NEW, EASY GUIDELINES ON PRESCRIBING

Adopted unanimously by the Medical Board on July 29, 1994.

"No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain."
—Business and Professions Code §2241.5(c)

1. HISTORY/PHYSICAL EXAMINATION
A medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function, substance abuse history, assessment of underlying or coexisting diseases or conditions, and should also include the presence of a recognized medical indication for the use of a controlled substance. Prescribing controlled substances for intractable pain in California, as noted in the definition in the text of the Report, also requires evaluation by one or more specialists.

2. TREATMENT PLAN, OBJECTIVES
The treatment plan should state objectives by which treatment success can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician should tailor drug therapy to the individual medical needs of each patient. Several treatment modalities or a rehabilitation program may be necessary if the pain has differing etiologies or is associated with physical and psychosocial impairment.

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

4. PERIODIC REVIEW
The physician should periodically review the course of opioid treatment of the patient and any new information about the etiology of the pain. Continuation or modification of opioid therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient has not improved, the physician should assess the appropriateness of continued opioid treatment or trial of other modalities.

5. CONSULTATION
The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. In addition, physicians should give special attention to those pain patients who are at risk for misuse of their medications including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

6. RECORDS
The physician should keep accurate and complete records according to items 1-5 above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, agreements with the patient, and periodic reviews.

7. COMPLIANCE WITH CONTROLLED SUBSTANCES LAWS AND REGULATIONS
To prescribe controlled substances, the physician must be appropriately licensed in California, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and the Medical Board's Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons for specific rules governing issuance of controlled substances prescriptions.

(The preamble and postscript of the Report are on page 8.)

THE MISSION OF THE MEDICAL BOARD OF CALIFORNIA
The mission of the Medical Board of California is to protect consumers through proper licensing of physicians and surgeons and certain allied health professions and through the vigorous, objective enforcement of the Medical Practice Act.
More Reforms Enacted, Lawsuits Continue,...

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

These pages are filled with reports of major Board decisions which will have a direct effect on physicians.

The lead story is the publication of new guidelines on prescribing — guidelines designed to help physicians. The guidelines represent an effort on our part to "make a deal" with the physician community. Follow these common sense, good medical practice rules and you get no trouble from us. In fact, follow these procedures and no drug enforcement entity would ever have a case against you.

MEDICAL EXPERTS
The second major story (pp. 4-6) represents perhaps the most far-reaching reform of any adopted by the Board in our almost two-year effort to become the most modern medical board in the nation. It reports (in outline format) the Board’s adoption of a brand new statewide system for the future use of medical experts and consultants in our enforcement process. The outline is the result of 15 months of deliberations by a Board task force that held nine public hearings, ordered and then evaluated four studies and reviewed nearly 18 hours of testimony, including some by out-of-state experts.

Elsewhere there is an announcement of the Governor’s Summit to enhance recruitment of appropriately trained primary care providers for under served areas of our growing and increasingly diverse state. There is also a report on our participation in a study to computerize the triplicate procedure, and the second phase of our study to develop more efficient and better understood enforcement priorities is under way.

1994 LEGISLATION
This year’s legislative results added emphasis to the Board’s enforcement program. SB 1775 (Presley II-A) contained a major new provision for suspending licenses of physicians convicted of (or pleading nolo contendere to) felonies that relate to the practice of medicine. Four felonies (murder, rape, selling drugs, and child molestation) are conclusively presumed to relate to the practice; other felonies will be reviewed by a Division of Medical Quality panel to determine that relationship on a case-by-case basis. A provision also was added to SB 1775 to clarify the residency requirements for doctors of podiatric medicine, at the request of the Board of Podiatric Medicine.

Other Presley II-A provisions were important technical changes to last year’s Omnibus Medical Board Reform Act (SB 916), such as quorum voting requirements on certain actions of the DMQ and changes relating to statistical reporting by the Medical Board to the Legislature.

In addition the Legislature passed AB 595 by Assemblywoman Jackie Speier (D-South San Francisco), culminating a two-year negotiated effort to regulate out-of-hospital surgery settings for the first time in California. The Medical Board accepted the task of creating a credentialing system with strict but reasonable standards for all such settings. Veterans of out-of-hospital setting issues will attest that this authority will add a major new arrow to the Board’s enforcement quiver by providing sanctions against the facilities of errant operators in addition to potential actions against their licenses.

Finally, the Legislature enacted two other Board-sponsored bills: AB 3260 by Assemblywoman Julie Bornstein (D-Palm Springs), which contained provisions setting protocols for HMO operation of so-called “shot card” systems and SB 799 by Senator Robert Presley (D-Riverside), which was an important technical bill confirming the Board’s fee increase of last year. SB 799 also permits the Board to reduce that fee by about $25 over the next two years, as the cost-effective way to return to physicians the $2.5 million recovered from the state’s General Fund as a consequence of the successful California Medical Association (CMA) lawsuit prohibiting transfer of special funds to the state’s General Fund.

LAWSUITS
Legislative success and major reforms bring out critics at the same time, however, and we are still locked in lawsuits which conflict with each other. The CMA still has its suit to enjoin the Board from carrying out its new information disclosure policy, especially the referral of cases to the Attorney General. The CMA thinks we disclose too much about doctors.

On the other hand, several of the state’s major newspapers (The Los Angeles Times, The Sacramento Bee, and the San Jose Mercury News) are suing the Board for raw computer data on doctors. They think we don’t disclose enough!

1995 LEGISLATION
At its November meeting the Board will review legislative proposals for next year which may generate controversy anew. Once again the Board will consider proposals to...
disclose information on Business and Professions Code section 805 reports from hospital peer reviews. This time the proposal will focus on only the most egregious cases and only on those where the reported physician has lost the confidence of his/her peers after contesting the proceedings.

Additional research to bolster a previous proposal to obtain interim suspension orders by a single or double signature will be presented to the Board. Proposals to outlaw EDTA Chelation Therapy and to codify a resolution to the "Kees decision" regarding diversion will also be made. A new measure on special licensing, that is bound to attract the attention of the state's medical schools, will be reviewed.

Finally the Board will consider two measures to enhance the equity to physicians of its procedures: (1) whether to impose upon itself a statute of limitations (not now law in administrative procedures) that would require any charge under the Medical Practice Act to be brought within a set number of years, and (2) a measure that would require that judgments be made on the basis of medical standards in existence at the time of an alleged violation of the Medical Practice Act in "quality of care" cases rather than using standards in effect at the time the charge of violation is made. (This latter is now the usual practice, but it is not required by law.) Both proposals are the result of discussions I and other Board members have had as we visited groups of physicians around the state this year.

Perhaps the greatest challenge to the Board in 1995 will be to defuse the announced attempt by the CMA and the CPIL to weaken the Board's Division of Medical Quality... (leaving it) as little more than an advisory committee.

"THE UNHOLY ALLIANCE"
Perhaps the greatest challenge to the Board in 1995 will be to defuse the announced attempt by the CMA and the Center for Public Interest Law (CPIL) to weaken the Board's Division of Medical Quality by eliminating, by legislation, the Division's judicial functions. In my view, this would leave the DMQ as little more than an advisory committee.

Some CMA and CPIL officials took umbrage when I called this joint effort an "unholy alliance," but how else can it be viewed? CPIL, for its part, has always advocated that only lawyers should judge doctors—or anybody else for that matter. But the CMA has traditionally protected, almost as religion, the direct involvement of doctors in judging other doctors. Removing that involvement should be a hard sell by CMA leadership to its members, but they are determined to proceed. A few days ago, however, I answered a letter from a member of CMA's House of Delegates who had never heard of the plan, much less approved it.

This joint attack comes when the Board has become more effective and efficient at physician discipline than ever. Just when our reforms kick into high gear, these two traditional competitors join to thwart success. Why? No one has made a case for this change. CPIL's data is two years old now and I have seen no data to bolster CMA's turnaround. Yet both groups seem to prefer a system of physician discipline that relies solely on civil service-protected administrative law judges, many of whom, despite a new provision in the law, still judge a wide variety of cases rather than specializing in physician or even health care cases.

The Board will hold a retreat at the Mandalay Beach Hotel in Oxnard on October 6-8. Unlike the CMA and CPIL, which are private organizations, our meetings are open to the public. Most of our program will be educational, but our discussion will also focus on "the unholy alliance." You are welcome to attend and listen.
Board Adopts Major Overhaul...

(Final report adopted on July 29, 1994.)

In March 1993, a Medical Summit was held in Burbank at the request of the Governor. It was sponsored by the State and Consumer Services Agency together with the Medical Board, and attendees included representatives from:

- The Medical Board of California
- The State Assembly and State Senate
- California Medical Association
- Other Medical and Allied Health Organizations
- Community Organizations
- Center for Public Interest Law and other Consumer Advocates
- Law Enforcement Agencies
- Academics and Generalists

Over a two-day period, presentations were made and discussed in depth. In response to the final recommendations made by the summit participants, the Board created this Task Force (among others) and charged it with reviewing the use of medical resources in the enforcement process and making recommendations to the Board.

The Task Force has met publicly on nine occasions in both Northern and Southern California over the past 16 months. It has received testimony from invited guests and interested parties, and its members have read and analyzed hundreds of pages of reports, figures, plans, and comments submitted to them, notably four reports ordered by the Task Force, including a study of the duties and functions of district medical consultants by an outside analyst. They have discussed all of the points raised and consulted with staff as well as with others having specialized expertise in pertinent areas of law.

This report summarizes the Task Force's recommendations to the Board. We believe that it builds on the strengths of the existing system and will allow the Board to craft an enforcement process that is more consistent, more objective, more efficient, more responsible, and more manageable. It creates a systematic approach to the qualifications, appointment, training, oversight, evaluation, and functions of the physicians who collectively constitute the Board's medical resources. It clarifies reporting relationships and facilitates communication among the investigator, Deputy Attorneys General, District Medical Consultants, and medical experts who are the vital organs of the enforcement team. It provides greater management flexibility while emphasizing lines of communication with local and statewide medical communities. It should lead to more timely disposition of cases with the enforcement process while protecting the public and ensuring fairness to licensees. Program oversight is maintained with an increased level of participation by Board members. The recent reallocation of workload as a result of Board organization makes this not only possible—but practical.

In closing, the Task Force expresses its thanks to staff for their assistance; and to the many District Medical Consultants and others who have given generously of their time, energy, and constructive criticism in our deliberations. We also thank former Board member, Michael Weisman, M.D., who originally chaired this task force, for his dedication and insights.

Alan E. Shumacher, M.D. (Chair)
Clarence Avery, M.D.*
Robert del Junco, M.D.
Bruce Hasenkamp, J.D.
Karen McElliott
Jacquelin Trestrail, M.D.

* Dr. Avery was present and voted for Parts I and II of this report but was absent for the vote on Parts III and IV.

I. UTILIZATION OF MEDICAL EXPERTS

A. Minimum Qualifications

1. Board certification (one of 24 ABMS Boards) or an "emerging" specialty, subspecialty or qualifications that are equivalent or superior under special circumstances
2. License in good standing; no prior discipline, no current accusation pending, no complaints "closed with merit,")
3. Minimum of five years in practice in area of specialty
4. Active practice (defined as at least 80 hours/month in direct patient care or clinical activity or teaching, at least 40 hours of which is direct patient care) or non-active for no more than two years at time of appointment to panel. Under special circumstances, this qualification may be waived, and
5. Peer review experience (hospital, medical society, or equivalent) (recommended, not required)

B. Appointment

1. Appointed by Division of Medical Quality (DMQ) after meeting qualifications, successfully completing training and signing a written agreement to serve and to testify as
...Improvements in Use of Experts, Consultants

needed in any case in which a written opinion is provided. Under special circumstances, such as the immediate need for a rebuttal witness in court, this procedure may be waived.

2. Appointed to a 2-year term
3. May be reappointed to subsequent terms after positive evaluation and continued qualification.
4. Appointment agreement includes obligation to testify or complete testimony on cases pending at the time term expires.

C. Training

1. Minimum of 8 hours
2. Training faculty consists of Supervising Investigator, Deputy Attorneys General (DAG), and District Medical Consultants
3. Utilizes statewide, standardized course outline developed by faculty
4. Retraining required every four years

D. Oversight and Evaluation

1. DMQ establishes written standards of performance (completeness of reports, clarity, objectivity, timeliness, capability as a witness, etc.)
2. Statewide panel of experts maintained by Board staff on data base
3. Oversight Committee composed of two members of DMQ (of which at least one must be a physician) and representatives from the Health Quality Enforcement Section/Attorney General (HQES/AG), District Medical Consultants, and Enforcement management which performs initial evaluations and evaluations of performance prior to reappointment.

E. Assignment to Cases

1. Made by District Medical Consultant from the statewide panel of experts
2. Board certification or area of practice should match that of respondent's specialty or area of practice under review
3. Ordinarily only one expert will be assigned per case in non-quality of care cases except when it is necessary to add a specialty or subspecialty in complex cases. In quality of care cases a second expert may be engaged to confirm potential violations of the Medical Practice Act.
4. Expert should not have, or appear to have, any conflict of interest which could be construed as economically competitive or have any professional, personal or financial association which could be construed as undue influence on independent judgement.
5. All quality of care cases shall be reviewed at a meeting (in person or by teleconference) among the investigator, the supervising DAG or the DAG assigned to a specific case, if assigned, and the District Medical Consultant prior to referral to the Attorney General for filing of an accusation. The expert shall be available to participate in this meeting, if required, after he/she has filed a written opinion. The same reviewers shall meet in similar fashion to conduct a retrospective review and analysis of cases that are not successful.

II. PEER REVIEW PANELS

A. Minimum Qualifications

1. Same as Medical Experts

B. Appointment

1. Appointed by District Medical Consultant
2. From pool of eligible local physicians

C. Training (Same as Medical Experts)

D. Oversight and Evaluation

1. Overseen by and report to District Medical Consultant
2. Evaluation same as for Medical Experts

E. Functions

1. Constituted in groups of 3-5, as needed
2. Provide counseling to local physicians who receive letters of concern or letters of reprimand
3. Assist in probation monitoring and in monitoring of practice restrictions
4. Administer or assist with clinical competency examinations
5. May serve as Medical Expert
6. Along with District Medical Consultant, provide outreach to local medical and public groups about the mission and functions of the Board

F. Compensation

1. Travel expenses per State schedule

(Cont. on p. 6)
III. UTILIZATION OF DISTRICT MEDICAL CONSULTANTS

A. Minimum Qualifications

1. Same as for Medical Experts, except
2. Active practice, as defined, is optional at the choice of the consultant
3. Should possess skills in interviewing and conflict resolution and have demonstrated administrative skills, and
4. If working part-time as a physician outside of employment with the Board, any perception of conflict of interest must be eliminated by the maintenance of strict confidentiality and by the recusing of himself/herself from cases presenting economic, professional, or personal conflict. The Expert Oversight Committee (I, D, 3) shall develop and publish a Code of Ethics to define conflict issues/parameters for consultants.

B. Appointment (Civil Service)

1. “Permanent intermittent”* employees of the Board
2. Selected by the Supervising Investigator of the District Office in which the Consultant is to perform duties with the advice and consent of a selection committee appointed by the Board, and
3. Drawn from a list of qualified applicants certified through civil service testing

C. Oversight and Evaluation

1. Report to Supervising Investigators of each District Office
2. Annual evaluation by Supervising Investigators, with the advice of the Expert Oversight Committee, (I, D, 3)—but not including the District Medical Consultants) based on performance standards to be developed and published by the Chief of Enforcement

D. Duties and Functions

1. Review records
2. Consult with investigators, DAGs, and medical experts as a part of the case management team during investigation and, through investigators, advise on case disposition, including retrospective review of case management and utilization of medical experts (can advise DAGs independently when asked)
3. Supervise local peer review panels and participate in same activities
4. Participate in regular case conferences and case tracking
5. Perform administrative duties as assigned
6. Provide outreach about the mission and functions of the Board, and
7. Participate, as appropriate, in regular meetings of District Medical Consultants, Supervising Investigators, Supervising DAGs, and headquarters’ personnel

E. Compensation

1. Per civil service classification

IV. MEDICAL CONSULTANT(S) TO THE BOARD

A. Qualifications

1. Same as District Medical Consultants

B. Appointment (Civil Service)

1. The position of Chief Medical Consultant is abolished and is replaced by “Medical Consultant(s) to the Board” in the category of “permanent intermittent”* civil service.
2. Selected by Executive Director with the advice and consent of the Board

C. Oversight and Evaluation

1. Reports to Executive Director
2. Annual evaluation by the Executive Director and the Executive Committee of the Board

D. Duties and Functions

Under the general supervision of the Executive Director:

1. Advises Board and/or Executive Director on issues affecting the Board, such as:
   • Health resources (under served areas)
   • Scope of practice issues
   • Licensure issues
   • Educational programs, such as introductory training for administrative law judges, training for medical students and counselling in the MBC Diversion Program
2. Researches specified issues (or recommend research) so as to better inform the Board
3. Reviews proposed accusations prior to signature and advises the Executive Director on quality of care cases, and
4. Testifies before legislative committees or other governmental entities on health issues affecting the Board, as requested

E. Compensation

1. Per civil service classification

* “Permanent Intermittent” — a civil service position or appointment which the employee is to work periodically or a fluctuating portion of the full-time schedule.
Physician Alerts

A Clarification—
Reporting Requirements

In our last Action Report, we published an article about physicians’ newly expanded duty to report criminal conduct to law enforcement (Penal Code section 11160). We have received a few calls from our licensees seeking clarification. The following is information in response to three of the most common inquiries.

- Regarding the enumerated “assaultive or abusive conduct” which physicians must report, the sexual acts listed refer to acts which constitute crimes under existing law (e.g., with a minor or against the will of an adult). Under existing law, sexual conduct between consenting adults normally does not constitute criminal conduct, and therefore need not be reported.

- All physicians, including solo practitioners, are required to report under the new law.

- The new law did not change the existing requirement that physicians must report self-inflicted wounds or injuries, which may include suicide attempts.

For more information, please write to: Medical Board of California, Executive Office, 1434 Howe Avenue, Suite 100, Sacramento, CA 95825.

Dementia Patients Must be Reported to DMV

The Department of Motor Vehicles (DMV) has implemented new guidelines for evaluating people reported with Alzheimer’s disease or other types of dementia by their doctors. Physicians licensed to practice in California are mandated by Health and Safety Code section 410 to immediately report patients they have diagnosed as having a disorder characterized by a lapse of consciousness, including Alzheimer’s disease or other related disorders. All reports must be submitted by the physician to the local county health officer. The health officer in tum sends the report to the nearest DMV Driver Safety Office.

A doctor’s report of a patient with dementia does not automatically mean the patient will lose his/her driver’s license. The Dementia Guidelines assist Driver Safety Hearing Officers to evaluate these individuals fairly and in a consistent manner. However, only individuals diagnosed as having dementia in the mild stage will be evaluated. People with a moderate or severe dementia diagnosis lack the skills necessary for safely operating a motor vehicle. Their drivers’ licenses will be revoked.

The evaluation process for those with mild dementia involves four steps. (1) The reported person must authorize release of his/her medical information to the DMV (the DMV must maintain its confidentiality). (2) DMV reviews the medical documentation received from the physician. (3) The person is given a written knowledge test. If he/she does well, a reexamination interview is held. (4) A driving test is given to those who do well during the reexamination.

Any person who loses his/her driver’s license may appeal the decision and request a hearing. For further information, please contact Patti Caraska, Driver Control Policy Unit, Department of Motor Vehicles, at (916) 657-5979.

Governor’s Summit on Health Care:
Work Force Resources

The Medical Board’s Task Force on Health Resources has been transformed into a “Governor’s Summit,” signifying that several state agencies have joined to develop an action agenda on common goals.

At the July meeting of the Board, State & Consumer Services Secretary Joanne Kozberg announced the Governor’s “call” in response to the Board’s request (see Action Report, July 1994).

The Summit will result in legislative recommendations for 1995 to address current shortages in primary care providers, particularly in underserved areas of California.

Theresa Claassen of San Francisco (left) and Jacquelin Trestrail, M.D., of San Diego recently completed two terms each as members of the Medical Board. At the July 29 meeting of the Board, each was presented with a State Senate Resolution honoring her service. Ms. Claassen served as Secretary of the Board’s Division of Medical Quality, and Dr. Trestrail served as President of the Board’s Division of Allied Health Professions and as President of the Board (1993).
Text of “Guideline for Prescribing Controlled Substances for Intractable Pain”

PREAMBLE

On May 6, 1994, the Medical Board of California formally adopted a policy statement entitled “Prescribing controlled substances for pain.” (Action Report, July 1994) The statement outlines the Board’s proactive approach to improving appropriate prescribing for effective pain management in California, while preventing drug diversion and abuse. The policy statement is the product of a year of research, hearings and discussions. California physicians are encouraged to consult the policy statement and these guidelines.

The Medical Board recognizes that inappropriate prescribing of controlled substances including the opioids can lead to drug abuse and diversion. Inappropriate prescribing can also lead to ineffective management of pain, unnecessary suffering of patients and increased health care costs. The Board recognizes that some physicians do not treat pain properly due to lack of knowledge or concern about pain. Fear of discipline by the Board may also be an impediment to medically appropriate prescribing for pain. This Guideline is intended to encourage effective pain management in California, and help physicians reach a level of comfort about appropriate prescribing by clarifying the principles of professional practice that are endorsed by the Board.

“A HIGH PRIORITY”

The Board strongly urges physicians to view effective pain management as a high priority in all patients, including children and the elderly. Pain should be assessed and treated promptly, effectively and for as long as pain persists. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment. Pain treatment may involve the use of several drug and non-drug treatment modalities, often in combination. For some types of pain the use of drugs is emphasized and should be pursued vigorously; for other types, the use of drugs is better de-emphasized in favor of other therapeutic modalities. Physicians should have sufficient knowledge or consultation to make such judgments for their patients.

Drugs, in particular the opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures, and cancer. Physicians are referred to the U.S. Agency for Health Care Policy and Research Clinical Practice Guidelines which have been endorsed by the Board as a sound yet flexible approach to the management of these types of pain.

The prescribing of opioid analgesics for other patients with intractable non-cancer pain may also be beneficial, especially when efforts to remove the cause of pain or to treat it with other modalities have been unsuccessful.

Intractable pain is defined by law in California as: “a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and surgeon and one or more physicians and surgeons specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.” (Section 2241.5(b) California Business and Professions Code)

Physicians who prescribe opioids for intractable pain should not fear disciplinary action from any enforcement or regulatory agency in California if they follow California law (section 2241.5(c)), which reads, “No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain.” Also, physicians should use sound clinical judgment, and care for their patients according to the following principles of responsible professional practice:

GUIDELINES

(Complete text of the guidelines is on page 1.)

POSTSCRIPT

Under federal and state law, it is unlawful for a physician to prescribe controlled substances to a patient for other than a legitimate medical purpose (for example, prescribing solely for the maintenance of opioid addiction), or outside of professional practice (for example, prescribing without a medical examination of the patient).

It is lawful to prescribe opioid analgesics in the course of professional practice for the treatment of intractable pain according to federal regulations and California Business and Professions Code Section 2241.5, the California Intractable Pain Treatment Act (CIPTA). However, the CIPTA does not apply to those persons being treated by the physician and surgeon for chemical dependency because of their use of drugs or controlled substances (Section 2241.5(d)), and does not authorize a physician or surgeon to prescribe or administer controlled substances to a person the practitioner knows to be using drugs or substances for nontherapeutic purposes (Section 2241.5(e)).
The Death Certificate: A Primer For Physicians

by
George R. Flores, M.D., M.P.H.
Sonoma County Public Health Officer and Assistant Clinical Professor of Family and Community Medicine, U.C. San Francisco

In California, a licensed physician is legally obligated to file a death certificate within 15 hours of the natural death of his or her patient. Disposition of remains cannot occur until the certificate has been filed. However, it comes as no surprise to funeral directors or to county registrars of vital records that most physicians in California have never received formal instruction in completing a certificate of death. These sources estimate that one in four certificates filed by physicians are unacceptable at first. Consequently, a staggering number of problem certificates must be re-done.

Since January of this year, the certificate has taken on a new format. The section for which physicians are responsible has been re-numbered and includes an additional line for listing cause of death.

The Death Certificate is a legal document as well as a public document. Its information is relied upon by insurers, by tax officials, and by the family of the deceased. Its demographic and cause of death information is used to compile a body of epidemiologic knowledge, for scientists and policy makers to initiate research or to fund health and social programs. Death certificates must be completed well and in a timely fashion.

Physicians need file a death certificate only for deaths from natural causes. Physicians should not initiate a certificate for death under the following circumstances, but should immediately report it to the county coroner for possible investigation:

- unattended death
- when the attending physician is unable to state the cause of death
- death due to injury, poisoning, suicide or SIDS
- death resulting from criminal acts
- death from occupational causes or from highly communicable diseases

The physician’s primary responsibility in death registration is to certify the cause of death and related factors. This requires an expert opinion, a concise and reasonable judgement of what led to death, based on the preponderance of available evidence. Absolute certainty is neither required nor expected.

The immediate cause of death listed in item #107(A) of the new certificate is the disease, injury, or complication that directly preceded death. Then listed on lines B, C, and D of item #107 is the underlying cause which is the antecedent or pathologically related condition that set in motion the chain of events that lead to death. The condition of shortest duration is listed first; the longest duration is listed last. The figure below gives an example of cause of death properly listed on the new certificate:

Mechanism of death should not be listed as cause of death; it is the physiologic abnormality or symptom brought about by the cause of death, such as: congestive heart failure, gastrointestinal hemorrhage, and cardiac arrest. Virtually everyone incurs “cardiopulmonary arrest” when they die, so listing it on the certificate is meaningless. Risk factors, such as “smoking” for atherosclerosis, or “alcohol intoxication” for automobile collision are most appropriately included in item #112 “Other Significant Conditions.”

A new video, “the Physician’s Guide to Proper Completion of the Certificate of Death,” is available for viewing from local funeral directors and county registrars. It gives case examples and makes important points such as use black ink only; make no alterations or corrections; and never sign a blank certificate.

For more information about completing death certificates or for assistance in deciding what to list as “cause of death,” contact the medical examiner in your county coroner’s office, or a local forensic pathologist, the Registrar of Vital Statistics in your county (usually the county Public Health Department); or the Department of Health Services Office of Vital Records and Statistics, (916) 445-2684.
New Studies Ordered

Enforcement Priorities, Triplicate Prescriptions

July Board actions included the start of Phase II — the "prospective" part — of the Schubert & Associates Study on Priorities, and participation in the study to computerize the system for triplicate prescription procedures maintained by the Bureau of Narcotic Enforcement of the Department of Justice.

Schubert, Phase II, will test the risk assessment model developed in the "retrospective" study completed earlier this year when statisticians reviewed the last three years' actual disciplinary case files. New ("prospective") cases will be matched against the model over the next year to test the model's validity.

By an action of the Board, however, the international medical school of graduation will be removed as a factor in the "prospective" part of the study. Inclusion of the international school created controversy over possible discrimination; thus, the Board ordered that the IMG factor be removed from Part II. Later, the statistical difference of removing it can be matched against the previous data of Part I.

Physicians and pharmacists are used to, even aggravated by, the triplicate prescription procedure requiring the filing of forms every time narcotics are prescribed. The so-called triplicate program is law enforcement's guard against illegal use of volumes of drugs.

It is also the last major enforcement program not yet fully computerized. After a year of evaluation, the Board of Pharmacy contracted for a $136,500 study to bring the triplicate program under the wing of the Justice Department's respected Hawkins Data Center. The end result will be enhanced efficiency for physicians, pharmacists and enforcement officials alike. The Medical Board authorized a $44,500 appropriation to fund one-third of the cost of the study.

Shirley Svorny, Ph.D. accepts the Federation of State Medical Board's 1993 Editorial Board Award for Excellence from Medical Board President Bruce Hasenkamp at the Board's July meeting in Burbank. Her award-winning article, "Advances in Economic Theories in Medical Licensure," appeared in Volume 80, Number 1, of the Federation Bulletin: The Journal of Medical Licensure and Discipline. Dr. Svorny is a professor of economics at California State University, Northridge.

### Explanation of Disciplinary Language

1. "Revoked"— The license is canceled, voided, annulled, rescinded. The right to practice is ended.

2. "Revoked - Default"— After valid service of the Accusation (formal charges), the licensee fails to file the required response or fails to appear at the hearing. The license is forfeited through inaction.

3. "Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' suspension"— "Stayed" means the revocation is postponed, put off. Professional practice may continue so long as the licensee complies with specified probationary terms and conditions, which, in this example, includes 60 days' actual suspension from practice. Violation of probation may result in the revocation that was postponed.

4. "Suspension from practice"— The licensee is benched and prohibited from practicing for a specific period of time.

5. "Temporary Restraining Order"— A TRO is issued by a Superior Court Judge to halt practice immediately. When issued by an Administrative Law Judge, it is called an ISO (Interim Suspension Order).


7. "Gross negligence"— An extreme deviation from the standard of practice.

8. "Incompetence"— Lack of knowledge or skills in discharging professional obligations.

9. "Stipulated Decision"— A form of plea bargaining. The case is negotiated and settled prior to trial.

10. "Voluntary Surrender"— Resignation under a cloud. While charges are pending, the licensee turns in the license — subject to acceptance by the relevant Board.

11. "Probationary License"— A conditional license issued to an applicant on probationary terms and conditions. This is done when good cause exists for denial of the license application.

12. "Effective date of Decision"— Example: "July 8, 1994" at the bottom of the summary means the date the disciplinary decision goes into operation.

13. "Judicial Review recently completed"— The disciplinary decision was challenged through the court system — Superior Court, maybe Court of Appeal, maybe State Supreme Court — and the discipline was upheld. This notation explains, for example, why a case effective "June 10, 1990" is finally being reported for the first time four years later in 1994.

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Medical Board of California
Action Report
October 1994 Page 10
Disciplinary Actions: May 1, 1994 to August 31, 1994

Decisions: Physicians and Surgeons

BARNES, CHESTER R., M.D. (A-28934) Los Angeles, CA

BROWN, STEVEN M., M.D. (A-49127) Dallas, TX

CALDWELL, JUDITH, M.D. (G-71774) Bakersfield, CA

COMAR, DAVE, M.D. (A-17667) Los Angeles, CA

CHEZ, DENNIS, M.D. (G-24790) Truckee, CA

CHU, CHENG-CHI, M.D. (A-30024) Kings Point, NY

COHEN, MELVIN WARREN, M.D. (C-37394) Brooklyn, NY

COMINGS, DAVID E., M.D. (G-17736) Duarte, CA

DIMMICK, JENS W., M.D. (G-26557) Rolling Hills Estates, CA

DUBLERMAN, ALAN, M.D. (G-32505) Denver, CO

ECOFF, ARTHUR, M.D. (A-29185) Denver, CO

FRAZIER, SHERVERT H., Jr., M.D. (C-34112) Waverly, MA

GRAHAM, CURTIS, M.D. (G-9793) Kalamazoo, MI
B&P Code §§2236, 2234(c), 2305. Federal conviction for mail fraud in falsifying at least 10 mortgage applications mailed to HUD. Restrictions placed on his Arizona license by the Arizona Board. Revoked, stayed, 5 years’ probation on terms and conditions. August 10, 1994.

HECK, BARRY, M.D. (A-31068) Fairfield, CT

HO, RICHARD KAY-YIN, M.D. (G-38504) Santa Clara, CA

HOLLIMAN, DANIEL, M.D. (G-71617) San Andreas, CA

HOWARD, BARRY, M.D. (G-42894) Boulder, CO

HURTADO, MONICA WATTS, M.D. (G-69245) Woodland Hills, CA

JOHNSON, HAROLD ZAY, M.D. (G-18683) Long Beach, CA

JULIAN, VENUS NAVARRO, M.D. (A-41783) Van Nuys, CA

KRAMER, JAMES JOSEPH, M.D. (G-37961) Jackson, MS

LAKE, ALAN S., M.D. (G-31864) Long Beach, CA
B&P Code §§2234(e), 2236, 2239. Alcohol abuse. Convictions for driving under the influence of alcohol, including a felony conviction involving an injury that led to a 2-year state prison sentence. Revoked, stayed, 3 years’ probation on terms and conditions. July 21, 1994.

LATONN, EDWARD D., M.D. (G-15030) Wilmington, DE

MAGNUS, VERNON J., M.D. (G-22438) Lodi, CA
B&P Code §2234(c). Stipulated Decision. Repeated negligent acts in abdominal surgery; failing to manage the patient’s clotting complication adequately; having too long a clamp time; keeping poor operative records; negligent rough handling of tissue during colectomy surgery. Revoked, stayed, 5 years’ probation on terms and conditions. August 29, 1994.

(Cont. on p. 12)
Disciplinary Actions: May 1, 1994 — August 31, 1994 (Cont. from p. 11)

MONROE, BYRON LEE, M.D. (G-25794) Santa Barbara, CA

MOONEY, HERBERT S., M.D. (A-19982) Longmont, CO
B&P Code §2305. Stipulated Decision. Discipline by Colorado Board for engaging in 2 or more acts which failed to meet generally accepted standards of medical practice while treating 3 emergency room patients. Revoked, stayed, 5 years' probation on terms and conditions. August 17, 1994.

MEYERS, GEORGE C., M.D. (C-36092) Bellevue, WA

MEYERS, RONALD A., M.D. (G-70050) Port Angeles, WA

MURAKAMI, CLIFFORD, M.D. (A-27799) Los Angeles, CA
B&P Code §§725, 2234 (b), (c), (d), 2236, 2242. Stipulated Decision. Conviction for prescribing controlled drugs without a legitimate medical purpose. Indiscriminate prescribing of Valium, Fasizn, Daltame, Tylenol #3 with Codeine without prior exam and medical indication, constituting gross negligence, incompetence, and excessive prescribing. Revoked, stayed, 5 years' probation on terms and conditions. May 26, 1994.

NOONAN, CHARLES A., M.D. (C-37051) Concord, CA
B&P Code §2234 (c). Repeated negligent acts in continuing to prescribe ever-increasing doses of vitamin B6, to a toxic level to a psychiatric patient for the treatment of a mental illness. Revoked, stayed, 5 years' probation on terms and conditions. May 26, 1994.

NOVAK, FREDDIE P., M.D. (G-61059) Portland, OR

PERMEN, LAWRENCE E., M.D. (C-27101) Oxnard, CA
B&P Code §§725, 2234 (b), (c), (d), 2242. Stipulated Decision. Excessive prescribing without prior exam and medical indication, constituting gross negligence and incompetent prescribing practices. Revoked, stayed, 5 years' probation on terms and conditions. June 24, 1994.

PITMAN, KATHRYN A., M.D. (A-40247) Brein, CA

RHA, MYUNG K., M.D. (A-33238) Palos Verdes, CA

PRAKASH, OM, M.D. (C-39398) Modesto, CA
B&P Code §§2234(e), 2262. Stipulated Decision. Dishonesty in making false chart notes for 8 patients in Modesto hospital when in fact he was visiting New York during that time. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. August 17, 1994.

ROTTSCHAEFER, ROBERT T., M.D. (A-12387) Palm Desert, CA
B&P Code §§2234(b), (d). Stipulated Decision. Gross negligence and incompetence in managing an overweight patient with high blood pressure and hypertension. Aldoril was refilled for 4 years without a physical exam and blood pressure monitoring. Fastin was contraindicated for a patient with hypertension, resulting in a stroke. Revoked, stayed, 3 years' probation on terms and conditions. August 4, 1994.

SCHULTE, JEROME L., M.D. (C-35364) Atascadero, CA

SCIARRO, MICHAEL J., M.D. (G-11083) Los Angeles, CA
B&P Code §2234 (b)(c)(d). Stipulated Decision. Engaged in unsupervised research for experimental treatment of terminally ill AIDS patients through inoculations under a "viruses compete theory." He failed to follow well-established standard research protocols, and failed to submit his research to an independent institutional review committee before conducting human experimentation. 90 days' suspension, stayed, 3 years' probation on terms and conditions. July 1, 1994.

SENTER, PHULLIS, M.D. (G-34906) Santa Rosa, CA
B&P Code §§725, 2234, 2242. Stipulated Decision. Multiple prescribing violations for supplying excessive amounts of narcotics and other controlled drugs to her abusive late husband, an addict who ultimately died — apparently from another drug overdose. Revoked, stayed, 3 years' probation on terms and conditions. August 26, 1994.

SHARPE, SHELTON E., M.D. (G-51390) Carmichael, CA

SHERWOOD, HAROLD R., M.D. (C-8095) Culver City, CA

SHETH, ALKA, M.D. (A-35689) Del Mar, CA

SILVER, DANIEL M., M.D. (C-31379) Los Angeles, CA
B&P Code §654.2. Stipulated Decision. Orthopedic surgeon had a significant beneficial interest in an orthopedic brace retail shop. He failed to disclose his interest to patients he referred to this shop for knee braces, as required by state law—B&P Code §654.2. 1 year suspension, stayed, 3 years' probation on terms and conditions. August 20, 1994.

SMILEY, EVELYN J., M.D. (C-20354) Lamesa, TX
B&P Code §2305. Disciplined by the Texas Board for failing to practice medicine in an acceptable manner consistent with public health and welfare in the care and treatment of 3 patients. Suspended 1 year, stayed, 5 years' probation on terms and conditions. June 30, 1994.

SOL, PETER M., M.D. (A-36298) San Jose, CA
B&P Code §§480, 2234 (a) (e) (f). Stipulated Decision. Dishonesty in removing a supply of vaccines from the Kaiser Hospital premises without permission, and then selling some of these drugs for profit. Revoked, stayed, 5 years' probation on terms and conditions. August 18, 1994.

SWENSEN, ALAN D., M.D. (A-16156) Bodega Bay, CA
B&P Code §2234 (b)(d). Stipulated Decision. Gross negligence and incompetence in managing a patient with gastrointestinal symptoms by continuously prescribing Combid Spansules or generic Combanex (Cont. on p. 13)
Disciplinary Actions: May 1, 1994 - August 31, 1994 (Cont. from p. 12)

Capsules for 9 years, and failing to vigilantly monitor for tardive dysinesia which developed from this long-term use of Combid, despite the warning issued by the drug's manufacturer. Revoked, stayed, 5 years' probation on terms and conditions. August 18, 1994.

VERBRUGGE, JOSEPH, M.D. (C-34826) Englewood, CO

WATSON, LLOYD, M.D. (A-20719) Grand Terrace, CA

WESENBERG, RICHARD L., M.D. (C-38221) Mobile, AL

WILLIAMS, FENTON A., M.D. (C-33205) Kansas City, KS

WILSON, JOHN D., M.D. (C-42303) Eugene, OR

WINELAND, RICHARD, M.D. (A-28629) Burbank, CA

WOLKOFF, KENNETH A., M.D. (G-27484) Palm Beach Gardens, FL

WINSTON, STEPHEN J., M.D. (A-28363) Los Angeles, CA
B&P Code §§725, 810, 2234, 2261, 2262. Fraudulently billed insurance companies for excessive diagnostic procedures and tests which were performed without medical indication, justification or documentation. Gross negligence, incompetence, dishonesty, false documents, deceptive alteration of records. Revoked. Default. June 15, 1994.

ZIMMERMANN, JOSEPH, M.D. (A-19234) Antioch, CA
B&P Code §2234 (d). Stipulated Decision. Incompetence in OB-GYN practice: used a prostaglandin suppository at a higher dose than would have been appropriate for cervical ripening in a patient with a live fetus. Revoked, stayed, 5 years' probation on terms and conditions. July 21, 1994.

NOTICE OF CORRECTION

In the January 1994 Action Report, the disciplinary status of Yusef Gurovich, M.D. was reported: "Probation is continued with further conditions imposed." This status was in error. In fact, Dr. Gurovich's license was clear and current, having completed his probation as of the time of that publication. We regret the error.

ADDENDUM

In the last Action Report, a default revocation was reported for Joel Fine, M.D. (A-42331) Watertown, N.Y. This default decision for revocation was ordered vacated by stipulation following an appeal to Superior Court by respondent and set aside on August 24, 1994. The Accusation will be scheduled for a regular hearing on the merits. Dr. Fine is now located in Hawaii.

ACUPUNCTURISTS

BAE, SANG KOOK, C.A. (AC-1456) Los Angeles, CA

CHA, HAN SOK, C.A. (AC-4789) Los Angeles, CA

CHAN, KUN CHUN, C.A. (AC-343) San Diego, CA

CHANG, DON HYUN, C.A. (AC-2244) Westlake Village, CA

CHOI, JIN HO, C.A. (AC-1485) Santa Ana, CA

CHOU, CHIN TZU, C.A. (AC-3258) Los Angeles, CA

CHUNG, RONALD, C.A. (AC-2245) Pacoima, CA

IM, SUN JOO, C.A. (AC-1509) Downey, CA

JUN, HYUN CHUL, C.A. (AC-1202) New York, NY

KIM, JUNG KI, C.A. (AC-2425) Fresno, CA

LEE, CHUNG KYU, C.A. (AC-120) Los Angeles, CA

LEE, HWY ZUNG, C.A. (AC-2485) Granada Hills, CA

LEE, KANG JOON, C.A. (AC-3383) Los Angeles, CA

(Cont. on p. 14)
Disciplinary Actions: May 1, 1994 — August 31, 1994 (Cont. from p. 13)

LEE, KWANG OK, C.A. (AC-2755) Los Angeles, CA

LEE, HYON WOO, C.A. (CA-2840) Lancaster, CA

LEE, MYOUNG SOO, C.A. (AC-2756) Westminster, CA

LIU, LAWRENCE, C.A. (AC-927) Thousand Oaks, CA

MOON, JOON WOONG, C.A. (AC-3098) Gardenia, CA

NIEN, CHEN YU, C.A. (AC-1245) Sunnyvale, CA
B&P Code §§4955, 2052. Stipulated Decision. Conviction for practicing medicine without a license. Revoked, stayed, 5 years’ probation on terms and conditions, including 60 days’ actual suspension. July 18, 1994.

OM, JOO HYUN, C.A. (AC-2784) Campbell, CA

OWH, SOOHOO, C.A. (AC-1386) Santa Ana, CA

PAK, CHUL KYOO, C.A. (AC-1387) Los Angeles, CA

PAK, SHUNG UHN, C.A. (AC-2218) Los Angeles, CA

PAK, UN BONG, C.A. (AC-1544) Los Angeles, CA

PARK, HYE SUK, C.A. (AC-2577) Los Angeles, CA

PARK, JONG YOUNG, C.A. (AC-2433) Torrance, CA

RHEE, YOON KEUM, C.A. (AC-2572) San Diego, CA

ROH, JEUNG WOO, C.A. (AC-1556) Honolulu, HI

SHIN, PUNG HO, C.A. (AC-3474) Norwalk, CA

SONG, BYONG CHAN, C.A. (AC-2808) Los Angeles, CA

YEE, SHIRLEY, C.A. (AC-2835) Los Angeles, CA

YOO, JUNG HEE, C.A. (AC-1602) Los Angeles, CA

YOO, YOUNG HAE, C.A. (AC-1618) Los Angeles, CA

PHYSICIAN ASSISTANT

FRANK, STEVEN, P.A. (PA-12636) Citrus Heights, CA

PHYSICAL THERAPIST

CROWTHER, NELSON C. (PT-9764) Lake Havasu City, AZ

DOCTOR OF PODIATRIC MEDICINE

SCHULHOFER, SANFORD DAVID, D.P.M. (E-3943) Mountain View, CA

REGISTERED DISPENSING OPTICIAN

DALZELL, REGINALD F. (SL-49 and CL 875) Menlo Park, CA

PSYCHOLOGISTS

HEDEBERG, ALLEN (PSY-4208) Fresno, CA
B&P Code §2960(i). Unprofessional conduct in failing to report child abuse where there was reasonable suspicion of abuse. Revoked, stayed, 1 year probation on terms and conditions. May 28, 1994.

(Cont. on p. 15)
Disciplinary Actions: May 1, 1994 — August 31, 1994 (Cont. from p. 14)

NAKANO, LOREN (PSY·7265) Sunnyvale, CA

PAPEN, JAMES H. (PSY·5124) Rancho Cucamonga, CA

SUTTON, WILEY D. (PSY·4467) Lakewood, CA

RESPIRATORY CARE PRACTITIONERS

ASHANTI, MICHAEL (RCP 7950) Long Beach, CA

BATEMAN, WILLIAM (RCP 10533) Van Nuys, CA

BELL, THEODORE (RCP 13896) San Clemente, CA

BLACKMAN, SHARON T. (RCP 12057) San Francisco, CA

BRIGGS, JEANNE L. (RCP 5737) Modesto, CA

HARRELL, WILLIAM E. (RCP 9444) Rialto, CA

HILL, LEE WILLIAM (RCP 12853) Santee, CA

HOLTKE, POLLY (RCP 10634) Tahoe Vista, CA

LINDY, MALIA J. (RCP 7039) Escondido, CA

PRASAD, RAJESH (RCP 12103) Arleta, CA

ROWSE, BRENDON (RCP 10116) Chico, CA

RONCO, STEVEN P. (RCP 16087) Torrance, CA

SANDERS, DONALD J. (RCP 7815) Lakeview Terrace, CA

VOLUNTARY SURRENDER OF LICENSE

PHYSICIAN AND SURGEON

BERGMAN, SANDER, M.D. (G·24765) Bremerton, WA
May 27, 1994

DEITZLER, MARGARET, M.D. (G·7397) Alameda, CA
May 27, 1994

KARGER, ROBERT, M.D. (G·6046) San Luis Obispo, CA
May 30, 1994

MADDEN, JOHN T., M.D. (A·23239) Carlsbad, CA
June 27, 1994

PETRIE, JONATHAN L., M.D. (A·26552) Princeton, NJ
August 23, 1993

WARREN, JEROME, M.D. (G·47480) Cherry Hill, NJ
June 13, 1994

WICKERSHAM, JAMES, M.D. (G·45694) Danville, CA
June 13, 1994

WILSON, MYRON, M.D. (A·18143) Los Angeles, CA
July 18, 1994

PSYCHOLOGIST

SCHILLER, IRA Z. (PSY 5002) Santa Cruz, CA
August 1, 1994

RESPIRATORY CARE

GREENE, WARREN E. (RCP 14888) San Diego, CA
July 1, 1994

PARKER, RICHARD C. (RCP 12740) El Paso, TX
August 4, 1994

MOVING?

If you are licensed by the Medical Board, remember, the law (Business and Professions Code §2021 (b)) requires that you report every change of address. To insure that we have your most current address of record, please include your name, license number, old address, and new address. Send this information to:

Medical Board of California
Consumer Information Unit
1430 Howe Avenue, Suite 54
Sacramento, CA 95825

Please inform us of address changes so that you will continue receiving the Action Report and your license renewal application.
Business and Professions Code
Section 2021(b) requires physicians to inform the Medical Board of any address change.
EXECUTIVE SUMMARY

Senate Bill 916 ("Presley II") — The Omnibus Medical Board Reform Act, which took effect January 1, 1994, included changes in the structure of the Board and new operating policies. These reforms include new enforcement sanctions; new information disclosure to consumers; new records access provisions; reorganization of the Board to emphasize enforcement; a new Medical Quality Review system; and a $100 biennial licensing fee increase to add investigators and attorneys to enforcement programs. In the current legislative session, the Board is sponsoring SB 1775 ("Presley II-A") which adds to SB 916 and also includes new provisions relating to convictions on felony charges.

Study on Enforcement Priorities — The Board ordered an outside retrospective study by an independent consultant, Schubert & Associates of Sacramento, to review actual disciplinary records over the previous three years and to provide a risk assessment based on statistical classifications of the files. Recently, the Board authorized a one-year prospective analysis to confirm the study’s findings to date.

Appropriate Prescribing — Governor Wilson sponsored a day-long "Summit" involving scores of experts from around the country after a task force of the Board spent a year engaged in public hearings and its own research. Following the Summit, the Board adopted the first formal policy statement on prescribing for pain management in the nation. In addition, guidelines have been issued to assist physicians by providing prescribing protocols to prevent misunderstanding about what constitutes malprescribing.

Medical Quality Review — After 15 months of study and nine public hearings, a Board task force created a systematic statewide program of improved qualifications for the Board’s medical consultants and its use of experts. The task force report has been adopted by the Board and is being implemented.

Lawsuits — Among a half dozen lawsuits relating to Board policy decisions are two dramatically opposed pleadings. On the one hand, the Board was sued by the California Medical Association to enjoin the Board’s information disclosure reforms, particularly the policy to inform the inquiring public about cases referred to the Attorney General. On the other hand, three of California’s major newspapers, The Los Angeles Times, the San Jose Mercury News and The Sacramento Bee sued to obtain the raw computer data on physicians, contending that the Public Records Act requires disclosure.

PHYSICIAN AND SURGEON VALID LICENSES BY COUNTY

<table>
<thead>
<tr>
<th>County</th>
<th>Valid Licenses</th>
</tr>
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<tbody>
<tr>
<td>Alameda</td>
<td>3,340</td>
</tr>
<tr>
<td>Alpine</td>
<td>100</td>
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<td>Amador</td>
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<td>Colusa</td>
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<td>Contra Costa</td>
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<td>Del Norte</td>
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<td>El Dorado</td>
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<td>Fresno</td>
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<td>Glenn</td>
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<tr>
<td>Humboldt</td>
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<tr>
<td>Imperial</td>
<td>500</td>
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</table>

MISSION STATEMENT OF THE MEDICAL BOARD OF CALIFORNIA

The mission of the Medical Board of California is to protect consumers through proper licensing of physicians and surgeons and certain allied health professions and through the vigorous, objective enforcement of the Medical Practice Act.
## Licensing Activity

<table>
<thead>
<tr>
<th></th>
<th>FY 92-93</th>
<th>FY 93-94</th>
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<tbody>
<tr>
<td><strong>Physician Licenses Issued</strong></td>
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<tr>
<td>Federation Licensing Exam (FLEX)</td>
<td>1,174</td>
<td>1,135</td>
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<tr>
<td>National Board Exam (NBME)</td>
<td>2,493</td>
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<tr>
<td>Reciprocity with other states</td>
<td>105</td>
<td>103</td>
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<tr>
<td>Total new licenses issued</td>
<td>3,772</td>
<td>3,510</td>
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<tr>
<td>Renewal licenses issued</td>
<td>51,906</td>
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<td>Total</td>
<td>55,678</td>
<td>53,465</td>
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<tr>
<td><strong>Physician Licenses in Effect</strong></td>
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<tr>
<td>California Address</td>
<td>76,367</td>
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<td>Out of State</td>
<td>26,524</td>
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<td>Total</td>
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<td><strong>Licensing Examination Activity</strong></td>
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<td>Federal Licensing Exam (FLEX)</td>
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<tr>
<td>Applicants who passed FLEX exam</td>
<td>349*</td>
<td>239</td>
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<td>Applicants who failed FLEX exam</td>
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<td>United States Medical Licensing Exam (USMLE)</td>
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<td>Applicants who passed USMLE exam</td>
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<td>Applicants who failed USMLE exam</td>
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<td><strong>Special Purpose Licensing Exam (SPEX)</strong></td>
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<td>Total</td>
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<td><strong>Oral Exam</strong></td>
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<td>Applicants who passed oral exam</td>
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<td>Applicants who failed oral exam</td>
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<tr>
<td>Total</td>
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<td><strong>Statement of Issues to Deny License</strong></td>
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<td>Denied/Application Granted</td>
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<tr>
<td>Stipulation/Probationary Cert. Granted</td>
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<td>2</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>0</td>
<td>1</td>
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</table>

*The number of "renewal licenses issued" for FY 93-94 includes 4,308 licenses that incur no revenue because the physicians are exempt from payment of renewal fees. The number also includes physicians with "non-practicing" license status (disabled and inactive).

**FLEX last administered in December 1993. The United States Medical Licensing Exam (USMLE) replaced FLEX effective June 1994.

**USMLE first administered in June 1994.

## Verification Services

<table>
<thead>
<tr>
<th>Verification Services</th>
<th>FY 92-93</th>
<th>FY 93-94</th>
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<tbody>
<tr>
<td><strong>License Status Verifications</strong></td>
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<td>Phone Verifications</td>
<td>201,768</td>
<td>230,543</td>
</tr>
<tr>
<td>On-Line Access Verifications</td>
<td>161,607</td>
<td>167,697</td>
</tr>
<tr>
<td>Written Verifications</td>
<td>100,944</td>
<td>111,290</td>
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<tr>
<td>Teale Data Verifications</td>
<td>66,259</td>
<td>107,473*</td>
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<tr>
<td>Verification Totals</td>
<td><strong>530,578</strong></td>
<td><strong>617,003</strong></td>
</tr>
<tr>
<td>Non-Verification Telephone Calls</td>
<td>28,379</td>
<td>67,763**</td>
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<td><strong>Certifications and Letters</strong></td>
<td></td>
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<tr>
<td>Certification Letters</td>
<td>2,174</td>
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<td>Letters of Good Standing</td>
<td>5,968</td>
<td>5,961</td>
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<tr>
<td>Fictitious Name Permits Issued/Renewed</td>
<td>1,354</td>
<td>1,350</td>
</tr>
</tbody>
</table>

**Report Verifications**

<table>
<thead>
<tr>
<th></th>
<th>FY 92-93</th>
<th>FY 93-94</th>
</tr>
</thead>
<tbody>
<tr>
<td>805.5 B&amp;P Reports Received</td>
<td>179</td>
<td>164</td>
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<tr>
<td>805.5 B&amp;P Reports Mailed</td>
<td>962</td>
<td>1,216</td>
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<tr>
<td>Malpractice 800-804 B&amp;P</td>
<td>842</td>
<td>959</td>
</tr>
<tr>
<td>Incomplete Medical Records 805</td>
<td>844</td>
<td>446</td>
</tr>
<tr>
<td>Nat. Pract. Data Bank Adverse Action</td>
<td>176</td>
<td>269</td>
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<tr>
<td>NPDB 805s</td>
<td>63</td>
<td>78</td>
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<tr>
<td>NPDB Malpractice</td>
<td>1,762</td>
<td>1,279</td>
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</table>

**Continuing Medical Education**

<table>
<thead>
<tr>
<th></th>
<th>FY 92-93</th>
<th>FY 93-94</th>
</tr>
</thead>
<tbody>
<tr>
<td>CME Audits</td>
<td>847</td>
<td>782</td>
</tr>
<tr>
<td>CME Waivers</td>
<td>351</td>
<td>361</td>
</tr>
</tbody>
</table>

* The increase is due to broader access of outside organizations to our dialup verification system.

** The increase is due to rerouting of these calls through a central Consumer Information Center. These calls are recorded by computer which allows the Board to gather more accurate statistical data.
DIVISION OF LICENSING

The Division of Licensing continued to improve public protection this year. Changes were made in the policy governing information disclosure, reviews were conducted of fellowship training programs, and the Division made progress in implementing SB 2036 (1992)—the specialty board advertising law. Our public information disclosure policy has the most potential of improving public protection. The licensing program performs over 500,000 license verifications each year, and more information than ever is now being disclosed.

On October 1, 1993, the Consumer Information Unit began operation. This unit continues to verify licenses and provides new facts. Callers requesting information on physicians may now be told, in addition to licensing status and California disciplinary action, if physicians have been convicted of a felony, have malpractice judgments in excess of $30,000 against them, and if disciplinary action has been taken by another state or the federal government.

The most significant change in the information disclosure policy was to tell callers that a physician had been investigated and a case referred to the Attorney General’s Office to file charges. However, the California Medical Association obtained a temporary court injunction to prevent the release of this information. The Board has responded that this information is important to consumers and is within the Board’s rights to release. Should the court agree, our Consumer Information Unit will again begin disclosing this information.

The Division’s Special Programs Committee, which reviews and approves Business and Professions Code section 2111 fellowship programs for foreign graduates, began more closely reviewing these programs and the laws that govern them. Next year, with the help of medical schools, laws will be drafted that will improve public protection by ensuring objective minimum requirements of participating fellows and assure that adequate supervision is provided.

Implementation of SB 2036, the law that restricts physicians from advertising that they are “board certified” unless they are certified by an ABMS or equivalent Board, is moving forward. The Division received one application for “equivalent” status and will be reviewing it this year. This law has been fraught with legal challenges driven by economic interests within the medical community. So far, the regulations have withstood these challenges and the specialty board application process should move forward next year.

<table>
<thead>
<tr>
<th>ALLIED HEALTH PROFESSIONS* LICENSES ISSUED</th>
<th>FY 92-93</th>
<th>FY 93-94</th>
<th>ALLIED HEALTH PROFESSIONS LICENSES IN EFFECT</th>
<th>FY 92-93</th>
<th>FY 93-94</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncturist</td>
<td>205</td>
<td>342</td>
<td>Acupuncturist</td>
<td>3,678</td>
<td>3,985</td>
</tr>
<tr>
<td>Audiologist</td>
<td>57</td>
<td>59</td>
<td>Audiologist</td>
<td>1,285</td>
<td>1,344</td>
</tr>
<tr>
<td>Hearing Aid Dispenser</td>
<td>216</td>
<td>172</td>
<td>Hearing Aid Dispenser</td>
<td>2,751</td>
<td>2,471</td>
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<tr>
<td>Physical Therapist</td>
<td>814</td>
<td>846</td>
<td>Physical Therapist</td>
<td>15,721</td>
<td>15,793</td>
</tr>
<tr>
<td>Physical Therapy Assistant</td>
<td>318</td>
<td>393</td>
<td>Physical Therapy Assistant</td>
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<td>3,065</td>
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<tr>
<td>Electromyographer</td>
<td>5</td>
<td>0</td>
<td>Electromyographer</td>
<td>38</td>
<td>38</td>
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<tr>
<td>Kinesiologic Elecromyographer</td>
<td>8</td>
<td>3</td>
<td>Kinesiologic Elecromyographer</td>
<td>24</td>
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<tr>
<td>Physician Assistant</td>
<td>225</td>
<td>194</td>
<td>Physician Assistant</td>
<td>3,084</td>
<td>2,831</td>
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<td>Physician Asst. Supervisor</td>
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<td>1,206</td>
<td>Physician Asst. Supervisor</td>
<td>10,524</td>
<td>9,453</td>
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<tr>
<td>Doctors of Podiatric Medicine</td>
<td>90</td>
<td>116</td>
<td>Doctors of Podiatric Medicine</td>
<td>2,863</td>
<td>2,645</td>
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<tr>
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<td>541</td>
<td>866</td>
<td>Psychologist</td>
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<td>488</td>
<td>Psychologist Assistant</td>
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<td>2,113</td>
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<tr>
<td>Registered Dispensing</td>
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<td></td>
<td>Registered Dispensing</td>
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<td></td>
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<tr>
<td>Optician Firm</td>
<td>142</td>
<td>181</td>
<td>Optician Firm</td>
<td>1,758</td>
<td>1,723</td>
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<td>Contact Lens Dispeners</td>
<td>50</td>
<td>47</td>
<td>Contact Lens Dispeners</td>
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<td>867</td>
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<td>Spectacle Lens Dispenser</td>
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<td>157</td>
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<td>Research Psychoanalyst</td>
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<td>55</td>
<td>59</td>
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<td>Respiratory Care Practitioner</td>
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<td>868</td>
<td>Respiratory Care Practitioner</td>
<td>14,873</td>
<td>14,670</td>
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<td>Speech Pathologist</td>
<td>388</td>
<td>357</td>
<td>Speech Pathologist</td>
<td>7,579</td>
<td>7,937</td>
</tr>
<tr>
<td><strong>Total Licenses Issued</strong></td>
<td><strong>6,444</strong></td>
<td><strong>6,297</strong></td>
<td><strong>Total Licenses In Effect</strong></td>
<td><strong>85,574</strong></td>
<td><strong>84,184</strong></td>
</tr>
</tbody>
</table>

* "Allied Health Professions," until July 1, 1994, a "Division" of the Board, now functions as a committee of the Board, per Business & Professions Code §2015.
For additional copies of this report, please fax your company name, address, telephone number and contact person to: Yolanda Gonsolis, Medical Board Support Services Unit, at (916) 263-2479, or mail your request to her at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.
### COMPLAINTS RECEIVED

<table>
<thead>
<tr>
<th></th>
<th>MD</th>
<th>470</th>
<th>265</th>
<th>506</th>
<th>3,696</th>
<th>211</th>
<th>2,471</th>
<th>281</th>
<th>7,902</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<td>72</td>
<td>29</td>
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<td>0</td>
<td>4</td>
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<td>55</td>
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<td>Society or</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>Trade Organization</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>15</td>
<td>12</td>
<td>4</td>
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<tr>
<td>Federal or Other</td>
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<td>0</td>
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<td>Complainant</td>
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<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>3</td>
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<tr>
<td>Miscellaneous</td>
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<td></td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>AH</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Subtotals</td>
<td>MD</td>
<td>470</td>
<td>265</td>
<td>506</td>
<td>3,696</td>
<td>211</td>
<td>2,471</td>
<td>281</td>
<td>7,902</td>
</tr>
<tr>
<td></td>
<td>AH</td>
<td>162</td>
<td>15</td>
<td>31</td>
<td>215</td>
<td>0</td>
<td>135</td>
<td>958</td>
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<td>Grand Totals</td>
<td></td>
<td>632</td>
<td>280</td>
<td>537</td>
<td>3,911</td>
<td>2</td>
<td>346</td>
<td>3,429</td>
<td>549</td>
</tr>
</tbody>
</table>

Key: MD = Medical Doctor; AH = Allied Health Professionals

1. Health and Safety complaints, e.g. excessive prescribing, sale of dangerous drugs, etc.
2. Non-Jurisdictional complaints are not under the authority of the Board, and are referred to other agencies such as the Department of Health Services, Department of Insurance, etc.
3. Competence/Negligence complaints are related to the quality of care provided by licensees.
4. Personal Conduct complaints, e.g. licensee self-use of drugs/alcohol, conviction of a crime, etc.
5. Unprofessional Conduct complaints include sexual misconduct with patients, discipline by another state, aiding/abetting unlicensed activity, failure to release medical records, etc.

Further, with excellent support from the Attorney General’s Health Quality Enforcement Section, the Enforcement Program increased its overall administrative filings from 308 in FY 91-92 to 583 in FY 92-93 to 672 in FY 93-94. The Program also increased its overall administrative actions/decisions from 261 in FY 92-93 to 398 in FY 93-94. All this was accomplished (without a measurable increase in field staffing) through the diligent efforts of conscientious and committed Enforcement Program staff.*

---

*Information required by Business and Professions Code section 2313.
1. **Additional data for Temporary Restraining Orders (TRO) and Interim Suspension Orders (ISO):**

<table>
<thead>
<tr>
<th>Orders Sought:</th>
<th>Orders Granted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRO/ISO</td>
<td>TRO</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>3</td>
</tr>
<tr>
<td>Sexual Misconduct</td>
<td>6</td>
</tr>
<tr>
<td>Self Abuse of Drugs or Alcohol</td>
<td>6</td>
</tr>
<tr>
<td>Fraud/Dishonesty</td>
<td>0</td>
</tr>
<tr>
<td>Gross Negligence/Incompetence</td>
<td>4</td>
</tr>
<tr>
<td>Conviction of a Crime</td>
<td>1</td>
</tr>
<tr>
<td>Unprofessional Conduct</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

**NOTE:** Some orders granted were sought in the prior fiscal year.

2. The number and type of action which resulted from cases referred by the state Department of Health Services pursuant to Section 14124 of the Welfare and Institutions Code, relating to suspension of provider status for state medical assistance:

- Received from Department of Health Services: 13
- Resolved by CCICU: 8

**NOTE:** In most of these cases, Board action (i.e. revocation) preceded the suspension of provider status by the Department of Health Services, and the information referred to the Board is redundant.

3. Consumer inquiries and complaints:

- Consumer inquiries: 80,484
- Jurisdictional inquiries: 43,295
- Complaint forms sent: 12,420
- Complaint forms returned by consumer: 4,739

4. Number of completed investigations at the Attorney General's Office awaiting the filing of formal charges:

- Physician and Surgeon: 329
- Allied Health: 131

5. **Number of probation violation reports sent to the Attorney General:**

<table>
<thead>
<tr>
<th>MD</th>
<th>AH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>14</td>
<td>22</td>
</tr>
</tbody>
</table>

6. **Petitions to Revoke Probation Filed:**

<table>
<thead>
<tr>
<th>MD</th>
<th>AH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>18</td>
<td>28</td>
</tr>
</tbody>
</table>

7. **Final dispositions of Probation Filings:**

<table>
<thead>
<tr>
<th>Type</th>
<th>MD</th>
<th>AH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Probation</td>
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<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Probation Revoked</td>
<td>7</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Petition Withdrawn/Dismissed</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

8. **Petitions for Reinstatement of License:**

<table>
<thead>
<tr>
<th>Type</th>
<th>MD</th>
<th>AH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filed</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Granted</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Denied</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

9. Average and median time in processing complaints received during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review:

<table>
<thead>
<tr>
<th>Average Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>(days)</td>
</tr>
<tr>
<td>1. Complaint Unit Processing</td>
</tr>
<tr>
<td>2. Investigation</td>
</tr>
<tr>
<td>3. Attorney General Processing to preparation of an accusation</td>
</tr>
<tr>
<td>4. Other stages of the legal process (e.g. appeals)</td>
</tr>
<tr>
<td><strong>Note:</strong> Data not available.Outside the control of the Medical Board or the Attorney General's Office.</td>
</tr>
</tbody>
</table>

10. Investigator caseloads as of June 30, 1994:

<table>
<thead>
<tr>
<th>Per Operations Caseload:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
</tr>
<tr>
<td>Active investigations:</td>
</tr>
<tr>
<td>AG Assigned Cases:*</td>
</tr>
<tr>
<td>Probation Unit Caseload. Monitoring Cases:**</td>
</tr>
<tr>
<td>Active investigations:</td>
</tr>
<tr>
<td>AG Assigned Cases:*</td>
</tr>
</tbody>
</table>

* These cases are at various stages of AG processing, and may require supplemental investigative work such as subpoena service, testifying at hearings, etc.

** *90 additional monitoring cases were inactive because the probationer is out of state.

11. **Number and type of action taken by disciplinary case type:**

<table>
<thead>
<tr>
<th>Type</th>
<th>Revocation</th>
<th>Voluntary Surrender</th>
<th>Probation with suspension</th>
<th>Probation</th>
<th>Probationary license issued</th>
<th>Public letter of reprimand</th>
<th>Other Action</th>
<th>Total Actions by Case Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligence</td>
<td>10</td>
<td>9</td>
<td>11</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>70</td>
</tr>
<tr>
<td>Inappropriate Prescribing</td>
<td>6</td>
<td>3</td>
<td>12</td>
<td>15</td>
<td>0</td>
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<td>2</td>
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</tr>
<tr>
<td>Sexual Misconduct</td>
<td>15</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Mental Illness</td>
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<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Self-use of drugs/alcohol</td>
<td>18</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Fraud</td>
<td>11</td>
<td>1</td>
<td>3</td>
<td>19</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>39</td>
</tr>
<tr>
<td>Conviction of a crime</td>
<td>18</td>
<td>3</td>
<td>13</td>
<td>29</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td>Unprofessional Conduct</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Miscellaneous violations</td>
<td>44</td>
<td>8</td>
<td>5</td>
<td>20</td>
<td>0</td>
<td>7</td>
<td>3</td>
<td>87</td>
</tr>
</tbody>
</table>

**Total Actions by Discipline Type**

| Physician only** | 124 | 37 | 57 | 143 | 15 | 9 | 14 | 397 |

**Total Actions by Physician only:** 224

**Total Actions by Case Type:** 397

*Most of the cases classified as "Miscellaneous violations" are reciprocal action based upon discipline by another state.

**Figures in parentheses represent physician discipline totals for each category.
DIVERSION PROGRAM

DIVERSION PROGRAM

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of fiscal year</td>
<td>224</td>
</tr>
<tr>
<td>Accepted into program</td>
<td>63</td>
</tr>
<tr>
<td>Completions:</td>
<td></td>
</tr>
<tr>
<td>Successful</td>
<td>49</td>
</tr>
<tr>
<td>Unsuccessful</td>
<td>26</td>
</tr>
<tr>
<td>Active at end of year</td>
<td>226</td>
</tr>
<tr>
<td>Applicants**</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Impairment</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>46</td>
<td>20</td>
</tr>
<tr>
<td>Other drugs</td>
<td>89</td>
<td>39</td>
</tr>
<tr>
<td>Alcohol and other drugs</td>
<td>83</td>
<td>37</td>
</tr>
<tr>
<td>Mental illness</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Mental illness &amp; substance abuse</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>226</td>
<td>100</td>
</tr>
</tbody>
</table>

*These statistics include participants who have been approved for informal participation only because of an open investigation. They also include doctors of podiatric medicine.

**Applicants are participants who either 1) have not been seen by a Diversion Evaluation Committee or 2) have not yet signed a Diversion Agreement.

The Board’s Diversion Program for impaired physicians fulfills both elements of the Division of Medical Quality’s mission to protect the public and to rehabilitate physicians. First, it protects the public by closely monitoring physicians who are impaired as a result of alcohol and other drug addiction or mental illness; second, it gives physicians with substance abuse problems the opportunity for rehabilitation and encourages lifelong recovery.

The Diversion Program, created by statute in 1980 as an alternative to discipline by the Board, allows participants, when appropriate, to continue to practice medicine. Both Board-referred and self-referred candidates can participate if deemed eligible by Diversion Evaluation Committees. The committees are composed of three physicians and two public members with expertise in alcohol and other drug addiction or mental illness. Participation by self-referred physicians is completely confidential. In addition to providing services for physicians, the Program administers a diversion program for the Board of Examiners in Veterinary Medicine and the Board of Podiatric Medicine.

In May 1993, the Board created the Task Force on the Diversion Program under the chairmanship of Dr. John Kassabian. After a series of statewide public meetings, the Task Force proposed, and the Board adopted, 10 recommendations, eight of which had been carried out by the end of the fiscal year.

The most vital determination by the Board was its continuing commitment to the sponsorship of the Diversion Program. To promote effective management and provide general guidance, the Board reinstated the Diversion Liaison Committee, which is a joint effort by the Board and the California Medical Association.

MEDICAL BOARD OF CALIFORNIA
FY 1993-1994

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Gayle W. Nathanson
Jacquelin Trestrail, M.D.
MEDICAL BOARD OF CALIFORNIA
1993-1994 FISCAL YEAR BUDGET

<table>
<thead>
<tr>
<th>Program</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enforcement</td>
<td>70.5%</td>
<td>$20,923,000</td>
</tr>
<tr>
<td>Licensing</td>
<td>12.3%</td>
<td>3,655,000</td>
</tr>
<tr>
<td>Executive</td>
<td>3.8%</td>
<td>1,127,000</td>
</tr>
<tr>
<td>Support Services</td>
<td>3.7%</td>
<td>1,102,000</td>
</tr>
<tr>
<td>Data Systems</td>
<td>3.2%</td>
<td>951,000</td>
</tr>
<tr>
<td>Diversion Program</td>
<td>2.9%</td>
<td>845,000</td>
</tr>
<tr>
<td>Probation Monitoring</td>
<td>2.5%</td>
<td>746,000</td>
</tr>
<tr>
<td>Medical Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Committees</td>
<td>1.1%</td>
<td>321,000</td>
</tr>
<tr>
<td><strong>Total Budget</strong></td>
<td>100%</td>
<td><strong>$29,670,000</strong></td>
</tr>
</tbody>
</table>

NOTE: Total amount (allocated to all programs) paid to Department of Consumer Affairs = $2,372,895

**Office of Administrative Hearings** 10.4% $2,184,927
**Consumer Affairs** 8.0% $1,674,783

Diversion Program 2.9%
Data Systems 3.2%
Support Services 3.7%
Executive 3.8%
Licensing 12.3%
Medical Quality Review Committees 1.1%
Probation Monitoring 2.5%

**Enforcement** 70.5%

MEDICAL BOARD OF CALIFORNIA SOURCES OF REVENUE 1993-1994

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and Surgeon Renewals</td>
<td>87.8%</td>
<td>$24,864,000</td>
</tr>
<tr>
<td>Applications and Examinations</td>
<td>5.8%</td>
<td>$1,639,000</td>
</tr>
<tr>
<td>Initial License Fees</td>
<td>4.4%</td>
<td>$1,248,000</td>
</tr>
<tr>
<td>Other Regulatory Fees, Delinquency/Penalty/Reinstatement Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>2.0%</td>
<td>$570,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
<td><strong>$28,321,000</strong></td>
</tr>
</tbody>
</table>