



ACTION REPORT

BOARD OF MEDICAL QUALITY ASSURANCE

No. 29—November 1985

FDA Declares Hepatitis B Vaccine Safe for Health Providers and Others at Risk

The Federal Drug Administration (FDA) has recently substantiated the safety of hepatitis B (HB) vaccine. The FDA and the Public Health Service's Advisory Committee on Immunization Practices (ACIP) have clarified recommendations for use in populations at risk.

There had been concern that HB vaccine might transmit acquired immunodeficiency syndrome (AIDS) because the vaccine is manufactured from pooled plasma of asymptomatic individuals with chronic hepatitis B infection, some of whom could be in the high risk groups for AIDS.

FDA reported in the agency's August Drug Bulletin that studies confirmed that HTLV-III, the human retrovirus identified as the etiologic agent for AIDS, is not transmitted by the HB vaccine.

The ACIP recommends that the following populations receive the vaccine:

- Health care workers, especially those frequently exposed to blood, blood

products and needlesticks. It is recommended that vaccination be completed during training in schools of medicine, dentistry, nursing, laboratory technology and other allied health professions. Vaccination is also recommended for groups at increased risk in some hospitals, including emergency room staff, nursing personnel and staff physicians. Other health care workers at increased risk include: Dental professionals, laboratory and blood bank technicians, dialysis center staff, emergency medical technicians and morticians.

- Hemodialysis patients.
- Clients and staff of institutions for the mentally retarded.
- Classroom contacts of deinstitutionalized mentally retarded HBV carriers who behave aggressively or have special medical problems that increase the risk of exposure to their blood or serious secretions.
- Homosexually active men.

- Heterosexually active persons with multiple partners and sexually transmitted disease.
- Users of illicit injectable drugs.
- Recipients of clotting factor concentrates.
- Household and sexual contacts of HBV carriers.
- Special high-risk populations. These include Alaskan Eskimos, native Pacific Islanders, and immigrants and refugees from areas with highly endemic disease, depending on specific epidemiologic and public health considerations.
- Inmates of long-term correctional facilities.
- International travelers who plan to reside more than six months in areas with high levels of endemic HB virus and who will have close contact with the local population. Also, short-term travelers who are likely to have contact with blood from or sexual contact with residents of areas with high levels of endemic disease.

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BMQA-Sponsored Licensing Reform Legislation Becomes Law

A BMQA sponsored package of bills constituting a major reform of physician licensing statutes was chaptered into law late in September. Co-authored by Assemblymen Gray Davis and William J. Filante, M.D. and Senator Joseph B. Montoya—the legislation was drafted in response to a growing crisis in BMQA's ability to maintain a quality standard for licensure of physicians and surgeons in California. AB 1859, SB 555 and SB 991 are the products of extensive study and numerous public meetings and hearings over the last two years. The bills address many issues, but of key importance are:

1. Changes in California law to accommodate the new Federation Licensing

Examination (FLEX), the Component I/II exam, which recently replaced the three part FLEX used in the past.

2. Requiring foreign medical graduates to pass the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) for certification by the Educational Commission for Foreign Medical Graduates (ECFMG) prior to being admitted to the FLEX. ECFMG certification is currently a licensing requirement in virtually all other states. The test confirms basic medical education and the ability to function effectively in the English language.

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CONSULTANT'S CORNER

This space reviews interesting and significant cases which have crossed a BMQA Medical Consultant's desk. Names are not used, nor do we identify the physician under discussion.

Please direct all comments to: Antony C. Gualtieri, M.D., Chief Medical Consultant, BMQA, 1430 Howe Avenue, Suite 100, Sacramento, CA 95825. (916) 920-6393.

Every two months the six BMQA medical consultants come together to review the latest malpractice actions of California physicians. These reviews give us the opportunity to observe trends in medical practices, evaluate physicians' deficiencies, and isolate the incompetent.

Our most recent review pointed to a growing trend on the part of physicians to rely too heavily on mammography as the ultimate method for diagnosing female breast cancer.

The widespread spawning of diagnostic screening centers (some even offer mammography to passing shoppers) is to be encouraged. But there is an unsuspected hazard in the comfortable reliance upon a "negative" mammography report.

BMQA consultants, during the past year, have reviewed an increasing number of malpractice cases which have resulted from the missed diagnosis of breast cancer. The examining physician's excuse: "The mammogram was normal."

The patient was a 29 year-old female. In December she noted a small "lump" in her left breast. The doctor believed it to be a benign cyst. He asked the patient to return after her

next menstrual period. In January, the "lump" was "unchanged." The doctor had the patient undergo a mammogram that week. The report returned "normal breasts." The doctor reassuringly spoke "not to worry." He did advise the patient to check herself regularly and return "if there is any change."

The patient returned one year later. The doctor found the "lump larger." A surgical biopsy by a consulting surgeon discovered that the "larger lump" had become an "infiltrating lobular carcinoma."

This doctor learned by painful experience that mammography, reputed to be the most accurate method known today for evaluating breasts, has its limitations. One of our consultants, who enjoys astounding us periodically with his knowledge, reported on a survey of recent data from medical literature. "Mammography may have a false negative rate as high as 10% in cases of clinically palpable carcinoma, particularly when the breasts are very dense."

The cumulative centuries of experience of our six wise consultants concurred that breast "lumps" can accurately be diagnosed only after biopsy.

DRUG ALERT Phony Rx Blanks

**... be careful who
gets your
DEA number**

The following information was given to the BMQA by the State Board of Pharmacy, following some investigations they conducted. Because of the continuing problems with illegal diversion of drugs to "street peddlers" we urge every prescriber to be vigilant about protecting your legitimate prescription blanks. Also be wary of anyone who requests information about your prescribing privileges. If you believe blanks have been stolen, or that phony blanks may have been printed, do not hesitate to contact your nearest BMQA regional office, the Board of Pharmacy at (916) 445-5014, or the Drug Enforcement Administration at 350 South Figueroa Street, Los Angeles, CA 90071, or at 450 Golden Gate Avenue, San Francisco, CA 94102.

A situation has come to our attention in the Los Angeles area. Unsuspecting physicians are being duped into furnishing the means for unlicensed persons to obtain prescription blanks or dangerous drugs and controlled substances. The scam involves advertising in newspapers for physicians to practice in a clinical environment. When a physician answers such an advertisement, he or she usually is asked to complete a questionnaire. They also are asked to provide their license and Drug Enforcement Administration (DEA) registration for photocopying, as proof of licensure.

Regardless of whether the physician is employed by the clinic or not, the clinic then uses the DEA registration copy as authority to purchase controlled substances, and to order prescription blanks. The blanks then are used for forged prescriptions for controlled substances.

The Pharmacy Board reminds drug wholesalers of the importance of positively identifying the purchaser. However, there still have been instances where drugs were illegally acquired. If you are asked to allow your DEA permit to be copied we suggest you write across the copy some statement such as "COPY-Not to be used for purchase of drugs or prescription blanks."

BMQA MEMBERS

November, 1985

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Board Vice President: Miller Medearis

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Andy CamachoPasadena
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Jerome H. Unatin, M.D.....Torrance

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John C. Lungren, M.D.....Long Beach
Raymond H. MallelLos Angeles
Audrey MelikianFresno

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John P. Kassabian, M.D.....Pasadena
Andrew Lucine, M.D.....San Jose
Neal MaslanBrea
John W. Simmons.....Flintridge

Executive Director: Kenneth J. Wagstaff

Full Complement of BMQA Appointments

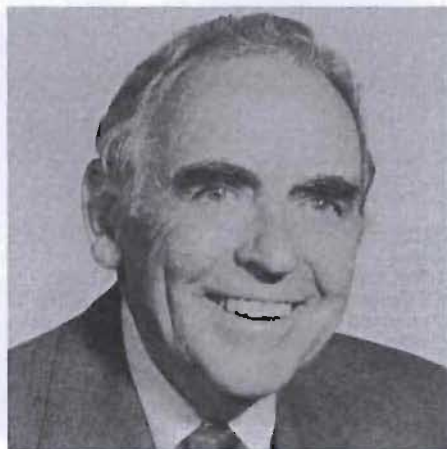
Governor George Deukmejian recently appointed the three members needed to give the Board of Medical Quality Assurance a full membership. The next vacancies will not occur until June 1, 1986, at which time the Board will lose four members.



**John Paul Kassabian, M.D.,
F.A.C.R.**

Dr. Kassabian has replaced Barry Warshaw, M.D. on the Division of Medical Quality. Dr. Kassabian received his B.A. degree from the University of Southern California, his M.D. degree from the University of Southern California School of Medicine, and completed his postgraduate training at Los Angeles County General Hospital. He is currently practicing radiology at the Huntington Memorial Hospital in Pasadena, where he is president-elect to the hospital staff.

Dr. Kassabian is a member of the Los Angeles County Medical Association, the California Medical Association, the Los Angeles Radiological Society, the California Radiological Society, the American College of Radiology, the Society of Graduate Radiologist and Faculty, and the Los Angeles County USC Medical Center.



**John Charles Lungren, M.D.,
F.A.C.P., F.A.C.C.**

Dr. Lungren has replaced Maire McAuliffe, M.D. on the Division of Licensing. He received his B.S. degree from the University of Notre Dame, his M.D. degree from the University of Pennsylvania School of Medicine, and his postgraduate training was completed at Los Angeles County General Hospital. He has been in private practice since 1946, specializing in internal medicine and cardiology. Dr. Lungren practices in Long Beach, and has served as Chief of Staff at the Memorial Hospital Medical Center of Long Beach.

Among Dr. Lungren's many affiliations, he is a Fellow of the American College of Physicians, the American College of Cardiology, and the Los Angeles Academy of Medicine; a Diplomate of the American Board of Internal Medicine; and a member of the American Medical Association, the California Medical Association, the California Society of Internal Medicine, the Los Angeles County Medical Society, the American Society of Internal Medicine, and the Long Beach Society of Internal Medicine.



**Jerome H. Unatin, M.D.
F.A.C.S.**

Dr. Unatin has replaced Charles Aronberg, M.D. on the Division of Allied Health Professions. Dr. Unatin received his M.D. degree from the University of Miami School of Medicine and has been in the private practice of Orthopedic Surgery in Torrance, California, since 1971. Dr. Unatin is Board-certified in Orthopedic Surgery and is a member of the American Academy of Orthopedic Surgeons and a Fellow of the American College of Surgeons.

Dr. Unatin has served as a member of the Governor's Task Force for Long Term Care for the Elderly and Disabled, a commissioner for Los Angeles County Paramedic Commission and participates in numerous civic and community activities.

Dr. Unatin is past-President of the Los Angeles County Medical Association, Southwest District and has served on many county and California Medical Association committees and offices.

Physician Licensing Activity Fiscal Year 1984

Basis of Licensure:

Reciprocity with another state	418
National Board Examination	2,587
Federation Licensing Examination (FLEX)	1,111
Total	4,116

On June 30, 1984, there were 84,886 physicians licensed in California. Of these, 60,932 had addresses of record in California, and 23,954 listed addresses outside the State.

CPR Required for Podiatrists

It was reported in the last *Action Report* that the Board's Division of Licensing no longer requires physicians and surgeons to be certified in cardiopulmonary resuscitation (CPR) prior to renewing their license. There has been some confusion as to whether this change also applies to podiatrists.

The Podiatry Examining Committee, which has authority over the licensing of doctors of podiatric medicine in California, reviewed the CPR requirement at their February 15, 1985 meeting and determined that possession of a current CPR card *will* continue to be required for the renewal of podiatric licenses.

DISCIPLINARY ACTIONS

March 1, 1985 to July 31, 1985

BALEIRON, Hector, M.D. (C-37263)—Laguna Beach
2234(b)(d) B&P Code
Stipulated Decision. Gross negligence and incompetence in the diagnosis and treatment of three hospitalized patients.
Revoked, stayed, 5 years probation on terms and conditions.
June 24, 1985

BORTMAN, Ronald A., M.D. (C-28370)—Albany
2236, 2234 B&P Code
Stipulated Decision. Conviction for filing false Medi-Cal claims.
Revoked, stayed, 7 years probation on terms and conditions.
March 8, 1985

CHEN, Ching-Tsai, M.D. (A-36094)—Stockbridge, Georgia
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
May 7, 1985

COX, Richard Henry, M.D. (A-38044)—Northbrook, Illinois
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
June 6, 1985

DeSOUSA, Byron Nagib, M.D. (C-40851)—Los Angeles
2234(a),(e),(f); 480(a),(2),(3),(c); 2261, 2235 B&P Code
False statements made in application to gain physician's license.
Revoked
April 26, 1985

DeVOUS, Arnold Scott, M.D. (C-40851)—San Francisco
2237 B&P Code
Stipulated Decision. Federal conviction in Wyoming while case on judicial review.
Revoked, stayed, 5 years probation on terms and conditions.
March 15, 1985

DUNN, Abraham G., M.D. (A-19590)—Fresno
Repeated failure to maintain records of all controlled substances prescribed or furnished, as mandated by probation order of prior discipline.
Revoked.
July 20, 1985

ETTINGER, Marvin Morris, M.D. (C-34877)—APO San Francisco
Stipulated Decision. Voluntary surrender of license while case on judicial review.
Accusation dismissed.
May 30, 1985

GOLEY, Donald, M.D. (C-26984)—Oxnard
725, 2238, 2242, 2261 B&P Code
Stipulated Decision. Excessive prescribing; violation of drug laws; prescribing without prior examination and medical indication; and falsifying documents.
Revoked, stayed, 5 years probation on terms and conditions, including 180 days actual suspension.
June 19, 1985

MANJUNATH, Madhure, M.D. (A-29758)—Long Beach
2234(c), 2242, 2236, 2261 B&P Code
Stipulated Decision. Prescribing without adequate prior examination and medical indication; misdemeanor conviction for presenting false medical claims.
Revoked, stayed, 5 years probation on terms and conditions.
May 22, 1985

MAHAPATRA, Satyabrata, M.D. (A-35604)—Los Angeles
725, 2338, 2242 B&P Code; 11154 H&S Code
Stipulated Decision. Excessive prescribing of controlled drugs; prescribing without prior examination and medical indication; conviction for violating drug statute.
Revoked, stayed, 5 years probation on terms and conditions, including 6 months actual suspension.
July 15, 1985

MILLER, Jon Kimmerle, M.D. (G-17900)—Spokane, Washington
2239 B&P Code
Stipulated Decision. More than one conviction involving the use of alcohol.
Revoked, stayed, 5 years probation on terms and conditions.
March 13, 1985

PEARSON, Keith, M.D. (A-28940)—Cedar Glen
2242, 2237, 2238 B&P Code; 11154 H&S Code
Prescribing controlled substances without prior examination and medical indication; conviction for violating drug statute.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
July 20, 1985

REYNAUD, Raymond A., M.D. (A-35604)—Los Angeles
2234(e), 2261 B&P Code
Stipulated Decision. Filed false claims with Medi-Cal.
Revoked, stayed, 5 years probation on terms and conditions.
July 5, 1985

SCHRENCOGOST, Raymond A., M.D. (A-27628)—Lodi
2234(b),(d) B&P Code
Gross negligence and incompetence in not recognizing and responding to critical problems of a patient after surgery. Prior discipline for prescribing offenses.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
July 5, 1985

SHICKMAN, Barry L., M.D. (G-15109)—Houston, Texas
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
June 6, 1985

SMITH, James J., M.D. (A-29142)—Auberry
2234, 2239 B&P Code
Stipulated Decision. More than one conviction involving the use of alcohol.
Revoked, stayed, 5 years probation on terms and conditions.
June 24, 1985

SPIRTOS, Jack, M.D. (A-29142)—Long Beach
2234(d) B&P Code
Stipulated Decision. No misconduct involved. Physical disability in the form of severe impaired vision requires limitations on practice for public safety.
Revoked, stayed, 10 years probation on terms and conditions.
June 20, 1985

TANENHAUS, Herbert M., M.D. (G-28610)—Eureka
2234 B&P Code
Stipulated Decision. Unprofessional conduct in allowing physician-patient relationship to develop into personal and physically intimate relationships.
Revoked, stayed, 7 years probation on terms and conditions.
June 6, 1985

THOMAS, Charles E., M.D. (C-34687)—Hacienda Heights
490, 2234, 2237, 2238 B&P Code; 111371 H&S Code
Stipulated Decision. Conviction for unlawful prescribing of controlled substances; excessive prescribing; prescribing without prior examination and medical indication.
Revoked, stayed, 5 years probation on terms and conditions, including 6 months actual suspension.
July 31, 1985

WEAVER, John C., Jr., M.D. (G-35959)—Los Angeles
2234(a),(d), 2242, 2238 B&P Code; 11154, 11157, 11173(b) H&S Code
Prescribing without good faith prior examination and medical indication; false prescriptions; violation of drug statutes; dishonesty in conspiring with others to distribute drugs illegally. No appearance by respondent.
Revoked.
July 12, 1985

WILLIAMS, John M., M.D. (G-16613)—Bridgeville, Pennsylvania
Stipulated Decision. Voluntary surrender of license accepted. Accusation dismissed.
March 11, 1985

Physicians in BMQA's Diversion Program Fiscal Year 1984

Diversion For:	<u>Active Participants</u>		<u>Successful Completion</u>
	<u>Number</u>	<u>Percent</u>	
Alcohol Problem	52	32.5	5
Other Drug Problem	70	43.8	15
Alcohol and Other Drug	16	10.0	3
Mental Illness	9	5.6	2
Mental Illness with Substance Abuse	13	8.1	2
	160		27

Guidelines for Prescribing Controlled Substances for Chronic Conditions

A Joint Statement by the BMQA and the CMA

The Task Force on Prescription Drug Abuse, with representatives from the California Medical Association, the Board of Medical Quality Assurance, the Board of Pharmacy, the California Pharmaceutical Association, the Bureau of Narcotic Enforcement (State), the Drug Enforcement Agency (Federal), the Department of Health Services, the California Society for the Treatment of Alcohol and Other Drug Dependencies, and Legal Counsel Dennis Warren, Esq., developed the following set of guidelines for the prescribing of controlled substances for chronic conditions.

These guidelines were approved by the CMA Council on June 28, 1985; and by the Division of Medical Quality of the BMQA on September 13, 1985.

The California Medical Association and the Board of Medical Quality Assurance believe that the best medical care occurs within the context of the physician-patient relationship, where the treating physician is familiar with the details of the patient's condition, medical history and life circumstances. That knowledge of the patient's individual circumstances makes the physician the most appropriate person to make clinical interpretations and treatment decisions, including the decision of whether to prescribe medications. Prescribing drugs, particularly controlled substances, requires the thoughtful application of clinical judgment. In the practice of medicine, physicians are often confronted with difficult situations—particularly in the treatment of chronic conditions involving pain, insomnia, anxiety or depression—that require carefully balanced judgment as to whether, when and where prescription of controlled substances is appropriate.

In our view, the best protection for the physician against allegations of inappropriate prescribing lies in the physician's knowledge of and close adherence to the existing standards of appropriate prescribing. Similarly, the best protection for the patient against the development of avoidable drug dependence is adherence to these same standards.

It is important to recognize that the standard for treatment of an **acute** clinical condition is quite different from the standard for treatment of a **chronic** condition. These guidelines discuss treatment and on-going care of chronic conditions.

GUIDELINES

When used within the context of a comprehensive treatment plan, the pharmaceuticals now available for pain, insomnia, anxiety and depression are safe and effective therapeutic agents and can safely be used for treatment of a chronic condition when these guidelines are followed.

1) History and Medical Examination

A Diagnostic examination must be performed and a medical history taken—appropriate for the clinical circumstances—sufficient to establish diagnosis, allow the formulation of a treatment plan and rule out presence of any contraindications to the use of any medication contemplated.

2) Diagnosis/Medical Indication

A working diagnosis should be delineated including the presence of a recognized and accepted medical indication for the continued prescription of controlled substances. The quantity and strength of a controlled substance prescribed must be reasonably necessary and must meet the patient's needs. When the decision is being made whether to use medication, consideration should be given to avoiding, wherever possible, overutilization of controlled substances and minimizing iatrogenic dependence problems.

3) Written Treatment Plan with Recorded Measurable Objectives

A written treatment plan should be prepared to include clearly stated measurable objectives, further planned diagnostic evaluation and alternative treatments contemplated. When the decision has been made to use medication, the physician should record the expected dosing schedules and the expected duration of treatment with medications.

4) Informed Consent

There should be a discussion with the patient of the risks and benefits of the treatments contemplated. When the treatment includes a controlled substance, there should be discussion of the addiction potential, possible adverse reactions to the drug, likely therapeutic end points, and the risks and benefits of this drug as compared with other drugs and other treatment methods. The discussions should be recorded in the patient record.

5) Periodic Reviews and Modification as Indicated

Periodically, the physician should review all aspects of the patient's treatment plan in light of response to treatment and progress toward treatment goals. The physician should consider the effect of any new information which has developed during the course of treatment.

For patients who have not improved despite continuation of controlled substances, the physician should consider (and document) the

appropriateness of a new trial of less dangerous treatment.

During these periodic reviews, the physician should

- assess and record the patient's response to treatment, both specific target signs and symptoms;
- assess and record compliance with the medication schedule;
- evaluate the patient for clinical or laboratory evidence of toxicity or adverse reactions to treatment, including the development of tolerance or psychological or physical dependence.

Adequate monitoring includes communication with pharmacists, nurses and other health professionals in an effort to assure that the patient is adhering to the intended treatment plan and that prescribed controlled substances are not being diverted or abused. After such a review, the physician should make any modifications indicated.

6) Consultation

In situations where treatment is not producing the desired improvement or where medication is required on an on-going basis, and other modalities are inappropriate or have failed, the physician should obtain appropriate consultation and/or refer the patient to specialists in the clinical problem area.

In geographic areas where specialists are not available, the independent opinion of any other physician with experience with this clinical condition would be helpful in ensuring (and documenting) appropriate care.

Consultation reports should be made a part of the patient's medical record.

7) Records

The physician should keep accurate and complete records documenting dates and clinical findings for all evaluations, consultations, treatments, medications, and patient instructions. The failure to maintain entries which fully disclose the type, extent and basis for therapy is one of the major factors in physician liability. In a situation where a physician decides on an approach which departs from customary practice, documentation justifying such a course of treatment is a critical prerequisite to continuing treatment.

In addition to following a comprehensive treatment plan based on these guidelines, the physician should incorporate two elements into his/her professional practices: 1) being watchful for any indications of manipulation

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CHRONIC CONDITIONS

(Continued from Page 5)

or illegal conduct by the patient, and 2) staying abreast of current medical information pertinent to the treatment of chronic conditions.

1) Patient Manipulation

The physician should be alert to the possibility of manipulation (which can be either consciously or unconsciously motivated) by the drug-seeking patient and ready to withhold potentially harmful treatments from a patient who fails to cooperate with prudent treatment recommendations. Physicians should never accept as a rationale for prescribing controlled

substances the argument that, if the physician refuses to prescribe, the patient will buy drugs from the street or obtain them from another physician.

In cases where a manipulative patient refuses to cooperate with the physician's treatment plan, the physician should take the appropriate steps to refuse to continue treatment. (See "Basic Legal Principles: Discontinuing Treatment with the Problem Patient.") At that point referral to a specialty program is generally the most appropriate course of action.

2) Current Information

The physician should keep current on new developments, approaches, and recommendations in prescribing. The

physician should select continuing medical education activities which address his/her clinical practice. The physician should use the opportunities for informal consultation which are provided by contact with colleagues at hospital medical staff meetings and county medical society and specialty society meetings.

CONCLUSION

This document reiterates the principles of good medical practice which guide physicians in the treatment of all patients. When the treatment is for a chronic condition, these principles take on additional significance for the protection of both the patient and the physician.

BASIC LEGAL PRINCIPLES: DISCONTINUING TREATMENT WITH THE PROBLEM PATIENT

Physicians are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and/or presents difficulties in the doctor-patient relationship. A patient has no legal right to force a physician to continue a particular course of treatment.

Three overriding legal obligations, however, must be meticulously honored when discharging the potential problem patient. These are the obligations to provide for continuity of patient care; to inform and make the patient aware of the consequences of following or *not* following the recommended treatment; and to give reasonable notice of intent to discontinue treatment.

Six areas of physician conduct should be emphasized:

1. **Medical Review.** The physician should review with the patient his medical history and treatment progress leading to his current medical condition. Where a problem patient is involved, emphasis should be placed upon compliance

problems and the adverse medical implications of the patient's past lack of cooperation.

2. **Recommend.** A proposed course of treatment should be proposed to the patient explaining how the particular treatment plan presents the most acceptable approach to dealing with the patient's current medical condition.

3. **Warn/Inform.** The patient must be informed and warned about not only the risk of proposed treatment and available alternatives, if any, but the risks of *not* following the treatment plan and/or discontinuing treatment. The physician must make the patient aware of all material risks which may result if a patient refuses or discontinues treatment.

4. **Continuity.** The physician should offer to implement the chosen treatment plan. If the patient refuses, he should be provided with a list of names and addresses of area physicians qualified to

deal with the patient's unique needs. An offer to assist the patient by consulting with any new physician should be made. Where the patient has become chemically dependent, needed medications should be prescribed only for a time period reasonably necessary to allow for the establishment of a new doctor-patient relationship.

5. **Confirm With Patient.** Where the medical risks associated with discontinuance of treatment are significant, the physician should confirm all of the above procedural steps by registered mail to the patient. This is an excellent way of documenting the "reasonable notice" requirements imposed by California law.

6. **Documentation.** Thorough documentation of the performance of all relevant procedural steps must appear in the physician's records. This is particularly true where the chemically dependent or high risk patient is involved.

LICENSING LEGISLATION

(Continued from Page 1)

3. Standardizing and simplifying reciprocity provisions. In particular, any reciprocity applicant who has been licensed in another state for more than four years will have to take and pass the clinical competency portion of the written FLEX component examination in order to get a California license. The bills also will eliminate several loopholes that have made it possible for some applicants to be licensed without meeting California standards.

4. Specifying standards for clinical clerkships. In particular, standards are established governing clerkships taken at hospitals which are geographically separated from the applicant's medical school.

5. Allowing the Board to evaluate and license graduates of special accelerated or advanced placement programs in approved U.S. medical schools on an individual basis. Previously the Board was limited to considering only the education formally received in a medical school.

6. Directing the Board to work with the Federation of State Medical Boards to explore the possibility of formally approving foreign medical schools meeting the standards required of U.S. medical schools, in addition to disapproving schools which are clearly unacceptable.

These bills were supported by the California Medical Association, the deans of California medical schools and several prominent foreign medical schools. Most of the bills' provisions become effective January 1.

Another Word on CPR . . .

In our last *Action Report*, #28, we stated "The Joint Commission for Accreditation of Hospitals (JCAH) now requires CPR for physicians to receive hospital staff privileges." Several readers have written or called to point out—correctly—that JCAH no longer has such a requirement.

We have since learned that the California Department of Health Services, which licenses hospitals, does have requirements for certain hospital employees to be trained in CPR. However, they do not require every physician practicing in a hospital to be competent in CPR.

For additional information about specific hospital staff standards, please contact the Licensing Division, Department of Health Services.

We regret any confusion or problems our misstatement may have caused.

BMQA's CONSUMER SERVICES REPRESENTATIVES

The Board has six Consumer Services Representatives who receive complaints from consumers and others about its licensees. Individuals who believe that a BMQA licensee may have violated the law can contact a CSR at any of the following locations. Counties served by each CSR are listed.

<i>COUNTIES</i>		<i>REPRESENTATIVE</i>
Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Fresno, Glenn, Inyo, Kern, Kings, Lassen, Madera, Mariposa, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, San Luis Obispo, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Trinity, Yolo, and Yuba.	}	Nancy Kraemer Sacramento Regional Office (916) 920-6013
Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma.	}	Merry Anne Boles San Mateo Regional Office (415) 573-3888
Los Angeles, Santa Barbara, and Ventura.	}	Joane Kinnard or Alicemary Hoffman Los Angeles Regional Office (213) 412-6363
Imperial, Orange, Riverside, San Bernardino, and San Diego.	}	Bertha Ruiz Santa Ana Regional Office (714) 558-4452
ALLIED HEALTH PROFESSIONS: Statewide	}	Tom O'Connor Headquarters Office (916) 920-6341

**BOARD OF MEDICAL QUALITY ASSURANCE
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