

# Action Report

## Medical Board of California

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### Medical Board of California Meeting Dates & Locations

2001

July 26 - 28 San Francisco

Nov. 1 - 3 San Diego

All meetings are open  
to the public.

## Physician Licensing: A Status Report

By Ron Joseph, Executive Director

The Medical Board of California is acutely aware of the importance of issuing physicians and surgeons licenses in a timely and competent manner. It is important to physicians and patients alike that qualified applicants are licensed to practice as soon as their education and training allow. The Medical Board is also aware that the process by which this is accomplished has experienced delays in recent months that have resulted in this standard being unmet in too many instances.

While the first half of the calendar year is always a period in which the pace of license processing is hectic, this year the Board has encountered a significant increase in the number of applications submitted, and those applications, on average, have had issues vastly more complex than has been the case in previous years.

Other reasons for delay are, regrettably, found within the Medical Board itself. In the past year there has been a considerable turnover of trained staff that, with hindsight, the Medical Board should have been prepared to replace in sufficient time to address workload more promptly. Additionally, some operational streamlining that had been previously identified was not implemented in time to assist with this year's heaviest workload period.

Indeed, the reasons for the period of time it has taken to issue licenses are many, some external to the Board's control, some internal. Unfortunately, that has resulted in process delays which have created hardship for individual physicians, residency programs, medical practices, and, ultimately, patients.

Nonetheless, the measure of an organization is fairly taken by the manner in which it responds to the challenges it faces. The Medical Board staff is committed to, and has already begun to address, its licensing process and operations to assure both early and permanent resolution of licensure delays. I want to take this opportunity to present those steps that are currently being taken, consistent with this commitment.

At the present time, all available trained staff have been dedicated to the processing of pending license applications. That staff is working overtime to process applications for those needing licensure to continue or begin training on July 1, along with those needed to fill positions in underserved areas or understaffed programs.

Additionally, the review process has been streamlined to limit, to the extent possible, time-consuming exchanges of additional information between the applicant and the program.

More important, in an effort to make sure that delays experienced this year are not repeated in the future, the Board has been working with an outside consultant on an in-depth assessment of the licensing process. This review, which began in April, was designed to identify improved processing modalities and establish system and resource requirements to assure the Licensing Program's ability to more effectively react to workload trends.

Once the findings of this study have been evaluated and approved for adoption by the Medical Board, they will be implemented to ensure future operational efficiency.

In summary, the Medical Board of California recognizes the importance of its commitment to physician licensure; it realizes that the experiences of the current year are inadequate to serve the profession and the public and it asserts its solemn commitment to a future system of utmost efficiency and responsiveness to the pool of license applicants.

As the Medical Board of California pursues this goal, I welcome any comments or suggestions, which can be sent directly to me at [rjoseph@medbd.ca.gov](mailto:rjoseph@medbd.ca.gov). I will respond to every communication as soon as practicable.

### 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

As a physician member of the Medical Board of California, I am continually aware of my role as participant in both the "regulator" and "regulated" class. Since there are relatively few of us with both monikers, we have a tacit responsibility, indeed obligation, to be as communicative and informative as possible with the large majority of the 300 Board employees whose perspective is that solely of the former group. This is in addition to representing the necessity and value of regulation to the community of licensed physicians. As an aside, I would say the circumspection provided in wearing both hats is beneficial, although understandably schizoid. IRS agents are still required to pay income tax. As Board President, my initial effort to act on the above theme was to address and engage in dialogue with California's core of Board investigators at a statewide conference in Sacramento the first week in June. I spoke of my intent to enhance two-way communication between our Board components and of the uniqueness of duality of perspective held by a regulator who is also regulated, a vantage point they could not have. I found the investigators to openly welcome this exchange, to be serious and professionally engaged in the work at hand, and, as in any group (including the regulated), to exhibit a normal cross section of traits we call humanity.

I began my formal remarks relating an incident that had actually occurred in my office a few days prior to the conference. It was to illustrate the profound impact the presence of an investigator from the Medical Board has on a practicing physician. As background, I confessed to a few personality traits, and proffered they might be shared by a healthy number of my colleagues. These specifically were that I tended to trust people, was risk-averse to the extent that I could be given the inherent risk of my duties, and possessed what I've come to refer to as a "healthy paranoia." The incident involved Mr. Dave Thornton, Chief of Enforcement for the Medical Board, being seated in the waiting room of my office, (we had a scheduled meeting on Board business). Two patients having post-operative visits and some family members were also in the room. I greeted Mr. Thornton and introduced him to one of the patients (who happened to be a close friend of mine), including his job title. Concerned expressions immediately appeared on all faces in the room (except Dave's and mine), and the silence was finally broken by a question from the other patient: "Is everything all right, Dr. Alpert?" I could only imagine my emotions under different circumstances.

I conveyed to the state's investigators that as regulators we could not ignore and indeed must have a keen awareness of the



*Bernard S. Alpert, M.D.*  
*President of the Board*

environment in which the regulated work. The magnitude of relatively recent change in this landscape has been colossal by all measures, and it is the direct charge of the Medical Board to filter all such phenomena through the lens of public safety. Therefore, it is our business. The inversion of incentives and resultant paradoxes created by various prospective payment systems and layered structures of the managed care environment have created palpable trends in the licensed M.D. population that warrant concern. Estimates exist that up to 80% of physicians will experience the occupational stress syndrome known as "burnout," felt by experts to be a measure of institutional dysfunction.

Surveys routinely indicate large numbers of practicing M.D.s discourage their children from entering medicine as a profession. I suggested to the investigators that ours is the first generation of American physicians where this has been observed. This saddens me. I specifically maintained that our licensee pool was one of society's most valuable human resource groups, and that the energy-depleting forces currently operating on the profession are counter-productive when our collective goal should be the raising of standards. It also seems to me that the public has not yet connected these dots to the extent that it is in their power to effect meaningful change.

Finally, I shared with the conferees my views on our Board's disciplinary goals. As a framework I invoked the consumer advocacy group Public Citizen's rating scale for state medical boards, published annually. This system ranks boards from 1 to 50 based on numbers of disciplinary cases, thereby assuring a given board a high standing if it exhibits an abundance of license actions. I postulated that a board consistently at the top of the charts can be there only by one of two mechanisms, both of which, paradoxically in light of the ranking, reflect poorly on the state: There must either be an inordinate number of problematic physicians, not a good situation, or an inappropriate overutilization of license action, also quite unsatisfactory. A state board ranked number 50 can be there only by having extremely few licensees with difficulties, a good thing and noble aspiration, or by inappropriate underutilization of discipline, an undesirable setting. The proper numbers and extent of disciplinary action for which to strive should be appropriate, fair, and hopefully low, reflecting a state where the standards of professional conduct are exemplary and adhered to.

*(Continued on page 6)*

# New Deputy Director for Medical Board

The Medical Board of California is pleased to announce the appointment of Joyce E. Hadnot as Deputy Executive Director. As Deputy Director and Chief Operating Officer of the Board, Ms. Hadnot is responsible for overseeing the efficient daily operations of the organization and the delivery of program services to the consumers and physicians of the state of California. She will work closely with the Board to ensure effective planning and implementation of its policies into program operations.

Ms. Hadnot has 18 years of state service including management assignments at the Department of Alcohol and Drug Programs, California Conservation Corps, Department of Transportation, Department of Industrial Relations, and the Department of Corrections. Her experience ranges from managing administrative and program functions to facilitating the development and implementation of strategic plans and performance management systems at the Department of



*Joyce E. Hadnot*

Transportation and California Conservation Corps. Ms. Hadnot has managed several pilot projects, which include California's participation in a national study to develop and implement an outcome-monitoring system for the substance-abuse-treatment community; and the state's Performance-Based Budgeting model. In addition, Ms. Hadnot's leadership skills include providing fiscal oversight and direction for the Drug Medi-Cal program which administered approximately \$46 million in local assistance to counties and direct providers. Ms. Hadnot serves as Vice-Chairperson on the Antelope Community Planning Advisory Council which advises the

Sacramento County Board of Supervisors on projects planned for the community based on constituency input. Ms. Hadnot is also the Vice-President of the Sacramento Chapter of the National Forum of Black Public Administrators, where she has primary responsibility for program development. She received her bachelor's degree in Government from California State University, Sacramento, with an emphasis in Accounting.

## 2001-2002 Medical Board Officers

### At its last meeting in May, the Medical Board elected new officers:

*President:* Bernard S. Alpert, M.D.  
*Vice President:* Gary Gitnick, M.D.  
*Secretary:* Hazem. H. Chehabi, M.D.

### Division of Licensing:

*President:* Gary Gitnick, M.D.  
*Vice President:* Mitchell S. Karlan, M.D.  
*Secretary:* James A. Bolton, Ph.D.

### Division of Medical Quality:

*President:* Hazem H. Chehabi, M.D.  
*Vice President:* Rudy Bermúdez  
*Secretary:* Lorie G. Rice, M.P.H.

# Medical Board Hires New Staff Counsel

The Medical Board recently hired Nancy Vedera as Staff Counsel. In her new position, Ms. Vedera will advise the Board and its staff on the complex and sensitive legal issues facing the Board, including those high-profile, legal problems with the greatest medical policy impact on the public and the Board's licensees.

She conducts research and provides legal advice to Board members and staff on licensing and disciplinary matters and resolves regulatory issues, responds to inquiries from legislators and other state agencies on a multitude of Medical Board issues, and provides litigation assistance to the Attorney General's



*Nancy Vedera*

Office relative to cases involving the Medical Practice Act.

After graduating from Santa Clara University School of Law, Ms. Vedera worked with the law firm of Heller, Ehrman, McAuliffe and White in San Francisco, with her primary assignment being asbestos insurance coverage litigation.

Ms. Vedera began her state service career in 1987 with the Department of Corporations where she gained experience in the regulation of health care service plans under the Knox-Keene Act. Before joining the Medical Board, Ms.

Vedera worked at the Secretary of State's Office, where she was lead counsel for reviewing corporate merger transactions.

# Governor Davis Names Medical Board Members

Governor Gray Davis recently announced the appointments of Steve Alexander and Linda Lucks to the Medical Board's Division of Medical Quality.

Mr. Alexander, of La Jolla, brings to this position his extensive experience on public and private boards and committees, having worked in the field of communications, public affairs and healthcare. He is founder and President of the Steve Alexander Group, Ltd., which specializes in community affairs, facilitation and marketing communications programs.

Mr. Alexander was formerly Regional Director of Burson-Marsteller San Diego, where he directed projects for QUALCOMM relating to their consumer products and corporate image. Mr. Alexander was Vice President at Stoorza, Ziegus & Metzger, Incorporated, managing the public affairs team for California's largest independently owned public relations firm. He now is the lead communications strategist for Scripps Healthcare, The Nature Conservancy, Alliance Healthcare Foundation and De Anza Development Corporation.

He served as Chair of the State Board of Behavioral Sciences and chaired the Mission Bay Committee as Commissioner for the City of San Diego Park & Recreation Board. Mr. Alexander earned a bachelor of arts degree from Merrimack College, and a master of arts degree from the U.S. International University.

Ms. Lucks, of Venice, a former elementary school teacher, is the former Principal and Owner of a community relations firm, Linda Lucks Associates, specializing in creating and managing special projects for non-profit organizations. She is the founder and Partner of the Los Angeles Resource Connection, an education reform organization that links social and health services with low-income students and families in the inner city schools to improve educational outcomes.

Ms. Lucks serves on several organizational boards, including the Friends of the City of Los Angeles, Commission on the Status of Women, Families in New Directions, and she formerly served with Boards of the Neighborhood Youth Association. She served for three years on the Legal Services Trust Fund Commission of the State Bar of California. In 1998, she was elected as the Chair of the Los Angeles County Beach Commission.

Ms. Lucks served as manager of public relations for the Olympic Torch Relay for the Los Angeles Olympic Organizing Committee. She also co-chaired an awards program for the NOW Legal Defense and Education Fund.

Ms. Lucks has nine years of experience serving on the Board of Psychology and two years on the Board of Dental Examiners. She earned a bachelor of arts degree from the University of California, Los Angeles.

## *Patients Provided With Warm-Weather Energy Information*

The medical community, patients and all Californians will be facing an energy challenge this summer. Rolling blackouts can present special health challenges. In light of this situation, the Department of Consumer Affairs has been reaching out to state residents with energy conservation messages targeted to those who may have special needs related to their medical condition.

One of the resources is a flier titled "Consumer Tips for Energy Emergencies." Your patients may receive this information from other sources, or you may wish to share it directly with patients.

The flier is available online at [www.dca.ca.gov](http://www.dca.ca.gov).



1-866-YOUR-PWR  
(1-866-968-7797)

[www.flexyourpower.ca.gov](http://www.flexyourpower.ca.gov)

## **Reminder: Provision of Prostate Cancer Information Mandatory if ...**

Business and Professions Code section 2248, known as the Grant H. Kenyon Prostate Cancer Detection Act, requires physicians who examine a patient's prostate gland to provide information to the patient about the availability of appropriate diagnostic procedures, including, but not limited to, the prostate antigen (PSA) test, if any of the following conditions are present:

1. The patient is over 50 years of age.
2. The patient manifests clinical symptomatology.
3. The patient is at an increased risk of prostate cancer.
4. The provision of the information to the patient is medically necessary, in the opinion of the physician.

Compliance with this law may be attained by giving the patient a copy of the National Cancer Institute's booklet, "What You Need To Know About Prostate Cancer," available in bundles of 25 at no charge through the Medical Board of California. Please fax your order to: (916) 263-2479.

This booklet also is available on the Board's Web site: [www.medbd.ca.gov](http://www.medbd.ca.gov), Forms and Publications, On-line Publications.



## Athletic Commission Issues Call for Advisory Committee Members

The Medical Advisory Committee to the California State Athletic Commission (Commission) was established in 1986 to provide technical medical assistance due to the nature of the injuries suffered by boxers and martial arts fighters.

The Medical Advisory Committee (Committee) needs qualified physicians and surgeons who are interested in becoming a member of this Committee. The Committee consists of six licensed medical doctors. Each appointment is for a term not to exceed four years. The Commission is looking for physicians with an interest or involvement in boxing and/or sports medicine and who: a) possess a current California medical license in good standing; b) have no prior discipline, and no Accusation pending; and c) possess a minimum of five years' active practice in their area of specialty or sub-specialty.

The Commission is the state regulatory body for professional/amateur boxing and full-contact martial arts. The purpose of the Committee is to study and recommend medical and safety standards for the conduct of boxing and martial arts contests. The Committee meetings are held throughout the state. The Committee members are paid for travel expenses and appropriate per diem.

If you are interested in becoming a member of the committee contact:

### **CSAC**

Medical Advisory Committee  
Robert Lynch, Executive Officer  
1424 Howe Ave., Suite 33  
Sacramento, CA 95825  
Phone: (916) 263-2195  
Fax: (916) 263-2197  
E-mail: Robert\_Lynch@dca.ca.gov

## Egregious Failures in Infectious Disease Control and the Reuse of Disposable Equipment

Routinely, the Medical Board reviews cases in which doctors are charged with unprofessional conduct, gross negligence, repeated negligent acts, and incompetence. Recently, there have been some cases against doctors who reuse disposable equipment. This practice has resulted in scores of patients developing potentially life-threatening infections. Following are two cases in which doctors committed acts and omissions constituting extreme departures from the community standard of practice.

*Case Number One:* This doctor performed liposuction on patients in his medical office. During the course of the surgery, when the physician suctioned the tumescent fluid from the patient, he deposited the fluid into glass jars. The fluid consisted of lipids, blood, saline, and anesthetic agents. The doctor instructed his employees to gather the glass jars containing the liposuction waste after surgeries, take them to the toilet in the office, pour the contents into the toilet, and then flush the waste into the sewer. On one or more occasions, the doctor found plastic tubes used for liposuction surgery that had been disposed of by an employee. He retrieved the tubes from trash containers behind his medical office and directed staff *not* to throw them away again and then reused the same plastic tubes on subsequent patients. Such tubes were used to direct the suction waste from the cannula to the glass jars used before.

During a three-month period, the doctor failed to use a hazardous disposal service to properly dispose of waste produced from lipectomies and other cosmetic surgical procedures. Under the direction of the doctor, waste from surgical procedures was placed into plastic bags and put out for regular trash pick-up. During the same time period, the doctor did not use a laundry service in connection with his practice. He took all soiled towels, surgical or otherwise, to his residence for laundering, after which the towels would be used during surgery in the operating room in his medical office (violations of Business & Professions Code §§2227 and 2234, and Health & Safety Code §120125).

*Case Number Two:* This practice, including at least two physicians, consisted primarily of performing LASIK eye surgery. A microkeratome, which contains disposable blades, is used to perform this surgery. Protocol was developed at this medical facility to reuse the microkeratome blade on up to two patients, or four eyes, and to reuse the blades without sterilizing or disinfecting them for up to four patients, or eight eyes, all while performing LASIK eye surgery.

Before a doctor performed surgery, the patient was asked questions about his or her medical history from a patient information sheet that did not contain specific questions relating to whether the patient had any infectious diseases. If a patient volunteered a history of any infectious disease, the microkeratome blade would be discarded after it was used on the patient and the microkeratome assembly cleaned and autoclaved before reuse. When the blades and/or assembly were to be reused, they would be rinsed with sterile water and allowed to dry. They would not be disinfected or sterilized. Approximately 2,700 patients had LASIK surgery performed under these protocols (violations of B&P Code §§2227 and 2234).

Both doctors were subject to discipline by the Medical Board. In the state of California, the community standard of practice is for a physician to use sterile technique to prevent the transmission of infectious agents between patients. Failure to adhere to proper infection control procedures puts patients at grave risk and will result in appropriate sanctions by the Medical Board.

# Board Pursues Health-Related Internet Violations

In the state of California computer-related violations of state law regarding healthcare are occurring over the Internet at a disturbing rate. California consumers can obtain prescription drugs, medical advice or be subjected to illegal advertising just by logging on to the Internet and going to one of many medical Web sites.

Unfortunately, many of these Web sites are operated by non-physicians who have a primary goal of profiting from the real or perceived needs of consumers. The most visible of these sites are those that offer “lifestyle drugs” with little or no medical review regarding necessity or safety. In other cases, there are violations of ethics and law related to false advertising that is designed to lure unsuspecting individuals to purchase worthless “medical devices.” Concern about these practices led to legislation enacted last January (SB 1828, Speier, Chapter 681), which created new penalties for physicians who use the Internet to prescribe drugs to patients when a good faith prior examination is not conducted.

In today’s rapidly changing world of e-commerce, almost anything, including prescription drugs, can be purchased over the Internet. In most cases, it is possible to order prescription drugs such as Viagra, Propecia, Xenical or other weight loss drugs via a Web site without being examined by a physician. These Web sites primarily Physician Licensing: A

Status Report engaged in the sale of drugs and are in violation of California laws. California Business and Professions Code section 2242(a) requires that a physician provide a patient with a good faith prior examination and that there exist a medical indication before prescribing, dispensing or furnishing a dangerous drug. (A dangerous drug is defined as any drug requiring a prescription, including controlled substances.) Essential components of proper prescribing and legitimate medical practice require a physician to obtain a thorough medical history and conduct an appropriate physical examination before prescribing any medication for the first time.

To implement this legislation and to aggressively investigate illegal Internet activity, the Board recently dedicated a full-time Senior Investigator as the Board’s Internet Crimes Specialist. This enables the Board to conduct investigations involving unlicensed individuals or Medical Board licensees who are using the Internet to illegally prescribe for or treat California consumers or who advertise in violation of state law.

Other laws sanctioning related conduct include Business and Professions Code sections 650, 2052, and 17500. Penalties under these sections range from administrative citation-and-fine to suspension or revocation of license, and could include criminal charges.

## President’s Report (continued from page 2)

### Licensing

The Board’s Division of Licensing evaluates offshore medical schools with regard to the appropriateness of considering graduates of same as candidates for California licensure. This activity, along with ongoing relationships at multiple levels with our state’s eight medical schools allows the Board a sense of trends in medical education, arguably inextricably linked to the quality of medical care available for our citizens. There is cause for careful observation.

America’s university-based medical education model is a crown jewel in our healthcare system. Its origins track to Abraham Flexnor’s 1910 Medical Education in the United States and Canada, which faulted the low quality of the medical education product of the time on the non-university-based, for-profit, proprietary schooling of the day. The public at the time, connecting medical education with the quality of healthcare, committed the energy and resources that enabled the transfer of medical education to the university environment.<sup>1</sup> At the turn of the twenty-first century, there are signs of reversal. Fiscal pressures on universities’ medical budgets and the privatization of university hospitals are daily subjects of news articles. The Board has seen ever-increasing activity in the development

of for-profit, proprietary offshore schools, including the most recent entrepreneurial activity wherein a majority ownership of one such school was purchased by an extremely distinguished and high-profile venture group for the price of a professional sports team — \$135 million. The chief executive of the school was quoted: “The U.S. system is designed to limit access to medical education.”<sup>2</sup> Are we witness to the innovative and enlightened morphing of progress, an adaptation to socioeconomic reality per the public’s will, or an atavistic pre-Flexnorian vision? Again, there is cause for careful observation.

### Note

To a person, the membership of the Medical Board of California is exquisitely sensitive to the necessity of timeliness in the processing of licensing applications. The realities of a doubling of application numbers in six years without an increase in staff, in addition to unplanned staff turnover, have placed exceptional pressure on the system. Adaptation including weekend processing have been instituted. The Board is committed to a maximum and sustained effort during this difficult period.

<sup>1</sup>Kenneth M. Ludmerer, A Time to Heal, Oxford University Press, Oxford, 1999, chapter 1, p.5.

<sup>2</sup>Forbes, May 14, 2001, Chana R. Schoenberger.

# The Data is In:

## Hospitals transfers and deaths reported from procedures performed in outpatient settings

On January 1, 2000, surgeons performing surgery outside of hospitals were required to report to the Medical Board when a patient died or was transferred to a hospital for more than 24 hours. AB 271 (Gallegos), Chapter 944, Statutes of 1999, added Business & Professions Code section 2240, which mandated these reports, and further mandated the Medical Board to publish the data collected.

While it is too soon, and the data is too sparse, to provide definitive conclusions, some interesting information is beginning to emerge from the reports.

Deaths Reported from January 1 to December 31, 2000:

Nine deaths were reported. Six of the nine deaths resulted from procedures that were medically necessary, and three resulted from elective cosmetic procedures. Of the medically necessary procedures, none would be considered particularly risky. Deaths in these cases were either unrelated to the procedure, or were due to excessive bleeding, cardiovascular and respiratory distress or drug reactions. All of those who filed reports were ABMS board-certified.

Transfers to Hospitals Reported, January 1 to December 31, 2000:

In summary, 295 transfer reports were filed for the year 2000.

Under the law, surgeons who perform a scheduled procedure in an outpatient surgery setting and transfers a patient to a hospital for more than 24 hours must report it to the Board. (After 2001, these reports will be sent to the Office of Statewide Health Planning and Development, instead of the Medical Board.)

As the data in the accompanying chart shows, of the 295 transfers, 58 were transfers of patients undergoing elective cosmetic procedures. This figure, however, is misleading in that 29 of those — exactly half — were pre-planned transfers and not the result of unforeseen complications. (Many plastic or cosmetic surgeons perform procedures in their surgical suite but make arrangements in advance to transfer the patient to a hospital for overnight monitoring.) Most of the unplanned transfers were a result of blood loss, severe drug reactions, pain

or discomfort, respiratory distress, or cardiac problems. Most were discharged from the hospital within one to three days.

Reports of patient transfers are to be filed anonymously, as they are for data only and are not for the purpose of investigation or enforcement for any wrongdoing. What is interesting is that a significant number of these reports are not sent anonymously, and surgeons are more than willing to discuss the events and complications.

This is not surprising, as the Board's investigative files most often show that surgeons who do not delay in transferring patients are those who are using good clinical judgment and show concern for the safety of their patients. It is frequently

those cases in which there is delay in transfer of the patient to a better staffed and equipped facility where the most tragic results are encountered.

Moreover, physicians who have complied with the law by reporting these events appear to be cautious, conscientious practitioners who themselves are reviewing the progress of the case to determine what factors caused the event and whether something different could have been done.

The reporting form asks surgeons for their ABMS and approved board-certification information, as well as the specialty in which they practice. According to the

reports, the vast majority are board-certified and are practicing in their certified specialty. Of the 295 practitioners, only 35 were not ABMS board-certified, and of certified physicians, all were practicing in a specialty related to their certification.

While the data provides too small a sample to draw any definitive conclusions, it certainly serves as a reminder that all surgery carries risk. As most of the procedures that resulted in death or complications severe enough to require hospitalization were not particularly risky, it points up that regardless of the procedure, caution and reasonable care always must be exercised.

Procedure Specialty*	#
Gastroenterology/Colorectal	66
Obstetrics/Gynecology	65
Cosmetic (Elective)	58
Orthopedic	29
Otolaryngology (Not cosmetic)	15
Anesthesiology/Pain Management	10
Urology	8
Ophthalmology	7
Podiatry	4
Other	31
<b>Total Reports Received</b>	<b>295</b>

\* (Not board-certification status, but the appropriate specialty of the procedure)

## Department of Managed Health Care Seeks Psychiatric-Physician Consultants

The Division of Plan Surveys in the Department of Managed Health Care (DMHC) is seeking California-licensed psychiatrists who would be interested in working intermittently as medical consultants for the Division's on-site audits of managed behavioral health organizations throughout the state.

Consultants evaluate certain clinical areas such as utilization review practices, enrollee grievance/appeal resolution and quality of care and help determine whether the health plan is in compliance with legal requirements.

Requirements include:

- an unrestricted California license as a physician;
- board certification in psychiatry;
- at least six years post-residency experience in a mental health setting including at least five years in a managed-care environment (with some administrative experience preferred);
- periodic availability to the DMHC to attend training and conduct two- to three-day surveys;
- experience and training in a clinical survey process with other recognized accreditation/licensing organizations (such as JCAHO, URAC, NCQA, CARF, etc.);
- ability to objectively evaluate managed-care organizations, function independently as a team member, communicate effectively both orally and in writing, and meet reporting deadlines.

Preferred qualifications include training in quality and utilization management or related areas.

An application can be downloaded from the DMHC Web site at [www.dmhc.ca.gov](http://www.dmhc.ca.gov). Please mail the completed application to Linda McCaul, DMHC, 980 9<sup>th</sup> Street, Suite 500, Sacramento, CA. The best-qualified candidates will be contacted for an interview.

### TDD Numbers

Medical Board telephone numbers for the hearing-impaired (TDD):

**Division of Licensing** — (916) 263-2687

**Central Complaint Unit** — (916) 263-0935

## Advertising with a Name Other Than Your Own

### How to Apply for a Permit

Physicians who advertise with a name other than their own must first obtain a Fictitious Name Permit (FNP) from the Medical Board.

The purpose of the permit, the content of which is public record, is to permit the public to obtain the identity of the physician(s) who own and are therefor responsible for the office or clinic.

The Medical Board may issue a citation-and-fine, up to \$2500, to a physician or podiatrist if advertising with a name other than his or her own. The number of physicians being cited for not having an FNP has increased.

If you are advertising under a name other than your own and without an FNP, please contact the Medical Board to request an FNP application. Section 2272 of the Business and Professions Code states: "Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct."

Title 16 California Code of Regulations Section 1350.2(c) states: "No licensed person shall render professional services using a fictitious, false, or assumed name or any name other than his or her own unless and until a fictitious name permit has been issued by this division." An FNP is required when a licensee desires to use any name other than his or her own either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, announcement, sign, or advertisement of his or her practice. This includes, but is not limited to: business cards, newspaper ads, letterheads, radio or television ads, yellow page entries, and signs visible to the public.

When you apply for an FNP, please note that the proposed name cannot be deceptive, misleading, or so similar to a previously authorized name as to cause confusion, and must contain one of the following designations: Medical Group, Medical Clinic, Medical Associates, Medical Center, Medical Office, or Medical Corporation.

If you would like an FNP application, along with an instructional pamphlet or would like additional information, please call (916) 263-2384. Information to assist in the completion of the application also is provided along with the application.



# Reminder: Triplicate Prescription Forms No Longer Mandatory for Terminally Ill Patients

This legislation is two-fold, benefiting the terminally ill patient who suffers with extreme and unrelieved pain, and the prescribing physician.

Effective January 1, 1999, AB 2693 (Migden), which relates to prescriptions for controlled substances, became law in California (Health & Safety Code section 11159.2). The law abolishes the requirement for a triplicate for Schedule II controlled substance prescriptions, *when written for a terminally ill patient*.

This legislation is two-fold, benefiting the terminally ill patient who suffers with extreme and unrelieved pain, and the prescribing physician. Previous regulations unintentionally hampered a physician's ability to administer or dispense controlled substances to persons with intractable pain for whom no relief or cure was possible after reasonable efforts.

This law attempts to facilitate appropriate pain management for terminally ill individuals by exempting them from the patient population for whom there is the requirement of triplicate prescription. In other words, this means that, for these patients, the physician is no longer required to submit an original prescription form to the Department of Justice. Removing this requirement allows physicians to prescribe

Schedule II medication for the treatment of pain in terminally ill patients more freely in accordance with their medical judgment.

The law does require the physician to document the applicability of this statute to the patient being treated.

It requires the prescription to be signed and dated by the prescriber and to contain the name and address of the person for whom the controlled substance is prescribed, the name and quantity of the controlled substance prescribed, and directions for use.

In compliance with previous law, it requires specific information about the prescriber, such as telephone number and federal controlled substance registration number.

The prescription must indicate that the prescriber has certified that the patient is terminally ill by the words "11159.2 exemption."

Finally, the law authorizes a pharmacist to fill a prescription when there is a technical error in the certification, provided that he or she has personal knowledge of the patient's terminal illness, and subsequently returns the prescription to the prescriber for correction within 72 hours.

Interested physicians may obtain a copy of this law through the Internet site [www.leginfo.ca.gov](http://www.leginfo.ca.gov). Just click on "BILL INFORMATION," select "1997-98 prior" and AB 2693.

## Update: Medical Board of California's Office of Safe Medicine

### Seven Arrests Made, Six Cases Referred to City or District Attorneys' Offices for Prosecution

An article in the April 2001 *Action Report* detailed the Medical Board's new Operation Safe Medicine (OSM). OSM is part of the Medical Board's efforts to steer consumers away from unlicensed practitioners whose treatment of patients has resulted in harm and even death in the last few years in vulnerable areas of California.

Operation Safe Medicine is a special unit of the Medical Board composed of trained investigators who seek to protect the public by reducing access to individuals who are unlicensed and pose a danger when they attempt medical treatment.

As this report goes to press, there have been seven arrests made and six cases referred to city or district attorneys' offices for prosecution by investigators of OSM. The latest arrest involved a Riverside woman who held herself out as a doctor and treated a 7-year-old child who has bone cancer. She was charged with violating Business and Professions Code section 2053, a felony, by risking great bodily harm, serious injury or death to the child by practicing medicine without a license.

The woman's treatment of the child, whose cancer is in her leg, consisted of herbal medicine and periodic examination of the child's eyes. She promised the parents a 100 percent cure of the cancer and advised them to cease the child's ongoing chemotherapy treatment. The parents did so, delaying the conventional treatment for approximately two months.

The arrest warrant was filed in the Superior Court of Los Angeles County. San Bernardino County also has filed a misdemeanor charge against the woman for practicing medicine without a license, based on her diagnosis of a Medical Board undercover investigator.

The Board also has begun an educational campaign that encourages the public to confirm they are receiving healthcare from licensed physicians. If you suspect unlicensed activity, you are encouraged contact the Medical Board at (800) 633-2322.

# Human Rabies Prevention:

## Current policies and recommendations now available to physicians

*Veterinary Public Health Section, California Department of Health Services*

The Veterinary Public Health Section, California Department of Health Services (DHS) is responsible for the surveillance, prevention, and control of animal rabies in California. Since 1988, all local health jurisdictions in California have been declared as rabies endemic areas, due to the persistence of the disease in native wildlife populations. In 1999, California ranked seventh nationally in the total number of animal rabies cases reported to the Centers for Disease Control and Prevention.

All mammals are susceptible to rabies, which invariably causes a fatal encephalitis. Rabies is most frequently reported in skunks and bats in California. When the prevalence of rabies in these wildlife populations increases, spillover may occur into domestic animals. Human exposure may occur due to contact with affected domestic animals, or through direct contact with wildlife species.

In September 2000, the first reported human case of rabies in California since 1995 was identified. An Amador County resident died, and a rabies virus variant associated with Mexican free-tailed bats was isolated from the patient. Although this patient did not specifically recall bat contact, physical contact with a bat was the most likely source of exposure. Since 1990, bat strains have been associated with four of the six human rabies cases in California. Although rare, human infection with rabies virus from bats is a considerable public health concern.

Human rabies can be prevented by:

- eliminating exposure to rabid animals,
- providing appropriate rabies preexposure prophylaxis, and
- prompt local treatment of wounds combined with appropriate rabies postexposure prophylaxis.

For the purpose of providing information on rabies to California's physicians, public health officials, practicing veterinarians, animal control officers, and other parties concerned with rabies control in the State, the DHS's Veterinary Public Health Section has prepared the "California Compendium of Rabies Control and Prevention, 2001". These recommendations can be found at DHS's Web site: <http://www.dhs.ca.gov/ps/dcdc/html/publicat.htm>. The recommendations are reviewed and updated on a periodic basis to reflect the current status of rabies and rabies prevention activities in California. Updates are based on a review of current rabies research and scientific literature, and

rabies prevention guidelines published by the Advisory Committee on Immunization Practices (ACIP) and by the National Association of State Public Health Veterinarians, Inc.

***Highlights from the "California Compendium of Rabies Control and Prevention, 2001" and the Centers for Disease Control and Preventions' "Morbidity and Mortality Weekly (MMWR) Report on Human Rabies Prevention—United States, 1999" dated January 8, 1999. Significantly more detailed information is available in the Compendium and the MMWR.***

### Rabies Postexposure Prophylaxis

The essential components of rabies postexposure prophylaxis are immediate local wound cleaning and treatment, and the administration of both human rabies immune globulin (HRIG) and rabies vaccine. Persons who are bitten by, or have significant exposure to, the saliva or nervous system tissue of a confirmed rabid animal should begin treatment immediately. Persons exposed to a suspected rabid animal should begin treatment if rabies testing on the animal is not immediately available. To appropriately manage potential human exposure to rabies, the risk of infection must be accurately assessed. Rabies postexposure prophylaxis treatments are occasionally complicated by adverse reactions, but these reactions are rarely severe.

Postexposure rabies prophylaxis should always include both vaccine and HRIG except in persons who have previously received completed prophylaxis regimens with a cell culture vaccine, or persons previously vaccinated with other types of vaccine that have had documented protective rabies antibody titers. These persons should immediately receive a 1-ml booster vaccination of HDCV, PCEC, or RVA administered intramuscularly, and a second booster three days later.

HRIG is given only once at the beginning of treatment to provide immediate antibodies while active immunization from vaccination is developing. HRIG should be administered at a dose of 20 IU/kg body weight for all age groups. If anatomically feasible, the full dose of HRIG should be thoroughly infiltrated in the area around and into the wound(s). Any remaining volume should be injected intramuscularly at a site distant from vaccine administration.

Human Diploid Cell Vaccine (HDCV), Purified Chick Embryo Cell Vaccine (PCEC), or Rabies Vaccine Adsorbed (RVA) is

*(Continued on page 14)*

# Gynecologic Cancer Materials Now Available in Four Languages

## *Request Your Free Packet of Materials*

*Office of Women's Health, California Department of Health Services — July 2001*

The California Department of Health Services (DHS) and the Medical Board of California are pleased to announce the completion of the first phase of the Office of Women's Health (OWH) Gynecological Cancer Information Program (GCIP). The gynecologic cancer pamphlet, "Gynecologic Cancers ... What Women Need to Know," is now available in English, Spanish, Chinese and Vietnamese.

Fact sheets on cervical, ovarian and uterine cancers also are available in the same four languages.

Physicians now may request a free packet of all the materials from the DHS' Office of Women's Health at (916) 653-3330 or by fax at (916) 653-3535.

These gynecologic cancer materials were produced by DHS to assist California physicians and other medical care providers to comply with AB 833 (Ortiz), Statutes of 1997, Chapter 754. This law requires **all** medical care providers to give written information on gynecologic cancers in layperson's language to their patients at the time of their annual gynecologic examinations.

### Legislative Intent

The intent of the law is to increase awareness of the gynecologic cancers and to encourage discussion between the patient and her physician about cancer screening. Many women are not receiving this information at their annual exams because their physicians remain unaware of this statutory mandate.

The attractive, two-color pamphlet provides easy-to-read information on all the gynecologic cancers, including signs, symptoms, risk factors, and benefits of early detection through appropriate diagnostic testing. The full-page fact sheets contain

more detailed information on the three major gynecologic cancers in a user-friendly format. These fact sheets are for patients who may have specific questions regarding cervical, ovarian or uterine cancers.

### Ordering Information

To obtain gynecologic cancer materials in bulk quantities, fax your request for a DHS Warehouse Order form to (916) 928-1326. Be sure to provide a contact name, agency/organization name and fax number on your fax transmittal sheet. To request an order form by phone, please call (916) 928-9217. When placing your order for the materials, please be sure to specify the name of the publication, publication number (e.g., Pub 306) and the quantity of each item you are requesting. (Please refer to the chart below.)

For physician groups that wish to reproduce the materials with a personalized local identifier, they also are available on the OWH Web site at [www.dhs.ca.gov/owh](http://www.dhs.ca.gov/owh). Physician groups also can reproduce the gynecologic cancer materials by contacting the OWH for free copies on CD-ROM.

All physicians who provide gynecologic services are encouraged to request a sample packet from the OWH. It contains all the available gynecologic cancer materials, specific information about the Gynecologic Cancer Information Program, and a simple one-page survey with a self-addressed and stamped envelope.

The purpose of the survey is to solicit feedback and comments from physicians on the materials. Physician comment is extremely important to the GCIP, as it begins the second phase of the program development of these materials in additional languages.

Item	English	Spanish	Chinese	Vietnamese
<b>Gynecologic Cancer Pamphlet</b>	<b>Pub 306</b>	<b>Pub 307</b>	<b>Pub 308</b>	<b>Pub 309</b>
<b>Cervical Cancer Fact Sheet</b>	<b>Pub 60</b>	<b>Pub 64</b>	<b>Pub 74</b>	<b>Pub 88</b>
<b>Ovarian Cancer Fact Sheet</b>	<b>Pub 62</b>	<b>Pub 69</b>	<b>Pub 75</b>	<b>Pub 96</b>
<b>Uterine Cancer Fact Sheet</b>	<b>Pub 63</b>	<b>Pub 72</b>	<b>Pub 77</b>	<b>Pub 103</b>

# Rodents and Respiratory Failure: Hantavirus Pulmonary Syndrome in California

By Curtis L. Fritz, D.V.M., M.P.V.M., Ph.D., Epidemiologist, Vector-Borne Disease Section, Division of Communicable Disease Control, California Department of Health Services

In 1993, an epidemic of deaths due to acute respiratory failure occurred among the residents of rural areas in northern New Mexico. By the time public health officials completed their investigation, 23 persons had been affected, over 80 percent of whom died. The culprit: a previously unknown virus from the hantavirus group. The accomplice: the small, inconsequential, by some accounts cute, deer mouse.

Today the virus is known as Sin Nombre (SNV) and the disease as hantavirus pulmonary syndrome (HPS). Since that initial outbreak in the early summer of 1993, the Centers for Disease Control and Prevention (CDC) has identified nearly 300 cases of HPS nationwide. The majority of cases continue to occur in the Four Corners area. California is second only to New Mexico in total number of HPS cases reported. In 2000, eight cases of HPS (including two deaths) were identified in California, the most ever for the state in a single calendar year. Several of these cases occurred in residents from areas of the state where HPS had not been previously documented, including the Sacramento Valley and urban southern California; some of these persons traveled to the eastern Sierra Nevada or to other states where SNV transmission is well recognized.

Although a disproportionate number of HPS case-patients in California have been residents of, or recent visitors to, the eastern Sierra Nevada region, clinicians should be alert to the possibility that anyone, anywhere in California, can present with HPS. This is because the deer mouse (*Peromyscus maniculatus*), which is the only species of rodent believed to shed the virus in sufficient quantity to effect transmission to humans, is, unfortunately, one of the most prevalent rodents in North America. Deer mice are present throughout the West and frequently visit human habitations in quest of food, shelter, and nesting materials.

Deer mice typically acquire SNV as juveniles and are believed to remain infected for life. SNV is shed in their urine, feces, and possibly saliva. Humans become infected by inhalation of aerosolized infectious excreta. Transmission risk is exacerbated by activity that disturbs rodent excreta in enclosed, poorly ventilated areas. Hand-to-mouth transfer of virus from contaminated surfaces and inoculation of breaks in the skin are other possible routes of infection.

## Incubation

Recent case reviews estimated the median incubation period for HPS to be 14 to 17 days. A few cases suggest that the incubation period may be as long as six weeks.

## Flu-like prodrome

The initial symptoms of HPS are invariably non-specific and flu-like. Low grade fever, headache, generalized muscle ache, and fatigue are common. Several recent cases in California presented with primarily gastrointestinal symptoms (abdominal pain, diarrhea). Interestingly, respiratory symptoms are comparatively infrequent during the prodrome.

## Respiratory distress

Following 3-7 days of flu-like symptoms, HPS patients experience compromise of respiratory function that is often acute and severe. The inflammatory response to viral infection compromises the integrity of the pulmonary vasculature—termed “leaky capillary syndrome”—causing accumulation of fluid in the pulmonary interstitium that impairs gas exchange.

## Clinical management/treatment

There is no specific treatment for HPS. Patients are medically managed as the severity of their cardiopulmonary dysfunction dictates. Some HPS patients recover with only a few days of supplemental oxygen; others require intubation and mechanical ventilatory support. As HPS patients are often concurrently hypotensive, vasopressors are a common component of management. Extra-corporeal membrane oxygenation has been used with modest success as a salvage therapy for patients who do not respond to conventional methods. Case-fatality for HPS patients in California is approximately 40 percent. Most patients who survive HPS have no apparent long-term adverse effects.

## Diagnosis

As the prodromal symptoms of HPS are generally non-specific and consistent with numerous etiologies, recognition of HPS cases prior to onset of respiratory distress is often difficult. However, several features are consistently observed in prodromal HPS patients and can provide the attending physician a clue as to the diagnosis:

(Continued on page 14)



# News From the U.S. Food and Drug Administration

*This article is the second in our continued series of updates for physicians from the federal FDA.*

## Drug Shortages

It is FDA's policy to help prevent or alleviate shortages of medically necessary drug products. A drug shortage may involve either an actual or a potential shortage of a drug product. Drug shortages occur for a variety of reasons, including manufacturing difficulties, bulk supplier problems, corporate decisions to discontinue drugs, and FDA enforcement actions. These drug shortages can have significant public health consequences.

FDA works with all parties involved to ensure that medically necessary products remain available. An on-line article, "Inside FDA: When a Drug is in Short Supply" provides background information. To read this article or report a shortage problem, please visit the following site: [www.fda.gov/cder/drug/shortages/#Introduction](http://www.fda.gov/cder/drug/shortages/#Introduction).

To report shortages, you may call (301) 827-4570 for drugs and (301) 827-6220 (Jerome Davis) for biologics.

MedWatch: Safety Information (for healthcare professionals and the public)

MedWatch provides safety information on drugs, biologics, dietary supplements, and medical devices to healthcare professionals and the public. Safety alerts, public health advisories, recalls, withdrawals, and important labeling changes can be found at the following Web site: <http://www.fda.gov/medwatch/index/htm>.

Click on "What's New" to see safety information added in the past two weeks. Searchable databases that contain information on adverse events reported in conjunction with the use of dietary supplements and devices are available on-line under the category of safety information.

MedWatch allows healthcare professionals and consumers to report serious problems that they suspect are associated with the drugs and medical devices they prescribe, dispense, or use. Reporting can be done on-line at the above-mentioned Web site, by phone, or by submitting the MedWatch 3500 form by mail or fax. Select "How to Report" for more details.

Join the MedWatch e-list. To receive immediate e-mail notification of new material on the MedWatch Web site, send an e-mail to: <http://www.fda.gov/medwatch/new.htm>. Enter "subscribe" in the subject field. You may leave the body of the message blank.

## Pediatrics and Drugs

Children are subject to many of the same diseases as adults and are therefore prescribed many of the same medications. Unfortunately, only a small percentage of these drugs have been studied in pediatric populations and the absence of testing and

labeling for children puts them at risk. In 1997, an incentive (six months exclusivity) to conduct drug studies in children was granted to manufacturers by Congress as part of the FDA Modernization Act. This coupled with a recent regulation that requires new drugs (with the exception of drugs designed for conditions rarely found in children) to include an assessment of the safety and effectiveness of the drug in children will help pediatricians and other physicians prescribe correct doses of medication to this population.

FDA anticipates that 40 pediatric studies will be completed on an annual basis. Of the 27 drugs that have been granted exclusivity, 18 have approved labeling based on pediatric studies. Some examples are:

- ibuprofen — Over the counter use in children as young as six months
- Claritin — 2-5 year-olds can receive half the dose of 6-year-old adolescents.

The public health benefit for children will increase as additional studies are completed. Healthcare professionals are encouraged to access the Internet and go to <http://www.fda.gov/cder/pediatric/labelchange.htm> for the list of the drugs that have pediatric labeling changes, and look at the pediatric Web site regularly to stay abreast of new developments.

For additional information, call the Division of Drug Information at (888) 463-6332.

## Navigating the FDA Web Site

Most government Web sites contain a wealth of information. The FDA site is no exception.

The question becomes, "How do you find the material you need in the most efficient manner?" A general search at [www.fda.gov](http://www.fda.gov) will provide you with the information that you need, but often you will have to sift through a significant amount of material. Use the advance search function to narrow your search.

The index on the main page can be very helpful. For instance, if you were looking for cancer clinical trials you could go to (c) cancer or if you forgot the address for drug shortages you could go to (d) drug shortage.

Most Centers also have an index: Center for Drug Evaluation and Research's (CDER) is hidden under "site map."

There are numerous paths to travel to arrive at your chosen destination. If you cannot find what you need, check with an FDA Public Affairs Specialist: Northern California (510) 337-6736 or Southern California (949) 798-7611.

## Rabies prevention (continued from page 10)

administered in conjunction with HRIG at the beginning of postexposure treatment. However, HRIG should **never** be administered in the same syringe or in the same anatomical site as vaccine. A regimen of five 1-ml doses of HDCV, PCEC, or RVA is given intramuscularly. The first dose should be given as soon as possible following an exposure (day 0). The other doses are given on days 3,7,14, and 28 after the first dose. For adult patients, vaccine should be administered by the IM route in the deltoid area (lateral aspect of the upper arm). For pediatric patients, intramuscular administration in the anterolateral aspect of the thigh is recommended. It is important that the needle length be adequate to ensure intramuscular delivery of vaccine. Rabies vaccine should **never** be administered in the gluteal region. Administration in the gluteal area may result in lower or inadequate neutralizing antibody titers.

## Preexposure Prophylaxis

In California, preexposure vaccination should be offered to persons at increased risk of rabies exposure. This category includes veterinarians, animal handlers, animal control officers, laboratory workers potentially exposed to rabies virus, and persons traveling to and spending time (i.e., >1 month) in foreign countries where canine rabies is endemic. Preexposure vaccination should be considered for other persons, such as wild mammal rehabilitators, whose vocations or avocations bring them into frequent contact with potentially rabid dogs, cats, skunks, bats or other species at risk of having rabies.

Such persons should receive preexposure immunization and have a serum sample tested for rabies antibody every two years. If the titer is less than complete neutralization at 1:5 or 1:8 (depending on dilution method used by the testing laboratory) by the Rapid Fluorescent Focus Inhibition Test, the person should receive a booster dose of rabies vaccine.

Should you have any questions regarding human rabies, please call the Veterinary Public Health Section at (916) 327-0332.

## Rodents and Respiratory Failure (continued from page 12)

- *Progressive thrombocytopenia.* The circulating platelet count often drops steadily during the prodromal period. Patients suspected of having HPS should have their platelet count monitored daily; observed drops of 40-60,000 cells/ $\mu$ L per day may be indicative of HPS. Total platelet counts at the onset of respiratory distress has been 20-50,000/ $\mu$ L among California HPS cases.

- *Circulating immunoblasts.* Presence of myelocytes or promyelocytes in the peripheral blood, concurrent with thrombocytopenia, are highly suggestive of HPS.

- *Thoracic radiographs.* Interstitial infiltrates are often evident on chest X-rays during the prodrome and precede onset of clinical respiratory symptoms.

- *Serology.* HPS can be definitively diagnosed through serology. Serologic assays, typically immunofluorescence or enzyme-immunoassay, based on SNV are highly sensitive and specific among patients with clinically compatible symptoms. By the time they experience symptoms, all persons infected with SNV will have seroconverted. Serologic testing is available at the California Department of Health Services' (DHS) Viral and Rickettsial Diseases Laboratory, as well as the CDC, University of New Mexico, and some commercial laboratories. (A few

commercial laboratories offer "hantavirus" testing, but use antigens from different hantaviruses [Puumala, Hantaan] that do not cause human disease in North America. While there is some cross-reactivity between these viruses, it is not reliably consistent.)

All healthcare providers should be cognizant of HPS as a possibility for their patients regardless of where they live: approximately half of California's HPS patients contracted their illness while engaging in occupational or recreational activities away from home. HPS should be considered in any previously healthy individual who experiences a febrile illness characterized by unexplained adult respiratory distress syndrome or bilateral interstitial pulmonary infiltrates that develop concomitant with respiratory compromise requiring oxygen supplementation.

Healthcare providers who desire serologic testing of, or consultation on, a suspect HPS patient may contact the DHS Division of Communicable Disease Control Duty Officer at 510/540-2566. General information on the ecology and epidemiology of HPS in California may be obtained from the DHS Vector-Borne Disease Section at 916/324-3738. A wealth of information on HPS and hantaviruses nationwide is available on the CDC Web site at [www.cdc.gov/ncidod/diseases/hanta/hantvrus.htm](http://www.cdc.gov/ncidod/diseases/hanta/hantvrus.htm).

# ADMINISTRATIVE ACTIONS: Feb. 1, 2001 to April 30, 2001

## PHYSICIANS AND SURGEONS

**ADVANI, MADHU, M.D. (A43415) Bakersfield, CA**  
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct for failure to make a timely transfer of a pediatric patient with diabetic ketoacidosis. Public Reprimand. April 30, 2001

**ALSTON, WARREN WEBSTER, M.D. (G61467) Chino, CA**  
B&P Code §822. Stipulated Decision. Suspended indefinitely until there is evidence of the control or absence of any condition, mental or physical, that impairs his ability to practice safely. March 2, 2001

**ANDRADE, SERGIO GILBERTO, M.D. (A25096) La Canada, CA**  
B&P Code §§2234, 2236(a). Stipulated Decision. Criminal conviction for the unlawful holding of a misbranded drug. Revoked, stayed, 5 years probation with terms and conditions, including 60 days actual suspension. March 12, 2001

**AZAD, ARMIN, M.D. (A50503) Los Angeles, CA**  
B&P Code §2266. Stipulated Decision. Failed to maintain adequate medical records regarding the care, treatment and monitoring of a surgical patient. Public Reprimand. April 17, 2001

**CHUA, WILLIAM ANG, M.D. (A34309) Montebello, CA**  
B&P Code §2234(b)(c)(d). Committed acts of gross negligence, incompetence and repeated negligence in the care and treatment of 1 patient. Revoked, stayed, 5 years probation with terms and conditions. February 5, 2001. Judicial review being pursued.

**CLARK, DENNIS LARRY, M.D. (G25400) Long Beach, CA**  
B&P Code §2234(a). Stipulated Decision. Inadequate supervision of a physician assistant in the care and treatment of 1 patient. Public Letter of Reprimand. March 21, 2001

**CORVALAN, JAIME GUILLERMO, M.D. (A25561) Pasadena, CA**  
B&P Code §2266. Stipulated Decision. Failed to maintain adequate and accurate medical records due to the dictation of an unusual operative report with questionable pre- and post-operative diagnoses and nonstandard narrative text. Public Letter of Reprimand. March 29, 2001

### Explanation of Disciplinary Language and Actions

**“Effective date of decision”** — Example: “March 10, 2001” 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).

**CURTIS, BRIAN VIRGIL, M.D. (G63107) San Bernardino, CA**  
B&P Code §2234. Stipulated Decision. Committed acts of unprofessional conduct by providing false statements to the county jury commissioner regarding the disability of a former patient; prescribed drugs without a good faith prior examination and medical indication and failed to maintain adequate medical records for the same former patient. Public Letter of Reprimand. April 30, 2001

**DAVIDSON, PLEASANT W., III, M.D. (C23973) Beverly Hills, CA**  
B&P Code §2234. Stipulated Decision. No admissions but charged with allowing an unlicensed person to practice psychotherapy and medicine, and dispensed prescription medicine over a 20-year period. Revoked, stayed, 5 years probation with terms and conditions, including 30 days actual suspension. February 5, 2001

**DODD, HALBERT B., II, M.D. (C37795) Union City, TN**  
B&P Code §§141(a), 822, 2234,(b)(e), 2239(a), 2280, 2305. Disciplined by Tennessee due to his inability to practice safely due to impairment from mental illness and substance abuse. Revoked. February 5, 2001

**DOLLINGER, ARMAND L., M.D. (A17418) Hanford, CA**  
B&P Code §2234, 2234(c). Committed repeated negligent acts in the evaluation of the cause of death of 5 infants. Suspended, stayed, 3 years probation with terms and conditions. February 9, 2001

**DONALDSON, KAREN ANN, M.D. (G30545) Albany, NY**  
B&P Code §2234(b)(c)(d). Stipulated Decision. Committed acts of gross negligence, repeated negligence and incompetence in the care and treatment of 1 patient. Revoked, stayed, 5 years probation with terms and conditions, including 100 days actual suspension. March 12, 2001

**DULKANCHAINUN, SATHIT B., M.D. (A62004) Sun Valley, CA**  
B&P Code §§2236(a), 2239. Stipulated Decision. No admissions but charged with conviction of driving under the influence of alcohol. Suspended, stayed, 28 months probation with terms and conditions. March 19, 2001

**ELMZADEH, MAHSHID, M.D. (A73928) Laguna Niguel, CA**  
B&P Code §§480(a)(1)(2)(3), 480(c), 2234(a)(e), 2236(a)(d). Stipulated Decision. Committed dishonest acts by providing false statements regarding a previous criminal conviction on a licensing application. License granted, revoked, stayed, 3 years probation with terms and conditions. February 15, 2001

**EVANS, THOMAS ROSS, M.D. (G30778) Tulare, CA**  
B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in the care and treatment of 1 patient by failing to adequately document the patient's care and authorizing a prescription refill without a follow-up examination. Public Reprimand. March 26, 2001

**EVENTOV, DANIEL A., M.D. (G5644) Bishop, CA**  
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct in the care and treatment of 1 patient by failing to properly monitor the care of the patient. Public Letter of Reprimand. February 9, 2001

**FEINBERG, HARVEY YALE, M.D. (G70248) Studio City, CA**  
B&P Code §§821, 2225.5(a)(1), 2225.5(d). Failed to comply with an order compelling mental and physical exams, failed to comply with a request for medical records and failed to comply with an investigative subpoena duces tecum for medical records. Revoked. February 13, 2001

**GIANNINI, ALBERT PETER JR., M.D. (G56201) San Diego, CA**  
B&P Code §§2238, 2285, 4077, 4170. Stipulated Decision. Violated federal and state statutes and regulations relating to drugs by allowing controlled substances to be dispensed by persons not authorized by law to do so and failed to properly label and package dispensed controlled substances. Practiced under a fictitious name without a permit to do so. Revoked, stayed, 2 years probation with terms and conditions. March 30, 2001

**GOSS, GRAYDON GREGORY, M.D. (G38487) Red Bank, NJ**  
B&P Code §§2234, 2234(c), 2266. Stipulated Decision. Committed repeated negligent acts in the care and treatment of 2 patients and failed to maintain adequate and accurate medical records. Revoked, stayed, 10 years probation with terms and conditions. March 30, 2001

**GRAVICH, ANNA, M.D. (A40805) Huntington Park, CA**  
B&P Code §§2234, 2234(e), 2236(a), 2264, 2266. Stipulated Decision. Aided and abetted the unlicensed practice of medicine, failed to maintain adequate and accurate medical records, convicted of income tax evasion and subscribing to a false income tax return. Revoked, stayed, 4 years probation with terms and conditions, including 30 days actual suspension. April 9, 2001

**GROVES, SHERIDON HALE, M.D. (G68029) Thousand Oaks, CA**  
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct by making inappropriate comments and inappropriately touching 2 female patients. Revoked, stayed, 7 years probation with terms and conditions. April 5, 2001

**HANSON, RAY WILLIAM, M.D. (G23309) Merced, CA**  
B&P Code §2234. Stipulated Decision. Failed to properly assess patient's condition following notification from the hospital and failed to respond to the patient in a timely fashion. Public Letter of Reprimand. April 26, 2001



**HARRIS, ALAN DAVID, M.D. (G13779) San Diego, CA**  
B&P Code §822. Stipulated Decision. Suspended indefinitely until there is evidence of the absence or control of any medical condition that impairs his ability to practice medicine safely. March 6, 2001

**HILLYARD, WILLIAM T., M.D. (A28981) Riverside, CA**  
B&P Code §§2234(e), 2236(a). Criminal conviction for committing insurance fraud. Revoked, stayed, 2 years probation with terms and conditions. April 11, 2001

**HURD, STEVEN MORRIS, M.D. (G41187) South San Francisco, CA**  
B&P Code §§822, 2234, 2234(e). Violated terms and conditions of Board probation, misrepresented himself as a board-eligible or board-certified orthopedist in declarations filed with the Board and in testimony, improperly touched a patient, and has impaired ability to practice medicine safely due to his mental condition. Revoked. April 20, 2001

**JEWELL, MARGUERITE RINDGE, M.D. (G35067) Lake Arrowhead, CA**  
B&P Code §2234, 2234(b). Stipulated Decision. Committed gross negligence by failing to adequately evaluate, monitor and treat an infant patient. Revoked, stayed, 3 years probation with terms and conditions. February 5, 2001

**KAY, BARRY STEVEN, M.D. (G33425) Kentfield, CA**  
B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in that on a routine basis for several years the microkeratome blades and the microkeratome assembly used in LASIK eye surgery were reused without sterilization or disinfection. Revoked, stayed, 3 years probation with terms and conditions. April 27, 2001

**KHASIN, MARIA, M.D. (A42143) Beverly Hills, CA**  
B&P Code §§650, 2234, 2234(e), 2236(a), 2273. Stipulated Decision. Convicted in federal court of 2 counts of aiding and abetting mail fraud. Revoked, stayed, 3 years probation with terms and conditions, including 60 days actual suspension. February 8, 2001

**KRINSKY, MICHAEL BARRY, M.D. (G22516) Castro Valley, CA**  
B&P Code §2234(b). Stipulated Decision. Committed gross negligence in that he inappropriately touched a patient. Revoked, stayed, 3 years probation with terms and conditions. March 26, 2001

**KUYPERS, MARCUS ERIC, M.D. (C38523) Camano Island, WA**  
B&P Code §§141(a), 2234. Stipulated Decision. Prescribed controlled substances without first establishing a proper physician-patient relationship. Public Letter of Reprimand. March 9, 2001

**LEE, CATHERINE CHUNGHEI, M.D. (A26578) Los Angeles, CA**  
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct in that her medical records and billing records were unclear, incomplete, and inaccurate in certain respects. Public Letter of Reprimand. April 24, 2001

**MATHEWS, ROGER D., M.D. (A20921) Sacramento, CA**  
B&P Code §2234. Stipulated Decision. No admissions but charged with participating in a wire fraud scheme to defraud investors. Revoked, stayed, 10 years probation with terms and conditions. April 16, 2001

## Help Your Colleague by Making a Confidential Referral

If you are concerned about a fellow physician who you think is abusing alcohol or other drugs or is mentally ill, you can get assistance by asking the Medical Board's Diversion Program to intervene.

The intervention will be made by staff trained in chemical dependency counseling or by physicians who are recovering from alcohol and drug addiction. As part of the intervention, the physician will be encouraged to seek treatment and be given the option of entering the Diversion Program. Participation in Diversion does not affect the physician's license.

Physicians are not required by law to report a colleague to the Medical Board. However, the Physicians Code of Ethics requires physicians to report a peer who is impaired or has a behavioral problem that may adversely affect his or her patients or practice of medicine to a hospital well-being committee or hospital administrator, or to an external impaired physicians program such as the Diversion Program.

Your referral may save a physician's life and can help ensure that the public is being protected. All calls are confidential. Call (916) 263-2600.

**Medical Board of California  
Physician Diversion Program  
1420 Howe Avenue, Suite 14  
Sacramento, CA 95825**

**MCALLEN, STEVEN JEROME, M.D. (G61667) Templeton, CA**  
B&P Code §2242. Stipulated Decision. Failed to conduct a good faith examination prior to prescribing medication in the care and treatment of 1 patient. Public Reprimand. February 2, 2001

**MCMENAMIN, PATRICK GEORGE, M.D. (C42081) Sacramento, CA**  
B&P Code §2264. Stipulated Decision. Aided and abetted the unlicensed practice of medicine by allowing a medical assistant to assist during a liposuction procedure. Public Reprimand. February 5, 2001

**MOSS, JERRY FRED, M.D. (G55036) Los Angeles, CA**  
B&P Code §§2234(e), 2236(a). Violated terms and conditions of Board-ordered probation and convicted by plea of nolo contendere to 1 count of violation of Penal Code section 273(a), willfully causing a child within his custody unjustifiable physical pain or mental suffering, and 1 count of violation of Penal Code section 148, obstructing a police officer. Revoked, stayed, 7 years probation. February 5, 2001

**NADGIR, LAKSHMI, M.D. (C50065) Los Angeles, CA**  
B&P Code §2234. Stipulated Decision. No admissions but charged with violating terms and conditions of Board-ordered probation and making false statements in a licensing application and an application for hospital privileges. Current probation extended for an additional 2 years with terms and conditions. February 16, 2001

**NEEDHAM, JAMES W., M.D. (G2873) Sherman Oaks, CA**  
B&P Code §2234, 2234(b)(c)(d). Committed acts of gross negligence, repeated negligence and incompetence in the care and treatment of 7 patients. Revoked. March 15, 2001

**OI, SEIJO, M.D. (G42915) Newport Beach, CA**  
B&P Code §§2234(c), 2266. Committed repeated negligent acts and failed to maintain adequate and accurate medical records in the care and treatment of several patients. Revoked, stayed, 3 years probation with terms and conditions. April 23, 2001

**ORGAN, PAUL GERARD, M.D. (A39998) Atlanta, GA**  
B&P Code §§141(a), 2310(a). Stipulated Decision. Disciplined by Arizona for violating the terms of a rehabilitation stipulation and order. Revoked, stayed, 5 years probation with terms and conditions. February 8, 2001

**PADILLA, JOHN FRANCIS, M.D. (A52881) Santa Barbara, CA**  
B&P Code §2234, 2234(c). Stipulated Decision. Committed repeated negligent acts during the care and treatment of 2 patients. Revoked, stayed, 5 years probation with terms and conditions. March 22, 2001

**RAMSDEN, CHARLES H., M.D. (A17273) Toluca Lake, CA**  
B&P Code §§2234(b)(c)(d), 2238, 2242(a), 2264. Committed acts of gross negligence, repeated negligence and incompetence. Aided and abetted the unlicensed practice of medicine, prescribed dangerous drugs without a good faith examination and violated drug statutes. Revoked. April 5, 2001. Judicial review being pursued.

**RESARI, LOLITA QUINTAL, M.D. (A33421) Los Angeles, CA**  
B&P Code §§810, 2234(e), 2236(a). Criminal convictions for Medi-Cal fraud, false written claims and grand theft. Revoked. March 23, 2001

**RIDGILL, EDWARD ALAN, M.D. (G40690) Whittier, CA**  
B&P Code §§725, 2234, 2234(b)(c)(d)(e), 2236(a), 2261, 2262, 2266. Stipulated Decision. Committed acts of gross negligence, repeated negligence, incompetence, and excessive prescribing in the care and treatment of 1 patient. Failed to adequately and accurately maintain patient records, altered medical records with fraudulent intent and criminally convicted of mail fraud. Revoked, stayed, 5 years probation with terms and conditions. February 7, 2001

**RODRIGUEZ-ELLIS, EVA, M.D. (A33241) Harbor City, CA**  
B&P Code §2234(c). Stipulated Decision. Departed from the standard of practice in the care and treatment of 1 patient. Public Letter of Reprimand. February 23, 2001

**RUIZ, GONZALO FLORES, M.D. (G75692) Lamont, CA**  
B&P Code §726. Stipulated Decision. Sexual misconduct with 1 patient. Revoked, stayed, 7 years probation with terms and conditions. March 23, 2001

**SAMBO, DELIA MANGA, M.D. (A33067) Los Gatos, CA**  
B&P Code §2234. Stipulated Decision. No admissions but charged with departing from the standard of care in the labor and delivery management of an infant. Public Letter of Reprimand. April 6, 2001

**SINGH, SWATI, M.D. (G84822) San Francisco, CA**  
B&P Code §2234, 2234(a)(b)(c). Stipulated Decision. Committed unprofessional conduct and repeated negligent acts in that during the performance of LASIK eye surgery the microkeratome blades were reused on up to 2 patients and the microkeratome assembly was used on up to 4 patients without being sterilized. Public Reprimand. April 9, 2001

**STIER, DAVID MARK, M.D. (G70818) San Francisco, CA**  
B&P Code §2234. Stipulated Decision. Convicted in North Carolina of a Class F felony. Revoked, stayed, 5 years probation with terms and conditions. February 9, 2001

**TAPSON, KERRI MICAEL P., M.D. (G71044)** Carmel Valley, CA  
B&P Code §2234. Stipulated Decision. Committed acts of unprofessional conduct by writing false prescriptions in the names of patients for the purpose of obtaining Vicodin for self-use and unsuccessful termination from the Board's Diversion Program. Revoked, stayed, 5 years probation with terms and conditions. March 2, 2001

**TRAN, PAUL CHI TIEN, M.D. (A35347)** Houston, TX  
B&P Code §§141(a), 2305, 3527(c). Disciplined by Texas for prescribing controlled substances to a patient without performing a physical examination and without obtaining a patient history. Also pled nolo contendere to a charge of fraudulent delivery of a prescription for a non-medical purpose. Revoked, stayed, 7 years probation with terms and conditions. March 31, 2001

**TSE, YARDY, M.D. (G82156)** Encinitas, CA  
B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in the care and treatment of 1 patient. Public Letter of Reprimand. April 24, 2001

**UPPAL, SATNAM SINGH, M.D. (A31940)** Merced, CA  
B&P Code §§2234, 2266. Stipulated Decision. Did not provide medical records in a timely manner and maintained inconsistent duplicate medical records. Revoked, stayed, 5 years probation with terms and conditions. April 11, 2001

**WEBSTER, WILMA PAULINE, M.D. (C42836)** Rosamond, CA  
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by the U.S. Air Force for performing in an unsafe and unacceptable manner due to a diagnosed neurological condition. Revoked, stayed, 3 years probation with terms and conditions. March 23, 2001

**WILLIS, LA VONNE THERESA, M.D. (C41645)**  
Hawaiian Gardens, CA  
B&P Code §§822, 2239. Stipulated Decision. Physical and mental impairment affecting her ability to practice medicine and self-use of drugs. Revoked, stayed, 6 years probation with terms and conditions. April 5, 2001

**WINTERS, KENNETH B., M.D. (A33139)** Long Beach, CA  
B&P Code §§725, 2234(b)(c), 2238, 2241, 2242. Committed acts of gross negligence and repeated negligence by failing to perform medically appropriate history and physical examinations, excessive prescribing, prescribing without a valid medical indication and prescribing dangerous drugs and controlled substances. Revoked. April 16, 2001

## **DOCTOR OF PODIATRIC MEDICINE**

**WEBER, BENNIE BUD, D.P.M. (E1441)** Victorville, CA  
B&P Code §2234. Stipulated Decision. Failed to comply with terms and conditions of Board-ordered probation. Revoked, stayed, 8 years probation with terms and conditions. March 1, 2001

## **SURRENDER OF LICENSE WHILE CHARGES PENDING PHYSICIANS AND SURGEONS**

**HIRSCH, MICHAEL ALAN, M.D. (C34797)**  
April 27, 2001

**JUHL, THOMAS RICHARD, M.D. (G20058)**  
February 27, 2001

**JULIAN, ALEXANDER, M.D. (A49823)**  
March 6, 2001

**LIN, JANG BOR, M.D. (A35329)**  
April 6, 2001

**MESSANA, BENEDICT JOSEPH, M.D. (G50162)**  
February 1, 2001

**MULFINGER, GEORGE L., M.D. (A16984)**  
February 27, 2001

**PIPER, MARVIN A., M.D. (G10907)**  
March 19, 2001

**PONRARTANA, PRASART, M.D. (A35226)**  
March 28, 2001

**STRAHAN, RONALD W., M.D. (C28592)**  
February 28, 2001

**SUMCHAI, AHIMSA PORTER, M.D. (G48983)**  
March 26, 2001

## **DOCTOR OF PODIATRIC MEDICINE**

**GOLDBERG, ALLAN MARSHALL, D.P.M. (E1832)**  
February 16, 2001

### ***For further information...***

Copies of the public documents attendant to these cases are available at a minimal cost by calling the Medical Board's Central File Room at (916) 263-2525.

**Business and Professions  
Code Section 2021(b) &  
(c) require physicians to  
inform the Medical  
Board in writing of any  
name or address change.**



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<b>Board of Podiatric Medicine</b>	<b>(916) 263-2647</b>
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<b>Board of Psychology</b>	<b>(916) 263-2699</b>
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**ACTION REPORT - JULY 2001**  
Candis Cohen, Editor (916) 263-2389

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