

BMQA Forms Credentials Fraud Task Force

The BMQA received special funding in its 1984-85 budget for a task force to investigate the use of fraudulent credentials in applications for physician licensure. Responding to an emergency request by BMQA President Ray Mallel and other key board members, the legislature inserted special funding into the board's budget at the last minute. Governor Deukmejian signed the special appropriation into law as part of the Budget Act, after trimming the initial request.

A NATIONAL PROBLEM

Credentials fraud appears to be a serious national problem of unknown dimensions, according to BMQA Executive Director Kenneth J. Wagstaff. The potential scope of the problem first became known with the arrest and conviction of Pedro DeMesones, a recruiter for a Caribbean medical school who then began cooperating with federal authorities. While most of the graduates

of the school DeMesones worked for, CETEC, were seeking licensure in East Coast states, applicants from CETEC and other suspect medical schools in the Caribbean basin were showing up in California and other states.

California opened a number of investigations into the credentials of applicants and a small handful of licensed physicians earlier this Spring. After obtaining new information during a visit by a special investigative team appointed by the President of the Dominican Republic, however, BMQA officials realized that it would take special resources to follow all the investigative leads they were now coming upon.

TASK FORCE FORMED

The special BMQA task force, nicknamed the Licensing Investigation/Fraud Team (LIFT), has two special investigators working full-time, with support staff and computer assistance. A "handful" of licensed physicians and in excess of 250 applicants for licensure are under active review by the team.

The problem seems to be limited to a small number of "offshore" medical

schools which cater to U.S. citizens. To complicate matters, all of the suspect schools have produced bona fide physicians in addition to those with problem credentials, necessitating that the board conduct an individual review of each applicant's file.

ARRESTS EXPECTED

By the time this Action Report appears in print, the first arrests as a result of the task force's efforts will likely have been made. According to Executive Director Wagstaff, these first arrests and accusations will represent only the beginning. After the initial group of arrests, however, the investigation will enter a slower and more difficult phase. "It is important that we take the threat posed by these producers of fraudulent documents seriously," said Mr. Wagstaff. "It is just as important however, not to panic. We believe that we have gotten on top of this problem early here in California. The public can still have confidence that the physician from whom they get care is properly trained in the best tradition of the profession."

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HOW TO FURNISH OR DISPENSE CONTROLLED DRUGS IN SCHEDULES III, IV, AND V?

In contrast to the prohibition for dispensing Schedule II drugs (except in emergency situations as described in the April 1984 issue of Action Reports) physicians may directly dispense to patients controlled drugs in Schedules III, IV, and V.

How Can I Do This Legally?

A section of law (Business and Professions Code 4228) states that doctors may "personally furnish any dangerous drug* prescribed by them to the patient provided such drug is properly labeled."

The governing terms in this law are "personally furnish" and "properly labeled."

Physicians who did not personally furnish these drugs have faced BMQA investigators. It is expected that physicians personally inspect all dangerous drugs to be certain of the identity, amounts, and dosage before giving them to a patient.

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*A dangerous drug is any drug which by federal or state law can be lawfully dispensed only on prescription or furnished as above.

CONSULTANT'S CORNER

With this issue we begin a new and regular feature in ACTION REPORT. This space will review in greater detail those interesting and significant cases which have crossed a BMQA medical consultant's desk, and have resulted in BMQA action against the physician. Names will not be used, nor will we identify the physician under discussion.

We will present situations that 99 percent of California physicians will never face; i.e., investigations—accusations—hearings—revocations—probations, etc. Despite the rarity of your present or future involvement with the BMQA, we suspect that all of you are interested (perhaps due to natural curiosity) in these and similar BMQA matters. The purpose of this column, therefore, is twofold: To educate and to inform. Our goal is to reach out to more physicians who want to better understand the workings of the BMQA.

Please direct all comments to: ANTONY C. GUALTIERI, M.D., Chief Medical Consultant, BMQA, 155 Bovet Road, Suite 660, San Mateo, CA 94402. (415) 573-3888.

What does a general practitioner who practices in a rural area do when the local hospital decides to close its Obstetrical Unit? The choices are: 1) Stop obstetrics and refer patients out of the county; 2) Establish an out-of-hospital local birthing center; or 3) Attend home births.

Faced with these choices, which would you take? One California physician who opted for the office as a birthing center came under scrutiny at a recent hearing before a five member Medical Quality Review Committee (MQRC) panel.

The hearing panel took specific aim at this physician's obstetrical management of three patients, and only obliquely at where the treatment took place.

In the first case the panel asked itself: "Why did this 26 year old patient's primigravida pregnancy end in a stillborn?"

The Board of Medical Quality Assurance (BMQA) had charged that the physician had "failed to evaluate, monitor and treat the well-being of the fetus prior to labor." This took into account the physician's omission of test like the estriol determination, the non-stress test, the contraction stress test and an ultrasound evaluation.

Further, BMQA criticism centered on two uncertainties: 1) Did the physician fail to recognize the significance of a uterus that had not changed in height in the last 3½ weeks? 2) Did the physician ignore the potential complications of a 42 week gestational pregnancy?

Believing the pregnancy to be viable and at term, the physician, on successive days, made two unsuccessful attempts to rupture the patient's membranes. Following this latter failure on the second day, the physician superimposed a course of buccal Pitocin over a three hour period in the office birthing center.

The panel reacted negatively when it learned that during these three hours while "continuing to receive buccal Pitocin series from the office assistant," the patient walked "around the block with her husband." The panel became even more concerned upon learning that the physician was at home eating

dinner for almost three hours while the patient received the uterine stimulating drug. To the physician's surprise the induction of labor failed, and the patient went home. Two days later she phoned to report that the "baby's movements had stopped." The patient was then directed to a consultant at the nearest hospital where she delivered a stillborn.

In listening to the standards of accepted practice as described by BMQA expert witnesses, the MQRC panel established that the physician had demonstrated incompetency in two ways: 1) By failing to carry out appropriate tests in a patient who was post-term; and 2) By failing to recognize the significance of an unchanging height of the uterus in the last 3½ weeks of pregnancy. The panel also concluded that the physician's prescribing of "Pitocin, whether buccal or intravenous, in an office setting—while the physician was absent from the office," constituted an extreme departure from the standards of medical practice (gross negligence).

In the second patient treated by this physician in the office birthing center, the panel had to answer the question: Did the physician's obstetrical management of a 31 year old primigravida contribute to the delivery of an infant with severe perinatal asphyxia?

The BMQA accusation charged that the physician had managed the patient's labor stage in a grossly negligent manner. Specifically, the "respondent failed to conduct continuous electronic monitoring of the fetal heart rate when dark meconium staining of the amniotic fluid was noted following the artificial rupture of membranes."

The panel heard testimony detailing the patient's course of labor. After five hours of labor, with the cervix completely dilated, there ensued uterine inertia with failure to progress. The physician applied forceps to effect an extraction. When this failed, the physician attempted an unsuccessful manual rotation of the baby's head. Finally, with the reapplication of forceps one hour after the first forceps attempt had failed, the baby was eventually delivered. The baby had an Apgar score of

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CONTROLLED DRUGS

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As with all dangerous drugs, their medical indications and appropriate use are guided by what peers consider to be the standards of practice. Under Business and Professions (B&P) Code Section 725 "Repeated acts of clearly excessive prescribing or administering of drugs . . . as determined by the standard of the local community of licensees is unprofessional conduct for a physician and surgeon . . ."

What Constitutes A Legal Label?

All dispensed dangerous drugs must contain the following information on the label (as per B&P Sections 4228 and 4047.5):

- a) Name of the drug (either the trade name or generic name).
- b) The directions for use of the drug.
- c) The name of the patient.
- d) The name of the prescriber.
- e) The date of issue.
- f) The name and address of the furnisher and the prescription number.
- g) The strength of the drug dispensed.
- h) The quantity of the drug dispensed.
- i) The expiration date of the effectiveness of the drug.

What Do I Tell The Patient?

It is the standard of practice to inform the patient of the potential side effects of the drugs (i.e., potential habituation, risks of motor or sensory impairments, reactions with alcohol or other drugs, etc.)

Do I Have To Keep A Record of These Drugs?

Yes. It is required by law (B&P Section 4322) that a "current inventory shall be kept." Further, that the "sale or disposition of dangerous drugs shall be at all times, during business hours, open to inspection by authorized officers of the law, and this record shall be preserved for at least three years."

(Lists of commonly prescribed controlled drugs in Schedules III, IV, and V on pages 5 and 6.)

THE CERTIFICATION OF RESPIRATORY CARE PRACTITIONERS WILL HAVE AN IMPACT ON PHYSICIANS

By Brad Lopez, MS, RRT, Chairman
Respiratory Care Examining
Committee

The Respiratory Care Practice Act (RCPA) became effective on July 1, 1983. The RCPA provides for the certification and regulation of persons engaging in the practice of respiratory care, respiratory therapy or inhalation therapy. The Respiratory Care Examining Committee (RCEC) was created to enforce and administer the RCPA.

The Committee has been working vigorously to establish regulations to certify respiratory care practitioners. Two applicant pools have been identified; those who will apply during the period of time known as the "grandfather period", and those applicants who will apply after the grandfather period has ended.

Section 3738 of the RCPA identifies the "grandfather period" and reads in part, "A person currently performing as a respiratory care practitioner, who provides acceptable documentation to the committee, may apply for certification as a respiratory care practitioner at any time within two years after the effective date of this chapter. Upon approval by the examining committee, the board shall issue a certificate without examination."

The grandfather period began on the effective date of the RCPA, on July 1, 1983, and will end two years from the effective date, on June 30, 1985. Applicants applying during the grandfather period must submit documentation to show that they are currently performing respiratory care within the scope of practice as outlined in Section 3702 of the RCPA.

The application form for the grandfather period applicants will require the signature of a physician and surgeon who has direct knowledge of the practice of, or who has supervised the respiratory care practitioner. Usually, the physician and surgeon signing the application will be the medical director. The medical director is the person who is most likely to have direct knowledge of the respiratory care practitioner's practice. The physician will be asked to verify that the applicant is currently performing within the scope of practice of a respiratory care practitioner. To assist the physician, the application will include the exact language concerning the scope of practice as found in Section 3702 of the RCPA.

The physician asked by an applicant to complete the endorsement should read the endorsement and the scope of practice carefully before signing. The physician should have direct knowledge

of the applicant's actual practice to complete the endorsement. The role of the physician is vital to the State certification of respiratory care practitioners.

Respiratory Care—Action Report

Applications will be available from the committee toward the end of this year. It is estimated that there are between 7,000 and 8,000 respiratory care practitioners in California. Respiratory care practitioners will be required to have a current, valid certificate after June 30, 1985 when the "grandfather period" ends. Unless specifically exempted from certification, individuals practicing respiratory care without a certificate after June 30, 1985 will be subject to misdemeanor prosecution.

If you should have any questions regarding the certification of respiratory care practitioners, please contact Mr. Mitchell C. Semer, the Committee's Executive Officer at the Sacramento office of the RCEC. The address and phone number follows:

Respiratory Care Examining
Committee
1430 Howe Avenue
Sacramento, CA 95825
(916) 924-2314

CONSULTANT'S CORNER

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zero at one minute. The physician immediately instituted CPR. Mouth-to-mouth resuscitation ensued for forty minutes before spontaneous respiration occurred.

After hearing the opinions of expert witnesses, the panel made the following conclusions concerning the physician's standards of practice. The physician was "negligent in failing to initiate and maintain continuous monitoring of the fetal heart rate after meconium stained amniotic fluid was seen." Furthermore, to use forceps where "appropriate anesthesia was not available constituted a departure from the standard of practice (negligence)." In a singular appraisal of the office birthing center, the panel concluded that the physician was grossly negligent in failing to have available equipment for "adequate means of infant monitoring and resuscitation—i.e., electronic fetal heart monitoring, (infant) endotracheal and resuscitative equipment as a minimum." The panel went on to explain that "it would have been obvious to a reasonably prudent family practitioner experienced in obstetrics that the fetus was at high risk when the meconium staining was

[initially] observed." Being aware of this complication, the physician had "sufficient time prior to the delivery to transport the patient to an adequate facility." Failure by the physician to have done so was another act of gross negligence. (It was established at the hearing that the nearest urban centers with hospitals affording obstetrical and neonatal pediatric care were approximately one hour travel by vehicle and that emergency medical evacuation was available by sheriff's helicopters.)

In a third case the panel found that the physician's inappropriate management of a 27 year old primigravida in labor resulted in the delivery of a moribund infant in the physician's office birthing center. In this case, as with the previous one, the panel established that the physician was grossly negligent in "failing to refer the patient to a hospital obstetrical facility and to a pediatric specialist at that point in the patient's labor when it would have become obvious to a reasonably prudent family practitioner experienced in obstetrics that the fetus was at high risk because of observed abnormalities in [auscultatory] fetal heart rate." Once again the panel concluded that the physician was repeatedly grossly negligent by not hav-

ing available "adequate means of infant resuscitation."

The MQRC panel's proposed decision, adopted by the Division of Medical Quality of the BMQA, revoked the physician's license, but stayed the revocation for seven years if the physician complied with special terms and conditions of probation. These conditions included the following requirements. The physician must take an "intensive clinical training program in obstetrics and neonatal pediatric care." Upon the completion of such training, the physician must then "take and pass an oral clinical examination [in these subject areas]." After passing this examination the physician will be prohibited from engaging in solo practice, but must practice in a "supervised structured environment in which the physician's activities will be overseen and supervised by another physician."

This physician is presently neither residing nor practicing in California. Consequently, the probation period is "tolled," which means that the "probation clock" of seven years begins to run only when the physician reenters the State. When that occurs, the terms of probation will be implemented.

DISCIPLINARY ACTIONS

January 1, 1984-March 31, 1984

Physicians and Surgeons

AABERG, Edgar Lindeman, M.D. (C-11417)—Los Angeles
2234(b),(d),(e), 2242, 725, 2238, 4390 B&P Code; 11154, 11157, 11173(b) H&S Code
Selling prescriptions for controlled drugs without good faith prior examination and indication; excessive prescribing; violation of statutes regulating drugs; gross negligence and incompetence; false prescriptions; dishonesty. No appearance by respondent.
Revoked.
March 1, 1984

BALKOVICH, Michael Evan, M.D. (G-33879)—Sacramento
2234 B&P Code
Stipulated decision. Aided another physician who filed false claims with Medi-Cal and insurance companies.
Revoked, stayed, 7 years probation on terms and conditions.
March 16, 1984

BEARDSLEY, Leon, M.D. (C-11915)—San Bernardino
2234(b),(c),(d), 725, 2242, 2238, 2241 B&P Code; 11154, 11171, 11007, 11217.5 H&S Code
Prescribing controlled drugs without prior good faith examination and medical indication; excessive prescribing; prescribing to addicts; gross negligence and incompetence; violation of statutes regulating drugs.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
March 29, 1984

BELL, Carl Ellis, M.D. (C-28530)—Alta Loma
490, 2234(a),(e), 650 B&P Code
Conviction for receiving kickbacks for referring Medi-Cal patients to clinical laboratory.
Prior discipline.
Revoked
March 16, 1984

BURSELL, Harold A., M.D. (A-9265)—Redding
Stipulated decision. Voluntary surrender of license. Accusation dismissed.
January 1, 1984

CONNOR, Ralph W., M.D. (A-28621)—San Diego
2242, 2234, 725, 2238 B&P Code; 11164(a) H&S Code
Stipulated decision. Prescribing controlled drugs without good faith prior examination and medical indication; excessive prescribing; failing to prescribe Schedule II drug (Dexedrine) on triplicate forms.
Revoked, stayed, 7 years probation on terms and conditions, including 30 day actual suspension.
March 16, 1984

DE GOLIA, Pershing, M.D. (A-15918)—Santa Rosa
2234(b) B&P Code
Stipulated decision. Gross negligence in failing to monitor intraocular pressure of patient on corticosteroid therapy; altered records to show that he did.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
January 23, 1984

DIBAJI, Said Nassar, M.D. (A-30824)—Fresno
2234, 2242 B&P Code
Prescribing controlled drugs without good faith prior examination and medical indication. Prior discipline.
Revoked, stayed, 10 years probation on terms and conditions.
Judicial review recently completed.
January 19, 1984

EVERETT, Benjamin Arthur, M.D. (C-24857)—Carson
820, 821 B&P Code
Failed to comply with a Board order compelling a psychiatric examination. No appearance by respondent.
Revoked
January 23, 1984

GHIGLIERI, Louis, M.D. (A-8379)—Stockton
Voluntary surrender of license. Accusation is dismissed.
January 1, 1984

GIBSON, George C., M.D. (G-1347)—Vallejo
2234(b), 725, 2242 B&P Code
Stipulated decision. Prescribing controlled drugs without a good faith prior examination and medical indication; excessive prescribing; gross negligence in prescribing practices and in a tubal ligation case.
Revoked, stayed, 5 years probation on terms and conditions, including 90 day actual suspension.
March 16, 1984

GRAVELLE, Rodrigue, M.D. (G-1800)—Northridge
2361(a),(e), 2411, 2399.5, 700 old B&P Code
Stipulated decision. Aided the filing of false Medi-Cal claims. Prescribed controlled drugs without good faith prior examination and medical indication; excessive prescribing. Dishonesty.
Revoked, stayed, 10 years probation on terms and conditions.
January 26, 1984

GUBERSKY, Victor, M.D. (C-26785)—Carmichael
2236(A), 2237(a), 2234(e) old B&P Code
Federal conviction for conspiracy. Respondent acted as a middle man or broker to buy the principal ingredients for the manufacture of "speed" (methamphetamine).
Revoked, stayed, 10 years probation on terms and conditions.
February 6, 1984

HARMAN, Charles E., M.D. (G-9533)—Brookings, Oregon
2416, 2417, 2361 old B&P Code
Refuse to obey a proper order of the Board by not allowing a psychiatric evaluation of him to be conducted.
Revoked, stayed, 5 years probation on terms and conditions.
Judicial review recently completed.
March 21, 1984

HAYES, Jude R., M.D. (C-20427)—Porterville
725, 2234(c), 2242 B&P Code
Stipulated decision. Prescribing controlled drugs without good faith prior examination and medical indication; excessive prescribing; repeated similar negligent acts.
Revoked, stayed, 5 years probation on terms and conditions.
March 19, 1984

HICKS, James Robert, M.D. (C-21473)—Fullerton
822 B&P Code
Stipulated decision. Mental illness affecting the ability to practice safely.
Revoked, stayed, 5 years probation on terms and conditions, including psychiatric treatment and monitoring.
February 17, 1984

HILDEBRAND, William Rex, M.D. (A-28826)—Susanville
725, 2234(b),(c),(d), 2242 B&P Code; 11154 H&S Code
Stipulated decision. Prescribing controlled drugs without a good faith prior examination and medical indication; excessive prescribing; gross negligence; incompetence; repeated similar negligent acts.
Revoked, stayed, 5 years probation on terms and conditions.
February 6, 1984

HODGES, Robert Marc, Jr., M.D. (G-1177)—Pasadena
490, 2234(e), 2261, 2236 B&P Code
Stipulated decision. Conviction for filing false Medi-Cal claim. Dishonesty in filing 30 claims charging for more time than actually spent with patients.
Revoked, stayed, 5 years probation on terms and conditions.
March 19, 1984

KRAVATZ, Arnold Stanley, M.D. (G-13304)—Sherman Oaks
2234(a), 2242 B&P Code; 11170 H&S Code
Stipulated decision. Repeatedly obtained, furnished to himself, possessed and used without prescription, Valium, Talwin, Florinal, Librium, Serax, and injectable Demerol, as well as Marijuana.
Prior discipline.
Revoked, stayed, 5 years probation on terms and conditions.
January 13, 1984

KUNZMAN, James D., M.D. (C-21489)—San Diego
2234(b),(d) B&P Code
Stipulated decision. During cancer surgery, failed to locate and remove the tumor, and never advised the patient of the error. Gross negligence and incompetence.
Revoked, stayed 5 years probation on terms and conditions.
March 19, 1984

MELLON, Horace M., M.D. (A-30748)—Culver City
725, 2392, 2399.5, 2361(b),(c),(d),(f), 2411 old B&P Code; 11170, 11173(a), 11174 H&S Code
Furnished narcotic drugs to himself through false prescriptions; aided others in the unauthorized practice; prescribed without good faith prior examination and medical indication. Excessive prescribing, gross negligence. Dishonesty and deceit.
Revoked
March 28, 1984

MORRIS, Tom Oliver, M.D. (A-14730)—Monterey
725, 2242 B&P Code
Stipulated decision. Prescribing controlled drugs without good faith prior examination and medical indication; excessive prescribing; gross negligence and incompetence.
Revoked, stayed, 5 years probation on terms and conditions.
February 6, 1984

PEOPLES, Robert W., M.D. (C-34824)—
Manhattan Beach

2236(a),(b), 2234(e), 2239(a) B&P Code
 Conviction for bribing a laboratory criminalist to dilute urine sample, following a drunk driving arrest. Self-use of ethrane while on duty as an anesthesiologist.
 Revoked, stayed, 5 years probation on terms and conditions.
 March 15, 1984

PRANESHWAR, Richard E., M.D. (C-36367)—North San Juan

2238 B&P Code; 11357, 11358, 11359 H&S Code
 Stipulated decision. Grew and cultivated marijuana on his property in violation of statutes regulating controlled substances. One year suspension, stayed, one year probation on terms and conditions.
 January 20, 1984

SCHLOSSMAN, Robert C., M.D. (G-10315)—
San Diego

2234(b),(d) B&P Code
 Stipulated decision. Gross negligence and incompetence in the management of fractures and injuries sustained in an automobile accident.
 Revoked, stayed, 5 years probation on terms and conditions.
 February 29, 1984

SENSEMAN, William R., M.D. (AO-7115)—
Lancaster

Stipulated decision. Voluntary surrender of license. The accusation is terminated.
 February 24, 1984

TALISMAN, Marc Zolla, M.D. (A-24315)—
Newport Beach

2236(a), 2261 B&P Code
 Conviction for filing false Medi-Cal claim.
 90 day suspension, stayed, one year probation on terms and conditions.
 February 6, 1984

WINDHAM Marion R., M.D. (C-34630)—
Laguna Beach

Failed to comply completely with probation under prior discipline. Revoked, stayed, 2 years probation on terms and conditions.
 January 11, 1984

YOUNGBERG, Gustavus Benson, M.D. (G-11087)—Vacaville

2234, 2234(e) B&P Code
 Conviction for lewd and lascivious act with a child under 14, resulting in a prison term.
 Revoked.
 February 6, 1984

Podiatrists

WORLEY, Ronald D., DPM (E-1454)—San Jose

2305, 2237 B&P Code
 Stipulated decision. Discipline by Texas Board for a felony conviction of dispensing Quaalude not in the usual course of professional practice for a legitimate medical purpose.
 Revoked, stayed, 5 years probation on terms and conditions.
 July 30, 1984

CONTROLLED DRUGS

(Continued from Page 2)

COMMONLY PRESCRIBED CONTROLLED DRUGS IN SCHEDULES III, IV AND V

SCHEDULE III

Narcotics	Non-Narcotics
Ascodeen	Butisol (butabarbital)
APC with Codeine	Carbrital
Citra Forte Syrup	Doriden
Empirin Cpd with Codeine	Didrex
Fiorinal with Codeine	Fiorinal
Hycodan	Nembutal SUPPOSITORY ONLY
Hycomine	Noludar
Paregoric Mixtures	Plegine
Percogesic with Codeine	Pre-Sate
Phenaphen with Codeine	Seconal SUPPOSITORY ONLY
Tussend	Voranyl
Tussionex	
Tylenol with Codeine	

SCHEDULE IV

Chardonna	Meprospan
Chloral Hydrate	Miltown
Clonopin	Noctec
Dalmane	Phenobarbital
Deprol	Placidyl
Equagesic	Pondimin
Equanil	Sanorex
Fastin	Sedadrops
Ionamin	Serax
Librium	Talwin
Libritabs	Tenuate
Mebaral	Tranxene
Meproamate	Valium
	Valmid

SCHEDULE V

Actified C Expect.	Lomotil
Ambenyl Expect.	Parepectolin
Donnagel PG	Phenergan Expectorants containing
Elixir Terpin Hydrate & Codeine	Codeine
	Robitussin AC

BMQA REJOINS NATIONAL ORGANIZATION OF MEDICAL BOARDS

Following three years of intermittent negotiations, the BMQA has voted to return to the nationwide association known as the Federation of State Medical Boards. Members of the BMQA had voted to withdraw from the Federation in 1981, following a number of unsuccessful attempts to break what some members felt was a disproportionate control long exercised by a small cadre of Federation members.

PAST QUARRELS WITH THE FEDERATION

Leaders of the BMQA "revolt" regarded the Federation as unresponsive to contemporary problems in professional licensure. Among other problems, the Federation appeared reluctant to create a clearinghouse for information about disciplinary actions against doctors in the fifty states. A doctor whose license is revoked may move to another state where he or she is already licensed and return to practice. Some states routinely share informa-

tion about their disciplinary actions, but there is no national clearinghouse.

ACCREDITATION OF FOREIGN MEDICAL SCHOOLS A PROBLEM FOR ALL STATES

A second serious issue affecting all state boards is the accreditation of medical schools outside the U.S. At present there is no national organization with the resources to review foreign medical schools to evaluate their curricula and clinical facilities. This is a role the Federation has been unwilling to assume in the past. In light of recent federal and individual state investigations of fraudulent credentials from certain Caribbean medical schools, the need for accurate information about foreign medical school programs has become increasingly critical.

Membership on Federation policy committees was yet another sticking point for the proponents of separation. At the time of the 1981 vote, California claimed over 10% of all American physi-

cians, and was paying membership dues based on its licensee population. Yet not one California representative sat on a major policy committee of the Federation. The BMQA also was disturbed that the Federation had no public (non-physician) members, and had sparse representation of women and minorities. A final issue was the unwillingness of the Federation to expand the content of the Federation Licensing Examination (FLEX) to include such areas as nutrition, child abuse, geriatrics and human sexuality.

BENEFITS OF MEMBERSHIP

Why, then, was California a member to begin with? One major function of the Federation is developing and administering the FLEX. This is the licensing exam taken by those medical school graduates who have not taken the National Board of Medical Examiners (NBME) test while they were in medical school. Virtually all foreign medical

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LEGISLATIVE NEWS

A number of bills of interest to the Board are now being considered by the Legislature. Final legislative action on these bills will likely have been completed by the time this issue reaches you.

SB 1551 (Watson)—Would provide that the determination of what constitutes excessive prescribing and treatment will be based on the statewide standard of the "community of licensees" rather than the unconstitutionally vague standard of the "local community of licensees". SB 1551 would also make various technical changes to legislation passed last year (SB 109), enabling the Board to require physicians believed to be unable to practice medicine with reasonable skill and safety to undergo a professional competency examination.

SB 1723 (Keene)—Would provide that five member Medical Quality Review

Committee panels assigned to hear disciplinary cases may be comprised of members from more than two committees. As recently amended, SB 1723 would also allow Medical Quality Review Committees to create physician peer counseling panels to provide review, education and assistance to physicians to strengthen various aspects of their practices, including the appropriate prescribing of drugs.

SB 1727 (Keene)—Would amend an existing statute to prohibit a physician whose license has been revoked or suspended, or who has been placed on probation, from petitioning for reinstatement or modification of penalty if a new charge for misconduct or violation of probation is pending. It would also enable the seven member Medical Quality Review Committee panels hearing petitions to be comprised of members from other Medical Quality Review Committees if a seven member panel cannot be convened from one committee.

SB 1796 (Rosenthal)—Would require an applicant for a physician's and surgeon's certificate who matriculates on or after September 1, 1985, to satisfactorily complete training in the detection and treatment of alcoholism and other chemical substance dependency.

SB 2307 (Watson)—Would make it a misdemeanor for any physician specializing in psychiatry or practicing psychotherapy to have sexual contact with a

patient during any treatment, consultation, interview, or examination session.

Two bills the Board sponsored this year were held in the Senate Business and Professions Committee and will be the subject for an interim hearing after the close of this session. One, AB 3154 (Moorhead), would have specifically authorized foreign medical graduates to engage in the practice of medicine during, and as a part of, their postgraduate training. The second, AB 3829 (Filante), constituted a major reform and cleanup of physician and surgeon licensing laws and brought California more into conformity with other states. It would have 1) placed restrictions on the frequency with which applicants could retake the Federation Licensing Examination (FLEX) after one or more failures (allowing for remedial study); 2) required the FLEX to be taken in one sitting, rather than in parts (complying with the June, 1985, FLEX changes); 3) consolidated reciprocity provisions (requiring all reciprocity applicants to have completed a resident course of instruction equivalent to that required in approved U.S. and Canadian medical schools); and 4) on and after June 1, 1985, would have required foreign medical graduates to pass the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) prior to admittance to FLEX (conforming with virtually every other state and avoiding a multitude of applicants applying to take the FLEX in California solely to escape the FMGEMS requirement).

BMQA REJOINS FEDERATION

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school graduates take the FLEX, as well as a small number of graduates. By rejoining, California will have the opportunity to serve on the important committee which develops the FLEX itself.

In addition, the Federation meetings each year provide the principal forum for face to face communication between members of the many state boards. It is an opportunity to discuss common problems and share information about programs being tried out in other states.

WHAT HAS CHANGED SINCE 1981?

At a meeting in Sacramento on June 22, 1984, in considering whether to rejoin the Federation, the BMQA reviewed changes in the past three years. At the meeting, Board members described their impressions of the annual Federation meeting in San Antonio, Texas in May. They mentioned that the Federation leadership showed much more willingness to consider issues such as foreign medical school accreditation, minority representation, proportional membership on policy committees, and the clearinghouse proposal. California would also have the opportunity to sit on key Federation committees.

An important consideration was the perception that the Federation board has accepted the legitimacy of California's concerns, and has begun working to resolve at least some of them. Recent changes in the leadership and executive staff of the organization hold promise of a more open and responsive relationship in the future. There is a renewed feeling among BMQA members that more can be accomplished from within the organization than as outsiders. For these reasons, the Board voted on June 22 to rejoin the Federation immediately.

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