Action Report
Medical Board of California

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IN THIS ISSUE

STD UPDATE

Updated guidelines for the medical management of STD patients are contained in the detachable insert, provided for physicians' easy reference by the Department of Health Services.

Medical Board of California Meeting Dates/Locations

1998

July 30 - Aug. 1 San Francisco
Nov. 5 - 7 San Diego

All meetings are open to the public.

Medical Board Solicits Input on the Corporate Practice of Medicine Prohibition

The Medical Board of California convened the Corporate Practice of Medicine Working Group over one year ago to address several issues regarding the impact of the prohibition against the corporate practice of medicine on physician delivery of health care. By prohibiting lay persons or entities from practicing medicine or exercising control over a physician's professional judgment, the corporate practice prohibition is designed to protect the public from possible abuses stemming from the commercial exploitation of medicine. Several meetings held statewide over the last year brought together over 80 interested parties. Physicians, attorneys, medical foundations, hospitals, numerous state government agencies, health maintenance organizations, insurance companies, the California Medical Association and the California Healthcare Association were among those that attended these meetings. A view held by all participants was that the prohibition against the corporate practice of medicine should not be removed from California statute. The Working Group sought to clarify the policies underlying the corporate practice doctrine as well as clarify the scope of the prohibition itself. At the May 9, 1998 quarterly Board meeting, the Working Group presented its Summary Report and working draft of the Perspective to Provide Guidance on the Prohibition Against the Corporate Practice of Medicine. The Medical Board would like to encourage more input from persons interested in the Perspective, the draft of which follows this article.

As noted in a prior *Action Report* (October 1996) article, the rationale behind the corporate practice prohibition becomes clear if you ask the question: "Why is it unlawful for a lay person to practice medicine or exercise control over a physician's professional judgement?" The physician must be able

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Medical Board Weighs In On Managed Care Regulation

At its May 9, 1998 Sacramento meeting, the Medical Board adopted a proposal drafted by members of the Board's Committee on the Quality of Care in a Managed Care Environment. This model for HMO regulation urges the Governor and Legislature to attack one of the causes of consumer dissatisfaction with managed care by removing its regulation from the Department of Corporations to a newly created Health Care Service Plan Board. The Board hopes that this model for regulation will influence policy makers in California and nationwide to create similar regulatory structures that promote the physician-patient relationship first, and provide meaningful oversight of the health insurance industry. The proposal follows in its entirety.

I. INTRODUCTION

Managed care is now—and will continue to be for the foreseeable future—the dominant force in the financing and delivery of health care in California. Best estimates indicate that 70-80% of Californians with health insurance are covered by some form of managed care. A dynamic tension exists between strict cost control and continuous high quality of care, with two distinct camps having developed in the debate about the proper role of government in regulating these issues. Engaged in these discussions are employers, health plans, consumers, providers, and regulators.

Of concern to the Medical Board of California (MBC) is a sense of public dissatisfaction in this system associated with declining quality and even decreased safety. In the interest of public protection mandated by the Medical Practice Act, the Board feels it must speak for the assurance and maintenance of quality and safety in the health care delivery system. Therefore, MBC advocates regulatory change that will:

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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.

President's Report

The past few months have been particularly busy at the Medical Board of California, with members and staff diligently working in the consumers' interest in many areas. Following are some of the current priorities of the Board.

Thomas A. Joas, M.D.
1998 President of the Board

✔ Licensure Fee Increase

Over the past several years, internal efficiencies and working with an exceptionally committed and knowledgeable staff have produced significant cost savings. Today, however, we still find our reserve funding precariously below that level mandated by statute. The Board therefore needs to augment resources to meet our commitments. This will require that fees be increased for the first time in six years. This is necessary to meet the growing investigative workload, and also to meet expectations of the Board's efforts on other issues strongly affecting both consumers' and physicians' interests, such as corporate practice and managed care. The Board is sponsoring legislation to increase the cap for licensing fees based on these needs. SB 1930 (Polanco) would increase the existing $600 biennial fee to $690.

✔ Managed Care

Our primary goals in this area are to underscore the sanctity of the physician-patient relationship and to promote meaningful, consumer-oriented oversight of managed care. The second article on page 1 of this *Action Report* underscores once again the Medical Board's continuing interest in the regulation of HMOs. At its meeting on May 9 in Sacramento, the full Board adopted a policy statement, "An Integrative Model for the Regulation of Managed Care in California," which is being widely disseminated, in the hopes of urging policy makers to improve the regulatory oversight of managed care.

The Board continues to speak at every opportunity where the regulation of managed care is considered, e.g., participation at recent Little Hoover Commission meetings, other public policy meetings, letters to major newspapers, etc.

✔ Plastic-Cosmetic Surgery Committee

Last year, following several patient deaths and in response to multiple marketplace changes, the Medical Board appointed a six-member committee to review the safety of plastic and cosmetic surgery in office-based settings. Since October, the Committee has been gathering information from specialty boards, ACGME training programs, specialty societies, malpractice insurers, and accreditation agencies. On June 20, the committee met publicly in Los Angeles with all of these parties to discuss issues of training, practice guidelines, liability, and the accreditation process, among others. Our hope is that the outcome will provide a clearer picture of whether legislation should be sought, and whether regulations need to be promulgated to ensure greater patient safety.

As we look at the issues surrounding elective procedures performed in physicians' offices, our members have the significant responsibility of identifying the types of laws or regulations needed. To be effective, we must look at some very controversial issues that are bound to be unpopular with some patients and physicians, but we are committed to rise above the various specialty overlaps and keep patient protection our first priority.

✔ Postgraduate Training

The Medical Board, together with many leaders in medicine, has long been concerned that changing standards and advances in medical practice require more than the one year of postgraduate training now mandated in California. In fact, most other states already require at least two years' postgraduate training.

After hearing the final report of Doraiswamy Ramachandran, Ph.D., California State University, Sacramento statistician, the Board has reaffirmed its decision to support AB 1079 (Cardoza), the Board-sponsored legislation which would increase the postgraduate training requirement for physician licensure in California from the current one year to two years. Dr. Ramachandran's analysis demonstrated that "there is a turning point in the rates of severe disciplinary actions when the licensee has less than two years of training as opposed to two or more years of training." The percentage of disciplinary actions in these cases more than doubles when the postgraduate training falls below two years. A parallel nationwide study conducted by the AMA reflects this same degree of increase in disciplinary actions as the years of postgraduate training decrease.

✔ MBC Site Inspection

The Medical Board of California takes very seriously the charge that it verify the educational training obtained by its licensees. Sixty-one percent of California's international licensees graduate from medical schools in 10 countries; 13% graduate from four medical schools in the Philippines. The Board's Division of Licensing intends to visit four Philippine medical schools in November 1998 as part of a project to evaluate the level of medical education being offered in other countries. These initial efforts will focus on four medical schools: the University of Santo Tomas, University of the East, Far Eastern University, and University of the Philippines.

We have received positive responses to the Division's request from the medical school Deans. The insights gained in the

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Board Solicits Input (Continued from p. 1)

to exercise his/her independent professional judgment as to what is best for a particular patient. A physician who is licensed to practice medicine in California has established at least a minimum level of education and competence. A criminal records check and background check also have been performed. The same is not true of an unlicensed individual or lay corporation. In other words, the physician should not be forced to choose between the dictates of his or her "employer" and the best interests of the physician's patients.

Working Group participants raised several issues related to the impact of the corporate practice prohibition on existing medical practice and business arrangements. Specifically, participants attempted to describe how the corporate practice prohibition affected the ability of licensed persons to pursue business arrangements beneficial to all interests involved—patients and licensed persons. Working Group participants agreed that clarifying the corporate practice prohibition would better enable licensed persons to practice in many arrangements which may be more conducive to patient care by reducing confusion and noncompliance. Most participants in the Working Group agreed that the items listed in the Working Draft are decisions and activities that are within the physician's control. The Draft attempts to provide guidance to the public about the corporate practice prohibition. If you have comments about the Perspective, please submit them, in writing, to John M. Puente, Legal Counsel to the Medical Board, 1426 Howe Avenue, #54, Sacramento, CA 95825. Fax: (916) 263-2387.

Medical Board of California's Perspective to Provide Guidance on the Prohibition Against the Corporate Practice of Medicine

The Medical Practice Act, Business and Professions Code Section 2052, provides:

"Any person who practices or attempts to practice, or who holds himself or herself out as practicing... [medicine] without having at the time of so doing a valid, unrevoked, or unsuspended certificate... is guilty of a misdemeanor."

Business and Professions Code Section 2400, within the Medical Practice Act, provides in pertinent part:

"Corporations and other artificial entities shall have no professional rights, privileges, or powers."

The policy expressed in Business and Professions Code Section 2400 against the corporate practice of medicine is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. From the Medical Board's perspective, the following health care decisions should be made by a physician licensed in the State of California and would constitute the unlicensed practice of medicine if performed by an unlicensed person:

- Determining what diagnostic tests are appropriate for a particular condition.
- Determining the need for referrals to or consultation with another physician/specialist.
- Responsibility for the ultimate over-all care of the patient, including treatment options available to the patient.
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work.

The above represents only those issues addressed by the board to date and is not intended to be all-inclusive.

In addition, from the Medical Board's perspective, the following "business" decisions and activities involving control over the physician's practice of medicine should be made by a physician licensed in the State of California and not by an unlicensed person or entity:

- Ownership and control of a patient's medical records, including determining the contents thereof.
- Selection (hiring/firing as it relates to clinical competency or proficiency) of professional, physician extender, and allied health staff.
- Set the parameters under which the physician will enter into contractual relationships with third-party payers.
- Decisions regarding coding and billing procedures for patient care services.
- Approval of the selection of medical equipment.

The types of decisions and activities described above cannot be delegated to any unlicensed person, including (for example) management service organizations. While a physician may consult with unlicensed persons in making the "business" decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.

Address of Record

In the April 1998 *Action Report* we reminded our readers that a physician must provide to the Medical Board a current address of record, which is by law public record and now appears on each physician's profile on our web site (www.medbd.ca.gov). Physicians may use their work or home address, or any other address where they receive mail. Physicians who are concerned about safety or privacy issues may use a post office box, *as long as a street address—which will remain confidential—also is provided.* An address of record may be changed by a physician at any time by faxing a signed notice of the change to the Board at (916) 263-2487.

Supervision of Physician Assistants

by Ray E. Dale, Executive Officer, Physician Assistant Examining Committee

Several hundred physicians this year will contact the Medical Board of California seeking their initial approval to use physician assistants (PAs). Those who are granted approval accept significant supervisory duties and responsibilities. According to California law, all care given to a patient by a physician assistant is the ultimate responsibility of the supervising physician.

Current law limits physicians to supervising no more than two PAs at any moment in time. A supervising physician must be available in person or by electronic communication at all times when a physician assistant is caring for patients.

Before authorizing a PA to perform any medical procedure, the physician is responsible for evaluating their education, experience, knowledge and ability to perform the procedure safely and correctly. The physician must also verify that a PA possesses a current license to practice in California from the Physician Assistant Examining Committee (PAEC).

For the mutual benefit and protection of patients, physicians and their PAs, the PA regulations require that the physician delegate in writing, for each supervised physician assistant, those medical services which the PA may provide. That document is often referred to as a Delegation of Services Agreement. Medical tasks which are delegated by an approved supervising physician may only be those which are usual and customary to the physician's personal practice.

Another one of the many important responsibilities of supervising physicians is the establishment of a signed and dated written statement which explains how, where and when they will review the activities of the PAs they supervise. The statement, often called a "written supervisory guideline," must be made available to the PA and to staff of the Medical Board of California or Osteopathic Medical Board on request.

In addition, if PAs are to be utilized in a hospital, the supervisory guideline and often the delegation of services agreement should be made available to the hospital's medical staff executive committee. Unless specifically delegated the authority by the medical staff, the granting of hospital privileges for physician assistants and their supervising physicians does not fall within the review of the hospital's committee on interdisciplinary practice. If physicians plan to utilize PAs in nursing homes, hospices, jails, prisons, or similar settings, they should first make arrangements with the facility's medical director.

There are four methods for providing legally adequate supervision outlined in Section 1399.545 of the Physician Assistant Regulations:

1. The physician may see the patients the same day that they are treated by the PA.
2. The physician may review, sign and date the medical record of every patient treated by the physician assistant within thirty days of the treatment.
3. The physician may adopt written protocols which specifically guide the actions of the PA. The physician must select, review, sign, and date at least 10% of the medical records of patients treated by the physician assistant according to those protocols.
4. Or, in special circumstances, the physician may provide supervision through additional methods which must be approved in advance by the PAEC.

To fulfill the required supervisor obligation, the physician must utilize one, or a combination of, the four authorized supervision methods.

To ensure that a PA's actions involving the prescribing or administration of drugs is in strict accordance with the directions of the physician, every time a PA administers a drug or transmits a drug order, a physician supervisor must sign and date the patient's medical record or drug chart within seven days.

There is no current law that authorizes a PA to orally issue a prescription, write or complete pre-signed prescription blanks, or sign a prescription for drugs or medical devices. Current law does not authorize the delegation of prescribing authority to PAs. However, Business and Professions Code section 3500 et seq. permits physician assistants to write and sign prescription "transmittal orders" when authorized to do so by their supervising physicians. Business and Professions Code section 4000 et seq. authorizes licensed pharmacists to dispense drugs or devices based on a PA transmittal order.

In the event there is a problem or violation involving a PA, the complaint process is comparable to that for the supervising physician. The PAEC processes the complaint and Medical Board investigators are used to conduct any investigation that may be required.

For physicians interested in utilizing physician assistants and who would like to know more about the benefits and requirements, several publications are available from the PAEC, including:

- *What Is A PA?*
- California Laws and Regulations regarding the use of PAs
- Guidelines for Delegation of Services Agreements
- Written Transmittal Orders (information bulletin)
- Application for Approval to Supervise a PA
- Patient Information Brochures (English and Spanish)
- *PAEC Update* (newsletter)

To request publications or verify physician assistant licensing information, contact:

Physician Assistant Examining Committee
1424 Howe Avenue, Suite 35, Sacramento, CA 95825-3237

Telephone: (916) 263-2670 / (800) 555-8038
Fax: (916) 263-2671

Medical Board Weighs In (Continued from p. 1)

1. Safeguard or improve a high quality of care for California consumers of health;
2. Preserve or increase their access to care;
3. Allow providers to keep the best interests of patients foremost; and
4. Maintain the fiscal viability of our health care system.

II. VISUALIZING A FUTURE WHICH INTEGRATES THESE ENERGIES

The current fragmented and vaguely defined regulatory scheme meets none of these objectives. The Medical Board of California proposes here a regulatory structure satisfying the above requirements with an integrated system tying together three key regulatory entities. These entities and their specific responsibilities are:

A. Health Care Service Plan Board

A newly created, independent Health Care Service Plan Board (HCSPB). Members would be appointed to a defined term by the Governor and by the Legislature with the Board Chair being a direct, full-time gubernatorial appointment. The Board would be mandated to have a majority of consumers. Expertise in the qualitative aspects of health care delivery should be a *sine qua non* for all HCSPB appointees. In carrying out its duties the HCSPB would have authority to make policy, to adopt regulations, to investigate, cite, fine, and suspend or revoke or otherwise discipline licenses through administrative processes as with other regulatory boards which have a public protection function. These active functions would specifically apply to Health Care Service Plans in their qualitative delivery of health care. Other specific board functions would be to:

a. License Health Care Service plans after clearance from Department of Corporations

b. Set standards for and regulate the provisions and execution of contracts between:

   i. Health Care Service Plan and a provider, provider group or intermediary

   ii. an intermediary and a provider

   iii. Health Care Service Plan and the consumer

c. Contract with other regulatory agencies (e.g. MBC, BRN, BPM, etc.) to investigate, and when appropriate to discipline, their licensees who may have violated one of the practice acts; or to contract with DHS with respect to possible institutional violations

d. Participate in consolidated audits of plans, providers, and provider organizations (similar to JCAHHS/DHS surveys)

e. Contract with private organizations to develop standards for:

   i. quality assurance

   ii. cost containment

   iii. outcome measurement

   iv. prospective/retrospective review of services

   v. timely, independent review of plan/consumer disputes by properly credentialed individuals or organizations

   vi. others as needed

The MBC also supports the elimination or substantial modification of the liability exemption currently enjoyed by many managed care organizations under the federal ERISA (Employee Retirement Income Security Act); and in the interests of public protection, the MBC advocates statutory change at the state or federal level to achieve this.

B. Department of Corporations

The Department of Corporations (DOC) would retain its current authority to regulate general corporate structure and operations, such as financial stability, marketing of securities, and general business practices. Any Health Care Service Plan applying for a license from the HCSPB would require clearance from DOC.

C. Licensing Agencies

Professional licensing agencies (e.g. MBC, BRN, etc.) or institutional licensing agencies (e.g. DHS) would function as in the past. In addition, they would contract with the HCSPB to investigate and deal with their licensees in matters that involve quality of care issues in managed care settings. The actual cost of services provided would be reimbursed by the HCSPB.

III. CONSUMER COMPLAINTS

Operationally, all complaints involving managed care would be screened through an HCSPB toll-free consumer assistance line. The existence of this line should be widely publicized and should be the subject of a major, ongoing public information campaign so that all Californians are aware that this is the line to call for all complaints involving Health Care Service Plans. Complaints after screening and prioritization would then be either retained for investigation by the HCSPB or assigned to another appropriate jurisdiction, such as a professional licensing agency or the DOC. Appropriate elements of the three key agencies would be mandated to meet on a regularly scheduled basis (at least monthly) to coordinate efforts and track cases of potential violations.

IV. THE GOAL

As a result of the changes suggested above, consumers could be assured that necessary and appropriate care would not be limited for economic reasons; providers would be able to render care as dictated by their professional judgement and by the patient's best medical interests; and employers, payors and intermediaries could function in a fiscally sound environment.

Health News

Avoid the "Last Minute Rush"— New 7th Grade Entry Immunization Requirements in 1999

Immunization Branch, California Department of Health Services, May 1998

New Requirements Starting Mid-1999

Recently, the Legislature passed and the Governor signed legislation (Health and Safety Code Section 120335) which will require hepatitis B immunizations for entrance to seventh grade in both public and private schools, effective July 1999. The California Department of Health Services has proposed changes to the California Code of Regulation (Title 17, Sections 6020 and 6035) which, if adopted, would also require a second dose of measles-containing vaccine (usually given as combined measles-mumps-rubella vaccine [MMR]), and a tetanus-diphtheria toxoids (Td) booster dose for seventh grade entry, effective July 1999.

These new requirements are based on national recommendations for 11-12 year-olds by the American Academy of Pediatrics (AAP), the U.S. Public Health Services's Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP) and the American Medical Association (AMA). The new requirements (if adopted) will be as follows for seventh grade entrants *who have not already received these vaccine doses:*

- ***3 doses of hepatitis B vaccine;***
- ***a 2nd dose of measles-containing vaccine*** (e.g., MMR);
- ***1 dose of Td,*** if more than 5 years have elapsed since the last dose of vaccine containing tetanus or tetanus-diphtheria toxoids.

  The proposed seventh grade Td booster requirement is consistent with national recommendations that the first "adult" Td booster be administered at 11-12 years of age rather than 14-16 years of age. This change has not resulted in an increased incidence of serious adverse reactions.

As with existing school-entry immunization requirements:

- ***exemptions*** will be allowed based on parent/guardian's ***personal beliefs*** and on ***medical reasons*** presented in writing by the child's physician (e.g., the child has laboratory evidence of immunity); and
- ***pupils part-way through the 3-dose hepatitis B vaccine series*** but not yet due for the next dose ***will be admitted*** to 7th grade on the condition that they complete the series on schedule.

National Recommendations for Preventive Health Care at Age 11-12 Years

The AAP, ACIP, AAFP and AMA recommend routine health care visits for all 11-12 year-olds, not only for the immunizations listed above, but also for:

- varicella vaccine (if not already received and the child does not have a history of clinical chickenpox);
- other immunizations if the child is in a high-risk group for which vaccines are recommended, such as influenza (in the fall) and pneumococcal vaccines; and
- other preventive health services appropriate for this age group.

Also, health care plans are starting to assess immunization coverage of their adolescent beneficiaries with hepatitis B, varicella and 2nd-dose MMR vaccines in order to comply with Health Employer Data Information Set (HEDIS) guidelines.

How Can Physicians Help Their Patients Avoid the "Last Minute Rush?"

When 11-12 year-olds are brought into the office for any reason, alert their parents to these new immunization requirements, assess the child's immunization status, and administer vaccine doses needed.

Identify 11-12 year-olds in the practice and issue notifications to their families, urging them to bring their children in for the immunizations they will need to enter seventh grade. Physicians' billing systems, affiliated health plans, medical groups or Independent Practice Associations (IPAs) may be able to provide lists of their patients in this age range.

Should you have any questions regarding these new requirements, please call your local health department and ask for the immunization program.

Sexually Transmitted Disease Treatment Guidelines Update

Sexually Transmitted Disease Control Branch, California Department of Health Services

June 1998

The following guidelines are intended as a source of clinical guidance. They are not a comprehensive list of all effective regimens. They and the information which follows have been prepared for your use and incorporation into your sexually transmitted disease (STD) treatment plans. Details on obtaining additional information are also listed below.

In its 1997 report, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*, the Institute of Medicine (IOM) cited a lack of appropriate screening and treatment of STDs as a factor contributing to the STD epidemic in the United States. The IOM panel concluded that patients who are diagnosed often receive inadequate treatment or treatment inconsistent with recommended practice. To improve STD care in the United States, the IOM called for wider dissemination of the guidelines, and for all primary care providers, including managed care organizations and other health plans, to implement the Centers for Disease Control and Prevention's (CDC) recommendations for STD care.

What are the STD guidelines?

The *1998 Guidelines for Treatment of Sexually Transmitted Diseases* update CDC recommendations for STD screening, diagnosis and treatment (the last update was in 1993). They have been developed by CDC staff in consultation with a group of nationally recognized STD experts from public health, academia, medical research and managed care organizations. After a careful review of scientific literature and clinical practice, recommendations have been developed for quality of care and outcomes of STD therapy: cure, relief of symptoms, prevention of complications, and prevention of further transmission.

What advances have been made since the last guidelines and why are these important?

- **Highly effective, single-dose oral therapies have been developed for almost all common curable STDs.** By simplifying the treatment for common diseases such as chlamydia to one doctor's visit, these therapies may significantly increase the number of people who are treated and cured. This will prevent the serious reproductive outcomes caused by these diseases and reduce the time period in which a person can transmit the disease to others. Additionally, because chlamydia and gonorrhea increase the chances of transmitting and acquiring human immunodeficiency virus (HIV) infection, these treatments may ultimately help slow the heterosexual spread of HIV.
- **Improved treatments are now available for herpes and Human Papillomavirus (HPV).** Since one in five Americans is now infected with herpes type 2, and HPV is a very common STD associated with cervical cancer and genital warts, advances in the treatment of these viral STDs are critical. Patient-applied treatment for HPV makes it easier to administer therapy when symptoms occur. And more effective treatments for genital herpes help to alleviate symptoms, reduce the emotional stress associated with viral STDs, and possibly reduce transmission.
- **The introduction of a simple urine test makes it much easier to diagnose and treat chlamydia in clinical and non-clinical settings.** Recent research advances have led to extremely accurate urine tests which make testing of both men and women more feasible and less uncomfortable than older tests. In addition, chlamydia testing may be conducted in non-clinical settings for large groups of adolescents who are at greatest risk for chlamydia. In high-school and other community-screening programs, as many as one in eight teenage girls tests positive for chlamydia.
- **Recommendations for hepatitis A and hepatitis B include vaccination for all sexually active youth.** With the availability of vaccines for hepatitis A and hepatitis B, all sexually active youth can be protected from the devastating consequences of liver disease that result from these infections which can be sexually transmitted.
- **Improved treatments for STDs in pregnancy may produce fewer side effects and reduce the number of infants born prematurely.** Significant advances have also been made in the treatment of STDs during pregnancy. New treatments for chlamydia produce fewer side effects. And new recommendations stressing the need for screening and treatment of bacterial vaginosis among high-risk women (with a previous history of preterm birth) will likely reduce the number of infants born prematurely as a result of this disease.

Who uses the guidelines and what are the benefits?

The guidelines are intended for use by health care providers, trainers, educators, researchers and others in primary care, adolescent care, family medicine, family planning, internal medicine, obstetrics-gynecology, urology, dermatology, emergency care, nursing and HIV care. The benefits of effective STD detection and treatment are greatest for the health of women, particularly adolescent and young adult women, and their babies, and for HIV prevention. These benefits translate to lower health care costs.

Why are the guidelines important for physicians in managed care and private practice?

The guidelines provide basic information for detecting and treating many "silent" STDs which are difficult to detect

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STD TREATMENT GUIDELINES FOR ADULTS AND ADOLESCENTS

These guidelines for the treatment of patients with STDs reflect the 1998 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens. To report STD infections; request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients, call the County Health Department. The California STD/HIV Prevention Training Center is an additional resource for training and consultation in the area of STD clinical management and prevention (510-883-6600).

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
CHLAMYDIA			
Uncomplicated Infections Adults/Adolescents[1]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Ofloxacin[3] 300 mg po bid x 7 d
Pregnant Women[4]	• Amoxicillin **or** • Azithromycin **or** • Erythromycin base	500 mg po tid x 7 d 1 g po 500 mg po qid x 7 d	Erythromycin base 250 mg po qid x 14 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Erythromycin ethylsuccinate 400 mg po qid x 14 d
GONORRHEA[5]			
Uncomplicated Infections Adults/Adolescents	• Cefixime[6] **or** • Ceftriaxone **or** • Ciprofloxacin[3] **or** • Ofloxacin[3] **plus**[5] • a chlamydia recommended regimen listed above	400 mg po 125 mg IM 500 mg po 400 mg po	Spectinomycin[7] 2 g IM **plus**[5] a chlamydia recommended regimen
Pregnant Women	• Ceftriaxone **or** • Cefixime[6] **plus**[5] • a chlamydia recommended regimen listed above	125 mg IM 400 mg po	Spectinomycin[7] 2 g IM **plus**[5] a chlamydia recommended regimen
PELVIC INFLAMMATORY DISEASE	**Parenteral**[8] • Cefotetan or Cefoxitin **plus** Doxycycline[2] **or** • Clindamycin **plus** Gentamicin **Oral Treatment** • Ofloxacin[3] **plus** Metronidazole **or** • Ceftriaxone or Cefoxitin **and** Probenecid **plus** Doxycycline[2]	 2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po or IM q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs 400 mg po bid x 14 d 500 mg po bid x 14 d 250 mg IM 2 g IM 1 g po 100 mg po bid x 14 d	**Parenteral** Ofloxacin[3] 400 mg IV q 12 hrs **plus** Metronidazole 500 mg IV q 8 hrs **or** Ampicillin/Sulbactam 3 g IV q 6 hrs **plus** Doxycycline[2] 100 mg po or IV q 12 hrs **or** Ciprofloxacin[3] 200 mg IV q 12 hrs **plus** Doxycycline[2] 100 mg po or IV q 12 hrs **plus** Metronidazole 500 mg IV q 8 hrs
MUCOPURULENT CERVICITIS[9]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Ofloxacin[3] 300 mg po bid x 7 d
NONGONOCOCCAL URETHRITIS[9]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Ofloxacin[3] 300 mg po bid x 7 d
EPIDIDYMITIS	Likely due to Gonorrhea or Chlamydia • Ceftriaxone **plus** Doxycycline Likely due to enteric organisms • Ofloxacin[3]	 250 mg IM 100 mg po bid x 10 d 300 mg po bid x 10 d	
TRICHOMONIASIS	• Metronidazole	2 g po	Metronidazole 500 mg po bid x 7 d
BACTERIAL VAGINOSIS			
Adults/Adolescents	• Metronidazole **or** • Clindamycin cream[10] **or** • Metronidazole gel	500 mg po bid x 7 d 2%, one full applicator (5g) intravaginally at bedtime x 7 d 0.75%, one full applicator (5g) intravaginally, bid x 5 d	Metronidazole 2 g po **or** Clindamycin 300 mg po bid x 7 d
Pregnant Women	• Metronidazole	250 mg po tid x 7 d	Metronidazole 2 g po **or** Clindamycin 300 mg po bid x 7 d
CHANCROID	• Azithromycin **or** • Ceftriaxone **or** • Ciprofloxacin[3] **or** • Erythromycin base	1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po qid x 7 d	
LYMPHOGRANULOMA VENEREUM	• Doxycycline[2]	100 mg po bid x 21 d	Erythromycin base 500 mg po qid x 21 d

1 Screen adolescents annually and women 20-24 years, especially if new or multiple partners.
2 Contraindicated for pregnant and nursing women.
3 Contraindicated for pregnant and nursing women and children < 18 years of age.
4 Test-of-cure follow-up is recommended because the regimens are not highly efficacious (Amoxicillin and Erythromycin) or the data on safety and efficacy are limited (Azithromycin)
5 Co-treatment for chlamydia infection is indicated if co-infection rates are high (>20%), less sensitive or no chlamydia test is done, or follow-up is uncertain.
6 Not recommended for pharyngeal gonococcal infection.
7 For patients who cannot tolerate cephalosporins or quinolones; not recommended for pharyngeal gonococcal infection.
8 Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total course of 14 days.
9 Testing for gonorrhea and chlamydia is recommended beause a specific diagnosis may improve compliance and partner management and these infections are reportable by CA State Law.
10 Might weaken latex condoms and diaphragms because oil-based; not recommended in pregnancy.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
HUMAN PAPILLOMAVIRUS			
External Genital/ Perianal Warts	**Patient Applied** • Podofilox[11] 0.5% solution or gel **or** • Imiquimod[12] 5% cream **Provider Administered** • Cryotherapy **or** • Podophyllin[11] resin 10%-25% in tincture of benzoin **or** • Trichloroacetic acid (TCA) or Bichloroacetic acid (BCA) 80%-90% **or** • Surgical removal		**Alternative Regimen** Intralesional interferon or laser surgery
Vaginal Warts	• Cryotherapy **or** • TCA or BCA 80%-90% **or** • Podophyllin[11] 10%-25% in tincture of benzoin		
Urethral Meatus Warts	• Cryotherapy **or** • Podophyllin[11] 10%-25% in tincture of benzoin		
Anal Warts	• Cryotherapy **or** • TCA or BCA 80%-90% **or** • Surgical removal		
HERPES SIMPLEX VIRUS[13]			
First Clinical Episode of Herpes	• Acyclovir[12] **or** • Acyclovir[12] **or** • Famciclovir[12] **or** • Valacyclovir[12]	400 mg po tid x 7-10 d 200 mg po 5 x q d x 7-10 d 250 mg po tid x 7-10 d 1 g po bid x 7-10 d	
Episodic Therapy for Recurrent Episodes	• Acyclovir[12] **or** • Acyclovir[12] **or** • Acyclovir[12] **or** • Famciclovir[12] **or** • Valacyclovir[12]	400 mg po tid x 5 d 200 mg po 5 x q d x 5 d 800 mg po bid x 5 d 125 mg bid x 5 d 500 mg po bid x 5 d	
Supressive Therapy	• Acyclovir[12] **or** • Famciclovir[12] **or** • Valacyclovir[12] **or** • Valacyclovir[12]	400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd	
SYPHILIS			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	Doxycycline[2] 100 mg po bid x 2 weeks **or** Tetracycline[2] 500 mg po qid x 2 weeks
Late Latent and Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	Doxycycline[2] 100 mg po bid x 4 weeks **or** Tetracycline[2] 500 mg po qid x 4 weeks
Neurosyphilis[14]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM q d x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d
Pregnant Women[14]			
Primary, Secondary, and Early Latent[15]	• Benzathine penicillin G	2.4 million units IM	None
Late Latent and Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None
Neurosyphilis[14]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM q d x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d
HIV Infection			
Primary, Secondary and Early Latent	• Benzathine penicillin G	2.4 million units IM	Doxycycline[2] 100 mg po bid x 2 weeks **or** Tetracycline[2] 500 mg po qid x 2 weeks
Late Latent, and Unknown duration[14] **with normal CSF Exam**	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None
Neurosyphilis[14]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM q d x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d

11 Contraindicated during pregnancy.
12 Safety in pregnancy has not been established.
13 Counseling especially about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
14 Patients allergic to penicillin should be treated with penicillin after desensitization.
15 Some experts recommend a second dose of 2.4 million units of Benzathine penicillin G administered 1 week after the initial dose.

STD Update (Continued from p. 7)

because they frequently have no symptoms, or symptoms that are very vague or confused with other disorders. A "silent" STD such as chlamydia can be unknowingly transmitted to partners, and can have major consequences in women when not diagnosed and treated—pelvic inflammatory disease, potentially fatal tubal pregnancy, infertility, and poor birth outcomes. Chlamydia and certain other STDs can also put patients at greater risk for acquiring and transmitting HIV.

What information is included in the guidelines?

The guidelines include diagnosis and treatment information for all common STDs, and are organized by syndrome—STDs characterized by genital ulcers, by urethritis and cervicitis, and by vaginal discharge. The guidelines also include recommendations for STD prevention, as well as special considerations for three high-risk populations—women, adolescents, and infants. Finally, the guidelines include sections on other problems that occur among patients with STDs—pelvic inflammatory disease, epididymitis, patients with penicillin allergy, sexual assault issues, and cervical cancer screening.

How many people are affected by STDs?

There are an estimated 12 million STD infections in the United States, with approximately 3 million of these occurring in teens. By the time they reach adulthood, one in four teens will have an STD, which may include herpes or HPV, two of the most common viral STDs for which there is no known cure.

How can providers receive a copy of the full guidelines or bulk copies for professional associations and managed care organizations?

Mail Order: Office of Communication, NCHSTP, Centers for Disease Control and Prevention, 1600 Clifton Rd, N.E., Mailstop E-06, Atlanta, CA 30333. *Fax Order:* (404) 639-8628. *Internet:* http://www.cdc.gov/nchstp/dstd/dstdp.html. A limited supply of camera-ready copies is available for printing.

Where can I find additional information?

Patient and consumer information is generally available from the local or state health department, community clinics for STDs, family planning or primary care centers, and from national hotlines: **STD Hotline:** 1-800-227-8922; **National Herpes Hotline:** 1-919-361-8488; **American Social Health Association:** http://sunsite.unc.edu/ASHA.

Professional information on STDs and training for clinical and behavioral management of STDs are available through the **National Network of STD/HIV Prevention Training Centers**, with 10 locations in health departments throughout the United States. For information on the center closest to you, call (404) 639-8360 or access course information at http//:129.137.232.101/STDPTC.html.

President's Report (Continued from p. 2)

Philippines will assist the Division in evaluating the level of medical education being offered in other countries and in developing appropriate, relevant standards for reviewing international medical schools.

✔ DIDO Program Update

The Health Quality Enforcement Section (HQES) of the Attorney General's Office provides deputy attorneys general who prosecute Medical Board cases. In January 1997 HQES began a pilot program with the Medical Board in which five Deputy A.G.s (DAGs) were assigned to five MBC district offices approximately two days per week. The purpose of this project, known as the Deputy in District Office (DIDO) Program, was to improve enforcement efficiency by enabling the Board's investigators and its attorneys to work more closely together.

The DAGs provide ongoing legal advice to MBC district office supervisors and field investigators. They are available to provide on-site legal services, including assisting in the preparation of investigative subpoenas, dealing with counsel representing prospective respondents during the investigative stages, and communicating with hospital legal staff regarding records requests. To reduce the time between case referral and case filing, the assigned DAGs also, to the extent possible, prepare the appropriate pleading.

As of July 1, all 12 Medical Board offices now have Deputy A.G.s assigned to them, with nine DAGs covering the 12 Medical Board offices. I am pleased to report that the DIDO Program has been extremely successful. The average AG filing time for cases referred under this program has been reduced more than 75%. Medical Board investigators and supervisors report increased efficiency of MBC investigations as a result of the on-site presence of DAGs. The increased efficiency and reduced filing times resulting from the DIDO Program are a very positive response to consumer and physician complaints about delays in the disciplinary process.

Congratulations!

At the May meeting of the Federation of State Medical Boards in Orlando, two members of the Medical Board were elected to leadership positions. Division of Medical Quality member Alan E. Shumacher, M.D. was elected President-Elect, and Division of Licensing President Bruce H. Hasenkamp, J.D. was re-elected for a third term as Treasurer. California's physicians will continue to be well represented at the national level on this prominent regulatory organization.

If you have an issue you would like addressed in future editions of the *Action Report*, please send your ideas to me c/o Medical Board of California, 1426 Howe Ave., #100, Sacramento, CA 95825.

State-Mandated Breast Cancer Treatment Booklet Now Available In Spanish

Essential for physicians who perform breast biopsies or treat breast cancer

The Spanish language version of the booklet, *"A Woman's Guide To Breast Cancer Diagnosis And Treatment,"* entitled *"Guía Para La Mujer Sobre El Diagnóstico Y El Tratamiento Del Cáncer Del Seno,"* will be released in July by the California Department of Health Services. The booklet is available through the Medical Board of California. Physicians are required by law (Health and Safety Code Section 109275, formerly Section 1704.5) to give the booklet to patients before they perform a biopsy or treatment, and to note receipt of it in the patient's chart.

Having this booklet in Spanish will assist health care providers when informing their patients of treatment options and will facilitate the decision-making process for Spanish-speaking women facing biopsy or treatment for breast cancer. The Spanish version includes the same information as the English version released in 1995 in a culturally appropriate format and incorporates multi-cultural illustrations. The booklet covers diagnostic and treatment options, including surgery, radiation, chemotherapy, hormonal therapy, complementary therapy, breast reconstruction, psychosocial information and other issues. Throughout the booklet are short lists of "questions to ask your doctor" designed to help facilitate patient/doctor communication during this traumatic time for the patient.

Response to release of the English version was overwhelmingly positive. Both patients and providers report that the booklet is easy to read, but thorough. It was extensively reviewed by oncologists, radiologists, breast surgeons, plastic surgeons, survivors/advocates, physical therapists, and psychosocial and literacy experts.

Physicians may order copies of the booklet by faxing their request to the Medical Board of California at (916) 263-2479 with the information listed below or by sending a written request to:

BREAST CANCER TREATMENT OPTIONS

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

Please specify number of copies (by bundles of 25), language (English or Spanish), and provide your return address. Booklets are available free of charge. Supplies may be limited.

Breast Cancer Treatment Options Booklet

Order Form

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825
or fax request to: (916) 263-2479

Physician name _____

Clinic or medical facility _____

Attention _____

Address _____

_____

Telephone _____

Number of bundles* (English) _____

Number of bundles* (Spanish) _____

**Bundles include 25 copies*

DISCIPLINARY ACTIONS: FEBRUARY 1, 1998 TO APRIL 30, 1998

Physicians and Surgeons

AINTABLIAN, IGHIA, M.D. (A42047) Glendale, CA
B&P Code §2234(c). Stipulated Decision. Failed to obtain a urine culture, failed to treat patient with antibiotics for a minimum of 72 hours, and failed to document a chest x-ray result for a patient undergoing a Cesarean section. Probation with terms and conditions. February 13, 1998

AL-BUSSAM, NAZAR, M.D. (A26479) Downey, CA
B&P Code §2234(b). Stipulated Decision. Gross negligence in the administration of medically unwarranted aggressive chemotherapy for 3 patients. Revoked, stayed, 3 years probation with terms and conditions. April 8, 1998

BERGER, PHIL ALAN, M.D. (G19375) Palo Alto, CA
B&P Code §2234(c). Stipulated Decision. Committed acts of repeated negligence by inappropriately prescribing dangerous drugs and controlled substances to several patients. Revoked, stayed, 5 years probation with terms and conditions. March 19, 1998

CHUANG, FRANCIS CHENHSIUNG, M.D. (A31779) Santa Ana, CA
B&P Code §§141, 2305. Disciplined by Maryland for failing to meet the standard of care in his administration of anesthesia. Revoked. April 10, 1998

COOKE, VIRGINIA ANN, M.D. (G71137) Dana Point, CA
B&P Code §2234(b)(c). Stipulated Decision. Committed acts of gross negligence and repeated negligence in care and treatment of 9 patients. Revoked, stayed, 3 years probation with terms and conditions. February 20, 1998

CURTIN, WILLIAM JAMES, M.D. (A24102) Modesto, CA
B&P Code §§726, 2234(b). Committed acts of sexual abuse on 2 patients while performing breast examinations. Revoked, stayed, 7 years probation with terms and conditions including 90 days actual suspension. March 30, 1998

DEPAULO, VINCENT J., M.D. (A12507) Atascadero, CA
B&P Code §§725, 2234(c). Stipulated Decision. Prescribed excessive amounts of controlled substances, Dilaudid, Compazine, Tenex, Phenergan, Morphine Sulfate, Restoril, Tylenol #4, Vicodin, Demerol, Percocet, Darvocet, Diazepam, and others to 2 patients. Revoked, stayed, 5 years probation with terms and conditions. April 9, 1998

DONAT, PETER CHARLES, M.D. (A26192) Laguna Hills, CA
B&P Code §2238, H&S Code §§11153, 11371. Stipulated Decision. Criminal conviction for writing false prescriptions to obtain controlled substances, Lortab and hydrocodone, for his own use. Revoked, stayed, 7 years probation with terms and conditions. February 9, 1998

FARAG, SAMY SHOUKRY, M.D. (A25821) Los Angeles, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with sexually abusing several patients. Revoked, stayed, 5 years probation with terms and conditions. April 3, 1998

Explanation of Disciplinary Language and Actions

"Effective date of Decision"— Example: "December 29, 1997" at the bottom of the summary means the date the disciplinary decision goes into operation.

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

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

"Judicial review being pursued"— The disciplinary decision is being challenged through the court system—Superior Court, maybe Court of Appeal, maybe State Supreme Court. The discipline is currently in effect.

"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.

"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.

"Public Letter of Reprimand"—A lesser form of discipline that can be negotiated for minor violations before the filing of formal charges (accusations). The licensee is disciplined in the form of a public letter.

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

"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.

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

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

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

"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).

FLANNIGAN, FREDRIC C., M.D. (C22542) San Marino, CA
B&P Code §2234. Stipulated Decision. Failed to diagnose and follow up on a cancerous breast mass. Revoked, stayed, 1 year probation with terms and conditions. March 13, 1998

FREEMAN, DAVID C., M.D. (C22763) North Hollywood, CA
B&P Code §2225.5. Stipulated Decision. Failed to comply with a request by a patient and the Board's enforcement staff for copies of the patient's medical records when presented with the patient's written authorization for release of records to the Board. Revoked, stayed, 2 years probation with terms and conditions added to existing 5 year probation. April 9, 1998

GEE, STEVEN H., M.D. (C20869) San Leandro, CA
B&P Code §2234(c)(d). Stipulated Decision. No admissions but charged with prescribing potentially toxic medication, theophylline, for 3 years to a patient without adequate history, physical examination, medical knowledge and appropriate testing; prescribing a controlled substance, xanax, to a patient without clear medical indication; and failed an oral competency examination given by the Board. Revoked, stayed, 5 years probation with terms and conditions. March 12, 1998

HAN, IN KYO, M.D. (A36080) Claremont, CA
B&P Code §2236. Convicted of grand theft and presenting false Medi-Cal claims. Revoked. April 9, 1998

HARBAUGH, ROBERT DWIGHT, M.D. (G48884) Santa Barbara, CA
B&P Code §2234(b). Stipulated Decision. Prescribed narcotic analgesics, hydrocodone, fentanyl and temazepam, to a patient over a nine-month period without adequate monitoring. One year suspension, stayed, 5 years probation with terms and conditions. March 6, 1998

HARMUTH, CHARLES ROBERT, M.D. (G42780) Columbia, TN
B&P Code §141(a). Disciplined by Tennessee for use and self-prescription of controlled substances, fraud and misrepresentation in gaining the drugs, and practicing while impaired by alcohol or drugs. Revoked, stayed, 5 years probation with terms and conditions. February 20, 1998

HATHAWAY, GARY F., M.D. (A28608) Torrance, CA
B&P Code §2234(c). Stipulated Decision. Failed to record in a patient's medical record, for whom he had surgically removed shave and excisional biopsies of a cancerous neck lesion, what, if anything, he did to determine the extent of the carcinoma. Revoked, stayed, 2 years probation with terms and conditions. February 19, 1998

HEIKOFF, LISA ELLEN, M.D. (G42782) San Diego, CA
B&P Code §2234. Stipulated Decision. Treated a patient for pneumocystis carinii pneumonia when it turned out the patient did not have that condition. Public Reprimand. March 31, 1998

HERMAN, PETER A., M.D. (C41304) New York, NY
B&P Code §§725, 2234(e). Performed doppler testing of asymptomatic senior citizens that was excessive, unwarranted and unnecessary, and fraudulently billed Medicare for these tests. Revoked. March 27, 1998. Judicial review being pursued.

HICKS, OBIE JOHN, M.D. (G30051) Los Angeles, CA
B&P Code §§2234(a), 2264, 2415. Stipulated Decision. Allowed an unlicensed person to treat patients at his clinic, and operated a clinic using a fictitious name without obtaining a permit from the Board. Revoked, stayed, 2 years probation with terms and conditions. February 20, 1998

HIRSCH, NEIL RICHARD, M.D. (G31451) Las Vegas, NV
B&P Code §141(a). Disciplined by Illinois based on a felony conviction in Arizona for fraudulent schemes and practices, willful concealment, and facilitation of theft. Revoked, stayed, 3 years probation with terms and conditions. April 3, 1998

HYDE, ROBERT L., M.D. (G8979) Lower Lake, CA
B&P Code §141(a). Disciplined by Arizona for unprofessional conduct, gross negligence, and repeated acts of negligence in the treatment of 1 patient, and failing or refusing to maintain adequate medical records on a patient. Revoked, stayed, 5 years probation with terms and conditions. April 10, 1998

IWAOKA, D. H., M.D. (GFE63448) Portsmouth, VA
B&P Code §2234. Stipulated Decision. Disciplined by the U.S. Navy for creating a false official record by electronically signing a computer-generated prescription. Public Letter of Reprimand. February 25, 1998

JANARDHAN, HARKALA, M.D. (A36754) Los Angeles, CA
B&P Code §726. Stipulated Decision. Inappropriately touched the breasts of a female patient during an examination. Public Reprimand. April 22, 1998

JONES, MILTON R., Jr., M.D. (AFE19314) Lone Pine, CA
B&P Code §822. Stipulated Decision. Mental impairment affecting ability to practice medicine safely. Revoked, stayed, 1 year probation with terms and conditions including 1 year actual suspension. March 27, 1998

KAZMI, MOHAMMAD A., M.D. (A41156) Lake Havasu City, AZ
B&P Code §§141(a), 2234. Stipulated Decision. Disciplined by Arizona for unprofessional conduct for violating a prior order entered into with the Arizona Medical Board. Public Letter of Reprimand. April 17, 1998

KRAMER, JAMES JOSEPH, M.D. (G37961) Jackson, MS
B&P Code §141(a). Submitted an altered certificate of completion to the Mississippi Board of Medical Licensure, while on probation to that Board for a chemical dependence problem, indicating his having completed 20 hours in a course on the ethical issues of drug prescribing when in fact he had only completed 13 hours. Revoked. February 13, 1998

LEADER, WILLIAM OCALLAGHAN, M.D. (A41125) Los Angeles, CA
B&P Code §2234. Stipulated Decision. Inappropriately accompanied a former patient to a restaurant on 1 or 2 occasions. Public Letter of Reprimand. November 20, 1997

MELKONIAN, SUZY, M.D. (G83152) Van Nuys, CA
B&P Code §§498, 2235. Stipulated Decision. Failed to disclose on her March 28, 1996 application for licensure in California a 1981 foreign-nation conviction. Public Reprimand. February 2, 1998

MENDOZA, DORA, M.D. (A31103) Los Angeles, CA
B&P Code §§2234(e), 2261. Stipulated Decision. Failed to disclose in a hospital reapplication that she had 4 pending civil lawsuits for medical malpractice and that her hospital privileges had been previously suspended. Revoked, stayed, 1 year probation with terms and conditions. February 23, 1998

MORRAY, JOHN ROBERT GAHA, M.D. (G40495) Flora, IL
B&P Code §§2234, 2234(e)(f), 2236, 2238, 2239, 2354. Violated terms and conditions of Board probation by self-administration and self-use of amphetamine and methamphetamine on 2 occasions, failed to successfully complete the Board's Diversion Program, and criminal conviction for petty theft. Revoked. February 13, 1998

NOVICK, JAMES STEPHEN, M.D. (C36874) Glendale, CA
B&P Code §§2234(c), 2236, 2239. Stipulated Decision. Failed to properly examine and treat a patient who had a history of alcoholism and heart disease, criminal conviction for drunk driving, and use of alcohol to the extent that his ability to practice medicine safely was impaired. Revoked, stayed, 3 years probation with terms and conditions. April 2, 1998

PARK, JOHN H., M.D. (G19634) Buffalo, NY
B&P Code §§2234, 2305. Stipulated Decision. Disciplined by New York for incompetent care provided while practicing as an ophthalmologist. Revoked, stayed, 5 years probation with terms and conditions. April 30, 1998

PARTRIDGE, LINDA JEAN, M.D. (G55872) Palmdale, CA
B&P Code §§2234(b)(c), 2261. Failed to see or examine a patient with a family history of breast cancer who had a lump in her breast, but instead allowed the patient to be seen by a student nurse practitioner. Made a false entry in the patient's medical record that prophylactic mastectomy had been discussed when no discussion occurred and she did not even see the patient on the date in question. Revoked. March 12, 1998

PRABHAKAR, ARUDI L., M.D. (A31627) Chula Vista, CA
B&P Code §2234(c). Stipulated Decision. Failed to diagnose a patient's cystic stump leak in a timely manner. Revoked, stayed, 3 years probation with terms and conditions. April 10, 1998

PRAKASAM, FELIX KELLY, M.D. (A37087) Loma Linda, CA
B&P Code §2234. Stipulated Decision. Improper supervision of a physician's assistant; allowed his physician's assistant to prescribe or dispense drugs when he was not present without a patient specific order or on written protocol; failed to maintain complete and accurate controlled substance records and/or inventories; and failed to provide adequate security by storing controlled substances in an area accessible to unauthorized or unsupervised individuals. Revoked, stayed, 3 years probation with terms and conditions. March 13, 1998

RIVERO, EVELYN C., M.D. (A37002) Los Angeles, CA
B&P Code §2236. Stipulated Decision. Felony criminal conviction for income tax evasion. Revoked, stayed, 3 years probation with terms and conditions. March 12, 1998

SHORE, EDWARD G., M.D. (G7953) Sherman Oaks, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with improper and inappropriate touching and sexual misconduct with 5 female patients. Revoked, stayed, 3 years probation with terms and conditions. April 27, 1998

SHUBHAKAR, S. N., M.D. (A33936) Porterville, CA
B&P Code §2234(e). Stipulated Decision. Violated terms and conditions of Board probation. Two additional years added to current 7 years of probation with additional terms and conditions. February 4, 1998

SIEW, VICTOR BOON HUAT, M.D. (G32104) Fountain Valley, CA
B&P Code §§2234(a), 2264. Stipulated Decision. No admissions but charged with aiding and abetting the unlicensed practice of medicine. Public Reprimand. February 18, 1998

STOLL, LEONARD H., M.D. (A27615) Torrance, CA
B&P Code §§2234, 2266. Stipulated Decision. Failed to maintain adequate and accurate medical records for 1 patient being treated for obesity. Public Letter of Reprimand. April 23, 1998

STOLL, SEYMOUR MARTIN, M.D. (A35055) Torrance, CA
B&P Code §§2234, 2266. Stipulated Decision. Failed to maintain adequate and accurate medical records for 1 patient being treated for obesity. Public Letter of Reprimand. April 23, 1998

STOUGHTON, NED STANLEY, M.D. (G34753) Albuquerque, NM
B&P Code §141(a). Stipulated Decision. Disciplined by New Mexico for failing to reveal history of psychiatric illness on his application for licensure. Public Letter of Reprimand. April 7, 1998

VERBRUGGE, JOSEPH JAMES, M.D. (C34826) Englewood, CO
B&P Code §§141(a), 2234, 2236, 2305. Disciplined by Colorado based on his criminal conviction for criminal medical negligence. Revoked. April 27, 1998

VICARY, WILLIAM TICE, M.D. (G30952) Los Angeles, CA
B&P Code §2261. Stipulated Decision. Falsified the medical records of a patient. Revoked, stayed, 3 years probation with terms and conditions. April 10, 1998

WELLER, WILLIAM J., M.D. (G13938)
Colorado Springs, CO
B&P Code §§141(a), 2234. Stipulated Decision. Disciplined by Colorado for failing to note in a patient's chart a diagnosis of an infiltrate in her upper left lung. Public Letter of Reprimand. April 9, 1998

WILLIAMS, NOEL A., M.D. (A18629) Walnut Creek, CA
B&P Code §§802.1, 2234. Failed to comply with terms and conditions of Board probation, and failed to notify Board of felony conviction. Revoked. March 3, 1998

WODKA, RICHARD MARK, M.D. (A44022) Marana, AZ
B&P Code §141(a). Disciplined by Arizona due to mental illness affecting his ability to practice medicine safely. Revoked. February 17, 1998

YAP, WILLIAM LOY, M.D. (A42467) Ellicott, MD
B&P Code §141(a). Stipulated Decision. Disciplined by Maryland for failure to meet the standard of care in his treatment of 12 patients. Public Reprimand. March 27, 1998

DOCTORS OF PODIATRIC MEDICINE

ANDREWS, WILLIAM CLARENCE, D.P.M. (E2294)
Eureka, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence and incompetence in his post-operative care of a patient who had undergone a bunionectomy. Revoked, stayed, 1 year probation with terms and conditions. March 12, 1998

LEVI, MICHAEL JEFFRY, D.P.M. (E3574)
Santa Monica, CA
B&P Code §2234. Stipulated Decision. Failed to adequately document informed consent for a joint implant procedure. Public Reprimand. February 6, 1998

PHYSICIAN ASSISTANT

HARKINS, ROBERT L., P.A. (PA13553) Palm Springs, CA
B&P Code §§490, 2054, 2234, 3527, 3531. Stipulated Decision. Falsely represented himself as a physician and surgeon and a nurse practitioner, and was criminally convicted of a misdemeanor charge of false representation as a physician. Revoked, stayed, 3 years probation with terms and conditions. March 30, 1998

SURRENDER OF LICENSE WHILE CHARGES PENDING

PHYSICIANS AND SURGEONS

ALWAY, PAUL ROLAND, M.D. (G47415) Alameda, CA
March 9, 1998

ARAM, DAVAR, M.D. (A46392) Chino Hills, CA
April 28, 1998

BERENSON, DAVID J., M.D. (G47556) Sausalito, CA
March 25, 1998

COLFER, HARRY F., M.D. (C29694) San Francisco, CA
Decision effective April 23, 1998. License will be surrendered 120 days after effective date.

CROSLIN, MICHAEL LARRY, M.D. (G66388)
Santa Cruz, CA
February 26, 1998

DEWBERRY, ROBERT W., M.D. (A28782) Los Angeles, CA
March 11, 1998

FORGEY, BURNELL G., M.D. (AFE10602)
Newport Beach, CA
February 9, 1998

JOHNSON, RICHARD A., M.D. (G48466)
Ft. Lauderdale, FL
March 11, 1998

LEVIN, ROGER MASON, M.D. (G23521) Palo Alto, CA
March 11, 1998

LURIE, JEROME L., M.D. (G5987) New Rochelle, NY
April 14, 1998

MILLER, MALCOLM GEORGE, M.D. (A32853)
Santa Ana, CA
April 1, 1998

PERALTA, MODESTO GUTIERREZ, M.D. (C39326)
West Sacramento, CA
Surrender in lieu of filing an accusation. April 28, 1998

ROHLFING, WALTER ALFRED III, M.D. (C33659)
Oakland, CA
February 25, 1998

SNYDER, LAWRENCE KENNETH, M.D. (G17319)
Berkeley, CA
February 25, 1998

SU, NINA NING, M.D. (G35511) La Jolla, CA
February 10, 1998

TORRES, NORBERTO PANOPIO, M.D. (A23635)
Villa Park, CA
March 4, 1998

WEST, MARIQUITA, M.D. (A20773) Los Gatos, CA
March 10, 1998

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Candis Cohen, Editor, (916) 263-2389

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STD TREATMENT GUIDELINES FOR ADULTS AND ADOLESCENTS

These guidelines for the treatment of patients with STDs reflect the 1998 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens. To report STD infections; request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients, call the County Health Department. The California STD/HIV Prevention Training Center is an additional resource for training and consultation in the area of STD clinical management and prevention (510-883-6600).

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
CHLAMYDIA			
Uncomplicated Infections Adults/Adolescents[1]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Ofloxacin[3] 300 mg po bid x 7 d
Pregnant Women[4]	• Amoxicillin **or** • Azithromycin **or** • Erythromycin base	500 mg po tid x 7 d 1 g po 500 mg po qid x 7 d	Erythromycin base 250 mg po qid x 14 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Erythromycin ethylsuccinate 400 mg po qid x 14 d
GONORRHEA[5]			
Uncomplicated Infections Adults/Adolescents	• Cefixime[6] **or** • Ceftriaxone **or** • Ciprofloxacin[3] **or** • Ofloxacin[3] **plus**[5] • a chlamydia recommended regimen listed above	400 mg po 125 mg IM 500 mg po 400 mg po	Spectinomycin[7] 2 g IM **plus**[5] a chlamydia recommended regimen
Pregnant Women	• Ceftriaxone **or** • Cefixime[6] **plus**[5] • a chlamydia recommended regimen listed above	125 mg IM 400 mg po	Spectinomycin[7] 2 g IM **plus**[5] a chlamydia recommended regimen
PELVIC INFLAMMATORY DISEASE	**Parenteral**[8] • Cefotetan or Cefoxitin **plus** Doxycycline[2] **or** • Clindamycin **plus** Gentamicin **Oral Treatment** • Ofloxacin[3] **plus** Metronidazole **or** • Ceftriaxone or Cefoxitin **and** Probenecid **plus** Doxycycline[2]	 2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po or IM q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs 400 mg po bid x 14 d 500 mg po bid x 14 d 250 mg IM 2 g IM 1 g po 100 mg po bid x 14 d	**Parenteral** Ofloxacin[3] 400 mg IV q 12 hrs **plus** Metronidazole 500 mg IV q 8 hrs **or** Ampicillin/Sulbactam 3 g IV q 6 hrs **plus** Doxycycline[2] 100 mg po or IV q 12 hrs **or** Ciprofloxacin[3] 200 mg IV q 12 hrs **plus** Doxycycline[2] 100 mg po or IV q 12 hrs **plus** Metronidazole 500 mg IV q 8 hrs
MUCOPURULENT CERVICITIS[9]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Ofloxacin[3] 300 mg po bid x 7 d
NONGONOCOCCAL URETHRITIS[9]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	Erythromycin base 500 mg po qid x 7 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Ofloxacin[3] 300 mg po bid x 7 d
EPIDIDYMITIS	Likely due to Gonorrhea or Chlamydia • Ceftriaxone **plus** Doxycycline Likely due to enteric organisms • Ofloxacin[3]	 250 mg IM 100 mg po bid x 10 d 300 mg po bid x 10 d	
TRICHOMONIASIS	• Metronidazole	2 g po	Metronidazole 500 mg po bid x 7 d
BACTERIAL VAGINOSIS			
Adults/Adolescents	• Metronidazole **or** • Clindamycin cream[10] **or** • Metronidazole gel	500 mg po bid x 7 d 2%, one full applicator (5g) intravaginally at bedtime x 7 d 0.75%, one full applicator (5g) intravaginally, bid x 5 d	Metronidazole 2 g po **or** Clindamycin 300 mg po bid x 7 d
Pregnant Women	• Metronidazole	250 mg po tid x 7 d	Metronidazole 2 g po **or** Clindamycin 300 mg po bid x 7 d
CHANCROID	• Azithromycin **or** • Ceftriaxone **or** • Ciprofloxacin[3] **or** • Erythromycin base	1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po qid x 7 d	
LYMPHOGRANULOMA VENEREUM	• Doxycycline[2]	100 mg po bid x 21 d	Erythromycin base 500 mg po qid x 21 d

1 Screen adolescents annually and women 20-24 years, especially if new or multiple partners.
2 Contraindicated for pregnant and nursing women.
3 Contraindicated for pregnant and nursing women and children < 18 years of age.
4 Test-of-cure follow-up is recommended because the regimens are not highly efficacious (Amoxicillin and Erythromycin) or the data on safety and efficacy are limited (Azithromycin)
5 Co-treatment for chlamydia infection is indicated if co-infection rates are high (>20%), less sensitive or no chlamydia test is done, or follow-up is uncertain.
6 Not recommended for pharyngeal gonococcal infection.
7 For patients who cannot tolerate cephalosporins or quinolones; not recommended for pharyngeal gonococcal infection.
8 Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total course of 14 days.
9 Testing for gonorrhea and chlamydia is recommended beause a specific diagnosis may improve compliance and partner management and these infections are reportable by CA State Law.
10 Might weaken latex condoms and diaphragms because oil-based; not recommended in pregnancy.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
HUMAN PAPILLOMAVIRUS			
External Genital/ Perianal Warts	**Patient Applied** • Podofilox[11] 0.5% solution or gel **or** • Imiquimod[12] 5% cream **Provider Administered** • Cryotherapy **or** • Podophyllin[11] resin 10%-25% in tincture of benzoin **or** • Trichloroacetic acid (TCA) or Bichloroacetic acid (BCA) 80%-90% **or** • Surgical removal		**Alternative Regimen** Intralesional interferon or laser surgery
Vaginal Warts	• Cryotherapy **or** • TCA or BCA 80%-90% **or** • Podophyllin[11] 10%-25% in tincture of benzoin		
Urethral Meatus Warts	• Cryotherapy **or** • Podophyllin[11] 10%-25% in tincture of benzoin		
Anal Warts	• Cryotherapy **or** • TCA or BCA 80%-90% **or** • Surgical removal		
HERPES SIMPLEX VIRUS[13]			
First Clinical Episode of Herpes	• Acyclovir[12] **or** • Acyclovir[12] **or** • Famciclovir[12] **or** • Valacyclovir[12]	400 mg po tid x 7-10 d 200 mg po 5 x q d x 7-10 d 250 mg po tid x 7-10 d 1 g po bid x 7-10 d	
Episodic Therapy for Recurrent Episodes	• Acyclovir[12] **or** • Acyclovir[12] **or** • Acyclovir[12] **or** • Famciclovir[12] **or** • Valacyclovir[12]	400 mg po tid x 5 d 200 mg po 5 x q d x 5 d 800 mg po bid x 5 d 125 mg bid x 5 d 500 mg po bid x 5 d	
Supressive Therapy	• Acyclovir[12] **or** • Famciclovir[12] **or** • Valacyclovir[12] **or** • Valacyclovir[12]	400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd	
SYPHILIS			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	Doxycycline[2] 100 mg po bid x 2 weeks **or** Tetracycline[2] 500 mg po qid x 2 weeks
Late Latent and Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	Doxycycline[2] 100 mg po bid x 4 weeks **or** Tetracycline[2] 500 mg po qid x 4 weeks
Neurosyphilis[14]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM q d x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d
Pregnant Women[14]			
Primary, Secondary, and Early Latent[15]	• Benzathine penicillin G	2.4 million units IM	None
Late Latent and Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None
Neurosyphilis[14]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM q d x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d
HIV Infection			
Primary, Secondary and Early Latent	• Benzathine penicillin G	2.4 million units IM	Doxycycline[2] 100 mg po bid x 2 weeks **or** Tetracycline[2] 500 mg po qid x 2 weeks
Late Latent, and Unknown duration[14] **with normal CSF Exam**	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None
Neurosyphilis[14]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	Procaine penicillin G, 2.4 million units IM q d x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d

11 Contraindicated during pregnancy.
12 Safety in pregnancy has not been established.
13 Counseling especially about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
14 Patients allergic to penicillin should be treated with penicillin after desensitization.
15 Some experts recommend a second dose of 2.4 million units of Benzathine penicillin G administered 1 week after the initial dose.