MEDICAL BOARD OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2389
Fax: (916) 263-2944
www.mbc.ca.gov

Governor Edmund G. Brown Jr., State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENISNG COMMITTEE MEETING

Embassy Suites by Hilton
1325 E. Dyer Road
Santa Ana, CA 92705
Laguna/LaJolla Room

Thursday, April 27, 2017

MEETING MINUTES

Committee Members Present:
Howard R. Krauss, M.D., Chair
Michael Bishop, M.D.
Dev GnanaDev, M.D.
Randy W. Hawkins, M.D.
Denise Pines
David Warmoth

Staff Present:
April Alameda, Staff Services Manager II
Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dennis Frankenstein, Staff Services Analyst
Kimberly Kirchmeyer, Executive Director
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant
Kerrie Webb, Staff Counsel

Members of the Audience:
Jonathan Burke, Manager, Board and Bureau Relations, Department of Consumer Affairs
Gloria Castro, Senior Assistant Attorney General, Health Quality Enforcement Section, Attorney General's Office
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Sarah Davis, Licensed Midwife, California Association of Licensed Midwives
Clint Dicely, Supervising Investigator, Health Quality Investigation Unit
Louis Galiano, Videographer, Department of Consumer Affairs
Renuka George, Deputy Attorney General, Attorney General's Office
Bridget Gramme, Center for Public Interest Law

Marian Hollingsworth, Consumers Union Safe Patient Project
Michelle Monseratt-Ramos, Consumers Union Safe Patient Project
James Murdoch, Arizona College of Osteopathic Medicine
Robert Pulido, Supervising Investigator II, Health Quality Investigation Unit, Department of Consumer Affairs
William Studley, Arizona College of Osteopathic Medicine

Agenda Item 1 Call to Order / Roll Call / Establishment of Quorum

Dr. Krauss called the Licensing Committee meeting of the Medical Board of California (Board) to order on April 27, 2017, at 1:47 p.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

No public comment was provided.

Agenda Item 3 Approval of Minutes from the May 5, 2016 Licensing Committee Meeting

Dr. Bishop made a motion to approve the May 5, 2016 meeting minutes; s/Dr. GnanaDev. Motion carried unanimously (6-0).

Agenda Item 4 Update and Possible Action on Postgraduate Training Requirements and Approval/Recognition of International Medical Schools

Ms. Alameda provided an update on the amendments for postgraduate training requirements. She stated that in response to the issue raised in the Board's Sunset Review Report, proposed statutory language was provided to the Senate, Business, Professions, and Economic Development Committee (Senate Committee) on April 4, 2017, for review and consideration. The language proposed changing the postgraduate training requirements for licensure from one or two years to three years for all applicants, regardless of where they graduated from medical school, and to also eliminate the Board's medical school recognition and approval process.

Ms. Alameda stated that current law for postgraduate training requirements for licensure differs between graduates of U.S./Canadian medical schools and graduates of international medical schools. Applicants who graduate from a Liaison Committee on Medical Education (LCME) approved medical school must successfully complete a minimum of one year of either Accreditation Council for Graduate Medical Education (ACGME)(US) or Royal College of Physicians and Surgeons of Canada (RCPSC)(Canada) accredited postgraduate training. Applicants who graduate from a Board recognized or approved international medical school must successfully complete a minimum of two years of ACGME or RCPSC accredited

postgraduate training. The Board does not believe the current postgraduate training requirements provide sufficient amount of training time to ensure consumer protection.

Ms. Alameda also stated the current length of time in a postgraduate training program is not consistent with the minimum years of postgraduate training for any of the ACGME accredited postgraduate training programs, which is three years. In addition, it is also required for any board certification by the American Board of Medical Specialties (ABMS), and recommended by the Federation of State Medical Boards (FSMB).

Ms. Alameda stated the U.S./Canadian medical schools go through a standardize evaluation by the U.S. Department of Education medical school accreditation entity, LCME. Currently there is not an international accrediting body similar to LCME. Therefore, the Board must conduct its own evaluation of international medical schools in order to determine if they meet the same standards of the medical schools that have been evaluated and approved by the LCME. The in-depth evaluation process can take a minimum of 30 days or as long as three or more years. The Board is also required to conduct a reassessment every seven years of the international medical schools recognized by the Board to ensure they still meet requirements outlined in the law. However, limitations on staffing, resources, and qualified medical consultants to conduct timely, thorough reviews results in delays. Consequently, this delays applicants from entering into a postgraduate training program or obtaining their license. The change in postgraduate training will allow the Board to streamline the recognition process for international medical schools by accepting schools recognized by the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER), and schools that are listed in the World Directory of Medical Schools.

If the proposed language is approved, applicants will be required to obtain a postgraduate training license within 180 days from enrollment in a postgraduate training program. The training license will be valid until 90 days after the holder has completed 36 months of postgraduate training, which will allow a holder of a postgraduate training license to engage in the practice of medicine as it relates to his or her duties as an intern or resident in an approved program. The proposed language also allows for combined dental and medical degree programs. The Board has requested for the change to take effect January 1, 2020, to allow enough time to implement changes and work with stakeholders to ensure compliance with the new law.

Dr. GnanaDev informed Ms. Alameda that program directors would like to know if trainees will be allowed to moonlight or is it discretionary, since a doctor in their intern year should not be moonlighting after 90 days versus their second year of postgraduate training.

Ms. Alameda stated the language allows for moonlighting as long as it is approved by the program director.

Dr. Bishop asked Ms. Kirchmeyer if it will be internal moonlighting within the residency program or moonlighting anywhere within the state.

Ms. Kirchmeyer stated moonlighting will be allowed anywhere the program director approves.

Dr. Bishop stated he believes that although it may be an inconvenience for some individuals due to the moonlighting issue, safety is a top priority. Residents are more experienced after two years of postgraduate training rather than after one year, but three years is even better and it is important to be cautious moving forward.

Dr. Krauss stated with regard to moonlighting, all residency program directors are very compulsive about recording hours because of the issue of physician fatigue and potential falling asleep at the wheel due to lack of sleep from driving from one place to another. Therefore, it seems contradictory to allow moonlighting to somebody who is limited to 80 to 100 hours a week in his or her residency program.

Dr. GnanaDev stated it is an ACGME requirement for the moonlighting hours to be counted in the work hours.

Dr. Bishop asked about disciplinary consideration and if the program director would be acting in a supervisory capacity when the individual is moonlighting elsewhere. If so, and discipline is invoked, is it like a physician assistant to physician relationship or is it an independent physician on their own once it has been approved by a program director.

Ms. Webb stated that all of these things would be determined on a case-by-case basis for administrative cases. In civil litigation, as it is now, they will likely be brought in if they have contact with a decision making process that could affect patient care.

Ms. Kirchmeyer stated the Board would have administrative oversight over the licensee once they receive the postgraduate training license, and then the Board would be able to take action through the normal process.

Agenda Item 5 Discussion and Possible Action on Physician Reentry to Practice Program

Ms. Kirchmeyer explained this agenda item relates to an issue raised in the Board's Sunset Review Report regarding physicians that have been out-of-practice for any length of time. The discussion of physician reentry and the development of a limited educational permit was discussed. It was determined that these issues would be addressed separately and Ms. Alameda would be presenting after Ms. Kirchmeyer on individuals who were already licensed and had not practiced medicine for a certain amount of time.

Ms. Kirchmeyer stated that a limited educational permit would address applicants that otherwise qualify for a physician and surgeon's license, however, have not been in practice

for many years. The limited educational permit would authorize the Board to assess an individual's clinical skills, such as through the Physician Assessment and Clinical Education (PACE) program or an equivalent program and require the applicant to practice while supervised for a period of time determined by the Board to ensure the individual is safe to practice medicine. Currently, the Board does not have a mechanism to require such evaluation or oversight unless a probationary license is issued. It would not be appropriate to issue a probationary license under these circumstances.

Ms. Kirchmeyer indicated that proposed statutory language regarding the limited educational permit was provided to the Senate Committee for review. If accepted, it would be placed in the Board's Sunset bill.

Ms. Alameda provided a presentation on physician reentry to clinical practice. Ms. Alameda explained that the American Medical Association's definition of physician reentry is, "[A] return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment." For ABMS, the clinical inactive practice definition is, "[N]o direct and/or consultative patient care has been provided in the past 24 months." Ms. Alameda stated that in 2015, the Board surveyed all medical boards to find out their requirements, if any, regarding reentry. The Board learned that out of the 25 responses, 14 states have current statutes, two have guidelines and policies, and nine had no requirements at all. The nine medical boards indicated that they require their licensees to include how long they have been out of practice on their renewal notice. The FSMB also surveyed all the medical boards around the same time and received a 78 percent response rate. The FSMB indicated 33 boards out of 57 responded and had reported some sort of a reentry procedure. The average length of time out of practice is 2.9 years before the medical board requires any type of reentry. Currently there are no national standards and they vary from state to state based on statutes, internal guidelines or policies, and procedures. The length of time out of practice is between two to five years. Some states require clinical skill assessments, clinical refresher training, practicing under the supervision of a licensed physician, board interviews, or licensing committee reviews to determine what the individual would need, based on the years they have been out of practice.

Ms. Alameda stated that the Board does not have authority to require a licensee to report to the Board if he or she has not been in practice. If an individual does not renew their license within five years, their license is automatically canceled. However, a licensee may continue to renew their license, even though they are not practicing medicine. Currently, the Board does not have a mechanism in place to know if an individual is out of practice for any length of time.

Ms. Alameda indicated that the discussion for the Committee is needed regarding the length of time a California physician is out of practice before a clinical assessment or training is required, what would be required to ensure consumer protection, how does reentry affect

physicians in an administrative capacity, does the Board wish to address these issues at a later time, or is further research needed.

Dr. GnanaDev stated a concern regarding the impact to a licensee in an administrative role who may eventually want to go back to practicing medicine.

Ms. Kirchmeyer stated that there are no clear answers and asked if the Licensing Committee wanted staff to continue to research this issue. Ms. Kirchmeyer stated that this would affect a small amount of individuals and most would be required to go through the credentialing process if they go to a hospital setting. Ms. Kirchmeyer indicated that she gave a presentation to the California Association of Medical Staff Services and asked about the process. Ms. Kirchmeyer was informed that a PACE assessment may be required, proctoring for oversight, or additional resident training. However, the issue of most concern is the individual that is not practicing, but continues to renew their license. The individual may want to return to practice with another physician or as a solo practitioner. Unfortunately, the Board does not maintain statistics for this information. Last year, the Board may have taken disciplinary actions against individuals that returned to practice after several years who injured patients. The Board's accusations are not identified in this manner; therefore, the size of the issue is uncertain. The Board is aware that there are states that issue administrative licenses that do not include direct patient care and require an evaluation if returning to direct patient care. Staff is requesting direction from the Licensing Committee on how to proceed with this issue.

Dr. Krauss stated it is a parallel issue if the Board is considering requiring clinical care for license renewal, then it is incumbent upon creating an administrative physician license. It may take a long time to know quantitatively how much practice is required to maintain clinical skills and to protect the public, but when a physician has not been in practice for a period of time, they need an assessment, some guidance, and a reentry evaluation to practice medicine. Therefore, someone who has been out of practice for a number of years would require the same reentry program. Dr. Krauss reiterated that it is incumbent upon the Board to design a reentry program, but at the same time, to work with the legislature to find out the best mechanism to create the law that would allow that to happen. Dr. Krauss asked if work is needed by the Licensing Committee or by staff to proceed on those two parallel issues.

Ms. Kirchmeyer stated that staff would need to conduct further analysis, determine what the reentry program would involve, and then bring language back to the Licensing Committee for further discussion.

Dr. GnanaDev stated once a physician or surgeon becomes an administrator, they often do not have time to practice medicine because it is important to provide oversight in that administrate role. That is an important scenario to consider. For reentry, unless they are practicing in a hospital with all the requirements, it is essential to look into public protection.

Ms. Kirchmeyer stated that the need for an administrative license would be necessary if the Board begins asking individuals how long they have been in clinical practice.

Dr. Krauss asked if the Board had the authority to ask physicians if they had provided clinical patient care or consultative services within the last 24 months.

Ms. Kirchmeyer stated that the Board already asks in the physician survey how many hours a week the licensees provides direct patient care, administrative, telemedicine, etc. This information can be pulled from the survey and brought back to the Licensing Committee.

Ms. Kirchmeyer stated no action is needed at this time. However, staff can use this discussion to continue to gather further information on this issue.

Dr. Krauss stated it is important and staff should continue on the project.

Agenda Item 6 Future Agenda Items

Dr. Krauss asked Ms. Alameda and Ms. Kirchmeyer whether the Licensing Committee should approach the subject of whether the medical schools and residency programs are doing an adequate job of screening those they accept. Dr. Krauss asked if it would be helpful for the Licensing Committee to consider accumulating data, especially amongst the new applicants coming out of California medical school residency training programs where there have been problems. This may begin with a dialogue between medical schools, residency programs, and the Board to see if there may be a collaborative effort for improving the screening process to help mitigate potential future problems. Dr. Krauss stated he understands staff are involved in outreach and are already doing a very important job, in terms of medical students and resident education, but he is unsure if it is incorporated as an official part of their medical school curriculum. He asked if it is something that the Licensing Committee should exert a voice on or if it is something that is carried out independently.

Ms. Kirchmeyer stated staff can gather information as far as finding out what the screening tools are. The same thing for postgraduate training, as staff can also talk to those who are involved in the match process and learn what is considered during a review of the individuals, how it impacts the Board, and where the cross over is since LCME approves medical schools that are in the United States or Canada. Ms. Kirchmeyer recommended that staff gather the information and provide a presentation with the requirements and what they look at during the process, if they are willing to provide that information. The Licensing Committee can think about how that fits into the mission and authority of the Board.

Dr. Krauss stated it would be helpful to begin some collaborative effort with medical schools, as it would be a valuable service for the public.

Dr. Krauss asked if there are any other future agenda items from the audience.

Ms. Fellmeth stated she would like to see more discussion on the number of hours residents are allowed to work, required to work, and how moonlighting on top of that poses great public risk.

Dr. Krauss asked if outreach should be discussed with residents, limiting moonlighting hours and being sure they are being approved by their residency program director.

Ms. Kirchmeyer stated if SB 798 passes, it is definitely something staff need to discuss because no moonlighting should occur without program director approval.

Agenda Item 7 Adjournment

Dr. Krauss thanked Ms. Alameda for stepping into the difficult position of filling in for retired Chief, Curt Worden. Dr. Krauss thanked Ms. Toof, Ms. Kirchmeyer, and all of the staff for their work.

Meeting was adjourned at 2:33 p.m.