping through the weekend." Her parents then drove her to the hospital. Respondent was "drowsy, awake, and alert," and "fully oriented to person, place, time, and situation. Her speech is responsive, low in volume, somewhat slow, but otherwise regular in rate and modulation." Her "thought processing is slow but linear and goal directed." He added, "The patient's cognitive functions are mildly impaired with deficits of concentration and short-term memory." Dr. Ricciardi's psychiatric impressions included major depression, chronic severe without psychosis and anxiety disorder not otherwise specified. He also referred to her migraine headaches. No reference was made to substance abuse. Respondent was discharged on December 30, 2002.

d. *January 5, 2003.* In an admission history dated January 6, 2003, Dr. Ricciardi referred to respondent's four recent "acute episode[s] of depression with suicidal ideation," resulting in admissions at Sharp Mesa Vista and Balboa Naval Hospital. Dr. Ricciardi noted that respondent "does not take lethal overdoses as a suicide act,[22] but has now twice overdosed on prescribed medications, the first time Xanax and currently Vicodin."[23] Dr. Ricciardi described respondent's present mental status as, inter alia, "drowsy, awake and alert. She is oriented to person, place, time, and situation. . . . Cognitive functions are mildly impaired with deficits of concentration and short term memory." His psychiatric impressions included major depression, chronic severe without psychosis, anxiety disorder not otherwise specified, and migraine headaches. Substance abuse was not included among Dr. Ricciardi's impressions. Respondent was discharged on January 6, 2003.

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[21] The matters set forth in this paragraph are based primarily on NMCSD medical records, not those of Dr. Ricciardi.

[22] However, according to a nursing admission assessment dated January 5, 2003, respondent stated that she had tried to commit suicide in December 2002.

[23] Dr. Ricciardi testified that the reference to a "current" Vicodin overdose pertained to the then-current hospitalization. His report did not provide any details as to what this overdose involved. It is possible that the "overdose" in question was respondent's taking of two Vicodin tablets on one occasion within a shorter time interval than prescribed (see Finding 35).

15. In a chart note dated January 22, 2003, Dr. Ricciardi wrote that respondent "had an argument with her mother yesterday afternoon because mother questioned the safety of the children with her." In a note dated January 29, 2003,[24] respondent was noted to be lethargic, with "affect blunt, pupils pinpoint, reacting equally to light, speech slurred, gait steady. Stated felt very tired. Was up last night with baby and relates, feeling [illegible] groggy with Neurontin."

In an outpatient progress note dated April 3, 2003, Dr. Ricciardi noted respondent's statement that "she has not acted on [suicidal ideation] however has missed Dilaudid[25] prescribed for headache." Dr. Ricciardi cautioned respondent "to not misuse medication—either analgesics, anxiolytics and other psychotropics." In his assessment, Dr. Ricciardi wrote, "Pt at this time is functioning poorly and in a regressed state of dependency." This statement was made in the context of respondent's service in the Navy, not medications.

In an outpatient progress note dated April 7, 2003, Dr. Ricciardi's "impression" was Depression, Anxiety and Benzodiazepine abuse. Dr. Ricciardi testified in somewhat unclear terms to the distinction between an "impression" and a formal "diagnosis." Dr. Ricciardi's note did not explicitly state the basis for his impression of substance abuse. However, the note states, "Girlfriend and parents now saying they think she has become drug dependent." Further, the note refers to a conversation Dr. Ricciardi had with Dr. Hicks. It thus appears likely that Dr. Ricciardi's impression of substance abuse was based primarily on the perceptions of respondent's family members and the opinion of Dr. Hicks.

In Dr. Ricciardi's April 11, 2003, discharge summary, he identified major depression, chronic, severe, without psychosis and post-traumatic stress disorder as respondent's diagnoses. He also made reference to anxiety, to "vague suicidal ideas," and to respondent's migraine headaches. He also noted, "At the time of discharge, the patient was able to accept and tolerate active duty service in the Navy . . . ." He made no reference to substance abuse.

16. Luis Becerra, M.D., is a board-certified neurologist, a Commander in the United States Navy, and an Assistant Clinical Professor of Surgery at the Uniform Services University. Respondent was one of Dr. Becerra's neurology students, and she was also his patient, from August 2001 to September 2003, when he treated her for migraine headache pain at the regional Navy headache clinic he headed as part of his duties as Head of the Neurology Division at NMCSD.

Dr. Becerra testified that among the medications he prescribed for respondent were beta blockers and, in late 2002 to early 2003, Neurontin and Topomax. These medications, even when taken as prescribed, can have significant side effects, such as diminished attention and concentration, and apparent impairment. With regard to Neurontin, significant side effects are possible at the 300 mg level (the "starting" dose), but the usual dose is much higher, from 900 to

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[24] The identity of the person who prepared this chart note is not known. It is, however, a Sharp Mesa Vista team progress note; Dr. Ricciardi is listed as the assigned physician.

[25] Dilaudid is an opioid spray used for pain relief.

1200 mg. He started respondent out at 300 mg, then later increased her dosage to 900, and then finally to 1200 (around early summer 2002).

Dr. Becerra testified that he never suspected respondent of abusing her medications, and never thought she was a drug-seeking patient. He added that between 2001 and 2003, he was the Chair of the Pharmacy and Therapeutics Committee, i.e., the narcotics "Czar." In that capacity, he had to know who was and who was not dependent on medications.

Dr. Becerra testified that he was aware of respondent's allegations of sexual harassment; he counseled her to address them by following the chain of command. Based on that harassment and respondent's physical condition, Dr. Becerra felt that she should leave the Navy. With regard to her headaches, respondent was found fit for duty by the Central Physical Evaluation Board. She was, however, later discharged as unfit for duty due to depression. Her migraines were a "factor" in her discharge.

January to August 2007

17. Rene Endow-Eyer, Pharm.D., is employed at the VA Hospital in San Diego as a psychiatric clinical pharmacist. She sees patients one-on-one (as a psychiatrist would) and prescribes medication under protocol. She is engaged, inter alia, in medication management, i.e., the prescribing, adjusting, and changing of medications. Dr. Endow treated respondent from October 2005 to February 6, 2007. Respondent was formally released from Dr. Endow's care on March 13, 2007.

During respondent's first visit with Dr. Endow, respondent denied alcohol use. Respondent identified Triazolam, a benzodiazepine, for insomnia, and Buproprion (Wellbutrin)[26] as the medications she was currently taking. Respondent did not advise Dr. Endow concerning any prescriptions for Dilaudid spray or Norco/Vicodin.[27] Dr. Endow testified that she would have wanted to know if respondent were taking other medications (e.g., for pain management), so as to avoid unintended duplication of therapy and to guard against unintended drug interactions. Dr. Endow prescribed Temazepam, also a benzodiazepine, for respondent's insomnia. Dr. Endow testified that it was her understanding that respondent would no longer be receiving Triazolam or any other benzodiazepine. Dr. Endow's prescription of Temazepam was also based on her understanding that respondent was not drinking alcohol—if she had known otherwise, it would have affected her continued prescription of a benzodiazepine.

In March 2006, Dr. Endow issued a prescription to respondent for Wellbutrin.

In May 2006, Dr. Endow increased respondent's Temazepam prescription from 30 to 45 mg. She did so based on the belief that respondent was not receiving benzodiazepines from any

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[26] Wellbutrin is an antidepressant.

[27] Norco is an opioid, used to treat pain. It is very similar to Vicodin, but each Norco tablet contains 10 mg of the opiate hydrocodone, whereas each Vicodin tablet contains only 5 mg of that drug.

other source. Dr. Endow testified that she was not sure she would have increased the dosage had she known that respondent was receiving benzodiazepines from another source. At this time, according to Dr. Endow's notes, respondent again denied alcohol use.[28]

On January 9, 2007, respondent expressed concern that "at times anxiety is too much for her while driving, stutters while speaks." On that date, Dr. Endow first issued to respondent a prescription for Lorazepam (Ativan), another benzodiazepine used to treat anxiety.

On January 23, 2007, at least in part based on respondent's suggestion, Dr. Endow increased the dosage of that prescription. At the same time, Dr. Endow discontinued respondent's prescription for Temazepam. Respondent advised Dr. Endow at this time that she had seen psychiatrist Laura Vleugels the preceding week, and that respondent had received Ambien CR[29] from that source. Respondent did not mention receiving benzodiazepines or Wellbutrin from any other source. Dr. Endow testified that if she had known respondent was receiving Wellbutrin from Dr. Vleugels, she would not have continued prescribing it, due to the danger of seizures at high doses. Dr. Endow also noted, "pt seems to minimize her symptoms and this is the first time she's been honest with her symptoms with writer."

On February 6, 2007, with respondent's agreement, Dr. Endow decreased respondent's Lorazepam prescription because respondent was noted to have "slurring speech." Dr. Endow also noted respondent was "somewhat unsteady walking down the hallway." Dr. Endow testified that if respondent were getting this medication elsewhere, that could also cause slurred speech, as could taking too high a dosage of the medication.[30] Dr. Endow also noted at this time that respondent "seems to minimize her symptoms."

On February 27 and March 7, 2006, respondent executed medical releases so that Dr. Endow and Dr. Vleugels could communicate with each other about her. On March 13, 2007, Dr. Endow phoned Dr. Vleugels. Dr. Endow and Dr. Vleugels discussed medications that each had prescribed to respondent. Dr. Endow learned that both she and Dr. Vleugels were prescribing

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[28] On several other occasions, Dr. Endow's notes reflected respondent's denial of alcohol use. Dr. Endow testified that it is her practice to manually enter (type) this information into each electronic chart note; she admitted, however, that she had no independent recollection of having done so in this case, or of her conversations with respondent about alcohol use. Dr. Endow's numerous references to respondent's alcohol and drug use consisted of the following identical language. "Denies ETOH/drug use. Denies tobacco use. Drinks occ caffeinated soda 3-4x/wk. Is being followed in FIRM [i.e., medical providers]." The conclusion seems inescapable that, whatever Dr. Endow's standard practice, in this case she in fact copied and pasted the quoted language into her notes on each occasion. Dr. Endow's claim that respondent repeatedly told her that she did not drink alcohol is thus rendered somewhat questionable. It is rendered more questionable by the undisputed fact (see below) that respondent freely told Dr. Vleugels that she drank alcohol.

[29] Ambien is used to treat insomnia.

[30] Dr. Endow testified that slurred speech can also be a side effect when the medication is taken as prescribed.

Wellbutrin XL to respondent.[31] As a result of her conversation with Dr. Vleugels, and because it would create a conflict for a patient to see two different providers for medications, as well as a risk of duplication of services and unintended drug interactions, Dr. Endow discontinued all medications she had prescribed to respondent. Further, Dr. Endow and the VA "team" determined that it was not in respondent's best interest to receive treatment and medication management from two providers, and that respondent should therefore be given the option to choose between the VA and Dr. Vleugels. It was respondent's decision to terminate her treatment with Dr. Endow.

Dr. Endow never had a concern that respondent had a drug abuse or dependence problem. She never observed respondent impaired and she never believed that respondent was taking excessive medications.[32]

Dr. Endow testified in an objective, fair manner. She did not come across as attempting to advocate for or against respondent.

18. Laura Vleugels, M.D., is a psychiatrist, licensed in California since 2003. She treated respondent from January 2007 to October 2008. From the outset, it was Dr. Vleugels' understanding that respondent was transferring her psychotherapeutic treatment from Dr. Endow to herself.

Dr. Vleugels stated[33] that at her initial session with respondent on January 12, 2007, respondent identified her symptoms as including "very poor concentration medical school—on (i.e. CME lectures)," "worried about catching pedestrians (driving),"[34] "exhaustion all the time," and "fatigue – wants to go to bed as soon as she gets home." Respondent told Dr. Vleugels that she had suffered from migraine headaches since she was in her early twenties. Among the medications respondent told Dr. Vleugels she was taking were Citalopram (Celexa), Fioricet,[35] and Dilaudid spray. Respondent stated that her alcohol use was "rare." Dr. Vleugels did not note in her chart that respondent identified Vicodin as one of her pain medications; she thus did not believe that respondent told her she was taking that drug. Dr. Vleugels' assessment included diagnoses of major depressive disorder (MDD), general anxiety disorder (GAD), and post traumatic stress disorder (PTSD). With regard to her plan, she noted, "No change in meds at this time—will send for VA records [and] Gifford records."

On January 17, 2007, respondent brought two VA medications to show Dr. Vleugels, Wellbutrin and Citalopram. Dr. Vleugels prescribed Lorazepam for respondent's anxiety. Dr.

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[31] As found below, Dr. Vleugels was already aware of this fact, since respondent had told her so.

[32] These facts are inferred from the absence of any such notations in Dr. Endow's chart.

[33] The Factual Findings relating to Dr. Vleugels are based both on Dr. Vleugel's testimony and on her chart notes.

[34] Dr. Vleugels was not certain but believed this chart note referred to respondent's anxiety, not to any substance abuse issues.

[35] Fioricet is a barbiturate used to treat headache pain.

Vleugels did not know at the time that respondent had already been prescribed a benzodiazepine from another source—though that knowledge would not have affected her decision to prescribe Lorazepam to respondent. Dr. Vleugels' assessment and plan remained unchanged. On January 24, 2007, Dr. Vleugels prescribed Clonazepam (Klonopin), another benzodiazepine, used to treat anxiety, and continued two prescriptions, for Wellbutrin and Citalopram,[36] which respondent had received from the VA. Dr. Vleugels noted that respondent's sleep had "markedly improved on Ambien CR."[37] Her diagnosis remained unchanged. On January 31, 2007, respondent advised Dr. Vleugels that a pharmacist at the VA told her two weeks before that "Celexa wasn't for me." Dr. Vleugels did not know at this time that the VA pharmacist had been prescribing benzodiazepines to respondent. Dr. Vleugels' assessment at this time was major depressive disorder (MDD), general anxiety disorder (GAD), and "panic."

On February 7, 2007, respondent told Dr. Vleugels that she had one drink per night. Dr. Vleugels "encouraged" respondent not to drink alcohol while taking benzodiazepines, due to the "additive effect," and noted that respondent "verbalized understanding." Dr. Vleugels' diagnosis remained unchanged.

On February 14, 2007, respondent told Dr. Vleugels that she had consumed two drinks during the preceding week. Dr. Vleugels again "cautioned [respondent] @ use of ETOH [i.e., alcohol] w/benzos given additive effect." Dr. Vleugels' diagnosis was MDD, GAD and post-traumatic stress disorder (PTSD). As of that date, respondent had still not told Dr. Vleugels that she had been prescribed Ativan from the VA.

On February 26, 2007, respondent told Dr. Vleugels about a conflict she had had with her husband while on vacation. According to Dr. Vleugels' chart note, respondent's husband expressed concern "about medicines combining and leading to" side effects. Specifically, respondent woke up with a headache one day after drinking two piña coladas the previous evening, and took dilaudid nasal spray.[38] Respondent's husband "felt she was unsteady on her feet, confused (per pt). He took away her meds" for one day. Respondent explained to Dr. Vleugels that she took Dilaudid spray, albeit rarely, and that her husband "has always had concern about dilaudid." Respondent made reference to a Dr. Tiffany, whom she saw every three months, and from whom she received "pain control" medications for her headaches. Dr. Vleugels' diagnosis was "MDD recurrent severe," "GAD w/panic," and PTSD. Dr. Vleugels "[d]iscussed importance of not drinking w/combo of benzos/narcotics." She noted that respondent "agrees not to drink," and "not to use nasal spray/dilaudid." Dr. Vleugels noted that

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[36] Like Wellbutrin, Citalopram is an anti-depressant.

[37] Dr. Vleugels testified that she did not know how or where respondent received this medication. Dr. Vleugels believed that she may have given respondent samples; her chart notes did not reflect this, however.

[38] Dr. Vleugels testified that if respondent used the Dilaudid spray "a number of hours" after she consumed the drinks, there would not have been an additive effect. Dr. Vleugels believed that in fact the alcohol respondent had consumed the preceding evening would have been out of her system by the time she took the Dilaudid spray.

she had phoned and left a message for Dr. Endow at the VA, and that respondent told her she was no longer seeing Dr. Endow.

On February 26, 2007, after her session with respondent, Dr. Vleugels received a phone message from respondent's husband, Mark. According to Dr. Vleugels, she called respondent, who "gave me permission to return his call but preferred that I not release info w/o her being present." According to her chart notes, Dr. Vleugels called Meoni, who expressed concern "that Jill is not presenting a clear picture of her medications. He notes she was extremely sedated last week 'this isn't the first time . . .' 'She is in denial.'" Meoni felt that Dr. Vleugels did not have a clear picture of what respondent was taking and the impact of her medication on her. Dr. Vleugels did not recall at the hearing whether Meoni's concern was about medications in general, or about Dilaudid in particular.

On March 7, 2007, respondent advised Dr. Vleugels that she had "had a bad [headache] the other night—husband had taken her Dilaudid & not given it back. Husband rubbed her head. Took Fioricet—didn't help." Respondent told Dr. Vleugels she was very upset that Meoni had called Dr. Vleugels, and that Meoni's lack of understanding of respondent's depressive and anxiety disorders was causing some conflict between them. Dr. Vleugels' diagnosis at this time was MDD, GAD, and PTSD. Dr. Vleugels discussed her recommendation that respondent decrease her use of benzodiazepines, and reviewed the side effects, including "mental clouding, sedation, care with driving potential for abuse/dependence, risks of combing with other meds—esp narcotics. No ETOH." Dr. Vleugels noted that respondent "agrees not to drink ETOH" and "[n]o longer plans to take Dilaudid for migraine pain."

On March 13, 2007, Dr. Endow phoned Dr. Vleugels, and they spoke concerning the various medications that each had prescribed for respondent. Dr. Endow told Dr. Vleugels that she had prescribed Lorazepam to respondent. Dr. Endow told Dr. Vleugels that she had terminated her care of respondent and would no longer be providing further treatment or medications for respondent. Until her conversation with Dr. Endow, Dr. Vleugels was unaware that respondent had been prescribed a benzodiazepine from another provider.

On March 14, 2007, Dr. Vleugels "confronted [respondent] with my concerns about her taking benzos from 2 sources, her having had at least 3 episodes of oversedation,[39] her continued use of ETOH, her need for narcotics." Respondent denied that she took more benzodiazepines than had been prescribed, and explained that she "felt badly about terminating with [Dr. Endow] and that the VA mailed refills." Dr. Vleugels stated that respondent had never disclosed to her that she was receiving benzodiazepines from the VA on an on-going basis, and that this raised a "red flag," as one indication of substance dependence is securing medication from multiple sources. Further, Dr. Vleugels was concerned that if respondent took too many benzodiazepines, this could result in oversedation, as could her taking benzodiazepines in combination with alcohol. Dr. Vleugels noted, "While [respondent] is not accepting of my concerns of substance dependence, she agrees with my plan to taper her off benzodiazepines. She agrees not to obtain

[39] Dr. Vleugels testified that the source of this information was respondent herself, as well as Mark's more general concern that respondent was oversedated.

benzos from other sources." Dr. Vleugels felt that respondent minimized Dr. Vleugels' concerns about respondent's securing benzodiazepines from two sources, offering as an explanation that she continued to receive these drugs from the VA, because they were shipped to her automatically. Regarding respondent's narcotic use, Dr. Vleugels was concerned that such use might lead to drug interactions with the medications she (Dr. Vleugels) was prescribing or to side effects that could impair respondent. Dr. Vleugels' diagnosis was MDD, GAD, PTSD, and, for the first time, "benzo dependence?"[40] Dr. Vleugels' plan included "No ETOH" and that respondent "agrees for all benzos to come from me."

On April 25, 2007, Dr. Vleugels noted that respondent complained of "difficulty w/focus at work." She also stated, however, that "concentration has improved—i.e. @ CME." Respondent told Dr. Vleugels that she was not taking Dilaudid spray, but instead Fioricet as needed, for her headaches. Dr. Vleugels' diagnosis was MDD, GAD, PTSD, and "Benzo abuse?"

On May 9, 2007, Dr. Vleugels' diagnosis was PTSD, GAD, MDD and "benzo abuse." No other information noted in the chart explains or suggests why the question mark was deleted from the "benzo abuse" reference. Dr. Vleugels testified that at this point, she had still not made a formal diagnosis of benzodiazepine abuse, but was keeping it on her list as something she was considering.

On May 30, 2007, respondent informed Dr. Vleugels of her May 24-25 hospitalization, "secondary to altered mental state."[41] Respondent admitted to using alcohol and headache medications on the date she was hospitalized, but denied any intentional overdose. She agreed to sign a release so that Dr. Vleugels could secure the relevant medical records. Dr. Vleugels' diagnosis remained unchanged. She cautioned respondent with regard to the use of alcohol and opioids.

On June 6, 2007, Dr. Vleugels reviewed certain medical records relating to respondent's recent hospitalization. She testified that the statement in one document (a narrative summary of respondent's hospitalization) that respondent had had "a couple drinks of ETOH daily over the past several days to help her sleep" was inconsistent with respondent's statements to Dr. Vleugels that she was not consuming any alcohol. Based on her review of the records, Dr. Vleugels understood that altered mental state was one of the diagnoses of respondent, and that respondent underwent a psychological evaluation. Dr. Vleugels' diagnosis was MDD, GAD, and PTSD; benzodiazepine abuse was no longer mentioned. No explanation for its absence was provided, but Dr. Vleugels testified that its removal meant that it was no longer an ongoing concern for her. On no subsequent occasion during her treatment of respondent did Dr. Vleugels identify substance abuse as a possible or actual diagnosis of respondent.

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[40] Dr. Vleugels testified that this note (in particular the question mark) meant that possible benzodiazepine dependence was becoming a concern to her, but was not at this point a formal diagnosis.

[41] 41 This hospitalization is described below.

On June 13, 2007, respondent informed Dr. Vleugels that she had had a rum and Coke the previous evening. Dr. Vleugels testified that doing so was contrary to respondent's agreement not to consume alcohol. Dr. Vleugels' diagnosis was unchanged.

On July 18, 2007, respondent reported increased anxiety, and "Had feeling crossing the bridge this am—had intrusive thought of driving off the bridge." Dr. Vleugels did not recall that this intrusive thought was a recurring one. Respondent reported "no significant use" of headache medication. Respondent did not report that she had taken Vicodin as prescribed by Dr. Umansky in connection with any plastic surgical procedure.[42] Dr. Vleugels' diagnosis remained unchanged.

On August 1, 2007, respondent told Dr. Vleugels that she was "just a basketcase,"[43] that she had "really bad anxiety—all day, everyday. Trouble thinking clearly." Respondent was experiencing "horrible" headaches, and was taking "round the clock Fioricet."[44] Dr. Vleugels' diagnosis remained unchanged.

19. On August 8, 2007, Dr. Vleugels submitted a complaint to the medical board about respondent. She wrote:

> "This physician struggles with chronic severe headaches and an anxiety disorder. She is on multiple medications. She was recently admitted to the hospital for altered mental status. She was under the influence of prescribed medications and admitted to recent alcohol use. I have concerns about this physician—she is a radiologist who is on call at all times to read images. Her prescription drug use, alcohol use may impair her ability to work."

Dr. Vleugels testified that she initially contacted the medical board because of three "red flags": (i) Respondent's receipt of benzodiazepines from two sources; (ii) Mark Meoni's phone call reflecting that respondent was having problems relating to medication; and (iii) respondent's May 2007 hospitalization. Her purpose in placing the call was to ascertain whether she was required to report respondent to the board. The board's representative told her that she "might want to file" the complaint, for "ethical reasons." Based on this statement, Dr. Vleugels felt compelled to file the complaint.

20. On November 28, 2007, respondent and Dr. Vleugels discussed a letter respondent had received from the medical board informing her that a complaint had been filed against her. Respondent "firmly believes someone in radiology reported her." Dr. Vleugels did not tell respondent that she herself was the reporting party. Substance use was discussed. Respondent told Dr. Vleugels she was decreasing her use of Dilaudid spray, and denied "obtaining from other sources.[45] Respondent acknowledged receiving benzodiazepines from two sources (i.e.,

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[42] Dr. Umansky's care of respondent is described below.

[43] This phrase is in quotation marks in Dr. Vleugels' chart notes.

[44] Again, the phrases are in quotation marks in Dr. Vleugels' notes.

[45] Dr. Vleugels testified that she did not recall ever hearing about a Dr. Umansky or the

Dr. Vleugels and the VA), and explained that this was because "she didn't want to tell VA she had a new care provider." Respondent further pointed out that "she tapered off without protest when evident they were not effective." Respondent also acknowledged having one drink per night on occasion. Respondent did not believe substance use was "problematic." Dr. Vleugels discussed with respondent the possibility of consulting with an addiction specialist, to which respondent replied, "That would be like my telling them [i.e., the medical board] they're right!"

21. Dr. Vleugels continued to treat respondent for over a year after filing the medical board complaint. Dr. Vleugels did not disclose to respondent that she was the individual who had filed the complaint until October 2008. Her disclosure effectively ended the therapeutic relationship. Dr. Vleugels testified that she did not tell respondent sooner because she did not want such a disclosure to interfere with their working relationship. In February 2009, respondent sent Dr. Vleugels an intent to sue letter.

Dr. Vleugels testified in an objective manner. She did not seem defensive when asked pointed questions. She did not exhibit any hostility toward respondent, but seemed to answer questions honestly. On the other hand, the pending lawsuit constitutes a substantial source of potential bias.

22. On March 18, 2007, respondent was treated by Dr. John Berry at Midway Urgent Care for acute ear pain secondary to earplug impaction. After cleaning respondent's ear, Dr. Berry discharged her with a prescription for Vicodin (16 tablets), which respondent filled the following day.

23. At about 3:00 a.m. on May 24, 2007, respondent was admitted to NMCSD with a complaint of ear pain. At that time, according to nursing notes, respondent "appears to be staggering and is in tears. Pt appears altered. Left ear pain. Pt slow to respond and answer questions." At 3:30 a.m., it was noted that respondent had "slurred speech, not appropriately answering questions. Pt anxious, tearful & stating 'my ear hurts.'" A note at 4:50 a.m. stated, "unable to maintain consent d/t [due to] AMS."[46] A note at 7:30 a.m. stated, "Pt continues to be irrational, tangential, weepy emotional." A psychological assessment was done at about 9:00 a.m. A blood alcohol test conducted at 11:30 a.m. reflected a blood alcohol content of 0.005 percent, i.e., a barely measurable amount. Lab tests were positive for barbiturates and opioids. As part of her treatment, respondent was administered morphine, which normally implies significant pain on the part of the patient. On physical examination at 1:00 p.m., respondent was found to be "awake, alert and oriented to time, person, place, and situation." Respondent was discharged on May 25 at 11:50 a.m. to the ENT clinic for further management of her mastoiditis.[47] At the time of discharge, respondent's diagnoses were "acute mastoiditis without complications," "depressive disorder, not elsewhere classified," and "migraine without intractable migraine."[48]

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prescription of Vicodin by Dr. Umansky to respondent.

[46] AMS refers to altered mental state.

[47] Mastoiditis is an inflammation (i.e., infection) of a bone behind the ear.

[48] The "admission diagnosis" had been identified as "altered mental status, Otitis Externa,

24. Frank Tiffany, M.D., is an internist. He is not Board certified. From 2004 to 2008, he was a staff physician at Dr. David Smith's San Diego Comprehensive Pain Management Center (PMC). He was terminated in February 2008,[49] and has since practiced as an independent contractor, engaging in internal medicine and pain management. He has no special training in pain management aside from what he has learned on the job.

Respondent was a patient at the PMC from early 2003 to at least December 2007. During most of this time, it was Dr. Tiffany who treated respondent for migraine headache pain. Dr. Tiffany testified that a number of different medications were tried to address respondent's severe migraine headaches, and she was eventually stabilized on a combination of Dilaudid, Fioricet, and Norco..

On April 9, 2003, respondent signed an "Informed Consent For Opioid Maintenance" agreement. The agreement stated, inter alia, that "I consent to receive prescriptions for all opioid medication(s) exclusively from Dr. David James Smith, at SDCPMC."

Dr. Tiffany tells patients to take whatever medication they need when they need it, so long as they don't exceed the total amount prescribed during the prescription period, i.e., he warns them that they only have a certain amount of medication that must last a certain period of time.

In 2005, respondent was prescribed Dilaudid spray to be used up to four times per day. From March 2005 to May 2007, respondent underutilized the spray. According to Dr. Tiffany, she used only nine spray bottles, though she could have gone through 17 bottles and still been "within the correct framework." Norco was also prescribed during much of this period.

In August 2007, Dr. Tiffany discontinued Dilaudid, since respondent wanted to try a different medication. Dr. Tiffany discussed Actiq (i.e., Fentanyl "pops")[50] with respondent, and he gave her a two-week supply, as a trial, with instructions that she take one pop twice per day. Dr. Tiffany also gave respondent a Norco refill, but asked her to hold off on taking it, to see if the Actiq was effective. In September 2007, Dr. Tiffany noted in his progress notes that respondent had been having some severe headaches recently. Further, "She states she cont[inues] to utilize the Actiq pops which she states at times is not as eff[ective] so she ends up using two pops at a time. She would like to discuss with MD what the next strength of the pop is." By January 2008, Dr. Tiffany's prescription to respondent was now two Actiq pops at a time, twice a day. In other words, at some point Dr. Tiffany modified his prescription of Actiq to coincide with the level of the medication that respondent was in fact taking.

Respondent never advised Dr. Tiffany of other medications she was taking as prescribed by other physicians. He was not aware whether any other doctor prescribed headache medications at the same time that he himself did. More specifically, he was unaware in June

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URI."

[49] Dr. Tiffany has sued Dr. Smith with regard to his termination.

[50] Fentanyl is an opioid, used to treat pain.

2007 that respondent was receiving Fioricet from a Naval hospital, at a time when he himself was prescribing to respondent another barbiturate, Fiorinal.[51] In a January 17, 2008 chart note, Dr. Tiffany stated, "Pt reports that she was prev[iously] obtaining fiorinal from Balboa Hospital. However states that she would like to obtain at this facility vs. Balboa. Pt denies any medication refills."

Dr. Tiffany testified that he would want to know if another physician were prescribing benzodiazepines. A failure to disclose these matters would "raise a red flag" for him. He explained that it is important for a physician to have this kind of information, to be sure that there is no unintended drug interaction. It could be dangerous if a patient does not inform her physician of all of her medications.

Dr. Tiffany testified that he had no indication that respondent used any medications inappropriately. He has never seen her somnolent and has never seen her impaired.

25. William Umansky, M.D., is a board-certified plastic and reconstructive surgeon. In November 2005, Dr. Umansky performed an abdominoplasty on respondent. Respondent had a post-operation serroma (fluid collection), lasting a little longer than average, so Dr. Umansky saw respondent for about three months post-surgery for that condition. His prescription of Vicodin in November 2005 for post-operative pain was within his usual custom and practice. Dr. Umansky was aware at the time that respondent was being treated elsewhere for migraine pain. He did not know she was receiving Dilaudid; he testified that even if he had known this, it would not have changed his own prescription.

Dr. Umansky performed two more surgical procedures on respondent in 2007, a liposuction (in July) and a second, related procedure (in September). In both instances, Dr. Umansky prescribed Vicodin for post-operative pain. Dr. Umansky was unaware that respondent was receiving Norco elsewhere at the time of his own Vicodin prescriptions. He testified that had he been so aware, he would have discussed the matter with respondent and, depending on the outcome of that discussion, may or may not have changed his Vicodin prescription. He might possibly, for example, have prescribed a stronger dose of Vicodin, if he concluded respondent's need for pain medication was greater than he originally thought to be the case.

Dr. Umansky testified that at no time did he believe that respondent was impaired, was abusing medication, or was engaging in drug-seeking behavior.

26. A Controlled Substance Utilization Review and Evaluation System (CURES) patient prescription history[52] reflected, inter alia, the following prescription-filling history of

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[51] Fiorinal is very similar to Fioricet and is used to treat headache pain.

[52] CURES patient prescription histories are compiled from information maintained by the Department of Justice, which consists of "Schedule II and Scheduled III prescription information that is received from California pharmacies and is therefore only as accurate as the information provided by the Pharmacies." Fioricet and Fiorinal, as well as benzodiazepines, are Schedule IV

respondent:

a. Between November 7 and 18, 2005, respondent filled three prescriptions for Vicodin, for a total of 110 tablets, prescribed by Dr. Umansky in connection with the plastic surgical procedural she underwent that month. She did not fill any other prescriptions for Vicodin or Norco during November 2005. However, she did during that month fill prescriptions for Fiorinal and Dilaudid spray, prescribed by PMC's Dr. Tiffany.

b. Between December 2005 and January 2007, respondent filled one prescription for Norco (20 tablets), four for Dilaudid spray, and two for Fiorinal (120 tablets), all prescribed by Dr. Tiffany.

c. In February and March 2007, respondent filled one prescription for Dilaudid spray and, on March 11, one for Norco (60 tablets), prescribed by Dr. Tiffany. On March 19, 2007, respondent filled one Vicodin prescription (16 tablets), prescribed by Dr. Berry for her ear pain. Between February 21 and March 7, she also filled three prescriptions for benzodiazepines prescribed by Dr. Vleugels (60 1 mg tablets of Clonazepam, 30 1 mg tablets of Lorazepam,[53] and 45 0.5 mg tablets of Lorazepam), as well as one prescription for Ambien CR (30 12.5 mg tablets), also prescribed by Dr. Vleugels.

d. Between May 10 and August 9, 2007, respondent filled one Dilaudid spray prescription and four Norco prescriptions (300 tablets), prescribed by Dr. Tiffany. In addition, respondent filled four Vicodin prescriptions (120 tablets), prescribed by Dr. Umansky in connection with the liposuction he performed in July 2007. Respondent did not fill any of the Dr. Tiffany prescriptions during the period she filled the Dr. Umansky prescriptions (i.e., July 12 through August 1).[54]

e. Between August 29 and December 13, 2007, respondent filled one Norco prescription (90 tablets) and five Fentanyl prescriptions (270 pops), prescribed by Dr. Tiffany. Respondent also filled one Vicodin prescription (30 tablets), prescribed by Dr. Umansky, in connection with the November 2007 procedure.

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depressants (Health & Saf. Code, § 11057, subd. (d)), and thus would not necessarily be identified in CURES histories, though at times, for reasons apparently not known to the parties, they do. Drugs prescribed by the VA (e.g., by Dr. Endow) also do not appear on CURES reports.

[53] This particular prescription was filled on February 24, 2007. Though not reflected on the CURES report, two days later respondent filled a Lorazepam prescription (60 2 mg tablets) that had been prescribed by Dr. Endow.

[54] It appears that respondent filled another Vicodin prescription, not reflected on the CURES report, 15 tablets on May 25, 2007, in connection with her discharge from the hospitalization of the previous day.

Respondent's Testimony

27. Respondent and her husband Mark were married in 1994. The couple has four children, presently 13, 12, 7 and 4 years old.

28. Respondent began her residency in radiology at NMCSD in 1998. She was the only female in her class.

Respondent testified that during the course of her residency, one of her male colleagues acted in inappropriate ways. Matters became more serious, despite respondent's attempts to talk to her colleague about his conduct, and during her second year respondent went to her program director. Finally, in March 2002, respondent filed a formal sexual harassment complaint. Shortly after filing the complaint, respondent was removed from her residency at NMCSD and placed elsewhere for further radiological training. Eventually, she was reassigned to NMCSD, where she completed her residency. In November 2002, she became Board certified, passing the exam on her first attempt. At some point during this period, respondent decided to seek a medical discharge from the Navy. The Navy initially refused the discharge, finding her fit for duty (in early 2003). Later, in August 2003, the Navy discharged her, based on findings of depression and anxiety.[55]

29. Respondent testified concerning her four inpatient hospitalizations in December 2002 and January 2003.

a. *December 11, 2002.* Respondent testified that several days before she was admitted inpatient on December 11, 2002, she received her copy of the 1,000-page EEO report pertaining to her sexual harassment complaint. While she had concerns before the report was released about how objective or fair it would be, she nonetheless hoped that the report would vindicate her. When she reviewed it, however, she felt that it was unfair and biased. She became discouraged and disillusioned. She referred to the report as a "traumatic event." She felt that she needed some time alone to process the report, away from her family, and from her family responsibilities. She denied suicidal ideation. She stated that she did have thoughts about how the people who had hurt or betrayed her would feel if she were gone, i.e., if she killed herself, but she had no thoughts of actually ending her life, as that would leave her children without their mother.

b. *December 16, 2002.* Respondent testified that she was very stressed, was not sleeping well, and was continuing to think about the EEO report and the implications of that report for her Naval career. She was exhausted. She wanted to take a nap, get some rest, and let her husband take care of the children. To that end she took a "handful" of (about six to ten)

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[55] The record was unclear with regard to whether respondent formally sought the discharge, or whether the Navy alone can institute discharge proceedings. In either case, the evidence was clear that it was respondent's desire and intention to be discharged. It is also clear that her discharge was for medical reasons, and not on the basis of any improper conduct on her part.

Xanax. "The instant I took that Xanax, I knew I had made a mistake." She called Dr. Hicks to make sure that the amount she had taken would not be dangerous. She did not tell Dr. Hicks that she had taken 50 to 60 tablets.[56] Dr. Hicks advised her to go to the emergency room. She had her husband take her to the Sharp Coronado Hospital emergency room, where she spent several hours before being transferred to NMCSD. The transfer to her duty station upset her. Respondent denied that she took the Xanax in order to hurt, much less kill, herself—she just wanted to get some sleep. She in fact denied that admission on an inpatient basis was even medically necessary, though she felt it provided a therapeutic benefit to her.

c. *December 27, 2002 and January 5, 2003.* Respondent testified that the reasons for these two hospitalizations were the same as for the previous two, i.e., the enormous stress she was under in connection with the release of the EEO report, and the desire to have some time away from her family so that she could take care of herself without having to focus on other people.

Respondent testified that she has not had any inpatient hospitalizations for psychological reasons since the January 5, 2003 incident.

30. Respondent testified concerning the CIOG. She stated that the program was very helpful to her in three ways. First, it got her out of the Navy library, where she had been temporarily assigned during the pendency of her EEO complaint, and where she was getting hate mail. Second, it taught her a healthy pro-active way to deal with a life-altering event in her life (i.e., the EEO matter). Third, she missed having structure in her life—a goal, a purpose, a way to be productive.

Respondent testified with regard to the January 29, 2003, CIOP session that she had taken Neurontin the day before in the prescribed manner. She told CIOP personnel about the effects of Neurontin. Respondent thus attributes any perceived or actual impairment on January 29 to this prescription medication.

31 Respondent testified that she sought counseling from Dr. Vleugels as a result of the rescission of an offer of acceptance into a breast imaging fellowship at UCSD in late 2006. When respondent met Dr. Vleugels, respondent told her "about" Dr. Endow and signed a release so that Dr. Vleugels could secure records from the VA. Respondent also told Dr. Endow about Dr. Vleugels and signed a release so that Dr. Endow could secure Dr. Vleugels' records. Respondent acknowledged that she did not advise Dr. Vleugels about all of the medications (specifically Ativan) she was receiving from Dr. Endow, and vice versa; respondent explained that she was preoccupied at the time with the rescission of her UCSD fellowship and was also trying to determine which of the two providers (Dr. Endow or Dr. Vleugels) she was going to stay with. She stated she never intended to deceive either provider. During the three-week

[56] Respondent testified that she never told anyone that she had taken Vicodin or wine coolers. Negative lab test results for opiates and alcohol confirmed respondent's testimony.

"transition period" (i.e., between January 12 and February 6, 2007),[57] respondent expected that the two providers would be communicating with each other.

32. Respondent testified that during a Disneyland trip at the end of February 2007,[58] she had two piña coladas during dinner one evening, woke up the next morning with a headache, and took Dilaudid spray in an effort to abort the headache. Respondent did not take any benzodiazepines during the Disneyland trip. Respondent was using Dilaudid about twice per week at this time under Dr. Tiffany's care, in contrast to four times per day that she was previously using that medication under Dr. Smith. She added that Dr. Vleugels never instructed her not to drink alcohol. Indeed, on the occasions when respondent told Dr. Vleugels that she had consumed alcohol, Dr. Vleugels did not show much of a reaction.

33. With regard to the May 24, 2007 incident, respondent testified that she went to the emergency room because of an ear infection that was resisting treatment and whose symptoms were recurring and becoming very severe. She had taken Norco earlier in the day, but not benzodiazepines and not Dilaudid. She had a rum and Coke that day as well, around 7:00 p.m. She may also have had one the previous day. At the time she checked into the hospital, she had various pains in her head, e.g., ear ache, a migraine. She did experience a degree of altered mental state that day, but not through abuse of medications, i.e., she took them as prescribed. Respondent testified that she did not tell Dr. Vleugels that she had been hospitalized secondary to altered mental state—instead, respondent had a secondary diagnosis of altered mental state.

Respondent denied that she ever gave Dr. Vleugels permission to speak to her husband Mark. At some point in late February or March 2007, Dr. Vleugels informed respondent that Meoni had called her; Dr. Vleugels asked respondent whether she could speak to Meoni, or at least listen to what Meoni had to say. Respondent explicitly told Dr. Vleugels, "No," explaining that she had trust issues and did not want anyone to speak to her husband without she herself being present.

34. Respondent testified that in November 2007, for the first time, Dr. Vleugels suggested that she see an addictionologist—as a strategy in connection with the medical board investigation, i.e., to be proactive, to be able to go before the medical board and prove that she did not in fact have a substance dependency problem. Respondent did not like this idea.

35. Respondent testified that on only two occasions did she take more medication than prescribed or in a manner other than as prescribed: The Xanax incident of December 16, 2002, and an occasion when she took a Vicodin dose earlier—relative to her last dose—than was prescribed. She stated that when she took Neurontin under the care of Dr. Becerra, and her dosage was increased from 900 to 1200 mg, it caused her to become sleepy and groggy, but it did help to relieve her headaches. She disclosed these side effects to Dr. Becerra. Whenever

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[57] Respondent's first session with Dr. Vleugels was on January 12; her last with Dr. Endow was February 6, though she technically remained Dr. Endow's patient until March 13.

[58] The February 26, 2007, incident about which Dr. Vleugels testified occurred during the Disneyland trip.

respondent was or appeared sedated, it was the result of having taken her medications in the prescribed manner. Since she was not practicing at the time, she did not think the side effects of her medication were a problem with regard to the practice of medicine.

Respondent testified that during 2006 and 2007, she drank alcohol on a social basis, i.e., less than one drink per day.

36. Respondent testified that she did not carefully read the opioid informed consent contract she signed at the San Diego Pain Management Center. In particular, she stated she did not read the requirement that she only obtain opiates from the PMC. Further, she believed the medication she received from Dr. Umansky for post-operative pain was unrelated to the headache medication she received from the PMC. She conceded that she did not advise Dr. Tiffany about the medication she received from Dr. Umansky, and vice versa.

37. Respondent testified that the filling of Dr. Umansky's Vicodin prescription on July 19 was a mistake: Her husband picked up the prescription, not knowing that she herself had already picked it up the preceding day. Respondent's testimony thus implies a claim that the pharmacy mistakenly filled the same prescription twice.

38. Respondent testified that she has taken no Benzodiazepines since March 2007, and has taken no opiates since December 2007. The CURES reports confirm her testimony. Today, respondent deals with the stressors in her life by exercise, various mind/body techniques such as biofeedback and deep breathing, and with the assistance of a psychologist. She deals with her migraine headaches by taking beta blockers, which she recently started, and by taking Fioricet and Frova as needed.

39. Respondent testified that she has never missed work because of a headache. Her headaches do not cause her "functional impairment." She added that when she was Director of Radiology at Promise, she had the majority of coverage, and was responsible for obtaining coverage when she was not available. However, other radiologists were also available, and, in addition, she always had one day off per week. Accordingly, respondent took issue with a statement by Dr. Vleugels that respondent was on call "24/7."

40. At times during her testimony, respondent was argumentative; she seemed to be advocating on behalf of herself, and to be providing more—or different—information than the question asked for.

Documents Submitted by Respondent

41. In her medical board pre-interview questionnaire signed on December 17, 2007, which respondent signed under penalty of perjury, declaring that the information provided was "true, complete and accurate," respondent was asked, inter alia, the following questions:

a. "To your knowledge, have you ever been the subject of an investigation? If yes, by whom and under what circumstances." In response, respondent checked the "Yes" box

and wrote, "Sexual harassment in the Navy."

According to Dr. Ricciardi's discharge summary in connection with respondent's December 11, 2002, inpatient hospitalization, respondent referred to "[a]llegations within the military of drug-seeking behavior, hit-and-run motor vehicle accident . . . ."

Respondent denied that she had ever been investigated by the Navy for a hit and run accident. She stated that Dr. Ricciardi's report inaccurately referred to such an investigation. However, a reference to hit and run charges against respondent also appears in NMCSD records of respondent's December 16, 2002 hospitalization. With regard to allegations that respondent and another colleague in the Navy had improperly written each other medication prescriptions, respondent testified that she considered these allegations to be within the scope of the sexual harassment issue, and she thus felt her general reference to sexual harassment provided sufficient detail.

b. "Have you ever had a chemical dependency, alcohol or substance abuse problem?" In response, respondent checked the "No" box.

Respondent testified that she did not consider the Xanax incident of December 16, 2002, to constitute a substance abuse problem. She explained that substance abuse implied (to her) a diagnosis or struggle. She thus considered her answer to this question to be truthful.

42. In a letter to the board dated September 30, 2008, respondent stated, inter alia, that "I have never had a single problem at work or any complaint against me in my personal or professional life."

Testimony of Mark Meoni

43. Respondent's husband Mark Meoni testified that during the late 2002 to early 2003 time period, near the time when the EEO report came out, respondent was taking medications for anxiety and headaches, was having great difficulty sleeping, and was drowsy on occasion. She was nevertheless able to take care of her family responsibilities, except at those times when she checked herself into the hospital. Meoni stated that he never saw respondent sedated or somnolent. He never observed her abusing any medication. In 2003, respondent went back to work in the civilian sector, she was able to put the Navy and the EEO investigation behind her, and she felt more confident and generally better.

Meoni testified that he did not like his wife taking Dilaudid, because it would "make her a little sleepy," and was potentially addictive. He asked her to find some other medication to take instead. At one point, Meoni took respondent's Dilaudid away from her—not because she was abusing it, but because it made her sleepy.

Meoni testified that when he spoke to Dr. Vleugels about respondent's medication, his main concern and the medication he specifically mentioned to Dr. Vleugels was Dilaudid. He did not express concern about respondent mixing alcohol and medication. If he used the phrase

"in denial," he was using it with regard to Dilaudid.

Meoni testified that the family never planned to implement an "intervention" to help respondent stop using medications or alcohol through some form of rigorous treatment.

Meoni seemed to slant his testimony in favor of his wife. His testimony in explanation of various matters was not always convincing, and at times was rather vague. He seemed to downplay the extent of his concern about his wife's condition at different times in the past. He seemed at times to try to steer away from subjects that he perhaps felt would be detrimental to his wife's case.

Expert Witnesses

44. Timothy Botello, M.D., graduated from the UCLA Medical School in 1979, where the same year he also earned a Master's Degree in Public Health. He completed an internship at Harbor General-UCLA Hospital in 1980, and a residency in psychiatry at the UCLA Neuropsychiatric Institute in 1983. He was Chief Resident from 1982 to 1983. He completed a forensic psychiatry fellowship at the USC Institute of Psychiatry in 1984. He has been licensed to practice medicine in California since 1981. He has been Board certified in Psychiatry since 1985, in Forensic Psychiatry since 1991, and in Addiction Psychiatry in 1997. He has been affiliated with the University of Southern California since 1983, first as a clinical instructor, and subsequently as an Assistant, Associate, and, for the past 10 years, a full Professor of Clinical Psychology. He has had experience teaching medical students, residents, and forensic psychiatry fellows. He provides training in general psychiatry matters, and in particular substance abuse and dependency problems. Among his many and varied administrative responsibilities, Dr. Botello has served at Los Angeles County USC Medical Center as a member of the Psychiatric Ethics Education Committee, as Chair of the Quality Assessment and Improvement Committee for the Department of Psychiatry, and as a member of the Physician Well-Being Committee.

45. In addition to conducting an interview of respondent on May 17, 2008, Dr. Botello reviewed numerous documents, including respondent's CURES history, and the medical records of Dr. Endow, Dr. Vleugels, Dr. Umansky, Dr. Tiffany, Dr. Ricciardi and others.

46. Based on his review of the records, and his interview with respondent, Dr. Botello reached certain opinions. It is his view that respondent has a documented history and DSM-IV-TR diagnosis of abuse of benzodiazepines and narcotic pain medications (opiates). Respondent's abuse of these medications has been compounded at times by her consumption of alcohol. Her abusive behavior has led to a number of episodes of oversedation and altered mental status. Her abusive behavior is comorbid with other mental disorders, specifically major depression, general anxiety disorder, and by chronic migraine headaches. Her abusive behavior is further complicated by her use of medications to address these other mental and physical conditions. It is Dr. Botello's opinion that respondent has used prescription medication and/or alcohol in such a manner as to be dangerous to herself.

Dr. Botello based the foregoing opinions on a number of matters contained in her medical records, including: Evidence of impairment (e.g., slurred speech, sedation) reflected in medical records of certain providers, such as Drs. Endow and Vleugels; respondent's use of benzodiazepines and narcotics obtained from more than one source (e.g., Hydrocodone from both Dr. Umansky and Dr. Tiffany in mid 2007); her failure to advise each provider of her use of medications prescribed by other providers (and in particular her failure to abide by her pain management contract with the San Diego Pain Management Center); the concerns expressed by respondent's husband to Dr. Vleugels; the incident of May 24, 2007 (including the diagnoses reflected in the relevant records); respondent's desire to try Fentanyl "pops," a strong narcotic; her filling of Hydrocodone prescriptions on two days "back to back" (i.e., July 18 and 19, 2007); the hospitalizations of December 2002 and January 2003; and respondent's drinking of alcohol while taking medications, contrary to Dr. Vleugels' advice.

Dr. Botello also formed the opinion that respondent is impaired with regard to her ability to practice medicine safely. This opinion was based on a number of factors considered collectively: Her depression and anxiety disorders, the medications she has taken to treat them (benzodiazepines), her migraine headaches, the medications she has taken to treat them (opiates), the abuse of these various medications, which has led to several instances of sedation and altered mental state, and her family history of alcohol abuse.[59] Notably, Dr. Botello's opinion was not explicitly based on respondent's conduct or statements or on any observations he made during his interview of respondent: instead, it was based on historical information.

Dr. Botello also expressed the opinion that respondent has engaged in unprofessional conduct by failing to adhere to the pain management contract, which led to episodes of oversedation. He opined that if respondent misrepresented her alcohol consumption to a physician, or used alcohol contrary to the directive of a physician, these matters would also constitute unprofessional conduct, because of her complicated family and medical history and because it was necessary that her treating physician have accurate knowledge about what drugs and alcohol she was ingesting.

47. David J. Sheffner, M.D., received his medical degree in 1968 from the UCLA Medical School. He completed his internship in internal medicine at L.A. County General Hospital in 1969, and his residency in psychiatry at the UCLA Medical School Department of Psychiatry in 1972. He completed a fellowship in legal psychiatry at the same institution in 1973. Dr. Sheffner is board certified in psychiatry and forensic psychiatry. He has been in full-time private practice since 1974. He previously served as an assistant clinical professor of psychiatry at UC Irvine. He was a past Chairman, Legal Psychiatry Committee, Southern California Psychiatry Society. He is a member of the Ethics Committee, Orange County Psychiatry Society and of the Ethics Committee, American Academy of Psychiatry and the Law. He has served as a consultant for the medical board on about four to six cases per year for the past 30 years.

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[59] With regard to the matters that took place in late 2002 to early 2003, Dr. Botello testified that his opinions were unaffected by the fact that respondent was not practicing at the time.

48. Dr. Sheffner reviewed Dr. Botello's report. He also reviewed certain medical records.[60] He met with respondent twice, for a total of seven hours. He asked respondent, as a "homework" assignment, to write down her response to each of 46 points raised in Dr. Botello's report, which he then went over with her. Dr. Sheffner expressed concern that Dr. Botello's report did not include respondent's version of the events.

Dr. Sheffner testified that he felt it was important to interview respondent's husband, and that he did so. He also met with Dr. Tiffany, and spoke with Dr. Becerra and another of respondent's physicians, Dr. Rudolph, by phone. Dr. Sheffner did not contact Dr. Vleugels, explaining that since respondent was suing her, he assumed she would not want to meet with him. He did not contact Dr. Hicks, because he had not seen his records and would not want to talk to him until he had had an opportunity to review them. He did not contact Dr. Ricciardi, because the events were so remote in time and there was so little data that he had doubts as to what information Dr. Ricciardi would be able to add to what was in his records. He did not contact Dr. Endow because he felt he understood her records (her records spoke for themselves), and he did not find any reference in her records to drug abuse.

Dr. Sheffner testified that he reviewed certain reference letters submitted by colleagues of respondent. These letters were significant to him, because, in Dr. Sheffner's view, the truest test of one's ability to function is to examine the area of functioning that is of concern.

Dr. Sheffner testified that he conducted two psychological tests on respondent, an MMPI II[61] and a personality assessment inventory (PAI). He considered the MMPI results to be significant (a "data point"), but not the PAI. With regard to the MMPI, respondent received a low score on the McAndrews Alcohol Subscale, indicating that she did not have the personality characteristics and MMPI findings that correlate with substance or alcohol abuse. Respondent also had low scores on MMPI scales correlating to persons who are manipulative. The PAI results suggested respondent may not have answered in a completely forthright manner, i.e., that respondent tended to present herself in a favorable light, and appeared reluctant to admit to any minor fault, thus minimizing areas where her functioning might be less than optimum.

49. Dr. Sheffner testified that he did not believe respondent was mentally ill. He elaborated that he saw no data supporting a present diagnosis of benzodiazepine or other substance abuse. He explained that the December 16, 2002 Xanax episode was too remote in time to establish such a diagnosis. The December 2002 and January 2003 incidents of sedation also did not support a substance abuse diagnosis, again because of their remoteness in time, and also because of the brief time period involved, as well as the fact that Xanax and Neurontin/Topomax in combination may produce sedation even when taken as prescribed.

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[60] Dr. Sheffner did not directly, explicitly, or precisely identify the records that he reviewed.

[61] MMPI refers to the Minnesota Multiphasic Personality Inventory.

Dr. Sheffner described certain indicia of substance abuse, which he apparently did not believe respondent exhibited, or exhibited sufficiently to support a diagnosis: A pattern of chronic abuse, doctor shopping, behavior manifestations of abuse (e.g., talking too much or inappropriately, impulse control, drowsiness, belligerence). Dr. Sheffner stated that if respondent was a drug abuser, she would not have volunteered to Dr. Vleugels that she drank, or that she drank while taking medication, or that she took medications other than those prescribed by Dr. Vleugels. Respondent's signing of reciprocal releases for the medical records of Dr. Endow and Dr. Vleugels was also inconsistent with physician shopping.

Dr. Sheffner testified concerning the CURES report. He observed that in 2005, respondent filled no Norco prescriptions between June and November, and that the Vicodin prescriptions of Dr. Umansky filled in November were within normal limits. Respondent did not thereafter fill any Norco prescription until January 3, 2006. To Dr. Sheffner, this history did not look like that of a drug-seeking or doctor-shopping individual. In Dr. Sheffner's opinion, Dr. Berry's prescription in 2007 of 16 Vicodin for ear pain was an isolated instance of securing the same medication from two physicians (the other being Dr. Tiffany). With regard to Dr. Umansky's several Vicodin prescriptions in July and August 2007, Dr. Sheffner assessed them in the broader context of all Vicodin and Norco prescribed to respondent during the period from May to August 2007. During that period, prescriptions totaling an equivalent of 330 Norco tablets were filled by respondent. Assuming she consumed all of those 330 Norco equivalent tablets, that worked out to about 3.7 Norco tablets per day, which is within normal limits.

Dr. Sheffner conceded that respondent departed from the PMC opioid agreement. However, in order to determine whether violating the contract is a manifestation of drug abuse, one must examine the entirety of the data. Dr. Sheffner added that violating the contract did not constitute unprofessional conduct in his view, unless (as he did not believe to be the case) it was a manifestation of substance abuse—absent that, it was not related to respondent's practice of medicine. In Dr. Sheffner's view, unprofessional conduct requires some reasonable notice to the licensee that the behavior in question is unacceptable—he does not believe such reasonable notice exists as to the violation of an opioid agreement.

Dr. Sheffner testified to the absence of evidence that respondent presently has general anxiety disorder accompanied by such severe symptoms as would render her impaired. Similarly, he testified that respondent's depression is not now sufficiently severe to be impairing. He added that respondent's MMPI score was within normal limits for depression.

50. Sheffner testified that respondent was impaired due to substance abuse (a Xanax overdose) on December 16, 2002, and that such impairment amounted to unprofessional conduct.

51. Sheffner testified in an especially careful, detailed, thoughtful, articulate, and precise manner.

Medical Character Witnesses

52. Steve Rindsberg, M.D., has been the Chairman of the Department of Radiology at Sharp Rees-Stealy Medical Group since 2002. He has worked with respondent several times a month. He considers her to be "very skilled at what she does," and "an excellent general radiologist." He is "extremely comfortable" with the procedures she performs for Sharp. Her interaction with staff is "great." Staff is very fond of her. Patients are "very comfortable with her." Other radiologists are always very happy when they know respondent is going to be present. Dr. Rindsberg does not believe respondent's migraine headaches affect her ability to work. In the past five years, he has never had occasion to question her medical judgment, has never seen her impaired, and has never suspected her to abuse medication. He has read the accusation in almost its entirety; he was "shocked and surprised" to read the allegations, as he has never seen any of that sort of behavior on respondent's part.

Dr. Rindsberg testified that respondent began working at Sharp in approximately February 2004, on a locum tenens basis,[62] starting at several days per month. Her employment gradually increased in frequency. For about a year until January 2009, respondent worked regularly on Mondays and Fridays. Once the accusation was filed, he had to curtail her schedule, based on a directive from the Medical Director. The credentialing committee never changed her status. She continues to work at Sharp on occasion, when the department is short-staffed.

53. George Scher, M.D., has been a staff radiologist at Sharp since 1983. He was the director of radiology for 20 years, until 2002, when he went to part-time status and was succeeded as chair by Dr. Rindsberg.

Dr. Scher testified that he has known respondent for about five years, i.e., since she came to Sharp. She has worked at the same facility where he works. He has observed her perform certain procedures and has reviewed some of the x-rays that she has read. He considers her an "excellent radiologist," who does an "excellent job" in relating with staff, peers, patients, and families. He has never noticed her migraine headaches cause any problems in terms of her work, has never questioned her medical judgment, has never seen her impaired, and has never suspected her of substance abuse. He has briefly read the accusation and has observed no behavior such as that alleged therein.

54. Michael McKenna, M.D., is an anesthesiologist who has practiced off and on at Promise Hospital since 1992. He testified that he has known respondent for five to six years, and worked with her about five times per week, when she reviewed x-rays for patients for whom Dr. McKenna performed central line placements, difficult intubations and other "intensivist" procedures. He has observed nothing "untoward" or unusual with regard to respondent's interaction with patients and others, has never had a reason to question her medical judgment, has never seen her impaired, and has never suspected her to abuse alcohol or medications.

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[62] Locum tenens refers to the practice whereby a physician fills in for another physician when the latter is not available on a given day.

55. Robert Haynes, M.D., a Sharp radiologist, has known respondent since 2005. He used to work with her about three times per week, though more recently he has worked with her between once per week and once per month.[63] The last time he worked with her was about three months before the hearing. Both Dr. Hayes and respondent work at Sharp on a part-time basis.

Dr. Haynes testified that respondent has "superlative" technical skills as a radiologist. He has also observed her interaction with patients, families, and staff. She is conscientious, pleasant and courteous. He has never seen her in a bad mood.

Dr. Haynes testified that he became aware of respondent's migraine headaches in late 2008 or early 2009, when she mentioned to him in passing one day that she had a headache. He has never seen her impaired, has never questioned her medical judgment, and has never suspected that she was overmedicated.

56. Judith Choonoo has worked at Promise Hospital as an ultrasound stenographer since 2000, first as a contractor and then, since December 2007, as a full-time employee.

Choonoo testified that she met respondent at Promise in November 2003, and worked with her three to four times per week until respondent left Promise in August 2008. Choonoo considers respondent an excellent radiologist. Her interaction with staff and patients is very professional, compassionate, well-mannered, friendly and respectful. Choonoo has never questioned respondent's medical judgment or suspected her of being impaired. Choonoo was not aware that respondent had migraine headaches.

Ultimate Findings

57. Respondent used prescription medication in such a manner as to be dangerous to herself, in violation of Business and Professions Code section 2239, subdivision (a), by virtue of her ingestion of Xanax on December 16, 2002, in a quantity substantially in excess of that permitted in her prescription.

The evidence bearing on respondent's abuse of prescription medication is of three basic types: (i) Specific episodes of sedation, altered mental state and other, similar behavioral indicia of impairment and medication abuse; (ii) respondent's prescription history, including her receipt of certain medications from more than one source and her failure to disclose this fact to each provider; and (iii) the perceptions and opinions expressed by respondent's treating providers and the parties' retained expert witnesses.

Specific behavioral episodes. The majority of the incidents in question occurred in late 2002 or early 2003, as reported by Dr. Hicks, CIOG's Kathleen Flanigan, and in the records of respondent's four inpatient hospitalizations. While the reported matters suggested possible

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[63] Dr. Haynes explained that "working with" respondent meant that they were at work on the same day, in their own work stations, across the hall from one another, and that throughout the course of the day they discussed cases and showed each other images that they are reviewing.

impairment due to improper use of medication, the evidence reflected that sedation and related conditions could also have been the result of respondent's use of her medications (e.g., Neurotin, Topamax, Xanax) in accordance with her prescriptions. Further, as to the inpatient hospitalizations, on none of the four occasions did respondent's discharge diagnosis include drug abuse or dependency. More recently (in 2007), Dr. Endow noted one occasion when respondent had slurred speech and seemed unsteady on her feet, which she attributed to respondent's Lorazepam use. Dr. Endow conceded that at least slurred speech could be a side effect of proper Lorazepam use. Finally, with regard to respondent's May 24, 2007, hospitalization, and because of the substantial—and possibly severe—pain respondent experienced in connection therewith, it cannot be inferred that any altered mental state she manifested at that time resulted from improper use of medication.

Of greater concern are the statements attributed to respondent's husband Mark Meoni (and possibly other family members) by Dr. Hicks and Dr. Vleugels about respondent's medication-related impairment at home. Not only did two different psychiatrists, with no relationship to one another, report the same basic concerns on Meoni's part, but these reports were over four years apart. Meoni's testimony in denial of most of these matters came across to some extent as an attempt to explain away or even retract statements he had made earlier and is not credible. While Dr. Hicks's demeanor raised concerns about his credibility, that of Dr. Vleugels did not—and, in addition, her contemporaneous chart notes describing Meoni's comments supported her credibility. Further, and regardless of Meoni's denials, it is undisputed that he initiated contact with Dr. Vleugels because of his concern about his wife's use of at least one strong opioid medication, and that at one point he physically took that one medication away from respondent so that she could not use it. On the other hand, Meoni is not a physician, and regardless of any subjective belief on his part about his wife's condition, his perception or understanding as to any impairment he may have thought he detected, not to mention the reason(s) for such impairment (e.g., proper use vs. abuse of medication), must be taken with a certain degree of circumspection.

Prescription history. Particular concern is raised by respondent's receipt of benzodiazepines from both Dr. Endow and Dr. Vleugels, and her receipt of opioids from both the PMC and Dr. Umansky/Dr. Berry, in both cases without respondent disclosing to each practitioner her receipt of medications from the other(s). With regard to opioids, further concern is raised by respondent's direct violation of her PMC opioid consent agreement. However, none of these matters directly prove medication abuse—they merely constitute circumstantial evidence that would provide some support for such a finding. In fact, only one specific, significant incident of actual drug abuse is reflected in the record: respondent's ingestion of multiple Xanax pills on December 16, 2002.[64] Further, as to the benzodiazepine prescriptions, respondent freely

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[64] Respondent's admitted taking of two Vicodin tablets without waiting the proper time interval between the two was an isolated and insignificant occurrence. Her utilization of two Fentanyl "pops" at a time when her prescription called for only one causes greater concern, but that concern is substantially reduced by two additional factors: (i) Respondent's voluntary disclosure of this fact to Dr. Tiffany; and (ii) Dr. Tiffany's subsequent modification of respondent's prescription, which reflected his judgment that two pops at a time was in fact an

disclosed to Dr. Vleugels at the outset that she had been seeing Dr. Endow, and she subsequently executed reciprocal releases for both providers. And, with one exception, respondent did not fill any benzodiazepine prescription from Dr. Endow after she filled her first such prescription from Dr. Vleugels.[65] As to the opioid prescriptions, the duplication resulted from discrete incidents of unrelated medical treatment for which pain medication was prescribed. The medication prescribed by Dr. Berry (16 Vicodin tablets) was not of great significance. The medication prescribed by Dr. Umansky was certainly substantial, but Dr. Sheffner's unrebutted testimony was that, assuming respondent ingested all Norco and Vicodin respondent received from any source between May and August 2007, the average amount ingested per day would have been within normal limits. Finally, respondent has not filled any benzodiazepine or opiate prescriptions since March and December 2007 respectively.

Respondent's receipt of benzodiazepine and opioid medications from multiple sources without disclosing these facts to the providers in question cannot be condoned or justified. However, the issue at this point is whether or to what extent these matters imply abuse of medication. As to this question, the evidence is decidedly mixed, i.e., some of the evidence suggests drugs abuse, but other evidence does not. The record as a whole is inconclusive.

Treating providers and expert witnesses. With regard to treating physicians and others, the evidence again is mixed. Dr. Hicks reached the conclusion, only after four-and-a-half years of treatment, that respondent had a diagnosis of polysubstance abuse. Dr. Ricciardi at about the same time noted "substance abuse" as an "impression." His chart note provided little guidance as to how he came to that conclusion—but from the content of the note it may be inferred that he relied heavily on statements made by others, including family members and the diagnosis of Dr Hicks. In contrast, Dr. Becerra, Dr. Endow, Dr. Tiffany, Dr. Umansky, and Dr. Vleugels did not diagnose respondent with any kind of substance abuse, and in most instances never even suspected such a condition.[66]

Dr. Botello and Dr. Sheffner were both highly-qualified experts, who testified in a professional, objective, and otherwise generally credible manner. Each emphasized or focused on somewhat distinct aspects of the evidence bearing on whether respondent had abused medication. Overall, Dr. Sheffner's testimony seemed slightly more persuasive—in particular with regard to his analysis of the CURES report and the inferences that could or could not reasonably be drawn from respondent's prescription history. Even Dr. Sheffner conceded, however, that respondent had abused medication on one occasion, i.e., when she overdosed on Xanax on December 16, 2002.

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appropriate dose. The related issue of respondent's use of alcohol and medications together despite Dr. Vleugels' cautions to the contrary is considered below in Finding 59.

[65] Respondent did not fill her first benzodiazepine prescription from Dr. Vleugels until February 24, 2007; she received one such prescription from Dr. Endow two days later, which respondent explained to be the result of the VA continuing to send prescriptions to her automatically.

[66] Dr. Vleugels' one-time reference to "benzo abuse" (without the question mark) reflected no more than a temporary concern, which Dr. Vleugels soon abandoned.

Conclusion. While the evidence as a whole raised considerable and troubling concerns about the existence and extent of respondent's medication abuse at various times, substantial evidence weighed in the other direction. Further, the force of the evidence that supported a finding of abuse was in many cases attenuated by reasonable inferences of non-abuse that could also be drawn. Accordingly, based on the entirety of the record, it was not established by clear and convincing evidence that respondent violated section 2239, subdivision (a), except with regard to the December 16, 2002 incident.

58. Respondent's ability to practice medicine is not impaired because of a mental illness or a physical illness affecting competency pursuant to Business and Professions Code section 822.

This Finding is based in part of the matters set forth above in Finding 57, and in particular the finding that respondent used prescription medication in a manner dangerous to herself on only one occasion, which occurred over six years ago. Though Dr. Hicks testified that a substance abuse diagnosis can follow or remain with an individual even during periods of non-use, he did not attempt to assess the likelihood of that happening in respondent's case. Further, a potential inclination to substance abuse must be distinguished from actual relapse.

Of course, a finding under section 822 need not be based on substance abuse, but may be based on a proper use of prescription medication, either alone or in combination with other matters. It is clear from the record that respondent went through an extremely difficult and painful period of great personal struggle in December 2002 and, to a lesser extent, the several months thereafter. She was hospitalized on a psychiatric basis four times in less than a month, overdosed on medication at one point, suffered from severe depression, and to one extent or another considered taking her own life. It may well be that respondent's ability to practice medicine was impaired within the meaning of section 822 at that time. At issue here, however, is not whether respondent was impaired in 2002, but whether she is impaired at present, six years later, after a great deal of medical and psychological treatment, and living under very different circumstances than those with which she had then to cope. Notably in this regard, Dr. Botello's opinion that respondent is presently impaired due to mental illness was not based on any observations he made during his examination of her, and he did not seek or receive any input from other persons as to respondent's present circumstances or condition. Instead, his opinion appeared to be based solely on matters of a historical nature, i.e., his review of the medical records. Dr. Sheffner's contrary opinion took into account respondent's present condition, as well as the opinions of other persons who know her, in particular her professional colleagues. Indeed, the opinions of respondent's numerous colleagues who testified at the hearing provided significant evidence that respondent is not presently impaired with regard to the practice of medicine. Finally, even Dr. Vleugels, who filed the board complaint against respondent, did not reach the conclusion that respondent was impaired. Instead, she could only state that respondent's alcohol and prescription drug use "may impair her ability to work." Accordingly, based on the entirety of the record, and even though respondent still suffers in a substantial way from depression, anxiety, and migraine headaches, it was not established by clear and convincing

evidence that these or any other mental or physical conditions presently impair respondent's ability to practice medicine.

59. Respondent engaged in unprofessional conduct in violation of section 2234, subdivision (a).

This finding is derivative in nature, based solely on the finding of a violation of section 2239, subdivision (a), as set forth above.

Dr. Botello in essence testified that respondent also engaged in unprofessional conduct on an independent basis by: (i) Violating the opioid consent agreement with PMC; (ii) using alcohol and benzodiazepines against the directive of Dr. Vleugels; and (iii) misrepresenting to Dr. Endow that she was not using alcohol.[67] Dr. Sheffner opined to the contrary that respondent did not engage in professional conduct on the basis of any of these three matters.

With regard to the first point, neither Dr. Botello nor Dr. Sheffner provided an entirely persuasive rationale for their opinions. However, Dr. Sheffner's point that unprofessional conduct requires reasonable notice to the licensee that the behavior in question is unacceptable seems well taken, at least as applied here, where it was not established that respondent's non-adherence to the consent agreement was a manifestation of drug abuse.

With regard to the second point, Dr. Vleugels' statements, which can best be characterized as general "cautions" to respondent about the use of alcohol, did not constitute the clear proscriptions against alcohol use that complainant contended they were. This understanding of the evidence is supported by the undisputed fact that respondent more than once freely disclosed her consumption of alcohol to Dr. Vleugels. The latter's records do not reflect that she ever responded to such disclosures by forcefully warning respondent against such use of alcohol. Finally, Dr. Sheffner's observations with regard to respondent's violation of the opiate consent agreement apply even more to respondent's failure to adhere to Dr. Vleugels' informal caution regarding alcohol and medication.

With regard to the third point, the evidence did not establish that respondent misrepresented her alcohol use to Dr. Endow. For the reasons noted earlier, Dr. Endow's chart notes are of little probative value in this regard. Further, the record as a whole clearly establishes respondent's habitual willingness to disclose her consumption of alcohol.

Accordingly, based on the entirety of the record, it was not established by clear and convincing evidence that respondent engaged in unprofessional conduct in any of these three independent respects. Otherwise stated, it has not been established that respondent in this regard engaged in conduct which is unbecoming to a member of in good standing of the medical profession, and which demonstrates unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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[67] Dr. Botello did not in all instances explicitly state respondent acted unprofessionally, but he at least opined that such conduct, if it occurred, would constitute unprofessional conduct.

CONCLUSIONS OF LAW

Burden and Standard of Proof

1. "The purpose of an administrative proceeding concerning the revocation or suspension of a license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners." (*Ettinger v. Board of Medical Quality Assurance* (1982) 139 Cal.App.3d 853, 856.)

2. Absent a statute to the contrary, the burden of proof in disciplinary administrative proceedings rests upon the party making the charges. (*Parker v. City of Fountain Valley* (1981) 127 Cal.App.3d 99, 113; Evid. Code, § 115.) The burden of proof in this proceeding is thus on complainant.

3. The standard of proof in administrative disciplinary proceedings brought against professional licensees to establish unprofessional conduct is "clear and convincing proof to a reasonable certainty." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1105.)

The "clear and convincing" standard of proof applies to the issue of whether physician's ability to practice medicine competently is impaired due to mental or physical illness under Business and Professions Code section 822. (*Medical Board of California v. Superior Court* (*Liskey*) (2003) 111 Cal.App.4th 163, 170-171.)

4. "The key element of clear and convincing evidence is that it must establish a high probability of the existence of the disputed fact, greater than proof by a preponderance of the evidence." (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.) This standard is less stringent than proof beyond a reasonable doubt. (*Ettinger v. Board of Medical Quality Assurance, supra,* 135 Cal.App.3d at 856.)

Motion in Limine to Exclude Expert Testimony

5. On May 7, 2009, complainant filed a motion in limine seeking "to exclude the expert testimony of each of respondent's six expert witnesses, on the grounds that respondent has violated the mandatory expert witness disclosure requirements of [Business and Professions Code] section 2334." The motion was based primarily on the following arguments: (i) Contrary to the requirements of section 2334, respondent's expert witness disclosure did not occur at least 30 calendar days before the commencement of the hearing; and (ii) the mandatory penalty for the failure to comply on a timely basis with the requirements of section 2334 is the automatic exclusion of the offending party's expert testimony. Complainant also contended that: (iii) Respondent's expert disclosures failed to comply with the requirements of section 2334 in other respects than timeliness (e.g., the description of the expected testimony of respondent's experts); and (iv) respondent's various failures to comply with the requirements of section 2334 were highly prejudicial to complainant's ability to prepare for the hearing.

6. Respondent has violated the requirements of section 2334 in two respects. First, respondent failed to provide its expert witness disclosure within 30 calendar days prior to the commencement of the hearing. On March 5, 2009, OAH granted respondent's motion to continue the hearing, and set the hearing to commence on May 14, 2009. Based on that hearing date, and pursuant to section 2334, subdivision (a), expert witness disclosure was to be made no later than April 14, 2009. Respondent did not, however, make her formal disclosure until April 30, 2009. [68] For purposes of the motion in limine, respondent's disclosure is deemed to have been 16 days late.[69] It is thus concluded that respondent's disclosure was untimely.

Second, respondent failed, as to two of its experts, to provide "a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis." Complainant argued essentially that the descriptions provided in respondent's disclosure were not adequate to meaningfully inform complainant of the actual substance of the expected testimony of respondent's experts, including the experts' actual opinions and the bases therefor. Complainant's argument is rejected with regard to William Umansky and Luis Becerra. The description of the expected testimony of these individuals as set forth in respondent's disclosure did not constitute the kind of testimony that is typically considered "expert testimony," i.e., as described, it did not consist of formal expert opinions, but instead involved the physician's course of care of respondent.[70] As such, such testimony is properly characterized as percipient witness testimony, not expert testimony per se.[71] On the other hand, the description of the expected testimony of Frank Tiffany and David Sheffner clearly involved, at least in part, the rendering of genuine expert opinions. The description of their testimony adequately set forth the general substance of the testimony, including opinion testimony,[72] but did not set forth any "basis" for such opinion testimony, and thus fails to comply

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[68] The analysis that follows focuses on respondent's formal expert witness disclosure of April 30, 2009. On April 16, 2009, respondent served a Final Witness and Exhibit List. This list may be viewed as constituting respondent's initial expert witness disclosure. Under either view, based on the reasoning set forth below, violations of section 2334 would be found, though the violations would differ to a certain extent. For example, respondent did not disclose the fee to be charged by all of her experts until April 30.

[69] On April 16, 2009, Presiding Administrative Law Judge Alan R. Alvord issued a prehearing conference order, in which the parties were ordered to exchange the information required by section 2334 by April 30, 2009. Complainant objected to that portion of the order and contended in her in limine motion that OAH lacked the authority to grant additional time within which to make a section 2334 disclosure after the 30-day deadline had already passed. For the purposes of ruling on the in limine motion, it is assumed arguendo that the disclosure was to be made on April 14, 2009, notwithstanding the prehearing conference order.

[70] Indeed, the testimony of these two physicians, as described above, was limited to issues directly relating to the course of care, and did not constitute expert opinion testimony.

[71] In the absence of any statutory, regulatory or judicial guidance as to the meaning of "expert testimony," recourse is taken to the somewhat analogous use of expert testimony in civil cases pursuant to Code of Civil Procedure section 2034.

[72] Complainant's contention that the disclosures provide insufficient detail to permit

with section 2334.[73]

7. In light of the conclusion that respondent has violated section 2334, the remedy for respondent's violations must now be addressed. The Administrative Law Judge denied the motion in limine and rejected exclusion of the expert testimony on the grounds that section 2334 affords both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

8. The administrative law judge determined that exclusion of respondent's expert witness testimony would not further the apparent legislative purpose of the statute, but would instead undermine the interests of justice, and based this conclusion on the following considerations.

First, with regard to the timeliness of disclosure, even though formal disclosure did not occur until April 30, the identity of respondent's six experts, and at least a short description of the subject matter of their expected testimony, was provided on April 16, 2009, i.e., just two days after the April 14 deadline.

Second, in the absence of clear guidance as to what level of detail satisfies the "brief narrative statement" requirement of section 2334, great caution and restraint is appropriate before excluding expert testimony based on a finding that a proffered description did not constitute an adequate "brief narrative statement."

Third—and closely related to the preceding point—complainant did not place respondent on notice prior to filing the motion in limine of the alleged inadequacy of respondent's disclosure.

Fourth, complainant did not establish prejudice by virtue of either the untimeliness or the inadequacy of respondent's disclosures.

Fifth, no evidence was presented that respondent's failure fully to comply with section 2334 was in bad faith, i.e., constituted a conscious attempt to "hide the ball" or otherwise circumvent proper disclosure.

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complainant to prepare to meet the testimony of respondent's experts at the hearing was unpersuasive given the absence at that time of any guidance—both for respondent and for the administrative law judge—as to how "brief" the required narrative statement may be. It is not appropriate to retrospectively construe that adjective in an unduly narrow fashion that would in effect constitute a trap for the unwary.

[73] Since respondent's other two experts, Christine Baser and Steven Rudolph, did not testify at the hearing, it is not necessary to address the adequacy of respondent's disclosures of their testimony.

Sixth, the administrative law judge presumed that the ultimate decision maker in this case, the Medical Board of California, would desire to have all relevant evidence available for its consideration, so that it can make the most well-informed and appropriate decision possible in this very important matter

9. In her written argument and during oral argument, complainant asked the board to reverse the decision denying the motion in limine, exclude expert testimony as a result of that reversal, and, in the decision itself, designate its decision as a precedent decision. The board denies these requests for the following reasons.

First, as required by law, the board has read all of the expert testimony in question as part of its review of the record and therefore does not believe it is appropriate, fair or equitable at this stage of the proceedings to attempt to "unring the bell."

Second, there is a process set out in regulation (Title 16 CCR section 1364.40) for designating precedent decisions and complainant's request is inconsistent with that process. Complainant may certainly renew her request in the manner prescribed in that regulation.

The board does agree with both the administrative law judge and with complainant about the critical need for guidance in interpreting Business and Professions Code Section 2334, in order to carry out the purpose for which that section was enacted, and intends to convey its interpretation of that section in this decision.

10. Business and Professions Code section 2334 provides as follows:

"(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

"(1) A curriculum vitae setting forth the qualifications of the expert.

"(2) A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.

"(3) A representation that the expert has agreed to testify at the hearing.

"(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

"(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.

"(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section." (Stats. 2005, c. 674 (S.B. 231), § 14.)

11. The board finds that Section 2334 governs the entire subject of expert witness disclosures in Medical Board cases, including the penalty to be imposed for failure to comply with the disclosure requirements by the statutory production deadline and therefore Section 2334 prevails over any other provision of law, including provisions of the Administrative Procedure Act (APA). Evidence of this is found in the first sentence of section 2334, subdivision (a), which begins with the phrase: "Notwithstanding any other provision of law . . ." This phrase is indicative of the Legislature's intent to have the provisions of section 2334 control notwithstanding the existence of other laws that might otherwise govern the subject. (See *People v. DeLaCruz* (1993) 20 Cal.App.4th 955, 963 [phrase "has been read as an express legislative intent to have the specific statute control despite the existence of other law which might otherwise govern."].)

12. A review of the legislative history of section 2334 confirms both the problem section 2334 was specifically enacted to address, as well as the legislative intent to place a mandatory obligation on the parties to make the required disclosures by the statutory deadline in order to promote, rather than defeat, its underlying public policy. In her Initial Report to the Legislature, the Medical Board's Enforcement Monitor[74] described the problems that result from defense counsel's failure to disclose the opinions of their experts as follows:

"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

[74] Business and Professions Code section 2220.1 provided for the appointment of a "Medical Board Enforcement Program Monitor" to 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." (Added by Stats. 2002, c. 1085, (Sen. Bill No. 1950), § 18; repealed by Stats. 2004, c. 909 (Sen. Bill No. 136), § 3, operative Jan. 1, 2006.)

central element of the administrative action disserves all parties to the process and the public interest as a whole."

(Initial Report, Medical Board of California Enforcement Program Monitor, prepared by Julianne D'Angelo Fellmeth and Thomas A. Papageorge, dated November 1, 2004, at pp. 160-161.)

In the wake of the Enforcement Monitor's Initial Report, Senate Bill 231, as amended, included a new statute specifically designed to address this problem. That statute, as originally introduced, provided that:

> "2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless a detailed written report by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings." (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on June 13, 2005.)

Thus, as original introduced, the Legislature only required that the disclosure be made "in advance of the hearing." As the bill moved through the legislative process, the Legislature amended section 2334, never losing sight of its objective to compel the timely production of information regarding expert witnesses. For example, the Legislature eliminated the requirement that "a detailed written report" be produced and, instead, required only that the expert testimony be "reduced to writing by the expert witness, including findings and conclusions of the expert witness, . . ." Thus, as later amended in the Assembly, section 2334 then provided:

> "2334. Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless ~~a detailed written report~~ *it is reduced to writing* by the expert witness, including findings and conclusions of the expert witness, is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings." (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 11, as amended in Assembly on July 11, 2005.)

Then, on August 30, 2005, the Legislature abandoned the requirement that the disclosure simply be made "in advance of the hearing" and, instead, established a specific statutory deadline for the production. In this regard, section 2334, as amended, stated:

"2334. *(a)* Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be

permitted by any party unless ~~it is reduced to writing by the expert witness, including findings and conclusions of the expert witness, and it is exchanged by the parties in advance of the hearing. The Office of Administrative Hearings shall adopt regulations in consultation with the Medical Board of California governing the required exchange of expert testimony in these proceedings.~~ *the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:*

(1) A curriculum vitae setting forth the qualifications of the expert.

(2) A brief narrative statement of the general substance of the testimony the expert is expected to give, including any opinion testimony and its basis.

(3) A representation that the expert has agreed to testify at the hearing.

(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party how retained his or her services.

(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.

(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section."
(Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 12, as amended in Assembly on August 30, 2005.)

This would remain the statutory production deadline throughout the remainder of the legislative process (see Sen. Bill No. 235 (2005-2006 Reg. Sess.) § 11, as amended on September 2, 2005) and ultimate approval by the Governor on October 7, 2005 (see Bus. & Prof. Code, § 2334). Thus, subsequent amendments to Senate Bill 231 confirm the Legislature's explicit rejection of the requirement that the expert witness disclosures be made simply "in advance of the hearing" and, instead, its intention that such disclosures shall be made "at least 30 calendar days prior to the commencement date of the hearing." (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"]; see also *Martin v. Szeto* (2004) 32 Cal.4th 445, 450 [subsequent amendments to bill cited as clarifying legislative intent].)

Permitting OAH to order the required expert witness disclosures to be made *less than* 30 calendar days prior to commencement of the hearing was included in an earlier version of Senate Bill 231 that was explicitly rejected by the Legislature and, thus, to permit it now would be entirely inconsistent with legislative intent. (Cf. *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865 [Legislature's direct consideration and explicit rejection of proposal to reduce grants of AFDC recipients sharing housing with an adult aid recipient an "unambiguous indicant of legislative intent"].)

13. The board finds that the obligation of both parties to make the required exchange of expert witness information by the statutory deadline set by the Legislature in section 2334 (b), is mandatory, not merely directory. (Business and Professions Code Sections 8, 19) This is also consistent with case law:

> ". . . 'Time limits are usually deemed to be directory unless the Legislature clearly expresses a contrary intent.' (*Id.* at p. 1145.) For example, if the statute attaches consequences or penalties to the failure to observe time limits, the statute is construed as mandatory. (*County of Sacramento v. Insurance Co. of the West* (1983) 139 Cal.App.3d 561, 565-566; see also *Edwards v. Steele, supra*, 25 Cal.3d at p.410.)" (*Matus v. Board of Administration* (2009) 177 Cal.App.4th 597, 608-609.)

14. In the proposed decision, the administrative law judge construed section 2334 as affording both OAH and the administrative law judge a measure of discretion with regard to the remedy for non-compliance to be applied in a given case, depending on the totality of the circumstances.

(a) The board finds, using well-settled rules of statutory construction, that an interpretation granting discretion as to whether to impose the statutory remedy of exclusion is inconsistent with the legislative intent underlying the statute, would defeat (rather than promote) the statute's general purpose and would lead to absurd consequences.

> "In construing a statute, our fundamental task is to ascertain the Legislature's intent so as to effectuate the purpose of the statute. (*Day v. City of Fontana* (2001) 25 Cal.4th 268, 272.) We begin with the language of the statute, giving the words their usual and ordinary meaning. (*Ibid.*) The language must be construed 'in the context of the statute as a whole and the overall statutory scheme, and we give 'significance to every word, phrase, sentence, and part of an act in pursuance of the legislative purpose." ' (*People v. Canty* (2004) 32 Cal.4th 1266, 1276.) In other words, ' "we do not construe statutes in isolation, but rather read every statute 'with reference to the entire scheme of law of which it is part so that the whole may be harmonized and retain effectiveness.' [Citation.]" ' (*In re Marriage of Harris* (2004) 34 Cal.4th 210, 222.) If the statutory terms are ambiguous, we may examine extrinsic sources, including the ostensible objects to be achieved and the legislative history. (*Day, supra*, 25 Cal.4th at p. 272.) In such circumstances, we choose the construction that comports most closely with the Legislature's apparent intent, endeavoring to promote rather than defeat the statute's general purpose, and avoiding a construction that would lead to absurd consequences. (*Ibid.*)" (*Smith v. Superior Court* (2006) 39 Cal.4th 77, 83.)
>
> Section 2334, subdivision (a), states that:
>
> "(a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert

testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, *as ordered by the Office of Administrative Hearings*: . . ." (Italics added.)

The board finds that section 2334 is a self-executing statute in the sense that it applies in all Medical Board cases, regardless of whether OAH orders the parties to comply with its provisions or not.[75] In this regard, section 2334 is similar to a statute of limitations (see, e.g., Bus. & Prof. Code, § 2230.5) which applies whether or not the parties are ordered to comply with its provisions.

To interpret the phrase "as ordered by the Office of Administrative Hearings" as requiring an OAH order before the statute could apply in Medical Board cases would violate the general rules of statutory construction cited above. It would also lead to the absurd consequence of section 2334 applying in those Medical Board cases where OAH has issued an order requiring compliance with its provisions but not to those cases where OAH has not issued such an order.

Here, the phrase "as ordered by the Office of Administrative Hearings" is more appropriately read as referring to an order from OAH prohibiting expert testimony offered by a party whenever it has been determined that the party has failed to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline. Without such an order from OAH, the statutory penalty fixed by the Legislature for violation of section 2334 could never be imposed. This reading is also consistent with other prescribed duties and responsibilities of administrative law judges under the APA, including those provisions requiring an administrative law judge to issue orders and decisions. (See, e.g., Gov. Code, §§ 11511.5, subd. (e) ["The administrative law judge shall issue a prehearing conference order incorporating the matters determined at the prehearing conference."]; and 11517 ["If a contested case is originally heard by an administrative law judge alone, he or she shall prepare . . . a proposed decision in a form that may be adopted by the agency as the final decision in the case."].) The Legislature was presumed to be aware of existing law (here, the authority of an administrative law judge to issue orders) when it required an order from OAH to impose the statutorily required penalty for failure to comply with the requirements of section 2334. (*People v. Cruz* (1996) 13 Cal.4th 764, 775)

(b) "The most basic principle of statutory construction is that courts must give effect to statutes according to the ordinary import of the language used in framing them." (*People v. Herman* (2002) 97 Cal.App.4th 1369, 1380-1381, internal quotes and citation omitted.) "If there is no ambiguity in the language of the statute, then the Legislature is presumed to have meant what it said, and the plain meaning of the language governs." (*Id.*, at p. 1381, internal quotes and citations omitted.) Here, there is no ambiguity regarding the penalty to be imposed for a violation of section 2334. The Legislature has made a policy choice to fix that penalty as exclusion of the expert testimony.

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[75] While OAH has reportedly begun the practice of routinely issuing orders requiring the parties to comply with the provisions of section 2334, issuance of such orders are not required since section 2334 is otherwise applicable in Medical Board cases, regardless of whether OAH orders the parties to comply or not. Such orders do, however, serve a useful purpose by helping to ensure that section 2334 does not become a trap for the unwary.

The board finds that OAH lacks the authority to refuse to impose the legislatively mandated penalty of exclusion where a party has failed to comply with the requirements of section 2334. Whenever it has been determined that a party in a Medical Board case has violated the expert witness disclosure requirements of section 2334, either by failing to disclose the information specified in section 2334, subdivision (b), and/or failing to make the required disclosures by the statutory deadline contained in section 2334(c), section 2334(a) requires that an order be issued prohibiting that party from presenting the proffered expert testimony in the case.[76]

The board notes that the conclusion expressed above applies equally to both complainant and respondent. Based upon its review of the record (Exh. 29 in particular), the board urges both parties in future cases to be diligent in fully complying with Section 2334 in order to fulfill the purposes of the statute.

What constitutes compliance with Section 2334(a)(2)? Merely listing topics or subjects that the expert witness will testify about, without disclosing the general substance of the expert's anticipated testimony, the actual expert opinions he/she will testify to, and the basis for each of those opinions, is plainly insufficient and would clearly violate the statutory requirements of section 2334. A "brief narrative statement" of the "general substance" of the expert's testimony means a short narrative statement that provides the main features of the testimony—the essential nature of the testimony to be proffered. The statement must include any opinion to be presented and the basis for that opinion. By way of example as to what is not acceptable, taken from the record in this matter: A party merely states (see Exh. 29) that an expert will testify "whether Respondent can practice medicine safely, and whether the circumstances surrounding Respondent's use of medication constituted general unprofessional conduct as alleged." This narrative does not state what expert opinion will actually be proffered (i.e. that respondent can practice medicine safely and that respondent's use of medication is not general unprofessional conduct). Nor does it describe whatsoever the basis for that opinion. This is simply insufficient.

Statutory Authority

15. Business and Professions Code section 2227 provides in part:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the

[76] Administrative disciplinary proceedings that are commenced by the issuance of an interim order of suspension (ISO) under Government Code section 11529 constitute an exception to the otherwise applicable provisions of section 2334. In ISO cases, the filing of the accusation and subsequent hearing are necessarily expedited (Gov. Code, § 11529, subd. (f)) and, as a result, the hearing may be scheduled such that is impossible for the parties to comply with the expert witness disclosure requirements of section 2334 by the statutory deadline set by section 2334, subdivision (c). Compliance with section 2234 is excused when it is impossible to comply. (See e.g., *McKenzie v. City of Thousand Oaks* (1973) 36 Cal.App.3d 426, 430 [compliance with procedural statute may be excused when it is "impracticable, impossible or futile" to comply].)

Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter: (1) Have his or her license revoked upon order of the division. (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division. (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division. (4) Be publicly reprimanded by the division. (5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper."

16. Business and Professions Code section 822 provides:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.
(b) Suspending the licentiate's right to practice.
(c) Placing the licentiate on probation.
(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

17. Business and Professions Code section 2239 provides in pertinent part:

"(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct."

18. Business and Professions Code section 2234 provides in part:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. . . ."

Final Conclusions

19. To summarize the foregoing authority in the context of this proceeding, disciplinary action may be taken against respondent only if complainant has established by clear and convincing evidence that: (i) Respondent's ability to practice medicine is impaired because of a mental illness or a physical illness affecting competency; (ii) respondent used prescription medication and/or alcohol in such a manner as to be dangerous to herself or others, or to the extent that her ability to practice medicine was impaired; or (iii) respondent engaged in unprofessional conduct by virtue of either of the above.[77]

20. By reason of Factual Findings 1 through 59 and Legal Conclusions 1 through 19, and based on the applicable burden of proof, it is concluded that:

a. Respondent's ability to practice medicine is not impaired because of a mental illness or a physical illness affecting competency, pursuant to section 822. In reaching this conclusion, section 822 is construed to involve a present impairment on the part of a physician, i.e., that a physician may have been impaired at some time in the past is insufficient to meet the requirements of section 822. This understanding of section 822 is based both on its language ("If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired") and on the non-disciplinary nature of section 822. No judicial authority has been found that addresses this issue, however.

b. Respondent used prescription medication in such a manner as to be dangerous to herself, in violation of section 2239, subdivision (a). In reaching the conclusion that respondent violated section 2239, subdivision (a) based only on her ingestion of Xanax on December 16, 2002, in a quantity substantially in excess of that permitted in her prescription, section 2239, subdivision (a) is understood to require some sort of improper use of medication, such as using more medication than prescribed, using medication as prescribed but under circumstances where the individual improperly obtained multiple prescriptions for the purpose of abusing the medication, or improperly combining the use of medication with other activities (such as driving a vehicle). By way of contrast, a physician's mere use of medication as prescribed, without more, is not understood to be a violation of section 2239, as such an interpretation of the provision is not required by its language and would seem to raise due process issues. No judicial authority has been found that addresses this issue, however.

c. Respondent, by virtue of Conclusion 20(b), engaged in unprofessional conduct, in violation of section 2234, subdivision (a).

21. By reason of Factual Findings 1 through 59, and Legal Conclusions 1 through 20, the board is authorized to take disciplinary action against respondent. Whether and what kind of disciplinary action should be taken is to be considered in the context of the board's highest

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[77] The Accusation does not allege any conduct to violate section 2234 that is independent of complainant's allegations under sections 822 and 2239, subdivision (a).

priority, the protection of the public. (Bus. & Prof. Code, § 2001.1.) To the extent not inconsistent with this priority, "disciplinary actions shall be calculated to aid in the rehabilitation of licensees." The Guidelines also state:

> "The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility and demonstrated willingness to undertake Board- ordered rehabilitation, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure."

(Medical Board of California Model Disciplinary Orders and Disciplinary Guidelines, p. 6.)

22. Respondent contends that even if any of the three causes are sustained in this matter, the imposition of probation would constitute unnecessary and unjustified punishment. Respondent's argument has a certain force, in that the only conduct found to be grounds for discipline is respondent's ingestion of Xanax on December 16, 2002, over six years ago. The board is greatly concerned about Respondent's repeated failure to fully appreciate and/or admit the extent of her problems. Respondent's state of denial is clearly manifested throughout the record. For example, Dr. Endow believed that respondent tended to "minimize her symptoms." Dr. Vleugels believed that respondent minimized concerns about her receipt of benzodiazepines from two different sources. Indeed, respondent's explanations for her failure reciprocally to advise Dr. Endow and Dr. Vleugels, and Dr. Umansky and Dr. Tiffany, of the medications she was receiving from the other, seemed casual and to reflect a lack of appreciation as to the importance—which, as a physician she of all people should recognize—of advising her health care providers of all medication she receives from every source. The same may be said for her failure to abide by the opioid contract—her explanation that she did not read the contract again reflects a casual attitude on respondent's part, a lack of appreciation for the seriousness of over medicating and the potential dangers of these highly potent medications. Further, her answers to the two questions on the medical board pre-interview questionnaire can hardly be considered "true, complete and accurate," notwithstanding respondent's forced and dubious attempt to explain why she answered the way she did. Remarkably, in her letter to the board dated September 30, 2008, respondent stated, inter alia, that "I have never had a single problem at work or any complaint against me in my personal or professional life." Dr. Sheffner's testimony that the PAI results suggested a lack of forthrightness on respondent's part and a tendency to minimize areas of less-than-optimum functioning only confirms these other observations. Even respondent's own husband stated that respondent was "in denial."[78]

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[78] Though Mark Meoni denied that he had concerns about any medication other than Dilaudid, he never denied that he made this statement.

However, given the age (2002) of the one incident found to be grounds for discipline and the lack of subsequent similar incidents, the board concludes that a public reprimand is the appropriate penalty under the facts of this case.

Accordingly, there issues the following:

ORDER

Certificate No. A 55229, issued to respondent Jill Siren Meoni, is hereby publicly reprimanded.

This decision shall become effective at 5 p.m. on **June 7, 2010**.

IT IS SO ORDERED this 6th day of May, 2010.

HEDY CHANG, Chairperson
Panel B, Medical Board of
California

Relevant Statutory and Decisional Law

1. Case Law on License Discipline

"The purpose of such a [administrative disciplinary] proceeding is not to punish but to afford protection to the public upon the rationale that respect and confidence of the public is merited by eliminating from the ranks of practitioners those who are dishonest, immoral, disreputable, or incompetent." (*Fahmy v.Medical Board of California* (1995) 45 Cal.Rptr.2d 486, citing *Borror v. Department of Investment* (1971) 15 Cal.App.3d 531, 540, 92 Cal.Rptr. 525; *Lam v. Bureau of Security & Investigative Services, supra,* 34 Cal.App.4th at p. 38, 40 Cal.Rptr.2d 137.)

2. Statutes Relating to the Medical Board

Section 2001.1 of the Business and Professions Code provides:

"Protection 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."

Section 2229 of the Business and Professions Code provides:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.

Project Overview

Medical Board of California

Today's Topics

- Brief Project Summary
- Project Concept & Benefits
- Transaction Fee
- Key Success Factors
- Project Leadership
- Recent Activities & Next Steps
- Tentative Implementation Schedule

Project Summary

- Integrated Licensing & Enforcement solution
- Completely replaces legacy licensing and enforcement systems (CAS, ATS, & Others)
- Replaces the iLicensing & CRIMS projects
- Incorporates document image storage

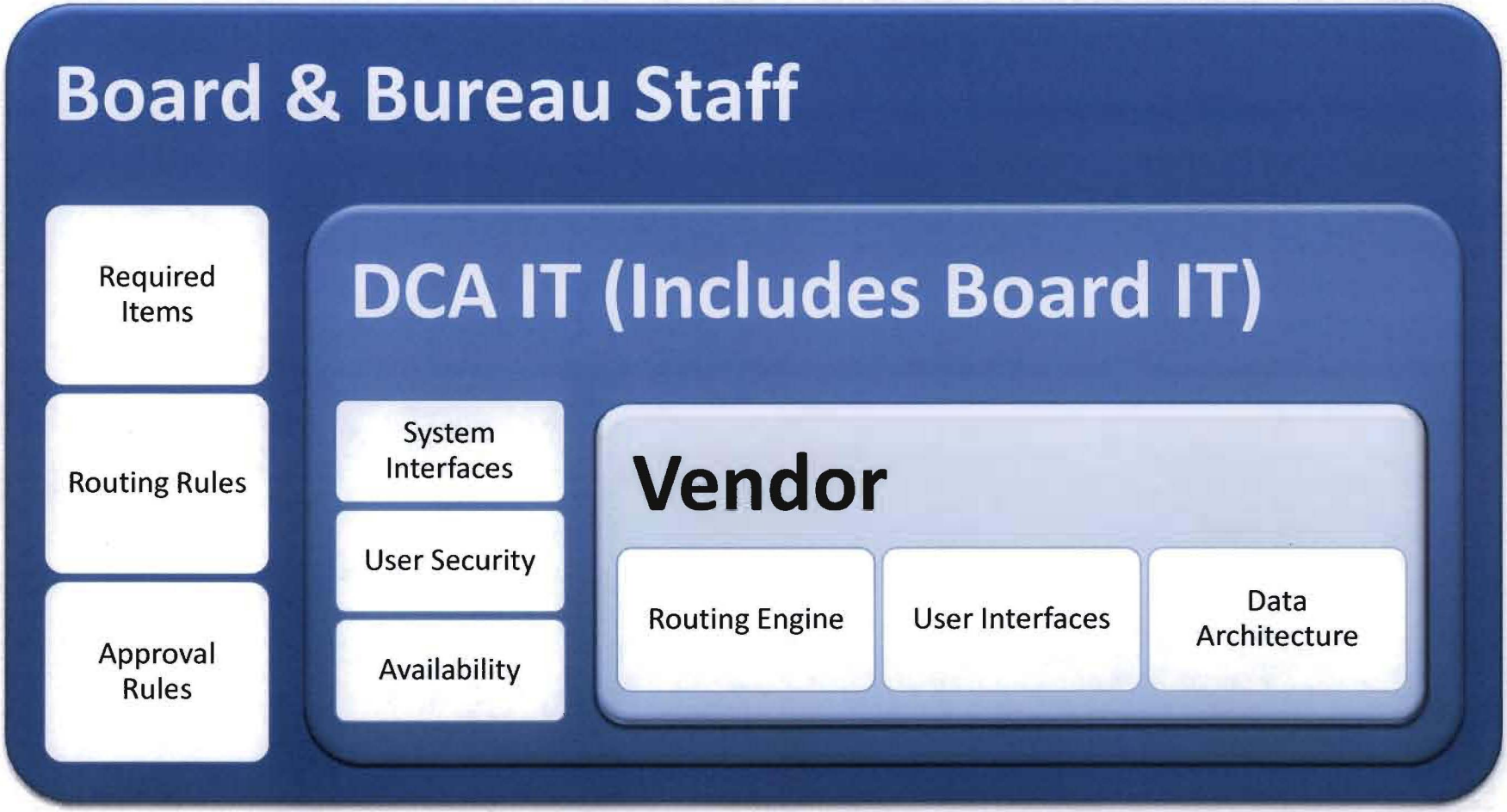
Project Concept

Online Applications	**Exams (Registration)**	Workflow	**Licensing**	Mobile	Enforcement
Online Renewals	**Reports**	**BreEZe**		**Imaging** *(Replaces ScanRRs)*	Case Management
Online Maintenance	**Auditing**			Geo-Spatial (GIS)	Complaint Resolution
Online Look-up	Online Payment	**Revenue**	**Security**	Continuing Education	External Interfaces

External	CA Partners	DCA Systems
Other States	DOJ	PSI
Schools	EDD	IVR

One System.....Many Boards

Question: How will one system work for 40+ unique entities?

Answer: Individual Board controlled configuration...

Conceptual Design