

Action Report

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Treatment
Options" is now
available.

Medical Board of California Meeting Dates/Locations

1995
February 3-4 San Francisco
May 11-12 Sacramento
July 28-29 Los Angeles
November 2-3 San Diego

Accurate And Complete 805 Reporting: Cooperation Between Hospitals And MBC A Near Crisis

by

Karen McElliott, President, Division of Medical Quality, Medical Board of California
John C. Lancara, Chief of Enforcement, Medical Board of California

The issue of 805 (peer review) reporting is one of the most important and most misunderstood Medical Practice Act requirements. Over the past year we have noted a deterioration in the cooperation required between hospitals and the Board in protecting consumer/patient safety. We have experienced incomplete reports, lack of access to records and, on some occasions, excuses for not reporting at all. Why is it important to notify the Medical Board that a staff physician has sexually abused a patient or practiced medicine negligently and jeopardized patient safety?

Failure to report properly, whether the failure is intentional or not, is punishable by civil penalty of \$5,000 per violation.



Karen McElliott

Section 805 reporting is an issue of increasing importance to the Medical Board because there is a direct relationship between timely/accurate reporting and public safety. Although the Board regularly receives 805 reports, they are often filed untimely, incompletely or inaccurately. When this happens, the Medical Board is unable to provide public protection.

The following are typical examples

of 805 reporting problems:

- Hospital reports its disciplinary committee took action against physician due to sexual harassment of female staff members. Subsequent Board investigation discloses that alleged violations included sexual misconduct (rape, sexual battery/abuse) against patients, not just hospital staff. Subsequent Board investigation also discloses physician has been practicing under severe hospital restrictions for a year before the hospital submitted the 805 report to Board disclosing the imposed restrictions.
- Hospital reports its disciplinary committee restricted physician staff privileges. Subsequent Board investigation discloses the hospital actually terminated the physician's staff privileges and/or employment.

Business and Professions Code section 805 requires certain medical administrators, executives and directors, as defined in section 805(b), to report to the Medical Board all peer review body actions taken due to a licensee's incompetence or professional misconduct which is "reasonably likely to be detrimental to patient safety or to the delivery of patient care." In essence, such actions include denial, rejection, termination, restriction or resignation of staff privileges or employment for a medical disciplinary cause or reason. The 805 reports are to be filed with the Board within 15 days after the effective date and must include "...a description of the facts and circumstances of the medical disciplinary cause or reason...."

The intentional failure to file an 805 report is a public offense and punishable by a fine up to \$10,000.

(Cont. on p. 6)

THE MISSION OF THE MEDICAL BOARD OF CALIFORNIA

The mission of the Medical Board of California is to protect consumers through proper licensing of physicians and surgeons and certain allied health professions and through the vigorous, objective enforcement of the Medical Practice Act.

Newspapers Win Suit for Records; 1995 Plans May Mean Less Tension

by

Bruce H. Hasenkamp, J.D., 1994 President of the Board

In previous columns I reported with pride the Board's strides toward reform—reform that better fulfills our consumer protection responsibilities and reform that better protects the legitimate rights of physicians. I also reported a plethora of lawsuits in reaction to reform.

One such suit, contested by the Board, was brought by three of the state's major news organizations—the *Los Angeles Times*, the *San Jose Mercury News* and *The Sacramento Bee*. The suit demanded that the Board provide all its public records on physicians to the newspapers in computer disc format.

The Board, as most know, routinely provides up to three physician public records to citizens who call or write requesting them. In September a Sacramento Superior Court judge said that wasn't enough. He ruled in favor of the plaintiffs, and in December the discs were delivered in accord with the court order. We, of course, have no control over how the newspapers use the data they obtained. We hope it will be responsibly.

When the plaintiffs asked for the discs, however, they only requested information as of December 6. Actions taken by the Board after that date, such as the completion of a probation or the imposition of a new interim suspension order, were not included.

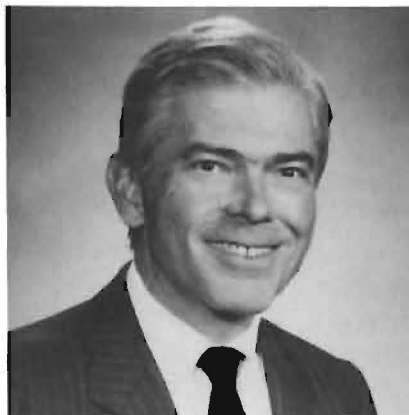
Since we must hereafter fill requests for all or large portions of our public records, the Board wants the data to be accurate and up-to-date. The Board, therefore, ordered the staff to present options for keeping public record data available on a current basis instead of the December 6 "snapshot" called for by plaintiffs in this case. The Board will act on the staff report at its February meeting.

CMA vs. Medical Board

The California Medical Association (CMA) persists in its suit to enjoin the Board's entire information disclosure policy, particularly the part that discloses a case that has been referred to the Attorney General before a formal accusation is filed. CMA won a preliminary halt to disclosure of a referral, but lost its attempt to block the whole policy.

While arguments and further motions have been prepared by both sides, discussions toward a settlement are in progress.

The participants hope for an agreement that is fair to both consumers and physicians. Unless there is to be a settlement in this case, in time to be presented at the Board's February meeting, time will run out.



Bruce H. Hasenkamp, J.D.

As I come to the end of my one-year term as Board President, however, I am pleased to report that relative calm is replacing the storm-tossed atmosphere of the last two years.

Fewer civil lawsuits are being filed. One big one has been resolved, and another may be settled. Another suit has been dismissed; and one more is likely to be. This will leave us with the

DalCielo case on peer review reporting (see article starting on page 1).

"Unholy Alliance" Abandoned

It also now appears that what I have combatively referred to as "the Unholy Alliance"—a plan to sponsor legislation to eliminate the judicial functions of the Board's Division of Medical Quality—has gone away, at least as it was to have been jointly sponsored. The scheme, against which I and most members of the Board drew a line in the sand, would most likely be vetoed by our just re-elected Governor. Our critics on this issue did, however, offer some constructive suggestions, and we will welcome a review of the DMQ's functions and operations.

1995 Legislative Program

The Board's adopted legislative program for 1995 continues our effort at reform. As in 1994 our program is modest but important to our operations. Our licensing division has adopted a small fee increase for oral exams and is asking the Legislature to approve two years' postgraduate residency instead of one. At the same time the division wants to tighten the special provisions in current law (B&P Code sections 2111 and 2113) for physicians from other nations who serve temporarily in our teaching institutions.

Board-sponsored enforcement legislation deals primarily with provisions requiring reporting of violations to the Board and obtaining of records to correspond to the reporting. As the article starting on page 1 of this Report attests, getting compliance on reporting and records is a fundamental issue for us as a regulatory agency. Without compliance it is harder for us to act on behalf of consumer protection.

The Push for National Licensure: Can High Standards be Maintained?

by

Terri Ciau, Manager, Licensing Program

Ideas about one-stop shopping for a single physician's license in the United States have been discussed since the dawning of computers. But never has the political pressure for national licensure been so great.

The objective for this design is user-friendly convenience for the applicant physician in a modern world where licensees function in an atmosphere of telemedicine and advanced science techniques.

The trends behind the pressure are:

- The advent of the information highway,
- A growing number of international medical graduates practicing in the United States,
- Increasing numbers of domestic graduates whose mobility is greater than a generation ago, and
- Ease of travel allowing practices in more than one state.

Hidden in the various versions of health reform bills in the last two years were provisions to develop a national license. The original submission to Congress by the Clinton Administration contained national licensure and the ill-fated Mitchell bill included Section 1161 which imposed a national system. But the demise of the health care reform bills does not mean that national licensure legislation might not be included as an amendment elsewhere.

So the Federation of State Medical Boards (FSMB), composed of member boards of the states, maintains a constant vigil against the idea of national licensure cropping up in any congressional vineyard. FSMB leaders do not necessarily object to a national system. In fact, some think a national system is inevitable. But they **do** object to a **federal** system. The theory is that "...he who brings you the post office and the pentagon is not the one to operate a one-stop system for physicians' licenses..."

Besides, the states argue, the need to set standards for licensure is nearly as old as the nation itself and is justified by demand for high quality measured against demand for quantity. For example, if California is oversupplied with physicians, standards for licensure can be tough not only to decrease the surplus but also to enhance consumer/patient protection. Conversely, a small rural state may have a hard time recruiting physicians so it can't afford to require standards as demanding.

FSMB is considering developing its own national system allowing flexible state standards and recruitment by ensuring a common denominator (**not** the least common), providing verification services to the state boards, as requested, but adding forms and instructions to accommodate any bonus requirements required by individual states.

***"...never has the
political pressure
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Through the American Medical Association, specialty societies and international graduate medical associations, ever greater numbers of physicians have "lobbied" for one-stop shopping—and the chorus is reaching a crescendo. The AMA, which tried to develop its own license verification system, recently pulled out because its system was not cost-beneficial. Also, in the long run it seemed obvious that

public policy-makers would regard an AMA system as a conflict.

FSMB, therefore, is the most logical candidate to provide national services, perhaps starting with simple document verification for its member state boards. While start-up costs would be substantial, the cost of providing at least one-stop document warehousing and verification (if not licensure) would be borne by the applicant so that, over time, the system would be self-supporting. This system should be attractive to physician applicants, as it would save substantial time and effort, and would greatly reduce the red tape in applying for multiple licenses. No longer would she or he have to jump through the same hoops over and over again when applying for licensure in multiple states.

Clearly, however, if FSMB can do verification, it may only be a short step away from a national license, and those who fear that the trade-off would be a lowering of state standards will object. For its part, FSMB is methodical and careful. It has no interest in any scheme that would lower standards, yet there is a strong sense at FSMB, reported by Executive Vice President Dr. Jim Winn, that a threat of **federal** licensure hangs over our heads like the Sword of Damocles. And, it is assumed, a federal bureaucracy will preempt the states, opting for the **least** common denominator and allowing for no local choice (only exceptions or waivers granted by federal authority after copious volumes of applications).

Those who follow medical licensure issues will confirm that state programs in licensure will be far different as we turn the corner into the 21st Century than they are today.

A New Year's Look Toward the 21st Century

by

Ira Lubell, M.D., M.P.H., Member, Division of Medical Quality

Recently, the Medical Board has enacted a whirlwind of reforms, clearly establishing itself in the forefront of consumer protection agencies. It would appear logical that the Board could reflect on its accomplishments and settle into a mode of managing those reforms.

But prevailing logic dictates that more changes are ahead, not a rest period. In the draft of their soon-to-be published history of the Medical Board, authors Linda McCready and Billie Harris, both veterans on the Board's senior staff, detail questions and trends for the future—important for us to evaluate as we approach another New Year.

These questions and assumptions are not an exclusive list, but they do represent a handy list of the major trends which will affect licensure and physician discipline in the near future.

To members of the Medical Board, both physician and public, this list is not new, but, instead, is a focus of



Ira Lubell, M.D., M.P.H.

continuous review and discussion. In the past two years the Board has turned the corner into the nation's leading reformer on behalf of consumer protection. Reformers, if they are true to their own actions, do not rest on laurels. Instead, they continuously assess and adapt to modern trends, however uncomfortable that may be (and understandably so) for the regulated.

While these are some of the mega-questions universal to health care and serve to set the stage for elements within the health care professions, we can also make some reasonable predictions about trends for the immediate future of medical licensure in California.

These trends are already set in motion, of course, and are not matters over which the Board has control, but these are issues which we must constantly monitor and evaluate for our potential to have some effect upon them within our own sphere of authority.

Issues for the Future

1. So-called scope of practice issues subject to border warfare among various health professionals will escalate in intensity.

2. Pressure to develop national (not federal) licensure for physicians and other health care providers will increase.

3. The growth of managed care systems, particularly vertically integrated like Kaiser, is a given, specifically in Northern California.

4. The influence of designated "primary care" physicians as "gatekeepers," along with the nexus of cost and access, will continue to ferment.

5. The maldistribution of health care professionals in under served areas of the state and nation will continue to worry policy-makers, with emphasis

- Will Congress, in the end, finally co-opt control of health care delivery and financing?
- 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?

toward breaking down linguistic and cultural barriers to health care.

6. Uncompensated and under-compensated care will be a continuing problem, exacerbated by growing populations of uninsured consumers.

7. Technology will have diverse impacts: What will be possible? At what price? In whose hands? Under whose control?

8. The "Information Highway": It is a matter of a very few years before the

entire national (international?) network of health regulators are linked with "wait-less" information sharing both license qualifications and disciplinary activity.

9. Efforts at improving processes and outcomes of enforcement will be perpetually fine tuned, but each time a notorious case makes headlines, the call for reform will echo again.

10. Enforcement issues, such as priorities, fitting sanctions to offenses, obtaining complete case records, standards for prescribing for pain management and physician involvement in decisions about death are but a sample of major concerns that will be at the forefront of the Medical Board's agenda.

Dr. Lubell is the Medical Director of the Santa Clara County Medical Center.

FOUR NEW MEMBERS APPOINTED TO MEDICAL BOARD

1995 Officers Elected

Governor Wilson has appointed four new members to the Medical Board — two to the Division of Licensing, and two to the Division of Medical Quality. These appointments require Senate confirmation.

Division of Licensing:

WILLIAM FOSTER FRIEDMAN, M.D., 57,
of Los Angeles



William Friedman, M.D.

- J. H. Nicolson Professor of Pediatrics (Cardiology) at the University of California, Los Angeles School of Medicine.
- Earned his medical degree from the State University of New York, College of Medicine in 1961.

- Has served on the research committee of the American Heart Association, the Cardiology Advisory Committee of the National Institutes of Health and several pediatric societies.

Division of Licensing:

RAJA MOHAN TOKE, M.D., 51, of Walnut Creek

- Physician and surgeon in Pittsburgh.
- Earned his medical degree from Kurnool Medical College in India.
- Member, American Academy of Family Physicians and the American Physicians of Indian Origin.

Division of Medical Quality:

CAROLE HUGHES HURVITZ, M.D., 52, of Los Angeles

- Director of the Pediatric Department of Hematology-Oncology, and vice chair of Pediatrics at Cedars-Sinai Medical Center in Los Angeles, and clinical professor of Pediatrics at the University of California, Los Angeles.



New Board members include (from left to right): Phillip Pace, Carole Hurvitz, M.D., and Raja Toke, M.D.

- Earned her medical degree from the University of Sheffield School of Medicine in 1967.
- Past president and member of the Los Angeles Pediatric Society and an active member of the Leukemia Society of America, the American Society of Hematology and the American Society of Clinical Oncology.

Division of Medical Quality:

PHILLIP JOSEPH PACE, 59, of Montebello

- President of Pace Development Company, a management consulting firm.
- Earned an associates degree in business from East Los Angeles College in 1954, and has been a licensed general contractor since 1989.
- Former member of the Beverly Hospital Foundation, and a member of the Lifeline Adult Day Care Center, the Rotary Club, the YMCA, the Montebello Chamber of Commerce and the Metropolitan Blue Ribbon Task Force. Pace serves on the board of directors for Commerce National Bank and is the former chairman of the board of Golden Securities Thrift and Loan.

1995 Officers



1995 Board President Robert Del Junco, M.D. is sworn into office by Nancy Campbell, Department of Consumer Affairs, Deputy Director, Board Relations.

President—ROBERT DEL JUNCO, M.D. Head and neck surgeon in private practice in the City of Orange. Received his M.D. from the School of Medicine at the University Autonamous de Guadalajara, 1980.

Vice president—ALAN E. SHUMACHER, M.D. Director Emeritus of the Division of Neonatology at Children's Hospital, San Diego. Received his M.D. from the University of Iowa, 1957.

Secretary—STEWART HSIEH, J.D. Partner in the law firm of Frye and Spencer in Los Angeles. Received his J.D. from Southwestern University School of Law, 1978.

Accurate and Complete 805 Reporting...

(Cont. from p. 1)

- Hospital reports that it did not complete its peer review evaluation and did not proceed to a formal hearing because the physician “voluntarily” resigned. Subsequent Board investigation discloses the physician did not voluntarily resign but was coerced to resign or formal charges would be pursued and the Board notified of the hospital’s action.
- Hospital reports physician self-administered controlled substances. Subsequent Board investigation discloses physician self-administered controlled substances during an operation and injured patient.
- Hospital reports the physician’s privileges are restricted for failing to monitor patient or failing to maintain complete medical notes. Subsequent Board investigation discloses that hospital omitted the more important imposed restrictions that physician cannot examine female patients without chaperon or physician is not authorized to procure and administer controlled substances.

There are two basic 805 reporting issues/requirements:

- The need to report timely.
- The need to report accurately.

First, and unfortunately, hospitals often fail to meet basic 805 reporting requirements related to timely filing, e.g., failure to file within 15 days of imposing staff privilege restrictions or termination. The hospital’s failure to report in a timely and accurate fashion seriously jeopardizes present and future patient safety.

Second, and equally important, but perhaps more troubling, hospitals often fail to report accurately, e.g., a report indicating sexual harassment might lead a reader to believe the case is one of inappropriate gender comments, when in fact, the action taken by the hospital may actually involve direct physician sexual misconduct with patients, such as sexual battery or rape.

One might ask why a hospital would not only risk jeopardizing patient safety, but also protect egregious physician misconduct. The answer is not easy but certainly includes hospital concerns that the physician will file suit against the hospital for defamation of character. However, section 805(f) specifically provides immunity for reporting: “No person shall incur any civil or criminal liability as the

result of making any report required by this section.” Thus, this aspect of reporting should not be an issue. Rather, and perhaps of greater concern to the hospital, there exists the real possibility that patients may sue the hospital for allowing the physician to have practiced for so long without controlling or disciplining him and not reporting his misconduct or incompetence to the Medical Board.

“(A) hospital’s failure to report in a timely and accurate fashion seriously jeopardizes present and future patient safety.”

These are moral and business considerations which hospital administrators and peer review bodies must decide. But the Medical Board’s position is plainly stated in the Medical Practice Act—public protection is the Board’s highest priority.

A related issue involves the right of the Medical Board to review hospital peer review records. In a recent court case, arguments were presented regarding protection which makes peer review proceedings exempt from discovery as it relates to Evidence Code section 1157.

The hospital claimed that the peer review records were also confidential with respect to Medical Board investigative subpoenas. The Superior Court judge did not agree and accepted the Board’s argument that:

1. Evidence Code section 1157 does not insulate physician peer review materials from the Board’s lawfully served investigative subpoena.
2. Evidence Code section 1157 does not apply to investigations or investigative subpoenas issued by the Medical Board because the Board does not act as complainant or litigant in civil proceedings for damages.
3. If Evidence Code section 1157 were applicable to Medical Board investigations, public policy would be subverted because the Board would be prevented from fulfilling its mandate to protect the public.
4. If Evidence Code section 1157 were interpreted to preclude the Board from subpoenaing peer review records, then private peer review bodies would become the sole arbiter of physician quality control in California. This would undermine the legislative intent which mandates the Medical Board review the quality of a physician’s medical practice.

Finally, as it relates to the hospital’s claim of confidentiality, the court indicated case circumstances must be balanced between the greater public interest in protecting consumers

...Cooperation Between Hospitals and MBC Vital

of medical services and reasonable privacy interests. The Superior Court judge stated public safety should prevail. The hospital has appealed the judgment of the Superior Court and the Court of Appeal has granted a stay of the Superior Court order pending outcome of the appeal.

As it relates directly to the issue of proper 805 reporting, Board staff return incomplete 805 reports to hospitals and, in cooperation with the Office of the Attorney General, pursue the sanctions provided by law in section 805 B&P Code for failure to comply with this section of the Medical Practice Act. Physicians who hold the position of Chief of Staff or Administrator and any other individual licensees required to report under section 805 may face charges of unprofessional conduct.

Also, the Medical Board receives more consumer complaints than it can possibly handle with existing staff resources. In the 1992/93 fiscal year, the Board received 8,757 consumer complaints and in 1993/94 fiscal year, it received 9,686 consumer complaints. This is a 22% increase in consumer complaints over a two year period with no commensurate increase in investigator staffing to deal with the complaints and resulting investigation, administrative accusations and DMQ imposed disciplinary orders. Nothing would satisfy the Enforcement Program more than to know that hospital peer review is conducted in a manner that ensures patient safety. But 805 reporting records cast a shadow of doubt over the peer review process. It is uncertain whether all hospitals pursue this vitally important responsibility equally. And who are the victims? The victims are the patients and their families and the vast majority of competent, honest physicians who continue to pay increased malpractice insurance costs as well as suffer the undeserved criticism prompted by the acts of a few incompetent, negligent or dishonest physicians.

Some members of the medical community feel that Board pursuit of hospital disciplinary or investigative records will have a chilling effect on hospital peer review process. The chilling effect argument loses its credibility when one compares it to the effect upon patients who trust their physicians and expect safe and competent professional health care.

And, even if the physician leaves the hospital due to an impending investigation, does the hospital have no further public reporting responsibility for the doctor's harmful acts just because hospital committee discipline was not begun or completed, or, because the physician practices in another hospital (where he may begin his misconduct anew)?

“...progressive and public minded hospitals find reduced incidents and fewer reportable adverse disciplinary actions.”

In 1989, the Center for Public Interest Law (CPIL) recognized these problems associated with reliance on hospital reporting in their “Code Blue” publication. CPIL expressed concern about inadequate physician misconduct information and hospitals’ tendency to allow voluntary resignation (or withdrawal of application for privileges) prior to formal hospital proceedings which result in neither the Board nor another hospital ever learning of the physician’s unprofessional conduct or incompetence.

Finally, physicians need not worry about confidential peer review information being disclosed in the vast majority of cases, since the information obtained remains, by law,

confidential throughout the investigation. Also, if after review at the investigative stage, an independent assessment does not find a violation of the Medical Practice Act, the entire case is closed, and the investigative report remains confidential.

The Medical Board commends those hospitals that are proactive and take appropriate preventive action (i.e., training and intervention) to avoid physician misconduct problems. These progressive and public minded hospitals find reduced incidents and fewer reportable adverse disciplinary actions. Moreover, when 805 reports are initially presented to the Board in an accurate and factual manner, investigative time and expenditure are

minimized and the public is better served.

“...when 805 reports are initially presented to the Board in an accurate and factual manner, investigative time and expenditure are minimized and the public is better served.”

The following attorneys from the Office of the Attorney General's Health Quality Enforcement Section contributed to this article: Al Korobkin, Assistant Attorney General, Vivien Hara Hersh and Jana Tuton, Supervising Deputy Attorneys General.

Physician Alert

State Disability Insurance Reforms Affect Physicians

New reforms in the State Disability Insurance (SDI) program require physicians to include both a diagnosis and an International Classification of Disease (ICD) code when certifying disability claims.

California's Employment Development Department (EDD) recently implemented reforms to insure continued economic security and affordable benefits to SDI claimants. SDI is California's mandated disability insurance program that provides partial wage replacement benefits to California workers who suffer wage losses when they are unable to work because of a disability that was not job-related.

Legislative changes (SB 1584-Johnson) effective September 28, 1994 require that:

- Medical certifications, filed to support SDI claims, have both a diagnosis and ICD code;
- Medical certifications be based on a physical exam (when applicable)

and documented medical history of the claimant;

- An administrative penalty of 25 percent of all benefits paid be assessed against any person falsely certifying the medical condition of any individual to obtain SDI benefits.

Beginning January 1, 1995, SDI will not process claims without both diagnosis and ICD codes.

To prevent unnecessary interruptions, physicians should complete only current versions of the SDI claim form (DE 2501). Versions are identified with revision numbers located on the reverse side of the doctor's certification in the lower left hand corner of the form. Any revision number higher than 59 is acceptable.

Physicians are an integral part of EDD's disability claim processing, and SDI's integrity depends on the accuracy of medical claims of patients' disabilities.

For more information, or to request current claim forms, please contact any of the following individuals.

Sacramento

Katy Hammans
(916) 227-4976

San Francisco

Chris Cervelli
(415) 557-3188

Woodland Hills

John Boghosian
(818) 596-4174

Los Angeles

Karen Anthony
(213) 580-3075

Long Beach

Shirley Bluman
(310) 599-8859

San Bernardino

Kim Lincoln-Hawkins
(909) 383-4739

San Diego

Ignacio Vazquez
(619) 688-0195

Physician Alert

"Foreign" Professional Corporations Not Allowed in California

The Medical Board has received numerous inquiries concerning the 1993 amendments to the Moscone-Knox Professional Corporations Act authorizing the formation of "foreign professional corporations."

These amendments resulted from legislation sponsored by professional associations representing lawyers and accountants (SB 687 and SB 312) and does not authorize "foreign professional corporations" other than those related to accountancy and law.

The legislation as originally enacted and as recently clarified (SB 2053 [Killea] Chapter 1010, Statutes of 1994) only authorizes those "foreign

professional corporations" for which there is a specific authorization in the Business and Professions Code to operate as a "foreign" corporation, that is, for accountancy and law corporations (Business and Professions Code §§5154 and 6151, respectively).

The legislation did not grant similar authority to medical or any other professional corporation currently authorized to exist under the law. As there is no authorization for medical corporations to be formed as a "foreign medical corporation," physicians should not enter into agreements with "foreign corporations" to practice medicine in this state or they could be found guilty of unprofessional conduct

for aiding and abetting the unlawful practice of medicine.

If you have specific questions, contact:

**Anita Scuri
Staff Counsel**

**Office of Legal Affairs
Department of Consumer Affairs
400 R Street, Suite 3090
Sacramento, CA 95814**

or

**Foone Louie
Staff Counsel**

**Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825**

Information for this Physician Alert was provided by Astrid G. Meghrigian, Legal Counsel, California Medical Association.

A Major New Initiative in Sports Medicine

by
*Jim Rathlesberger, Executive Officer
Board of Podiatric Medicine*

The Medical Board and the Board of Podiatric Medicine are working together to initiate a unique, instructive and appealing program of continuing education in sports medicine aimed at armies of physicians and other health care professionals who volunteer their services routinely throughout California.

Crafted as local offerings in high school or community college district settings, the one-day courses are designed to attract an audience of physicians and health professionals whose specialties do not include sideline game management or knowledge of legal liability risks. The course does not attempt to duplicate more sophisticated and complete courses taught by specialty societies, but tries to reach the hundreds, if not thousands, of physicians who make decisions every day that football, soccer, basketball, volleyball, field hockey or other games are played.

The Sports Medicine Steering Committee, cochaired by John McShane, M.D., and Bill Olsen, D.P.M., team doctors for the University of California at Berkeley, has suggested an initial set of six day-long seminars in different geographic areas of the state. The Committee recommended that a survey of health professionals be conducted in each of the six areas to ascertain the interest and needs of prospective classes.

There is to be a core curriculum developed by the Steering Committee from which local faculties will choose. The curriculum will be a mixture of lectures and round-robin hands-on workshops providing registrants the opportunity to work along side the core faculty under workshop titles such as "High Risk Injuries," "Sideline Organization," "Acute Injuries," "Lower Extremities and Rehabilitation" and "Bracing/Splinting." Lectures include "Medico-Legal Issues," "Endurance," "Wellness" and "Children." These modules will be designed so that any combination can be put together to command proportional credit for continuing medical education (CME). A fee will be charged to each registrant—an amount not to exceed actual direct and indirect costs.

Celebrity sports figures will be recruited to promote each one-day event and to participate as "faculty." It is expected that the celebrities will report their own stories about health care in a sports setting and serve to complement the volunteerism of community doctors and health care professionals.

Tribute to Senator Presley



State Senator Robert Presley (D-Riverside) retired this year from the Legislature after more than two decades of distinguished service, during which he authored SB 2375 in 1991 ("Presley I"), SB 916 in 1993 ("Presley II") and SB 1775 in 1994 ("Presley II-A")—all major legislation designed to improve the consumer protection mission and operations of the Medical Board. In tribute to Senator Presley's service, Board President Bruce Hasenkamp said, "No legislator has done more to shape the current policy and performance of the Medical Board than Bob Presley. And no one could have done so with as much good faith and skill as did Bob Presley. He has earned our respect and our appreciation."

The potential audience for each day-long seminar is physicians and health care professionals who are asked to serve school and club teams, who see sports medicine cases as part of an office-based practice, who want to participate in sports medicine teams or who seek introductory exposure prior to advanced training.

Coaches and administrators will be encouraged to attend so that they will understand the role of volunteer team physicians and health professionals.

The initial Steering Committee, not an exclusive structure, consists of professional and college team doctors. They represent four University of California campuses, two private universities, several professional sports teams and local level sports. The Steering Committee voted, at its meeting in October, to divide into two groups (NorCal and SoCal) but to focus on each location with a planning group and faculty for each, to include experienced experts and local leaders from the various healing arts.

It is expected that the first six seminars will be conducted in late spring.

Financial Interest Disclosure in Health-Related Facilities

Effective July 1, 1994 (Business and Professions Code section 2097), physicians are required to report any financial interests that they or their immediate family may have in health-related facilities as a condition of license renewal. **All that is required is a listing of the name and address of the facility and your signature. No other information is required.**

Physicians must report this information at the time of renewal to comply with this new law (completing Box "G" on Part 3—shown immediately below this paragraph—and the reporting section on the reverse side of Part 3 of the license renewal application—shown at the end of this text). Failure to complete the reporting sections will delay the renewal.

G. FINANCIAL INTEREST STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM, THE NAMES OF THOSE HEALTH-RELATED FACILITIES THAT I OR MY FAMILY HAVE FINANCIAL INTEREST.

SIGNATURE REQUIRED HERE _____

The renewal application includes definitions of the terms "financial interest," "immediate family," and "health-related facilities." The facilities included are those that provide any of the following eight services: 1) clinical laboratory services; 2) radiation oncology; 3) physical therapy; 4) physical rehabilitation; 5) psychometric testing; 6) home infusion

therapy; 7) diagnostic imaging; or 8) outpatient surgery. Consequently, disclosure of a financial interest pertains only to any of these eight types.

Another new law (B&P Code section 650.01), effective on January 1, 1995, makes it unlawful for a physician to refer a patient to a facility in which he/she has a financial interest that provides any of the eight services listed above. Patient referrals to facilities that provide services other than these are permitted, if the physician first discloses the financial interest in writing to the patient at the time of referral.

A violation of section 650.01 is a misdemeanor. The Board also has the authority to take appropriate disciplinary action against a physician for unprofessional conduct. In some cases, this could result in license revocation. (There are exceptions to this statute regarding patient referrals which are included in B&P Code section 650.02.)

It may be difficult for a physician to easily determine whether or not he/she is required to disclose a particular financial interest. If this is true for you, you should consult with independent legal counsel for assistance.

To obtain copies of the laws mentioned above, write to: Lisa Knapp, Medical Board of California, Licensing Program, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.

DISCLOSURE OF FINANCIAL INTERESTS

PLEASE PRINT OR TYPE CLEARLY THE NAMES(S) AND ADDRESS(ES) OF EACH HEALTH-RELATED FACILITY IN WHICH YOU OR YOUR IMMEDIATE FAMILY HAVE A FINANCIAL INTEREST. IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL LISTINGS. **IF YOU HAVE NO INTERESTS TO DECLARE, PLEASE WRITE "NONE" IN THE AREA BELOW AND SIGN YOUR NAME IN SECTION "G" OF PART 3, ON THE FRONT OF THIS FORM.**

	HEALTH-RELATED FACILITY NAME(S)	ADDRESS
1.		
2.		

Explanation of Disciplinary Language

1. **"Revoked"**— The license is canceled, voided, annulled, rescinded. The right to practice is ended.

2. **"Revoked - Default"**— After valid service of the Accusation (formal charges), the licensee fails to file the required response or fails to appear at the hearing. The license is forfeited through inaction.

3. **"Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' suspension"**— "Stayed" means the revocation is postponed, put off. Professional practice may continue so long as the licensee complies with specified probationary terms and conditions, which, in this example, includes 60 days' actual suspension from practice. Violation of probation may result in the revocation that was postponed.

4. **"Suspension from practice"**— The licensee is benched and prohibited from practicing for a specific period of time.

5. **"Temporary Restraining Order"**— A TRO is issued by a Superior Court Judge to halt practice immediately. When issued by an Administrative Law Judge, it is called an ISO (Interim Suspension Order).

6. **"Probationary Terms and Conditions"**— Examples: Complete a clinical training program. Take educational courses in specified subjects. Take a course in Ethics. Pass an oral clinical exam. Abstain from alcohol and drugs. Undergo psychotherapy or medical treatment. Surrender your DEA drug permit. Provide free services to a community facility.

7. **"Gross negligence"**— An extreme deviation from the standard of practice.

8. **"Incompetence"**— Lack of knowledge or skills in discharging professional obligations.

9. **"Stipulated Decision"**— A form of plea bargaining. The case is negotiated and settled prior to trial.

10. **"Voluntary Surrender"**— Resignation under a cloud. While charges are pending, the licensee turns in the license — subject to acceptance by the relevant Board.

11. **"Probationary License"**— A conditional license issued to an applicant on probationary terms and conditions. This is done when good cause exists for denial of the license application.

12. **"Effective date of Decision"**— Example: "July 8, 1994" at the bottom of the summary means the date the disciplinary decision goes into operation.

13. **"Judicial Review recently completed"**— The disciplinary decision was challenged through the court system—Superior Court, maybe Court of Appeal, maybe State Supreme Court—and the discipline was upheld. This notation explains, for example, why a case effective "October 10, 1991" is finally being reported for the first time four years later in 1995.

Disciplinary Actions: September 1, 1994 to October 31, 1994

Decisions: Physicians and Surgeons

AUGUSTINE, LOWELL K., M.D. (G-47652) Los Angeles, CA
B&P Code §2305. Stipulated Decision. Disciplined by Louisiana Board through a Consent Order. California: Revoked, stayed, 5 years' probation on terms and conditions. September 5, 1994

AZEN, STANLEY A., M.D. (G-39558) Sherman Oaks, CA
B&P Code §§490, 2236, 2239, 2234(b). Conviction of felony possession of cocaine. Self use of cocaine. Furnished cocaine to addicts. Gross negligence in attempting to render unassisted emergency resuscitation of girlfriend who overdosed, and in delaying a timely call to 911 for emergency help and equipment. Revoked, stayed, 6 years' probation on terms and conditions. October 21, 1994

BABCOCK, BRUCE, M.D. (C-15907) Concord, CA
B&P Code §2234(b). Stipulated Decision. Gross negligence in failing to diagnose cancer of the larynx despite numerous office visits. Revoked, stayed, 3 years' probation on terms and conditions. September 15, 1994

BOAZ, JOHN, M.D. (C-33337) Alameda, CA - Caro, MI
B&P Code §2234. Stipulated Decision. He admits "there is a factual and legal basis for the imposition of discipline against his certificate under B&P Code §2234 in that he engaged in general unprofessional conduct in violation of the American Medical Association's Principles of Medical Ethics." Revoked, stayed, 3 years' probation on terms and conditions. October 24, 1994

BONGIORNO, FRANK P., M.D. (G-39302) Hudson, MI
B&P Code §2305. Disciplined by U.S. Air Force Hospital, a federal agency. Revoked, stayed, 5 years' probation on terms and conditions. October 8, 1994

CADAG, SANTIAGO, M.D. (A-39899) Los Angeles, CA
B&P Code §2234(a),(b),(e). Stipulated Decision. Respondent admits that the allegations in the Accusation constitute sufficient cause for discipline: Gross negligence, unprofessional conduct and acts involving corruption. Revoked, stayed, 5 years' probation. September 16, 1994

CHAN, JOHN K., M.D. (A-23924) Monterey Park, CA
B&P Code §§725, 2261, 2262. Stipulated Decision. Clearly excessive and unnecessary treatment to a worker's compensation insurance patient; and involving false and misleading billings. Revoked, stayed, 3 years' probation on terms and conditions. October 21, 1994

CHAN, HON YUEN, M.D. (G-49302) Fairfield, CA
B&P Code §2234(c). Stipulated Decision. Licensee acknowledges that the Board could establish with prima facie evidence that the administration of 5-FU (Fluorouracil) was done incorrectly during chemotherapy and constituted repeated negligent acts. Revoked, stayed, 5 years' probation on terms and conditions. October 24, 1994

COPELAND, JOHN, M.D. (C-26299) Antioch, CA
B&P Code §§2234(c), 2236. Stipulated Decision. Conviction for providing controlled substances without medical indication to several patients. Also constitutes repeated negligent acts. Revoked, stayed, 5 years' probation on terms and conditions. October 21, 1994

DEFEO, DONALD, M.D. (G-15019) Orange, CA
B&P Code §2234. Stipulated Decision. Gross negligence, repeated negligent acts and incompetence in renal surgery practice. Revoked, stayed, 5 years' probation on terms and conditions. September 29, 1994

DURPHY, MICHAEL, M.D. (G-28170) San Anselmo, CA
B&P Code §§2234(b), 726. Sexual relations with psychotherapy patient;

gross negligence. Revoked, stayed, 5 years' probation on terms and conditions. October 27, 1994

FREDERICKS, CRAIG A., M.D. (G-48228) Thomasville, GA
B&P Code §2305. Stipulated Decision. Disciplined by Georgia Board for abuse of self-administration of drugs. Revoked, stayed, 7 years' probation on terms and conditions. October 3, 1994

HARP, GRADY E., M.D. (G-16160) Altadena, CA
B&P Code §§726, 2236, 2234. Conviction for battery on patient, related to sexual misconduct in urology practice. Gross negligence. Revoked, stayed, 7 years' probation on terms and conditions. September 5, 1994

JELDERKS, ROBERT M., M.D. (C-30165) San Luis Obispo, CA
B&P Code §§2234(b),(c),(d). Gross negligence, incompetence, and repeated negligent acts in OB-GYN practice, including laser laparoscopy, abdominoplasty, liposuction, and other procedures. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. September 13, 1994

JENKINS, EARL C., M.D. (A-25009) Avenal, CA
B&P Code §725. Stipulated Decision. Clearly excessive prescribing of drugs to patients. Revoked, stayed, 5 years' probation on terms and conditions, including 30 days' actual suspension. September 16, 1994

KHATCHERIAN, YERVANT, M.D. (A-45730) Newport Beach, CA
B&P Code §2234(b). Gross negligence in mismanaging a patient with sharp abdominal pain by failing to diagnose acute inflammation of the gallstones, or alternatively, by failing to refer the patient for additional diagnostic work, or to a surgeon for consultation. Revoked, stayed, 3 years' probation on terms and conditions. September 23, 1994

KLEPP, ARNE LEONARD, M.D. (C-17787) Encino, CA
Stipulated Decision. Declines to require the Board to put on its case proving gross negligence, incompetence, and repeated negligence in family medicine; admits the Board can present a prima facie case establishing the allegations in the written charges; waives the right to present a defense. Revoked, stayed, 5 years' probation on terms and conditions, including 45 days' actual suspension. October 21, 1994

KRAUS, LEON, M.D. (A-28446) Newport Beach, CA
B&P Code §§2234, 2236. Stipulated Decision. Conviction for conspiracy to commit battery. Aided and abetted unlicensed person to see patients as a physician. Revoked, stayed, 5 years' probation on terms and conditions, including placing license on inactive status. October 12, 1994

KRAUSE, ROBERT W., M.D. (C-28583) Middletown, CA
B&P Code §§2239(a), 2240. Stipulated Decision. Intoxicated while treating patients. Use of alcohol impairing safe practice. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. August 24, 1994

LaROCHELL, WILLIAM, M.D. (A-19454) San Carlos, CA
B&P Code §822. Stipulated Decision. Mental illness affecting competency. Revoked. September 30, 1994

MANYAM, AMMAJI, M.D. (A-39054) Westbury, NY
B&P Code §2305. Disciplined by New Jersey Board for two felony convictions related to defrauding Medicaid of over \$50,000 by ordering unnecessary laboratory tests. Revoked. Default. September 7, 1994

MAYMAN, DAVID, M.D. (G-25532) Sacramento, CA
B&P Code §2234 (b),(c),(d). Stipulated Decision. Gross negligence,

incompetence and repeated negligent acts in the field of pediatric oncology. Unprofessional behavior with a baby patient and the patient's mother. Revoked, stayed, 10 years' probation on terms and conditions. October 31, 1994

MINEO, RONALD M., M.D. (G-13361) Gulf Breeze, FL
Stipulated Decision. Does not admit nor deny the charges in the Accusation, but does agree that the Board may enter an order revoking his license. Revoked. September 7, 1994

MONTOJO, PEDRO M., M.D. (C-38665) Sparta, TN
B&P Code §2305. Stipulated Decision. Disciplined by Washington State Board for failure to exercise proper judgment in the care of 5 patients in the hospital emergency room by a non-ER physician. Revoked, stayed, 5 years' probation on terms and conditions. September 5, 1994

OLIVER, JAMES W., M.D. (A-21934) Sebastopol, CA
B&P Code §2234. Stipulated Decision. Unprofessional conduct in that as a physician employed at an institution for developmentally disabled persons, he examined a female adult patient without a chaperone present. Revoked, stayed, 5 years' probation on terms and conditions. October 31, 1994

PARKISON, GARY A., M.D. (A-349604) Antioch, CA
B&P Code §2305. Disciplined by Oklahoma Board related to charges of excessive prescribing and prescribing without medical need. Revoked, stayed, 3 years' probation on terms and conditions. October 26, 1994

PINKERNELL, BRADLEY, M.D. (G-3337) Carpinteria, CA
B&P Code §§2234, 2241, 2242. Stipulated Decision. Prescribed narcotics and other dangerous drugs to persons he knew or should have known were addicts or abusers, and to patients without prior examination and medical indication. Revoked, stayed, 5 years' probation on terms and conditions. October 19, 1994

RAFFINAN, JOSE A., M.D. (A-41232) Clearwater, FL
B&P Code §2305. Disciplined by Florida Board on charges of sexual misconduct with several patients. Revoked. Default. October 28, 1994

ROSCHEN, FRITZ, M.D. (G-17730) Elk Grove, CA
B&P Code §2305. Clinical privileges revoked by U.S. Air Force at Mather Air Force Base because of departures from the standard of care. Revoked. Default. September 5, 1994

SIMMONS, MARVIN W., M.D. (C-12065) Fresno, CA
B&P Code §2234(b). Stipulated Decision. Decision to continue with a lingual tonsillectomy on a morbidly obese patient under local anesthetic and in the presence of high risk factors was an extreme departure from the standard of care. Revoked, stayed, 3 years' probation on terms and conditions. September 16, 1994

SINGH, BALDEV D., M.D. (C-40540) Yuma, AZ
B&P Code §2305. Restriction by Arizona Board due to drinking problem and high stress. Revoked, stayed, 5 years' probation. September 29, 1994

STERN, THOMAS K., M.D. (G-25191) Berkeley, CA
B&P Code §2234. Stipulated Decision. Failure to maintain proper records to account for the in-take and out-go of the controlled drugs inventory in the office constitutes unprofessional conduct. Revoked, stayed, 3 years' probation on terms and conditions. October 24, 1994

STOERMER, DIETRICH, M.D. (C-39091) Las Vegas, NV
B&P Code §2304. Disciplined by Nevada Board for failure to make medical records available to patients for inspection and copying, as required by law. Revoked. Default. September 1, 1994

TURNER, STEPHEN B., M.D. (G-46572) Hayward, CA
B&P Code §§2236, 2234(e). Stipulated Decision. Conviction for indecent

exposure. Prior exhibitionism; prior discipline. Revoked, stayed, 7 years' probation on terms and conditions, including 1 year actual suspension; ongoing therapy; sexual offender treatment program. September 14, 1994

VARLEY, JR., ARTHUR J., M.D. (C-32129) Vista, CA
B&P Code §2234(c). Stipulated Decision. Repeated negligent acts in the care of 2 orthopedic patients. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. September 1, 1994

YAP-CHIONGCO, BASILIO, M.D. (A-22880) Pittsburg, CA
B&P Code §2234(b)(c). Gross negligence in failing to monitor patient's electrolytes during post-operative period. Repeated negligent acts in failing to order follow-up bowel x-rays and further laboratory studies. License now on voluntary retired status is ordered indefinitely suspended subject to terms and conditions. September 28, 1994

ACUPUNCTURISTS

ALEXANDER, ROBERT E. (AC-2666) Sonora, CA
B&P Code §4955(d). Stipulated Decision. Conviction for possession of concentrated cannabis (hashish). Revoked, stayed, 3 years' probation on terms and conditions. September 16, 1994

CHAN, KUN CHUN (AC-343) San Diego, CA
B&P Code §§651, 1399. 453 CCR Title 16. Stipulated Decision. Deceptive, false, or misleading advertising and claims. Failure to maintain adequate treatment records. Revoked, stayed, 5 years' probation on terms and conditions. July 27, 1994

NIEN, CHEN YU (AC-1245) Sunnyvale, CA
B&P Code §4955, 2052. Stipulated Decision. Conviction for practicing medicine without a license (related to his "live cell therapy"). Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. July 18, 1994

SON, CHON JU (AC-3933) Fullerton, CA
B&P Code §§4955 (e),(f), 4976. Stipulated Decision. Aided and abetted unlawful use of her license by allowing it to be displayed in a place of business owned by unlicensed person, and where acupuncture was not being performed. Revoked, stayed, 3 years' probation on terms and conditions. October 25, 1994

PHYSICIAN ASSISTANTS

MELENDEZ, BERNARD, P.A. (PA-10901) Glendora, CA
B&P Code §§3527, 3503. Revocation of privileges by VA Medical Center. Recorded aspects of physical exam which did not take place. Misleading resume. Revoked, stayed, 3 years' probation on terms and conditions, including 10 days' actual suspension. October 17, 1994

GUTIERREZ, ALFONSO, P.A. (PA-10050) Loma Linda, CA
B&P Code §§3527, 2052, 1399. 540 CCR Title 16. Conviction for practicing medicine without a license. Practiced at medical clinic without an approved supervising physician. Prior discipline. Revoked. September 15, 1994

DOCTORS OF PODIATRIC MEDICINE

LEDESMA, NESTER, D.P.M. (E-1515) Salt Lake City, UT
B&P Code §2234(b),(c),(d). Gross negligence, incompetence, repeated negligent acts in podiatric practice, as detailed in a 58-page decision. Revoked. October 21, 1994

MCFARLAND, JAMES, D.P.M. (E-2416) Redding, CA
B&P Code §2234 (b),(d). Stipulated Decision. Gross negligence and incompetence in 8 causes of action involving unnecessary surgeries, inadequate treatment for post-surgical infections, misdiagnosis of foot

fracture, and mistreatment of a foot infection. Revoked, stayed, 7 years' probation on terms and conditions, including 9 months' actual suspension. October 21, 1994

GARNER, JOHN, D.P.M. (E-2054) Bakersfield, CA
B&P Code §§725, 2234 (c),(d). Stipulated Decision. Excessive treatment. Repeated negligent acts. Incompetence. Revoked, stayed, 2 years' probation on terms and conditions. September 8, 1994

PHYSICAL THERAPISTS

DALLMEYER, DAVID A. (PT-6421) Santa Barbara, CA
B&P Code §§725, 726, 2234, 2660. Stipulated Decision. Sexual misconduct; also gross negligence, incompetence, repeated negligent acts and excessive treatment. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. August 22, 1994

DOLLINGER, DAVID L. (PT-7419) Lodi, CA
B&P Code §2661. Conviction for inflicting corporal punishment on a spouse. Revoked, stayed, 10 years' probation on terms and conditions. September 26, 1994

HERPIN-WILSON, APRIL (PT-6701) Fountain Valley, CA
B&P Code §§810, 2630, 2660. False insurance claim. Aided and abetted unlicensed practice of physical therapy. Revoked, stayed, 3 years' probation on terms and conditions, including 90 days' actual suspension. October 11, 1994

SCIGLIANO, JOHN (PT-15055) Sacramento, CA
B&P Code §726. Stipulated Decision. Sexual misconduct. Revoked, stayed, 5 years' probation on terms and conditions, including 35 days' actual suspension. September 26, 1994

PHYSICAL THERAPIST ASSISTANTS

BECERRA, OMAR (AT-2092) Ontario, CA
B&P Code §2660. Stipulated Decision. Sexual misconduct. Conviction of sexual battery and indecent exposure. Revoked. September 19, 1994

FOX, AUTUMN (AT-2175) Warrensburg, MO
B&P Code §§2630, 2660. Stipulated Decision. Conviction of aiding and abetting unlawful practice of physical therapy. Revoked, stayed, 5 years' probation on terms and conditions, including 90 days' actual suspension. October 7, 1994

MCARDLE, CAROL ANN (AT-2470) Los Angeles, CA
B&P Code §2661. Stipulated Decision. Conviction of prostitution. Revoked, stayed, 5 years' probation on terms and conditions. August 25, 1994

PSYCHOLOGISTS

BENJAMIN, STEVEN L., Ph.D. (PSY-5228) Encinitas, CA
B&P Code §§726, 2960(n). Stipulated Decision. Sexual misconduct with 3 patients. Revoked. September 8, 1994

CARTER-HARGROVE, JAMES, Ph.D. (PSY-9514) Corona, CA
B&P Code §2960(p). Stipulated Decision. Incompetence in lacking special training and experience to treat patients with borderline personality disorders. Revoked. September 20, 1994

EDSON, WINFIELD D., Ph.D. (PSY-3350) Bakersfield, CA
Superior Court overturned Board's revocation decision which was effective April 23, 1993 and previously reported in the *Action Report*. September 19, 1994

EVANS, JEROME R., Ph.D. (PSY-3537) Ventura, CA
B&P Code §§2960 (j),(n), 726. Gross negligence, sexual misconduct with a patient. Revoked April 7, 1994. Superior Court stay issued May 27, 1994; Superior Court upheld board decision effective September 22, 1994.

HEDBERG, ALLEN, Ph.D. (PSY-4208) Fresno, CA
Probation decision reported in last *Action Report* was stayed by the Superior Court on May 27, 1994.

LEONELLI, DAVID, Ph.D. (PSY-14045) Redondo Beach, CA
B&P Code §2960(a). Stipulated Decision. Drug conviction was not disclosed on application for licensure. Probationary certificate issued, 5 years' probation on terms and conditions. August 19, 1994

STEWART, RALPH H., Ph.D. (PSY-2986) Phoenix, AZ
B&P Code §2305. Default Decision. Discipline by the Arizona Board for alcoholism and improper billing. Revoked. October 21, 1994

RESPIRATORY CARE PRACTITIONERS

BAUMGART, TERRY (RCP-13943) San Gabriel, CA
B&P Code §§3750, 3755. Procured license by fraud, by concealing conviction for driving under the influence of alcohol. Unprofessional conduct toward a supervisor. Revoked, stayed, 5 years' probation on terms and conditions, including 60 days' actual suspension. October 5, 1994

BRODY, SETH (RCP-11158) Seattle, WA
B&P Code §§490, 3750. Stipulated Decision. Convictions for welfare fraud; making annoying telephone calls; vehicular manslaughter. Revoked. September 3, 1994

CASTRILLO, KELLY (RCP-7408) San Lorenzo, CA
B&P Code §§3750, 3752. Conviction of driving under the influence of drugs and alcohol. Revoked. Default. October 6, 1994

CLARKE, NELLO (RCP-11884) Long Beach, CA
B&P Code §§3750, 3752. Stipulated Decision. Conviction for false statements to increase unemployment benefits. Dishonesty. Revoked, stayed, 5 years' probation on terms and conditions. October 11, 1994

ECKERT, LEWIS D. (RCP-13680) Fontana, CA
B&P Code §3750(d), 3750.5. Stipulated Decision. Convictions for driving with blood alcohol level above the statutory limit. Also conviction for carrying a concealed weapon. Revoked, stayed 5 years' probation on terms and conditions. October 21, 1994

ESTELLE, VERONNI (RCP-10840) Long Beach, CA
Stipulated Decision. Violated terms of probation of prior discipline. Revoked, stayed, 5 years' probation on terms and conditions. September 19, 1994

FERRER, DAVID A. (RCP-14084) Fresno, CA
B&P Code §§3750(d), 3750(j), 3752.5. Conviction for injury to a child, and corporal injury on a spouse. Revoked, stayed 5 years' probation on terms and conditions, including 5 days' actual suspension. October 3, 1994

FORTIER, PATRICIA A. (RCP-8470) Oakland, CA
B&P Code §3750(d). Conviction for petty theft at Safeway. Another conviction for petty theft at Andronico's Market. Revoked. Default. September 12, 1994

JENNINGS, GARY (RCP-14677) Chico, CA
B&P Code §3750.5. Extensive alcohol and drug history. Conviction for driving under the influence of alcohol, resisting arrest, evading a peace officer. Revoked. October 28, 1994

RICHARD, GARY (RCP-10224) Pomona, CA

B&P Code §§3750, 3750.5. Stipulated Decision. 1984 conviction for cultivating marijuana. 1991 conviction for DUI. 1992 conviction for transporting marijuana. Revoked, stayed, 5 years' probation on terms and conditions. October 21, 1994

ROSE, CARL (RCP-7075) Oakland, CA

B&P Code §§3750, 3752. Convictions for driving under the influence of alcohol. Revoked, stayed, 5 years' probation on terms and conditions. October 3, 1994

SAVEDRA, CHRIS (RCP-9997) Monrovia, CA

B&P Code §3750.5. Using a controlled substance illegally possessed. Prior discipline. Revoked. September 8, 1994

SOULE, LENA (RCP-9193) Riverside, CA

B&P Code §§3750, 3760. Conviction of practicing respiratory care without a license. Altered expiration date on license to avoid paying renewal fee. Revoked. September 29, 1994

WHITE, RICHARD H. (RCP-8946) Modesto, CA

B&P Code §§3750.5(c), 3750(j), (b). Stipulated Decision. Convictions in 1982 and 1990 for driving under the influence of alcohol. Obtained license through a false application in 1985 concealing the 1982 DUI conviction. Revoked, stayed, 5 years' probation on terms and conditions. September 9, 1994

YAPLE, CARYN (RCP-12323) Placerville, CA

B&P Code §3750. Stipulated Decision. Conviction for possession of marijuana. Revoked, stayed, 5 years' probation on terms and conditions. September 5, 1994

VOLUNTARY SURRENDER

PHYSICIAN AND SURGEON

BARR, EDDIE, M.D. (A-12585) Stockton, CA

October 21, 1994

CHRISTENSEN, DAVID D., M.D. (G-46490) Indio, CA

September 15, 1994

FRAIDE, RAUL, M.D. (A-11369) La Habra, CA

September 6, 1994

HIGNELL, THOMAS E., M.D. (A-34837) Chico, CA

September 29, 1994

JENNINGS, KENNETH, M.D. (A-17932) Los Angeles, CA

September 20, 1994

JOHNSON, SIDNEY, M.D. (C-29891) Oxnard, CA

September 27, 1994

KOSER, WILLIAM J., M.D. (A-11655) Albany, CA

October 21, 1994

MOHIT, MORTEZA, M.D. (A-45266) Bayside, NY

September 7, 1994

NEWTON, DOUGLAS, M.D. (G-35807) Kennewick, WA

September 9, 1994

PHILLIPS, DONALD, M.D. (A-38618) Bakersfield, CA

October 7, 1994

ROBERTS, EDWIN, M.D. (C-14397) Hayward, CA

September 1, 1994

WALINSKI, THOMAS, M.D. (G-17996) Scottsdale, AZ

September 29, 1994

HEARING AID DISPENSER

GOLDBERG, HYMAN (HA-1165) San Diego, CA

October 8, 1994

PSYCHOLOGIST

FERGUSON, ROBERT, Ph.D. (PSY 11724) Mission Viejo, CA

October 19, 1994

CALL FOR MEDICAL EXPERTS

Medical experts to the Board provide an invaluable public service by evaluating the merits of complaints and investigative reports, thus protecting consumers from violations of the Medical Practice Act.

In accord with the Board's recently adopted report on medical quality, we seek additional experts to assist our enforcement efforts.

The Board has approved a revised medical expert program. In summary, this program requires that newly appointed experts be Board certified (or equivalent), be in good standing, have an active practice and five years in a specialty with peer review experience recommended. The MBC will provide eight hours of training to the experts and compensate them at a rate of \$75/hour for time reviewing complaints/files or in office conferences, \$100/hour for

time providing expert testimony, and pay actual travel expenses.

Some medical experts may be asked to serve on peer review panels to provide counseling to local physicians, monitor probationary practice restrictions, assist with clinical competency examinations, and/or provide outreach to local medical and public groups. Panelists will be compensated for their travel expenses. The Board plans to implement the revised program in early 1995.

Your immediate response to this request is appreciated. Let us know how you can help and the time you can commit. Send your CV to Linda Whitney, Medical Board of California, 1430 Howe Avenue, Suite 100, Sacramento, CA 95825. For more information, call Ms. Whitney at (916) 263-2677.

New Mandated Breast Cancer Treatment Brochure Available

Essential for physicians who perform breast biopsies or treat breast cancer

A new breast cancer treatment brochure, developed by the California Department of Health Services (DHS) and distributed by the Medical Board of California, is now available to physicians. Physicians are required by law (see below for summary of Senate Bill 112—Roberti) to give the brochure to patients before they perform a biopsy or treatment, and to note receipt of it in the patient's chart.

The 32-page brochure covers diagnostic and treatment options—including surgery, radiation, chemotherapy, hormonal therapy and complementary therapy—breast reconstruction, psychosocial information and other issues. Throughout the brochure are short lists of “questions to ask your doctor” designed to help facilitate patient-doctor communication during a traumatic time for the patient.

The brochure is written at a broadly accessible reading level and incorporates multi-cultural illustrations. The brochure was extensively reviewed by more than 20 reviewers including oncologists, radiologists, breast surgeons, plastic surgeons, survivors/advocates, physical therapists, and psychosocial and literacy experts. In addition, DHS' Breast and Cervical Cancer Advisory Council has also reviewed the brochure and is raising funds to cover the costs of its development and printing.

Last fall, the brochure was tested with ethnically diverse women from a variety of backgrounds and socioeconomic levels. This research found that the brochure had the right balance of information.

DHS plans to produce a Spanish version and possibly some

Asian language versions. Look for these later in 1995.

Physicians may order copies of the brochure by writing to:

BREAST CANCER TREATMENT OPTIONS

**Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825**

or

Fax requests to (916) 263-2479.

Please specify number of copies (by bundles of 25), and provide your return address. Brochures are free of charge. Supply may be limited.

Summary of Senate Bill 112

SB 112, signed into law by Governor Wilson in October 1993, updates Health and Safety Code section 1704.5 regarding breast cancer informed consent. The three main requirements:

1. Physicians must provide a written summary of treatment options to women prior to performing a biopsy or treatment and note receipt in the patient's chart.
2. The Department of Health Services will update the written summary every three years commencing January 1, 1995.
3. The Medical Board of California will print the brochure and establish a distribution system that is linked to the biennial renewal of physician licenses.

BREAST CANCER TREATMENT OPTIONS ORDER FORM

**Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825**

or

Fax requests to (916) 263-2479.

Physician name _____

Clinic or medical facility _____

Attention _____

Address _____

Telephone _____

Number of bundles _____

Department of Consumer Affairs
Medical Board of California
1426 Howe Avenue
Sacramento, CA 95825-3236

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1-800-MED-BD-CA (1-800-633-2322)

(Non-complaint calls to this number cannot be transferred.)

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ACTION REPORT-JANUARY 1995

The *Action Report* is a quarterly publication of the Medical Board of California. For information or comments about its contents, please contact: Candis Cohen, Editor, (916) 263-2389.

For additional copies of this report, please fax your company name, address, telephone number, and contact person to: Yolanda Gonsolis, Medical Board Support Services Unit, at (916) 263-2479, or mail your request to her at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.

Medical Board of California

1426 Howe Avenue, Suite 54, Sacramento, CA 95825 (916) 263-2389

January 1995

The Medical Board's Diversion Program

Over the years, the Medical Board's Diversion Program has developed a record of accomplishment known and appreciated best by those who have graduated from it. The Program is also known throughout the nation as one of the best for its record of rehabilitation in a peer group setting.

In the past two years the Board established a task force to evaluate and improve the Program. The task force, under the chairmanship of Dr. John Kassabian, reaffirmed the Board's commitment to direct sponsorship of the Program—at the same time making 19 specific recommendations for improvements. The recommendations were adopted by the Board and are being implemented under the oversight of a "Liaison Committee" jointly established by the Board and the California Medical Association.

This supplement, written by Program Director Chet Pelton, is intended to explain the Diversion Program and answer questions about its purpose and operations.

What is the Diversion Program?

The Diversion Program is a program administered by the Medical Board of California to monitor the recovery of physicians who have abused alcohol and/or drugs or who have a mental problem.

Success Rate of Participants

Since the inception of the Diversion Program in 1980 to September 30, 1994, there have been 479 successful participants out of a net total of 695 participants. After considering the physicians who were terminated for reasons unrelated to the disease, this results in a 78 percent success rate for physician participation.

To successfully graduate from the Diversion Program, a participant must be alcohol and drug free for a minimum of two years and have demonstrated a life style that supports sobriety. The decision to graduate a participant successfully rests solely on the Diversion Evaluation Committee (DEC) members.

Of the 479 successful participants, 31 participants (7 percent) have reentered the Diversion Program. Please note—this may not identify all participants who relapse.

The success rate of graduates with mental illness problems is about 60 percent. This number is not as

meaningful because the number of participants is small and the mental illnesses differ, based on each case.

Protection of the Public

In the course of rehabilitating the physician, the Diversion Program can take numerous actions to protect the public. If these actions were taken as part of the enforcement process, they would be perceived as disciplinary. For example, during 1993-94 fiscal year, four participants surrendered their medical license at the request of Diversion Evaluation Committees. Also, during that period, the Diversion Evaluation Committees requested that two participants have oral clinical exams because committee members had questions about the participants' ability to practice.

In addition, during 1993-94 60 physicians were requested to stop their practice of medicine. Forty-one of these times, the physicians were requested to stop practice because they entered a treatment program. In addition, another 25 physicians had their practice restricted in some way.

These actions were taken immediately, at the request of the Program Manager of the DEC. The Diversion Program does not have to wait for a lengthy hearing process to take a physician participant out of practice or restrict a participant's practice.

MISSION STATEMENT OF THE MEDICAL BOARD OF CALIFORNIA

The mission of the Medical Board of California is to protect consumers through proper licensing of physicians and surgeons and certain allied health professions and through the vigorous, objective enforcement of the Medical Practice Act.

Testing Urine Samples

The costs of the testing of the urine samples by the laboratory is \$28 per test. The collection of the sample costs an additional \$13-50. The fee for the testing also includes a confirmation screen for all tests. The participant pays the collector at the time the urine is collected.

One urine sample is randomly collected at the group meeting and one sample is randomly collected outside of the group meeting. A minimum of two urine samples are collected per month. More frequent samples are collected when there is a question of use.

The testing by MetWest/UNILAB includes 22 screens per test, over 95 percent of the drugs commonly used by the participants. Some of the screens actually include many subcategories of different drugs. For example, a screen for benzodiazapines would also detect variations of different types of benzodiazapines. When a participant is suspected of using other drugs not included in the screens, a specific test can be requested.

Diverting Physicians

The Deputy Chief of the Enforcement Program has the ultimate responsibility to determine if a physician should enter the Diversion Program in instances where a complaint has been filed. When a physician requests entry to the Diversion Program, staff must first verify if a complaint has been filed against the physician. If there is a complaint, staff must request approval from the Deputy Chief for the physician to enter the program. The Deputy Chief has three options: 1) deny the physician's request; 2) approve the physician to enter the program; or 3) approve the physician to enter the program on an informal basis but continue pursuing the complaint, which may lead to formal disciplinary action.

If the physician's request is approved informally, the physician becomes a participant in the program pending formal approval from the Deputy Chief at a later date. The physician is notified that he/she may participate in the Diversion Program on an informal basis, and may be approved for formal entry at a later date. The informal approval is used to monitor the physician while an investigation is being conducted.

Approximately 64 percent of the physicians who participate in the Diversion Program are self-referred and do not have a complaint against them. These physicians request entry to the program at the urging of a hospital, colleague, or family member. The self-referrals have had a positive influence attracting other physicians because they are willing to seek

assistance much earlier than if they had waited until a complaint was filed against them.

Self-referrals receive the same level of monitoring as physicians who have been referred by the Medical Board.

Monitoring Participants

Participants are more closely monitored while in the Diversion Program than physicians who are placed on probation. A participant is usually seen twice a week by the group facilitator; observed by other peers two or three times per week at AA meetings; assigned a work site monitor; and required to submit to at least two urine samples per month. The participant is also observed by the case manager every one to two months. Case managers confront the participant whenever unusual incidents or behavior is reported by group facilitators, work site or hospital monitors, or urine collection monitors.

Monitoring issues are also identified through a review of monthly

operational reports generated by a computerized Diversion Participant Tracking System. The system identifies when participants are not submitting to urine samples or fail to attend group meetings. The system also identifies the case manager when he/she fails to follow up on incidents with participants.

Risks of Allowing Participants to Practice

When physicians are accepted into the Diversion Program, they are evaluated by DEC members to determine if they are competent to practice without risking the health and safety of patients. If it is determined that they cannot practice, participants are advised immediately of the decision. The DEC also decides when participant-physicians are ready to resume the practice of medicine.

Current Active Participants by Specialty

Administrative Medicine	0
Anesthesiology	31
Cardiology	3
Dermatology	2
Ear, Nose and Throat	1
Emergency Medicine	16
Family Practice	26
General Practice	12
Internal Medicine	33
Neurology	4
Obstetrics/Gynecology	19
Ophthalmology	3
Orthopedics	4
Other	12
Pathology	0
Pediatrics	12
Plastic Surgery	4
Psychiatry	14
Radiology	5
Surgery	3
Thoracic Surgery	0
Urology	2

Total **206**

9/30/94

Participants are monitored in group meetings by the facilitators and in their practice by work site monitors. When competency concerns arise, a participant is told by the Diversion Program to stop practicing medicine.

Participants who do not comply with the terms of their Diversion Agreement are terminated from the program. This decision is made by the Diversion Evaluating Committee. The Chief of Enforcement is immediately notified of the termination of Board-referred participants and forwarded the Diversion records documenting the termination.

The names of participants who have been ordered into the Diversion Program as part of a disciplinary action are

Drugs of Choice	
Alcohol	103
Amphetamines	8
Cocaine	43
Demerol	26
Fentanyl	18
Marijuana	24
Narcotics (other than Demerol, Fentanyl and Vicodin)	63
Other	58
Vicodin	27
Total participants	206
(Most participants are poly-drug abusers.)	
9/30/94	

public record. The statutes establishing the Diversion Program require the confidentiality of all other participants who enter the program voluntarily.

Diversion Evaluation Committees

There are five DEC's throughout the state. The committees are used for physicians with alcohol, drug abuse, and mental illness problems. Each committee

consists of three physicians and two public members. Each of the committee members have expertise in the areas of alcohol or other drug abuse, or mental illness.

Each Diversion Committee meets four times a year. The meetings are held to assess physicians for entry to the program, to determine if a participant is ready to graduate from the program, and to deal with participants who are not complying with their Diversion Agreement. DEC members are also available to provide consultation and advice to participants for various recovery issues.

Diversion Agreements

Each physician signs a Diversion Agreement that contains the specific provisions that the physician must follow while in the program. The agreement is tailored to each physician. However, in general, most physicians enter

inpatient treatment programs, attend two diversion group meetings and three AA meetings each week, submit to random urine tests twice a month, have hospital and work site monitors, agree not to practice medicine when requested, and agree to remain in the program for five years.

Group Facilitators

There are 11 group facilitators throughout the state for diversion participants of the Board. Five of the 11 facilitators have been with the Diversion Program since its inception in 1980. Four other facilitators have been with the program for more than three years.

Facilitators are recruited by forwarding vacancy notices to all therapists in the city of the group meetings. The selection process requires that the facilitators submit resumes which are reviewed by staff to determine if they meet the specifications of the position.

The facilitator is responsible for groups that may range from between six and 12 participants. When a group increases to more than 12 participants, the group is divided into two groups, but is facilitated by the same facilitator.

The number of groups each facilitator manages varies. In the smaller areas, a facilitator has only one group and this is a part-time job. In Los Angeles, the facilitator has 10 groups and it is a full-time job.

Facilitators are paid directly by the participants. Each participant pays the facilitator \$235 per month for two meetings per week or \$165 per month for one meeting per week. The cost per meeting is lower than the average fee that is charged by the majority of private therapists for group meetings.

Case Managers

The role of the case manager is to ensure that the 45 to 55 participants who are assigned to their workload comply with the provisions of their Diversion Agreements and are solidly in the recovery process. The case manager is responsible for resolving participant problems for noncompliance or poor recovery.

Current Active Participants by Problem

Alcohol Abuse	42
Alcohol and Other Drug Abuse	81
Mental Illness	4
Mental Illness and Substance Abuse	2
Other Drug Abuse	77
Physical Illness	0
Total:	206

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Mental Illness Diagnosis

Each physician who has been identified as having a problem related to mental illness is evaluated and diagnosed by a private psychiatrist prior to entering the Diversion Program.

Physician-applicants are allowed to select their own psychiatrist for the evaluation, with the Diversion Program's approval. However, the psychiatrist is requested by the Diversion Program to include specific information in the evaluation that is relative to assessing the physician for participation in the program. DEC members often recommend additional evaluations.

Sexual Misconduct

Since the beginning of 1992, physicians with sexual misconduct problems have not been accepted into the Diversion Program.

Funding

The costs associated with the administration of the Diversion Program were approximately \$739,400 in the 1993-94 fiscal year. Administrative costs are funded by the initial and renewal license fees collected from physicians.

The participants in the Diversion Program pay the facilitator \$235 per month to attend Diversion group meetings. Approximately \$83 per month is paid by the participant for urine testing. Inpatient treatment programs cost the participant approximately \$4,800-\$12,000 for 30 days of hospitalization. Treatment resources are found for physicians who truly cannot pay.

Alcoholism, Drug Addiction-Physician Status

Physicians are as susceptible to alcohol addiction as the general population and may be more vulnerable to drug addiction because of access and familiarity with addictive, mood altering drugs. The drugs most frequently abused by physicians seem to be proportionate to the availability and familiarity of a particular drug in a treatment or social setting. Like the general population, the most frequently abused drug of physicians is alcohol.

Because the populations of those abusing alcohol and other drugs often overlap and because of the illegality of drug abuse, it is difficult to derive an estimate for alcohol and

drug abuse. However, many believe the total percentage of persons who may abuse alcohol or drugs during their lifetime exceeds 15 percent. Additionally, those with expertise in the field who work with health care professionals estimate the lifetime risk for developing a problem of abuse among health professionals may be as high as 18 percent.

Estimates of prevalence are often misinterpreted to indicate that all of the abusing population is addicted and need treatment at the same point in time. Therefore, it is

important to note that although the lifetime risk for abusers may be 15-18 percent, the percentage of those who are addicted and need treatment at any given time is closer to 1-2 percent of the population.

Physician Substance Abuse Persists

To assess what has been accomplished in California to address the problem among physicians, we can examine the number of physicians in California who have been identified since 1980 for addiction problems and those who are currently being treated. About 1,300 physicians have contacted the

Diversion Program since 1980. An informal study in 1990 leads us to believe that there are at least another 1,300 physicians who have sought recovery outside the Diversion Program. Therefore, there probably are at least 2,600 physicians who have received treatment or been identified since 1980 out of the estimated 13,600 (18 percent of 76,000 licensed physicians practicing in California) who may abuse alcohol or drugs during their lifetime.

There are an estimated 500 physicians in California who are in treatment at this time (206 active Diversion participants, 44 Diversion participants awaiting approval and 250 outside the Diversion Program). If one assumes about 2 percent (or 1,560) of the licensed physician population practicing in California needs to be in treatment at any one particular time, we are making notable efforts to address the problem.

Protecting the Public and Saving Costs

Sixty-four percent of the physicians currently in the program entered Diversion prior to a complaint about them being made to the Medical Board, and prior to the physician violating any laws or professional codes. This means that the physician is being monitored and seeking treatment one

Summary of Participants Since 1980

Successful Participants	479
Terminations From Program*	154
Other**	62
Total	695

*Of the 154 participants terminated from the program, 143 were terminated for noncompliance or voluntarily withdrew, and 11 died of substance abuse-related causes.

**The other 62 were terminated for the following reasons unrelated to program success. 36 moved out of state, 11 died, 2 put on probation, 3 licenses revoked, 8 surrendered licenses, and 2 other miscellaneous reasons.

to two years earlier than if he/she had waited until a complaint was filed, the complaint was investigated, an accusation was filed and a disciplinary hearing was held.

This group of self-referred physicians saves the Medical Board up to \$20,000 for each physician because the Medical Board does not have to pay for investigative costs, Attorney General costs and the costs of a hearing officer.

The Diversion Program also provides greater public protection when a physician who is the subject of a complaint enters the Diversion Program prior to or while the complaint is being investigated because the physician is

being monitored and treated during the investigative process. Frequently, during this time the physician is temporarily taken out of practice by the Diversion Program.

Dealing With An Alcohol or Drug Problem?

Current law does not require a physician to report another physician suspected of drug abuse. However, "The CMA along with the American Medical Association recognizes that such impairment among physicians is an important issue and should be addressed by organized medicine.When the physician is unable to make a rational assessment of his own ability to function professionally, it

What are the Warning Signs of a Physician with an Alcohol or Drug Problem?

Physicians who are substance abusers do well at hiding the problem and colleagues often don't recognize the signs as indicators of substance abuse. Some of the signs that frequently come with self-abuse are:

I. Personal

- Deteriorating personal hygiene and dressing habits
- Multiple physical complaints
- Frequent E.R. visits
- Frequent accidents and hospitalizations
- Personality and behavioral changes
- Inappropriate tremulousness and/or sweating
- Many prescriptions for self and family
- Emotional crises
- Irritable and short-tempered behavior

II. Home and family

- Behavior excused by family and friends
- Drinking activities are a priority
- Fights, arguments, violent outbursts
- Sexual problems: impotence, extramarital affairs
- Withdrawal from family and fragmentation of family
- Children neglected: abnormal, illegal, antisocial actions of children, including alcohol and drug abuse
- Financial crises
- Separation or divorce
- Unexplained absences from home

III. Friends and community

- Personal isolation
- Embarrassing behavior
- Drunk driving arrest(s)
- Legal problems
- Neglect of social commitments
- Unpredictable behavior, such as inappropriate spending

IV. Office

- Workaholic
- Disorganized schedule
- Unreasonable behavior
- Inaccessibility to patients and staff
- Frequent office absences
- Decreased workload and tolerance
- Excessive drug use—prescriptions and supply
- Excessive ordering of drug supplies
- Frequent complaints by patients to staff regarding doctor's behavior—altercations with patients
- Prolonged lunch breaks
- Alcohol on breath

V. Hospital

- Often late, absent or ill
- Decreased work/chart performance
- Inappropriate ordering
- Unavailable for verbal orders at night
- Slurred or incoherent over phone
- Subject of hospital gossip
- Unavailable for discussions
- Heavy drinking at staff functions
- Altercations with hospital personnel
- Appears at rounds at inappropriate times
- Negative patient feedback

VI. Other professional problems

- Frequent job changes or relocation
- Unusual medical history
- Vague letters of reference
- Inappropriate qualifications
- Deteriorating relationship to patients and staff (hospital and office), deteriorating professional performance, increasing malpractice incidents

becomes essentially the responsibility of colleagues to make that assessment for him, and to advise him whether he should obtain treatment and curtail or suspend his practice."

Some of the options to carry out this task are:

- 1. If the suspected physician has hospital privileges, a colleague can inform the well-being committee of the hospital.** Each hospital is required by regulation to have a well-being committee to assist physicians who are impaired. This committee's function is to assist physicians in a rehabilitative way and to provide encouragement for them to seek help. Many well-being committees refer physicians to the Diversion Program for monitoring of their recovery. The diversion case managers maintain contact with the monitor or the well-being committee member to let him/her know how the participant is progressing in the program. The Diversion Program can be a strong aid to the hospital because it relieves most of its duties of monitoring the physician and it demonstrates that the hospital has taken a major step to protect patients.
- 2. Make a complaint to the Medical Board.** The complaint can be made by requesting a complaint form by calling (800) MED BD CA. The complaint can be made by identifying yourself or anonymously. The Medical Board will investigate the case and proceed with disciplinary action if there is enough evidence of a violation of the Business and Professions Code.
- 3. Call the Diversion Program at (916) 263-2600.** By this method a complaint with the Medical Board is not filed. However the Diversion Program staff can contact the physician and attempt to get him/her to attend Diversion Group meetings. The caller can be informed of the results after one month so that he/she can make a decision whether to proceed with a complaint to the Medical Board.
- 4. Confront the physician about your observations.** This may be very difficult for most colleagues and medical staff. Because a major aspect of the disease is denial, you should be prepared for the physician to have a good explanation for the problem you have observed or the reason for his/her use. However, if this is attempted, you should have suggested resources available in case the person does indicate he/she is willing to accept help. You may want to talk to a staff person in the Diversion Program about some approaches you may use and resources that are available in your area. Conversations with staff of the Diversion Program are confidential.
- 5. Call the CMA Hotline at (415) 756-7787 in Northern**

California or (213) 383-2691 in Southern California. You will be connected with a network of local physicians who are experienced with chemically dependent health professionals or who are recovering. These local networks are confidential and independent from the Medical Board or the CMA.

Current Active Participants by Gender

Male Participants	186
Female Participants	20
Total	206

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In encouraging a physician to select an option, you should keep in mind the need for a long-term monitoring program. The experience of the Diversion Program is that the best recovery is developed over several years. The problem is not successfully dealt with in 30 days. Over 57 percent of the physicians in the Diversion Program have been in a treatment program at least once previously and about 30 percent will relapse in their first year of the program.

Hospitals that take disciplinary action as a result of self-abuse of alcohol or drugs and suspend a physician's hospital privileges for more than 30 days must report the situation to the Medical Board as part of an 805 report. If the incident does not result in a disciplinary action and self-abuse is suspected, hospitals are encouraged to inform the physician about the Diversion Program for an evaluation by the Diversion Evaluation Committee.

How Someone Enters the Diversion Program

A physician may enter the Diversion Program by calling the Sacramento office at (916) 263-2600. The physician will immediately be referred to a local diversion group in his/her area. The physician will soon be scheduled to be evaluated by the Diversion Evaluation Committee. Hospitals or colleagues who request a physician to enter diversion may get verification that they have done so by having the physician give the Diversion Program permission to inform the hospital or colleague of the call.

Confidentiality of the Program

Information about a physician's participation in the Diversion Program is confidential. All physicians who enter the program without a complaint filed against them are not known to the Enforcement Division of the Medical Board. However, if a participant is unsuccessfully terminated from the program and the Diversion Evaluation Committee determines that the physician is a danger to practice medicine, the physician's name will be provided to the Enforcement Division of the Board for appropriate action.

One Physician's Recovery From Drug Addiction

by
Raymond B. Kropp, M.D.

I had always achieved my goals that were set before me. It was sort of an unspoken contract that I had unknowingly established with my parents during my childhood, and carried with me into my adult life. Equally important, but also unspoken, was my need to look good, to be independent and to (apparently) be in control of all life situations with which I was directly, or indirectly, involved. This facade is probably consistent with the layperson's view of the physician. The personal reality for me, however, was that this behavior laid the foundation for my life, and directly contributed to my alcohol abuse and drug addiction.

I am a recovering drug addict, being "clean and sober" for more than eight years now. I am also a board-certified anesthesiologist and practice both at California Pacific Medical Center and the San Francisco SurgiCenter, the latter of which I am the medical director. It was not always this way.

Eight years ago I had just completed a second drug treatment program, had been out of work for seven months, had learned that my hospital was about to send an "805" to the Board of Medical Quality Assurance (now Medical Board of California), was about to be formally suspended from the hospital for at least two months, and was running out of cash reserves. All of this was the inevitable consequence for me of alcohol/drug addiction.

How I arrived at this point in my life might appear to be very complex, but in reality, it was quite simple. I lost the integrity and spirituality of childhood as a consequence of surviving in a world that appeared not to need these characteristics, indeed even to scorn them. I learned that achievement is what "really" counted, and that truthfully, the end did justify the means. I saw this in my family, in my friends, in school, in my father's business, and in medicine. I saw it all around me and I came to believe it.

I grew up in a household that was quite different than it appeared to the outside world. To this day, my childhood friends cannot understand my feelings of loneliness and emptiness that I recall from that time in my life. It was then that I learned to protect myself from those feelings by "pushing them away" or "numbing out." I discovered later, at the age of 14, that I could do this easier with alcohol.

Once I found that I could escape through alcohol, it was only a matter of time for my other addictions to be uncovered. One of those addictions developed quite subtly, because it was based on a desirable human need to be successful. With me, however, this need became an obsession to achieve new goals, and the behavior allowed me to "numb out" those unwanted feelings, just as surely as alcohol could. "Workaholism" fit perfectly in my life.

This obsession also had its benefits. It afforded me admission to the best undergraduate school, medical school, internship and residencies. In spite of all of this success, I began to have an uneasy, disquieting feeling inside. I continued to achieve a

handsomely paying position as a staff anesthesiologist at a prestigious hospital in San Francisco; I had an attractive wife, two beautiful sons and a gorgeous home in Marin County. And yet, something felt bad. I started to become weary of striving for new successes, and without the distractions of the obsessions, the same feeling that I tried to leave behind as a child and young adult, began to reappear.

I suppose I would have turned to alcohol at this time in my life, but I could not allow myself to be mentally dulled during the work week. So, I looked for another drug that would allow me to feel better, but not affect how I functioned. I

found dexadrine. For years I used the oral amphetamines to supplant the compulsive work routine and weekend alcohol binges. Eventually, even these drugs became less effective in preventing the return of those unwanted feelings.

In the end, the harder I tried to push away the emptiness in my soul, the stronger the feelings would reappear. My last attempt to abate those empty feelings was intravenous narcotics. It took only three and one half months until I was beaten. Lying in the intensive care unit of my own hospital with sepsis and subsequent respiratory and hepatorenal failure, I could not physically continue my self-destructive ways.

I spent six weeks in the hospital and then entered an outpatient recovery program. In spite of the program and the near-miss with death, I relapsed. All of my negative experiences of the past did not matter: I wasn't ready to change. I wasn't ready to do the thing that in the end would save me from myself. And that, to me, is the crux of recovery: to become aware that the way I had approached life needed to change, and that I needed to trust in someone or something other than myself to show me how I could enable this change within my own framework.

I subsequently entered a second recovery program, and this time became willing to change my old patterns. I started going to Alcoholics Anonymous and Narcotics Anonymous meetings more frequently, and actually looked forward to the fellowship that they offered. I saw trust and intimacy in those people, and it felt good. At this same time, my hospital suggested that I enroll in the diversion program. I wasn't thrilled with the prospect, but my other choice was less exciting—to permanently lose my staff privileges.



Raymond B. Kropp, M.D.

I entered diversion with the thought that it would basically be a weekly monitoring program for the State of California. As it turned out, it was much more than that. Indeed, random urines were obtained, and more importantly, individuals were frequently assessed clinically for compliance.

But of greater significance to me as a recovering health care professional has been that the diversion meetings offered a "12-step" forum for personal topics to be presented, that would otherwise be inappropriate in regular Alcoholics Anonymous or Narcotics Anonymous meetings. It has been a safe place to practice a recovery program oriented to the day-to-day adversities of a medical practice. Besides being a touchstone for emotional and personal issues related to the practice of medicine, it also has been a vehicle by which I have obtained personal advice that otherwise might not have been available to me.

My suspension terminated in November 1986 (about one year after I had been hospitalized so seriously ill) with the formation of a Physician's Well-Being Committee at Children's Hospital

and the signing of a "re-entry" contract. All of this was greatly facilitated by representatives from both the California Medical Association and the diversion program.

The day after I returned to work, I spoke at the weekly operating room staff meeting, told the nurses what had actually happened to me, what I expected from them (as it related to my recovery program) and asked them what they thought they expected from me. This set a tone of openness and honesty, that helped allay suspicion and foster trust.

Presently, my life is working better for me than it ever has— only because I chose to change my old, self-destructive patterns. That change is the recovery offered by the 12-steps of Alcoholics Anonymous, to which I am grateful. I also feel as much gratitude toward the enlightened people in the health care field who understand the efficacy of facilitating the impaired physician in returning to his profession.

This is a reprint of an article that appeared in the September/October 1989 issue of *California Hospitals*.

Frequent Questions

What is the Diversion Program?

It is a Program administered by the Medical Board of California (MBC) to monitor the recovery of physicians who have abused alcohol or drugs or who have a mental problem.

Who is eligible for the Diversion Program?

Any licensed physician who has an alcohol, drug, or mental problem, and who is approved to enter the Program by a Diversion Evaluation Committee, is eligible for the Diversion Program.

Will a physician's license be affected if he/she is in the Diversion Program?

A physician's license is not affected as a result of being in the Program.

Are some physicians required by MBC to be in Diversion?

About 36 percent of the Diversion participants are required to be in the Program as a result of a complaint or an accusation filed against them for alcohol and/or drug abuse, or a mental problem. Sixty-four percent of the participants have been referred by hospital staff, colleagues, or themselves.

Will the MBC know if a physician is in the program?

The Board does not know a physician is in the Diversion Program if no complaint has been filed. However, if a physician unsuccessfully completes the Program and is determined to be unsafe to practice medicine, the Board will be notified of that physician's unsuccessful completion of the Program.

How does a physician apply to the Diversion Program?

The process is started by the physician calling the Diversion Office in Sacramento at (916) 263-2600. The physician is requested to immediately begin attending local physician group meetings. An intake interview and a meeting with the next Diversion Evaluation Committee is then scheduled.

**Diversion Program
Medical Board of California
1420 Howe Avenue, Suite 14
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(916) 263-2600