STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA – DIVERSION
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Diversion Advisory Council
Greg Gorges Conference Room
1420 Howe Avenue
Sacramento, CA 95825

June 12, 2007

Minutes

Agenda Item 1 Call to Order

Mr. Valine called the meeting to order on June 12, 2007, at 9:10 a.m. A quorum was present and notice had been sent to all interested parties.

Members Present:

Shannon Chavez, M.D.
Marvin Firestone, M.D., J.D.
Laurie Gregg, M.D.
Bruce Kaldor, M.D.
David Pating, M.D.
Stephanie Shaner, M.D.
Lee Snook, M.D.
Thomas Ciesla, M.D., Alternate Member
Michael Parr, M. D., Alternate Member
Barry Rosen, M.D., Alternate Member

Staff Present:

Frank Valine, Program Administrator, Diversion Program
Kim Kirchmeyer, Deputy Director
Linda Whitney, Chief of Legislation
Rhonda Baldo, Staff Services Analyst, Diversion Program
Kelly Nelson, Analyst, Legislative/Regulatory Unit
Scott Johnson, Business Services Assistant, Business Services Office
Kurt Heppler, Legal Counsel, Department of Consumer Affairs

Members of the Audience:

Sandra Bressler, California Medical Association (CMA)
Ed Howard, Center for Public Interest Law

Agenda Item 2 Bagley-Keene Open Meeting Act

Kurt Heppler, DCA Legal Counsel, made a presentation to the Diversion Advisory Council members regarding the Bagley-Keene Open Meeting Act. Mr. Heppler defined what constitutes a public meeting and provided examples of illegal meetings and different types of members' interactions that could result in violations.

Agenda Item 3 Election of Officers

It was M/S/C (Gregg/Firestone) to nominate Dr. Pating as Chair.

It was M/S/C (Firestone/Gregg) to nominate Dr. Snook as Vice Chair.

Agenda Item 4 Role, Responsibility, Mission and Vision of Council

Dr. Gregg reported that the Diversion Committee (Committee) believed the role of the Diversion Advisory Council (DAC) would be to provide scientific expertise to the Committee for issues that are not within the Committee's expertise. The Committee wants the DAC to answer questions pertaining to clinical issues about diversion participants, while the Committee maintains the oversight of the Diversion Program.

Dr. Pating stated that diversion is an outstanding program and it has done a great service to the medical and physician community. The DAC should look at the structure of the program, the policies and procedures, aspects of the matrix that are being measured to determine whether the goals of the program are being met, and also look at communication with case managers and participating physicians to maintain the standards of the program. It was recommended that the DAC set standards in a way that would be beneficial to the program and the public. The Council would not be looking at personnel issues or individual case issues, nor is it a quality assurance committee. An example of a DAC agenda item could be to review the fact that a lot of urines were coming up falsely positive. The DAC would determine what is technically going wrong with the process. The DAC should create quality improvement recommendations that the Board can act on.

Dr. Gregg stated there is a lot of work to get done in the next six to 12 months and asked the DAC to expedite their advice to the Committee. Dr. Pating suggested forming a workgroup to discuss criteria for termination and non-compliance. Mr. Heppler reiterated the Bagley-Keene Act and suggested materials be given to Mr. Valine prior to the meeting for dissemination to the members.

It was agreed that the working draft Mission Statement would be: to serve the Diversion Committee in its goal of overseeing the Diversion Program by providing technical, scientifically-based answers to the Diversion Committee, and in the absence of questions from the Committee or the Board, to provide clinical quality improvement recommendations in furthering the monitoring functions of the Diversion Program. Final consideration would be made at the next meeting.

Dr. Gregg referred to the auditor's highlights and pointed out four things: case managers are contacting participants on a regular basis and ensuring that the participants appear to be attending group meetings and completing drug tests as required; the Diversion Program does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and worksite monitors; the

Diversion Program has reduced the amount of time it takes to bring new participants into the program and begin drug testing, but the timeliness of testing falls short of its goal; and the Diversion Program has not always required a physician to immediately stop practicing medicine after a positive test for alcohol or non-authorized prescribed or prohibited drugs. Although the Diversion Program has received credit for improvement, it still has criticisms that need to be addressed.

Mr. Valine suggested the DAC could assist the Diversion Program by expediting the requests that the Committee makes to the DAC regarding the Enforcement Monitor's recommendations. Dr. Gregg indicated that the DAC could help the Diversion Program and the Committee by assisting with the matrix developed from the audit.

Mr. Howard, Center for Public Interest Law, stated that the Diversion Program has major areas where improvement is needed. The fact that the Board has a zero tolerance policy is concerning to the organization, Senator Ridley Thomas, and the public. If the Diversion Program goes away, doctors who otherwise might self-refer and enjoy the benefits of such a program would not, would be less likely, or have no vehicle to self-refer and could create public risk. On the other hand, the program has been looked at since 1982 and every audit has found significant problems. Even in light of the sunset date and the enforcement monitor's report, the zero tolerance policy of the Board is not being implemented consistently. Successful completion of the program does not mean that the program was successful in preventing the physician from relapsing at a future time or prevent harm to a patient because it does not track what happens after physicians leave the program. Mr. Howard stated that the organization does not have a position right now that sunset should be permanent or if there should be a sunrise of it, but the DAC adhering to a clinical role and providing advice to the Committee is invaluable in promoting the program's success.

Dr. Snook stated that he is here voluntarily as a clinician. He strongly believed the protection of the public is the best served by diagnosis and treatment of the impairment, regardless of who is afflicted. Clinical input is in large part consensus derived and experiential based. After reading through the report, Dr. Snook is concerned about having too high of a standard.

Ms. Bressler indicated that having been involved with clinicians and talking about impairment issues with them, there are clinical issues. She added termination from the program is a decision that involves a clinical assessment of the individual. The same issue arises when a physician has a relapse. A relapse is technically non-compliance with the program, but one would not conclude, in every instance, that the physician should be terminated from the program.

Agenda Item 5 Guidelines for Determining when to Order a Clinical Competency Examination

Dr. Firestone stated that the Liaison Committee addressed the competency evaluation previously. The Liaison Committee came up with a draft that was submitted to the

Medical Board with guidelines to determine when to order a clinical competency examination. Depending on the physician's specialty, time out of practice would vary from six months to five years to adequately give each physician due process.

Mr. Heppler directed the members to the last section of Business and Professions Code 2350: "The Board shall develop regulations that provide guidelines for determining when this examination should be ordered." Dr. Pating suggested removing the need for a clinical evaluation being performed.

Ms. Bressler indicated that section (b) of the proposed language could be cause to remove a physician from practice. It describes circumstances where it might be clear when there is an immediate problem and the physician should not be working. This would eliminate the need for a competency exam before deciding if something needs to be done with the physician, and would improve the ability to monitor the individual.

After further discussion, Dr. Shaner suggested the process flow as follows: objective observations, reasonable cause, DEC/case consultant input, interview to rule out physician/psychologist cause, and order clinical competency exam.

It was unanimous opinion that if there are concerns about a physician's competence, he or she must cease practicing. It was expected that if a physician is ordered to stop working, the investigation that ensues be timely so the practitioner can demonstrate his or her competency, and return to work as soon as possible.

Dr. Shaner agreed with the process; however, stated that the consultation should be done as soon as possible with either the DEC or by the case consultant. It was suggested that when a concern is brought to Mr. Valine's attention, he interview the participant prior to removing the participant from work.

It was M/S/C (Shaner/Gregg) to approve guidelines as follows: Prior to recommending a clinical competency examination, the program manager may order any clinical competency examination or prior to recommending the program manager order a clinical competency examination, the DEC/consultant should rule out a physical or psychiatric cause for the physician's inability to practice medicine safely and may conduct a reevaluation interview of the physician. The program manager may order a physician to undergo a clinical competency examination if the physician has not practiced medicine for at least one year, and reasonable cause must be demonstrated by written or objective observations and may include the reported symptoms. And it was M/S/C to strike the clause "a clinical evaluation has been performed by an independent clinical source."

Agenda Item 6 Enforcement Monitor's Recommendations

Dr. Gregg gave an overview of the Enforcement Monitor's recommendations numbers 5 and 6. Dr. Gregg suggested forming a task force with two members to make recommendations to the Committee at the July board meeting. Dr. Pating and Dr.

Snook were appointed to this task force. The sub-committee will develop preliminary termination recommendations and schedule a teleconference with the DAC prior to the July board meeting.

Agenda Item 7 Schedule of Future Meetings

A telephone conference was scheduled for July 10, 2007, at 7:00 p.m.

The next Diversion Advisory Council meeting was scheduled for August 27, 2007, at 10:00 a.m. in Sacramento.

Agenda Item 8 Public Comment on Items not on the Agenda

There was no public comment.

Agenda Item 9 Adjournment

The meeting was adjourned at 12:15 p.m.

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Diversion Advisory Council

Medical Board of California
Greg Gorges Conference Room
1420 Howe Avenue
Sacramento, CA 95825

July 10, 2007

Minutes

Agenda Item 1 Call to Order

Mr. Valine called the meeting to order on July 10, 2007, at 7:00 p.m. A quorum was present and notice had been sent to all interested parties.

Members Present:

Shannon Chavez, M.D.
Marvin Firestone, M.D., J.D.
Laurie Gregg, M.D.
David Pating, M.D.
Stephanie Shaner, M.D.
Lee Snook, M.D.
Michael Parr, M.D., Alternate Member

Members Absent:

Bruce Kaldor, M.D.
Thomas Ciesla, M.D., Alternate Member
Barry Rosen, M.D., Alternate Member

Staff Present:

Frank Valine, Program Administrator, Diversion Program
Kim Kirchmeyer, Deputy Director
Linda Whitney, Chief of Legislation
Rhonda Baldo, Staff Services Analyst, Diversion Program
Kelly Nelson, Analyst, Legislative/Regulatory Unit
Scott Johnson, Business Services Assistant, Business Services Office
Anita Scuri, Supervising Senior Counsel, Department of Consumer Affairs
Kurt Heppler, Senior Counsel, Department of Consumer Affairs

Members of the Audience:

Sandra Bressler, California Medical Association
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Linda Starr
Tina Minasian

Agenda Item 2 **Review of Proposed Regulation Language for Guidelines for Determining when to Order a Clinical Competency Examination**

Dr. Pating reported that after reviewing the proposed language for ordering a competency examination, a few wording changes were requested by legal counsel. Dr. Firestone expressed opposition to (b)(1) on agenda item 2A. He stated the way the language is written it appears that a physician is incompetent because he or she has been out of work for one year. Mr. Heppler stated that if there is a request for a competency examination for somebody out of practice for one year, psychiatric cause would still have to be ruled out. Dr. Chavez objected to the fact a group facilitator can bring concerns to the attention of the program manager, because the group facilitator's training is not competent enough to make these statements or evaluations. Dr. Pating concurred. Dr. Gregg stated anyone could bring concerns forward, including a member of the public.

Ms. Scuri suggested that subsection (a)(2) should read, "reasonable cause should be demonstrated by one or more clinical evaluations or by written documentation that contains specific factual descriptions of objective observations" and leave out the list of people since it doesn't matter from whom the concern comes.

Dr. Gregg suggested removing the section after the word "documentation" to the word "incident". Ms. Fellmeth, CPIL, agreed with Dr. Gregg's suggestion; however, she stated that this regulation lacks clarity for the following reasons: it uses phrases and titles that do not appear anywhere else in any statute or regulation and the terms "case consultant, program case manager, group facilitator, worksite monitor and, hospital monitor" are not defined or mentioned in any statute or regulation. Ms. Fellmeth suggested removing the clause in subsection (b). It implies that the Diversion Evaluation Committee (DEC) or the physician's case consultant has the authority to order a clinical competency exam. It was agreed to change the wording to, "prior to the program manager ordering a clinical competency examination" in section (b).

It was M/S/C (Pating/Firestone) to adopt the written language to, "reasonable cause shall be demonstrated by one or more clinical evaluation or written documentation that contains specific factual descriptions of objective observations or repeated incidents that raise concerns about the physician's ability to practice medicine safely."

Dr. Firestone made a motion to strike section (a)(1) and change (a)(2) to (a)(1). There was no second, nor any further discussion on the motion. Further discussion ensued as to changes to the language in sections (a)(1) and (a)(2).

It was M/S/C to leave in line (a) stating the program manager may order a physician to undergo a clinical competency examination and leaving in (a)(1) and (a)(2) with previous amendments previously voted on, and, section (b) which states "prior to the program manager ordering a clinical competency exam."

Agenda Item 3 **Discussion of Whether to Modify the Criteria for Termination from the Diversion Program (Enforcement Monitor's Recommendation #5)**

Dr. Pating discussed the Enforcement Monitor's recommendation numbers 5 and 6 and the statute and regulations pertaining to these recommendations. The statute clearly indicates that the legislature wanted the Board to rehabilitate physicians with impairments so they can be treated and returned to practice in a manner which is safe and does not endanger the public. The Diversion Program is responsible for making sure there is emphasis on public safety by requiring the physician to enter treatment and to remove him/her from practice, if necessary, in lieu of discipline. The Enforcement Monitor's report shows emphasis on trying to clarify which situations are unsafe. Dr. Pating stated there are three criteria upon which to focus: the "red light" includes issues that "shall" definitely result in termination from the program because the situation is too unsafe for rehabilitation to continue; the "yellow light" indicates it is not quite clear if the participant is unsafe or not and has to be inherently part of the work of the DEC review and assessment; and the "green light" indicates that rehabilitation can continue because there is assurance that all criteria are being met.

Dr. Pating referred to the Diversion Program regulations draft dated July 10, 2007. As written, section 1357.5 which contains the causes for termination from the program, are the "red lights" and everything else constitutes a "yellow light" situation.

Dr. Pating discussed section 1357.4 of the regulations regarding the denial of an applicant to the program. Dr. Gregg and staff recommended that language be added to deny an application if the applicant has been disciplined in California, participated in the program as a condition of probation, and was terminated as unsuccessful.

Concern was brought forward on not allowing a participant who failed to finish the program as a condition of probation back into the program. Dr. Gregg pointed out the program is not a treatment program but a monitoring program. Ms. Scuri referred to those who have participated in the program pursuant to the Business and Professions Code section 2350(b), which permits an individual that has come to the attention of the Medical Board to be referred by enforcement to the Diversion Program in lieu of discipline. If the participant fails diversion, the original discipline will continue. Dr. Pating inquired as to what happens to the participants that unsuccessfully complete the program. Mr. Valine stated if the evidence of a problem is substantiated, discipline will be issued and the individual may be ordered back into the program as a condition of probation. A question arose as to whether there would be a length of time prior to consideration for re-admission. Ms. Kirchmeyer recommended at least three years.

When there is a "yellow light" condition that requires the judgment of the committee, it is recommended the following be considered: what is the participant's health status and program compliance; is there an issue of patient safety; and is the participant's license

valid? The DEC should look at the participant's compliance, monitoring requirements, and health status and provide the program manager a written decision as to whether the participant can continue in the program.

It was M/S/C (Pating/Firestone) to adopt changes to section 1357.5 as follows: the program manager shall terminate a physician's participation in the program for any of the following reasons: (a) refusal or failure to stop practice when directed to do so by the program, (b) failure or refusal to comply with an order for a clinical competency exam, and remove item (c).

It was M/S/C (Pating/Snook) to adopt section 1357.4 as follows: the program manager shall deny an applicant admission to the program if the applicant has been disciplined in California, participated in the program as a condition of probation, and was terminated as unsuccessful.

Dr. Pating will review the diversion manual when it is released and incorporate the discussed guidelines.

Agenda Item 4 Discussion of the Establishment of a Mechanism for Termination and Revocation of a License for Continuously Repeating Participants (Enforcement Monitor's Recommendation #6)

Discussion of the establishment of a mechanism for termination was discussed under agenda item 3. It is not within the scope of the DAC to determine the automatic revocation of a license. Dr. Pating suggested deferring this to either enforcement or the executive committee.

Agenda Item 5 Public Comment on Items not on the Agenda

Tina Minasian expressed concern about agenda item 4 not being properly addressed with respect to participants that repeatedly relapse. She believes the program is not adequately overseeing its participants.

Dr. Gregg reported at the last executive committee meeting immediate actions were being imposed as follows: pulling all positives from work; imposing strict vacation policies; ensuring work site monitors are compliant with their contracts; and immediate removal of participants from practice if they refuse to provide urine samples.

Agenda Item 6 Adjournment

The meeting was adjourned at 9:02 p.m.