THE MEDICAL BOARD OFCALIFORNIA

Department of Consumer Affairs

Diversion Program Summit Meeting
Summary of Public Comments

The Diversion Summit was held on January 24, 2008. Medical Board Members in attendance included: Dr. Richard Fantozzi, Dr. Janet Salomonson, Dr. Ron Wender, and Dr. Cesar Aristeiguieta. Kimberly Kirchmeyer represented the Medical Board staff. The Summit was professionally facilitated by Cheri Douglas, CPF, of Positive Impact Consulting.

By way of introduction, facilitator Cheri Douglas reminded attendees that the current Diversion Program will sunset on June 30, 2008 and the purpose of the Summit was not to reopen debate of that decision. She called attention to posted ground rules designed to assure equal access to each participant, including a limit of one presenter per program or proposal, focus on options for the future, and the five-minute time limit. Participants were also instructed that complaints or comments regarding a specific person would not be allowed and that such comments could compromise the outcomes of cases which might come before the Medical Board in the future.

In opening remarks, Dr. Fantozzi, Medical Board President, set the stage for the Summit:

> "Today is a great day for all of California, as well as our physician licensees. It marks the beginning of an endeavor by the Medical Board of California to improve its mission to protect the public, while also attempting to find common ground with others who are interested in a proactive approach to help physicians who need help in the arena of substance abuse.

"This past year, the medical board was faced with a disappointing audit, consistent with past audits that underscored the continued failure of our diversion program. Consumer groups and individuals also expressed their concern that the diversion program, not only did not protect the public, but it was a failed concept, despite 27 years of efforts to improve it.

"The auditors, but more importantly the consumers, spoke and the board listened. Diversion, I want to stress, is not treatment. It is the act of diverting substance-abusing physicians from administrative disciplinary action to a program designed to monitor the impaired physician. The program, based on information from evaluators and diversion evaluation committees, required biologic fluid testing, practice monitors, and group facilitator recommendations, based on individuals' needs. The evaluators, though required to be licensed in a field of expertise, had no consistent standard by which to base their evaluations.

"Although the intent was to provide a comprehensive plan for recovery, the flaws have been in the human element and the clinical disease being treated. It can be said addiction is a complex disease. Audit after audit showed the plan did not work for some participants. Abuse of the privilege of the program by some participants repeatedly put consumers at risk. Repeat offenders were pointed out in several audits as well the ability for the participants to game the system."

Dr. Fantozzi explained that after the end of the Diversion Program with discipline as the only option, the board would still recommend that individuals seek treatment but that participation would not be kept confidential from the public. He said that the diversion program has been confidential to encourage more voluntary participation. But, while experts estimate 10,000 – 15,000 California physicians suffer from some degree of substance abuse, the average number of physicians in the diversion program was only 250. There had been very little voluntary participation, despite confidentiality.

Dr. Fantozzi called for new ideas to come from Summit participants to reach out to the thousands of physicians suffering from substance abuse who had been ignored by the diversion program and he affirmed that the Medical Board's mission of public protection would be its first priority.

The following is a series of selected quotes from participant comments organized by major themes. The purpose of this section is to focus on specific ideas and recommended policies for a new program. This section ***excludes*** generalities that all or most participants shared, including:

- Patient protection is the highest priority;
- Addiction is a disease that can afflict anyone, from any socio-economic background;
- The Medical Board has a duty to protect the public;
- Several audits of the expiring Diversion Program have exposed serious concerns and deficiencies, and a range of weaknesses and inconsistencies in dealing with physician participants;
- The existing program has failed to protect some patients.

The comment themes are sorted into five issue-categories addressed by the participants:

1. Early detection and intervention;
2. Comments in favor of a confidential program that permits physician participants to continue to practice medicine;
3. Comments in favor of a non-confidential program that prevents or limits continued medical practice by physician participants;
4. Recommendations for the organizational structure and funding of a new program;
5. Presentations of treatment programs by the owners of those programs.

1. Early Detection & Intervention

Jeffrey Uppington California Society of Anesthesiologists	"If managed correctly, an effective diversion program identifies doctors with potential problems early, ensuring they are monitored and get the treatment they need before a problem can endanger patients." "Shame and fear motivate these physicians to hide their problems and to engage in inappropriate acts. The inability of local peers to recognize or assist them may further endanger the public"
James Hay, M.D. California Medical Association	"Patients will be better protected with a program that focuses on early intervention and assessment and monitoring."
Jack Shale, M.D. California Psychiatric Association	"Now, the important thing is to intervene early before there is harm. If you wait until someone gets a DUI or someone gets sued or someone has done harm, and it turns out after the fact that it was a result of addiction to alcohol or drugs, then you are too late. You have to intervene early."
Sharon Levine, M.D. Permanente Medical Group, Northern California	"...our approach at Kaiser Permanente… is the prevention identification and early intervention in a physician who is ill, depressed, who has a predilection for substance abuse, but who has not yet been impaired. I think there is no way we can underemphasize the importance of prevention and early identification and detection." "We spend a lot of time every year marketing and doing outreach from our well being and our wellness committee, so that every physician in our organization can recognize the signs of trouble in a physician. Everything from changes in attendance, tardiness, changes in demeanor, signals that can signal that a physician whose practice is not yet affected could, down the road, have a problem that is developing. We have 16 professional staff well being committees, with 175 active members of our medical staffs who sit on these committees."

2. In Favor of a Confidential Program that Permits Physician Participants to Continue to Practice Medicine

James Hay, M.D. California Medical Association	"It must be open to voluntary, as well as board referred participants and be confidential for compliant participants, because if it isn't, you won't identify the physicians that have the problems early, you won't have them in the plan, and you will see only a tip of the iceberg as has been discussed." "The bottom line is that strong monitoring, together with confidential treatment affords the most protection for the patients of California."
Shannon Chavez, M.D. UC San Diego	"We share the same message from all UC campuses that the state of California join the Federation of Physician Health Programs to safely monitor physicians confidentially that suffer from the disease of addiction."
Georgiann Walker Former patient of a physician in the diversion program	"[My doctor] did beautiful work on me. I am more than happy. I would go back to the man in a heartbeat. I feel as though your diversion program not only hurt the doctor by releasing the confidentiality, you really did hurt the patients." "I deserve to have that confidentiality and not be bothered, not be encouraged by someone who has a vendetta against a doctor to try and encourage me and coerce me into saying things about him…" "We have to let our doctors know that they are safe in a [confidential] program that they are going to be involved in, so that they will come forward."
Rory Jaffe University of California	"…placing physicians on probation when they enter a diversion program creates a significant disincentive for them to self-report and seek treatment, which in turn increases risk for their patients. For physicians who self report without the protection of confidentiality, the likely outcome is that these physicians would be placed on probation, which could adversely impact their future employability and insurability even after successful treatment."

Luis Sanchez, M.D. Federation of State Physician Health Programs	"All our programs are confidential. We promote early referrals. We want physicians to identify their issues way before they become impaired." "…a successful state physician health program should be able to … issues in a confidential manner, allowing physicians, early on, to pick up the phone and seek help."
Jack Shale, M.D. California Psychiatric Association	"But, the law is that it takes a high standard of proof to take away somebody's license. Consequently, most of the people I saw in diversion were people who were volunteers in the sense that somebody said they smelled alcohol on his breath. And, the well being committee at the hospital had a talk with him. They didn't have enough evidence to take away his privileges. Intervening early is important. The other side of that is you can't throw away confidentiality entirely."
Joseph Dunn, California Medical Association	"With respect to the program in question today, the single greatest risk to patient safety is doctors who keep their dependency problems secret. As it was over 25 years ago when the [diversion] program was created as it is today…Without [the diversion] program, no one – not patients, not healthcare professionals, not you the medical board, not we at CMA – are going to know of physicians with dependency programs until it is too late. That is exactly what this program was designed to avoid.

3. In Favor of a Non-confidential Program that Prohibits or Limits Continued Practice of Medicine by Physician Participants

Michel Sucher, M.D. Arizona Medical Board's Physician Health Program	"Our current client list in Arizona - we operate the Arizona Medical Board's Physician Health Program, the Arizona State Board of Dental Examiner's program, by the way, which is completely non-confidential and our last review - 92% five year success rate – comparable to any other program. So, not being confidential, while it has its down sides, is not a barrier to successful recovery."
Tina Minasian Former patient of a participant in the diversion program	"…it was my understanding that you had been told repeatedly throughout the years, no patient has ever been injured by a participant in a diversion program. That statement was absolutely false. I was injured by a participant in the program while he was in the program, and I am just Exhibit A." "I know dozens and dozens of other patients who have been victims of the same physician while he was a participant in the diversion program. In fact, some have died and others are dying." "The doctor that operated on me was a participant in the diversion program. This information was precluded from me because diversion is a secret program. Furthermore, at the same time this doctor treated me, he directed his office manager, who also happened to be his worksite monitor for the diversion program, to lie for him repeatedly." "When a pilot, school bus driver, police officer, or athlete is caught under the influence of drugs or alcohol, they are suspended from their profession. Some of these professions have automatic termination of employment. Why are these doctors' lives and livelihood more important than the lives of patients?" "Doctors should not have the privilege of working while they are in rehab. Doctors who abuse drugs or alcohol should have their licenses suspended or revoked, just like any other profession in America, until they can prove that they can practice medicine safely…Do not let them run a secret diversion program again. You abolished it because it was a failure and public safety was compromised."

Ken Mikulesky Patient Advocate	"Tina Minasian said most of what I had to say. I believe that most of you people are upright and righteous, and you want to do the right thing. But 27 years of failure, and I've seen a lot of human destruction up close and personal. "… you don't tell a doctor you are going to test him at 9:45 and be there to test him and let his nurse take the sample. You must practice what you preach. There are a lot of people getting hurt out there. As I speak right now, there is probably a doctor with an addiction problem that is carving some poor person up. It makes me sick to my stomach. It breaks my heart. You have got to stop this. You got to. That's all I have to say."
Judy McDonald Patient Advocate	"In 1999, I had breast cancer. It was stage 0, but it was the third time that I had had it. I was told that I needed a mastectomy… surgery was my only choice. I was referred to a doctor to remove my breast who, in turn, referred me to a plastic surgeon, telling me that he was one of the best." "And how could I ever know the problem this man was battling with alcohol when he had been recommended to me as one of the best? I went to this doctor with full faith that he would do a fine job on me…However, I ended up with massive, massive infections that took months to heal." "I have personally met and seen the bodies of other patients who were operated on by this doctor and were all scarred for life. Why? Because we were treated by a doctor who had secret alcohol problems and was in a secret diversion program." "The expressed purpose of the medical board and diversion program is to protect us, the public. I was not protected. Has the purpose been changed to protect the doctors?" "Doctors who have drug or alcohol problems should not be allowed to take our bodies and lives into their hands. They should have their license revoked until they can prove that they can safely treat you and I – the patient."

Senator Mark Ridley-Thomas, Chairman of the Committee on Business and Professions	"I felt that the question had to be posed - why some [physicians] could continue to treat patients after having learned some of the things we did about their performance and their state of preparedness as it relates to surgery and other issues that we take seriously." "I don't believe patients ought to be in a mode of being unsuspecting about their physicians, feeling in any way that they are at risk or being harmed by them, as a result of those physicians being impaired."
Linda Starr Patient Advocate	"I have no sympathy for the doctors who supported and continued to support the secrecy. They know the harm, devastation, and death. They know about past and potential harm. They hide information and evidence and send doctors into surgery with loaded guns. These doctors should be held responsible for the negligence and damages caused. But no - secrecy and protection is business as usual." "If this program is continued with the current secrecy controls, you open it up to criticism. What if teacher groups protected their teachers in this way and allowed pedophiles to go into rehab while teaching our children and we kept it secret? It's a joke. It's terrible." "We need whistleblowers. We need notices posted in the doctor's office that tells what the board has information about."
Julie D'Angelo Fellmeth USD, School of Law, Center for Public Interest Law	"Today you have been presented with a number of options as to how you should approach the issue of the impaired physician. Obviously, you have been asked by physician organizations to let them design and run a new program for you, and their proposal contains all of the hallmarks of the failed program, including confidentiality. " "The medical board should not conceal the identities of physicians who are in treatment or recovery and who come to the attention of the board's enforcement program. None of this is your job." "You are a government agency. Your job is public protection. You are a regulatory board that patients must be able to trust. Your core functions are licensing and discipline."

Janet Mitchell Patient Advocate	"In my eyes, your diversion program is a form of concealment. It is created to hide a doctor's problems with drugs and alcohol from a patient. I have yet to meet a patient who would knowingly choose a doctor in a drug or alcohol program." "Secrets, such as your diversion program, easily become lies. When a patient looks at your Web site and they seek information on a doctor and they see that he is in good standing with you, when in truth he could be in diversion and to me that is every color of deception. By allowing the known fact to be a secret, you have withheld and concealed the truth." "Citizens in other professions, they are not allowed to have a diversion program. I've called. A nurse is suspended right away until she gets into rehab. I called a representative from Disneyland to ask if you could operate the Dumbo ride if you were having trouble with alcohol and drugs. I got a call back. And they said, 'You're kidding.' 'You're asking what?' And, they said 'Heavens, no. We wouldn't want the liability. We wouldn't want to put our visitors at risk.'"
Ed Howard Center for Public Interest Law	"You have heard a lot of testimony today, both explicit and alluded to, that the end of the board's program, which would divert drug and alcohol addicted doctors away from a disciplinary path and into a monitoring path will somehow endanger patients, because it will imperil the motivation of physicians who may have drug or alcohol addiction from coming forward into the program. While the logic of that cannot really be tested in and of itself, we have experience that indicates that that fear simply isn't warranted." "Dr. Fantozzi mentioned those data at the outset of the summit. There are in all, according to the board's own data, about 200 people in the diversion program at any given time. 75 of those – a minority – are classified as self referrals and if I've heard Dr. Fantozzi correctly, there is a question, at the very least, as to how and whether those 75 are, in fact, true self referrals." "People who have had an epiphany about their disease and affliction have voluntarily come forward, rather than coming forward one step ahead of a notification of a plea of DUI from a court or because they have been cautioned by their hospital that they had better get help. Likewise, Dr. Fantozzi quoted data at the very beginning that indicated

Ed Howard (continued)	that the secrecy that surrounded the former program was utterly unsuccessful at enticing anywhere close to the number of drug and alcohol addicted doctors that data projects are actually out there." "So, when you hear those prior folk testify about the importance of secrecy, I caution they did not address those data. " 'Any future program that is secret and secretly allows physicians to continue to practice while in it, means simply this, you are going to be forcing California patients to be unwitting guinea pigs for a proposal that you know has failed, and we would simply submit that that's inconsistent with the enforcement and licensure role of the Medical Board of California."

4. Recommendations for the Organizational Structure and Funding of a New Program

Howard Kornfeld, M.D. Physician in private practice	"The matter of chronic pain management among physicians entering and graduating from a new diversion program must be considered…Some of the physicians in diversion may have developed a problem with opiate pain medicines due to legitimate pain and/or addiction issues." "I want to suggest that medically related decisions regarding pain and addiction treatment for physicians participating in diversion be made with full participation of physicians experienced in and preferably certified in both pain and addiction medicine."
James Hay, M.D. California Medical Association	"Our operational recommendations…include that it must be established, as a formal, legislatively sanctioned, not for profit, independent, but publicly accountable entity. It must be regularly audited for clinical quality and fiscal integrity. That is, have better accountability. It must be supported by a stable and continuing source of funds that must come, or should primarily come, from professional licensing fees. And the funding must be adequate to do the job, which it was not in the past. This means doctors are saying we are willing to pay for the program we think needs to be." "Finally, this program must be governed by a board that is composed of both

James Hay, M.D. (continued)	physicians and non-physicians, but all of whom must have expertise in physician health and impairment, must be managed by a medical director who is knowledgeable and responsive to the board, and must be staffed by individuals with strong clinical training where participant contact is required."
Shannon Chavez, M.D. UC, San Diego	"On behalf of the UCSD Physician Well Being Committee, as well as the UCSD PACE program, I respectfully urge the Medical Board of California to join all other states to consider a new, improved, non-profit, confidential, physician health program separate from, but reporting to, the Medical Board of California."
Rory Jaffe University of California	"We strongly agree with the joint CMA, California Psychiatric Association, and Society of Addiction Medicine statement that this program should be structured to provide a continuum of medically based services including comprehensive assessment, triage, and monitoring services for behavioral disorders, as well as support for substance abuse and possibly other medical conditions. We also agree that such a program should be operated by an independent non-profit entity and should be audited regularly for clinical quality and fiscal integrity."
Elinore McCance-Katz, M.D. American Academy of Addiction Psychiatry	"Monitoring programs are essential to patient safety by providing a mechanism for requiring treatment for those with impairing illness, a mechanism of ongoing review and assessment of participants, and the ability to remove physicians from practice if deemed unsafe or if they violate their monitoring contracts." "The [Virginia program] enabling legislation…provided immunity from civil liability for those reporting and acting on reports of impairment. The law, in my opinion, should go further and require reimbursement of legal fees should a monitor or reporting individual who made a report in good faith be sued." "The [Virginia] program was independent of the medical board, but contracted by them. We worked collaboratively with the board, always being careful to give an accurate and straightforward accounting of the monitoring progress of any participant." "The program had a full time medical director with board certification in addiction psychiatry and training in addiction medicine. This is extremely important to the assessment of substance use disorders and mental disorders and preparation of appropriate recovery monitoring contracts."

Elinore McCance-Katz, M.D. (continued)	"The program costs were paid from licensing fees, so we were not compelled to negotiate with clients about anything to help ensure adequate program funding." "…in Virginia…no practitioner with chemical dependence could work while taking mood altering substances."
Luis Sanchez, M.D., Federation of State Physician Health Programs	"Many of the state programs are non-profit – 501C3's – where we have a board of directors that provide oversight. Funding is an issue for many of these programs. There are a variety of ways that the programs are funded, through licensing fees, as mentioned, through malpractice carriers. In my state, all the malpractice companies contribute to our organization, feeling that it is a risk management venture, that by being involved with us we are reducing the chances of patient harm that could happen with a physician who is impaired." "We are also broad in our approach – we are not only focusing on substance use disorders. In Massachusetts, half the physicians that we deal with have substance abuse problems. The other half have a variety of issues – mental health issues, depression, bi-polar illness, fears of malpractice suits, stress, these are all the issues that are impacting on doctors today, and a successful state physician health program should be able to address all these issues in a confidential manner, allowing physicians, early on, to pick up the phone and seek help."
James Conway, Pacific Assistance Group	"…any future program will need access to the board's information base on consumer complaints."
Senator Mark Ridley-Thomas Chairman of the Committee on Business and Professions:	"I believe this summit is a first step towards dealing with healthcare practitioners who have substance abuse issues or have mental health problems that affect their ability to practice medicine safely. We need to look at other alternatives and programs that have successes in dealing with impaired healthcare professionals." "At the same time, there has to be consistency in the way in which all health related boards deal with their licensees that have substance abuse problems and/or challenges. So, therefore, it is my goal to work with all of the boards to develop more uniform standards of enforcement and oversight of medical professionals who may

Senator Mark Ridley-Thomas (continued)	become involved with substance abuse and assure that there will always be appropriate monitoring and restrictions placed on the practice of healthcare under such conditions so that we have the highest level of confidence that we are providing the care that patients have come to expect." "It is my intent that the legislation that we will introduce will make these important changes and continue seeking input from health boards, the medical profession itself, and experts from successful substance abuse programs to identify other changes, which are necessary. There is a lot of work to be done. I believe in a collaborative approach in doing it. I want to join forces with the medical board with the range of boards that have concerns with the profession itself, those who have been in a diversion program who have success stories to report with the CMA, and the whole range of entities who want to make sure that we come out of this with our heads high, with a full sense of purpose and direction as it relates to providing the kind of leadership and care for both the patients themselves and those who are sworn to an oath to protect those patients and the degree of high quality healthcare services."
Linda Starr Patient advocate	"I want to say doctors do need help, but again I stress, it needs to be separate and apart [from the Medical Board.] The board needs to refocus and re-identify its role for the protection of the citizens of California."
Julie D'Angelo Fellmeth USD, School of Law	"Based on the information contained in this and prior reports on the diversion program, the medical board must reevaluate whether the diversion concept is feasible, possible, and protective of the public interest. I suggest to you that the diversion concept is none of those things, and it should never again be on your table." "…what should you do as the medical board? Having thought about this for 15 years, and having had the unique opportunity to audit the diversion program for a two-year period, I would offer you the following advice. The medical board should not run any kind of monitoring program for substance abusing physicians. That is not your job, nor should you oversee such a program, nor should you pay for such a program." "The medical board should never again consider diverting substance abusing physicians from discipline. The medical board should not conceal the identities of physicians who are in treatment or recovery and who come to the attention of the

Julie D'Angelo Fellmeth (continued)	board's enforcement program. None of this is your job. You are a government agency. Your job is public protection. You are a regulatory board that patients must be able to trust. Your core functions are licensing and discipline." "Should other people run programs that offer drug treatment monitoring and testing? Absolutely. Others already do. And now that you are out of the picture, I expect new programs to pop up. In fact, they are here today. You have heard from them. Should you anoint one to the exclusion of all others? No, I don't think so. We need a lot of them. Let the private sector handle this. Rather than competing with the private sector, you should focus on researching state of the art standards and requirements for the mechanisms that will replace the diversion program." "What is it that you want your staff to do when a person who has been ordered to undergo drug testing, tests positive? What do you want the attorney general's office to do? You need to answer that question." "The bottom line is that your job as the medical board is to detect an impaired physician and remove or restrict that doctor's medical practice in a way that is transparent to his patients. What happens after that is up to that doctor? That is his business, not yours."
Jack Shale, M.D. California Psychiatric Association	"I also heard from Dr. Hay who made several important comments in my opinion that what replaces [the diversion program] must be independent. It must be non-profit so there is no conflict of interest. It must have adequate resources and authority, and it must monitor effectively." "I actually agree with Mrs. Fellmeth that the board should not run diversion. You should set standards, and the standards must be observed, and you need consequences; you need a hammer." "In law school, one of the first lessons I learned is every story has at least two sides. In medical school, I learned that anecdotes is not evidence….You have a 27-year database. Look at it. You know the rates of complaints and malpractice lawsuits and settlements against doctors in general, by specialty, per capita, and you also know what the rates are against people who successfully completed diversion. Before you move forward, look at that database."

David Pating, M.D. Addiction Psychiatrist	"…my organization, CSAM, wants to look forward of the next solution…we support the creation of a new physician health program, and its essential program elements as described by Dr. Hay. We believe that there should be early intervention, referral, and then monitoring as necessary. If the medical board is really committed to this concept of wellness, you have to realize that for every well physician, somewhere out there is a physician that might be not well. There is a spectrum of services that we need to address. We support the evidence-based practice of the spectrum of care for physicians, as they go from being well to being stressed to perhaps having personal difficulties. And at the moment that they become unsafe, we do recommend that there be issues to make the public safe."
Ed Howard Center for Public Interest Law	"…some of the proposals that we have heard revived today have the hallmarks of the prior failed program. Let me just sketch out what the hallmarks of the prior failed program are: secrecy from patients; diversion away from a disciplinary track; allowing doctors to continue to practice while diverted, where the whole program is run by physicians whose day in and day out practice is caring for alcohol and drug addicted doctors. Such, that the policies that they might impose with their hat on as working with diversion, might actually have an impact on the patients they are seeing at that time."
Joseph Dunn, California Medical Association	"Numerous independent audits and reports have identified, correctly, I believe, some serious deficiencies with the program that may indeed raise the risk to the patients…our sole priority – their safety. We all agree those deficiencies are unacceptable. The question then is how do we deal with this challenge? Do we correct the deficiencies, or do we end the program? The latter magnifies the risk to patient safety. The former minimizes those risks. Our choice is clear in my humble view. Let us minimize those risks and, together, correct the deficiencies." "And I am here to pledge today that we the physicians of California will want and are willing and ready to work with the medical board toward solving those deficiencies and maintaining this program, which is all about patient safety – it remains our one and only true priority." "…walking away is not the answer. Correcting the problem is. Sadly, we all know we are going to continue to see dependency problems in all walks of life. Ending this program on June 1 leads to one inescapable conclusion. We raise the risk to patient safety, which is our only priority. Let us work together, solve the deficiencies, and maintain this patient protection program."

Randal Hagar California Psychiatric Association	"…one of the things I do want to inject into the conversation is, to the extent the program has dealt with physicians who have addictions, it has also not dealt with physicians successfully who have mental illness. This is what the issue that my members have asked me to bring to this forum and raise, and it is just as impairing to have depression, as it is to be a drunk, or to be someone who is abusing substances." "So, it is very, very important that we do address physicians who are suffering from the mental disorders."

5. Presentations of Treatment Programs by the Owners of Those Programs

Michel Sucher, M.D. Arizona Medical Board's Physician Health Program	"We run monitored aftercare programs, we do assessments, we do consulting to hospitals with healthcare systems. We provide MRO services. We do a considerable amount of education and training, and we understand the full range and deal with the full range, including mental health, boundary disorders, disruptive behavior." "We run the full range of monitoring programs and very much as comprehensive as diversion has been, except we hold people accountable, we do compliance measuring, there are consequences, we have no issue taking unsafe doctors out of practice. We work in collaboration with the medical board very closely to do this. We participate in investigations and in summary suspensions and other appropriate actions. We are fully prepared to help do that in California."
James Conway Pacific Assistance Group	"Our strengths include unparalleled expertise in the state of California. We are in all the major metropolitan areas of Los Angeles, which gives us a decided strength, in that we are on the ground, we know the resources."

Background and Credentials of Speakers as Reported at Summit

Shannon Chavez, M.D.	Associate Professor of Psychiatry at UC San Diego, Medical Director of UC San Diego Outpatient Psychiatric Services, Chair of the UCSD Physician Well-Being Committee, and I also hold Diversion Committee membership for the BRN and the State BAR; proud graduate of the California Medical Board Diversion Program
James Conway	Group facilitator with the existing diversion program in the Los Angeles area
Joseph Dunn	Former State Senator and CEO of the California Medical Association
Julie D'Angelo Fellmeth	Center for Public Interest Law, USD School of Law, and former Medical Board Enforcement Officer
Randall Hager	Government Affairs Director, California Psychiatric Association
James Hay, M.D.	Family physician from San Diego and one of the officers of the California Medical Association
Ed Howard	Senior counsel for the Center for Public Interest Law
Rory Jaffe	Executive Director of Medical Services for the University of California, Senior Physician for the UC Health Systems, responsible for licensure and accreditation, quality of care, medical staff governance, risk management, and the provision of clinical services
Dr. Howard Kornfeld	Physician in private practice in Mill Valley; certified and a Fellow of the American Society of Addiction Medicine: Board Certified in pain medicine by the American Board of Emergency Medicine; Faculty, Department of Medicine, University of California, San Francisco; teaches seminars on addiction aspects of pain medicine, UCSF Mt. Zion Pain Management Center; Expert Medical Reviewer, California Medical Board
Sharon Levine, M.D.	Responsible for Physician and Professional Support Services, Permanente Medical Group, Northern California

Background and Credentials of Speakers (Continued)

Elinore McCance-Katz, M.D.	Physician at San Francisco General Hospital Medical Center; Board Certified Addiction Psychiatrist; President of the American Academy of Addiction Psychiatry; Former Medical Director of the Virginia Health Practitioner's Intervention Program
Judy McDonald	Patient Advocate
Ken Mikulesky	Patient Advocate
Tina Minasian	Former patient of a physician who was a participant in the Diversion Program
Janet Mitchell	Patient Advocate; Author of "Taking a Stand"
David Pating, M.D.	Addiction Psychiatrist; Chair of the Diversion Advisory Committee; President of the California Society of Addiction Medicine
Mark Ridley-Thomas	California State Senator; Chairman of the Senate Committee on Business and Professions
Luis Sanchez, M.D.	Board Certified Psychiatrist; President of the Federation of State Physician Health Programs; Director of the Massachusetts Health Program
Jack Shale, M.D.	California Psychiatric Association; Physician and Attorney; former member and Chair of the Diversion Evaluation Committee; Former member of the Lawyer Assistance Program; "19 years, eight months, and a few days of sobriety."
Linda Starr	Cancer Advocate
Michel Sucher, M.D.	Physician; ASAM member; CSAM member; operator of monitored aftercare programs
Jeffrey Uppington	California Society of Anesthesiologists
Georgiann Walker	Former patient of a doctor who was in the diversion program