

Department of Consumer Affairs



ACTION REPORT

BOARD OF MEDICAL QUALITY ASSURANCE

No. 36 - March 1989

Physician Dispensing Subject of New Law

Pharmacy Board Will Refer Unlawful Dispensing Complaints to BMQA for Action

Legislation authored by Assemblyman Phillip Isenberg which took effect on January 1, 1989 places new requirements on physicians and podiatrists who dispense drugs in their practices. Assembly Bill 1732 contains several provisions affecting physicians.

The bill provides that the Division of Licensing should encourage physicians to include a course in pharmacology and pharmaceuticals as part of their continuing medical education. This is similar to existing laws encouraging CME in the areas of nutrition, human sexuality, child and elder abuse, and acupuncture for physicians who are likely to come into contact with these aspects of practice.

Existing laws pertaining to requirements for dispensing (see accompanying article, page 6) are noted in the bill. It then adds a provision that "The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of it and personally dispenses the drugs or dangerous devices to the patient, packaged, labeled, and recorded in accordance with paragraph (4) [see accompanying article]."

PRESCRIBERS MUST OFFER PATIENTS WRITTEN PRESCRIPTION

Among other provisions, the bill requires physicians to offer to give the patient a written prescription which he or she may elect to have filled by the prescriber or by any pharmacy, and a written disclosure to that effect. Drugs must be stored in a "secure" area, which is to be defined in regulations by the BMQA.

Finally, the bill requires the Board of Pharmacy to promptly forward all complaints related to drugs or dangerous devices dispensed by physicians, to the BMQA, and requires the BMQA to handle those complaints involving serious bodily injury as a case of greatest potential harm to a patient. The Board is to report to the Legislature on January 1, 1991 on the complaints it receives from the Board of Pharmacy.

CASE REFERRAL PROCEDURE

BMQA has reached an agreement with the State Board of Pharmacy (SBP) on the procedure

to be followed when the SBP receives complaints about physician dispensing violations. SBP will send the physician a letter describing the violation, and enclosing copies of relevant laws. The letter will constitute a warning to the physician that subsequent violations will result in a formal complaint to the BMQA, which could lead to disciplinary action. Copies of SBP warning letters will be routinely sent to BMQA.

See accompanying article on Page 6 for laws which affect dispensing.

Board Elects 1989 Officers

On December 3, the Board elected new officers for the 1989 calendar year. Galal Gough, M.D. is the new President, John Tsao, M.D. is Vice President, and Madison Richardson, M.D. is Secretary.

The Division of Allied Health Professions elected Jacquelin Trestrail, M.D. as President and Madison Richardson, M.D. as Vice President.

New President of the Division of Licensing is Jerome Unatin, M.D., Vice President is C. Fredrick Milkie, M.D., and Secretary is Raymond Mallel, a public member.

Presiding over Division of Medical Quality will be outgoing Board President Eugene J. Ellis, M.D., with Andrew Lucine, M.D. as Vice President, and public member Theresa L. Claassen as Secretary. Each office is for a one year term.

Retired State Senator Appointed to Board



Senator Alfred H. Song (Ret.)

Adding to a long and distinguished career in public service, former California State Senator Alfred H. Song has been appointed to the Board by Governor George Deukmejian. Song received his BA, MLaw and JD degrees from the University of Southern California. Admitted to the State Bar in 1950, he practiced law until his election to the Assembly in 1962. Four years later he was elected to the Senate, where he served until 1978.

Since completing his stint in the Senate, Mr. Song has practiced law privately and as a

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The Board May Owe You A Refund

IF:

1. You were initially licensed to practice medicine in California in 1985 or 1986, AND
2. You were enrolled in an approved postgraduate training program at the time you were licensed, AND
3. You paid the full initial license fee, AND
4. You paid a full first renewal fee.

Until January 1, 1987, the law afforded physicians who were enrolled in approved residency programs a 50 percent reduction in their first license renewal fee. In 1987 this law changed. Rather than providing residents a reduction in their first renewal fee, the law now provides residents a reduction in their initial license fee. While this change is appropriate and was well received, the transition inadvertently excluded resident physicians who had paid full initial license fees and then were required to pay full first renewal fees. It is this population of physicians that was addressed in Assembly Bill 4018 (Filante) which was enacted by the California Legislature this year.

Assembly Bill 4018 specifically provides that the Board shall remit a refund to any physician and surgeon who, prior to January 1, 1987, paid a full initial license fee and then a full biennial renewal fee. The amount of the refund shall be an amount equal to 50 percent of the initial license fee in effect on January 1, 1987. This provision specifically applies only to those physicians and surgeons who were enrolled in an approved residency program and did not receive the benefit of a reduction either in their initial license fee or their first biennial renewal fee. This special refund is available until January 1, 1990.

If you believe you are in this category, please furnish the Board with evidence, such as cancelled checks, that you paid both fees in full and were enrolled in an approved residency program at the time. Upon review and verification, you will be sent a check for \$127.50 (50 percent of the \$255 initial license fee in effect January 1, 1987). This evidence should be forwarded to the attention of "Resident Refunds" at the Board's Sacramento address at least eight weeks prior to January 1, 1990.

RESIDENT REFUNDS

Board of Medical Quality Assurance
1430 Howe Avenue
Sacramento, CA 95825

The time required for processing and issuing refunds is expected to be approximately eight to ten weeks. We regret this inconvenience, but are pleased that we can compensate those who were inadvertently excluded. Thank you for your patience.

STUDY RAISES CONCERNS ABOUT EXPOSURE OF HEALTH WORKERS TO ANTIVIRAL RIBAVIRIN

by Kenneth Kizer, M.D., Director, Department of Health Services

The California Department of Health Services (DHS) has issued a warning to health care workers who are pregnant, and to male and female workers who are attempting to conceive about the dangers of exposure to the antiviral agent **Ribavirin**.

Animal studies have shown that ribavirin is teratogenic, causing severe malformations in offspring of exposed females. In a recent study*, DHS found that exposure of health care workers who tend patients receiving ribavirin aerosol via oxygen tent or mist mask may exceed recommended safety levels to protect against reproductive harm.

Surgical masks and similar respiratory protection are not likely to reduce exposure to the

aerosol sufficiently. Hospitals are urged to consider alternative job assignments for health care workers who are at risk and to develop policies to minimize occupational exposure to the drug.

Additional information may be obtained from the Occupational Health Surveillance and Evaluation Program, California Department of Health Services, 2151 Berkeley Way, Room 504, Berkeley, CA 94704, (415) 540-2115.

*California Department of Health Services. Health Care Workers Exposure to Ribavirin Aerosol: FI-86-009, 1988.

CONTINUING EDUCATION NEVER MORE IMPORTANT

by Eugene Ellis, M.D., President

California physicians are required to complete an average of twenty-five hours of continuing medical education (CME) each year. Most physicians report more than twice that amount. Perhaps the most valuable CME is not the kind which is taken on cruise ships or at resort hotels, but is that which occurs as an organic part of the daily practice of medicine.

A recently published book on physician CME suggests some strategies for maintaining lifelong learning which both enhances the physician's practice and maintains the zest which makes medicine so satisfying. **MEDICINE: PRESERVING THE PASSION**, by Phil R. Manning, M.D. and Lois deBakey, Ph.D., (Springer-Verlag, New York, 1987) explores this topic in detail.

Learning which emerges from actual patient problems generally is retained better and longer than learning acquired in formal courses. When a physician consults with peers, researches the literature, seeks specific answers for specific problems, he or she will remember the answers.

Another very important approach to CME is daily reading or study in the area of practice. Physicians, who regularly schedule time for study and who have some sort of organized information retrieval system, benefit measurably compared to those who do not organize their self-study.

Overall, a planned, sustained commitment to lifetime learning is the hallmark of those physicians who are recognized by their peers as being outstanding in their field.

State Supreme Court upholds competency exam

In September 1988, the California Supreme Court rejected a challenge to the Board's competency examination. A physician whose practice was in question complained that the examination process violated his rights. The Board had ordered him to take an examination without first providing him with a hearing.

At issue was Business and Professions Code Section 2292, which allows the Board to examine a physician's competence if there is reasonable cause to suspect problems. The law provides a 45 day period in which the physician may appeal the order and request a hearing. The Board has discretion whether or not to grant a hearing.

The examination is administered by a panel of two physicians with expertise in the subject's area of practice. An oral examination, the questions cover both general and specialized medical subjects, and is tailored to the physician's specialty.

If both examiners fail the candidate, a second examination before a different panel is scheduled within 45 days. Again, both examiners must fail the physician or the examination is passed. If even one of the four panelists passes a candidate, the information used as the basis for the petition for the examination cannot be used in any later proceeding against the physician.

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CONSULTANT'S CORNER

An Interview With Dr. Donald ReVile on Physicians and Long Term Care

by Richard Ikeda, M.D., Chief Medical Consultant

Donald ReVile, M.D., is on the staff of the Sutter Hospital System of Sacramento. For many years he has focused his practice in long term care. Recently, Dr. ReVile served on the Advisory Committee on Quality Medical Care in Nursing Homes, of the Commission on California State Government Organization and Economy, also known as the Little Hoover Commission. The Advisory Committee held hearings in Sacramento and Los Angeles last summer, which formed the basis for an upcoming report to the Governor and Legislature.

Past activities of the Commission have led to over twenty legislative bills aimed at correcting problems and abuse in nursing homes. Dr. ReVile talked about nursing homes and the physician's role in assuring quality of medical care for persons in long term care, with Richard Ikeda, M.D., Chief Medical Consultant for the Board, shortly after completing his service on the Advisory Committee.

Dr. Ikeda: Dr. ReVile, in your testimony before the Little Hoover Commission, you clearly stated that most doctors in Long Term Care (LTC) are doing an adequate job in an area that is unappreciated, misunderstood and underfunded. Yet the Commission has chosen to be sharply critical of physicians in LTC. Why is this so?

Dr. ReVile: One reason may be that physicians play a key role in nursing home care. They admit patients to nursing homes, periodically reaffirm their need to remain there, and are responsible by law and regulations for monitoring the care of their patients on an on-going basis.

A second reason may be that, although most physicians do a good job in monitoring the care of their long term care patients, there was testimony indicating some physicians do a mediocre job of providing on-going care, and are not responsive to periodic special care needs of their patients.

The specific problem areas seem to be physician responsiveness to calls from the nursing home asking that they come out to see the patient in response to an episodic problem, careful review and updating of medication needs, and thoroughness of periodic evaluations of patients needs.

Dr. Ikeda: Do you believe there is more mediocre care in LTC than in other areas?

Dr. ReVile: Yes, I believe there is, particularly when we compare acute care in hospitals and chronic care in Skilled Nursing Facilities (SNF). There are two reasons why this is so:

1. Hospital care is high status, better paid and more interesting to the physician, whereas caring for persons in SNF tends to be viewed as lower status, underfunded and - unfortunately - less interesting and satisfying for most doctors.
2. In hospitals, because of a long history of quality review, there is a strict systematic structure of peer review and patient care reviews. In LTC facilities, there is no history and no structure of peer quality reviews.

These are the two main reasons for a larger amount of mediocre care being given in SNF than in hospitals.

Dr. Ikeda: Do you think peer review would be valuable for SNFs?

Dr. ReVile: Yes, and already there are SNFs which have started peer review. Furthermore - and this is something the public and most physicians do not know - but every Medi-Cal patient in a skilled nursing or intermediate care facility is reviewed yearly by a Utilization Review Nurse. In other words, there is 100% review of every Medi-Cal patient in long term care by trained, very stringent Medi-Cal Utilization Review Nurses. Remember 50% of all patients in SNF are Medi-Cal. The other 50% - which are private pay - may not be so well-monitored. Here is where abuse may lie. But this is where we hope interested family members are watching the care being provided.

If any instances of questionable care are reported to BMQA by Medi-Cal, I am sure these will be looked into.

Dr. Ikeda: You are absolutely right, Dr. ReVile. Last year we opened formal investigations on five

to ten cases under our authority covering gross negligence and incompetence. In two of the most egregious cases our investigations were halted because the local district attorney filed criminal charges against the doctors in question. We hold up our investigations in cases like this in order not to jeopardize the district attorney's work and criminal filing. This takes precedence over our actions, which by law are purely administrative; that is, actions against a medical license.

In addition to these formal cases, we intervened informally in other cases to encourage physicians to improve their care.

Dr. ReVile: I think it should be up to physicians in LTC, just as it was up to us in hospitals, to develop tough peer review on quality issues. It was done in the hospital and it can be done in LTC. Hopefully if any legislation is passed based on the current Little Hoover Commission study it will be over this issue. Hopefully laws will be enacted that will encourage and protect peer review in SNF.

Already this review is being done here in Sacramento, the new Asian Nursing home is doing it, headed by a well-known local internist, Dr. William Fong. He is also Sacramento's delegate to the CMA. In my own institution, Sutter, we already have stringent staff criteria. Physicians must have admitting privileges to the Sutter Hospitals in order to qualify to admit to our LTC facilities. I can answer you. Change is on the way! Any legislation will hopefully encourage this peer review infrastructure.

Dr. Ikeda: Are there other actions that could enhance physician participation in long term care?

Dr. ReVile: Most important, laws that will encourage physicians to participate. More important - deregulation to cut down on the masses of time-consuming, useless paperwork that we seem to be mired in in LTC, and better reimbursement. Maybe it is fine that hands-on care be done by allied health personnel - family nurse practitioners, physician's assistants. Emphasis on high touch - away from the high touch expertise of physicians in acute care, to more ongoing case management in long term care, involving allied health personnel under physician supervision.

The physician in LTC must be able to manage the allied health team. The physician still must be prepared to respond when his/her expertise is needed.

Dr. Ikeda: When is this managerial input most needed?

Dr. ReVile: Right from the very beginning. It is here with patient and relatives that the seed bed for later decisions are made. Both patient and relative should become aware of things they must start thinking about. CPR, no CPR? Acute hospitalization, no hospitalization? Flu shots? Antibiotics? Special diets? Continued physical activ-



Dr. ReVile



Dr. Ikeda

DISCIPLINARY ACTIONS

April 1, 1988 to July 31, 1988
Physicians and Surgeons

ANTHONY, Neville N., M.D. (A-35302) - Dix Hills, NY

2236 B&P Code
Stipulated Decision. Conviction for filing false Medi-Cal claims.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days suspension.
April 22, 1988

CHAMBERS, Charles, M.D. (G-40189) - Petaluma, CA

822 B&P Code
Stipulated Decision. Mental impairment.
Revoked, stayed, 7 years probation on terms and conditions.
June 13, 1988

CHUNG, Joseph M., M.D. (A-39427) - Battle Creek, MI

2234(d), 2293 B&P Code
Twice failed professional competency exam in his field of practice. Incompetency.
Revoked, stayed, 5 years probation on terms and conditions.
June 13, 1988

CLARK, Robert T., M.D. (C-40805) - Decatur, GA

2305 B&P Code
Probationary order by Georgia Board.
Revoked. Default.
July 11, 1988

COHN, Frederick, M.D. (G-05087) - Albuquerque, NM

Stipulated Decision. Disciplined by New Mexico Board.
Revoked, stayed, 10 years probation on terms and conditions.
April 25, 1988

DREIER, Randolph J., M.D. (A-28883) - Hemet, CA

2234(b), (d) B&P Code
Stipulated Decision. Gross negligence and incompetency in connection with a hysterectomy.
One year suspension, stayed, 5 years probation on terms and conditions.
April 14, 1988

FERGUSON, John S., Jr., M.D. (C-24651) - Fort Worth, TX

2236, 2237, 2238, 2305 B&P Code
Federal conviction in Arkansas for unlawfully distributing a controlled substance. Disciplined by Arkansas Board.
Revoked. Default.
May 9, 1988

FIGATNER, Joel, M.D. (G-32022) - North Fork, CA

2238 B&P Code; 11158, 11190 H&S Code
Stipulated Decision. Violated statute providing that no Schedule II controlled substance may be dispensed without a triplicate prescription.
Revoked, stayed, 5 years probation on terms and conditions.
April 22, 1988

FLORES, Martin G., M.D. (G-46704) - Kensington, CA

2234(a), (e), 2261 B&P Code
Dishonesty in filing false report with federal NHSC certifying full time practice in underserved Galt (to satisfy scholarship obligation) when in fact he was working full time in residency program at UCD Med Center in Sacramento.
Revoked, stayed, 5 years probation on terms and conditions, including 60 days suspension.
May 1, 1988

GOLD, Ilene, M.D. (G-51974) - Newton Centre, MA

2305 B&P Code
Disciplined by Massachusetts Board for self use of drugs.
Revoked, stayed, 5 years probation on terms and conditions.
June 3, 1988

GREENWALD, Gerald, M.D. (A-32041) - Miami, FL

2305 B&P Code
Disciplined by Florida Board.
Revoked. Default.
May 11, 1988

GRIER, Barnett J.W., M.D. (A-37975) - Daly City, CA

2234(b) B&P Code
Gross negligence in failing to properly supervise his physician's assistant as to treatment and prescriptions.
Revoked, stayed, 8 years probation on terms and conditions.
October 30, 1987 (Judicial Review completed)

HMURA, Michael, M.D. (G-23983) - Marina Del Rey, CA

2234(e), 2261 B&P Code
Stipulated Decision. Knowingly made false statements in applications for hospital privileges and malpractice insurance.
Revoked, stayed, 5 years probation on terms and conditions, including 45 days suspension.
May 11, 1988

HURST, James L., M.D. (A-28722) - Los Angeles, CA

725, 490, 2236, 2237, 2238, 2242 B&P Code
Stipulated Decision. Conviction for prescribing to a person not under his treatment for a pathology or condition. Excessive prescribing. Prescribing without prior physical exam and medical indication.
Revoked, stayed, 5 years probation on terms and conditions, including 30 days suspension.
April 14, 1988.

HUYNH, Them, M.D. (A-38341) - San Jose, CA

2234(e), 2236 B&P Code
Stipulated Decision. Conviction for filing false Medi-Cal claims.
Revoked, stayed, 5 years probation on terms and conditions, including 3 month suspension.
July 22, 1988

KAY, Burns, Wen-Fun, M.D. (A-30785) - Monterey Park, CA

490, 2236, 2234(e), 2242, 2238 B&P Code; 11154 H&S Code
Stipulated Decision. Conviction for violation of statutes governing controlled substances. Prescribing without good faith prior examination and medical indication therefor.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days suspension.
April 11, 1988

MACK, Donald, M.D. (A-17918) - Portland, OR

2305 B&P Code
Stipulated Decision. Disciplined by Oregon Board for violating drug restriction.
Revoked, stayed, 5 years probation on terms and conditions.
April 25, 1988

Copies of complete disciplinary Decisions and Accusations (Statements of Charges) may be ordered by writing to:
BMQA Enforcement, 1430 Howe Avenue, Sacramento, CA 95825.

For quick, orderly processing, please send your request by letter and enclose a check based on \$2.00 for each copy of a decision or an accusation. Give complete name and license number of doctor, as listed here. Please, no telephone requests.

McCOOK, William F., M.D. (A-29421) - Potter Valley, CA

2305 B&P Code
Disciplined by Hawaii Board for sex with patients.
Revoked. Default.
April 27, 1988

MILLIGAN, John O., M.D. (C-25951) - Fremont, NE

2234(b), (c), (d) B&P Code
Gross negligence, incompetence and repeated similar negligence in obstetrical care.
Revoked, stayed, 5 years probation on terms and conditions. Judicial review recently completed.
April 27, 1988 (Judicial Review Completed)

MITCHELL, Charles H., M.D. (A-28623) - Ramona, CA

725, 2234, 2264 B&P Code
Stipulated Decision. Aided and abetted an unlicensed person (his son) to diagnose, prescribe and excessively treat patients seeking medical services at respondent's office.
Revoked, stayed, 3 years probation on terms and conditions, including 30 days suspension.
June 24, 1988

NGUYEN, Chuong Nhu, M.D. (A-39598) - Santa Ana, CA

490, 2234(e), 2236, 2261 B&P Code
Conviction for Medi-Cal fraud. Sentence includes one year county jail and restitution.
Revoked, stayed, 5 years probation on terms and conditions.
April 18, 1988

NOTTINGHAM, John Fletcher, M.D. (A-21231) - San Jose, CA

2239, 2238 B&P Code
Self-administration of Demerol, and being under the influence while serving as an anesthesiologist during surgeries.
Revoked.
August 19, 1976 (Long Drawn Judicial Review Recently Completed)

OLIVERIO, Michael T., M.D. (A-33227) - Loma Linda, CA

490, 2276, 2237 B&P Code
Conviction for unlawful prescribing of a controlled substance.
Revoked, stayed, 5 years probation on terms and conditions, including 45 days suspension.
June 10, 1988

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Disciplinary Actions

Continued from Page 4

REED, Alan E., Jr., (G-24549) - Milwaukee, WI
726, 2242, 2238 & P Code
Sexual misconduct with patients, and prescribing controlled substances for non-medical purposes.
Revoked. No appearance by respondent.
June 13, 1988

RUECKL, Frank Victor, M.D. (G-34734) - Reno, NV
Disciplined by Nevada Board. Federal conviction for distributing a small amount of cocaine.
Revoked, stayed, 5 years probation on terms and conditions.
July 11, 1988

SAYANI, Ian, M.D. (C-38490) - San Jose, CA
2234(d) B&P Code
Incompetence in orthopedic practice.
Revoked, stayed, 3 years probation on terms and conditions.
April 18, 1988

SONNTAG, Robert W., M.D. (A-19460) - Hollywood, CA
725, 2234(b), (d), 2238, 2239, 2242 B&P Code
Self use of morphine sulfate (an opium derivative). Gross negligence and incompetence in prescribing morphine sulfate to numerous patients, excessively and without medical indication.
Revoked. Default.
May 9, 1988

STEELE, Russell B., M.D. (G-14669) - Lodi, CA
2234(b), (d) B&P Code
Stipulated Decision. Gross negligence and incompetence in handling obstetrics case. Failed professional competency exam twice.
Revoked, stayed, 5 years probation on terms and conditions.
April 14, 1988

STEPAK, Paul Howard, M.D. (G-50113) - San Francisco, CA
490, 2234, 2237, 2238 B&P Code
Stipulated Decision. Federal conviction for distribution of a controlled substance, and possession of a controlled substance containing LSD.
Revoked.
May 6, 1988

VEGA, Julio Cesar, M.D. (A-33429) - Santa Ana, CA
725, 726, 2234, (b), (c), (d) B&P Code
Stipulated Decision. Sexual misconduct with patients. Also excessive treatment, gross negligence, repeated negligence and incompetency.
Revoked, 10 years probation on terms and conditions, including one year suspension.
January 1, 1988

VOLUNTARY SURRENDER OF LICENSE ACCEPTED WHILE CASE PENDING

McCAMPBELL, Ernest Guy, M.D. (G-42218) - Hantramck, MI
July 25, 1988

NAYYAR, Som N., M.D. (C-23375) - Hyderabad, India
June 6, 1988

APPLICANT CASES

Decisions affecting applicants for physician's license following written notice (Statement of Issues) and an opportunity for a hearing.

CICMANEC, Joseph A. - San Diego, CA
480(a)(2), (c), 2287 B&P Code
Stipulated Decision. False statement in license application regarding medical degree, medical courses and attendance at CETEC University, Dominican Republic.
License denied.
April 25, 1988

GRUBER, Victor N. - Hidden Hills, CA
480, 2261, 2234, 2102, 2089 B&P Code
Failed to establish that he completed a medical school education (at CETEC and CIFAS) or resident course of instruction equivalent to that required for licensure in California. Also, false application.
License denied.
July 5, 1988

Consultant's Corner Dr. Donald ReVile on Long Term Care

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ity whenever possible? But remember, I said start thinking about it. Each of us grapples with these problems at our own speed. To be or not to be...

And everyone on the health care team by attitude and encouragement, fosters an environment where patient and relatives can begin to think about and then decide. Some will do it all at once, others step by step. This is where a mature physician can be of so much help.

Dr. Ikeda: Dr. ReVile, do you have a word of advice for the young physician?

Dr. ReVile: I know that many of the new physicians have not put too much thought about the elderly patients. It is changing, though. Demographics force that change - and economics. And medical schools are beginning to teach about the different medical needs and responses in the elderly. Learn as much as you can, but also learn about the broader context - how the elderly fit into family and society. Try to get a feeling about how it must be to reside in a long term care facility. Talk to the elderly, find out about them. Just think, in a few short years, the new crop of young physicians will have the pleasure of looking after you and me!

Reporting Program Identifies Thousands of Lead Poisoning Cases

Since April 1987, the California Department of Health Services has received over 6,000 reports of elevated blood lead in Californians pursuant to recently enacted legislation Health and Safety Code, Chapter 481, Section 309.7 requires medical laboratories to report blood lead levels exceeding 25 micrograms per deciliter in patients of any age. Over 95% of all reports have been in adults, with occupational exposure to lead the most important contributing factor.

Scores of reports involved workers with blood lead levels exceeding 80 micrograms per deciliter. Most reports were linked to individuals employed in occupations with known lead exposure such as lead battery manufacturing, lead smelting, gun firing ranges, brass foundries, radiator repair and construction involving paint stripping or demolition.

Physicians are reminded that state law (Labor Code Sec. 641.5) requires filing of **Doctor's First Reports** for suspected occupational illnesses, including lead-related illnesses.

Information and Assistance is Available

The California Occupational Health Program (COHP) is available to consult with patients and their treating physicians in cases of severe workplace lead exposure. Children also may be at risk of exposure from their parent's contaminated work clothing. Such cases will be referred to the California Department of Health Services, Childhood Lead Poisoning Prevention Program - a corollary effort also initiated in early 1987.

Additional information can be obtained from the COHP, Occupational Lead Registry, 2151 Berkeley Way, Room 504, Berkeley, CA 94704, telephone (415) 540-3572. Medical guidelines for treatment of lead-exposed workers, summaries of lead registry data, and factsheets for lead-exposed patients are available. Inquiries concerning proficiency testing for medical laboratories should be directed to CDHS Air and Industrial Hygiene Laboratory, (415) 540-2768.

NEW FEDERAL LAW REQUIRES RECORDS, REPORTING OF IMMUNIZATION COMPLICATIONS

A federal law which took effect on March 22, 1988 now requires physicians and others to keep detailed records of all immunizations administered, and to report any adverse events. Public Law 99-660, as amended in 1987, pertains to diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps and rubella vaccines and toxoids.

Office or clinic records must include the vaccine type, date of administration, manufacturer and lot number of the vaccine, and the name, (business) address and title of the person who administered it. Records may be kept in individual patient records or in a separate permanent log.

Whenever there is an adverse event, it must be reported to the local health department, or in some cases to the Food and Drug Administration, HFN-730, Rockville, MD 20857. Reporting forms and detailed information about the reporting requirements are available at that address.

The new federal law also has additional informed consent requirements, but these will not take effect until sometime in 1989.

For more detailed information about this new law, please contact the California Department of Health Services, Immunization Unit, 2151 Berkeley Way, Berkeley, CA 94704.

drug, or the generic name and the manufacturer; directions for use; name of the patient and prescriber; name and address of the furnisher; the date the prescription was issued; the expiration date of the effectiveness of the drug; and the strength and quantity of each drug dispensed.

A physician may dispense drugs in an emergency where lack of the drug would present an immediate hazard to the patient's health and welfare or would result in intense suffering to the patient.

However, a physician may dispense not more than a 72-hour supply of Schedule II controlled substances, provided that the patient is not expected to require any additional amount of the controlled substance beyond 72 hours. When a Schedule II drug is dispensed in this manner, the physician must complete a triplicate prescription form and forward the original to the Bureau of Narcotic Enforcement.

California Law Provisions Affect Dispensing of Drugs by Physicians and Podiatrists

Physicians and podiatrists who dispense drugs or dangerous devices (i.e. those which require a prescription) must comply with several provisions of pharmacy law. The principal requirements are set out in Section 4051, which is reproduced here for your retention and reference. Additional provisions are summarized in the accompanying article (page 1) on recent law changes. Section 4051 contains amendments which take effect January 1, 1989.

Section 4051. (a) No prescriber shall dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The drugs or dangerous devices are dispensed to the prescriber's own patient and the drugs or dangerous devices are not furnished by a nurse or attendant.

(2) The drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, drugstore, advertised or otherwise, for the retailing of drugs or dangerous devices or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4047.5, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of child-proof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of it and personally dispenses the drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4) [above].

(b) The Board of Medical Quality Assurance and the Board of Osteopathic Examiners shall

have authority with the Board of Pharmacy to assure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate or a certificate to practice podiatry, and who is duly registered as such by the Board of Medical Quality Assurance or the Board of Osteopathic Examiners of this state.

(d) This section does not prohibit the furnishing of a limited quantity of samples by a prescriber, if the prescriber dispenses the samples to the patient in the package provided by the manufacturer, no charge is made to the patient therefor, and an appropriate record is entered in the patient's chart.

(e) This section does not apply to clinics, as defined in subdivision (a) of Section 1204 or subdivision (b) or (c) of Section 1206 of the Health and Safety Code, to veterinarians furnishing drugs for the treatment of animals, to programs licensed pursuant to Sections 11876, 11877, and 11877.5 of the Health and Safety Code, or to a prescriber dispensing parenteral chemotherapeutic agents, biologicals, or delivery systems used in the treatment of cancer.

OTHER RELEVANT LAWS

The information which the label on a container must contain includes the trade name of the

FEDERAL LAW REGARDING SAMPLES

Federal drug law amendments this year prohibit the sale, purchase or trade of drug samples. Manufacturers and distributors may not give away samples without a written request on a form with the name, address, professional designation and signature of the practitioner making the request, the identity and quantity of the requested drug, the name of the manufacturer, and the date of the request.

Samples may be distributed only to licensed prescribers, or on the request of a prescriber, to a pharmacy in a hospital or other health care facility. These restrictions apply to samples which are shipped as well as those delivered in person.

Several other laws apply to dispensing in clinics and group settings. Physicians who practice in those situations may want to request copies of those sections from the Board of Pharmacy. There also are exceptions to the general prohibition on dispensing by registered nurses.

For copies of these laws, you may write to the State Board of Pharmacy, 1020 N Street, Room 448, Sacramento, CA 95814.

26 NEW LAWS ON AIDS Legislature Acts on Consent, Disclosure, Reporting and Other Related Concerns

During the just-completed 1988 legislative session, Governor Deukmejian signed 26 bills on AIDS into law. Of particular interest to physicians and other health workers are Chapters 1216, 1581, and 1582, which contain provisions that relax both the consent requirements for testing for human immunodeficiency virus (HIV) infection and the provisions governing the disclosure and reporting of AIDS test results. A brief description of these three new laws as well as a review of current AIDS reporting requirements follows.

Chapter 1216 (Senate Bill 2788, Maddy) repeals a previous law requiring specific written consent from the individual tested for each disclosure of HIV-antibody test results. The bill also provides that no physician or surgeon shall be held criminally or civilly liable for disclosing a patient's positive AIDS-virus test results to a person reasonably believed to be the spouse, a sexual partner, or a person with whom the patient has shared hypodermic needles, or to the county health officer. When notifying a spouse, sexual partner, or needle-sharing partner, no identifying information about the test subject may be revealed.

The law permits notification of these contacts or the county health officer only after the physician or surgeon has discussed the test results with the patient, offered the patient appropriate counseling, and attempted to obtain the patient's voluntary consent for notification of his or her contacts. The physician or surgeon must provide any contacts thus notified with referrals for appropriate care, counseling, and follow-up.

Such disclosure may be made only for the purpose of diagnosis, care, and treatment of the persons notified, or for the purpose of interrupting the chain of transmission. The same provisions govern any notification efforts by the county health officer. In addition, the county health officer must purge from all county records all information regarding the person believed to be infected as soon as the notification efforts are completed.

This new law does not require physicians to inform contacts of their patients who have tested positive. Nor does it imply that they have a duty to do so. Quite the reverse. The law says: "No physician has a duty to notify any person of the fact that a patient is reasonably believed to be infected...." Thus, the new law may serve to protect physicians from liability for not notifying contacts.

Chapter 1581 (Senate Bill 2847, Hart) establishes an "informed consent" requirement prior to HIV antibody testing in place of the written consent previously required. The law also permits disclosure of test results to an individual's provider of health care; permits the State Department of Health Services or the local county health officer to disclose information about possible HIV infection to the blood banks; and permits test results to be documented in a medical record, without being considered disclosure, as long as it is recorded by the physician who ordered the test.

Chapter 1582 (Assembly Bill 3255, Jones) permits disclosure of HIV test results to health care workers who provide direct patient care. In addition,

tion, this law allows documentation of test results in the medical record, and establishes an "informed consent" requirement prior to HIV antibody testing in place of the written consent previously required.

NO SIGNIFICANT CHANGES IN REPORTING REQUIREMENTS:

In general, the requirements for reporting AIDS cases have not changed. The federal Centers for Disease Control definition for AIDS case surveillance took effect for reporting purposes on September 1, 1987. Since that time, the inclusion of a patient's HIV antibody status on the AIDS case report form has been essential to establishing a diagnosis in cases involving HIV encephalopathy, wasting syndrome, or opportunistic infections presumptively diagnosed.

There has been some confusion about these requirements. A number of health jurisdictions have experienced difficulty in obtaining antibody status from physicians who apparently believe it is illegal to report the antibody status of a person diagnosed with AIDS. However, the law is clear: disclosure of antibody status by physicians in conjunction with reporting of diagnosed AIDS cases is permissible under Chapter 1.1, Section 199.21 (i) of the California Health and Safety Code, which says:

(i) Nothing in this section shall be construed to impose liability of criminal sanction for disclosure of a blood test to detect antibodies to the probable causative agent of AIDS in accordance with any reporting requirement for a diagnosed case of AIDS by the state department or the Centers for Disease Control under the United States Public Health Services.

Thus, although it is necessary to obtain the patient's consent before performing an HIV antibody test, it is not necessary to obtain the patient's consent to release the results of the test to the county health officer in conjunction with the reporting of a diagnosed AIDS case.

Legal Basis for AIDS Reporting Requirement:

The basis for the reporting requirement deserves review as well. AIDS became a reportable disease when the California Department of Health Services declared it so on March 23, 1983. The Department's authority for making this declaration was Title 17, Section 2503 of the California Administrative Code, which says:

Occurrence of Unusual Diseases: Any person having knowledge of a case of an unusual disease not listed in Section 2500 of the California Administrative Code shall promptly convey the facts to the local health officer.

In addition, Section 1603.1 of the California Health and Safety Code as amended by the legislature on April 4, 1985, specifies the following:

(c) A physician shall report immediately all cases of transfusion associated AIDS (by name, date of birth, address, and social security number) to the county health officer for investigation.

(d) As soon as is practical following hospitalization, a hospital shall report the name, date of birth, address, social security number, name of the hospital, the date of hospitalization, and any other information required on all confirmed cases of AIDS to the State Department of Health and the county health officer.

For additional information or copies of these and related laws, you may contact:

Department of Health Services
Office of AIDS
830 S Street
Sacramento, CA 95814
(916) 445-0553

Competency Exam Upheld

Continued from Page 2

Refusal to take a competency examination is grounds for disciplinary action. In the subject case, the courts ruled the examination is an investigative proceeding, not a disciplinary proceeding. Failing does not immediately, or necessarily, put a physician's license at stake. A physician who fails is entitled to an administrative hearing before any disciplinary action may be imposed.

Instead of complying with the order compelling the examination, the physician in this case filed suit to challenge the process. He argued the statute was unconstitutional. Both the superior court and district court of appeal found for the Board. The state Supreme Court refused to hear the case, thus bringing it to an end. (Smith v Board of Medical Quality Assurance, 1st DCA, 6/22/88.)

Hospital Wellbeing Committees Will Assist Physicians With Substance Abuse And Other Problems

Song Appointed to BMQA

Continued from Page 1

All California hospitals are required to create Committees on the Wellbeing of Physicians under regulations recently adopted by the Department of Health Services (DHS). The committees will be responsible for recognizing physicians who have problems with substance abuse, physical or mental illness which impair their ability to practice safely and effectively.

The regulations follow more than two years of efforts by the Board and the California Medical Association, in cooperation with the DHS. Prior to their adoption, less than one third of California hospitals had any internal committee or organization to deal with these problems.

Informational Materials Available

In anticipation of the regulation, CMA has prepared informational materials to assist hospitals in creating committees. For a copy of the CMA guidelines, call the CMA Medical Staff office at (415) 541-0900. The guidelines include model bylaws for hospital staffs.

The CMA and BMQA are preparing joint workshops for presentation in February and May 1989 to assist hospitals in this process. Information about the workshops is available from the CMA office (above) or the **BMQA Diversion Program**, at (916) 924-2561.

BMQA Diversion Program

The **BMQA Diversion Program** has existed since 1980, and has been the subject of a number of articles in recent issues of **ACTION REPORT**. For information about how the program operates, or about making referrals of physicians to the program, you may call the above number. We also maintain information about local treatment programs for physicians throughout the state. Additional information about referrals is available through the **CMA Confidential Hotline at (415) 756-7787 in Northern California, or (213) 383-2691**

Deputy Attorney General. He also has served terms on the California Occupational Safety and Health Appeals Board, and the Agricultural Labor Relations Board. He also served as Special Consultant to Attorney General John Van de Camp on nursing homes.

A democrat, Song is unusual in having received major appointments from both democratic and republican governors. His appointment to BMQA is in the Division of Allied Health Professions, and will expire June 1, 1992.

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE

SACRAMENTO, CA 95825

EXECUTIVE OFFICE (916) 920-6393

Physicians and Surgeons:

Applications & Examinations (916) 920-6411

Chief Medical Consultant (916) 920-6393

Complaints - call nearest regional office:

Fresno (209) 445-5664

Los Angeles Region:

Torrance (213) 320-8530

Woodland Hills (818) 713-0124

Sacramento (916) 920-6013

Santa Ana (714) 558-4452

San Bernardino (714) 383-4755

San Mateo (415) 573-3888

Continuing Education (916) 920-6074

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805 Reporting (916) 924-2338

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License Renewals (916) 920-6943

Verification of Licenses (916) 920-6343

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Physical Therapy (916) 920-6373

Podiatry (916) 920-6347

Psychology (916) 920-6383

Registered Dispensing Opticians (916) 924-2612

Respiratory Care (916) 924-2314

Speech & Audiology (916) 920-6388

BMQA has many phone numbers. To avoid transfers, please refer to the above list before calling the Board.

