From Quackery to Quality Assurance: The First Twelve Decades of the MEDICAL BOARD OF CALIFORNIA

Linda A. McCready
and Billie Harris

Medical Board of California
1426 Howe Avenue
Sacramento, CA 95825-3236
February 1995

Written by Linda A. McCready
and Billy Harris

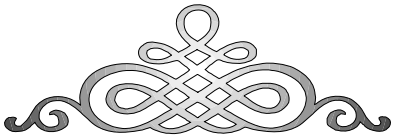
Edited and Designed by Linda A. McCready

Printed by Reprographics Division
Department of General Services
State of California

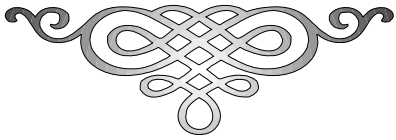
Contents

I. THE BOARD OF MEDICAL EXAMINERS: A 100-year Search for Professional Identity

II. THE BOARD OF MEDICAL QUALITY ASSURANCE: The Consumer Board



THE BOARD OF MEDICAL EXAMINERS: A 100-Year Search for Professional Identity



THE ESTABLISHMENT OF THE BOARD OF MEDICAL EXAMINERS 1876 - 1913

On January 24, 1848, James Wilson Marshall discovered gold while constructing a sawmill at Coloma on the American River. Not until May did the gold fever become virulent. By December 5, 1848, President Polk took official notice of the discovery and his words became the signal for a stampede. Marshall's discovery changed the course of California history as hundreds of thousands of gold seekers poured West. Some of the disappointed ones returned to the states, but vast numbers remained in the West, the majority in California, in particular in San Francisco.

When gold was discovered, San Francisco was a village boasting two hotels, two nearly completed wharves, and eight hundred and twelve persons. Early in the summer of 1848, the population shrank almost to zero — everyone had gone to the mines. But the City revived rapidly under the impetus of hundreds of thousands of dollars in gold pouring in from the diggings. Eighteen forty-eight saw the real boom with 40,000 argonauts avalanching upon the town. Whereas San Francisco had at least a municipal existence prior to the gold rush, several other communities owed their origin to it. Such were Grass Valley, Auburn, Placerville, Columbia, Sonora, Sacramento and Stockton.

Throughout the first decades of California's American period, growth and development were largely confined to the northern part of the State. Stimulated by the gold discovery, the north was where rapid population growth centered, where most of the city building, the lion's share of industrialization, most of the banking and merchandising, the main transportation improvements, the major innovations in politics and government, and the principal cultural advances took place.

Good doctors, for example, were rare and medicine was practiced by a variety of healers unchecked in their theories, methods, and prices.

Public services in expanding urban centers were unable to keep pace with population expansion and economic development. Good doctors, for example, were rare and medicine was practiced by a variety of healers unchecked in their theories, methods, and prices. But it was in Southern California that the quality of medical practice early became a prominent issue.

From the time of the American occupation, and particularly after the Gold Rush, California as a whole, and particularly the Southern portion, became the magnet that drew the physically weak and ailing from everywhere in the Eastern and Northern States and even from Europe. In a sense, it may be said that the original impetus to the development of Southern California, and of Los Angeles, came from the influx of health seekers. Indeed, Southern California in general rapidly became a vast tuberculosis sanitarium.

The counties south of the Tehachapi Mountains experienced modest but substantial growth: from 1850 to 1870,the population increased from 6,000 to 39,000. By the seventies, the south state was less beset by bandits and desperados; it was outfitted with improvements in transportation, particularly the railroad, and in accomodations. It had developed a number of new pursuits in which invalids or their relatives might find opportunity or employment.

At the same time, the medical profession was entering a phase in which a "healthy climate" was a favorite prescription. This combination of circumstances touched off a rush of health seekers which proved to be a chief dynamic for southern California development from the 1870s. The population jumped from 76,000 in 1880 to 325,000 in 1900.

The migration of thousands and then tens of thousands of invalids to Southern California was accompanied by a migration of doctors. In 1875, Dr. G. W. Linton, a well-traveled physician, remarked, "We in Los Angeles have a larger percentage of doctors in relation to the population than in any other city I know." One doctor, arriving in 1888 and looking about for a professional opening, had his hopes somewhat dampened when, on a single average block on Spring Street, he counted the signs of thirty-three doctors.

Inspection of the City Directory revealed the names of 165 doctors for a city of 70,000 inhabitants. The migration of physicians, and the experiences they gained in local practice with this bonanza of patients, stimulated medical advances. The opening of rest homes, convalescent homes,

and eventually sanitoria and hospitals specializing in tuberculosis and other maladies, relieved the chronically inadequate facilities and noxious conditions for semi-invalids.

There was a high susceptibility to cults and fads and a great deal of quackery.

The early doctors of Los Angeles, however, were hardly to be termed specialists. A prize exhibit of the versatility of early Los Angeles physicians is William Money, self-described as "astrologer, theologian, and physician." In 1855 he claimed to have treated 5,000 patients and lost only four cases. There was a high susceptibility to cults and fads and a great deal of quackery. The vogue of patent medicine was tremendous. Herbs, in particular, were given credit for the relief or actual cure of stubborn diseases. Fad diets for the curing of specific ailments were introduced by physicians.

The newspapers of these decades before 1900 were often blatant with advertised cure-alls, with quack doctors and quack remedies for very realistic and complicated diseases. There was Farak, the self-acknowledged "Wonder Worker" who made the blind to see, the lame to walk, who cured the sick, nervous, weak, dyspeptic, rheumatic, and paralytic, all by means of a "new system of medicine from Europe." The crucial element in his treatment appears to have been his "specific" medicines, which he declared "go straight to the diseased organs".

. . . in 1876 the Legislature passed the first Medical Practice Act.

State public officials began to look seriously at the inadequacies of medical practice in California during the 1870s as part of the new consciousness of the social responsibility of government. In an attempt to impose basic regulation on the practice of medicine in order to ensure quality medical care, in 1876 the Legislature passed the first Medical Practice Act. The new law provided for the California State Medical Society to appoint a Board of Examiners consisting of seven members. Dr. James Simpson was elected the first President of the newly organized Board.

An Executive Committee was appointed, consisting of the four members residing in or near San Francisco: Drs. J. Simpson, H. Gibbons, C.M. Bates, and H.P. Babcock. Dr. H. Gibbons was appointed Corresponding Secretary and Treasurer. The three remaining members of the Board were Drs. J.F. Montgomery of Sacramento, H.S. Orme of Los Angeles, and L. Robinson of Colusa. Because of the amount of clerical labor involved with the Board's activities, it was decided to appoint a recording secretary from outside the Board, and Dr. W.A. Grover, an active member of the

The first Board of Examiners' meeting was held in San Francisco on Thursday, June 29, 1876.

various medical organizations in the State, was chosen.

The principal regulations of the Board required that physicians holding diplomas or licenses exhibit them, accompanied by an affidavit of their authenticity, to any of the Board members. Practitioners who had never graduated nor procured legal licenses were required to present their names to the Board as candidates for examination. The granting of licenses could be done only at regular meetings of the Board. As meetings of the Board involved the State Medical Society in considerable expense, all unnecessary meetings were avoided. The Board held no meetings outside of San Francisco except for the purpose of examination, when meetings were held at Sacramento, Chico, and Los Angeles, according to announcement. The first Board of Examiners' meeting was held in San Francisco on Thursday, June 29, 1876.

Recognition and approval of the Medical Practice Act by the various medical societies of the State representing the recognized medical theories of the day, and by practitioners, was slow in coming. The act's acceptance came after heated argument, public debate, and legislative changes molded a Board of Examiners satisfactory to the profession, and to the concerned public.

. . . the 1878 Legislature revised the Medical Practice Act to provide for three separate Boards: a State Medical Society Board, an Eclectic Medical Society Board, and a Board [of the] Homeopathic Medical Society.

Conflicts over representation, power of appointment, and jurisdiction of the Board were devisive issues among the State's private medical societies. Many of the societies refused to recognize the Medical Practice Act, insisting that a Board appointed by the California Medical Society could not govern the quality of practice of systems of medicine not represented on the Board. For example, in 1876, the California State Medical Society of Homeopathic Practitioners initiated a legal scuffle for the recognition of its Board of Examiner's franchise and privileges. In order to end the conflict between medical societies over Board jurisdiction, the 1878 Legislature revised the Medical Practice Act to provide for three separate Boards of Examiners: a State Medical Society Board, an Eclectic Medical Society Board, and a Board elected by the Homeopathic Medical Society.

During the period between 1876 and 1901, the original Board of Examiners, and the three Medical Boards established in 1878, issued a total of 8,535 certificates to practice medicine at $5.00 each, which represented an income of $42,675. The costs of administration were extremely low, a fact which could have created a sizeable surplus in the Board's treasury to be used for the expansion

of its activities.

Unfortunately, the Medical Practice Act required that at the end of each year all surplus funds of the Board be reverted to the State. The Board treasury remained depleted until the fees for the next examination were collected. This annual depletion of the treasury occasioned repeated assertions by Board members that lack of funds severely restricted the Board's ability to control the quality of medical practice.

In 1901, the Legislature repealed all prior Medical Practice Acts and enacted a new law consolidating the three Boards of Examiners into one nine-member Board consisting of five members elected by the State Medical Society, two by the State Homeopathic Society, and two by the Eclectic Medical Society. Only this new Board of Examiners could grant the right to practice medicine in California. The Board was authorized to issue licenses only to physicians and surgeons passing the written examination required of all applicants.

The fee for this written examination was raised to $20.00 in an attempt to keep Board income in line with the increasing costs of administration. A salary of $2,400.00 per year was now provided for the Secretary. Badly needed legal counsel and clerical assistants were employed. As in the previous Medical Act, all excess Board funds were to be turned over to the State at year's end. During this period, California was still overcrowded with unlicensed practitioners. Prosecutions, spasmodically conducted, proved a serious financial drain. Enforcement dragged as expenses rose above Board income.

But the most serious threat in the Board's struggle for acceptance and stability was the continuing issue of the right of specific medical societies to elect members to the Board. In July of 1903, Dr. D. A. Hodgehead, Dean of the College of Physicians and Surgeons, initiated proceedings in Superior Court to have the members of the Medical Board ousted from their civil servant status. The reason for this action, according to Hodgehead, was that the medical societies which elected representatives to the Board were private corporations and had no right to appoint public officials.

In 1902, when the Board refused to certify a large class from the Pacific Coast Medical College because it was a night school, the College took the Board to court. Judge

Hunt decided that since the Board had not been appointed by a governing power, it was not a responsible agency and, therefore, the court did not recognize its actions as state law. Eclectic and homeopathic physicians declared, in a 1902 *San Francisco Chronicle* article, that the Board had "exercised its sweeping power to injure them and to promote solely the interest of the allopathic school," and that they would seek redress by demanding the repeal of the 1901 law creating the Board.

"The object of the law is clearly to protect the public from being preyed upon by a class of unscrupulous professional charlatans whose knowledge of medicine and surgery is the merest sham . . ."

The constitutionality of the 1901 Medical Act was finally tested in the State Supreme Court in 1904. There the law was upheld, the Court stating the 1901 Act showed plainly that the main purpose was to admit no one to practice who had not passed the Board's examination, and that such regulations were for the general welfare and to protect the people from mistakes of incapable practitioners.

The court decision prompted a *Chronicle* editorial which declared,

> The object of the law is clearly to protect the public from being preyed upon by a class of unscrupulous professional charlatans whose knowledge of medicine and surgery is the merest sham . . . If there is any fault to be found with the law in its present form, it is because its terms are not sufficiently stringent. The higher the standard of efficiency exacted of practitioners the better it will be for the medical profession and the public.

Another critical issue remained: did the examinations given by the Board actually aid in the selection of qualified physicians? A portion of the practicing medical profession had not yet agreed that examination was beneficial.

Peter Remondino, who felt compelled to voice his objections to Medical Board activities in book form, strongly condemned the examination system. According to Remondino, many competent physicians, skilled in hospital and surgical procedures, would fail a written examination because it emphasized information which a long practicing physician had no use for.

The paramount importance given to well-defined scholastic methods in the study of medicine, Remondino said, made the examination an unreliable gauge of the efficiency of the examinee. He also criticized the California Board's handling of examination procedures. His description of a

Board examination proctor reveals the intensity of feeling over the Board's expanding control.

> He would charge down, to and fro, like a stamping Apache waving his old blanket, circling among the students employed at their desks; would peek over their shoulders, apparently to familiarize himself with their handwriting, and generally comport himself in the most disturbing manner, as if he were a rustic bucolic judge at a Kansas cattlefair moving around the exhibited steers.

"He would charge down, to and fro, like a stamping Apache waving his old blanket, circling among the students employed at their desks; . . ."

In September of 1902, the breach in the medical profession caused by the questions and results of the examinations of that year widened. The Board was accused of contriving "by means of particular examination questions" to pass as many as possible of the student candidates from Toland Medical College, the State University College, and Cooper Medical College. Professors from colleges with high failure rates on the examination complained that half the questions in the pathology section of the test were "catch" questions designed to trip up students who had not been warned ahead of time.

Dr. F. W. Harris of the College of Physicians and Surgeons circulated a petition to repeal the Medical Practice Act and establish a new law making the Board directly responsible to the governing power of the State. In defense, Board members insisted that to give the Governor appointment power over the Board would be to involve it in unnecessary politics and that difficult examination questions were needed to "save the people from incompetents".

The charges of unfairness, favoritism, and corruption against the Board by a large group of physicians were further intensified in September of 1902 by the "French question" given in the pathology examination written by Dr. Dudley Tait of the Board. Dr. Winslow Anderson, President of the College of Physicians and Surgeons and editor of the *Pacific Medical Journal*, felt that the question "Describe the characteristic lesions in Hanot's cirrhosis." was unfair.

The physicians in the dispute insisted they had never heard of Hanot and that his name did not appear in the current medical dictionaries. In response, Dr. Tait, and Dr. W. S. Thorne, another member of the Board, stated that the critics consisted of "rejected physicians and professors of disgruntled colleges," and that among them was a Dr.

Tiedemann, "an illegal practitioner, who formerly wore stripes at San Quentin". For those remarks, Tait and Thorne were hauled into court on charges of criminal libel against Tiedemann, and the well publicized court proceedings further scandalized the Board of Examiners and dissolved its credibility with the medical profession and the public.

To alleviate the situation, and to strengthen the Board's controlling power, in 1907 the Legislature proposed new reforms of the Medical Practice Act. The 1907 law provided for a composite Board of eleven members appointed by the Governor rather than the medical societies. Five of the eleven members were chosen from the State Medical Society, two from the Eclectic Society, two from the Osteopathic Society, and two from the Homeopathic Society. The Osteopathic system of medicine was a new licensing duty for the Board. Board duties were further broadened to include the power to decide which medical schools would receive "approval" in terms of the quality of their educational facilities.

The Board also was given the responsibility for fixing examination fees and employees' salaries. An increase in examination fees from $20.00 to $25.00 raised Board revenue slightly, but did not cover the rising costs of administration. Some of the county medical societies attempted to help the Board with investigation and prosecution duties through fund appropriations. Since the Board did not publish a directory of names of licensed physicians, it adopted one published by the California Medical Society, although it was not of particular value in determining whether an individual was legally entitled to practice.

From 1876 to 1913, the Board of Medical Examiners spent most of its energies fighting to establish itself as a legal entity with jurisdiction over the medical profession.

From 1876 to 1913, the Board of Medical Examiners spent most of its energies fighting to establish itself as a legal entity with jurisdiction over the medical profession. It was a financially struggling commission dependent for its enforcement activities on contributions from medical associations. Investigation and prosecution duties lagged and the profession remained unpoliced.

Quacks and specialists operated openly in California's major cities. Telephone directories and advertising media were filled with announcements of self-asserted specialists of reknown who practiced, defiant of public welfare. Although the powers of the Board were developing and expanding, they remained weak due to finances and the continual crises over Board legality and jurisdiction.

THE DEVELOPMENT OF THE BOARD'S PUBLIC WELFARE ACTIVITIES - 1913-1950

In 1913 the Medical Practice Act was amended again to provide for a Board of Medical Examiners consisting of ten members, to be appointed by the Governor for a period of four years. This Board functioned as the sole medical regulatory agency until 1922 when the osteopaths and chiropractors succeeded in passing voter initiative acts. The initiatives authorized creation of a Board of Osteopathic Examiners and a Board of Chiropractic Examiners, each assuming jurisdiction and administering all matters pertaining to their respective schools.

This Board functioned as the sole medical regulatory agency until 1922 when the osteopaths and chiropractors succeeded in passing voter initiative acts.

The original 1913 Board of Medical Examiners consisted of Drs. W. W. Vanderburgh, Harry E. Alderson, both of San Francisco, Fred F. Gundrum of Sacramento, H. V. Brown, Robert A. Campbell, William R. Malony and D. L. Tasker of Los Angeles, H. Clifford Loos of San Diego, S. H. Buteau of Oakland, and Charles B. Pinkham of San Francisco who acted as Secretary for the Board. From its beginning in 1913, the new Board gradually developed from a financially struggling state commission, barely self-sustaining, into an organization nationally recognized as outstanding in its administrative activities. The Board was so well funded that by 1932 it had contributed $40,000.00 to the establishment of a State Medical Library.

An immediate challenge was made on the constitutionality of the 1913 Medical Practice Act. P. L. Crane brought action against the Board in the U.S. District Court for prosecuting him as a drugless practitioner. The courts upheld the Act and denied Crane's injunction. In another case, a "Chinese herbist" was denied a writ of habeas corpus, which further sustained the constitutionality of the Act.

Regardless of the challenges and attacks, the new Board attempted to smooth the conflicts of past years in order to establish itself on a firm footing. In the introduction to the Board's first "Quarterly Report" (March 1914) Charles Pinkham emphatically stated:

> The Board has no desire to establish itself as an arbitrary power, but on the contrary, it earnestly

wishes to bring about a spirit of cooperation with all practitioners. This body is administering a governmental function and feels that it must be responsive, promptly and efficiently, to all those who have any dealings with it.

Pinkham also outlined the public welfare responsibilities of the Board: (1) The certification of qualified practitioners; (2) the protection of the unwary from the wiles of the unscrupulous; (3) the offering of guidance to laymen as well as licentiates to promote better understanding of the law and the procedure connected with the medical arts. By 1916, the Board could report less conflict and unrest and more cooperation with members of the profession over licensing procedures and Board jurisdiction.

The enactment of the 1913 Medical Practice Act heralded a renaissance in finance. The most outstanding feature of the law was the creation of the Board of Medical Examiners' Contingent Fund in which all receipts were placed and used for administrative purposes rather than being turned over to the State at year's end. A revolving fund also was established out of which weekly expenses were paid. The provision for a reciprocity fee of $50.00 further increased Board receipts.

In 1917, the Legislature developed another source of revenue in the form of annual registration.

In 1917, the Legislature developed another source of revenue in the form of annual registration. Convinced of the value of annual registration as a means of keeping accurate addresses of licensed physicians, as a method of control over discredited physicians, and as a ready reference to determine credentials, the Board established a $2.00 annual fee. For a ten year period, from 1913 to 1923, the Board's surplus funds gradually increased, even though administrative costs rose as well.

Backed by a solid financial base and augmented revenues, the Board was able to expand its activities significantly. In 1916 the Board published its first directory which contained the names, addresses, and type of licenses held by all practitioners certified by the Board. It was sold for $2.50 a copy. The Board also began to issue quarterly bulletins beginning in March of 1914. The purpose of the bulletin was to furnish information to the public on medical licensure, on the interpretations of the provisions of the law, and on the technical phases of the Board's work. The quarterly bulletin formed the basis for the Annual Reports which began appearing in 1914.

The Board finally was able to develop an active enforcement department. In 1913, enforcement personnel consisted of one chief counsel and two special agents, as well as attorneys for northern and southern California. By 1920, the department had increased to nine, composed of a chief counsel, an associate counsel, three special prosecutors, two special agents with two assistants, and the northern and southern California attorneys. In 1913, 26 cases of violations of the Medical Practice Act were handled by the Board's enforcement department. By 1922, the number of cases had jumped to 48.

In 1913, 26 cases of violations of the Medical Practice Act were handled by the Board's enforce-ment department. By 1922, the number of cases had jumped to 48.

In order to accomplish the responsibilities assigned to it under the Medical Practice Act, (and after 1937, The Business and Professions Code), the Board appointed committees with specific tasks at the annual meeting each year. By 1920, eight committees had been established:

1. Finance Committee — established budget system for the Legal and Investigation Departments.
2. Credentials Committee — met two weeks prior to each meeting of the Board to check over each application and license, and make recommendations to the Board.
3. Law and Education Committee — gave legal opinions and analyses on issues needing clarification and updating.
4. Reciprocity Committee — reported on requests by out-of-state practitioners for California licenses.
5. Review Committee — graded examinations.
6. College Investigating Committee — investigated and reported on medical colleges for the purpose of receiving approval by the Board.
7. Legal Committee of the North, and
8. Legal Committee of the South — investigated violations of the Medical Practice Act for revocation and prosecution.

Beginning in 1914, written examinations were given to physicians, surgeons and drugless practitioners four times a year at different locations in the State. From 1918 to 1949, the Board was issuing nine different classes of certificates based on these examinations, reciprocity, or credentials:

From 1918 to 1949, the Board was issuing nine different classes of certificates based on . . . examinations, reciprocity, or credentials . . .

- Class A — Physicians and Surgeons, written examination
- Class BB — Drugless Practitioners, written examination

- Class C — Physicians and Surgeons, reciprocity
- Class D — Physicians and Surgeons, government credentials
- Class E — Chiropodists, written examination
- Class CE — Chiropodists, reciprocity
- Class F — Midwife, written examination
- Class CF — Midwife, reciprocity
- Class G — National Board Certificates

After 1937, no new certificates were issued to midwives, and after 1949, drugless practitioners were no longer being licensed.

The requirements for applicants wishing to be examined in each class became more specific and rigorous over time as the Board made every effort to insist on high educational standards in California medical colleges, and standards which kept up with the advances in medicine. The Board defined and redefined the number of units, the types of courses, the number of years of internship, and the amount of laboratory work required for examination. Each class of applicants required a special set of examination questions, and each group of questions could be translated into a foreign language if the applicant requested.

In 1914, as a result of passing grades on the examinations, the Board issued 139 certificates for licenses within the various classes. By 1920 the number had risen to 712 and then dropped down in 1928 to 525. By 1933 the number of certificates issued had decreased again to 442. Thereafter, it continued to rise; 655 certificates issued in 1937, 759 in 1940, and 1,107 in 1944.

The problem of out-of-state physicians attempting to gain a license to practice medicine in California was a challenge during the early years of the Board. According to Secretary Charles Pinkham:

> To the hospitable shores of California, attracted by the vast acreage of productive land, by the wonderful variety of climate and scenery, and by the ever courteous reception extended by her citizenry, flock our Eastern inhabitants . . .The Board must determine those migrating physicians who can be accorded the privilege of practicing medicine in California.

In 1915, progressive and rational standards had been established for the consideration of licentiates from other

states. The Board was empowered to enter into reciprocal relations, an exchange of the courtesies of licensure through the exchange of contracts with other states. Secondly, the law permitted California to issue reciprocity certificates to practitioners other than in medicine or surgery. Thirdly, applicants licensed in other states could take an oral examination as well as the clinical examination.

By 1920 Board Secretary Pinkham could report that California had established an "enviable reputation for the excellence of its educational standards and enforcement of regulations" as evidenced by reciprocal courtesies, unknown in 1913, that were extended to California by the examining boards of 25 states. From that point, the number of reciprocal courtesies grew until by 1945 they included all 48 states and United States territorial possessions.

Control over the qualifications of applicants to the Board was further extended when the Board began to put to use the provision of the Medical Practice Act requiring that an applicant for any form of certificate must be a graduate of a school approved by the Board. This power of approval ensured Board supervision over the regular course of medical study.

In April of 1915, the College Investigating Committee was appointed to thoroughly investigate the medical teaching institutions of California to determine which schools maintained a standard of efficiency meriting approval of the Board. The ultimate purpose of the Committee was to urge the maintenance of a high standard of professional education, ensuring the individual student access to adequately equipped laboratories, well-stocked libraries, an abundance of clinical material, as well as facilities for bedside instruction, as a foundation for the sane and successful practice of medicine.

In 1915, the Committee investigated, individually, all the California medical institutions of which it had knowledge, a total of 21 schools.

In 1915, the Committee investigated, individually, all the California medical institutions of which it had know-ledge, a total of 21 schools. Yearly investigations continued and expanded as an increasing number of schools were opened. In each case, the Board either approved the school, rejected it, or urged specific improvements in the school's curriculum and facilities before approval could be obtained.

For example, the original inspection of the College of Physicians and Surgeons of San Francisco demonstrated that the college buildings were inadequate, that the college clinic department was not well organized and supervised, and that the library was poorly arranged and equipped. No

fulltime professors or assistants were employed by the College. The College Investigating Committee submitted a report to the College and to the Board on the improvements required before approval could be given.

In 1916 the Committee could report that "this college has made extensive and very satisfactory improvements in their facilities . . . Ample laboratory space . . . has been provided, and the work is well organized and supervised. The Faculty has been reorganized and fulltime and half-time teachers provided for the laboratory departments. An excellent library has been established and is available to the students at all times." The committee recommended temporary approval of the College of Physicians and Surgeons.

In inspecting the Ratledge System of Chiropractic Schools of Los Angeles, the Committee found that no material or essential change had been made in the organization and management of the school. "Your committee feels that any college wishing to conduct a teaching institution properly under the law . . . should endeavor to place the educational work of their institution on such a high plane as to be outside of any question of approval by this board." Ratledge School was not approved.

Before the chiropractic initiative recognized drugless methods as respectable, and gave an independent Chiropractic Board responsibility for licensing the drugless practitioner, the College Investigation Committee found the majority of the schools teaching various drugless systems to be deficient in meeting the required educational standards. Even after the 1922 initiative enactment, the Investigation Committee carefully watched the establishment of drugless schools.

The need for particularly cautious and detailed inspections of schools was caused by California's early corporation laws. The laws were so framed that any group of individuals could incorporate to conduct a medical institution, and without manifestation of faculty, equipment, or financial responsibility, issue diplomas which were of no benefit to the holder. Since no legal safeguard against fake schools existed, the Medical Board attempted to assert its power of approval to expose the "diploma mills" in California.

Since no legal safeguard against fake schools existed, the Medical Board attempted to assert its power of approval to expose the "diploma mills" in California.

The job was long and tedious. According to Charles Pinkham, as long as the lax state laws permitted the incorporation of "sundown" institutions, traffic in fake diplomas would continue. For example, California's most

notorious "incorporated" school was the Pacific Medical College of Los Angeles. The College Investigation Committee refused approval to the school and its diploma was never recognized by the Board. The College's avowed object was to furnish the degree of "Doctor of Medicine" by short cut.

Board investigators reported that alleged students of the College were at the same time students at the College of Osteopathic Physicians and Surgeons located on the opposite side of the street, and that Pacific Medical College diplomas were issued without attendance.

On the eve of threatened prosecution for fraudulent issuance of diplomas, the institution reported disincorporation proceedings in 1918. Evidently a surplus lot of diplomas remained on hand, for frequent reports from various states related possession of these diplomas by individuals who had never been in Los Angeles. Andrew Draser, a graduate of a California chiropractic school and a licensed drugless practitioner, testified before the California Medical Board that in 1920 he purchased a 1917 Pacific Medical College diploma for $150.00.

Andrew Draser, a graduate of a California chiropractic school and a licensed drugless practitioner, testified before the California Medical Board that in 1920 he purchased a 1917 Pacific Medical College diploma for $150.00.

Between 1923 and 1925 a national "diploma mill" ring centered in Missouri was exposed by the *Saint Louis Star*. The exposé revealed the magnitude of the traffic in fraudulent medical credentials, diplomas, and state licenses. The *Star* reported that a clique of doctors in Missouri operated a nationwide clearing house for the sale of fraudulent medical documents. Nearly every state was touched by the scandal.

One of the main leaders of the ring had purchased fraudulent Pacific Medical College credentials in Los Angeles and distributed them to some three or four thousand persons throughout the United States. They became graduates of an institution which, in reality, never had a graduating class. Sporadic outbreaks of diploma mill epidemics continued to make newspaper headlines throughout the 1920s and 1930s. The crises occupied the Medical Board's constant attention as they attempted to investigate any credentials that might be fraudulent and to prevent profiteering in false documents.

In 1925 the Medical Practice Act was strengthened by the addition of a section empowering the Board to revoke the license of anyone found guilty of the purchase, sale, altering, or fraudulent use of any diploma in connection with the application for a license. The "Diploma Mill" Bill, passed

by the Legislature in 1927, made it a felony to file fraudulent credentials with the Board, with a penalty of one to three years imprisonment.

Armed with its new weapons, the Board began to take action against the use of fraudulent credentials in California. The *San Francisco Chronicle* reported a Board charge against a Pasadena physician who obtained his degree by hiring another man to take his examination in Georgia, and then obtaining a certificate to practice in California. Another physician was charged with having a fake high school diploma and with having purchased medical college credentials in California. Board annual reports during the 1920s are filled with investigations of fraudulent credentials, and explanations of methods of recognizing fraudulent documents.

Board annual reports during the 1920s are filled with investigations of fraudulent credentials, and explanations of methods of recognizing fraudulent documents.

The 1927 annual report, for example, demonstrates how the Board recognized an imposter, Agnes May Martin, who managed to obtain the full University of California transcripts of the legitimate doctor Alma Stevens Pennington, and then applied to the Board for a credential with these documents. The California Board helped the District of Columbia revoke the license of Harry Stewart Wittkopp. He had obtained a medical diploma from a defunct San Francisco Medical School which had no record of his attendance, and then had gained entrance to the District of Columbia examination with the false diploma.

But the Board was not always successful at punishing imposters. In 1928, the Board vigilantly watched the development of an organized diploma mill ring which proposed to supply diplomas from recognized medical schools and a state license to practice medicine for $950.00. Board investigators arrested the leader of the ring, K. Higashi of Los Angeles, who confessed how he and his co-conspirators had planned the diploma mill ring while serving sentences at Leavenworth Penitentiary. Higashi was released on bail and fled to Mexico, where he remained at large.

The investigation of fraudulent credentials and diploma mills continued throughout the 1920s on a wide scale. The Board continually urged legislation to curtail the incorporation and operation of fraudulent institutions before public harm could be done. In the Board's opinion,

> Our lax corporation laws permit a small number of individuals without demand as to educational qualifications to incorporate an asserted educational

> institution under any euphonious name, obtain authority to issue degrees of all kinds and thereby obtain money from the credulous. . . .California unfortunately is one state where about three individuals with approximately $12.50 to spend can incorporate any kind of a non-profit sharing college and issue any kind of a degree without molestation.

In 1928, the first College Incorporation Bill came into effect, which set standards for incorporation that could be met only by bona fide, *responsible institutions.*

In 1928, the first College Incorporation Bill came into effect, which set standards for incorporation that could be met only by *bona fide*, responsible institutions. The Board noticed an immediate decrease in the incorporation of fly-by-night schools. In 1931 a second College Incorporation Bill was passed adding another check on schools granting professional degrees by requiring an annual report from each institution. These reports listed the names and addresses of its students, the courses of study offered, the names and credentials of the teachers employed, the degrees granted, and any other important education activities.

Lax corporation laws permitted the granting of diplomas such as "Doctor of Cinesitherapy Manipulation" and "Doctor of Massage" by legally chartered one-man schools.

Although the "diploma mill" scandals were curbed dramatically by these controls, the problems of the spurious diploma wore on. In 1939 Secretary-Treasurer Charles Pinkham again urged strengthening of California's corporation laws. He noted that the worthy purpose of earlier legislation had been circumvented by the purchase of charters of defunct schools which permitted the establishment of a "University" for fraudulent purposes. Lax corporation laws permitted the granting of diplomas such as "Doctor of Cinesitherapy Manipulation" and "Doctor of Massage" by legally chartered one-man schools. The Board continued its vigilant efforts to halt issuing of diplomas without merit or value to either the student or the general public.

The problem of verification of diplomas and credentials was particularly difficult in the case of foreign medical school graduates. The problems of the verification of documents and quality of education of foreign medical school graduates grew over the years as the number of these graduates increased. The issue first drew the attention of the Board because of the large number of Americans, unable to qualify for the regular course of instruction in approved medical schools in the United States, who entered and completed their medical education at foreign medical schools.

The political turmoil in Germany and Russia at the close of World War I worsened the situation because of

the great influx of medical school graduates from these countries into the United States in search of a haven to practice. The Board experienced tremendous difficulty in obtaining satisfactory credentials from these graduates. Many of the Russians contended they were forced to flee, leaving everything behind, and were unable to secure documents evidencing their education from the Soviet Government.

The problem of spurious foreign documents became a difficult issue for the Board from the early 1920s on. Hamilton McClasky, for example, applied for the Board's examination in 1928 on the basis of a diploma from the Kansas City College of Medicine, one of the principal institutions involved in the 1924 diploma mill scandal, and one from the National University of Belgium. McClasky presented the Board with a diploma, a certification of course of study, and translations of the documents by the Belgian Consul, from this last institution. But despite this impressive portfolio of documents, the Board quickly proved that a National University of Belgium never existed. It was, and the documents were, frauds perpetrated by McClasky.

In 1933 the California Board adopted resolutions of the Federation of State Medical Boards . . . [for] national standards for foreign medical school graduates.

In 1933 the California Board adopted resolutions of the Federation of State Medical Boards in an attempt to conform with developing national standards for foreign medical school graduates. The resolution exacted of the graduates compliance with the same standards of premedical and medical education established by the Association of American Medical Colleges and Hospitals of the American Medical Association. An added requirement was that each foreign medical school graduate must also hold a license to practice medicine in the same country in which he received his medical education.

In 1936 California adopted a resolution by the American Medical Association resolving that in order to adjust the inequalities of medical education and to show knowledge of accepted medical practices, each foreign graduate should be required to present a certificate acknowledging the completion of one year's work as an intern before being admitted to the written examination. If the internship was not completed at a foreign medical school, then it must be completed at an American medical college under close supervision as a fourth year.

In 1939 foreign graduates were requested by the California Board to complete a fifth year post-graduate internship in a school approved by the Board. Beyond setting uniform standards for foreign medical graduates seeking to practice in California, the Board continued to review each individual

applicant in order to verify all credentials and to ensure continual standards of quality by all physicians licensed by the State.

Between 1913 and 1940, under the leadership of Secretary-Treasurer Pinkham, the Board established and developed a major campaign against the medical fakes, imposters, and swindlers who inhabited California's cities. In 1913, when Pinkham took over the secretariate for the new Board, any California city of any size contained a variety of quack and specialty offices which advertised openly and played on the innocence of the general public. A chain of quack "specialist" offices under the ownership of one small group operated in all of California's largest cities.

Between 1913 and 1940, . . . the Board established and developed a major campaign against the medical fakes, imposters, and swindlers who inhabited California's cities.

Los Angeles, in particular, was overrun with specialist offices and wax work museums of anatomy, a number of the offices being run by three individuals who operated a chain all along the coast. Immunity from punishment seemed to bless these large groups, while petty violators of the Medical Practice Act were harassed with persistent prosecution. It was the organized violators of the Medical Practice Act, adept at victimizing the public on a large scale, who became the main target for the Board's enforcement campaign. According to Pinkham,

> Bitter was the fight. Threats were made to bludgeon our investigator. Mysterious nocturnal telephone calls sought to lure the administrative officer of the Board of Medical Examiners to various unfrequented parts of the City of San Francisco. . . . Gradually the fight was won. Editorials in our daily papers expressed the gratitude of the people of our State and a deluge of letters commended the Board . . . for their agressive and successful campaign.

The *San Francisco Call* newspaper provided active support for the efforts to close down quack offices. Front page publicity written by a specially assigned reporter related the details of the campaign and vividly portrayed the stories of their victims. A daily "box" requesting those victimized to communicate with the *Call* produced a fund of otherwise unobtainable information in prosecuting offenders.

Each year the Board's annual report reflected its strenuous efforts to advance the standards of medical service furnished the State's citizenry and to protect the public from imposition. The Board's activities aroused nationwide attention. In 1925 the *Journal of the American Medical*

Association commented:

> . . . during the last seven years the Board of Medical Examiners [of California] has conducted a thorough and continuous campaign against pseudo doctors . . . the prosecutions have been quite successful . . . from no other state during the last six or seven years have so many reports been received regarding the prosecution of illegal practitioners and the revocation of the licenses of physicians found guilty of criminal or illegal practice . . .

Supported by an annual tax on licensed physicians, the Legal and Investigation Department of the Board grew from four to a force of ten individuals who devoted conscientious effort to discourage violation and encourage compliance with the law. Efficiency of operation required that California be divided by an imaginary line from the Nevada border on the east, through the City of Fresno and southwest through the City of San Luis Obispo. The Northern Department had jurisdiction above the line, while the district to the south was covered by the Southern Department with headquarters in Los Angeles.

A carefully devised system of records assured efficiency of operation and provided in the office of the Board Secretary an accurate check of the entire system of operation. Originally, when the special agent of the Board had secured satisfactory evidence of violations of the Medical Practice Act, the facts were presented to the local authorities on whom dependence was placed for the issuance of a warrant for arrest.

In 1939 legislation made the special agents peace officers themselves and eliminated this dependence. Court proceedings then began. If found guilty, the violator was fined, could be given a jail sentence, and was placed on probation during which time he could not practice medicine, or had his license to practice medicine revoked altogether. The Board continually urged stronger penalties for the objectionable medical methods practiced by quacks.

Some of the major targets of the Board's enforcement campaign during the 1920s were the "beauty specialists" — outlaw "face lifters", "peelers", and "fillers".

Some of the major targets of the Board's enforcement campaign during the 1920s were the "beauty specialists" — outlaw "face lifters", "peelers", and "fillers". These predators advertised in daily papers and inflicted irreparable damage on a large number of individuals who subjected themselves to the ministrations of these fakers in the hope of

delaying the inevitable marks of age. For example, permanent disfigurement resulted from "fillers" who injected a paraffin base all about the region of the wrinkles in an attempt to smooth the skin surface.

The victims were reluctant to admit their disfigurement and refused to testify in court against the filler quacks. Finally, the mother of a well-known stage celebrity in San Francisco who suffered almost complete ptosis (drooping) of both eyelids following a filler procedure, agreed to help the Board prosecute the San Francisco filler. Several other convictions, combined with the publicity given this case, closed down most of the fillers who haunted California's cities.

Another group in the "beauty specialist" classification were the "face peelers". The Board's 1927 annual report described the procedures followed in face peelings, varying from brushing the face with carbolic acid solution to the application of a paste composed of salicylic acid, biocloride of mercury, or some other equally dangerous poison. Absorption of the chemicals used caused numbers of deaths. Pressure from the Board of Medical Examiners finally forced legislative action to regulate the practice of cosmetology in California. The new law prohibited the application of carbolic acid by cosmetologists.

The notorious waxworks museums of anatomy finally closed their doors during the 1920s after a long and bitter battle with the Board of Medical Examiners and other State and federal agencies. Noisy automatic pianos attracted attention to the museums and to the "Admission Free" announcement. Inside would be found a pretentious display of life-sized wax figures depicting alarming disease conditions, all designed to frighten the visitor into consultation with the doctor.

In one of many cases, a "specialist" agreed to perform a varicocele operation in his office for a fee of $12.50. When the specialist's cohort searched the victim's clothing during the operation, and found a bank book showing a $115.00 deposit, the quack threatened to let the victim bleed to death unless he signed over to him a check for $112.00. Extinct by the early 1930s, the wax work museums had plagued California for more than 40 years, and were suppressed only by a constant and vigorous campaign by the Board.

The Board also waged relentless warfare on the eyesight swindlers who, traveling in pairs, located some elderly person of means, suffering from failing eyesight. By a convincing sales talk, these fakers agreed for a large

. . . the procedures followed in face peelings, var[ied] from brushing the face with carbolic acid solution to the application of a paste composed of salicylic acid, biocloride of mercury, or some other equally dangerous poison.

payment in advance to absorb an allegedly fast-developing cataract. Mythical "radium water" was dropped into the victim's eye. By some sleight of hand manipulation, a piece of rubber tissue was made to appear as if taken from the victim's eye. This was displayed as the cataract which had been removed. The fee for this operation was as much as $6,000.00.

The Board published warnings to the public in every newspaper in the State, and a comprehensive article written by the Board Secretary for the *Bulletin* of the Federation of State Medical Boards fully exposed the sales talk of these sharpers. Board annual reports were filled with the photographs, descriptions, methods, and investigations of the swindlers who continued to victimize older citizens of California into the early 1940's.

Cooperating with other licensing boards under jurisdiction of the Department of Professional and Vocational Standards, the Board of Medical Examiners presented an exhibit and display at the 1930 State Fair unique in its educational value. It graphically pictured the various frauds used by those who preyed upon the sick and afflicted. The exhibit included affidavits and reports on the harm caused by X-ray machines used to remove hair from the human body, a rogues gallery beneath a placard reading "Beware of Eyesight Swindlers", exhibits of fraudulent credentials seized by the Board. The purpose of the exhibit according to Pinkham was to carry a "warning message throughout the State that will be most helpful in guarding our citizens against such swindlers".

It was not only the quacks whom the enforcement department concerned itself with; licensed California physicians who preyed upon the public also came under its scrutiny.

It was not only the quacks whom the enforcement department concerned itself with; licensed California physicians who preyed upon the public also came under its scrutiny. After a three year investigation, an abortion ring covering the entire Pacific coast was cracked in 1936. Hospital associations rackets felt the Board's wrath in 1933 and 1934.

Over a comparatively short period of time, the Board of Medical Examiners had developed its regulatory and enforcement powers to the extent of ridding California of some of the worst offenders and abuses in the medical profession. By the Board's efforts, the public welfare was made more secure and less open to the dangers of medical chicanery. Fully established as a powerful regulatory agency, the Board could now develop and continually modernize its organization in the hopes of staying abreast of the problems within the medical profession.

ADMINISTRATIVE AND ORGANIZATIONAL CHANGE 1950-1976

Under Wallace W. Thompson, who served the Medical Board as Executive Secretary from 1953 to 1971, William Faux, 1971 - 1972, and Raymond Reid 1972 - 1976, the Board of Medical Examiners continued to fulfill its public welfare responsibilities, and to develop new methods of assuring quality medical practice in California.

The Board's first duty remained the examination for licensure. Board members themselves continued to prepare the written examination. One member was assigned to each of the following nine subject areas covered in the test; anatomy, physiology, bacteriology, biochemistry, obstetrics and gynecology, pathology, general medicine and therapeutics, general surgery, public health and preventive medicine. The written examinations were in essay form until 1953, when the Board decided to try objective, multiple choice type questions, in a number of subject areas.

Beyond examination for licensure, the Board continued to expand its role in the approval of medical schools, hospitals for the training of interns and hospitals for the treatment of narcotic addiction. It also focussed on consideration and approval of rules and regulations, hearing of accusations filed against licensees, and making suggestions to the Legislature concerning amendments to the *Business and Professions Code*.

THE ALLIED HEALTH PROFESSIONS

A number of new independent committees came under the Board's jurisdiction during the 1950s. Prior to 1957, the licensing of podiatrists was carried out directly by the Board of Medical Examiners but in that year the Podiatry Examining Committee was established. The Association of Podiatrists had petitioned for a licensing board of their own; however, the Legislature responded by authorizing a Committee under the Board. Comprised of five licensed podiatrists and one public member, the Committee received and approved applications, prepared and conducted examinations, and recommended to the Board those persons to be licensed.

The Board also has regulated Physical Therapists since 1953. At the time the Physical Therapists sought licensing, the members of the group could not reach agreement on the conditions under which they would be "blanketed" into licensure (licensed on the base of prior practice). This resulted in two forms of licensing, one for Registered Physical Therapists (RPT) and one for Licensed Physical Therapists (LPT). In the latter case, a Physical Therapy Examining Committee was established, comprised of three Physical Therapists, one physician, and one public member.

The distinction between the two groups of therapists is that the RPT was required to work under a physician, whereas the LPT could work independently, but could not diagnose. The LPT group had drastically declined by 1963 when the last examination was given.

In 1957 the Psychologist Examining Committee was created by legislation and although attached to the Board, was assigned the full range of functions normally exercised by an autonomous licensing board. The Legislature placed the committee under the Board's jurisdiction because of its reluctance to create new independent boards. However, according to the law, the Board of Medical Examiners must act "solely at the direction of the committee".

The Board also began to license Registered Dispensing Opticians, who could fill prescriptions issued only by physicians and surgeons. This was not conventional individual licensing, but a license to a person, partnership, or firm to do business at a particular location.

One of the most important functions of the Board continued to be the consideration of accusations filed against licensees . . .

One of the most important functions of the Board continued to be the consideration of accusations filed against licensees who allegedly violated the provisions of the Business and Professions Code relating to the practice of medicine. The Code was continually developed and refined to cover the situations and violations which constituted grounds for disciplinary action, the denial of applications, and the suspension and revocation of licenses.

The consideration of disciplinary matters also was governed by the provisions of the Administrative Procedure Act (APA). According to the APA, the hearing of an accusation could be considered either by the Board, by a hearing officer sitting alone or, after 1965, by a District Review Committee. The decision as to how the case would be heard was originally made by a poll of the Board membership. During the 1950s the Board delegated this authority to the Secretary-Treasurer and the Executive Secretary.

If the accusation was being heard by the Board, the Board went into executive session after the public hearing and determined whether the licensee was guilty or not guilty and if found guilty, it determined the penalty that was to be imposed. If a hearing officer heard the matter, (s)he made a proposed decision which was either accepted or rejected by the Board.

In 1965, District Review Committees were created as a new approach to exercise of discipline.

In 1965, District Review Committees were created as a new approach to exercise of discipline. Five Committees were established, each serving a defined geographic area of California. Each Committee consisted of five licensed physicians appointed by the Governor from panels of candidates nominated by the local medical societies, medical school deans, and the Board of Medical Examiners. The Committees heard disciplinary cases assigned to them, sitting with a hearing officer, and made a decision which was then proposed to the Board. The Board either accepted the decision or ordered a rehearing.

The same legislation redefined and increased the authority of the Board to take disciplinary action against licensees in areas other than those previously included under "unprofessional conduct". Offenses now included gross negligence, gross incompetence, gross immorality, dishonesty and corruption, any conduct that warranted the denial of a certificate, and mental illness. These types of cases were generally heard by a District Review Committee or by the Board itself. During the 1960s, the Board participated in approximately 20% to 25% of the total number of hearings.

The 1965 legislation also permitted the Board to revoke a license for certain acts such as narcotics use, which formerly could be done only after a court conviction on criminal charges. However, the legislative provision was not wholly satisfactory since an individual could still appeal the revocation to the courts and thus stay its execution.

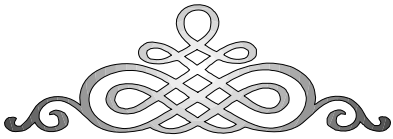
Commonly reported offenses involved improper use or prescription of narcotics and dangerous drugs, intemperance, illegal abortions, and practicing medicine without a license.

There was a substantial similarity in the enforcement programs affecting all groups licensed by the Board of Medical Examiners for several reasons: the Board set general policy, the same staff served all the groups, and since all functioned in the field of the healing arts, the punishable offenses were the same. Commonly reported offenses involved improper use or prescription of narcotics and dangerous drugs, intemperance, illegal abortions, and practicing medicine without a license.

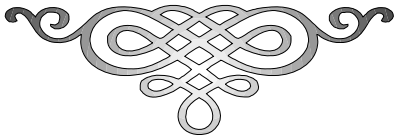
For example, in 1953, a Dr. M. Green was convicted of four counts of abortion and one count of moral turpitude.

Charles Price had his license revoked for intemperance to the extent of impairing his ability to practice medicine and surgery with safety. To understand the extent of the accusations heard by the Board, during 1965, 140 accusations were filed with the Board. Twenty-seven licenses were revoked. Forty revoked licenses were stayed with imposed terms and conditions of probation.

Legislation in 1976 introduced the concept of Continuing Medical Education, and required the Board to adopt standards for its reporting. Physicians would have to complete CME in order to renew their licenses.



THE BOARD OF MEDICAL QUALITY ASSURANCE:
The Consumer Board



THE BOARD OF MEDICAL QUALITY ASSURANCE 1975 - 1991

Cultures experience major changes in direction fairly rarely, perhaps most often following a war or natural disaster. Less commonly, a trend in the culture arrives at a juncture where continuing in the original direction is seen as an unacceptable option. In this context, a new way of looking at reality may emerge — a socalled pradigm shift.

Such a paradigm shift occurred in the early 1970s in the way the American culture viewed medical malpractice. With the advent of widespread health insurance, and the urbanization of America, the traditional relationship between physicians and their patients changed. This was especially true of their financial relationships.

. . . Americans became more likely to see the physician as a sort of mer-chant of medical care, and to expect the same implied warrantees of success as they ex-pected from plumb-ers or mechanics.

One consequence of this change was that Americans became more likely to see the physician as a sort of merchant of medical care, and to expect the same implied warrantees of success as they expected from plumbers or mechanics. When medical care did not succeed, we became more likely to seek recompense. By 1975, increases in the cost of medical malpractice insurance had begun to resemble the increases in the national debt.

It was not always possible for a physician to increase his or her fees to cover the increases in insurance costs. In practices where a significant portion of the patients served were in the Medicare or Medi-Cal programs, or had insurance which limited payments, higher fees often did not lead to higher payments to physicians. Malpractice insurance premiums became so burdensome that many physicians were forced to consider whether to change specialty to one with lower malpractice exposure. In one chilling example, for a period of time in the 1970s there were no physicians in Butte County willing to practice obstetrics. Pregnant women were forced to seek prenatal care outside the county. In other parts of the State, anesthesiologists and other physicians staged walkouts at hospitals to protest insurance costs.

California State Assemblyman Barry Keene accepted the challenge of trying to find a legislative solution to the growing crisis. When the regular Legislative session of 1975 did not produce reform legislation, Governor Edmund G. “Jerry” Brown, Jr. called the Legislature back into its second extraordinary session of the year, with one goal:

Assemblyman Keene's AB 1xx, the Medical Injury Compensation Reform Act or "MICRA" was passed and signed in December 1975.

malpractice reform. Assemblyman Keene's AB 1xx, the Medical Injury Compensation Reform Act or "MICRA" was passed and signed in December 1975.

MICRA had three principal foci: limitations on increases in insurance premiums without clear justification; controls on the amounts of monetary awards juries could make for socalled "pain and suffering"; and, controls on the contingency fees attorneys could charge for litigating malpractice actions.

A secondary issue addressed by the Keene bill was the structure and function of the Board of Medical Examiners. Under provisions of AB 1xx, a massive reorganization of the BME was mandated.

The new law changed the name of the Board of Medical Examiners to the Board of Medical Quality Assurance. The membership of the Board was increased from ten physicians and one public member, to twelve physicians and seven public members. The new emphasis on public members reflected the growing concern over regulation of physicians by members of the profession, and the importance of a public share in the responsibility for professional regulation. While the physician members continued to be appointed by the Governor, two of the seven public members were to be appointed by the Speaker of the Assembly and the Senate Rules Committee. All members were subject to confirmation by the Senate.

The new nineteen member Board comprised three sections: The Division[s] of Medical Quality . . . Licensing, and . . . Allied Health Professions.

The new nineteen member Board comprised three sections: The Division of Medical Quality, the Division of Licensing, and the Division of Allied Health Professions. Although working within the shell of the old Board of Medical Examiners, each division would operate as a semi-autonomous entity with plenary power in its own domain.

The **Division of Medical Quality** consisted of seven members, three of whom were public members. The responsibilities of the Division included:

- reviewing the quality of medical practice of physicians under the jurisdiction of the Board;
- administering discipline of physicians found to violate the law or regulations; and,
- carrying out disciplinary action appropriate to findings made by a Medical Quality Review Committee, an Administrative Law Judge, or the Division.

The seven member **Division of Licensing**, five physicians and two public members, was given responsibility for:

- developing and administering the physician and surgeon

examinations;
- issuing licenses and certificates;
- suspending, revoking or limiting licenses and certificates upon the order of the Division of Medical Quality;
- administering a program of continuing education for certificate holders;
- approving undergraduate and graduate medical education programs;
- approving clinical clerkships and special internship programs; and,
- administering student loan programs and grants.

The five member **Division of Allied Health Professions**, three physicians and two public members, had the following responsibilities:
- oversight over the activities of the examining committees and nonphysician certificate holders under the jurisdiction of the Board;
- discipline of nonphysician certificate holders to the extent such discipline is not within the jurisdiction of an examining committee; and,
- acting as liaison with other healing arts boards concerning the activities of their licensees.

The allied health professions within the jurisdiction of the Division of Allied Health Professions to varying degrees, included audiologists, acupuncturists, hearing aid dispensers, physical therapists, medical assistants, physician assistants, podiatrists, psychologists, registered dispensing opticians, and speech pathologists.

In order to aid the divisions in their new responsibilities, the legislation required the Board to establish and maintain a central historical file for each licensee. The file was to contain
- records of any conviction of a crime constituting unprofessional conduct, any judgement over $3,000 against a licensee for injury or death caused by malpractice,
- any public complaints, and
- any disciplinary information.

The law also established a Bureau of Medical Statistics under the Board whose responsibility was to compile statistical data to assist the Board in performing its responsibilities.

The five District Review Committees of the old Board of Medical Examiners were disbanded in favor of fourteen Medical Quality Review Committees...

The five District Review Committees of the old Board of Medical Examiners were disbanded in favor of fourteen Medical Quality Review Committees (MQRC) under the jurisdiction of the Division of Medical Quality,

established on a geographic basis. Each MQRC was to have a specified number of physicians and public members, ranging in size from ten to twenty (later forty) members, all appointed by the Governor.

Medical Quality Review Committees were given the authority and duty:

- to initiate reviews of the quality of medical care practiced by physicians,
- to investigate all matters assigned to them by the Division of Medical Quality,
- to initiate investigations of complaints that a physician has been guilty of unprofessional conduct,
- to investigate circumstances which resulted in any judgements requiring a physician to pay damages in excess of a cumulative total of $30,000,
- to seek injunctions or restraining orders, and
- to conduct disciplinary hearings.

One goal of the new law was to increase the quantity and quality of information the Board received from outside sources about the conduct of physicians. The law required all hospitals and medical facilities to inform the Board when medical staff privileges were restricted or revoked. Insurers were required to send a complete report to the Board when a settlement or arbitration award over $3,000 was made for injury or death caused by malpractice. And, attorneys, court clerks and the physicians themselves were required to report any judgements in excess of that amount.

It has been estimated that these reforms increased the costs to the Medical Board's Contingent Fund by at least $2,200,000 annually. These funds were needed for the per diem and expenses of eight additional board members, and the salaries and operating expenses for fifty-four additional technical, consultant, investigative, and clerical positions to staff the Medical Quality Review Committees, the Bureau of Medical Statistics, and the Divisions of Medical Quality, Licensing, and Allied Health Professions.

An increase in the biennial physician and surgeon certificate renewal fee to $175.00 was necessary to fund these changes. The renewal fee prior to the legislative act was $20.00 and there were currently 80,000 physician and surgeon licenses in effect in California.

To accomodate its growing size, in 1976 the Board moved from its old location at 1020 N Street in Sacramento to new quarters at 1430 Howe Avenue in the same city.

1977 - 1980

Several major structural and functional changes occupied the Board and its staff during the years immediately following passage of MICRA. The metamorphosis was particularly dramatic in 1977. During that year, the Board took over its own investigation of consumer complaints from the Department of Consumer Affairs. To accomplish this, regional offices were established in four cities statewide, and staffed with investigators, medical consultants and clerical support.

Several major structural and functional changes occupied the Board and its staff during the years immedi-ately following passage of MICRA.

In April of 1977, the Board hired a new Executive Director to replace Raymond Reid. Robert G. Rowland served as director until 1983, and oversaw numerous changes. A graduate of Stanford University with a Masters Degree in Business Administration, Rowland served as the Stanford Medical School's business manager prior to coming to the Board. Between the retirement of Director Reid in October 1976, and Rowland's arrival the Board was administered by Joseph P. Cosentino, M.D. Dr. Cosentino subsequently returned to his principal role as Chief Medical Consultant.

The first Chief of Enforcement appointed by the Board, Vernon A. Leeper, came with an extensive background in local law enforcement, and Medi-Cal Fraud investigations. The Board also acquired the services of Foone Louie, J.D, as its staff counsel.

While the Enforcement Program was swinging into full gear in 1977, the Division of Allied Health Professions was heavily involved in the rapid evolution of supportive health occupations. With new licensure programs for Acupuncturists and Research Psychoanalysts, development of regulations for Medical Assistants, recommending standards for administration of topical drugs by Optometrists, developing examinations and licensure standards for Physician Assistants, and pressure to legalize midwifery, the DAHP was meeting monthly.

In response to the demands of several health occupations for licensure programs, the Legislature instructed the DAHP to make recommendations on the ***"Desirability of Certifying Currently Noncertified Categories of Personnel Providing Health Services of a Technical Nature"***. This report, with the short title ***"The Credentialing Report"*** recommended creation of a Health Occupations Council with

"The Credentialing Report" *recommended creation of a Health Occupations Council . . . to evaluate proposals for regulation of emerging health occupations . . .*

legislative mandates to evaluate proposals for regulation of emerging health occupations, and to make recommendations to the Legislature on such proposals.

Although legislation was introduced for several years to create such a council, none was successful. Similar "sunrise" committees were tried in other states, with varying degrees of success. The key issues they addressed included whether the public needed to be protected from unregulated practice of a specific occupation, whether regulation could be effective without actual licensure, whether there was a clear definition of the occupation and its scope of practice, and whether there was some private organization which already was providing appropriate controls on practitioners.

A new requirement emerging from AB 1xx (MICRA) was that hospitals had to report internal discipline of physicians to the Board. Business and Professions Code, §805 required reporting suspension or termination of privileges, and other limitations on practice for medical quality reasons if the cumulative total exceeded 45 days in a year.

A topic of ongoing debate in the meetings of the Board during this period was the discussion of "scientific issues" and how the Board should respond to them.

A topic of ongoing debate in the meetings of the Board during this period was the discussion of "scientific issues" and how the Board should respond to them. Examples included use of experimental therapies such as chelation therapy, laetrile, and DMSO. After several years of having a standing agenda item to discuss these problems, the Board finally concluded it could not adopt formal postures on the specifics. Instead, it continued to rely on expert testimony when it prosecuted disciplinary actions involving their use.

Beginning in the Spring of 1977, the Board published a set of "Disciplinary Guidelines" which it would use to assure consistency in the penalties it imposed for various violations of the law. The original guidelines were published in the May 1977 *ACTIONREPORT,* which was sent to all licensed physicians. The *ACTIONREPORT* was the successor to a two-page newsletter *MEDICAL MEMO,* which was begun in 1972 to inform physicians of the Board's activities, meeting schedules, and disciplinary activities. By 1977, the *ACTIONREPORT* was four pages, and included articles on a variety of subjects affecting the practice of medicine.

Yet another issue before the board in the late 1970s was the appropriate prescribing of dangerous drugs.

Yet another issue before the Board in the late 1970s was the appropriate prescribing of dangerous drugs. The Board developed standards for what constituted "a good faith prior examination and medical indication", and in collaboration with the California Medical Association published guidelines for

physicians. The *ACTIONREPORTS* for the period also carried articles urging doctors to warn patients about possible interactions between prescribed medications and alcohol, as well as articles about the requirements for triplicate prescription blanks when prescribing narcotics.

The Medical Quality Review Committees (MQRCs) created by AB 1xx came into full activity in 1978, and began exploring the roles given them by the law. Local committees became involved in activities such as preparing public service announcements about the Board and the MQRCs, giving presentations to local groups, and exploring options in the local community for physicians with alcohol problems.

Hospitals and other health facilities, in the late 1970's, shared concerns about the legal scope of practice for registered nurses, RN midwives, physician assistants and other health occupations working in their facilities. In 1978, the Division of Allied Health Professions began developing proposed regulations to require Committees on Interdisciplinary Practice in all California hospitals. Eventually adopted by the Department of Health Services, the regulations required hospitals to establish a committee to evaluate the credentials of nonphysician health professions, and to determine what activities each could perform within that facility. The committees were to be composed of representatives of the medical staff, the hospital administration, and the affected health occupations.

Prior to 1978, physicians on license probation were monitored by having them appear at regular Board meetings for an interview with Board members. Beginning in that year, the Board initiated a probation monitoring system in which probation monitors periodically contacted the probationers. Monitoring included observation of the probationer in his or her medical practice and annual interviews with regional medical consultants. The focus of the probation period was rehabilitation and education, rather than punishment.

Finally, 1978 was the year the Board almost drowned in paper.

Finally, 1978 was the year the Board almost drowned in paper. Under AB 1xx, physicians were required to complete and return two documents to the Board when they renewed their licenses. The Physician Questionnaire was intended to provide a large amount of detailed data about the

demographics and practice profiles of California physicians. With 74,000 licenses in effect, all renewing at the same time, the two page questionnaire created a mountain of mail.

At the same time, the new laws required physicians to document that they had completed at least 25 hours of continuing medical education for eachof the prior two years. These documents arrived in the same envelopes with the questionnaires and the regular renewal forms. At that time, the Board still cashiered all its license renewals, not only for physicians, but for 20,000 allied health licensees as well. By the Spring of 1978, the Board had taken over about a fourth of the Consumer Affairs conference room at the Howe Avenue office complex just to hold the boxes of forms. It was many months before the paper got sorted out and processed.

Consistently, each year that an audit has been done, the sampled physicians have documented well over twice the required amount of CME.

In response to this unanticipated flood of paper, the Board developed an alternate approach to CME reporting. Physicians were required to sign a statement under penalty of perjury that they were in compliance, which was submitted with each license renewal.

A random one percent sample of physicians then were required to document their compliance. Consistently, each year that an audit has been done, the sampled physicians have documented well over twice the required amount of CME. The few physicians who were unable to document their hours were given two years to comply, and then were denied renewal of their licenses.

An innovation in 1979 improved the service the Board provided the public. Using a combination of telephones and computers, staff now were able to provide immediate verification to callers of the status of physician and other licenses.

Legislation developed jointly by the Board and the California Medical Association in 1979 created the Diversion Program for Impaired Physicians. The goals of the program were to provide early detection and intervention with physicians impaired by alcohol or other drug abuse or certain mental or physical impairments. The philosophy of the program was rehabilitation, and it was created to be confidential, even from the Board's Enforcement Program. Only if a physician "failed" in Diversion would the Board or its staff learn of his or her participation.

The spreading problem of prescription drugs becoming street drugs led the Board to focus on the role of physicians in drug diversion. The Board created a strikeforce of investigators who worked in close collaboration with the Board of Pharmacy, the Attorney General, local law enforcement and federal drug agencies. In its first two years, the Drug Strikeforce identified 182 physicians involved in illicit diversion of drugs to street sale. Accusations were filed against 166, criminal arrests made of 94, and 13 out of 14 temporary restraining orders sought were granted by judges.

As a result of insights gained through the Strikeforce activities, the Board sponsored legislation, carried by Assemblyman Leo McCarthy, which required physicians to use triplicate prescription forms for all Schedule II controlled substances. The law requires the prescribing physician to send one copy of the prescription to the State Department of Justice, and to retain the other.

Other 1979 legislation recognized the right of physicians to advertise their services as long as the advertising was truthful, did not make claims about quality or efficacy of services, and did not promote overuse of services. A bill supported by the Board increased the level at which malpractice settlements or judgements must be reported to the Board, from $3,000 to $30,000. The Board believed most small payments were made to settle nuisance suits without regard to whether there actually was malpractice involved.

Other 1979 legislation recognized the right of physicians to advertise their services as long as the advertising was truthful, did not make claims about quality or efficacy of services, and did not promote overuse of services.

During 1979, legislation required hospitals to check with the Board before granting or renewing staff privileges, to determine whether other health facilities had filed an "805 report" against the physician. Another bill made sexual relations with a patient unprofessional conduct. And under two additional bills, the requirement that Acupuncturists have a referral from a physician was repealed, and the Division of Medical Quality was allowed to assign petitions for reinstatement of license, or for modification or termination of probation to the MQRCs for hearing.

A major project of the Board that year was producing a booklet for physicians to assist them in intervening with colleagues who were impaired or had other practice-affecting problems. The "Physician Responsibility" booklet made the point that physicians are the most appropriate individuals to recognize problems, and to take the first steps to get them resolved. The booklet also provided information on the limits of exposure to personal liability when physi-

The "Physician Responsibility" booklet made the point that physicians are the most appropriate individuals to recognize problems, and to take the first steps to get them resolved.

cians exercise this responsibility. The booklet was distributed to all California-licensed physicians early in 1980.

1980 also was the year that the Board began to seriously explore the legal and practical relationships between physicians and other health professions and occupations. Under Section 2141 of the Business and Professions Code (later renumbered Section 2052), the practice of medicine had a global definition encompassing all aspects of the diagnosis and treatment of all physical and mental conditions of humans. The practice of all other health occupations was essentially prohibited except to the extent specific laws carved out exemptions from Section 2141.

The Board was able to enlist the financial support of three foundations to conduct a study of this issue. For more than a year, the Board conducted a series of three colloquia and two public hearings to reconsider the Section 2141 definition of the practice of medicine. During the following year, an outside contractor, Public Affairs Research Group, prepared nine reports, summarizing the colloquia and hearings, researching the literature and the relevant laws of other states, and recommending some changes in the law. Finally, Linda McCready, a BMQA staff member was enlisted to write a lengthy proposal to the Board for introducing legislation to make dramatic changes in how medicine was defined in California.

The proposal would have narrowed the exclusive domain of physician practice to diagnosis, prescribing drugs, surgery, certain endoscopic procedures, and the use of ionizing radiation for treatment.

The proposal would have narrowed the exclusive domain of physician practice to diagnosis, prescribing drugs, surgery, certain endoscopic procedures, and the use of ionizing radiation for treatment. All other activities could be done by other health professions and occupations without legal restraint, although persons using certain professional titles would be required to register with the State. As with then-current law, certain specified use of the five restricted activities would be permitted to other professions such as nursing, podiatry, dentistry, etc. pursuant to specific laws. Physicians, of course, would continue to have unrestricted practice of not only the defined activities, but of all other health care functions.

After lengthy debate over the course of several Board meetings, the Board concluded that the proposal was not politically feasible, and it was tabled. A complete set of the socalled "2052 Reports" is available in the Board library, but cannot be circulated.

During the 1970s, concern was widespread about the incidence of alcohol and drug abuse, and other

forms of impairment affecting California physicians. The Medical Assocation had an excellent voluntary program to assist its members, but there was no formal governmental intervention available. If the Board investigated a doctor and learned that substance abuse was a factor in the case, it had no option but to impose formal discipline. Addressing this problem, 1979 legislation created a diversion program for impaired physicians. In addition to those with substance abuse, the program was designed to assist physicians with mental or physical disabilities which affected their practice of medicine.

The designation "diversion" came from the provision that participants are diverted from formal discipline as long as they comply with the terms of an agreement enrolling them in the program and establishing a formal treatment plan. Under the original law, participation was limited to those who volunteered to enter the program. The goal stated in the preamble to the statute was

> . . . to identify and rehabilitate physicians and surgeons with impairment . . . so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.

The fact that a physician was in diversion was confidential, even to the Division of Medical Quality, except that in the event the physician failed to comply with the agreement, quit, or was terminated unsuccessfully, the Division would be notified.

During the late 1970s the BMQA became concerned about what it perceived as unresponsiveness from the Federation.

The Board of Medical Examiners and later the Board of Medical Quality Assurance had been an active member of the Federation of State Medical Boards since it was founded in 1912. In addition to being a national forum for all medical boards, the Federation administered the FLEX licensing examination. During the late 1970s the BMQA became concerned about what it perceived as unresponsiveness from the Federation. At the 1980 annual meeting, the Federation voted down a California resolution calling for increased participation of the various boards' public members in Federation business.

Other issues BMQA raised included adjusting the way Federation decisions were made to provide for at least somewhat proportional representation, relating to the size of the member states and their dollar contributions to the

Federation budget. There also were concerns about the content of the licensure examinations, and appointment of California board members to important Federation committees.

On September 27, 1980, following several months of discussions, the BMQA voted to withdraw from the Federation.

An interesting reinforcement of California concerns occurred at the May 1982 Federation meeting. The California Board of Osteopathic Examiners (BOE) joined the Federation. Based on the existing bylaws, this left the BMQA — if it rejoined — with half a vote to represent its 80,000 licensed physicians. With fewer than 2,000 osteopaths, the BOE also would have one-half vote.

Another major undertaking of the Board during 1980 was the Professional Performance Pilot Project (PPPP). Mandated by legislation, the PPPP selected three pilot areas in the State for development of a model for identifying substandard medical care and initiating improvements in healthcare delivery. Under the enabling law local MQRC groups were heavily involved in the Project. Participants also included hospital quality assurance bodies, medical societies, insurance companies and other quality of care organizations. The law provided specific protections from liability for participants.

During 1980, the Board sponsored an omnibus Medical Practice Act cleanup bill. Senator Barry Keene authored SB 1558, which reexamined 104 years of laws and amendments, and attempted to clarify, organize, renumber, and generally overhaul the statute. Many sections were ambiguous, or conflicted with other provisions, and many others were thrust haphazardly into articles dealing with unrelated subjects. For the next few years, the desk copies of the lawbooks included a "scorecard" to enable users to find the new section number for familiar old sections.

During 1980 and 1981, the Board and CMA developed and presented a series of workshops at hospitals and regional physician conferences.

Another 1980 bill repealed the requirement for medical corporations to register with the Board. This bill recognized that registration provided little or no consumer protection, duplicated the registration of corporations by the Secretary of State, and imposed unnecessary costs on physicians.

Following distribution of the "Physician Responsibility" booklet to all California physicians, the Board concluded more was needed. During 1980 and 1981, the Board and CMA developed and presented a series of workshops at hospitals and regional physician conferences. The work-

shops focussed on actual cases drawn from Board files. In small-group settings, participants were encouraged to develop strategies for intervening with colleagues experiencing practice problems. Wishing to impact an even wider audience, the Board and CMA eventually produced a videotape incorporating the case scenarios. The tape and instructional materials were made available statewide for hospitals and medical society programs.

The little profession that no-one knew took up a good deal of the Division of Allied Health Professions' time in 1978 and 1979. Three small schools in Los Angeles and one in San Francisco trained physicians and psychologists in classical psychoanalysis. Once in awhile, they also admitted an exceptional Ph.D. from another field. Since these lay analysts could not legally treat patients, the four schools persuaded Assemblyman Howard Berman to author a bill to license them as "Research Psychoanalysts". The bill also allowed the DAHP to approve other schools to train RPs if they deemed the schools equivalent to the founding four.

For nearly two years, the Division held marathon public hearings trying, through eight drafts, to adopt regulations defining equivalence. Witnesses from as far away as New York came to refight the ancient schisms between Freudians and their numerous prodigal progeny. At last, however, the Division wearied of the elegant, hairsplitting debate and said "This is how it shall be."

The fruit of this effort was a program which licensed 50 the first year;by the end of 1994, the number of active licenses had grown to only 53!

BLANK PAGE

THE BOARD, THE NATION AND THE WORLD 1981 - 1985

Concern continued in 1981 over the content of the national medical licensure examinations. Legislation in prior years added a number of subject areas for which the Board was expected to establish the competence of applicants for licensure. These included nutrition, geriatrics, child abuse and human sexuality. A series of meetings with representatives of medical schools made it clear that adding meaningful study of these topics to curricula was not feasible. There were 128 medical schools in the United States and another 900 worldwide, and each jealously guarded decisions about the content of its curriculum.

There were 128 medical schools in the United States and another 900 worldwide, and each jealously guarded decisions about the content of its curriculum.

Next, the Board explored enhancing the testing for those subjects in the National Board of Medical Examiners and Federation Licensing Examinations (NBME and FLEX). Even though the testing organizations made a sincere effort, they were unable to meet the expectations of the BMQA. The Board then contracted with CTB/McGraw-Hill to develop a supplemental examination for use in California.

However, a 1981 legislative bill to authorize the Board to administer this examination was defeated under strong opposition from organized medicine. Further negotiations with the national testing organizations led to a commitment to include the California questions in their test question pools. The Board then shelved the project while it evaluated the national effort.

The Professional Performance Pilot Project was concluded in June 1982 when its project manager accepted another position. Although the project funding would continue through the end of 1982, the Division of Medical Quality decided it had not produced the anticipated results, and decided not to hire another manager. The San Francisco pilot was offered the opportunity to continue its fairly successful quality assurance activities, but the County Medical Society declined. A more detailed analysis of the termination of this project can be found at page 46 of the Board's Annual Report for 1982.

THE CARIBBEAN MEDICAL SCHOOL CRISIS

Shortly after the beginning of 1983, reports began reaching the Board of what appeared to be a major international scandal over medical credentials. New York State and the United States Postal Service were investigating allegations that degrees from several Caribbean medical schools were being sold, sometimes by mail.

In June 1983, the BMQA Division of Licensing formally disapproved CETEC, and denied licensure to hundreds of its "graduates".

The initial investigations focussed on *Universidad Central de Estudios Technicos* (CETEC) in the Dominican Republic. This school was found to be producing fraudulent documents, granting credit for marginal or outright "bogus" courses, and following "liberal" transfer credit policies. In June 1983, the BMQA Division of Licensing formally disapproved CETEC, and denied licensure to hundreds of its "graduates".

The evaluation of individual applicants from CETEC and several other Caribbean schools was complicated by the discovery that at least some of the students actually had attended classes, and had received at least some if not all of a U.S. style medical education.

A taskforce was created in the Summer of 1983 by the Division of Licensing, to sort out the schools, the documents and the applicants. Board members and licensing staff went to the Caribbean and met with school representatives, government officials and students. They toured campuses and saw first hand the calibre of classrooms, laboratories, libraries and other facilities. One chilling photograph they returned with is of a rundown building with a cow grazing on the lawn, which represented the main building of one school.

The taskforce reports told of libraries with periodical collections that were decades out of date; . . . of whole classes sharing a single microscope or a single cadaver.

The taskforce reports told of libraries with periodical collections that were decades out of date; of one library that consisted of several boxes of books from a faculty member's personal collection; of whole classes sharing a single microscope or a single cadaver.

On the recommendations of the taskforce, the Division of Licensing adopted a set of guidelines for the licensing program staff to follow in evaluating the medical education of individual applicants who were trained outside the U.S. or Canada. The guidelines recognized that some students could have at least some acceptable credentials, and also sought to avoid charges of selective enforcement between countries and their schools.

The policy adopted by the DOL in August 1983 also included the concept of remediation. It gave students who were short of training in certain areas the option of taking additional work and correcting their deficiencies. This permitted eventual licensure of numerous applicants who attended the Caribbean schools. After the guidelines were implemented on an interim basis, the taskforce conducted a survey of the curricula of all 128 U.S. medical schools. Using the data thus gathered, the Division and staff developed regulations formalizing the guidelines with some modifications. Those regulations were adopted early in 1984.

Three schools, Ross University, Ameri-can University of the Caribbean (AUC) and St. Georges, filed suit against the Board in both state and federal courts.

The guidelines/regulations were challenged. Three schools, Ross University, American University of the Caribbean (AUC) and St. Georges, filed suit against the Board in both state and federal courts. The suits sought to disallow use of the guidelines and asserted they and the proposed regulations were without legal basis. While investigating these three schools, Board investigators uncovered similar abuses at three other Caribbean schools: St. Lucia, UTESA and CIFAS.

On October 11, 1984, the Division disapproved all six schools for 25 days and scheduled a "show cause" hearing for the following month. Following the hearing, the Division permanently disapproved CIFAS (which had already been closed by the Dominican government) and Ross University. It reached agreements with AUC and St. Georges to resolve outstanding issues, and extended the temporary disapproval orders on St. Lucia and UTESA for six months pending fact-finding and site visits.

In July 1985, the Division of Licensing permanently disapproved UTESA School of Medicine, following intensive scrutiny of its programs and faculty.

In December 1984, Ross was reinstated on five years probation subject to terms and conditions. Ross, St. Georges and AUC were to be bound by numerous restrictions to assure that they complied with California laws and licensure requirements. They also agreed to pay for site visits and other compliance costs. The lawsuits then were dropped. In July 1985, the Division of Licensing permanently disapproved UTESA School of Medicine, following intensive scrutiny of its programs and faculty. This decision was upheld in November 1986 when the school attempted to obtain probationary status.

A sequel to the Caribbean crisis was creation of an ongoing investigative effort to identify other instances of credentials fraud. Known as LIFT (Licensing Investigation/Fraud Team) the team focussed initially on 250 pending applications and a small number of current licensees.

What should have been an uneventful public speaking engagement in the Spring of 1983 turned into a minefield for the Board's Executive Director, Robert Rowland. Addressing a mixed group of consumers and physicians gathered at Merced College, Rowland described a variety of things which can lead a doctor into difficulties. He summarized by saying "With the problems that doctors and other health professionals can have, the kindest I can be is to say that 10% of the physicians who are practicing today should not be practicing in a totally unconstrained environment."

A local reporter collapsed Rowland's speech into a brief story which included the statement ". . . ten percent of California's 60,000 doctors are impaired with problems ranging from drug addiction to alcoholism to mental illness and senility." This story was picked up verbatim by United Press International (UPI) and appeared statewide and elsewhere.

Without contacting the Board or verifying the allegations in the news story, the president of the California Medical Association wrote a vehement letter to Governor Deukmejian demanding that Rowland apologize to the organization which sponsored the speech, the physicians of California and the public, and that the Governor request his immediate resignation. A similar statement was published in the CMA's weekly "Medical Executives Memo". After a month of efforts to set the record straight, Rowland submitted his resignation to the Board in June of 1993.

During the Summer, the Board conducted a nationwide search, and at the September Board meeting selected Kenneth J. Wagstaff as its Executive Director. A former Undersecretary of the Health and Welfare Agency, and Director of the Department of Mental Health, Wagstaff should be recalled as the consultant to the Assembly Health Committee, who was the author of the portion of MICRA which reorganized the medical board.

Other happenings in 1984 included several law changes. One bill allowed members of more than one MQRC to sit on a single disciplinary hearing panel. Another bill expanded the criteria for unprofessional conduct to include "repeated negligent acts". Previously, the negligent acts had to be "similar" to constitute a pattern of unprofessional conduct. The same bill authorized the Division of Medical Quality to issue orders compelling physicians to take a competency examination.

Important allied health legislation included repeal of the

provision allowing acupuncturists to become licensed based on three years of experience. Instead they had to complete specified education and pass an examination. The Acupuncture committee also was required to establish standards for approval of schools and colleges. Podiatry legislation expanded the scope of practice of podiatry to include medical and surgical treatment of the ankle.

The Physician Incentive Loan Program continued, and by June 30, 1984, 26 physicians had been given $10,000 loans.

The Physician Incentive Loan Program continued, and by June 30, 1984, 26 physicians had been given $10,000 loans. Twelve recipients had completed their two year commitment in an underserved area and had their loans forgiven; one had completed one year and then repaid half the loan; the remaining loans were still in practice or were pending. During the following year, the law was changed at the Board's recommendation to award only five loans per year, but in the amount of $20,000 each.

The MQRCs continued to conduct disciplinary and petitioner hearings, although a growing trend toward stipulated decisions was beginning to impact the number of cases heard. A good deal of committee effort was devoted to publications, which included brochures on "How to Choose a Physician", "Patients Rights and Responsibilities", "Confidential Services for Physicians with Alcohol and Drug Related Problems", standards for prescribing Schedule II drugs, and "Guidelines to Physician Care in Skilled Nursing Facilities".

These written materials were used as adjuncts to the MQRCs' continuing involvement in community level education of both consumers and health care providers. One district MQRC also initiated efforts to educate hospital chiefs of staff on the importance of filing Section 805 hospital disciplinary reports with the Board.

In 1985, the Board collaborated with the Department of Health Services to amend DOHS regulations to require all California hospitals to develop committees on physician impairment. During the same year, the Board contracted with Arthur Young International to conduct a management study evaluating the effectiveness of the enforcement program. Following the recommendations of the study report, the Board restructured various procedures relating to case assignment and control, field office organization and supervision, utilization of personnel, and probation surveillance.

It became apparent that in some medi-cal offices, MAs were being used more like nurses, in violation of the law.

A series of inquiries from physicians and medical assistants had raised concerns about how unlicensed MAs were being used in medical offices. Current law allowed MAs to give injections and draw blood, but very little else was legal for them. It became apparent that in some medical offices, MAs were being used more like nurses, in violation of the law.

During 1985, the Division of Allied Health Professions drafted legislation to clarify the medical assistant scope of practice, and to expand it slightly to include simple routine assistive tasks. Although the Division's bill was unsuccessful, the issue remained alive, and in 1988 a bill sponsored by the California Medical Association was passed. The process of adopting regulations to implement the bill was long, and fraught with controversy, which still continued as late as the Spring of 1994.

The bill mandated onsite inspections of educational programs on three continents. Site visit teams subsequently went to Mexico, the Philippines and England . . .

Continuing fallout from the Caribbean medical school issues included 1985 legislation which required representatives of the Division of Licensing to evaluate medical education around the world. Assembly Bill 1859 mandated onsite inspections of educational programs on three continents. Site visit teams subsequently went to Mexico, the Philippines and England, where they inspected schools and met with education and government authorities to discuss the standards for each country. The same legislation made a variety of other changes in the licensure laws aimed at improving evaluation of the qualifications of applicants.

Legislation passed in 1984 and 1985 included a record number of bills relating to the activities of the Board. A comprehensive summary of the bills can be found in the 1985/86 Annual Report, pages 9-13. Significant legislation included creation of Peer Physician Counseling Panels (PPCP) to counsel physicians with prescribing problems; elder abuse reporting requirements; authority to issue citations and assess fines; and, a bill changing the name of the Podiatry Examining Committee to the Board of Podiatric Medicine, and giving that board more authority over its activities.

An innovation in the conduct of physician discipline came with adoption of a policy to request that Administrative Law Judges conduct prehearing conferences to resolve legal issues and arrive at stipulations. This significantly expedites the actual hearing. The Board policy was subsequently codified in law.

The Faculty in Exile Committee; A Growing Backlog; Chiropractors 1986 - 1988

A situation which had been evolving for several years took center stage in 1987 and 1988: evaluating the credentials of refugees from Vietnam. When the North Vietnamese army took control of Saigon in 1975, many students, graduates and faculty of the University of Saigon became refugees. Thousands of them eventually made their way to the United States and Canada. Among their numbers were an unknown number of medical doctors.

Many refugees who left Vietnam before the fall of Saigon in 1975 were able to bring some or all of their educational and licensure credentials with them. Those who left after the occupation generally left with little or nothing. For a number of years, California was unwilling to accept credentials from Vietnam because the Communist government would not verify their authenticity. Eventually, the American Medical Association and other organizations coordinated creation of a Faculty Council In Exile. This committee consisted of physicians who were on the faculty of the University of Saigon prior to 1975, and who knew its students and graduates. The FCIE had some of the records from the university, including a register of students enrolled in the medical school.

For a number of years, California was unwilling to accept credentials from Vietnam because the Communist government would not verify their authenticity.

By using those records, AMA was able to document a large number of Vietnamese physicians, many of whom were subsequently licensed in California. The problems continued, however, for refugees who left Vietnam after the Communist takeover in 1975. A group of 33 individuals sued the Medical Board in an effort to compel the Board to license them. These were people who were not documented by the FCIE, and who could not produce any other credentials to establish that they were qualified for licensure.

After a lengthy and convoluted process, State Senator Royce passed legislation creating a California version of the FCIE, known as the Faculty in Exile Committee (FIEC). This committee, which included Vietnamese physicians already licensed in California, Saigon University faculty members, and representatives of the Board, met a number of times to try to resolve the problems with licensing those 33 individuals and others in similar circumstances. Eventually, the FIEC recommended the physicians be licensed or

For a time, the Federation of State Medical Boards considered estab-lishing a program to accredit non U.S./ Canadian medical schools, as a service to all the medical boards.

approved to continue in the licensure process.

The international medical school site visits mandated by AB 1859 were completed in 1988, and the Board reported to the Legislature on their findings. Among other things, the reports recommended that five years of Philippine medical education count as four years in the U.S. The first year of the five is actually more akin to premedical education here.

For a time, the Federation of State Medical Boards considered establishing a program to accredit non U.S./ Canadian medical schools, as a service to all the medical boards. However, the Federation was unable to resolve serious concerns about potential litigation accompanying the approval process, and eventually discarded the proposal.

Other options considered by the Board included approving only those schools which were willing to fund site visits by the Board so that their programs could be thoroughly evaluated. Another option was to accept the graduates of schools in countries with accreditation standards similar to those of the Liaison Committee on Medical Education (LCME) of the U.S.

Finally, the Board considered whether to focus on postgraduate training rather than undergraduate education as a measure of medical competence. As Executive Director Wagstaff phrased it, evaluate the product, not the factory. One proposal was to require foreign trained physicians to complete three years of postgraduate clinical training in the U.S. instead of the current one year prior to licensure. In addition, the Board explored seeking legislation to require applicants for residency programs in California to pass a clinical skills examination. The NBME was in the process of developing this sort of examination at the time.

Under the regulations, chiropractors could perform physical therapy, "chiropractic perinatal care", enemas and colonic irrigation, and numerous other procedures.

In 1987, the Board of Chiropractic Examiners adopted regulations widely expanding the scope of chiropractic practice. Under the regulations, chiropractors could perform physical therapy, "chiropractic perinatal care", enemas and colonic irrigation, and numerous other procedures. The next year, the California Medical Association and the Physical Therapy Association filed suit to have the regulations overturned, and the Board joined into the suit.

In 1988, the judge in the suit issued a preliminary ruling overturning parts of the regulations, but the Chiropractic Association appealed the decision. Then, late in the Sum-

mer of 1988, the Chiropractic Association served the Board with a 152 page set of interrogatories, 678 in number. The Board immediately sought judicial relief from what it considered a clearly excessive and punitive request, but the judge ordered the Board to respond.

Also in 1988, Assemblywoman Jackie Speier passed legislation requiring the Board to establish a toll-free telephone number statewide for consumers to file complaints against physicians. The bill also required the Board to improve its directory listings. This legislation was the outcome of a report issued by Ms. Speier alleging that it was difficult or impossible for consumers in much of the State to locate the Board in the phone book.

In April 1988, the Board hosted the first national meeting of the Federation of State Medical Boards of the United States to be held in California. The weeklong meeting was held in San Diego, and included a privately-funded dinner cruise on San Diego Harbor for delegates and guests. Among issues considered at the meetings was formation of a national taskforce on impaired physicians, and a meeting among larger states to discuss largescale enforcement problems.

The Board began preparing for the expiration of the probationary periods of three Caribbean medical schools in December of 1989. The Board and staff were concerned with allowing enough advance time to permit site visits to the St. Georges University, American University of the Caribbean, and Ross University schools of medicine. They recognized the need for a thorough review of the changes implemented in 1984 and later, to bring the schools into compliance with California licensure requirements. The Division of Licensing eventually would need to decide whether to grant full permanent approval of the schools, extend the provisional approval or withdraw approval.

The growing popularity of outpatient surgical centers, and office-based surgery led to extensive discussions of how to protect consumers from incompetent surgeons working in unregulated settings. The Board received a number of complaints involving physicians who either did not have, or had lost, surgical privileges at acute hospitals, and continued to perform surgery in a surgery center or medical office. While hospitals had intricate

Stories abounded of small groups of practitioners who banded together, declared themselves a specialty society, and certified their members.

procedures for monitoring the performances of members of their medical staffs, most surgical centers did not. Private medical offices were not required to have any quality assurance mechanisms at all.

Of particular concern to the Board were cosmetic surgery and outpatient cataract removal. A related issue was the proliferation of "specialty societies" with questionable pedigrees. Stories abounded of small groups of practitioners who banded together, declared themselves a specialty society, and certified their members. Often the only qualifications might be a brief seminar or workshop, or no additional training at all. Another element of the problem was the pressure from insurors to avoid costly inpatient procedures if outpatient options were available.

On the national front, efforts were well underway in 1988 to develop a single national uniform medical licensing examination for U.S., Canadian and foreign medical graduates. Currently, applicants for licensure had to pass either the National Board of Medical Examiners (NBME) or the Federation Licensing Examination (FLEX). Some foreign trained physicians also took the Education Commission for Foreign Medical Graduates (ECFMG) examination, which was subsequently replaced with the much more demanding Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Needless to say, the confusion demanded a solution.

A taskforce of these organizations, the AMA, and other interested groups made an initial recommendation in late 1988 to combine Parts I and II of the NBME examination with a modified version of the clinical component of the FLEX, and administer the combined examination during the first year of residency. The taskforce also announced that the ECFMG would be using the NBME Parts I and II for certifying foreign medical graduates.

While some of the complaints were resolved through mediation and other means, by the Aut-umn of 1988 over 700 cases were awaiting assignment to an investigator.

By the middle of 1988, the Board was becoming very concerned about the number of complaint cases which were awaiting investigation. Since the creation of its own investigative staff in 1977, the Board had been authorized only two new investigator positions. Those were assigned to probation surveillance in 1979. Meanwhile, the number of complaints reaching the Board climbed from 4,265 in 1977 to 6,293 in 1988. Of the 1977 complaints, 2,539 investigations were opened, and 2,089 were closed. In 1988/89, 2,658 cases were opened and 2,561 were closed.

While some of the complaints were resolved through mediation and other means, by the Autumn of 1988 over 700 cases were awaiting assignment to an investigator.

Staff reported to the Board in December 1988 that their ongoing efforts over the prior several years to gain approval to hire more investigators and support staff had been unsuccessful. At least three program audits, conducted by the Little Hoover Commission, the Department of Finance and Arthur Young and Company, each recommended increasing the staffing of the enforcement program. Assemblywoman Jackie Speier's bill requiring the Board to establish tollfree complaint service also invited the Board to inform the Legislature of its needs in order to effectively protect the public. At the same December 1988 meeting, the Board voted to have its public information unit disseminate press releases about significant cases to the media in the physician's community.

A dialogue with the Coroners Associ-ation disclosed that while members were interested in cooperating with the Board, they preferred to have a legal mandate to report.

Also in the area of enforcement, the Board began what would become an ongoing interest in getting reports from county coroners when there was reason to suspect a death may have resulted from physician incompetence or negligence. A dialogue with the Coroners Association disclosed that while members were interested in cooperating with the Board, they preferred to have a legal mandate to report. They felt this would ease relations with local physicians.

In November 1988, the Department of Health Services regulations took effect requiring every California hospital to have a Committee on the Wellbeing of Physicians. The Board's Diversion Program and the CMA were developing a series of workshops to assist hospitals in establishing the committees.

An ongoing issue was the Board's efforts to gain legislative authorization to use undercover surveillance equipment. At times, in order to protect an investigator, or to secure usable evidence under difficult circumstances, the Enforcement Program uses recording or listening devices worn by an investigator. For many years, the Board has been required to secure the loan of equipment, and the authority to use it, from other law enforcment agencies. Board investigators are sworn peace officers, and the staff felt it would be more operationally effective if the Board had legal authority to own and use such equipment.

BLANK PAGE

Postgraduate Training; The Backlog; Nursing Homes 1989-1990

A continuing topic of much heated discussion at the end of the decade was whether to increase the requirement for supervised postgraduate training before a physician could be licensed. A proposal to increase the residency requirement from one year to three drew much attention. The main objections to making it mandatory, and to deferring licensure until after the third year focussed on two issues:

- Until a physician is licensed, (s)he cannot sign death certificates. This would be a problem for many physicians, especially those working in emergency rooms.
- While in residency, some physicians "moonlight" to help with their expenses. If they cannot be licensed after the first year, they are precluded from working outside the formal residency setting.

. . . a study by the National Resident Matching Program . . . indicated that in 1984, 95% of physicians had completed at least three years of postgraduate training.

At the June 1989 Division of Licensing meeting, a delegation from the Nevada Board of Medical Examiners gave a presentation on that state's requirement for a three year residency. They reported that their board believed modern medicine had become so complex that a single postgraduate year was no longer adequate. They quoted a study by the National Resident Matching Program which indicated that in 1984, 95% of physicians had completed at least three years of postgraduate training. Under the Nevada law, second-year residents are given a limited license which permits them to prescribe within the training program, and to sign death certificates. Third year students are permitted to "moonlight" in certain controlled circumstances.

Discussion following the presentation raised other issues including the need to rotate residents out into other hospitals for certain kinds of experience; the frequent practice of residents to take one or more years off to practice general medicine, to begin a family, to perform public service, or to begin paying back educational loans. All these things would be precluded if licensure was deferred until three years had been completed.

Postgraduate training remained high on the Division of Licensing's agenda, and on November 30, 1989 they adopted a proposal to seek legislation. The bill would require three

years of postgraduate training, and would prohibit "moonlighting" outside the training program until the third year, when a limited license would be issued.

The backlog of cases awaiting investigation . . . was exacerbated in 1988 when the Governor authorized a "golden handshake" retirement option.

The backlog of cases awaiting investigation continued to occupy the attention of the Board, its constituents and members of the Legislature. The situation was exacerbated in 1988 when the Governor authorized a "golden handshake" retirement option. A significant number of experienced investigators exercised this option to retire early with enhanced benefits. Faced with an already growing backlog, the Board was compelled to recruit and train replacements for these investigators. The situation was further complicated by several factors:

- Several other State agencies which use investigators also lost senior people to retirement at the same time.
- Through a fluke in the way Board investigators had been classified in the past, other agencies were able to offer candidates significantly higher pay scales.
- Medical Board investigators carried an average of thirty open investigation cases at any time, while competing agencies could offer candidates caseloads of fewer than ten cases at a time.
- Recruitment of investigators is a slow process because of the need to do intensive background checks on applicants.
- It takes a minimum of three to six months to provide basic training in medical investigations to the point where an investigator is prepared to undertake independent work.

With only forty field investigators, a serious problem of burnout threatened to further dilute the effectiveness of the enforcement program.

With only forty field investigators, a serious problem of burnout threatened to further dilute the effectiveness of the enforcement program. At the March 1989 Board meeting, the Division of Medical Quality adopted criteria for prioritizing pending investigations. Four case priority levels were set: #1 demonstrate actual or high potential for patient harm; #2 require more information before a decision about priority can be made; #3 are cases which are unlikely to result in discipline, but may be amenable to counseling or other non-disciplinary action; and #4 are less serious cases not involving patient care issues. Priority 3 and 4 cases would be handled all or in part by non-investigator staff.

Early in 1989, the Little Hoover Commission engaged the Board in a dialogue about the role of physicians in the care of nursing home patients. The Commission had

conducted an intensive study of nursing homes, and several of its findings focussed on the inadequacy of physician involvement in patient care. The Board was called to task for lacking a process for regular oversight of nursing home care. Among Little Hoover Commission recommendations were:

The Board was called to task for lacking a process for regular oversight of nursing home care.

- Establishing quality assurance or peer review mechanisms in nursing homes.
- Establishing minimum standards for medical care.
- Developing formal protocols for information sharing among state agencies involved in the regulation of nursing homes, including the Board.
- Seeking legislation to give the Board authority to examine the medical records of nursing home patients in addition to those who had filed a complaint, to identify patterns of neglect.
- Finding ways to deal with patient abuse and abandonment.
- Implementing a system of citations and fines for violations.
- Working with the medical schools to increase training in geriatrics and gerontology.

The Board already had begun to implement some of these recommendations, and was participating in an interdepartmental taskforce to develop standards of care for nursing homes. A Board subcommittee was appointed to work on the issues of information sharing and access to medical records.

A shortage of qualified psychiatrists in rural State hospitals led the Department of Mental Health (DMH) to enlist the Board's help in an unusual project in 1989. As part of the annual meeting of the American Psychiatric Association, the Department set up a recruiting booth, and the Board conducted an oral examination onsite. Pre-conference advertising by DMH invited interested candidates to bring required application documents with them for preliminary screening by Board staff.

The 1984 death of Libby Zion in a New York City hospital, while being attended by medical residents who allegedly were exhausted from working extremely long shifts, led to another 1988 Board issue. The Board undertook a study to determine the number of hours per week that California medical residents were working, and what effect, if any, long shifts were having on quality of medical care.

Questionnaires were mailed to 2,500 residents and residency program directors, and the response was extremely good.

The Board provided survey results to the deans of the California medical schools, and urged them to explore ways of easing the burden of long working hours for their residents. The Board expressed the hope a solution could evolve without legislative intervention in the matter.

The licensure of acupuncturists in California had, from its inception, been a source of considerable challenge to the Board and the Division of Allied Health Professions. No other state licensed this profession in the late 1970s, and there was no uniform examination in use elsewhere. With a number of distinct "schools" of theory, and practitioners from several Asian ethnic groups, there was a great deal of disagreement about what should be covered by an examination, who should write it, what texts should be used and other issues. To further complicate matters, the examination was given in English, Japanese, Korean and two dialects of Chinese, creating a translating nightmare.

For several years in the 1970s and early 1980s there were rumors of cheating on the acupuncture examination, but no real evidence could be documented. Then a licensee named Chae Lew was arrested, along with more than fifty other licensees and applicants. They were charged with selling and buying the written examination, and the total amount involved allegedly exceeded half a million dollars. Lew was the mastermind of the scheme, as well as the main beneficiary of the sales. He was convicted of felony bribery in 1989 and sentenced to five years in state prison.

. . . the Acupuncture Examining Committee . . . was stripped of its authority to develop or administer examinations . . .

Concern about this scandal, and other ongoing problems with the Acupuncture Examining Committee led the Department of Consumer Affairs to seek budget control language and legislation to assume more direct control over the committee. It was stripped of its authority to develop or administer examinations, and was renamed the Acupuncture Committee. The Committee was required by AB 2367 (Filante) to contract with an outside consultant to develop future exams.

For more than a year, the Division of Allied Health Professions and the Physician Assistant Examining Committee labored to adopt regulations clarifying the legal scope of physician assistant practice. The regulations were

rejected by the Director of Consumer Affairs, and subsequently by the Office of Administrative Law. In late November, the Division voted to override the Director's veto of the regulations, and they were submitted once again to the Office of Administrative Law.

In a similar scenario, the Division repeatedly revised and resubmitted regulations establishing a set of simple procedures which could be performed by unlicensed medical assistants. After more than three years of effort, the regulations were finally approved by the Department and OAL. However, shortly after they took effect, the California Optometric Association filed suit to overturn the regulations on the grounds that they permitted medical assistants to practice certain aspects of optometry.

After more than two years in court, the suit finally resulted in a 1994 ruling that ordered the Division to repeat the rulemaking process relating to the offensive provisions, but left the remainder of the regulations intact.

Early efforts included a student loan program, and an incentive loan program for practicing physicians.

Since the earliest days of the Board of Medical Quality Assurance, members struggled with the need to improve the distribution of physicians in inner city and rural areas of the state. Early efforts included a student loan program, and an incentive loan program for practicing physicians. Each of these programs provided for forgiveness of the loan if the recipient practiced in a qualifying medically underserved area for at least two years.

The Physician Incentive Loan Program sunsetted on December 31, 1988, but the $100,000 appropriation remained in the 1988-89 Board budget. Board member Dr. Madison Richardson suggested the Board explore alternative ways to use those funds to improve health care in underserved areas, and a committee was appointed to study the issue and make recommendations.

Anticipating the new year, the Division of Allied Health Professions ended 1989 by initiating a dialogue on its future role and responsibilities. The members acknowledged that law changes during the past 13 years had greatly reduced its direct authority over the allied health boards and committees. The central question now had become whether the Board should seek to reestablish more statutory authority, or should acquiesce to change and abolish the Division. In 1993, the question was finally decided, and SB 916 (Presley II) abolished the Division and transferred its remaining responsibilities to the Board.

BLANK PAGE

THE MEDICAL JUDICIAL PROCEDURE IMPROVEMENT ACT OF 1990 - ("Presley I")

Interest in and concern about the Board's Enforcement Program, including the case backlog, peaked in April of 1989. Almost simultaneously, the Board submitted a report on the enforcement backlog to the Joint Legislative Budget Committee; and the Center for Public Interest Law (CPIL), at the private University of San Diego, issued a report on the Board.

The Board's *Special Budget Report: Curing the Backlog* noted a huge increase in complaints against physicians over a five-year period. During that same period, the report pointed out, the Board had submitted budget requests for 30½ additional positions to handle the case growth and the resulting backlog. Instead, only 3½ permanent and 3 temporary positions were approved.

The Board's Special Budget Report: Curing the Backlog *noted a huge increase in com-plaints against physicians over a five-year period.*

Numerous efforts had been made to improve the efficiency of the enforcement program, including realigning the caseloads of district offices, and improving case prioritization. The report recommended budgetary approval of eighteen permanent investigator and support staff positions to accommodate case growth, and eight limited-term investigator and two limited-term Consumer Services Representative positions to eliminate the backlog.

The CPIL report, *Physician Discipline in California: A Code Blue Emergency* echoed the Board's own findings and recommendations regarding the need for additional staff to investigate and prosecute physicians who violate the law. The CPIL report went much further, recommending a major overhaul of the laws governing physician discipline. Among other things, the report urged creation of a "Medical Quality Court" to hear all physician discipline cases, greatly expanded reporting requirements including reporting of all malpractice cases at the time they are initially filed with a court, and elimination of Superior Court level review of Board decisions, in favor of direct review by the Appeals Courts. The report also recommended more direct involvement of the Attorney General's Office early in the discipline process.

The CPIL report included a total of 32 recommendations relating to the structure, functions and authority of the Board.

The CPIL report included a total of 32 recommendations relating to the structure, functions and authority of the Board. At a special meeting on April 28, 1989, the Division of Medical Quality reviewed and discussed all 32 recommendations, and took positions on each one. Notice also was taken that during the time CPIL was preparing its

report on the Board, it also was a litigant in a suit seeking to compel the Board to license certain Vietnamese applicants who could not document their medical educations (see pages 47-48).

Shortly after publication of these reports, Senate Bill 1434, was introduced by Senator Robert Presley. The bill incorporated most of the recommendations of the CPIL report. After a brief discussion at a special May 5 meeting on budgets and legislation, the Board deferred taking a position on the bill, and decided to hold public hearings. The hearings would be in Northern and Southern California early in the Summer.

Even as the case backlog was ballooning, and the Board was subjected to criticism from the Legislature, the media and CPIL, its members and staff became increasingly concerned about relations with the administration. There was a growing perception that the Department of Consumer Affairs, and the cabinet-level State and Consumer Services Agency did not support the Board's efforts to improve its operations and eliminate the backlog of cases. Indeed, events suggested to some an intent to thwart the Board's efforts.

At the June 1989 meeting, Board President, Galal Gough, M.D., read a lengthy statement describing the Board's efforts, and the roadblocks which had been thrown in its path by the Department and the Agency. Dr. Gough began by reminding the Board that the responsibility for protecting California consumers from bad doctors rested on their shoulders, and no others. He spoke of the circumstances which led the Legislature to order the Board to detail its needs directly to the Joint Legislative Budget Committee. He described being excluded from budget hearings, and learning long after the fact that staffing requests were denied, and that existing positions had been cut from the budget.

The Board called for a meeting with the Agency Secretary and the Director of Consumer Affairs to explore these and other issues.

Dr. Gough went on to describe the Department's opposition to a bill to simplify the Board's name, and opposition to the proposal to bring investigator salaries up to prevailing levels. He spoke of a statement made to a complainant that the Department was in charge of investigating the complaint, and of correspondence which the Department answered on behalf of the Governor, without confirming the facts with the Board. The Board called for a meeting with the Agency Secretary and the Director of Consumer Affairs to explore these and other issues.

This meeting took place on July 27, 1989. Dr. Gough reported at the September Board meeting that relations with Secretary Shirley Chilton and Director Michael Kelley were greatly improved as a result of the July meeting. He also announced that with their support, the Legislature had approved the request for 28 additional enforcement positions. In addition, the Department had dropped its opposition to changing the Board's name, and had agreed to work with the Board on investigator pay parity. Finally, the Department agreed to consult the Board before responding to letters concerning its activities.

By September 1989, Chief of Enforcement Vern Leeper was able to report to the Division of Medical Quality that recruitment of the 28 new positions was underway, along with the ordering of new vehicles, safety and other equipment for the eighteen new investigators. He also reported on progress toward opening two new district offices in the East San Francisco Bay area and the eastern part of Los Angeles County. These locations were chosen because they served the areas with the highest number of backlogged cases.

Because of the large number of new enforcement staff, the program developed an investigation "mini-academy" which was presented for the first time early in 1990. A comprehensive overview of the Board and its activities, the mini-academy also provided intensive technical training for new and existing investigators in conducting medical cases.

At the September 1989 meeting, the Board learned that Senator Presley's SB 1434 had been held over for action the following year. It was reintroduced in 1990 as SB 2375, subsequently widely referred to as "Presley I" (see page 65).

The Central Complaint and Investigation Control Unit (CCICU) was created in June 1990 to improve the efficiency of complaint intake. All the Consumer Service Representatives and Assistants formerly located in the district offices were centralized in Sacramento. With several parttime Medical Consultants, two supervisors and two additional CSRs, the unit was staffed to handle the expanding complaint workload.

Among its duties, CCICU received, screened and did initial workups on all complaints. Whenever appropriate, complaints were mediated within the unit. Following investigation, cases returned for closure without action were reviewed within the unit to assure that the investigation was

The Board's action focussed on the physician's failure to adequately document the medical reasons for the large quantities of pain medication.

completed properly. And, periodically, a Deputy Attorney General reviewed closed cases for appropriateness.

A bill of intense interest to the Division and Board was Senator Leroy Greene's SB 711. This bill came about after the Board disciplined a Sacramento physician for excessive prescribing of narcotics to patients suffering from chronic pain. The Board's action focussed on the physician's failure to adequately document the medical reasons for the large quantities of pain medication. However, the physician initiated a media and letter writing campaign against what he perceived as the Board's opposition to the use of the medications altogether.

At this physician's urging, Senator Greene carried a bill to prevent the Board from disciplining physicians based on the prescribing of pain medications. The Board was concerned that they would be seriously hampered in their efforts to protect the public from indiscriminate prescribing of narcotics, drugs which have extreme potential for diversion to street trade. The Board and the DMQ lobbied against the bill, and then unsuccessfully urged Governor Deukmejian to veto it.

The Universidad Autonoma de Ciudad Juarez *(UACJ) had resisted the Division's efforts to evaluate their curriculum since 1984.*

Yet another medical school outside the United States attracted the attention of the Division of Licensing in 1989. The *Universidad Autonoma de Ciudad Juarez* (UACJ) had resisted the Division's efforts to evaluate their curriculum since 1984. After numerous attempts to secure various materials from UACJ, the Division notified the school it would be filing an Order to Show Cause to disapprove the school. UACJ immediately sent their attorney, with two books of information, to plead with the Division to delay action until the university could more fully respond to the request. The Division voted to impose the Order to Show Cause, but also voted to permit the university to make a further showing at the December 1989 Division meeting.

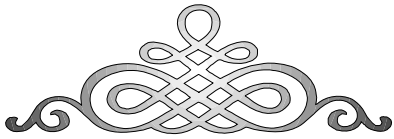
The Division of Licensing tentatively approved the curricula of American University of the Caribbean (AUC) and St. Georges University, contingent on completion of site visits to the undergraduate clinical training programs conducted by those universities at Camarillo State Hospital and Rancho Los Amigos Medical Center in California.

Universidad Mundial Dominicana **(World University)** joined the cadre of Caribbean schools disapproved by

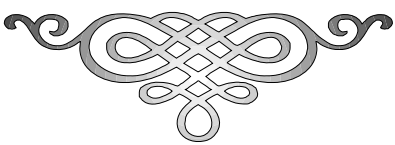
the Division of Licensing. Four UMD graduates had applied for licensure, but the school declined to provide the necessary documentation of its curriculum and facilities. An order disapproving the school was adopted on December 1, 1989.

The end of 1989 also was the end of the Board of Medical Quality Assurance. For several years, members of the Board and others had complained that BMQA was not a "user-friendly" name. Some thought it sounded like an insurance company, while others felt the acronym "BUMQUA" was undignified. Most people agreed that ordinary consumers probably would not know how to find the Board in a phone book. After considerable debate, the Board sponsored legislation, authored by Assemblywoman Jackie Speier, which changed the name. On January 1, 1990, the Board became **THE MEDICAL BOARD OF CALIFORNA.**

BLANK PAGE



THE MEDICAL BOARD OF CALIFORNA: Reappraisal, Reform, Rebirth



CONSOLIDATION OF REFORMS
1991 - 1992

Following passage of Senate Bill 2375 ("Presley I"), the Board turned its efforts to implementing the enforcement reforms, slashing the case backlog, and improving its level of service to the public. Funding the additional resources needed to meet these objectives took considerable effort. One aspect of the funding issue was supporting the additional attorneys in the Health Quality Enforcement Section of the Attorney General's office. Assistant Attorney General Alvin Korobkin estimated the HQES would need at least 23 attorneys plus support staff to draft pleadings and litigate cases for the Board. By law, support for these positions is to be funded by the Board.

During 1990, the Board resumed the dialogue about its location within the structure of State government.

During 1990, the Board resumed the dialogue about its location within the structure of State government. Members again were concerned that the State and Consumer Services Agency, and particularly the Department of Consumer Affairs might not be the most appropriate organization for a health regulatory body. There were serious concerns about the level of service the Board had been getting from the Department, including ongoing conflicts over the review of budgets, delays in personnel transactions, major difficulties in acquiring office space for new or relocating investigative offices, and lengthy delays in data processing system improvements.

During the transition between the Deukmejian and Wilson administrations, the Board wrote to the incoming Governor, asking that he consider transferring the Board out of the State and Consumer Services Agency. Governor Wilson asked the Board to pend its request until a new Director of Consumer Affairs was appointed, and until the Department completed a study of whether various functions of the boards and commissions could be consolidated.

Meanwhile, the Board faced another dilemma: the Legislature had frozen its budget and given the Board a deadline for eliminating the case backlog. A special bill, authored by Assemblyman William Filante, was needed to restore the Board's funds in 1991. A provision of the original legislative action withheld the salary of the Executive Director. The Filante bill also repealed this provision.

Among an ambitious set of goals and objectives for 1991 were:

- Improving public and health facility access for verification of licensure;
- Implementing a proactive fulltime public information and press relations program;
- Successfully implementing Presley I;
- Improving relationships with the allied health boards and committees;
- Securing salary parity with other investigative agencies for board investigators;
- Implementing the Department of Consumer Affairs data processing system, and developing a longrange DP plan for the board;
- Establishing an effective working relationship with the new Health Quality Enforcement Section.

By the final weeks of 1990, all cases in the backlog had been assigned to investigators, and were being worked.

By the final weeks of 1990, all cases in the backlog had been assigned to investigators, and were being worked. The Board acknowledged the ongoing existence of a small number of cases in transition between the central complaint unit and the district offices, and recognized that there always will be a certain number of cases, in the range of 50-100, in that status. The Enforcement Program was shifting its immediate focus to meeting the statutory target of completing routine investigations in an average of 180 days, and complex cases in an average of one year.

The need to be able to interrupt the practice of really dangerous physicians quickly was addressed by a provision of Presley I. The Board was given authority to petition an Administrative Law Judge for an interim suspension of the license, pending an accelerated hearing. However, the procedure was, in some ways, more cumbersome than seeking a temporary restraining order in Superior Court. In 1991, the Board voted to seek legislation to simplify the process, and to give the Board more direct authority to summarily suspend licenses.

Another weapon in the enforcement armamentarium is the use of petitions to compel examinations to establish whether a physician has problems of competence or psychiatric disability. Originally enacted in 1982 (psychiatric exams) and 1990 (competency examinations), this authority had proved very useful in bolstering investigations, and in some instances in exonerating physicians. In 1991, the Board sought to expand the competency examination au-

thority to include single instances of incompetence, regardless of whether patient harm resulted.

The Board was confronted with the task of adopting regulations setting standards for accrediting specialty boards which did not have ABMS or ACGME approval.

Truth in professional advertising, particularly with respect to specialty board certification, had commanded the Board's attention for several years. Senator Dan McCorquodale carried legislation (SB 2036) which restricted advertising of specialties. Physicians could advertise they were "board certified" only if the certification was given by a board approved by the American Board of Medical Specialties (ABMS), by the Accreditation Committee on Graduate Medical Education (ACGME) or by the Medical Board. The Board was confronted with the task of adopting regulations setting standards for accrediting specialty boards which did not have ABMS or ACGME approval. Since the regulations affected both the Divisions of Licensing and Medical Quality, a joint committee was appointed to develop regulatory language.

During 1991, the committee conducted several meetings and hearings around the State. Plastic and cosmetic surgeons were particularly interested in the proposed regulations because of philosophical differences among their professional groups. While the board for plastic and reconstructive surgeons was approved, other boards were not. There also were numerous other physicians who included plastic/cosmetic surgery in their practices, but were not certified in plastic and reconstructive surgery.

Two operational issues needing resolution were which division of the Board would be responsible for approving specialty boards; and whether the programs would be reviewed/approved before the fact, or only after a complaint was received alleging improper advertising in violation of the law.

Following several public hearings, the regulations were adopted and submitted to the Director of Consumer Affairs and the Office of Administrative Law for approval.

The overall rate of complaints filed against program graduates was significantly lower than against physicians in general.

The Diversion Program continued its historic record of successes. During 1990, approximately 73% of enrollees leaving the program were successful in their recovery. Of 293 successful "graduates" during the program's 10 year history, only 18 had returned, and some of these had again achieved sobriety. The overall rate of complaints filed against program graduates was significantly lower than against physicians in general.

Under regulations adopted by the Department of Health

Services, every hospital in California is required to maintain a Committee on the Wellbeing of Physicians. The Board and the California Medical Association put on workshops at numerous hospitals to educate committee members on recognizing and intervening with physicians who exhibited symptoms of drug or alcohol abuse or mental health problems. Probably as a result of these efforts, the percentage of self-referred physicians in Diversion increased from 30% to 67% by 1991. While most of these were "self-referrals under compulsion" from colleagues, family members or hospital authorities, the board was spared the need to impose discipline in order to get these physicians into treatment.

The Medical Quality Review Committees (MQRC) completed a project in 1991 to establish a course in medical ethics for physicians who were disciplined for ethical matters. For many years, the board had included a requirement for such a course in disciplinary decisions. However, its experience was that while there were many general courses in ethics available, there were few or none specific to medical issues.

The MQRC Council, an *ad hoc* organization of the 14 district chairs, contracted with William May, Ph.D. to develop a curriculum. With the assistance of staff from the Medical Association, the Council and Dr. May presented the one-day class twice in Los Angeles and once in San Francisco. Participants were assessed $225 to cover administrative costs and the professional services of Dr. May for presenting the course. Between 15 and 20 physicians participated in each session.

The first several sessions were audited by Board and MQRC members. Eventually the Council recommended to the Division of Medical Quality that continuing administrative oversight of the course be turned over to CMA, who also would be responsible for the fiscal management of the classes.

The Board's 1988 lawsuit against the Board of Chiropractic Examiners was finally resolved in 1991 (cf. page 48). Following extensive negotiations with BCE and the Physical Therapy Examining Committee, the Board approved a settlement which clarified that chiropractors are not permitted to practice medicine or physical therapy except to the extent permitted in the original chiropractic initiative act.

Medical Board investigator positions were reclassified in April 1991, and pay levels were increased. The reclassification recognized the special skills and experience needed to investigate medical complaints. While the Board had hoped for a 12.5% increase, which would have achieved parity with other investigative agencies in the state, the Department of Personnel Administration recommended, and the State Personnel Board approved only 10%. This did, however, considerably ease the problems with recruiting new investigators and retaining those currently with the Board.

This coincided with renewed efforts to increase the staffing of the Enforcement Program. With the support of the Department of Finance and the State and Consumer Services Agency, the Board had requested an additional fourteen investigator positions and ten support staff including medical consultants and clericals. These positions were to be assigned to the new district offices, and would help in efforts to reduce caseloads from the current range of 27-30 per investigator, down to 20-23 cases. The positions were approved, and by the end of the year the new staff had been hired.

Even with creation of the Health Quality Enforcement Section, it still was taking more than six months, on average, to get an accusation completed.

The reforms set in motion by Presley I inevitably led to a dramatic increase in the workload of the Attorney General's office. In addition, there was intense pressure to decrease the delays in getting pleadings drafted. Even with creation of the Health Quality Enforcement Section, it still was taking more than six months, on average, to get an accusation completed. This was due, at least in part, to a miscalculation of the number of hours required for a Deputy Attorney General to review a case, draft pleadings, litigate and follow up on the case.

With more accurate data, based on actual experience of the HQES, the Attorney General's office proposed in 1991 the immediate addition of 27 attorneys and four paralegal assistants to the HQES. By yearend, this proposal was refined to include thirteen permanent Deputy Attorneys General, ten three-year limited term DAGs and four legal analysts. The costs, to be funded by the Board, totaled approximately $1.3 million for the remainder of the 1991-92 fiscal year, and $2.5 million for the full 92-93 fiscal year. An additional $857,000 would be needed as well to fund more Administrative Law Judges in the Office of Administrative Hearings, to hear Board cases.

The Board also endorsed a legislative proposal to

clarify a provision of SB 2375. Under that law (Presley I), the Board was required to complete investigations in an average of 180 days, or one year for complex cases. A recent review of the enforcement process by the Auditor General's Office strongly recommended expanded staffing as a means of achieving this goal. However, the audit also recognized the legitimate delays that often preceded formal initiation of an investigation.

The Board proposed legislation to amend this provision to specify that the clock would begin when the case was assigned to an investigator. This would accommodate the difficulties the Board often had getting medical records and other documents it needed to initiate an investigation.

The Board also agreed to seek legislation to require physicians to provide medical records within fifteen days of receiving a properly executed records release signed by the patient.

Among 1991 legislation was a bill authored by Assemblywoman Jackie Speier which, if successful, would have affected the way the Board selected medical experts. The bill required the Board to give preference to peers in the same specialty when reviewing a physician's medical practice as part of an investigation. Hard experience had taught the Enforcement Program that some self-styled "specialists" would insist that review of their practice could be done only by someone who shared their specific philosophical convictions. After being held over to the second year of the legislative session, and facing vigorous opposition, the bill was dropped by the author.

The Board's successful fee bill increased the maximum level for biennial license renewals and initial license fees to $500. The additional revenue was needed to fund the new enforcement staff, deputy attorneys general, administrative law judges and related operating expenses. This legislation reduced the mandated fund reserve from four months' operating expenses to two months.

Legislation to increase the postgraduate training (residency) requirement from one year to two was unsuccessful. However, legislation authored by Assemblyman William Filante, required the Board to report to the Legislature with options for improving postgraduate medical education. The Board submitted a proposal which would assure that all license applicants had completed at least two years of accredited clinical training. This could be accom-

plished through a combination of undergraduate clinical training in accredited hospitals and a single postgraduate year, or by completing two years postgraduate training.

A bill, authored by Assemblyman Filante, would have accomplished this goal. However, it was amended to remove the two-year requirement, and instead to provide immunity for program directors who evaluated and certified a physician's completion of postgraduate training. The Division of Licensing agreed to continue to seek legislation to require two years of clinical training.

Pursuant to amendments included in Presley I, county coroners were required to report to the Board if they believed a patient death was the result of physician incompetence or gross negligence. The enforcement program notified coroners, district attorneys, Superior Court Clerks and probation departments of this and various other reporting requirements during 1991.

. . . the Legislature imposed a provision, (SB 101) prohibiting the issuance or renewal of professional licenses to individuals who fell behind in child or spousal support.

In an effort to assure payment of court-ordered family support, the Legislature imposed a provision, (SB 101) prohibiting the issuance or renewal of professional licenses to individuals who fell behind in child or spousal support. The law took effect July 1, 1992, and the Board was required to issue a temporary, 150-day license to those who were reported on lists prepared by district attorney offices. The Board sought legislative clarification of whether a fee could be charged for the temporary license, and what the status of the physician would be if the temporary license expired.

Harkening back to the disapproval of Caribbean medical schools in 1984 and 1985, the Division of Licensing reexamined the issue of applicants who had attended *Universidad Tecnologica de Santiago* (UTESA). Although the school remained disapproved, the Division agreed to perform case by case review of applicants who attended UTESA prior to the time when it was disapproved. The amended policy did not apply to anyone who enrolled at UTESA after it was disapproved.

A long-running issue in the Division of Allied Health Professions re-emerged in 1991. During the mid-1980s, the Division became aware that certain acupuncturists were appending the initials O.M.D. to their names, with no further explanation. When questioned, they said they were "doctors of Oriental medicine". A heated and prolonged debate ensued, with the Division insisting that those initials

could mislead the public into believing the acupuncturists were medical doctors.

The Division of Allied Health Professions initiated a rulemaking process to prohibit the use of the initials O.M.D. by acupuncturists, but to permit use of D.O.M. if the licensee actually possessed a legitimate degree in Oriental medicine. However, the Division was advised by counsel that the rulemaking authority belonged to the Acupuncture Examining Committee. The Committee declined to adopt regulations.

The AG issued an opinion in April 1988, holding that an acupuncturist could not use the controversial initials "without more" . . .

The Division then sought the advice of the Attorney General. The AG issued an opinion in April 1988, holding that an acupuncturist could not use the controversial initials "without more", which he went on to define as some sort of explanation of what the initials stood for, and making clear the user is an acupuncturist. This opinion was published to the industry, but compliance was not forthcoming.

The issue re-emerged at the September 13, 1991 Division meeting when members were told that licensees were continuing to violate the AG opinion. Following a discussion of the matter, the executive officer of the Acupuncture Committee and the President of the California Acupuncture Association agreed to notify acupuncturists again of the limits on use of such titles.

However, this issue refused to be laid to rest, and in May of 1992, the Division again had to be assured that the Acupuncture Committee and the California Acupuncture Association agreed to abide by the five-year-old Attorney General opinion. The committee planned further discussion in July 1992 on what sorts of additional information would be required when an acupuncturist used the O.M.D. designation in advertising.

The members were concerned whether these mechanisms would be cost-effective, and whether a successful defendant could petition for recovery of defense costs.

The issues of administrative fines and cost recovery were explored several times during 1991. The Division of Medical Quality twice voted not to adopt regulations to impose fines for minor offenses, nor to seek recovery of investigative and prosecutorial costs. The members were concerned whether these mechanisms would be cost-effective, and whether a successful defendant could petition for recovery of defense costs. However, at the end of 1991, the Division appointed a subcommittee to research the issue further and to bring back recommendations. However, no action was taken on this issue until 1993.

The Division also initiated a legislative effort to restore

misdemeanor penalties for practicing on patients while intoxicated. This provision was inadvertently amended out of Business and Professions Code Section 2435 when the laws were recodified in 1981.

In 1991, the Board still was waiting for the NPDB to complete its organizational process and begin accepting reports.

Federal Public Law 99-660, the Health Care Quality Improvement Act of 1986, requires state medical, dental and psychology boards, hospitals, medical societies, insurance companies and various other entities to file a report with the National Practitioner Data Bank (NPDB) if a health practitioner is disciplined, loses privileges or other actions are imposed. In 1991, the Board still was waiting for the NPDB to complete its organizational process and begin accepting reports. Once it was operating, hospitals would be required to query the data bank at least biennially to determine whether physicians on their staffs had been reported. Licensing boards also would be able to request information on current or prospective licensees.

As part of the effort to improve public access to information, the Board implemented a system known as "Dial Up Verification". Large organizations which must verify hundreds of licenses each year can subscribe to the service. It allows them to access the public information contained in the computer database, to verify that physician licenses are current and clear. Access is through phone connections, and is available 24 hours. It provides significant cost and time savings for both participants and the Board. Eighty-four subscribers were using this service by January 1992.

On a broader front, the Board began discussing how much information should be available to the public concerning physician discipline. Policy at the moment was to keep complaints and investigations confidential, but to disclose accusations, final decisions and other formal orders such as Temporary Restraining Orders and Interim Suspensions. Staff recommended not disclosing raw complaints or ongoing investigations since a high percentage of both are closed without any adverse action. However, the Board considered releasing information to the public at the time a completed investigation is transmitted to the Attorney General for the drafting of charges. They also began considering other information in Board files, such as records of criminal conviction, discipline by other states, malpractice judgements, and malpractice filings.

Some speakers expressed concern that premature disclosure of information could irreparably harm physicians who were later exonerated.

Certain information, such as coroner's reports and hospital disciplinary reports are confidential by law, and would require legislation before they could be disclosed. The Board has discretion regarding disclosure of investigations, but staff pointed out that doing so would have a significant workload impact. Some speakers expressed concern that premature disclosure of information could irreparably harm physicians who were later exonerated.

At the January 1992 Board meeting agreement was reached to continue to study the issue of public disclosure. They also decided to continue existing policy that the subject of a complaint or his/her representative could receive a comprehensive summary on request but that actual complaints would not be released.

There are no requirements for peer review of qualifications or performance, no standards for physical equipment or facilities, in short, no regulation.

Surgery in outpatient settings became a major trend in the 1980s, and with it came new problems in consumer protection. Under existing law, any physician can set up a surgical unit in an office, clinic or "surgicenter", and no specific licensure or registration is required. There are no requirements for peer review of qualifications or performance, no standards for physical equipment or facilities, in short, no regulation. A number of cases raised concerns that perhaps the Board or some other agency such as the Department of Health Services should have a role in regulating out-of-hospital surgery. A particular source of concern was the fact that some physicians are unable to get staff privileges in licensed acute hospitals because they do not meet the qualifications of the facility. Others may have lost privileges for quality of care or competence reasons. Nothing in the law would prevent such a doctor from performing surgery in an office or unlicensed clinic.

The Department of Health Services had been struggling with the problem of defining surgicenters for several years. In 1992, the Board's Division of Medical Quality became involved in the search for a solution.

Large-scale health care and insurance fraud was a growing problem, and in 1991-92, the Board established a distinct unit in Glendale to focus on investigating fraud. The unit works closely with the Federal Bureau of Investigation (FBI), the Los Angeles Police Department and District Attorney, the office of the United States Attorney and the state Department of Insurance. By the beginning of 1992, the fraud unit had more than 175 cases under investigation.

The Budget Act of 1992 included a provision transferring various "surplus funds" from a variety of special funds into the state general fund to help in balancing the budget. Among those transfers, three directly affected the Board. The amount of $408,000 was transferred to reflect three areas:

- "salary savings,"a budgetary construct based on the assumption that a percentage of any agency's positions will be vacant during a given year;
- a personal leave program imposed by the Governor which cut employee salaries 5% and instead authorized granting of eight hours per month leave credit; and
- benefit savings identified in other provisions of the budget bill.

A second provision required the Board to identify increased operational efficiencies equal to at least 10% of its budget, and to transfer that amount to the general fund. A total of $1.915 million was transferred under this provision. Third, the Board was required to yield up the interest it earned from investment of its unappropriated reserve, an amount approximating $243,000. Altogether, the Board was relieved of more than $2.5 million by this act. In addition, more than two million dollars were taken from the funds of some of the allied health boards and committees.

Altogether, the Board was relieved of more than $2.5 million by this act.

After a hiatus of several years, the Board resumed sending physicians a questionnaire along with license renewal forms. The purpose for the questionnaire was to identify the overall practice patterns of the state's doctors, including their specialties, locations, type of practice (solo, group, clinic, etc.), and various other information. While individual responses were confidential, aggregated data were to be provided to the Office of Statewide Health Planning and Development to assist in their planning activities.

To assure that physicians returned the questionnaire, the Division of Licensing adopted a regulation allowing for non-renewal of licenses. If a physician did not comply, the license would be renewed the first time, and the physician would be notified that failure to return the information within the following two years would result in non-renewal. Three such notices would be sent.

The Division of Allied Health Professions had been engaged in an examination of its role and mission for several years, and this issue came into focus early in

Division members debated whether to seek legislation to restore some of its former responsibilities and authority, or, in the alternative, to consider dissolving the body.

1992. At the May meeting, a formal discussion was held on the evolution of the allied health boards and committees since creation of the Division by MICRA in 1976. Division members debated whether to seek legislation to restore some of its former responsibilities and authority, or, in the alternative, to consider dissolving the body. Comments and recommendations were taken from a variety of individuals and organizations, including some of the allied health committees and boards, but no action was taken at that meeting.

After a lengthy study of medically underserved areas in California, the Committee on Physician Services for Underserved Areas recommended that the Board sponsor legislation inviting physicians to make a voluntary donation of $25 when they send in their renewal fees. The money would be used to augment the Song-Brown Family Physician Training Act funds. The committee also recommended sponsoring legislation to expand the use of nonphysician health care practitioners in underserved areas.

During 1992, the Medical Quality Review Committees, through their Council, endeavored to find additional ways to increase their service to the public and the Board. They collaborated in developing a broadly-based list of new and enhanced activities, and surveyed all committee members to determine the level of interest in each activity on the list.

One activity which attracted a lot of interest was developing a set of protocols for members to use when they interviewed physicians. Such interviews were used for certain physicians who had been investigated but not prosecuted (i.e., the case had been closed with merit without further action).

Producing a protocol was not without a certain amount of controversy. Council members wanted to include a policy that addressed the highly unlikely event that during an interview previously unknown information might emerge that would affect the decision to close the investigation. Representatives of the California Medical Association who were participating in the working sessions objected to this as a sort of "double jeopardy". They maintained that if the case was already closed, it should remain closed. Council members, on the other hand, insisted that if egregiously bad information came to light, it must, in good conscience, be disclosed to the Enforcement Program.

This debate was finally resolved by limiting the inter-

views to cases which had been identified for closure, but not yet closed. By the end of 1992, the Council had produced a detailed protocol, which gained the approval of the Board, and was published under the title *"With a View to Learning . . . A Protocol for Educational Interviews with Physicians"*.

Some of the district [MQRC] committees were at or below the bare quorum level . . .

During this same time period, the MQRC Council was becoming extremely concerned about the falling level of membership on the committees. The Governor had not made any new appointments for many months. Some of the district committees were at or below the bare quorum level, and as of September 1992, most of the rest would reach the point where they no longer would be able to conduct hearings or other business.

In the interests of increasing efficiency and limiting costs, the Council approved a proposal which would have reduced the number of committees from 14 to 10, and the number of members from 210 to 110. This proposal was approved by the Division of Medical Quality, and enabling legislation was drafted. However, the passage of Presley II (SB 916) made the issue moot by repealing the MQRC Program.

The ongoing evaluation of the Board's relations with the State and Consumer Services Agency and the Department of Consumer Affairs was discussed again in November of 1992. Board member John Lungren, M.D. recommended that the Board seek to regain the independence of judgement and action described in a letter he read from Senator Barry Keene, the author of MICRA. The Board agreed to appoint a committee to study the feasibility of establishing the Board as an independent agency.

In September of 1992, long-time Chief of Enforcement Vern Leeper retired, and the Board began recruiting for a new Chief. At the November meeting, John Lancara, former Deputy Chief of the Department of Consumer Affairs' Division of Investigation was selected for this position.

1992 witnessed an interesting, and to some, a bewildering reversal of position by the Board. At the July 31, 1992 Board meeting there was a discussion of a segment of the CBS show "Sixty Minutes", which assailed the Board. Executive Director Wagstaff and public Board

When the show aired, their careful and well-documented gloss on due process had been edited down to a few snippets and sound bites.

member Frank Albino engaged in an open, free-flowing three-hour interview with show host Mike Wallace. When the show aired, their careful, and well-documented gloss on due process had been edited down to a few snippets and sound bites. Several Board members responded to a letter from the Agency Secretary about the show, and expressed their indignation about how it distorted the facts.

At the July meeting, the Board unanimously approved a motion which stated ". . .that the members of the Medical Board of California rigorously support and endorse the honesty, integrity and leadership of the Executive Director and his entire competent staff."

Four months later, on November 6, 1992, the Board accepted Wagstaff's resignation. Wagstaff spoke briefly at the meeting, summarizing the Board's accomplishments during the nine years he served it.

The Board appointed a search committee, and on December 16, 1992, voted to hire Dixon Arnett as its Executive Director. A graduate of Stanford University, Arnett served in the State Assembly from 1971 through 1978, and was minority whip for two years. He then served under President Reagan as Deputy Undersecretary for Intergovernmental Affairs for the Department of Health and Human Services. When Governor Pete Wilson was U.S. Senator from California, Arnett was his Legislative Director in Washington, D.C.

UNDER FIRE . . . AGAIN
1993-1994

In July of 1992, with the "60 Minutes" show still fresh in the mind, the Director of the Department of Consumer Affairs notified the Board that he had received a number of complaints alleging improprieties by Board staff. Initially, the Director reviewed the allegations, then asked the Department of Justice to investigate them. Since the Attorney General's office acts as counsel to the Board, Justice declined to become involved on the grounds it could constitute a conflict of interest.

The Director then approached the Department of the Highway Patrol (CHP), which agreed to provide investigators to Consumer Affairs. In January, 1993, the CHP returned a fifteen volume report and one volume summary to the Director of Consumer Affairs documenting a variety of findings.

The report described incidents involving misuse of state vehicles and other equipment, huge numbers of private phone calls, misuse of state time and facilities for private business purposes, and dishonesty.

Although eleven Board employees are named in the report, only six were accused of wrongdoing, including an investigator, a private contractor, and four employees in the Diversion Program. The report described incidents involving misuse of state vehicles and other equipment, huge numbers of private phone calls, misuse of state time and facilities for private business purposes, and dishonesty. In response to allegations, the report stated that CHP investigators were **not** able to verify charges that large numbers of complaint cases had been improperly dumped in order to reduce the case backlog.

The report was released to the public at a press conference on January 20, 1993, attended by the Secretary of State and Consumer Services, Ms. Sandy Smoley, The Director of Consumer Affairs, Mr. James Conran, the Board's new Executive Director, Mr. Dixon Arnett, and Board President Dr. Jacquelin Trestrail. At the press conference, Secretary Smoley set out an eight-point process for responding to the report, including:

- Reopening six closed cases relating to physicians practicing at Martin Luther King Jr. Hospital in Los Angeles, which involved four patient deaths, and allegedly were closed inappropriately.
- Overhauling the Enforcement Program to assure cases are handled properly.
- Upgrading complaint handling.
- Studying whether to contract out the Diversion Program

- Weeding out poor players.
- Seeking public comment.
- Reporting progress to the Governor, Agency Secretary, Department and public.

At the February 5, 1993 Board meeting, Executive Director Arnett announced he was recommending that two employees be terminated, one be suspended for sixty days, and one be suspended for thirty days and permanently demoted. A contract employee already had her contract terminated. During the subsequent year, all but one of the sanctions involving civil service employees were reviewed and overturned or modified by the State Personnel Board. The termination of one employee for dishonesty was sustained.

Following up on the eight-point plan, the Board and Agency jointly called a "Summit Meeting" on March 18, 19, and 20, 1993. During the Summit, several taskforces were appointed including:

- Diversion (study and make recommendations on the future of the Diversion Program)
- Information Disclosure (recommend policy relating to disclosure of disciplinary information to the public)
- Appropriate Prescribing (recommend policy on the prescribing of narcotics and other drugs with high abuse potential)
- Health Policy and Resources (recommend policy relating to the distribution of health resources in California)
- Medical Quality Resources (evaluate current system of medical consultants and experts and recommend improvements)
- Audit and Performance Standards (oversee fiscal operation of the Board; develop standards for evaluating executive director)

The six controversial cases at Martin Luther King hospital were reopened, although because of the passage of time the actual complaints and original investigation materials were no longer available. Investigation of those cases was ongoing at the end of 1994.

The Consumer Affairs investigation of the Board, the subsequent summit meeting, and passage of Presley II (SB 916) resulted in numerous changes in Board structure, processes and policies during 1993 and 1994. Many of these changes built upon things which already were in motion, while others were the direct outcome of the three trigger events.

The Taskforce on the Enforcement Process recommended implementing a program of administrative citations and fines, public letters of reprimand, infraction citations ("tickets"), interim suspension orders, and monetary sanctions for failure to produce medical records. The first two could be accomplished by adopting regulations, while infraction citations would require legislative authority. The Board already had authority to petition for interim suspensions, but wanted to simplify the process, possibly by gaining authority to issue a suspension upon the signature of one or two individuals, such as the Executive Director or Board President.

In a related area, staff recommended the DMQ reconsider its policy not to seek cost recovery in cases heard by Administrative Law Judges. Assembly Bill 2743, which took effect January 1, 1993, provides for Consumer Affairs boards to request reimbursement of investigative and prosecutorial costs up to the date of the hearing. The division subsequently voted to implement this cost recovery authority.

In a related area, staff recommended the DMQ reconsider its policy not to seek cost recovery in cases heard by Administrative Law Judges.

The Diversion Program Taskforce recommended keeping the program under the direct control of the Board, but also made several recommendations for improvements. These included requesting a legal opinion about the State's liability for group facilitators; increasing involvement of the California Medical Association's Liaison Committee in the program; developing performance appraisals for facilitators; refining selection criteria for facilitators; developing an in-depth annual and five-year report; developing a select list of psychiatric consultants; expanding awareness of the DMQ members about the program; and, making sure the program has adequate resources including management resources.

Specific program policies were reaffirmed, including contracting out laboratory tests; requiring facilitators to have continuing education; excluding unlicensed physicians and sexual misconduct cases from the program; reporting unsuccessful terminations of Board referred physicians to the Division of Medical Quality, as well as certain self-referred physicians if they are found incapable of practicing medicine safely; and keeping enrollment in the program unofficial until the Enforcement Program completes its investigation and determines whether a complaint has been filed.

The Complaint Processing and Information Disclosure Taskforce also made numerous recommendations to the Board. These included improving consumer access, sensitivity of intake personnel, multilingual capability, timely complaint handling, ongoing review of complaint processing, and universal notification of complainants when cases are closed or referred for other action.

In the area of public disclosure of information about complaints and investigations, the taskforce recommended disclosing discipline by other state boards, prior California disciplinary actions which occurred within a ten-year period, felony convictions, certain final actions taken by hospitals and other agencies, cases forwarded to the Attorney General for filing, current accusations, and malpractice judgements after the time for filing an appeal has elapsed.

The taskforce recommended not disclosing malpractice settlements, coroners reports, open investigations, raw complaints, and cases closed with or without merit. The taskforce also recommended creating a public information unit to respond to inquiries for both license verification and disciplinary information.

The primary goal would be to assure that patients not be forced to suffer needlessly because their caregivers are afraid to prescribe appropriately.

Concerned about the growing incidence of discipline for mal-prescribing, the Board created a Taskforce on Appropriate Prescribing. After conducting two public hearings on the subject, including the broad field of prescribing for chronic, intractable pain, the taskforce recommended that the Board develop courses for practicing physicians and other health professions. The courses would focus on the simple steps needed to avoid getting into trouble for prescribing practices, and education on the Board's enforcement process to help dispel misperceptions about discipline. The primary goal would be to assure that patients not be forced to suffer needlessly because their caregivers are afraid to prescribe appropriately.

Following several meetings and hearings on the issue, the Board unanimously adopted detailed guidelines on prescribing for intractable pain, on July 29, 1994. The complete guidelines, which were published in the October 1994 *ACTIONREPORT*, focus on seven critical steps:

1. History and physical examination
2. Treatment plan and objectives
3. Informed consent
4. Periodic review of the course of treatment
5. Consultation, especially for patients with a history of substance abuse

6. Careful recordkeeping
7. Compliance with controlled substances laws and regulations

Building on the provisions of Senator Leroy Greene's earlier legislation SB 711 (see page 62), the guideline makes clear that physicians can and should prescribe in a manner which spares patients unnecessary pain, while avoiding substance abuse. As SB 711 states: "No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain." However, the Board can, and does, retain the authority and responsibility to discipline a physician for sloppy or irresponsible medical practice even when it involves such prescribing.

The Audit and Performance Standards Taskforce recommended that the Board review the performance of the Executive Director annually, that the Executive Committee develop a three to five year plan for the Board, and that the first review of the Executive Director be accomplished by the end of 1993.

In addition to the activities of the Summit taskforces, the Board voted to adopt a formal mission statement:

> ***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.***

Continuing the previous years' dialogue on its location in the state government, the Committee on the Feasibility of Establishing the Medical Board as an Independent Agency reported in May on its findings. The committee recommended continuing to refine its analysis of the costs of services provided by the Department, including the costs of duplicative services. The committee also consulted with other independent boards regarding their administrative costs. At the July 1993 meeting, the committee reported that it estimated the cost of converting to an independent

The suggested criterion . . . was the administration of general anesthesia, or regional or local anesthesia with any type of supplemen-tal intravenous or inhalation agents.

agency would be about $700,000 the first year, but this would be offset by annual savings of about the same amount in subsequent years through avoidance of duplicative services and expenditures.

The Board continued to study the issue of out-of-hospital surgery, and early in 1993 recommended that such settings should be certified if they were not otherwise licensed. The suggested criterion for determining whether certification would be required was the administration of general anesthesia, or regional or local anesthesia with any type of supplemental intravenous or inhalation agents. Assemblywoman Jackie Speier agreed to author legislation to impose these requirements.

The Division of Licensing recommended that the Board approve private certifying organizations which meet specific standards, rather than taking on the actual certification process itself.

Late in the 1993 Legislative session, following intensive negotiations among numerous concerned groups, Assemblywoman Speier had reached near consensus on all provisions of her AB 595. However, the clock ran out and the bill was put over to 1994. It was passed and signed, and the Board immediately began developing regulations to set specific standards for certification agencies. By early 1995, the Division of Licensing expects to have forms and procedures in place and begin accepting applications.

The Division of Licensing pursued its study of the training of Doctors of Podiatric Medicine during 1993. The issue was that 1992 amendments to the podiatry law permit graduate podiatrists in residency programs to practice beyond the scope of podiatry, under the supervision of a licensed physician or osteopathic physician. The Division of Licensing was interested in assuring that podiatrists doing allopathic medical rotations were properly supervised.

A general provision of the Business and Professions Code, Section 726, prohibits health professionals from having sexual relations with patients. A State Court of Appeal overturned a Board decision to discipline a physician under that section. The court ruled that the act was between consenting adults, and that the Board had failed to show that it was substantially related to the qualifications, functions or duties of the profession.

The Board agreed to seek an amendment to Section 726 to remove the substantial relationship provision and substitute an absolute prohibition against sex between health professionals and patients. There were concerns whether such an amendment, if passed, would be challenged on constitutional grounds. However, legislation was successful, and the law now prohibits such acts except for the spouse or "person in an equivalent domestic relationship" with a physician.

The law also was amended to include a detailed definition of sexual exploitation, to provide for specific penalties including criminal penalties, and to clarify that consent of the patient is not a defense.

In response to the Governor's budget language ordering confiscation of "surplus money and interest" from special funds, the California Medical Association petitioned the Superior Court for a preliminary injunction to prevent the taking of Board funds.

San Francisco County Superior Court Judge Kenneth G. Peterson ordered the administration to return all money it had taken from the special funds, with interest. The Medical Board received reimbursement of $2,491,000, and in addition the court ordered repayment to CMA of $75,000 for its attorney fees. A provision of Presley II (SB 916) required the Board to refund the money to physicians if the suit succeeded. Beginning in the Summer of 1994, the Board reduced renewal fees by $25 for a two-year license renewal cycle *in lieu* of mailing a check to every physician.

The long-awaited regulations setting standards for professional advertising of specialty board certification were filed with the Office of Administrative Law. However, when OAL questioned some technical provisions of the regulations, they were withdrawn and revised, then resubmitted. None of the revisions were substantive, so no additional public hearings were required.

Following continuing discussions of the future role of the Division of Allied Health Professions, the Board recommended that the Division be dissolved. Its statutory functions would be assumed by the Board as a whole, and ongoing activities would be assumed by a Committee on

Allied Health Professions, appointed from the members of the Divisions of Licensing and Medical Quality. The five members of the DAHP were to be reassigned, with five new slots created in the DMQ. These recommendations were incorporated into Senator Presley's SB 916, and on June 30, 1994, the Division of Allied Health Professions faded into history.

COMING DOWN FROM THE SUMMIT

On August 1, 1993, the Board submitted its report to the Governor on events subsequent to the Medical Summit of March. The complete text of the report, as well as a summary by the Board President were published in the *ACTIONREPORT*, which was sent to all licensed physicians, and numerous others. (Copies are available from the Board on request by calling (916) 263-2389).

Under the title ***"The Medical Board: A New Beginning"***, the report described the events leading up to the Consumer Affairs investigation of the Board, the report from the CHP investigators, the Summit, and the eight-point plan. Highlights of the reforms emerging from the Summit include:

- Significant expansion of the information which is disclosed to consumers about discipline
- New enforcement sanctions
- New provisions for records access
- Elimination of the Division of Allied Health Professions and expansion of the Division of Medical Quality
- A new emphasis on the Board's role in enforcement of the Medical Practice Act
- New provisions for developing a better qualified system of medical quality review
- A study to refine how enforcement cases are prioritized
- A new system of data links with the Board's regular reporting sources
- Creation of taskforces to study issues about which the Board can help its licensees avoid trouble and perform better
- A $100 biennial fee increase to enhance the enforcement staff and provide more attorneys in the Health Quality Enforcement Section of the Attorney General's Office.

"Presley II" — Senate Bill 916 — became the vehicle for implementing many of the reforms described in the report to the Governor. Authored by Senator Robert Presley, sponsored by the Center for Public Interest Law, supported by the Board and the California Medical Association, SB 916 was the product of many hours of negotiations. As with MICRA eighteen years earlier, this was a three-legged stool, cleverly jointed, artfully carved, crafted with sharp and precise implements. It goes without saying there

were certain large and small scraps which may become future legislation, as well as many shavings and chips which were swept away.

The CPIL leg included additional reforms aimed at increasing the Board's public protection role including public access to information and provisions aimed at streamlining the process. The CMA leg focussed on assuring that physicians continue to have reasonable protection for their rights and effective due process. The Board leg sought to assure that it would continue to have an effective role in adjudication of disciplinary cases, adequate resources to perform its tasks, and statutory tools which give it the ability to work both faster and more effectively.

Provisions of SB 916 can be grouped in six main categories, many of which are directly descended from the Summit recommendations on the previous page:

- New enforcement sanctions including letters of reprimand and infraction citations
- Broader information disclosure, such as interim suspension orders and temporary restraining orders, prior discipline in California and elsewhere, felony convictions and cases transmitted to the Attorney General for drafting of pleadings
- New tools for accessing medical records, including a 15-day compliance deadline and a fine of $1,000 per day for non-compliance
- Board reorganization including dissolving the Allied Health Division and increasing DMQ from seven members to twelve
- Enhanced medical quality resources including expert witnesses, medical consultants, specialty board certification for specialists, elimination of the outdated MQRC program and more direct community-level involvement
- The $100 increase in the biennial renewal and initial license fees to fund additional investigators and attorneys.

One of the most visible and controversial changes wrought by Presley II was the public disclosure of information about disciplinary cases. Under policy adopted at the May 7, 1993 Board meeting, new information became available on October 1. This included records already in the Board's database, as well as new records specially entered. Such things as felony convictions, malpractice judgements and discipline by a board in another state were disclosed only if the Board already had knowledge of the case. That

is, no extraordinary efforts were made to ferret out previously unknown information. Persons who requested this information were to be read a carefully crafted disclaimer steering them to the original sources if the information came from outside the Board. The Board also agreed to release information about cases which had been transmitted to the Attorney General's Health Quality Enforcement Section for preparation of an accusation.

A month after the disclosure policy was implemented, the California Medical Association filed suit in Sacramento County Superior Court to enjoin the Board from releasing information on cases which had not been formally charged, and on certain other kinds of disciplinary activity. The suit also argued the policy was an illegal "underground regulation" because it had been adopted without going through a formal rulemaking process.

On December 2, 1993, Superior Court Judge Ronald Robie issued a split preliminary ruling. While upholding release of all the other information included under the policy, Judge Robie imposed a preliminary injunction against releasing information regarding cases pending at the Attorney General's office until such time as charges are actually filed against the physician.

In one of those peculiar phenomena which occur with some regularity in a democracy, the Board was caught in litigatory crossfire in 1994. Three major newspapers, the *Sacramento Bee*, the *Los Angeles Times* and the *San Jose Mercury*, sued the Board, to compel release of raw computerized records upon request. While the CMA was arguing in one courtroom that the Board wanted to tell too much, the papers were in another courtroom testifying that the public had a right to know a great deal more!

The newspapers argued in their suit that the people have the right to access non-confidential government records, and it is not up to the agency to determine what use the people make of that information. They also contended that cost was not an issue since the papers were willing to pay for the production of the records. On October 12, 1994, Superior Court Judge Roger K. Warren ordered the Board to provide the newspapers with computer tapes containing the requested information, and to pay the costs of the suit.

While the suits were pending, SB 916 was passed and signed, giving statutory authority for the information release, including the cases pending accusation. The Board

decided to go forward with adopting regulations to implement the Presley II provisions, and they were adopted on November 3, 1994, just a year after the suit was filed.

In 1988, a woman in Las Vegas became a tiny footnote in history when she did not renew her California license to practice as a midwife. Charlotte Alarcon had been the last licensed midwife on the Board's rolls for a number of years. The law under which she became licensed was repealed in 1937, but Alarcon and her colleagues were permitted to continue renewing their certificates. In the mid-1980s, she phoned a staff member to ask about ordering birth certificate blanks. She said she still attended births in some small desert towns occasionally, but was getting pretty old and probably would retire soon.

On January 1, 1994, a new law took effect which reintroduces the licensure of midwives in the state. Senate Bill 350 by Lucy Killea represents a negotiated consensus among numerous groups. It did not address the most contentious issue — how or if midwives would be supervised by physicians. A standing committee on Midwifery Licensing was appointed by the Division of Licensing and given the task of settling this issue through regulations. The regulations were adopted in November, 1994, and provide only for modest supervision.

Under legislative term limits, Senator Robert Presley completed his final term in the Senate in 1994. Before his departure, however, he authored one more bill to refine and expand the reforms begun in SB 2375 and SB 916. Presley II-A, as it was nicknamed, permits the Board to suspend the license of a physician convicted of or pleading *nolo contendere* to felonies related to the practice of medicine. Four specific felonies are conclusively presumed to be so related: murder, rape, selling drugs and child molestation, while the board can make determinations in other kinds of cases. SB 1775 also clarifies requirements for podiatric residencies and makes some technical changes to the two prior Presley bills.

One measure of the effectiveness of the many reforms beginning with the Board's "Curing the Backlog" report to the Legislature in April 1989 is the dramatic increase in physician discipline over those five years. To illustrate, the following activities were reported in the Board's annual reports:

	89/90	90/91	91/92	92/93	93/94
Complaints	6,658	6,825	7,892	8,757	9,686
Investigations completed	2,533	2,172	2,530	2,272	2,966
Cases to AG or DA	431	519	617	778	931
Accusations / other filings	319	310	308	583	673
Final actions	211	252	256	261	397

NOTE: all figures include both physicians and allied health professions

What can the past tell us about the future? One of humanity's oldest questions brought the Board to use humanity's newest and most powerful crystal ball — the computer — to look into the future. Could the Board identify parameters which strongly predict which physicians will or will not violate laws? With such a tool, could the Board exercise prevention and save its licensees from the disruption, stress and expense of the disciplinary process? Also, could a set of predictors enable the Board to maximize the effectiveness of its resources by triaging complaints at the point of intake?

A study conducted under contract with Schubert & Associates examined over 1,000 cases, including 732 which led to discipline and 303 which did not. They identified several "indicators" which strongly associated with high versus low risk of a result of discipline. The study examined factors including the type of complaint, physician age, source of the referral, level of harm, specialty, specialty board certification, prior discipline record and levels of insurance awards.

Having established which factors were most likely to predict which outcomes, Schubert & Associates entered Phase II of the study. For a year, beginning in mid-1994, they are applying the same methodology prospectively to incoming complaints and evaluating the predictive value of the model. One element which will not be used in the prospective phase, however, is the whether the physician was trained outside the United States. Concern that this could be perceived as discriminatory led the Board to discard that element of the study.

Returning to the issue of truth in professional advertising, the Division of Licensing succeeded in adopt-

ing regulations setting standards for advertising specialty board certification (cf. page 67). The process of adopting these regulations took nearly four years from the passage of the enabling legislation, Senator Dan McCorquodale's SB 2036. Earlier versions were twice submitted to the Director of Consumer Affairs and the Office of Administrative Law (OAL), only to be rejected.

The final language approved by the OAL in February 1994, in effect defines what a specialty board is. During the development of regulations, the Division melded a compromise between those who wanted standards essentially identical to those of the American Board of Medical Specialties, and others who wanted quite different, and usually less demanding standards.

From time to time the Legislature directs the Board to inform physicians about certain issues or information. In 1994, the Board published two brochures in response to such directives. *"Breast Cancer — Understanding Treatment Options"* actually is the third edition of a pamphlet first published in the late 1970s. Later editions include more recent research and treatment strategies. A copy was included in the April 1994 issue of ***ACTION REPORT***. *An even newer edition became available from the Board early in 1995.* The July 1994 ***ACTION REPORT*** included a copy of *"Treatment of Prostate Cancer"*, which describes the condition and discusses various approaches to diagnosis and treatment. Both brochures are available free of charge, either singly or in bundles of 25 copies by writing or calling the Board.

LOOKING AHEAD

As 1994 ended, the Board continued to consolidate the changes, reforms and improvements it began in 1975. The twentieth year of MICRA may witness a legislative battle between the forces which led to its enactment, the California Medical Association (CMA) and the California Trial Lawyers Association (CTLA). There have been rumblings of this confrontation for some time now, as the value of the $250,000 cap on awards for non-economic damages shrinks in relation to the inflation of the economy. Once this issue is joined in the Capitol, no-one can predict how it will affect the regulation of medicine in California.

People have a need to put brackets around things, and there is a special need to bracket centuries and millenia. As the end of both the 20th century and the second millenium of the Christian Era approach, we can speculate about how those eras will end and how the new ones will begin.

Will professional regulation continue as it has in the past, with only incremental change, to use a current phrase? Will dramatic changes occur on the national stage which will ripple through the states? Will Congress finally co-opt control of health care delivery and financing, and if so, how will that impact professional licensure? Will universal access to health care be realized? How will the AIDS epidemic play out? What happens when the baby boomers extend their consumption patterns into gerontology?

There are some trends which probably can be safely predicted for the coming decade or two.

- The scope of practice apportioned to various health professions will continue to be subject to border warfare.
- Pressure to develop national (not to be confused with Federal) licensure for health professions will continue, and probably will intensify. As the Federal Government, through its entitlement programs, pays for an ever-growing chunk of health care, politicians and bureaucrats will find more to object to in the Balkanized state licensure system of today.
- Managed care systems, primary care practitioners as gatekeepers, and the nexus between cost and treatment decisions will continue to ferment.
- The current concern over primary care versus specialization will continue, and intensify. We may see greater Federal intervention in decisions about how many and

what kinds of specialists will be trained. This may be direct, in terms of controls on student loans and grants, or indirect through limits on payments to specialists for procedures which could be done by GPs.

- The maldistribution of health care in some areas of the state and nation will continue to worry policymakers. Language and cultural barriers to medical care will be challenged, and may become the next arena for Federal legislation.
- Uncompensated and under-compensated care will be a continuing problem, exacerbated by growing populations of undocumented immigrants, and ever-tightening limits on Federal matching funds.
- Technology will have diverse impacts: What will be possible, at what price, in whose hands, and under whose control? Who will make the decisions about who receives the benefits of technology? Will some people be excluded on the basis of age, other health conditions, income or insurance coverage?
- The *cliché du jour* is "information superhighway". The Federation and the individual boards already are exploring how communications technology can help them work faster and better. It is a matter of a very few years before the entire national network of health regulators will be linked with "wait-less" information sharing about both license qualifications and disciplinary activity.
- A related issue already confronting the Board is "telemedicine" — diagnosis and treatment by televised video-conferencing. Computer linkage is the obvious next step. The Board must grapple with the problem of regulating doctors outside of California who conduct virtual-practice within the State.
- Enforcement will continue to exert a powerful influence on both boards and policymakers. Processes and outcomes will be perpetually finetuned, but we probably never will achieve perfect assurance of safe, effective, honorable health care. And, each time a notorious case makes headlines, the call for reform will echo again in the halls of the Legislature.
- Enforcement issues for further work will include continuing to refine case priorities; fitting sanctions to offenses; appropriate prescribing and standards for pain management; physician involvement in decisions about death.

SOME OBSERVATIONS ON TWELVE DECADES

The Board of Medical Examiners which convened for its maiden meeting in June 1876 was a far different creature than it would become. It was made up of members of the state medical society, met at society quarters, and received neither state funds nor state powers. For more than a quarter of a century, it would not even have the security of continued existence, as the Legislature repeatedly created and recreated the Board.

During its early years, most of the Board's struggles were internal to the subculture which is medicine. They focussed on establishing a definition against which to assess the qualifications of those who wanted to be admitted to the subculture, quashing those who strayed too far from the definition, and maintaining a degree of control over the initiates. The medical care provided to the rest of society was almost incidental. In part that was a function of the still mostly empiric nature of the science of medicine. In part it also was a function of the nature of Americans of that period who did not yet expect to be cured, who did not yet expect to be paid for failure, and who still regarded the physician as friend/almost family.

With the social revolution brought on by two wars and a depression, medicine was forced to change. The first health insurance plans sounded a knell only dimly heard initially. The social contract between physician and patient was slowly extended to embrace insurors, employers, and beginning with the passage of Titles 18, 19 and 5 (Medicaid, Medicare and Child Health and Disability Prevention) in the 1960s, to embrace government. Even the regulation of hospitals under Hill-Burton and other health planning legislation contributed to what was becoming a very complex stew indeed. Physicians no longer were the captains of the health care vessel.

With all these evolutionary pressures, the emphasis in the realm of physician regulation began to shift from controlling entry into the profession as the principal task, to controlling performance once admitted. When Ralph Nader branded the Chevy Corvair "Unsafe at any Speed" he jolted Americans into looking quite differently at how governments regulate everything from bacon to Buicks. The realization that consumers should be both beneficiaries of

regulation and participants in the regulatory function was seismic.

MICRA did a great deal more than just rein in the explosion of malpractice litigation that sprang from the combination of the ravelling of the patient-physician bond and the consumerism of the sixties and seventies. It told physicians they were no longer free to regulate themselves like a gentlemen's social club. It told consumers there were several seats at the boardroom table. It told hospitals and insurance companies they could not just hustle their drunks, incompetents and larcenists out past the loading dock at midnight, and pretend there wasn't a problem.

And, just as the Board began to regard enforcement as its prime directive, the media discovered it and all hell broke loose. The Caribbean medical schools were a media event. The Vietnam physicians were a media event. Individual cases became *causes celebre* for various newspapers: an infanticidal obstetrician in Valencia, a fake cardiologist in Campbell, a messy plastic surgeon in La Jolla, a buccaneer ophthalmologist in Coronado, a rapist in Redwood City.

The Board became a soccer ball buffeted by consumers, legislators, reporters, talkshow pundits, Naderites, professional societies and even its own staff. For every swing toward consumerism, someone slammed it back toward due process. Each time a goal loomed, someone in yet another mask threw himself into the breech and the Board caroomed off on another tangent.

Things seem to be settling down as 1994 ends, but only a night-blooming innocent would believe that the Board can anticipate calm seas and a prosperous voyage into the 21st century.

BIBLIOGRAPHY

ACTION REPORT, Medical Board of California (MBC), Sacramento, CA, Vols. 1 - 51, Aug.1976 - Oct. 1994.

ANNUAL REPORTS, MBC, Sacramento, CA, 1978 - 1994

"Article in *LACMA Physician*", (Memorandum to Board members from Robert Rowland), BMQA, Sacramento, CA, Feb. 11, 1982.

"Computer Data Policy/Public Records Act", (Memorandum to Board Members, summarizes court action on newspaper suit against Board), MBC, Sacramento, CA, Nov. 9, 1994

Letter to Robert D. Burnett, M.D., President of CMA, from Jeoffry B. Gordon, M.D., President of BMQA, (re speech made by Robert Rowland in Merced and CMA reaction), BMQA, Sacramento, CA, May 11, 1983.

"Medical Board: A New Beginning — A Report to the Governor, The", MBC, Sacramento, CA, July 30, 1993.

MEDICAL MEMO, Board of Medical Examiners (BME), Sacramento, CA, 1972 - 1975.

MINUTES, Meetings of the BME, Board of Medical Quality Assurance (BMQA), MBC, Sacramento, CA, 1976 - 1994.

(No Title), (Memorandum to Board Members from Robert Rowland, regarding talk he gave in Merced and CMA reaction), BMQA, Sacramento, CA, May 11, 1983.

"Performance of Robert Rowland as Executive Director", (Memorandum for the record from Jeoffry B. Gordon, M.D., President, BMQA), San Diego, CA, June 3, 1983.

PHYSICIAN DISCIPLINE IN CALIFORNIA: A CODE BLUE EMERGENCY - An Initial Report on the Physician Discipline System of the Board of Medical Quality Assurance, Center for Public Interest Law, San Diego, CA, Apr. 5, 1989.

PUBLIC REGULATION OF HEALTH CARE OCCUPATIONS IN CALIFORNIA, Final Report (A Study conducted for the California BMQA. This is the last of nine reports.), Public Affairs Research Group, Sacramento, CA, Undated but released in 1981.

REPORT TO THE CALIFORNIA STATE LEGISLATURE ONTHE DESIRABILITY OF CERTIFYING CURRENTLY NONCERTIFIED CATEGORIES OF PERSONNEL PROVIDING HEALTH SERVICES OF A TECHNICAL NATURE - "The Credentialing Report", BMQA, Sacramento, CA, Feb. 1977.

SPECIAL BUDGET REPORT: CURING THE BACKLOG - Report to the Joint Legislative Budget Committee, BMQA, Sacramento, CA, Apr. 14, 1989.

MEMBERS

BOARD OF MEDICAL QUALITY ASSURANCE (1975 to 1989)
MEDICAL BOARD OF CALIFORNIA (1990 to present)

ALBINO, Frank, Los Angeles - March 1985 - June 1, 1992
ANDREWS, Richard, Fresno - March, 1985 - June 1, 1988
ARONBERG, Charles, M.D., Beverly Hills - April 1982 - June 1, 1985
AVERY, Clarence, M.D., Oakland - Aug. 13, 1991 - June 1, 1995
AXELRAD, A. David, M.D., Sacramento - Jan. 23, 1978 - June 1, 1979
BABITZ, Marc, M.D., Guerneville - Jan. 23, 1978 - June 1, 1982
BERSCH, Blanche, Los Angeles - 1976 - 1978
BLACKER, Hope, Santa Monica - June 1, 1976 - June 1, 1978
BUNKER, John P., M.D., Stanford - March 16, 1976 - June 1, 1978
CAMACHO, Andy, Encino - Dec. 13, 1982 - June 1, 1987
CARELLA, Michael J., Ph.D., San Diego - Apr. 13, 1977 - June 1, 1979
CASTRO, Margaret, San Diego - June 1, 1976 - June 1, 1978
CLAASSEN, Theresa, San Francisco - June 1, 1986 - June 1, 1994
COFFEY, William J., Jr., M.D., Los Angeles - June 1, 1981 - June 1, 1984
DEL JUNCO, Robert, M.D., Orange - Aug. 13, 1991 - June 1, 1995
DORR, Lawrence, M.D., La Canada - Aug. 11, 1992 - June 1, 1996
DUGAN, Paul J., M.D., Roseville - May 1973 - June 1, 1976
ELLIS, Eugene J., M.D., Los Angeles - July 29, 1983 - June 1, 1991
ESCANDON, Luis, M.D., Hacienda Heights - June 11, 1980 - June 1, 1981
FELDMAN, Eugene C., M.D., Sunnyvale - March 16, 1976 - June 1, 1983
FRIEDMAN, William Foster, M.D., Los Angeles - Sept. 27, 1994 - June 1, 1998
GERBER, William G., M.D., Berkeley - March 16, 1976 - June 1, 1983
GORDON, Jeoffry, M.D., San Diego - Aug. 16, 1976 - June 1, 1984
GOUGH, Galal S., M.D., Montebello - July 29, 1983 - June 1, 1991
HASENKAMP, Bruce, San Mateo - June, 1987 - June 1, 1996
HILL, Lawrence N., M.D., Eureka - June 11, 1980 - June 1, 1983
HSIEH, Stewart, Los Angeles - Oct. 30, 1992 - June 1, 1994
HURVITZ, Carole Hughes, M.D., Los Angeles, Sept. 27, 1994 - June 1, 1998
IMBERT, Anabel Anderson, M.D.- Oct. 28, 1993 - June 1, 1997
JOAS, Thomas, M.D., October 28, 1993 - June 1, 1997
KASSABIAN, John P., M.D., Pasadena - Aug. 30, 1985 - June 1, 1993
KELLY, Joyce, Los Angeles - July, 1982 - June 1, 1983
KUMAGAI, Lindy, M.D., Sacramento - June 11, 1980 - June 1, 1986
LEE, Jane F., M.D., San Francisco - March 16, 1976 - June 1, 1979
LEVONIAN, Rendel, M.D., Pico Rivera - July 29, 1983 - June 1, 1991
LEVY, Edward I., M.D., San Diego - Jan. 1975 - June 1, 1977
LINDHEIM, Roslyn, Berkeley - Oct. 16, 1980 - June 1, 1983
LOCKHART, James P., M.D., Menlo Park - Sept. 1976 - June 1, 1984
LUBELL, Ira, M.D., Santa Cruz, Oct. 30, 1992 - June 1, 1996

LUCINE, Andrew, M.D., San Jose - Oct. 2, 1984 - June 1, 1992
LUNGREN, John C., M.D., Loomis - Aug. 1985 - June 1, 1993
MAGNALL, James, M.D., Long Beach - July 29, 1983 - June 1, 1987
MAHDESSIAN, Haig, M.D., Santa Monica - Sept. 1990 - 1991
MALLEL, Raymond, Los Angeles - April 1982 - June 1, 1986, and June 1, 1987 - June 1, 1995
MASLAN, Neal, Brea - Dec. 1983 - June 1, 1987
McAULIFFE, Maire, M.D., San Francisco - June, 1982 - June 1, 1985
McELLIOTT, Karen L., San Diego - Oct. 30, 1992 - June 1, 1996
MEDEARIS, Miller, J.D., Los Angeles - Oct. 12, 1979 - June 1, 1986
MELIKIAN, Audrey, Fresno - March 1985 - June 1, 1992
MEMEL, Sherwin, J.D., Los Angeles - May 1973 - June 1, 1976
METCALF, Versia M., Bell - March 16, 1976 - June 1, 1979
MILKIE, C. Fredrick, M.D., Lynwood - June, 1987 - June 1, 1991
MILLER, Sara (Suki), San Francisco - Sept. 1, 1978 - June 1, 1982
MILLS, Warren, M.D., Sunnyvale - June 1982 - June 1, 1986
MIRAHMADI, Mike, M.D., Beverly Hills - Aug. 11, 1992 - June 1, 1996
NATHANSON, Gayle, Lawndale - June 10, 1987 - June 1, 1995
OBERHELMAN, Harry A., Jr., M.D., Stanford - April 1970 - June 1, 1981
PACE, Phillip Joseph, Montebello, September 27, 1994 - June 1, 1998
QUEVEDO, Frederic G., M.D., Burbank - Dec. 31, 1979 - June 1, 1983
RICHARDSON, Madison, M.D., Los Angeles - March 1, 1987 - June 1, 1993
RIDER, J. Alfred, M.D., San Francisco - June 1974 - June 1, 1976, and Oct. 1, 1984 - June 1, 1992
SALSBURY, Anne E., San Francisco - Jan. 16, 1979 - June 1, 1984
SHUMACHER, Alan E., M.D., San Diego - Aug. 11, 1992 - June 1, 1996
SIMPSON, Louis, Jr., M.D., Venice - May 11, 1977 - June 1, 1980
SONG, Alfred, Sacramento - July 27, 1988 - June 1, 1992
STEMPLE, Barbara A., San Diego - Aug. 11, 1992 - June 1, 1996
STROUD, Florence M., R.N., San Francisco - March 16, 1976 - June 1, 1984
TOKE, Raja Mohan, M.D., Walnut Creek, Sept. 27, 1994 - June 1, 1998
TOMA, Kay, M.D., Bell - April, 1970 - June 1, 1977
TRESTRAIL, Jacquelin, M.D., National City - March 1, 1987 - June 1, 1994
TSAO, John, M.D., Torrance - Oct. 1, 1984 - June 1, 1992
UNATIN, Jerome H., M.D., Torrance - Aug. 1985 - June 1, 1990
WARNER, Cathryne Bennett, San Francisco - Aug. 11, 1992 - Oct. 1, 1992.
WARSHAW, Barry, M.D., Lynwood - April 2, 1976 - June 1, 1985
WEISMAN, Michael, M.D., San Diego - Aug. 13, 1991 - June 1, 1995
WILKINS, Harold E., M.D., Downey - May, 1973 - June 1, 1976
WILLIAMS, B. Camille, M.D., Orinda - Nov. 19, 1991 - June 1, 1994
WINTERS, Ben, Los Angeles - Feb. 22, 1979 - June 1, 1984