

Action Report

Medical Board of California

July 1995 Vol. 54
A Quarterly Publication

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INSERT: MANAGED CARE

In response to growing concerns about problems with managed care, the board has appointed a Committee on Quality of Care in a Managed Care Environment. This issue's insert contains excerpts from recent speeches on the impact to consumers and physicians of managed care.

Medical Board of California Meeting Dates/Locations 1995

July 28-29 Los Angeles
November 2-3 San Diego

1996

February 2-3 Los Angeles
May 10-11 Sacramento
July 26-27 San Francisco
November 1-2 San Diego

Board Adopts Priority System to Guide Case Management, Information Disclosure

At its May meeting, the Medical Board continued its reforms by adopting a formal system of priority cases—an eight-part list of the most egregious cases to be handled on an expedited basis by the Board's investigators and prosecuting attorneys.

The vote came as a by-product of negotiations between the California Medical Association (CMA) and the Board in which both sides are attempting to settle a one and one-half year-old lawsuit filed by the CMA against the information disclosure policies of the Board. In particular, the CMA sought, and received, a temporary injunction against the Board's new policy to disclose to the public, upon request, when a case had been referred to the Attorney General (AG) instead of after a formal accusation had been filed (much later in the process).

While declining to agree to all the terms of a proposed settlement, the Board did agree to restrict disclosure to a priority listing of egregious cases. The Board also agreed to modify the timing of disclosure to when a case has been formally "accepted" for prosecution by the AG (later in the process than "referral" but prior to "accusation"). The Board ordered its staff and counsel to prepare amendments to current regulations to accomplish this. The regulations will be considered at the Board's November 3 meeting. The Board then ordered its staff and counsel to return to negotiations to try to resolve the remaining issues of the lawsuit.

The net effect of the adoption of formal priorities is that overall cases must be handled in priority, for reasons of consumer protection and fairness to respondent physicians and also to manage scarce budget resources even as the total number of complaints and investigations are growing (revocations increased by half in the fiscal year prior to the current year and are projected to remain at that increased level).

A Medical Board analysis, "the Schubert Study," published a year ago (see *Action Report*, April 1994), provided the research basis for the now-approved priority list.

After formal adoption of new regulations and while they await approval by the Office of Administrative Law, the staff will activate a system for early identification of priority cases and for tracking them through the process of investigation and prosecution by computer. Reports showing aggregate numbers of priority cases and the number of days it takes to handle each phase of investigation and prosecution will be published in the disciplinary section of the quarterly *Action Report*.

Priority Cases

- A.** Cases alleging sexual misconduct with 2 or more patients (appropriate cases involving only 1 patient will be considered for a Temporary Restraining Order (TRO) or an Interim Suspension Order (ISO));
- B.** Cases alleging repeated acts of clearly excessive prescribing, dispensing, furnishing or administering of controlled substances; or alleging repeated acts of prescribing, dispensing, furnishing or administering of controlled substances without a good faith prior examination of the patient and medical indication therefor;
- C.** Cases alleging fraud involving 5 or more patients being treated pursuant to the Workers' Compensation Act, Labor Code sections 3299 et seq.;
- D.** Cases alleging drug or alcohol abuse by a physician and involving death or serious bodily injury to a patient;
- E.** Cases alleging such an extreme departure from the standard of care and involving death or serious bodily injury to a patient, that the physician presents a danger to the public;
- F.** Cases alleging gross negligence and involving death or serious bodily injury to 2 or more patients (appropriate cases involving only 1 patient will be considered for a TRO or an ISO);
- G.** Cases alleging incompetence and involving death or serious bodily injury to a patient; or
- H.** Cases in which the Attorney General's Office has determined that it will seek a TRO or an ISO.

THE MISSION OF THE MEDICAL BOARD OF CALIFORNIA

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

Peer Review Belongs To Physicians — Not To Hospital Lawyers

by
Robert del Junco, M.D., President of the Board

No sooner had Division of Medical Quality President Karen McElliott and Chief of Enforcement John Lancara published their article (*Action Report*, January 1995) calling the lack of peer review reporting to the Medical Board a “near crisis” than two new developments served to highlight their point.

First, the tragic case of a former chief of staff at a San Diego hospital who contracted Alzheimer’s came to light. The hospital peer review action was slow in coming, slower in reporting, after which there was almost a year’s delay in getting records—even after a subpoena—based on the advice of the hospital’s counsel.

The problem is that, during the delays, the physician was allowed to continue to practice. Consequently, after peer review had begun, there were six malpractice actions—one in which there was a death and two involving permanent, serious bodily injuries. The hospital’s and physician’s insurers, of course, have paid a fortune, not to mention the tragedies to the patients and families involved.

Outraged at the advice of the lawyers and angered at the lack of focus on the patients in this case, Assemblywoman Barbara Friedman (D-Hollywood), vice-chair of the Assembly Health Committee, introduced AB 1974. This bill would provide that when a hospital peer review committee opens an inquiry of a physician because of a suspected mental impairment, the Board’s Diversion Program must be notified so that the physician can be evaluated as a candidate for that program. At the same time, Board investigators are to determine within 30 days if the impairment is an “immediate danger to the public” and thus a candidate for an interim suspension of the physician’s license.

Second, the Board on May 17 filed a civil complaint against a hospital administrator in the San Jose area who failed to file a peer review report (Section 805 of the Business & Professions Code) after co-worker complaints alleged that an anesthesiologist on staff had a drug and/or alcohol problem, and after a hospital peer review panel had reviewed the charges on more than one occasion. In fact, the hospital never filed a report. The Board seeks civil penalties of \$10,000 against the administrator—the first case of its kind in Medical Board history.

In this case, too, the culprits may be the lawyers who apparently advised the hospital that no report was required under the law until the peer review committee had taken a “final” action (which, presumably, could be in the next millennium). In the meantime, based on additional complaints alleging mental impairment, the Board acted and it was determined by a court that the doctor was an “immediate danger to the public” and should have his license suspended. Since then, the physician in this case has been convicted of drug-related charges in San Francisco and the Board has filed a formal accusation for revocation (in the meantime, his license remains suspended).



Robert del Junco, M.D.

What goes through the minds of attorneys who ignore the purpose of the law while risking public protection and even greater culpability of their clients? What goes through the presumably educated minds of hospital administrators and peer review committee members when they accept such advice? These examples (and there are many others, unfortunately) risk loss of confidence in the physician peer review system.

Where peer review does work, it works in conjunction with the Medical Board. The two are compatible, if, for no other reason, than the Board plays the role of “bad cop” for peer reviewers. If the twin systems work together, they do so, in part, because peer reviewers at a local setting are able to get a fellow physician to correct his/her errant ways or else—“else” being an 805 report to the Medical Board because

privileges were restricted. In fact, the two *must* work together inasmuch as a peer review committee is hospital site-specific, while the Medical Board’s responsibility covers the entire state.

When will physicians retake control of their own peer review system from hospital lawyers?

Thus, hospital lawyers who advise peer review committees that reporting errant physicians to the Medical Board may bring a lawsuit from the alleged wrongdoer are, in my view, callous about potential harm to patients. Also, they may be way too concerned about potential litigation from errant physicians without examining the facts, and seemingly unaware that to hide from responsibility may allow consequences for which their very clients—the hospitals—may suffer even more if the physician being reviewed is negligent, incompetent, or impaired.

Free Vaccine Program For Children Kicks Off In California

The California State Department of Health Services (DHS) urges physicians, clinics, hospitals, etc., providing childhood immunizations to infants, children and youths to enroll in the new federal Vaccines For Children (VFC) Program, if they have not already done so. The VFC Program was implemented in public clinics in October 1994. It began for private medical care providers in late May 1995. Under this program, the federal government bulk purchases standard childhood vaccines—polio, MMR, Hib, hepatitis B, DTP, DTaP, DT, Td, DTP-Hib—for administration by participating providers to eligible children.

As new vaccines (e.g., varicella vaccine) are licensed and recommended for general use, it is expected that the federal government will add them to the VFC Program. Eligible for this Program are persons age 18 years or younger who are (a) eligible for California's government third-party payer programs—Medi-Cal and Child Health and Disability Prevention (CHDP), (b) do not have private health insurance, or (c) are American Indians. Nationwide, an estimated 60-65% of children are expected to be eligible.

The free vaccines are shipped, at no shipping cost, to the participating medical care provider's door. The intent of the VFC Program is to reduce vaccine cost as a barrier to timely immunization of children. Among the program's benefits: (1) physicians do not have to purchase vaccines for eligible children themselves "up-front," as the vaccines are supplied

free; (2) physicians do not have to charge families of eligible children the approximately \$270 or more which the full set of currently recommended vaccines costs, so fewer children will have immunizations delayed or have to be referred by private physicians to public health departments because of the cost; (3) physicians still control whom they see and are not obligated to take new patients for this program; and (4) the Legislature is expected to authorize the Medi-Cal and CHDP programs to use savings realized by the VFC Program to increase the immunization administration cost reimbursements paid to fee-for-service providers.

While some paperwork is associated with participating in the VFC Program (e.g., screening children for eligibility and ordering vaccines), the federal government and the DHS kept it to a minimum. Further, though participation in the program is voluntary for physicians in general, for those who immunize CHDP or Medi-Cal program beneficiaries age 18 years or younger on a fee-for-service basis, enrollment in the VFC Program and use of the VFC vaccines will be mandatory after a transition period which will allow providers to use up inventories they have already purchased.

Physicians, clinics and hospitals who have not already received information and enrollment forms should call the VFC Program office, at (510) 704-3750, or write to the VFC Program, Immunization Branch, California Department of Health Services, 2151 Berkeley Way, Berkeley, CA 94704.

Participation in the Vaccines For Children (VFC) Program Steps for Physicians, Clinics, and Hospitals

1. Complete and submit to the VFC Program Office just once, at the time of original enrollment, the one-page VFC Program Provider Enrollment form. (Providers who previously enrolled in the VFC Program do not need to re-submit this form.)

2. Complete and submit to the VFC Program Office once each year, the one-page VFC Program Provider Profile form. (The Profile Form is used to record information such as the delivery address, delivery days, and estimates of numbers of VFC-eligible children to be served in the coming year.)

3. Complete and submit to the VFC Program Office no more than once every two months (i.e., six times each year), a vaccine order (a one-page form). Allow up to 30 days for vaccine delivery.

- On the order form, furnish the amount of VFC vaccine used from the preceding order (no patient age breakdown or vaccine lot number accounting is required).
- The vaccine is shipped to the office or clinic, at no cost to the physician.
- Though this may be the easiest way to keep track of inventories, VFC vaccine does not have to be stored separately from privately purchased vaccine. For example, if 75% of a physician's vaccine is VFC vaccine and 25% is privately purchased vaccine, it is not critical that the

physician only give his/her VFC-eligible patients only the VFC vaccine, and vice-versa. However, this physician must carefully maintain the overall 75:25 ratio for use of vaccines for his/her entire clientele. Also, the physician must accurately report the amount of VFC vaccine use each time he/she submits a VFC vaccine order.

4. Screen children for VFC program eligibility (three to four questions) with no verification of patients' responses required. Keep a record for at least three years, for each eligible child, indicating by what criterion he/she qualifies. (No tabulations or submission of these records required.)

5. Do not charge patients for the VFC vaccine, which is supplied free.

- CHDP/Medi-Cal fee-for-service providers—Can bill CHDP/Medi-Cal for administration cost for each vaccine dose given to beneficiaries.
- Do not charge private-paying VFC-eligible patients more than \$17.55 per dose for vaccine administration. Do not deny vaccine to VFC-enrolled child if family cannot pay the administration fee.

For VFC Provider Enrollment, Profile, and Vaccine Order forms, call VFC Program Office at (510) 704-3750.

Medical Board Adopts Plan: Using The Best From Technology

by

Douglas Laue, Deputy Director, Medical Board of California

At its quarterly meeting of May 12, 1995, the Medical Board adopted an information systems strategic plan which will carry it into the 21st century. The plan emphasizes efficiency and cost savings to the Board. "The proper use of technology reduces cost and increases efficiency," said Carol Fieldhouse, the Board's Manager of Information Systems.

The Board's information systems plan includes the replacement of a 1970s-era mini-computer, which is used to track applicants for a California license. In its place, the Board will use a 1990s PC and software developed by the Department of Consumer Affairs. "The cost of the maintenance and repair of our old mini-computer alone will pay for the new system and we will have a more reliable, secure, and flexible system. Besides, you cannot even buy replacement parts for the old system!" said Fieldhouse.

The Board also plans to reduce telephone operator costs by linking up with the Internet. "By making public information available on the Internet," Fieldhouse explained, "licensees, hospitals, medical groups, and the public will be able to access the Board's public files without a toll call and without the expense of an operator on the Board's staff. And the service will be available at all times of the day or night."

Document storage and retrieval expenses are another target of the Board's plan. Currently, to satisfy the more than 2,000 annual requests for copies of public documents, the Board gathers the documents manually from a paper file, photocopies them, and refiles them by hand. "We have extracted all the efficiencies possible out of a manual retrieval system," explained Judith Turner, file room supervisor. "We use the color-coded terminal digit filing system common to modern offices and have organized our paper files into active and non-active sections to minimize our retrieval costs, but computer imaging offers even greater potential savings and more accurate filing."

The Board plans to explore a public-private partnership in the task of computer imaging of its public files. Under this arrangement, the Board would partner with a private company to provide this service. "The private sector has the lead in modern imaging systems," explained Fieldhouse, "and the Board can benefit by their experience and expertise." Government and private sector alliances in the

use of emerging technologies, such as imaging, are popular since such arrangements minimize the financial risks to the Board while maximizing the efficiency gains.

Even the 19 individual members of the Medical Board will be impacted by the adopted information systems plan. Led by the vision of Board President Robert del Junco, M.D., individual Board members will be linked to the local area computer network of the Board in Sacramento so that the members can communicate with Board staff via electronic mail, can read and update "bulletin boards" with information on current Board topics, and can link with the database of the Federation of State Medical Boards, for nationwide communication. This service will be available to them from their homes or offices.

"By the adoption of the information systems plan, the Medical Board will continue to extract the best from technology while preserving the security and efficiency necessary to the Board's operations."

California, traditionally at the vanguard of the application of appropriate technology, was the first state to apply computer technology to the regulation of physicians. By the adoption of the information systems plan, the Medical Board will continue to extract the best from technology while preserving the security and efficiency necessary to the Board's operations. "It is inspirational to me to realize that the first meeting of the Medical Board was held on June 29, 1876, more than 11 decades ago, and that all the licensed doctors at that time were handwritten into one file" said Fieldhouse. "To find out the status of those early licensees, you could write or telegraph the Board. In 1995, we seek ways of transmitting this information within seconds to anybody in the world. Amazing!"

Fieldhouse, affectionately known as the "Diva of Data" by fellow staff members, has worked for 11 years in the data processing world. Data security and cost savings are of utmost importance to the Board's adopted strategic information plan. As President of the Information System Security Association, Fieldhouse is a leader in reducing the risk posed to computer data bases by hackers, espionage artists, computer "viruses", and sabotage. "The Board has very sensitive information about our licensees and we must be extremely vigilant to prevent unauthorized access to our files," said Fieldhouse.

For more information on the system plan, please write Carol Fieldhouse, Manager, Information Systems, Medical Board of California, 1430 Howe Ave., #52, Sacramento, CA 95825 or Internet: CAROL@SMTP.MEDBD.DCA.CA.GOV

Data Processing In The Information Age

Medical Board's Strategic Information Systems Plan

1st Year

Applicant Tracking System

This system will replace the old "IV Phase" mini-computer currently housed at MBC which is inflexible, old, unreliable and expensive to maintain.

automating much of their tracking and report completion and allowing them direct access to the Enforcement System for real-time inquiry and update.

Improved ad hoc reporting.

The purpose of this project is to fully use the existing information and any new system information jointly to improve ad hoc reporting to the Board, the Legislature and others, and to empower the end users.

Pilot remote access to the Local Area Network (LAN) by Board members.

This project will improve the communications among staff and Board members. Members will be able to send electronic mail, read and update bulletin boards, send and receive documents, and have access to the BoardNet (a communications system maintained by the Federation of State Medical Boards) from their homes or offices.

Rewrite and enhance the Diversion Tracking System.

The purpose of this project is to develop a tracking system for the Board's Diversion Program that is in supportable, standard software, fully documented and allows for remote access by Diversion field staff.

Pilot a dial out capability to provide data to the Federation on BoardNet.

This project will improve reporting to the Federation and improve obtaining information from sources outside of the Board.

3rd Year

Begin development of document imaging for both public and confidential documents.

The purpose of this project is to bring all information on a licensee together in an electronic format which would include all paper files, thus reducing our storage needs and cost of retrieval.

Improved access to public disclosure on licensing and enforcement.

This will be a multiple approach project. One will be an INTERNET, GOPHER or WEB server. This will allow the public and institutions to query the current status of a physician's license from his/her computer at home or work.

Upgrade the network to handle images.

Currently the MBC Local Area Network is connected using an Ethernet network at a rated speed of 10 megabits per second. As communications traffic increases and new data intensive applications (e.g., imaging) are added, this rated speed will be inadequate.

Schubert Priority Feasibility Study

The purpose of this project is to determine the feasibility and cost of programming the Schubert prioritization system for complaints.

Field Offices Local and Wide Area Networks (WAN)

To provide Board-wide access to the proposed new systems, as well as to certain office automation capabilities (e.g. E-Mail and Group Calendaring), it will be necessary to install a total communications network. This network should include LANs within each field office and WANs to tie the field offices to Headquarters.

2nd Year

All Board members to have access to LAN.

This project will complete Board member access to the Local Area Network.

Enhance Productivity of Enforcement Investigators.

The purpose of this project is to enhance the tools of enforcement investigators to increase their productivity by

With the completion of these projects, MBC will be a leader in information systems among other medical boards throughout the country.

Board Advised To Expand Cost Recovery To Fund Investigations And Prosecutions

The Medical Board has accepted a basic assertion by the State Auditor that a far higher proportion of costs of investigations and prosecutions can be secured from those who are disciplined, the wrongdoers, as contrasted to funding of Board operations from license fees.

Two years ago the Board authorized what is called "cost recovery". Since then, many case settlements, primarily involving license suspension or probation, also include provisions for cost recovery. As investigators, attorneys and administrative law judges have become familiar with the program's provisions, it has been used more.

But the State Auditor says that the use of cost recovery is far below what it could be. In fact, the Auditor claims that as much as 40 percent of the enforcement budget could be obtained this way (\$9.4 million). In the first year of the program the Board collected less than \$100,000 (but an additional \$300,000 in restitution was collected for a group

of seniors who were defrauded by a physician). In the second year the Board staff projects cost recovery at just under \$175,000 (not including restitution).

"Whether the Auditor's goal can be achieved is problematical," said Chief of Enforcement John Lancara. "But we agree that the errant physician should pay for his or her misdeeds as much as possible. On the other hand, we believe that the profession generally has a stake in good discipline—and we don't want to rely on cost recovery so much that we are accused of being bounty hunters."

The Board's response to the audit, ordered as part of SB 916 (1993), the Omnibus Medical Board Reform Act, was formally approved at the Board's May meeting. The audit also raised questions about the billing procedures of the Health Quality Enforcement Section of the Attorney General (the Board's prosecuting attorneys) and the Office of Administrative Hearings (the Board's administrative law judges).

Sports Medicine Day Program

The Medical Board and the Board of Podiatric Medicine plan to begin their sports medicine series (see *Action Report*, January 1995) late this summer, pending approval of continuing medical education credits. Current leading contenders for the location of the first seminar are Santa Barbara, Fresno, or Orange County.

Below is the draft schedule for the first seminar. For more information contact Rick Wallinder of the Medical Board's Support Services Unit at (916) 263-2480.

Time	Activity/Event	Time	Activity/Event
9 a.m. - 9:30 a.m.	Keynote Speaker Introductions Purpose Format	11:10 a.m. - 11:55 a.m.	Common Injuries (Workshop) Knee, hand-wrist-elbow, forearm, shoulder, ankle sprains, foot injuries, overuse Bracing/splinting Protective gear Rehabilitation
9:30 a.m. - 10:15 a.m.	Sideline Organization (Seminar—Doctors and Athletic Personnel) Participation Decisions <ul style="list-style-type: none"> • What are the most frequent injuries? <ul style="list-style-type: none"> -head and neck -dehydration -stingers -ankle sprains -foot injuries -fractures • Coach-Doctor Relationship • Access Issues • Emergency Triage 	Noon - 12:45 p.m.	Lunch
10:20 a.m. - 11:05 a.m.	High Risk Injuries (Workshop) Concussion, head, neck, cervical, spinal, stingers	12:45 p.m. - 1:30 p.m.	Endurance (Workshop) Dehydration, fluids, heat, asthma, altitude
		1:35 p.m. - 2:20 p.m.	Stabilization of Severely Injured (Seminar—Doctors and Athletic Personnel)
		2:25 p.m. - 3:10 p.m.	Medico-Legal (Seminar—M.D.s and Athletic Personnel) "Good Samaritan" Law Liability
		3:15 p.m. - 3:30 p.m.	Wrap-up, Evaluation

Californians Gain Expanded Roles In The Federation Of State Medical Boards

Three California Board members were elected to offices of the Federation of State Medical Boards (FSMB) at this year's FSMB annual meeting in San Antonio, April 20-22.

1994 Board President Bruce Hasenkamp was elected Treasurer (a post which includes a new full term on the Board of Directors). This year's President, Dr. Robert del Junco, was elected to a three-year term on the Examining Committee and current Board Vice President, Dr. Alan Shumacher, was elected to the Board of Directors to fill out the remainder of Mr. Hasenkamp's prior term. This year's results highlight the active involvement of more Californians at top levels of FSMB than has been the case for many years.

Also, former Board member Rendel Levonian, M.D., was honored by the Federation as this year's recipient of the Dr. John H. Clark Leadership Award, given to recognize the person who has contributed the most over his career to the advancement of medical licensure in the United States. Dr. Levonian has been active in FSMB for over a dozen years.

Speakers at this year's conference (in addition to Mr.

Hasenkamp and Drs. del Junco and Shumacher) included 1993 Board President Dr. Jacquelin Trestrail (on appropriate prescribing), Licensing Division Vice President Dr. Thomas Joas (on licensing midwifery) and former Licensing Division Manager Terri Ciau (on modern licensing techniques).

Prominent among the FSMB actions at the meeting was adoption of a plan for a national center to authenticate core documents required for licensure—authentication which could be verified by individual state boards at no cost (costs would be paid by fees of applicants). The idea is to simplify the licensing process from state to state.

Also, FSMB delegates adopted the concept of state "registration" (not full licensure) of those who wish to practice telemedicine. Such a concept for California is the subject of a committee of the Board, chaired by Dr. del Junco.

And, in keeping with the age of the information highway, there were demonstrations of new computerized testing for license applicants.

Triplicate Study Completed; Funding For On-Line Service Sought

A new on-line system for reporting narcotics prescriptions to replace the triplicate procedure has been found feasible after a year-long study which the Medical Board supported with funds, staff and Board oversight.

Begun as a joint effort by the Board of Pharmacy, the Bureau of Narcotic Enforcement and the Medical Board, the study sought to evaluate the usefulness of the triplicate system and to determine if upgrading the system was feasible.

The triplicate procedure program had become antiquated. "Stacks of unprocessed paper forms are an unacceptable contrast to available computer processing efficiencies," said Medical Board Chief of Enforcement John Lancara.

At its May meeting the Board learned from its delegates to the oversight committee, Drs. Fred Milkie and Anabel Anderson Imbert, that the study had proven that on-line triplicate registration by a central data system can be achieved by piggybacking on existing pharmacy billing systems. This would eliminate paperwork and provide better controlled substance tracking.

The results of the study will be shared with Attorney General Dan Lungren who has been asked to consider funding such a system in the budget of the Department of Justice over the next several fiscal years.

Physician Alert

Pesticide Reporting — A Reminder

The Department of Pesticide Regulation has begun a program of sending notifications to doctors who have examined pesticide-exposed patients but not reported them. Health and Safety Code section 2950 requires reporting within 24 hours by any doctor who knows "or has reasonable cause to believe" that a patient's condition was caused by pesticide exposure.

If you get such a letter, it will provide a telephone number where reports can be filed. County agricultural commissioners also have lists of telephone numbers designated by health officers to receive reports.

Copies of these letters are sent to the health officers who should have received the reports and to the agricultural commissioners who must investigate the episodes. The first time a doctor receives a notification letter, nothing is sent to the Department of Industrial Relations (DIR), which has enforcement authority for section 2950. If the Department of Pesticide Regulation identifies another pesticide case examined a month or more after the first notification letter was sent, it will send DIR a copy of that letter for possible enforcement action.

WE'RE LOOKING FOR A FEW GOOD EXPERTS

LOW PAY!

Would you take a job

that pays \$75 an hour (\$100 if you testify in a hearing, plus actual expenses), has no benefits, and requires you to supply your own office, secretary, equipment, and reference materials?

Then the Medical Board wants you!

We are recruiting for 2,000 top-drawer physicians who would like to serve as expert reviewers for the Board. Over 1,000 of your peers already have applied, but it is not too late to join their ranks. The Board's Division of Medical Quality approved the initial group of 200 experts on May 11, 1995, and more are being approved each month.

We need board-certified physicians in every specialty, from every part of California. Our goal is to have a pool of qualified, trained experts available by the end of 1995. If you are currently in active clinical practice, or inactive for two years or less, have never been disciplined by the Board, and have a current California license, keep reading.

We need people with at least five years experience in their specialty or subspecialty (not including internship and residency), who practice at least 80 hours per month in direct patient care, clinical activity, or teaching which includes at least 40 hours of patient care. Specialty certification by an

NO BENEFITS!

ABMS or equivalent board, or equivalent/superior qualifications in an "emerging" specialty or subspecialty is required. Peer review experience is recommended but not mandatory. If you want more information about requirements, give us a call.

**DO YOU HAVE
WHAT IT
TAKES TO BE
A MEDICAL
BOARD EXPERT
REVIEWER?
FIND OUT
TODAY!**

What do Expert Reviewers Do?

The Board receives hundreds of complaints each month from consumers, other health professionals and other governmental agencies. Many of the complaints are closed without any action, but several thousand are reviewed by physicians each year to determine whether there might be law violations. To assure a fair and appropriate review, the Board uses experts in the specialties of the physicians involved. With more than 24 specialties, and dozens of communities statewide, we need a large pool from

BASIC TRAINING!

which to select experts. This also allows us to find reviewers who don't know the subject of the complaint personally, and to avoid overloading our experts with too many cases.

We especially need more experts in: OB/Gyn, Family Practice, Otolaryngology, Plastic Surgery and Surgery, but we still have a need for all specialties.

What's this about basic training?

If you apply for the Expert Reviewer Program, you will be given a loose-leaf binder containing a variety of fascinating, well-written, Board-approved training materials. We think you will need about six hours to study them. Then we will ask you to attend a two-hour face-to-face session at a Board office to learn more about working with our medical consultants, investigators and attorneys. If you complete these steps, you will be added to our pool of experts, and may be called to advise on a case-by-case basis. That's it!

How Can I Apply?

Send us your CV. Our address is:
Linda Whitney
c/o Medical Board of California
1426 Howe Avenue, Suite 100
Sacramento, CA 95825-3236
(916) 263-2677

FREE GIFT TO FIRST 2,000 RECRUITS

Apply now and receive an attractive binder containing everything you need to know to be an MBC Expert Reviewer!

A Medical Board Symposium

“Toward The 21st Century”: Telemedicine, Actuarial Medicine, Disciplinary Data And Computerized Testing

It's time for a reality check—or so it seems. Can that which is geometrically advancing technology really be reality?

Medical Board members, at a symposium open to the public, will try to find out at a one and one-half day gathering at the State Capitol in Sacramento on September 28-30.

The highlight of the event will be a telemedicine demonstration presented by the National Information Infrastructure Testbed (NIIT), a consortium of public and private interests which explores the multifaceted uses of the information highway. This demonstration, presented last year for members of Congress and their staffs in the Rayburn House Office Building in Washington, has been developed by NIIT's Health Care Working Group.

The demonstration will be co-hosted by the Joint State Senate and Assembly Rural Caucus and by the TeleHealth/TeleMedicine Planning Project Coordinating Committee. A keynote address prior to the demonstration will be made by The Honorable Sandra R. Smoley, R.N., Secretary of the California Health & Welfare Agency.

Leading the discussion of telemedicine will be the nation's most prominent proponent and practitioner of telemedicine, Dr. Jay H. Sanders, Director of the Telemedicine Center of the Medical College of Georgia. Dr. Sanders has developed throughout Georgia the most extensive telemedicine system in the United States.

The President and staff of the Federation of State Medical Boards will present sessions on modern licensure (FSMB has recently committed several million dollars to the development of a national center to authenticate core documents for licensure) and on computerized testing pioneered by the National Board of Medical Examiners. And four major speakers will explore the impact of the electronic world on discipline by medical boards and the role of actuarial data used by managed care companies and third-party payers to evaluate or authorize treatment.

Finally, the Board and two of its committees will meet in open session to focus on the Board's role in these issues and to formulate recommendations for its November meeting.

One-Day Summit On Health Resources Set For September 15

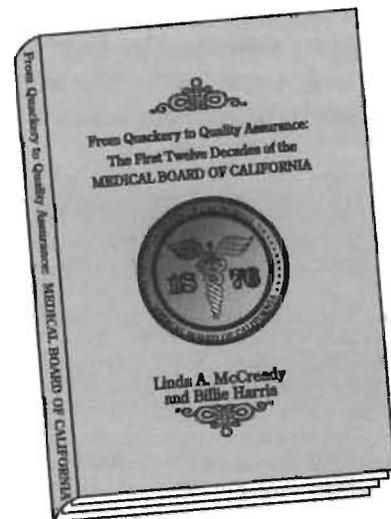
Who is a primary care physician (by legal definition) or who should be? And what can be done to provide incentives for primary care physicians to serve in underserved areas?

These major topics are the subject of a one-day “Summit” on Health Resources, sponsored by the Medical Board, and cosponsored by the State & Consumer Services Agency, the Health & Welfare Agency, the Department of Consumer Affairs, the Department of Health Services and the Office of Statewide Health Planning & Development. The Summit is scheduled for Friday, September 15, at the LAX Hilton Hotel, beginning at 9 a.m.

Speakers will range from cabinet officers to health care association executives to academic leaders. State senators and assembly members who are involved in budget decisions to allocate incentive dollars are also presenters.

Participants in the discussions will be broadly representative but by invitation only. Audience observation is open to the public; reservations are advised by calling the Medical Board at (916) 263-2389.

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Disciplinary Actions: February 1, 1995 to April 30, 1995

Decisions: Physicians and Surgeons

AGUILAR, ALEJANDRO F., M.D. (A-36086) Huntington Park, CA
B&P Code §2234(b). Stipulated Decision. Gross negligence in failing to follow up the results of an ultrasonic exam performed on a pregnant patient at approximately 27 weeks' gestation. Revoked, stayed, 5 years' probation on terms and conditions. March 10, 1995.

ANDERSEN, WILLIAM PAUL, M.D. (A-26018) Woodland, CA
B&P Code §§2234, 2239, 2354. Stipulated Decision. For noncompliance, he was terminated from Board's Diversion Program for impaired physicians. Relapsed, used cocaine; missed meetings and appointments. Revoked, stayed, 5 years' probation on terms and conditions. March 9, 1995.

AZAR, SI HOUSHANG, M.D. (A-24623) St. Petersburg, FL
B&P Code §2305. Discipline by Florida Board for gross malpractice in cardiology practice. California: Revoked. Default. March 6, 1995.

BEASLEY, BARBARA, M.D. (G-19869) New Rochelle, NY
B&P Code §2305. Discipline by New York Board due to chemical dependency problem. New Jersey Board imposed a restrictive license based on New York case. California: Revoked. Default. April 6, 1995.

BITZER, JOHN W., M.D. (C-19783) Taft, CA
B&P Code §§725, 2234(b),(c),(d), 2242. Stipulated Decision. Gross negligence, incompetence, repeated negligent acts, excessive prescribing, and prescribing without prior exam and medical indication, mainly involving weight control patients. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. February 28, 1995.

BLAND, JAMES H., M.D. (A-43584) Minot, ND
B&P Code §2305. Stipulated Decision. In 1989, the U.S. Army revoked his clinical privileges for using marijuana. In 1992, the U.S. Air Force revoked his clinical privileges for false statements in his application regarding the U.S. Army matter. In 1993, the North Dakota Board disciplined him for concealing the Army and Air Force revocations. Revoked, stayed, 5 years' probation on terms and conditions. March 9, 1995.

BORDEN, LARRY I., M.D. (C-31710) Arcadia, CA
B&P Code §2234(b),(d). Gross negligence and incompetence in anesthesiology practice resulting in 2 deaths. Revoked. August 7, 1992. Court appeals recently completed upholding the revocation. February 23, 1995.

BOURKE, ROBERT S., M.D. (G-9971) Rockville, MD
B&P Code §2305. Discipline by Maryland Board for mental impairment. Revoked, stayed, 5 years' probation on terms and conditions. February 3, 1995.

BURKE, ROBERT W., M.D. (C-18151) San Rafael, CA
B&P Code §2234(c). Stipulated Decision. Repeated negligent acts in the management of a 13 year-old with genetic abnormal behavior with lithium and amitriptyline, without adequate documentation, rationales and monitoring. Revoked, stayed, 3 years' probation on terms and conditions. March 8, 1995.

BURVANT, MICHAEL, M.D. (C-27859) Orangevale, CA
B&P Code §§2236, 2239, 2240. Stipulated Decision. Excessive use of alcohol. Revoked, stayed, 7 years' probation on terms and conditions. March 17, 1995.

CASTILLO, BORIS D., M.D. (A-25803) La Habra, CA
B&P Code §2234(c). Repeated negligent acts in diagnostic procedures, physical examinations, and drug prescriptions in family practice. Prior discipline. Revoked, stayed, 3 years' probation on terms and conditions, including 90 days' actual suspension. March 30, 1995.

CHO, LARRY M., M.D. (A-32478) Bakersfield, CA
B&P Code §§650, 2234(e). Stipulated Decision. In a year's time, received at least \$64,000 in illegal referral fees for referring 407 patients for magnetic resonance imaging to another physician. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. Agrees to testify truthfully at the other physician's hearing. March 24, 1995.

COBB, CHARLES R., M.D. (A-22892) Saipan, Guam
B&P Code §2305. Default revocation by Arizona Board for failing to respond to board subpoenas for records related to 2 malpractice claims; and for failing to answer Arizona Board correspondence or provide his new address. California: Revoked. Default. April 27, 1995.

DAQUIOAG, RODOLFO A., M.D. (A-29896) Vallejo, CA
B&P Code §§725, 810, 2234(b),(c),(d),(e). Stipulated Decision. Dishonesty in filing fraudulent insurance claims. Excessive physical therapy. Also, gross negligence, repeated negligent acts and incompetence in the care of elderly patients in nursing homes. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. April 21, 1995.

DELEON, JR., BALDOMERO, M.D. (G-35749) Walnut Creek, CA
B&P Code §2234. Stipulated Decision. Repeatedly failed to visit an elderly patient in a skilled nursing facility within 30 days of the previous visit, as required by regulations 22 CCR 72307(a). One year suspension, stayed, 4 years' probation on terms and conditions. April 29, 1995.

DELL, STEPHEN OWEN, M.D. (G-25195) Durham, NH
B&P Code §2305. Stipulated Decision. Discipline by Vermont Board for certain misrepresentations in his medical practice and of his pre-medical education. Following similar action by the New Hampshire Board. Revoked, stayed, 3 years' probation on terms and conditions. February 20, 1995.

DEVINE, JAMES S., M.D. (G-3938) Las Vegas, NV
B&P Code §725. Stipulated Decision. Repeated acts of clearly excessive prescribing of controlled drugs. Prior discipline. Revoked, stayed, 5 years' probation on terms and conditions, including actual suspension until he passes an oral clinical examination. March 10, 1995.

DOWBAK, JOHN MAX, M.D. (G-39616) Naples, FL
B&P Code §2305. Discipline by Mississippi Board for a felony conviction of arson, involving the burning of his own office building. California: Revoked, after contested hearing. April 27, 1995.

DRISCOLL, EDWARD T., M.D. (C-9498) Odessa, TX
B&P Code §2305. Discipline by Texas Board due to negligent or incompetent care provided to several patients. California: Revoked. Default. March 17, 1995.

EBRAHIM, GUL M., M.D. (A-42994) Culver City, CA
B&P Code §§2234(e), 2236. Stipulated Decision. Conviction for hit and run, went through a stop sign, struck a bicyclist, fled the scene. Revoked, stayed, 3 years' probation on terms and conditions. February 24, 1995.

ELIAN, GILBERT J., M.D. (G-26558) Santa Clara, CA
B&P Code §§725, 2234(b),(c),(e). Ophthalmologist scheduled numerous elderly patients for cataract surgeries when there were inadequate indications and findings to justify these surgeries. Failed to provide patients with full disclosure. Gross negligence, repeated negligent acts, excessive treatment, dishonesty. Revoked. Discipline recently upheld by Court of Appeal. New effective date: April 21, 1995.

FORD, JR., W.H., M.D. (C-25660) San Jose, CA
B&P Code §2236. Conviction for murder of his wife, and for assault with a firearm against his brother-in-law. Revoked. Default. February 3, 1995.

GERNER, ROBERT H., M.D. (G-25068) Los Angeles, CA
B&P Code §§726, 2234(b),(c),(d). Stipulated Decision. Gross negligence, repeated negligent acts and incompetence in engaging in sexual relations with a female patient in therapy. Revoked, stayed, 7 years' probation on terms and conditions, including 60 days' actual suspension. November 10, 1994.

GHOSH, BHARATI, M.D. (A-034230) Pomona, CA
B&P Code §2234(c),(e). Repeated negligent acts in neonatal practice involving theophylline monitoring. Also, dishonesty in not disclosing relevant information in application for hospital privileges. Revoked, stayed, 5 years' probation on terms and conditions. October 26, 1994.

GEORGE, PHILIP N., M.D. (A-50027) Houston, TX
B&P Code §2305. Discipline by Iowa Board for substandard practices in a blood plasma center, and for a conviction for resisting arrest when he refused to be removed from the center. Revoked. Default. February 24, 1995.

GOLDBERG, LAWRENCE DAVID, M.D. (G-44327) Quartz Hills, CA
B&P Code §§495, 2236. Stipulated Decision. Conviction for practicing medicine without a license. (He plea bargained this charge with District Attorney's Office.) Revoked, stayed, 4 years' probation on terms and conditions. April 8, 1995.

GRUBER, RONALD, M.D. (A-22597) Oakland, CA
B&P Code §§2234(e), 2238, 2241, 2242, 2261, 4390. Violated statutes regulating controlled substances. Improper procedures for administering controlled substances to an addict. Inappropriate prescribing. False certification, false prescription. Failed to keep inventory record for demerol and cocaine. Revoked, stayed, 3 years' probation on terms and conditions. June 20, 1995.

HAMILTON, WM. GORDON, M.D. (A-30470) La Costa, CA
B&P Code §§2234, 2238, 2239, 2240. Stipulated Decision. Self use of ethyl chloride impairing his ability to work as a psychiatrist. Prior heavy amphetamine use through supplies obtained by mail orders. Gross negligence, repeated negligent acts, intoxication on the job, self abuse of drugs. Revoked, stayed, 7 years' probation on terms and conditions. March 6, 1995.

HEPNER, GERSHON W., M.D. (A-30885) Los Angeles, CA
B&P Code §§650, 2236, 2234. Stipulated Decision. Convicted of 25 felony counts involving insurance fraud and grand theft, capping, false tax returns, perjury. Defrauded insurance companies and the State Victim of Crime

Funds for services not performed. Paid kickbacks for patient referrals. Revoked. March 31, 1995.

HUNTER, WILLARD, M.D. (C-23614) Phoenix, AZ
B&P Code §2305. Discipline by Arizona Board for failing to maintain adequate records regarding drugs to patients, and for dispensing drugs for other than therapeutic purposes. Also, disciplined by Utah Board based on Arizona action. Both boards reinstated full privileges now. California: Public reprimand. February 20, 1995.

INGRAHAM, BETTE ANN, M.D. (C-39047) Tehachapi, CA
B&P Code §§2234(b),(e), 2261, 2262, 2239, 2292. Gross negligence in performing pre-surgery exam and lab work-up of a patient for another distant surgeon who selected Dr. Ingraham by random. Her medical report was false, containing incomplete testing and the lab results of another patient. Self-use of controlled drugs. Unprofessional conduct in failing to comply with a board order compelling a professional competency examination. Revoked, stayed, 5 years' probation on terms and conditions. March 9, 1995.

JAMES, DWIGHT, M.D. (G-40223) Whittier, CA
B&P Code §2234(a),(e). Stipulated Decision. Filed false claims with MediCal representing he did the work when in fact services were actually rendered by another physician indefinitely suspended from the MediCal program. 15-day suspension, stayed, 1 year probation on terms and conditions. March 27, 1995.

JAVANSHIR, DARIUSK, M.D. (A-42017) Anaheim, CA
B&P Code §§725, 2242, 2234, 2238. Stipulated Decision. Excessive prescribing of multiple addictive controlled drugs without appropriate medical indication and examination. Failed to maintain meaningful records, failed to take meaningful histories. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. February 21, 1995.

JOSEF, AVELINO SAMSON, M.D. (A-34659) Long Beach, CA
B&P Code §2234(c). Stipulated Decision. Repeated negligent acts in mismanaging an elderly patient with gouty arthritis. Administered excessive intravenous doses of colchicine that resulted in toxicity. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. March 3, 1995.

KALEKA, VIRENDER S., M.D. (A-43546) Fresno, CA
B&P Code §§726, 729. Stipulated Decision. Sexual relationship with

Explanation of Disciplinary Language

1. **"Revoked"**— The license is canceled, voided, annulled, rescinded. The right to practice is ended.
2. **"Revoked - Default"**— After valid service of the Accusation (formal charges), the licensee fails to file the required response or fails to appear at the hearing. The license is forfeited through inaction.
3. **"Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' suspension"**— "Stayed" means the revocation is postponed, put off. Professional practice may continue so long as the licensee complies with specified probationary terms and conditions, which, in this example, includes 60 days' actual suspension from practice. Violation of probation may result in the revocation that was postponed.
4. **"Suspension from practice"**— The licensee is benched and prohibited from practicing for a specific period of time.
5. **"Temporary Restraining Order"**— A TRO is issued by a Superior Court Judge to halt practice immediately. When issued by an Administrative Law Judge, it is called an ISO (Interim Suspension Order).
6. **"Probationary Terms and Conditions"**— Examples: Complete a clinical training program. Take educational courses in specified subjects. Take a course in Ethics. Pass an oral clinical exam. Abstain from alcohol and drugs. Undergo psychotherapy or medical treatment. Surrender your DEA drug permit. Provide free services to a community facility.
7. **"Gross negligence"**— An extreme deviation from the standard of practice.
8. **"Incompetence"**— Lack of knowledge or skills in discharging professional obligations.
9. **"Stipulated Decision"**— A form of plea bargaining. The case is negotiated and settled prior to trial.
10. **"Voluntary Surrender"**— Resignation under a cloud. While charges are pending, the licensee turns in the license — subject to acceptance by the relevant Board.
11. **"Probationary License"**— A conditional license issued to an applicant on probationary terms and conditions. This is done when good cause exists for denial of the license application.
12. **"Effective date of Decision"**— Example: "July 8, 1994" at the bottom of the summary means the date the disciplinary decision goes into operation.
13. **"Judicial Review recently completed"**— The disciplinary decision was challenged through the court system—Superior Court, maybe Court of Appeal, maybe State Supreme Court—and the discipline was upheld. This notation explains, for example, why a case effective "October 10, 1991" is finally being reported for the first time four years later in 1995.

female patient, resulting in a conviction of sexual exploitation by a psychotherapist under B&P Code §729. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. February 14, 1995.

KEMSLEY, GRAHAM, M.D. (A-42139) Newport Beach, CA
B&P Code §§725, 810, 2234, 2261, 2262, 2273. Stipulated Decision. Performed plastic surgeries for cosmetic purposes; misrepresented in false reports and billings to insurance the surgeries were for pathology or functional disorders. Failed to maintain proper medical records and charts. Business procured from Vietnamese sector by paid runner or steerer. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. March 16, 1995.

KERN, SEYMOUR P., M.D. (G-26212) Santa Ana, CA
B&P Code §§2234(a),(c), 2271. Stipulated Decision. Ophthalmologist negligently advertised to the public that radial keratotomy would be covered by health insurance. This was misleading. Negligently billed insurance for "keratoplasty" when, in fact, radial keratotomy, an elective procedure, was actually performed. Revoked, stayed, 5 years' probation on terms and conditions. April 29, 1995.

KIM, YOUNG HON, M.D. (A-35428) Sooncheon City, South Korea
B&P Code §2305. Surrender of license to Texas Board. California: Revoked. Default. March 17, 1995.

KINZIE, DANIEL, M.D. (G-11801) San Antonio, TX
B&P Code §2305. Stipulated Decision. Discipline by Texas Board for failing to properly supervise the activities of an employee who held himself out as a physician's assistant when he was not registered as such. California: Public reprimand. April 28, 1995.

KLEIN, EDMUND, M.D. (C-27915) Williamsville, NY
B&P Code §2305. Surrender of New York license based on chemical dependency on cocaine, and on bi-polar disorder. California: Revoked. Default. March 17, 1995.

KNIGHT, CAROL LYNN, M.D. (A-23275) Palo Alto, CA
B&P Code §2234(d). Ophthalmologist, now practicing as a midwife, was incompetent for failure to transfer pregnant patient to the hospital in light of dangerous circumstances during a home delivery. Revoked, stayed, 5 years' probation on terms and conditions. April 28, 1995.

KONSTANTIN, KARL A., M.D. (A-20979) Oakland, CA
B&P Code §2237. Stipulated Decision. Convicted of 3 misdemeanor violations of H&S Code §11154, prescribing controlled substances to a person not under his treatment for a pathology or condition. Revoked, stayed, 5 years' probation on terms and conditions. April 27, 1995.

KOOSHIAN, GEORGE A., M.D. (G-41247) Garden Grove, CA
B&P Code §§2236, 2237, 2238, 2242, 490, 725. Conviction for improper prescribing of anabolic steroids for non-medical purposes (bodybuilding and weight lifting). Revoked, stayed, 5 years' probation on terms and conditions. March 10, 1995.

KRAVATZ, ARNOLD S., M.D. (G-13304) Sherman Oaks, CA
B&P Code §§2234, 2238, 2239. Self-use of drugs, mostly controlled drugs such as vicodin. Violated statutes regulating drugs. Prior discipline. Revoked. March 24, 1995.

LAMARCA, DONALD D., M.D. (G-13959) San Francisco, CA
B&P Code §§726, 2306, 2234(b),(d),(e). Violated probation of prior discipline involving Anucare anorectal practice. Dishonest, corrupt grossly negligent, incompetent and thoroughly unprofessional physician. Sexual abuse with male patient. Unauthorized disclosure of patient's HIV status in violation of H&S Code §199.21. Unconscionable billing practices. Revoked. Default. April 7, 1995.

LAUTT, MARVIN E., M.D. (C-23582) Warren, PA
B&P Code §2234(b),(c),(d). Stipulated Decision. Incompetency in becoming overly solicitous thereby blurring the boundaries between physician and patient. Revoked, stayed, 5 years' probation on terms and conditions. April 22, 1995.

LAWRENCE, GENE C., M.D. (C-29177) Newport Beach, CA
B&P Code §2234(b). Stipulated Decision. Gross negligence in failing to order appropriate testing to detect breast cancer in light of findings, complaints of dimpling, and a strong family history of breast cancer. (Mother and two aunts died from breast cancer, all in their 30s.) Revoked, stayed, 3 years' probation on terms and conditions. April 4, 1995.

LLEWELLYN, FRED W., M.D. (A-23238) Tripler Army Med. Center, HI
B&P Code §2305. Stipulated Decision. Clinical privileges suspended by U.S. Army at Tripler Army Medical Center for intemperate use of alcohol. Revoked, stayed, 3 years' probation on terms and conditions. April 4, 1995.

LUNDAHL, GERALD, M.D. (A-28772) La Habra, CA
B&P Code §§725, 2242, 2234(b),(c),(d). Stipulated Decision. Excessive prescribing of controlled drugs without prior exam and medical indication therefor, constituting gross negligence and incompetence. In another case, misdiagnosed patient's condition as a yeast infection when she was pregnant, thus exposing her subsequently to x-rays and to medications contraindicated in pregnancy. Revoked, stayed, 5 years' probation on terms and conditions. April 3, 1995.

MALAKOOTI, HAMID, M.D. (A-40504) La Habra, CA
B&P Code §§490, 2237, 2238 and H&S Code §11350. Stipulated Decision. Conviction for possession of heroin. Revoked, stayed, 3 years' probation on terms and conditions. August 11, 1994.

MANI, HAMID, M.D. (A-40472) San Diego, CA
B&P Code §§725, 2234(b). Stipulated Decision. Gross negligence and excessive treatment. Over a 2-year period, incorrectly diagnosed an elderly patient with macular edema and performed excessive laser treatments to the right eye. Revoked, stayed, 5 years' probation on terms and conditions. March 31, 1995.

MARCUS, M. BENNETT, M.D. (A-17220) Whittier, CA
B&P Code §2234(b),(c),(d). Gross negligence, incompetence and repeated negligent acts in obstetrical practice. Revoked. Default. April 14, 1995.

MARK, HOWARD L., M.D. (C-27883) Encino, CA
B&P Code §§725, 2234(b),(c),(d),(e), 2238, 2241, 2242, 2261. Stipulated Decision. Prescribed controlled drugs without prior exam and medical indication, excessively, to addicts and in violation of statutes regulating controlled substances. Gross negligence, repeated negligence, and incompetence. Dishonesty in preparing a false medical document to excuse a criminal defendant. Revoked, stayed 10 years' probation on terms and conditions, including 60 days' actual suspension. June 22, 1994.

MCBAY, MICHAEL H., M.D. (G-63748) Los Angeles, CA
Violated probation of prior discipline. Revoked. Default. April 28, 1995.

MOORE, WILLIAM D., M.D. (A-16032) Boise, ID
B&P Code §§490, 2236, 2234(e). Conviction in Idaho for murder of wife by strangulation. Revoked. Default. February 3, 1995.

MOOREHEAD, JAMES F., M.D. (G-65240) College Park, GA
B&P Code §2305. Stipulated Decision. Discipline by Georgia because of alleged substance abuse and psychiatric problems. California: Revoked, stayed, 7 years' probation on terms and conditions. March 3, 1995.

MORTON, KAREN ANN, M.D. (G-64852) Tacoma, WA
B&P Code §2305. Discipline by Washington State Board for false information in license application. California: Revoked. Default. February 6, 1995.

NORWICK, SYDNEY, M.D. (C-9855) Laguna Hills, CA
B&P Code §§2234, 2242. Stipulated Decision. Prescribed demerol and other controlled drugs without good faith prior examination, and failed to establish medical indication requiring the drugs. Revoked, stayed, 5 years' probation on terms and conditions. March 13, 1995.

OLMSTED, LUKE R., M.D. (G-58314) San Diego, CA
B&P Code §2234(b),(c),(d),(e). Gross negligence, incompetence, and repeated negligent acts in the treatment of AIDS patients. Used typhoid vaccine in a medical research without having protocol approved by the Human Use Committee of his local hospital. Dishonest open letter to the gay community. Revoked. Default. April 26, 1995.

ORENS, SCOTT SAMUEL, M.D. (G-51914) Sarasota, FL
B&P Code §2305. Stipulated Decision. Suspension by Florida Board pending psychiatric care. California: Revoked, stayed, 5 years' probation on terms and conditions. March 13, 1995.

PENTECAST, RICHARD L., M.D. (C-19974) Muskogee, OK
B&P Code §2305. Disciplined by Oklahoma Board for indiscriminate prescribing. California: Revoked, stayed, 5 years' probation on terms and conditions. April 15, 1995.

PINHAS, SIMON J., M.D. (G-36334) Beverly Hills, CA
B&P Code §§810, 2261, 2262, 2234(b),(c),(d),(e). Stipulated Decision. Gross negligence, repeated negligent acts and incompetence in the management of ophthalmology patients. False records, false billings. One-year suspension, stayed, 5 years' probation on terms and conditions. April 6, 1995.

PONCEDELEON, MIGUEL A., M.D. (G-23240) Duarte, CA
B&P Code §§2052, 2053, 2054, 2234, 2238, 2264. Aided and abetted his adult son, Junior, an unlicensed person, to pose as a physician in elderly seniors' office and examine, diagnose, treat and prescribe controlled drugs to patients in the unlawful practice of medicine. Revoked. Default. April 21, 1995.

ROBINSON, WENDELL E., M.D. (A-24617) Richland, WA
B&P Code §2305. Discipline by Washington State Medical Board as a result of charges of sexual harassment at Kadlec Hospital. Revoked, stayed, 5 years' probation on terms and conditions. April 23, 1995.

ROCHE, MARTIN M., M.D. (A-23257) Coral Springs, CA
B&P Code §2305. Discipline by Florida Board for conviction for income tax evasion. Revoked, stayed, 3 years' probation on terms and conditions. April 13, 1995.

ROOP, WALTER E., M.D. (G-24748) North Hollywood, CA
B&P Code §822. Mental illness affecting the ability to practice safely. Revoked. Default. April 10, 1995.

ROSS, GARY STUART, M.D. (G-29892) San Francisco, CA
B&P Code §2234(b). Stipulated Decision. In house call, gross negligence in establishing an intravenous line for an overdose patient in a comatose state for many hours, and then leaving the comatose patient in the care of unskilled wife and family friend. Revoked, stayed, 3 years' probation on terms and conditions. March 29, 1995.

RYDER, ROBERT CHARLES, M.D. (A-24968) Casper, WY
B&P Code §2234(b),(c),(d),(e). Gross negligence, incompetence and repeated negligent acts in failing to properly diagnose and treat signs and symptoms of sepsis in a newborn he delivered at his birthing center. Altered the infant's records dishonestly. Revoked. Default. April 14, 1995.

SARGEANT, THOMAS L., M.D. (G-60457) Fairfield, CA
B&P Code §§2234(e), 2238, 2239. Substance abuse problem with self-use of methamphetamine. Billing Medicare for services not provided. Violated statutes regulating drugs. Revoked. Default. March 9, 1995.

SCHEIDEMANN, WAYNE H., M.D. (G-61678) Lakeport, CA
B&P Code §§2234, 2242, 2242(e), 2239. Stipulated Decision. History of amphetamine abuse. Obtained drugs by deceit. Prescribed drugs without prior exam and medical indication. Gross negligence in orthopedic practice. Revoked, stayed, 5 years' probation on terms and conditions. April 10, 1995.

SCHOMER, VALANA ELSIE, M.D. (G-30297) Ventura, CA
B&P Code §2234(b),(c),(d). Stipulated Decision. Dual relationship with psychotherapy patient, constituting gross negligence, repeated negligent acts and incompetence. Revoked, stayed, 7 years' probation on terms and conditions, including 30 days' actual suspension. April 21, 1995.

SHAFEY, SHERIF, M.D. (A-22736) Miami, FL
B&P Code §2305. Stipulated Decision. Discipline by Florida Board for filing false insurance bills for 5 patients. Neurologist billed for complex and comprehensive exams whereas the evidence supported only follow-up visits or ongoing care. Public reprimand. March 23, 1995.

SILBERSTEIN, STEPHEN G., M.D. (G-10602) Davis, CA
B&P Code §2234(b). Stipulated Decision. Gross negligence in prescribing droperidol (inapsine) IV, a self-injectable drug, to a psychiatric patient with a history of self-mutilation with a knife and suicide attempts. Revoked, stayed, 3 years' probation on terms and conditions. April 20, 1995.

SINHA, RAMANDA, M.D. (C-38850) Bakersfield, CA
B&P Code §§725, 726, 2234(b),(c),(d). Stipulated Decision. Negligence and incompetence in subjecting patients to fiberoptic bronchoscopy without medical indication. Gross negligence in respiratory care practice. Sexual misconduct with female patients. Revoked, stayed, 5 years' probation on terms and conditions. February 27, 1995.

SMOLEV, BARRY ALAN, M.D. (G-23299) Los Angeles, CA
B&P Code §2234(e). Stipulated Decision. Engaged in a dishonest scheme to defraud insurance by creating phony psychiatric reports stating falsely that patients (for weight loss) had psychiatric disorders to justify insurance payments for \$35,000—29-day stay in an acute care facility where he was a treating psychiatrist. Also, dishonesty for tax fraud. Revoked, stayed, 7 years' probation on terms and conditions, including 21 days' actual suspension. April 5, 1995.

STREFLING, AARON M., M.D. (G-39209) Los Altos, CA
B&P Code §2236. Stipulated Decision. Conviction for misdemeanor battery. Revoked, stayed, 1 year probation on terms and conditions. April 19, 1995.

SWEET, BRIAN, M.D. (C-42022) Apple Valley, CA
B&P Code §§726, 2234(b). Sexual misconduct with female patients, including sexual intercourse. Revoked. April 26, 1995.

TALISMAN, MARC, M.D. (A-24315) Orange, CA
B&P Code §§726, 2234(b),(c). Sexual relations with female patients, constituting gross negligence and repeated negligent acts in psychiatric practice. Prior discipline. Revoked, stayed, 10 years' probation on terms and conditions, including 6 months' actual suspension. Judicial review recently completed. Retroactive to October 19, 1994.

TAKHAR, PARAMJIT SINGH, M.D. (A-34676) Garden Grove, CA
B&P Code §2305. Discipline by Iowa Board for making a false statement of a material fact in his application for Iowa license. Reprimand. April 6, 1995.

TARTARO, THOMAS J., M.D. (G-41688) El Centro, CA
B&P Code §2236. Stipulated Decision. Conviction of felony sexual battery while victim is restrained, involving sexual misconduct with numerous female patients during office visits. Revoked. May 5, 1995.

TAN, OSCAR, M.D. (A-35799) La Jolla, CA
B&P Code §2234(b),(e). Stipulated Decision. Committed gross negligence by denying responsibility for the delivery of pregnant patient's baby, and by failing to make specific arrangements with that patient for the delivery of her baby. (At labor, patient went to Emergency Room because pre-natal care physician had no hospital privileges.) Revoked, stayed, 3 years' probation on terms and conditions. March 23, 1995.

VENANZI, ENZO J., M.D. (A-29186) Woodbury, NJ
B&P Code §2305. Discipline by New Jersey Board requiring closure of private practice and retirement from medical practice. Revoked. Default. March 10, 1995.

VIDRICKSEN, KARL L., M.D. (G-35324) Tulelake, CA
B&P Code §§2236, 2239. Violated probation of prior discipline. Conviction of corporal injury to spouse, false imprisonment, brandishing a firearm. Self-administration of halcion, a controlled drug. Prior disciplines. Revoked. August 24, 1994.

VOLOSHIN, PETER J., M.D. (A-22795) Newport Beach, CA
B&P Code §§725, 810, 2234, 2261, 2262, 2273. Companion case to Graham Kemsley, M.D. Stipulated Decision. Performed plastic surgeries for cosmetic purposes; misrepresented in false reports and billing to insurance the surgeries were for pathology or functional disorders. Failed to maintain proper medical records and charts. Procured business from Vietnamese sector through a paid runner or steerer. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. March 16, 1995.

WEBBER, JAMES T., M.D. (G-29186) San Diego, CA
B&P Code §§2234, 2261. Assisted an unlicensed person owning a laser clinic to engage in the unlawful practice of medicine by treating patients with cold laser therapy. As a nominal medical director (to qualify the clinic for insurance payments), M.D. was gullible in knowingly signing various false documents, including a false application for a fictitious name permit for the lay person's laser clinic. Prior discipline. Revoked, stayed, 5 years' probation on terms and conditions, including 120 days' actual suspension. April 5, 1995.

WEINTRAUB, ARTHUR H., M.D. (G-41965) Lahaina, Maui, HI
B&P Code §2234(b). Stipulated Decision. Gross negligence by an internist in the care and management of a patient, 44, with severe hypotension. Revoked, stayed, 3 years' probation on terms and conditions. April 26, 1995.

WILSON, DONALD L., M.D. (C-26063) Larkspur, CA
B&P Code §2273. Stipulated Decision. Advertisement material for his book, "Total Mind Power," included an offer of a referral fee to those who referred patients to him. Capping and steering. Public reprimand. March 13, 1995.

WOOLLAMS, STANLEY J., M.D. (C-25843) Ann Arbor, MI
B&P Code §2305. Discipline by Michigan Board for sexual relations with patient, and for false billings for therapy sessions never rendered. Revoked. Default. April 21, 1995.

ZAKI, OMAR SHAHID, M.D. (A-26707) Framingham, MA
B&P Code §2305. Discipline by Virginia Board. Revoked. Default. March 13, 1995.

ACUPUNCTURIST

YOM, TAE HWAN, C.A. (AC-1410) Flushing, NY
B&P Code §4955. Stipulated Decision. Collected payments from applicants and shared the loot with cohorts and a licensing official in return for advance receipt of questions and answers to the 1983 state acupuncture "written" examination, which were provided to the paying applicants. Probation for 3 years on terms and conditions, including 3 years' suspension. February 24, 1995.

HEARING AID DISPENSERS

ECHOLS, BARRY (HA-1892) Laguna Hills, CA
B&P Code §§490, 3401(b), 3403. Stipulated Decision. Conviction for loitering in public toilet area for the purpose of soliciting a lewd act. Revoked, stayed, 5 years' probation on terms and conditions. February 12, 1995.

NICHOLS, DON (HA-1311) Indio, CA
B&P Code §§3365, 3367, 3401(g), 3366(a),(b). Deceptive advertising.

Fraud. Sales receipts failed to include Song-Beverly Warranty Act language. Failed to maintain records, test results, receipts. Failed to give refund for unsatisfactory hearing aids. Revoked. Default. March 30, 1995.

PHYSICIAN ASSISTANT

HINOJOSA, FEDERICO, P.A. (PA-10150) West Covina, CA
B&P Code §§3502, 3527. Stipulated Decision. P.A. issued prescriptions in his supervising physician's name without patient specific orders or proper protocol. Practiced under a supervising physician whose supervisory approval permit was delinquent. Revoked, stayed, 2 years' probation on terms and conditions. January 4, 1995.

DOCTORS OF PODIATRIC MEDICINE

FANOUS, MICHAEL M., D.P.M. (E-3544) Laguna Hills, CA
B&P Code §§726, 2234(b),(d). Sexual abuse, gross negligence and incompetence in touching and opening the vagina of a 12 year-old patient being examined for her foot problem. Revoked. April 7, 1995.

TA, QUOC-HUAN V., D.P.M. (E-3735) San Francisco, CA
B&P Code §2234(b),(d). Stipulated Decision. Gross negligence and incompetence in dispensing phenol, a strong organic acid, to a mentally ill patient for self-application to the great toe to treat a fungal nail problem, which resulted in a significant second degree burn to the left hallux. Revoked, stayed, 5 years' probation on terms and conditions. January 19, 1995.

ZAMZOW, DENNIS, D.P.M. (E-2033) Santa Clara, CA
B&P Code §2234(d). Stipulated Decision. Repeated negligent acts in the management of a diagnosed bilateral hallux valgus with bunion deformities. Failed to obtain written informed consent for the surgery. Failed to document any evaluation of patient's left first metatar sophalangeal joint, failed to immobilize the patient in a cast. Revoked, stayed, 5 years' probation on terms and conditions. March 10, 1995.

PSYCHOLOGISTS

ABRAMS, DANIEL EDWARD, Ph.D. (PSY-9435) Newhall, CA
B&P Code §2960(j). Gross negligence in failing to appropriately address patient transference issues. Revoked, stayed, 5 years' probation, suspended until psychological evaluation is passed. April 6, 1995.

BULL, BONNIE A., Ph.D. (PSY-3589) Pasadena, CA
B&P Code §2960(j),(h). Stipulated Decision. Gross negligence in engaging in dual relationships. Breach of confidentiality. Revoked, stayed, 5 years' probation on terms and conditions. February 19, 1995.

GOLDBERG, SONNY DAVID, Ph.D. (PSY-8210) Los Angeles, CA
B&P Code §§820, 821, 822. Failed to comply with a Board order requiring a psychological evaluation. Revoked. Default. April 21, 1995.

HAASE, RENNE C., Ph.D. (PSY-9775) San Diego, CA
B&P Code §§2960(j),(n),(o), 726, 729. Gross negligence in sexual misconduct with a former patient. Revoked. March 30, 1995.

LORANDOS, DEMOSTHENES A., Ph.D. (PSY-6907) Brighton, MI
B&P Code §2960(m). Discipline by Michigan Board for sexual relationship with a woman who had been his patient. The patient left therapy in order to have the relationship with respondent. Revoked, stayed, 2 years' probation on terms and conditions. April 21, 1995.

LUSTIG, JAN, Ph.D. (PSY-8272) Vancouver, WA
B&P Code §§726, 2960(n), 2961(j). Sexual relations with female patient; dual relationship; gross negligence. Revoked. June 6, 1994. Judicial review recently completed.

OTTESON, JAMES PAUL, Ph.D. (PSY-7051) Thousand Oaks, CA
B&P Code §§726, 2960(j),(n). Stipulated Decision. Terminated a therapeutic relationship and engaged in a boundary violation with former patient. Revoked, stayed, 5 years' probation on terms and conditions. March 29, 1995.

SHOOSTER, CHARLES NATHAN, Ph.D. (PSY-4502) Beverly Hills, CA
B&P Code §§490, 2960(n). Stipulated Decision. Conviction for filing false sales tax returns from 17 gasoline stations that he owned. Revoked, stayed, 5 years' probation on terms and conditions. March 29, 1995.

RESPIRATORY CARE PRACTITIONERS

CHAN, DENNIS WILLIAM (RCP 12160) Sacramento, CA
B&P Code §§3750(d),(j), 3750.5(b), 3752. Numerous convictions for driving under the influence of alcohol, while having .08 percent or more, by weight, of alcohol. Violated probation of prior discipline. Revoked. April 3, 1995.

CHAVARRIA, CARLOS (RCP 12944) Hayward, CA
B&P Code §§3750(d), 3752.5, 3752. Conviction for threatening to commit a crime which would result in death or great bodily injury; exhibiting a firearm in an angry manner; carrying a loaded firearm in a public place. Revoked. March 27, 1995.

COOPER, ALBERT (RCP 14109) Fresno, CA
B&P Code §§3750(d), 3752.2. Stipulated Decision. Conviction for first degree murder in the shooting death of his wife. Use of firearm in the commission of a felony. Revoked. March 27, 1995.

EASLEY, ANTHONY (RCP 10216) Oakland, CA
B&P Code §§3750.5(b), 3750(d), 3752, 3752.5. Conviction for discharging a firearm at an inhabited vehicle, involving a highway dispute. Conviction for driving under the influence of alcohol. Revoked. February 10, 1995.

GLENNON, PAUL (RCP 4891) San Francisco, CA
Violated probation of prior discipline. Revoked. Default. March 10, 1995.

GRISHAM, MICHAEL (RCP 14687) Hemet, CA
B&P Code §§3750 (d), (j), 3755. Conviction for possession of a controlled substance, and other offenses. Self-use of cocaine. Dishonest conduct. Revoked. March 10, 1995.

KESSLER, PAULETTE (RCP 7281) San Jose, CA
B&P Code §3750.5. Stipulated Decision. Violated probation of prior discipline. Use of controlled substance. Revoked. March 13, 1995.

LOZANO, TONY (RCP 3184) Santa Ana, CA
B&P Code §3750.5(a). Stipulated Decision. Self-use of a controlled substance, cocaine. Revoked, stayed, 3 years' probation on terms and conditions. April 17, 1995.

NICOLA, CLARISSA (RCP 9290) Oakland, CA
(aka Clarissa Walker) B&P Code §3755. Gross negligence in her practice as a respiratory practitioner in failing to place patient on supplemental oxygen upon obtaining a resting 51 percent oxygen saturation level and other shortcomings. Revoked. March 16, 1995.

SWITZER, MICHAEL (RCP 9475) Tarzana, CA
Violated probation of prior discipline. Revoked. Default. February 11, 1995.

THOMAS, JUDITH (RCP 11551) San Diego, CA
Violated probation of prior discipline. Revoked. Default. March 27, 1995.

VOLUNTARY SURRENDER OF LICENSE WHILE CHARGES PENDING

PHYSICIANS AND SURGEONS

ASAD, YOUNIS AHMAD, M.D. (A-31603) Toledo, OH
March 10, 1995

DOBROW, BERNARD, M.D. (C-11599) Los Gatos, CA
April 21, 1995

FIER, MORRIS, M.D. (C-14348) Newport Beach, CA
February 22, 1995

GALVEZ, TIMOTEO, M.D. (C-40709) Madison, WI
November 7, 1994

HANSEN, STEPHEN CRAIG, M.D. (G-31823) Napa, CA
April 24, 1995

HUNT, JOHN D., M.D. (G-43205) San Angelo, TX
April 24, 1995

LEVITT, GILBERT W., M.D. (C-29050) Mercer Island, WA
February 22, 1995

MONTALBO, SERAFIN A., M.D. (C-38802) Monroeville, PA
December 15, 1994

MORSE, HOWARD TILTON, M.D. (A-18547) Pasadena, CA
April 20, 1995

OUYANG, RUITSON, M.D. (C-39889) Buena Park, CA
August 1, 1994

ROBERTSON, CHARLES, M.D. (G-39727) Newport Beach, CA
April 20, 1995

SEUBOLD, JAMES H., M.D. (A-25365) Naperville, IL
March 23, 1995

SHALLENBERGER, FRANK A., M.D. (G-27254) Gardnerville, NV
April 7, 1995

STERNBERG, JOSHUA L., M.D. (C-20239) Miami, FL
April 10, 1995

YALDUA, RAMON ALAGVATE, M.D. (A-35869) Chula Vista, CA
March 13, 1995

PSYCHOLOGISTS

COGEN, MICHAEL JAY, Ph.D. (PSY-9241) San Anselmo, CA
March 30, 1995

McMANAMAN, KATHLEEN, Ph.D. (PSY-20854) Woodland Hills, CA
March 28, 1995

WEST, WILLIAM GEORGE, Ph.D. (PSY-5413) Marina del Rey, CA
April 25, 1995

DOCTORS OF PODIATRIC MEDICINE

KAPLAN, ROBERT J., D.P.M. (E-3017) Phillipsburg, NJ
March 10, 1995

BENSON, BRADLEY E., D.P.M. (E-2937) Turlock, CA
February 23, 1995

REGISTERED DISPENSING OPTICIAN

THEXTON, JOHN A., R.D.O. (SL 2625) Citrus Heights, CA
March 2, 1995

Business and Professions Code Section 2021(b) requires physicians to inform the Medical Board of any address change.



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ACTION REPORT-JULY 1995

The *Action Report* is a quarterly publication of the Medical Board of California. For information or comments about its contents, please contact: Candis Cohen, Editor, (916) 263-2389.

For additional copies of this report, please fax your company name, address, telephone number, and contact person to: Yolanda Gonsolis, Medical Board Support Services Unit, at (916) 263-2479, or mail your request to her at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.

Medical Board of California

1426 Howe Avenue, Suite 54, Sacramento, CA 95825 (916) 263-2389

July 1995

Quality of Care in a Managed Care Environment: Board Committee Will Explore Consumer Issues

To the Physicians of California:

Dear Colleagues:

Managed Care is not a new concept. The physicians of ancient Greece and Rome undoubtedly made at least some efforts to develop treatment plans for their patients, and to combine efforts to maximize their effectiveness in relation to their incomes. In our times, the concept of health maintenance organizations — HMOs — dates from 1945, when Kaiser Industries created its first group health plan.

However, with the demand for health care, the complexity of available options, and the cost for providing them all expanding geometrically, managed care has taken on an enormous role in the health care delivery system. As more and more consumers find themselves enrolled in insurance plans which impose managed care on participating physicians, concern is growing that managed care may equate with inadequate, inconvenient, and in some cases nonexistent care.

At the same time, physicians find themselves under increasing pressure to enroll in managed care plans, in order to remain competitive in their communities. The risks they take when they do enroll may include having their medical judgement second-guessed by remote reviewers with the ability to deny payment; being “de-selected” for reasons which have nothing to do with the quality of the care they give; finding that after being de-selected their patients no longer “belong” to them; even finding themselves being sued for failure to provide medically necessary care because a plan reviewer denied service.

In response to growing concerns about the negative effects of managed care, the Board has appointed a **Committee on**

Quality of Care in a Managed Care Environment. Beginning with its first meeting on April 19, 1995, this committee has begun to focus on identifying key issues which enhance or diminish the quality of care patients are receiving in these plans. We anticipate that over the coming months, the committee will recommend a variety of endeavors to the Board, possibly including legislative proposals, aimed at strengthening the protections available to consumers, and reducing or eliminating abuses.



Carole Hurvitz, M.D.

As we proceed with this enterprise, I invite each of you to share your experiences and ideas with us. We especially would like to hear from you about techniques which **WORK**: that is, ways in which managed care can be a “win-win” for payers, physicians and consumers.

As part of our work on this project, we anticipate holding one or more public colloquia on quality of care strategies later this year. If you would like to receive notices of upcoming meetings, send your address to us at: Executive Office, Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.

This **ACTION REPORT** insert addresses several topics of current interest and concern in the managed care realm, ranging from information and data management, to legal issues and patient care concerns.

Sincerely,

A handwritten signature in cursive script, appearing to read "Carole Hurvitz M.D.".

CAROLE HURVITZ, M.D., CHAIR
Committee on Quality of Care
in a Managed Care Environment

MISSION STATEMENT OF THE MEDICAL BOARD OF CALIFORNIA

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

HOW DO PATIENTS LOOK AT MANAGED CARE?

by Linda A. McCready

In many ways, managed care has made life a lot easier for the consumers it serves. For a working person, a senior with limited mobility, a mother struggling to corral small children, having most or all medical services co-located can be a tremendous convenience. Being able to see a primary care physician, get lab work, X-rays, injections and prescriptions at a single site, which usually has ample parking and protection from the elements, can save time, effort and even some of the expenses of driving and parking.

In a managed care plan, the patient usually has only a small copayment, which frequently applies to prescriptions as well. Often employers will pay the entire premium for a capitated plan, but will require employees to pay a share of the premium if they select a more expensive fee-for-service plan. Because patient charts are maintained at a central location, and are retrieved by the unit where the patient will be seen, patients are spared the frustration of filling out personal information and medical history questionnaires at each new office. This is especially true where records are maintained electronically. And, there are no claim forms, no large out-of-pocket payments, no waiting for retrospective approval of service and reimbursement.

Probably the biggest concerns consumers have about managed care plans are denial of coverage for certain services, delays in being seen or receiving certain kinds of care, having to see someone other than the patient's regular physician, long waits for appointments, crowding in clinics, and fear that the physician they prefer will be de-selected and they will be forced to find another physician. Other recurring concerns include having to see a primary care physician and get a referral to a specialist, seemingly irrational changes in health plan policies and procedures, and limited choices of specialists, hospitals, laboratories and other ancillary services.

Although only a small percentage of consumers ever face this problem, mandatory arbitration can prove to be a major concern for those who do. Many plan enrollees never read the contract they agree to when they enroll. When a bad outcome occurs, they often assume they can sue the physician, hospital or health plan for malpractice. It comes as a shock to learn that the health plan contract compels them to submit to arbitration, and that they have essentially given up the right to seek restitution — and retribution — through the courts. Arbitration awards generally are more conservative than jury awards, and are less likely to result in huge payments for punitive damages and pain and suffering.

The View from Inside the Managed Care Industry

The April 17, 1995 issue of LACMA Physician contains interviews with six managed care insiders, Molly Joel Coye, MD, Good Samaritan Health System; Edward C. Geehr, MD, HealthCare Delivery System, UniHealth; Oliver Goldsmith, MD, So. Cal. Permanente Medical Group; James O. Hillman, Unified Medical Group Assn., Michael E. Linn, Healthcare Partners Medical Group; and Marc D. Moser, Bay Shores Medical Group. Following are selected quotes from their responses to several questions posed by LACMA Physician.

Dr. Coye: "In general terms, and I'm sure it's no surprise to most physicians, it's hard to imagine an environment where any substantive number of solo practitioners are going to be able to make a living without being part of a larger network."

"The market is demanding not only that we provide care that our patients like and appreciate, but also that we provide measurable value in keeping them healthy, on the job and in school."

"There's no question that quality of care assurance under managed care is far superior than in fee-for-service medicine."

Dr. Geehr: "... these new physician partnerships will view the delivery of healthcare as a privilege — an opportunity to improve patients' lives — rather than just as an opportunity to build business."

"Tremendous demand exists for primary care physicians who are willing to practice in IPAs and medical groups. . . . Considerable opportunity also exists for specialists who proactively organize themselves."

". . . consumers and payers are increasingly holding providers accountable for the outcomes of our decisions, and we must have measurement systems in place that can serve to objectively verify our outcomes from both a financial and a clinical perspective."

". . . at UniHealth we have developed our own outcomes management system called 'BestPractices.' . . . It is interesting to note that in the majority of cases, those practices determined to be best from a clinical perspective have also been found to be the most cost-effective."

Dr. Goldsmith: "Ultimately, the successful [managed care] systems are going to have to meet our patients' needs. And in order to do this, a clear-cut alignment amongst insurance carriers, hospitals, and physicians will be needed. I think nurses and other health professionals should be added to this equation because medical delivery is a team endeavor."

(On competition and "the bottom line"): "We are going to be responsive to purchaser requests on service issues. For instance, they have been asking about workers comp, sick leave policies, access issues, and most of all, cost reductions."

Continued, page viii, Insiders

The Federation of State Medical Boards: The Herbert Morris Platter Lecture

PROTECTING QUALITY IN THE MANAGED CARE ERA



Arnold S. Relman, M.D., is Editor-in-Chief Emeritus, New England Journal of Medicine. He currently is a member of the Board of Registration in Medicine for the Commonwealth of Massachusetts. He presented the 30th annual Platter Lecture on April 20, 1995 in San Antonio, Texas.

This is an era of revolution in the organization and delivery of healthcare. More than 50 million Americans are in HMOs of various kinds, another 60 million are covered by various other managed care entities. Less than a quarter of U.S. physicians are totally uninfluenced by managed care, and 35% to 40% of total physician income comes through arrangements with managed care entities.

In a parallel revolution, managed care entities, with a few exceptions, are becoming acquired, owned, managed and dominated by profit making businesses. The entry of for-profit companies into healthcare to this degree may be the most troubling development in medical care in this century. There are at least eight reasons to worry about the quality of healthcare in this context:

1. Managed care is driven by the need to cut the cost of premiums to the businesses which employ the enrollees. However, there are no independent mechanisms for protecting quality in the face of cost-containment measures.
2. Physicians are rapidly losing the power to control their own practices. Their traditional professional motivation to control and monitor their own performance is being diluted by the domination of managed care entities. Except in the few physician controlled health plans, their fiduciary duty is being limited, with unfortunate consequences for quality of care.
3. Managed care has perverse economic incentives to underserve. Under the term "medical loss ratio" managed care describes the costs of providing care to patients as a "loss" to the corporation. Plan administrators strive to contain this ratio at 70% to 80% of premium dollars. Capitation encourages the companies to underserve and to cut corners.
4. Capitation also is applied to individual physicians. Plans pay a fixed rate per patient to a physician, who then is expected to cover ALL care, including that provided by specialists and labs, and in some cases even hospitalization.

It's hard to imagine a more stark economic requirement to do less.

5. In response to the leverage applied to them by managed care companies, many physicians are responding by becoming investors, owners, or limited partners of the insurers. They then are seduced by the company to do what the company wants them to do in return for sharing in the profits. In my opinion this is unethical, an obvious conflict of interest with the physician becoming a double agent.
6. The managed care system does not need all the doctors in a community because of the efficiency with which the plans operate, so many physicians are left out. Physicians must fight for income, and that is an invitation to bad quality medicine.
7. Hospitals, faced with the increasingly outpatient-oriented managed care entities, are being forced to cut their staffs. It is reasonable to assume that mistakes are being made in hospitals simply because they are cutting costs.
8. Finally, the managed care market, like all competitive commercial markets, is not interested in the customers who do not have the money to play in the market. Managed care ignores the uninsured, says they are somebody else's problem. And managed care ignores education and research. It is jeopardizing education, teaching hospitals, and academic health centers because even though it depends on research and education, it will not pay for them.

However, in principle, managed care offers opportunities for improving quality. Managed care encourages doctors to practice in groups, which leads to cross-fertilization of ideas, cooperation, and better peer review. It leads to a more integrated approach to care of individual patients.

Outcome assessment, and process measures are more easily applied, although there is need for a lot of development in these areas. There is no science yet, no epidemiological science adequate to control for all the confounding factors.

Attention can be given to measuring consumer satisfaction, but it is not clear what this really means. Some of the worst, most out-of-date, incompetent doctors are also charming, accessible and kind. They are just not good doctors, but patients love them!

If I had to define quality, I would say that good quality medical care is the care that competent, compassionate and well-informed physicians provide in circumstances that enable them to do the best they can for their patients. They are physicians who work in physical and economic settings that offer no incentive to do more or less than is appropriate for the best interests of their patients, and who accept the need for public accountability and peer review.

Telemedicine, Telecomputing, Teleconferencing, Teleconsultation, Telesurgery

Ray Bumgarner, Executive Director, Ohio State Medical Board

The age of electronic medicine is here. Electronic or virtual* medicine offers a number of unique attributes to the practice. It can bring the doctor to the patient without regard to where they are located—in effect, long distance housecalls. It requires that significant amounts of information need to be transmitted confidentially from place to place. It permits physicians to perform virtual surgery on computer generated patients.

The electronic and human aspects of medicine have been linked for many years. In 1968, Kenneth Bird created a two-way audio/visual link between Logan Airport and Massachusetts General Hospital. A telemedicine “space bridge” has existed between the former Soviet Union and the United States since the December 1988 earthquake in Armenia.

In 1992, the first “Robodoc” was used successfully to core a femur to accept a prosthesis almost without cement. And at the LDS hospital in Salt Lake City, computers continuously monitor patients for changes in various parameters, determine when changes in treatment are indicated, and automatically institute or adjust such things as drugs or

oxygen. At Stanford Research Institute, telepresence surgery creates the illusion of physical proximity between separate patients and surgeons.

With electronic medicine comes a new set of problems.

What if the computer “crashes”? What if a robot is given the wrong instrument or cuts too deep? Who is liable: the hospital, the surgeon, the nurse, the manufacturer?

Courts now will accept certain computer records, but what if the data is compressed and then decompressed? How about digitally enhanced sound or visual images? Will they be considered legally effective documents? Can computer records be altered without leaving a trail? How can this kind of fraud be prevented? All of these issues will impact enforcement policies, and eventually must be addressed by medical boards.

Continued, p.vi, Telemedicine

*In computerese, “virtual” refers to any computerized activity in which the actions of the human user direct the reactions of the electronic system. For example, if the user turns her head, the image on the screen shows what she would see in the new direction.

*“With
electronic
medicine
comes a
new set of
problems.”*

“AS I SEE IT . . .” MANAGED CARE

Excerpts from four presentations made at the annual meeting of Administrators In Medicine, an organization of medical board administrators,

Economics Increasingly Impacts the way Medical Boards do Their Jobs

John Hinton, D.O., M.P.H., Medical Director, ChoiceCare, Cincinnati

“Hospitals, to be sure of improvement:

- Must find out what the results are;
- Must analyze the results to find their strong and weak points;
- Must compare their results with those of other hospitals;
- Must promote their staff on a basis which gives due consideration to what they can do and accomplish for their patients.”

E.A. Codman, a cofounder of the JCAH, 1917

There are many ways to look at medical competency. Managed care looks at population management, not just one patient, one physician. It considers care over time, cost effectiveness against underutilization, case management, information fragmentation, performance measurements including entry competence, ongoing performance over time, and recertification. It looks as well at how physicians perform within multi-specialty groups, the patchwork of federal and state regulation, especially as they affect multi-state MC organizations, risk management, and the market economy versus the political environment.

The Corporate Element

The real control over managed care comes from Procter and Gamble, not Washington. If GE demands a 5% reduction in medical costs, without a reduction in quality of care, the plan has to comply or die. To maintain that quality, plans use such things as volume-based credentialing: in order to be competent in a procedure, a physician must do a certain volume of cases. Medical providers must assure patient satisfaction, or their patients will vote with their feet.

Looking at change forces change. Licensing agencies look at change in terms of new ways to regulate. Legislatures tend to apply the brakes to change, but change is inevitable. There is room for collaboration between managed care plans and licensing agencies. The plans examine performance at the individual, group and unit level. They evaluate case management and scrutinize medical providers. And they continually look for new ways to optimize delivery of care.

Some emerging issues in managed care include workers compensation; legal issues relating to denial of care; managed Medicare and pharmacy plans; employer alliances; managed care in mental health; access to care; and portability of professional licensure.

Incentives to Decrease Services and Conflicts of Interest

Donald P. "Rocky" Wilcox, J.D., General Counsel, Texas Medical Association

Like other states, Texas is facing up to issues of responsibility for care and conflicts of interest in the managed care realm. Traditional fee-for-service medicine had built in incentives to provide more care, while managed care has the reverse. In this context, what is the obligation of the treating physician to be aggressive in pursuing authorization for needed treatment? What should a medical board do with an emergency room physician who doesn't admit a patient because the HMO has denied payment? What about the responsibility of the HMO physician who makes the decision to deny? Is there an implied physician/patient relationship between the patient and the HMO physician reviewer?

Texas law says a physician has a fiduciary duty to the patient, and is responsible for allowing someone else to unduly influence that responsibility. The code provides criminal penalties for both the fiduciary and the person influencing the fiduciary. Some court cases (notably one involving DuPont) have even taken responsibility for bad utilization review decisions past the UR physician to the corporation which contracted for the managed care (i.e. the patient's employer) as having responsibility for the healthcare

plan they employed. The court saw the UR entity as the agent of the employer.

The quandary facing the attending physician is that if he causes the health plan any trouble, he faces the risk of being de-selected. Many managed care plans are very one sided, and include termination-without-cause provisions. While hospitals and licensing boards must meet standards of due process, under many state laws, there are no similar requirements for healthcare plans. (See "MANAGED CARE: Guidelines for Physicians from the California Medical Association," page vi, for California standards.)

Physicians in high per-patient cost specialties may find themselves de-selected for non-quality of care reasons. They may be compared to others in their specialty, or may have an unusual number of high-cost cases. Often patients are notified of de-selection, but are not told the reason, leading to a perception that there is something wrong with the care they received. The physician may lose patients at that point, and also may lose out on new patients even if in the plan, as well as newly covered patients, because the physician is not listed

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FROM VARIOUS VIEWPOINTS

in conjunction with the annual meeting of the Federation of State Medical Boards of the United States, April 19, 1995, San Antonio, Texas.

Virtual Regulation/Virtual Discipline: Medical Boards in the Electronic World

Dale Austin, Deputy Executive Vice President, Federation of State Medical Boards of the United States

The thrust in health care is to do more and more with less and less until eventually you are doing everything with nothing at all. Hospitals and other healthcare providers must focus on three areas: decreasing the cost of services, improving or maintaining clinical quality, and improving or maintaining service to patients and clients.

Healthcare currently is witnessing a "feeding frenzy" of corporate buyouts and national conglomerates. In the midst of this, it is critical to stay focussed on patients. Providers are in a catch-up mode in the area of information technology (IT). They have long searched for the perfect all-encompassing IT system, one which can be accessed with the touch of a button. It doesn't exist. It can't be had. It can't be afforded.

The option now is to acquire or build a system which is amenable to add-ons, a system with flexibility. Some elements of such a system include:

- Horizontal and vertical integration between physicians, health facilities and payers.
- A master patient identifier, regardless of where service

is given.

- Steadily reduced use of paper; electronically transferable records.

"Healthcare currently is witnessing a feeding frenzy of corporate buyouts and national conglomerates."

- Solutions to the problems of transferring records when a patient changes provider; issues of confidentiality and competition among providers.

There is a tension between healthcare as business and healthcare as community service. The business side is winning right now, but emerging concerns are turning toward the community perspective.

The future of healthcare information technology can be illustrated by looking at the Domino's Pizza chain. When you order a pizza by phone, considerable information about you is stored in a nationwide database. The next time you call they already know where you live and what you like on your pizza. If you move to another town, your call is directed to the store nearest your new address. With an integrated database, patient medical records should be this accessible from provider to provider. That is where the healthcare enterprise is trying to go.

INCENTIVES

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in the plan brochure. This possibility has serious implications for physician decisions regarding really sick patients. States must assure due process, and assure that the duty to the patient comes first. Undue pressure on the physician to withhold treatment options must not compromise the physician's duty to offer and provide high quality medical care to patients.

In some cases, there may be incentives for utilization review physicians to balance approving extremely costly care against the possibility of a lawsuit. While medical decisions should be isolated from actuarial decisions, this is not always the case. Another form of conflict occurs when a medical director of a managed care plan receives bonuses or other rewards for minimizing expenditures. Similar pressures apply to physicians who are required to pay for services which the physician recommends or orders, if they are not covered by the plan. Surprisingly, this is not an uncommon provision employed to control the physician by penalizing his advocacy for what is best for the patient.

Many employer-funded health plans introduce another element: under federal law, they fall under the Employee Retirement Income Security Act (ERISA), which preempts state laws relating to due process and tort actions. ERISA plans provide less protection to patients, and lower damages for patient harm, because state laws passed to safeguard patients are preempted.

Some other concerns relate to how health plans deal with physicians who are under investigation, have malpractice suits pending, or are under discipline by a Board. In a sense, if a plan de-selects a physician who is under investigation or

is on probation, it is usurping the Board's authority to determine who can practice medicine. Likewise, at least 90% of investigations do not result in discipline, and there is no direct relationship between malpractice suits and bad medical care. But a physician who is de-selected is punished nonetheless.

TELEMEDICINE

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The Ohio Study (see page vii) is leading toward a state-wide, standardized, unified recordkeeping system. This already is underway for prescriptions, with all drugstore chains keeping prescription records on computers and sending records through the air unencrypted. The opportunity for mischief is tremendous.

Boards should consider defining an original, or an acceptable duplicate of an electronic record, and an electronic signature. There is a need to specify an appropriate degree of confidentiality in storing and transmitting electronic records. [Boards] may want to criminalize the alteration, falsification, unauthorized access to or tampering with electronic records.

A related issue is that Boards may need to obtain legal jurisdiction over out-of-state providers who practice by air in their states. In disciplinary cases, they need to be able to access electronic records. They also need to address the blurring concepts of space, time, physical reality, jurisdictional licensure through multiple bureaucracies, and whether licensure in multiple states will remain viable. Ultimately, Boards must address how to protect the public without interfering with progress.

MANAGED CARE: Guidelines for Physicians from the California Medical Association ("California Physicians' Legal Handbook", Chapter 13.5)

A wealth of information for physicians who are considering enrolling in a managed care health plan, or are currently participating in such a plan, can be found in the CMA Legal Handbook's chapter on managed care. The handbook examines a variety of issues in considerable depth, and with periodic updates, provides current developments in law, contracts, liability and other critical topics.

In the area of the participation contract, for example, the handbook addresses arbitration and other forms of alternative dispute resolution, contract termination, both with and without cause, issues relating to the physician/patient relationship, discrimination and antitrust.

A lengthy section on denial of payment by utilization reviewers details recent changes in California law which provide important protections for both patients and physi-

cians. The section describes risks physicians face in a malpractice action if they fail to provide appropriate care because payment was denied. It also explores the liability of UR physicians and health plans in such cases. Included in this section is information on how physicians can appeal denials, and guidance on documenting the efforts a physician makes to assure that patients receive medically necessary care. The section also outlines legal constraints on retaliation against physicians who advocate vigorously for their patients.

For information on ordering this chapter, or the entire "California Physician's Legal Handbook" contact:

Publications Section
California Medical Association
P.O.Box 7690
San Francisco, CA 94120-7690.
(415) 882-3309

HEALTHCARE MANAGEMENT INFORMATION: THE KEYSTONE TO MANAGED CARE?

The Ohio Healthcare 2000 Alliance Project*

The key to making sense of the millions of healthcare interactions that happen every day in the United States is to reduce them to manageable data. For decades, everyone from the Pentagon to your local hospital has struggled to continually improve the ability to capture, organize and interpret burgeoning masses of data. If only an accurate picture can be created, then all sorts of decisions can be made about deployment of resources, quality of care and — of undeniable importance — management of costs.

An ambitious project is underway in the state of Ohio to create a system which, if successful, would integrate an astonishing amount of data about virtually every individual in the state who interacts with the healthcare system in any way. Described as “. . . an open, interoperable, and integrated healthcare information infrastructure for the State of Ohio,” the project, nicknamed H2000, “. . . will demonstrate the value of collecting, analyzing, and disseminating outcomes performance measurement data to improve healthcare quality and access while reducing the costs of healthcare delivery.”

In a nutshell, H2000 seeks to develop a statewide management information system which will provide interconnectivity among a wide array of existing data systems operated by hospitals, insurers, governmental agencies, community health organizations, employers, health practitioners, consumers and others.

Using data maintained by all these sources, the system would provide “. . . access to a wide variety of demographic, clinical, and administrative information which can be used to examine population-based health outcomes, to measure healthcare costs and access to care, and to support a wide variety of administrative and operational performance improvement efforts by healthcare providers and payors, while protecting the privacy and confidentiality of the information supplied by consumers, healthcare providers, and payors.”

The roots of H2000 lie in a taskforce formed by the Ohio Manufacturers' Association in 1992 to recommend strategies for improving healthcare. The OMA taskforce applied for and received a grant from the John A. Hartford Foundation to explore developing a community healthcare management in-

formation system. In January 1993, OMA formed the Ohio Corporation for Health Information to plan and implement such a system.

Under Ohio legislation, the corporation teamed up with the Ohio Department of Health and the Ohio Health Care Board to fit the private sector model into a broader state mandate for a public sector healthcare data center and a statewide electronic data interchange network.

“An ambitious project is underway in the state of Ohio to create a system which, if successful, would capture an astonishing amount of data about virtually every individual in the state who interacts with the healthcare system in any way.”

Among its goals, H2000 hopes to accomplish:

- Electronic information exchange between healthcare providers, employers, payors, and other entities as a primary basis for improving productivity and patient care management.
- Acquiring meaningful administrative and clinical information from providers, employers and patients, and merging such information into a “blended data set” that provides comparative outcomes performance measurements which can be used by providers, payors, and healthcare services purchasers.
- . . . develop[ing] various specialized databases whose data content is useful to a healthcare related enterprise, payor, etc., to improve the performance, productivity, and quality of their own healthcare business transactions and caregiving processes.
- Ensur[ing] the integrity of healthcare data, so information is accurate, complete, and trustworthy.
- Ensur[ing] the availability of health data so that authorized persons who need information for legitimate healthcare delivery and management purposes have ready access to that data.
- . . . defining a comprehensive data confidentiality and privacy protection policy. . .

At the time the interim report was issued in February 1995, the project was still in the development phase, but pilot testing is being planned for three hospital sites initially. No date is given in the report for startup.

*Petrarca, W.H., et al., OHIO HEALTHCARE 2000 ALLIANCE INTERIM REPORT, Ohio Corporation for Health Information, February 15, 1995.

INSIDERS

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"We believe that cost reduction and high-quality medicine are compatible. . . . Take the immunization of children. We expect the immunization rate of Kaiser Permanente children to be 100%. Our information systems will monitor this for us. By expanding our information system, we reduce paperwork and cost while simultaneously augmenting our quality of care."

Mr. Hillman: "Prepaid group practice has always been an effective way to deliver healthcare. . . . Patients benefit from peer review, payers benefit from cost-effective expense-sharing, and providers have more time to concentrate on what they do best — practice medicine."

"Most physicians are used to being captains of the ship; they don't want to relinquish medical decisions to insurers, corporate executives, or other non-medical third parties. And rightly so. The solution is to affiliate with an organization that keeps medical decisions in the hands of physicians."

"Healthcare purchasers are demanding and getting significant reductions in premiums. . . . The challenge our members face is to increase their efficiency and not let the quality of healthcare suffer."

"The concern about quality in the prepaid sector is a myth. Studies continue to show that the quality of care. . . is equal to or better than that provided through fee-for-service plans. In addition, the percentage of Californians enrolling in prepaid health plans is growing by leaps and bounds."

Mr. Linn: "At Healthcare Partners we have found the need to consolidate into a larger group to (1) derive efficiency through economies of scale and 'best practice' techniques, (2) to improve our negotiating position in a consolidating hospital and insurance industry, (3) to support our information and administrative systems infrastructure development, and (4) to provide access to capital to support this infrastructure development and future expansion."

"We believe that physicians prefer to work in organizations that are physician-owned and physician-managed."

"Consumers have always been savvy about healthcare; they just haven't been as vocal as they are now. . . . In today's environment, patients will bring issues to their employer, the health plan, and consumer organizations in their attempt to deal with a sense of loss of empowerment and advocacy."

"When providers are placed at risk for their patients' health status through capitation, their orientation quickly moves away from illness and toward wellness. Providing appropriate and timely healthcare services is the mantra of any mature managed care group."

Mr. Moser: "Do we understand the implication of having healthcare delivery dominated by Wall Street? The effects of these trends are substantial, and I think that physicians need to come together in organizations that can represent their interests and those of their patients, and can do that from a base of strength."

"Reimbursement is decreasing from Medicare, PPOs, HMOs, and indemnity plans. Physicians' ability to make income from other sources, such as in-house laboratory, radiology, and ownership of joint ventures have been drastically reduced in California. The revenues are under intense pressure, so you have to look at the expenses and how to control them."

"The patient doesn't care about the fact that reimbursement is down 10%. They don't expect their waiting room to be 10% less clean, or their doctor to be 10% less available, or for us to skimp on the quality we provide."

"This isn't just a reimbursement issue, it's a deeper social issue. We have to look at how much HMOs can reduce reimbursement before care is really affected."

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This special insert on Managed Care was prepared by Linda A. McCready, Manager for Special Projects, drawing from the speeches, interviews and articles identified. Grateful appreciation is extended to the various contributors for their permission to reproduce, quote, or excerpt from their words and ideas.