

Action Report

Medical Board of California

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Medical Board of California Meetings 2002

Jan. 31-Feb. 2	Los Angeles
May 9-11	Orange County
Aug. 1-3	San Francisco
Date TBD	San Diego

All meetings are open
to the public.

Online Licensing Services Now Available

The Medical Board of California is pleased to announce the availability of some licensing services through the Internet. Based on the high level of interest that has been expressed over the years, the Medical Board has long sought to move more of its services to an online environment. With the advancement of California's e-government initiative, the Medical Board applied for and was given approval from the Governor's Office to be added to the State's online licensing program.

Beginning this month, physicians will be able to renew their license online through the Board's Web site (www.medbd.ca.gov) while paying by credit card. Additionally, services will be available to licensees who wish to use this online

service to update their address and to submit the processing fee when requesting a duplicate license. Also, first-time applicants will be able to complete a basic application along with submission of the payment of the initial application processing fees. At this time, these latter services will continue to require the submission of paper documents to supplement the electronic transaction.

Currently, physicians with active or inactive licenses are eligible to renew online if their license is current with no holds or restrictions, they have fulfilled the continuing medical education requirements, and the expiration date is within three months or is delinquent by less than 90 days.

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Legislative Update

The following legislation, which impacts physicians licensed in California, has been chaptered into law and took effect on January 1, 2002 (bills with an urgency clause take effect upon enactment). For additional information on all of these bills, please visit the Web site maintained by the Legislative Counsel of California at www.leginfo.ca.gov (click on "Bill Information").

General Medicine, Health Facilities, and Office Practices

AB 258 (LaSuer, Chapter 841) This bill deletes gamma-hydroxybutyrate or gamma-hydroxybutyric acid (GHB) from Schedule II and reclassifies it as a Schedule I controlled substance, unless the GHB is contained in a drug product approved by federal law thereby classifying it as a Schedule III controlled substance.

AB 1311 (Goldberg, Chapter 325) This bill requires a healthcare provider to provide a patient or former patient or the patient's representative a copy, at no charge, of the relevant portion of the patient's records upon presenting to the provider

proof that the records are needed to support an appeal regarding eligibility for a public benefit program.

AB 1444 (Maddox, Chapter 628) This bill subjects additional nutritional professionals to certain provisions governing registered dietitians. It creates an exception to the written prescription requirement where a referring physician and surgeon has established or approved a written protocol governing the patient's treatment. The bill authorizes registered dietitians and other nutritional professionals who are not specified licensed healthcare providers to order, when

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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.

President's Report

Sunset Review is a process undertaken by our Legislature every four years to scrutinize the activities of state regulatory agencies. The Medical Board is currently undergoing this analysis, which is conducted by a joint legislative committee. The first step consisted of approximately six hours of committee questioning and responsive testimony by Board representatives and other interested parties in December. I support the concept and view it as an opportunity for constructive interchange regarding regulation in the dynamic and complex healthcare delivery environment. It's a kind of risk-benefit assessment, and is especially useful to evaluate outcomes of policies and processes instituted by the Board subsequent to the previous Sunset Review.

Examples of questions posed by the committee and the Board's answers were: "When was the last license fee increase, and does the Board see a current need for one?" Answer: "1993 and no." "Is the Board concerned with and how do you account for the decline in disciplinary numbers over the past year as compared to previous ones?" Answer: "The Board has no disciplinary quotas; it responds to complaints. It remains vigilant as to license impropriety, and at present we see no evidence of large numbers of such events going unaddressed. A spate of unlicensed activity has occurred recently, and this is being vigorously pursued, with measurable success. The concurrent number of malpractice claims does not lead to a conclusion that disciplinary cases are being missed. A low number of disciplinary actions might actually reflect an appropriate disciplinary posture in a high-quality practice environment. Conversely, a high number of license actions would definitely indicate a problem, either that of a low medical quality or of an over-disciplinary environment."

Constructive critical review is useful for many reasons, not the least of which is the focus it may bring to specific issues, particularly if policies have existed long enough to allow outcome measures or trends to become apparent. Let us briefly apply this method to perhaps the two most impacting legislative acts dealing with healthcare delivery in California over the past quarter century, a 25-year "Sunset Review" of the Knox-Keene Act, and MICRA.

First, MICRA, the Medical Insurance Compensation Reform Act of 1975. The law was enacted in the wake of a malpractice premium escalation crisis that threatened to dramatically alter physician practice patterns and demographics. Passage required bold action on the



Bernard S. Alpert, M.D.
President of the Board

protagonists' part. A 25-year review demonstrates reasonable stability in the premiums that precipitated the crisis, and a lack of evidence of individuals' access to procedural or remunerative rights being significantly abridged, and certainly not to crisis proportions.

A comparison to the MICRA review is readily available. A concurrent malpractice premium crisis existed in Eastern Pennsylvania in the mid-70s, and the legislative response was the creation of a two-component system for malpractice award remedies, consisting of the liability carriers as well as a separate trust fund into which physicians paid in addition to their carrier premiums. Twenty-five years later

the trust fund is insolvent, and 1,000 physicians in the region are facing 2002 without liability insurance. It is estimated that for 2001, the malpractice award payments in the city of Philadelphia will exceed the total amount for the entire state of California. Premium increases will average 25%, with some up to 400%. An 18-person orthopedic surgical group will cease doing surgery altogether and limit activity to office practice.

Similar effects are apparent in other states. It is estimated that in 2002 West Virginia will have zero neurosurgeons in clinical practice, the exodus due to fiscal pressures. The insalubrious impact of all of the above on the healthcare of citizens in these regions is obvious. Policies have consequences, and the comparative review is stark in its contrast in effects on practice patterns and demographics, and, ultimately, and most important, on the consumer's access to healthcare.

The Knox-Keene Act of 1975 represented a sea-change in the prescription for a template for healthcare delivery in California. To no surprise, economics, this time exigencies in health insurance premiums, were the driver for the legislation. A 25-year "Sunset Review" is provocative if not head-spinning. The architectural ambiguity of the 250-plus page document is apparent in the first 20 pages, in which the following two mutually exclusive concepts are proffered. First, a fundamental tenet is expressed that for a healthcare delivery system to assure the highest quality of care, medical decision-making must be removed from the financial aspects of that care (so as to remove financial incentives from the mix). It is then expressed elsewhere that the Legislature intends on "helping to ensure the best possible healthcare for the public at the lowest possible cost by transferring the financial risk of healthcare from patients

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Four New Members Appointed to the Medical Board

Governor Gray Davis has appointed four new members to the Medical Board—one to the Division of Licensing and three to the Division of Medical Quality.

Division of Licensing

Richard D. Fantozzi, M.D.

Dr. Fantozzi is an otolaryngologist, a member of the American Academy of Facial Plastic and Reconstructive Surgery, and is a fellow of the American Academy of Otolaryngology and Head and Neck Surgery, and the American College of Surgeons. He is an active fellow in the American Triologic Society. He served on the Scripps Clinic Respiratory Care Committee, Managed Care Utilization Review Committee, and serves on the Clinic's Head and Neck Tumor Board. He was a co-director for Scripps Clinic Division of Head and Neck Surgery and Otolaryngology.

Dr. Fantozzi earned his medical doctorate degree from the University of Illinois College of Medicine.



Dr. Fantozzi

Division of Medical Quality

Arthur E. Lyons, M.D.



Dr. Lyons

Dr. Lyons practices neurological surgery in San Francisco. He also is an Associate Clinical Professor at the University of California, San Francisco School of Medicine. He belongs to several professional societies, including the Congress of Neurological Surgeons, the American Association of Neurological Surgeons, and the California Academy of Medicine. He serves as a delegate for the California Medical Association. He was President of both the San Francisco Medical Society and the San Francisco Neurological Society. From 1960 to 1962 he served as a lieutenant commander in the U.S. Navy Medical Corps, Department of Neurosurgery, U.S. Naval Hospital, Philadelphia.

Dr. Lyons earned a bachelor of arts degree from Columbia University and a medical doctorate degree from Vanderbilt University.

Ronald L. Morton, M.D.

Dr. Morton is an ophthalmologist on the faculty of the University of California, Los Angeles. Since 1979, he has been President of the Central Valley Chapter of Surgical Eye Expeditions, an organization that provides free eye care and surgeries to disadvantaged persons worldwide. He also has served on the Kern Eye Bank Board of Directors, is secretary of the California Academy of Ophthalmology Board of Directors, and the Kern County Medical Society. He is active in the California Medical Association, where he served on the Board of Trustees.

Dr. Morton earned a bachelor of science and medical doctorate degrees from the University of California, Los Angeles.



Dr. Morton

Steven B. Rubins, M.D.



Dr. Rubins

Dr. Rubins has over 30 years of medical experience in private practice specializing in internal medicine/cardiology. He is an Assistant Clinical Professor at the UCLA School of Medicine as well as an attending physician in medicine and cardiology at Cedars Sinai Medical Center. He has served as Chairman of the American Heart Association, Western Division.

Dr. Rubins earned a medical doctorate degree from Hahnemann Medical School.

No. 1 Question Asked by Licensees on Medical Board's Division of Licensing Information Line: *'Why haven't I received my renewed license?'*

Routinely, the Board is contacted and asked why a renewed license has not been received, why a physician's license has not been updated, and/or why language on the public record indicates the physician's financial statement or continuing medical education (CME) is inadequate.

These contacts come from a variety of sources, including physicians, medical office staff, credentialing agencies, health insurance companies and the public.

This is most frequently the result of the omission of a signature that is required as part of the renewal-application process, and may result in the public being uncertain about the status of a physician's license.

Most often overlooked is the physician's signature certifying that he or she has met the CME requirements, or whether he or she holds any financial interest in the place of practice.

It is critical that the physician signs both of these statements for the renewal to be processed.

When the signature is missing, the system automatically places a hold on the license and it cannot be updated.

The processing time for a renewal can be delayed by days, and sometimes weeks, if the required information is omitted. These omissions require Board staff to notify the physician by letter that corrections are necessary and that the hold on the license can be released only after the proper information is obtained.

The form below specifically designates each area that must be signed by the physician at the time of renewal. A physician who has already mailed the renewal without a signature may contact the Consumer Information Unit to request a CME or Financial Interest Statement, and then immediately fax or mail a signed statement to the Board.

For additional information concerning the renewal process, please contact the Division of Licensing Information Line at (916) 263-2382.

Example of Form Indicating Where Physicians Should Sign

MEDICAL BOARD OF CALIFORNIA
 PART 3 State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON'S

SSN= _____

F. YES, I WISH TO CONTRIBUTE \$25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM TOGETHER WITH THE LICENSE RENEWAL FEE.

LICENSE NO.	EXPIRES	FEE OWED
		VOLUNTARY - \$25
		TOTAL ENCLOSED - \$

CME CERTIFICATION STATEMENT
 I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE COMPLETED AND CAN DOCUMENT (IF AUDITED) AN AVERAGE OF 25 HOURS OF APPROVED CME EACH CALENDAR YEAR, WITH 100 HOURS OVER THE LAST 4 YEARS OR THAT I HOLD A PERMANENT CME WAIVER FROM THE MEDICAL BOARD OF CALIFORNIA.
 D. SIGNATURE REQUIRED HERE **SIGN HERE** DATE _____

DELINQ. FEE IF POSTMARKED AFTER

\$25
\$

E. FOR ADDRESS CHANGE ONLY
 IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.
 STREET _____
 CITY _____ STATE _____ ZIP _____
 PHONE NUMBER (_____) _____

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 IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST.
 SIGNATURE REQUIRED HERE **SIGN HERE**

Reissuing Previously Dispensed Medications is a Violation of Law

In two recent cases brought to the attention of the Medical Board, physicians were found to be reissuing—in violation of state and federal law—previously dispensed medications. The Board is concerned that this practice may be occurring with greater frequency, placing some patients at risk and the physician in jeopardy of discipline.

In both cases referenced, the physicians improperly dispensed medication to patients that had been previously dispensed and later returned by another patient. The returned medications were kept in the physicians' desk drawers, without security to prevent tampering, and then reissued to other patients.

When reissued, the medications were not properly labeled. In one instance, the label was torn off, and in another instance the previous patient's name was blacked out. In both cases, a proper record was not kept for the medications. The physicians failed to record in their patients' medical files that a drug was dispensed or whether the patient was provided with verbal or written instructions. Although the physicians claimed that the medications were returned from "trusted" patients, their actions violated state and federal law.

The actions described violate numerous codes including the Code of Federal Regulations section 460.300 relating to *Return of Unused Prescription Drugs to Pharmacy Stock*, Business and Professions Code sections 2238, 2242(a), 2266, 4074, 4076, and 4170, and Health and Safety Code section 11154. **Remember:** The legal responsibility for the proper prescribing and dispensing of prescription drugs rests upon the prescribing practitioner.

To highlight the above areas of concern, a relevant excerpt from the Code of Federal Regulations is reprinted below:

460.300 (Compliance Policy Guide 7132.09) A pharmacist should not return drugs products to his stock once they have been out of his possession. It could be a dangerous practice for pharmacists to accept and return to stock the unused portions of prescriptions that are returned by patrons, because he would no longer have any assurance of the strength, quality, purity or identity of the articles.

REMINDER

Please Check Your Profile at the Medical Board Web Site

A Physician's Address of Record is Public Information

Physician profiles have been available to the public on the Medical Board's Web site (www.medbd.ca.gov) since 1997, as required by Government Code section 6252(d); and Civil Code section 1798.61(a).

Each profile includes the physician's address of record. The Medical Board encourages you to check your entire profile for accuracy and advise the Board of any changes or corrections, in particular, changes in your address of record.

You must be able to receive mail at your address of record, whether it be a home, business office, or post office box. If you choose a post office box as your address of record, by law you also must provide a street address. In this case, the street address will remain confidential.

The change of address form can be mailed to you by calling the Board at (916) 263-2382 or downloading it from the Board's Web site.

Please complete and return to:

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

Or fax to: (916) 263-2944.

Physician profiles are updated twice monthly.

TDD Numbers

Medical Board telephone numbers for the hearing-impaired (TDD):

Division of Licensing
(916) 263-2687

Central Complaint Unit
(916) 263-0935

Bioterrorism Recognition and Reporting

Update on New Reporting Requirements and Training Resources

By Sandra Huang, M.D., Medical Epidemiologist, California Department of Health Services
Division of Communicable Disease Control

Clinical Recognition of Bioterrorist Threat Diseases

Healthcare providers should be alert to diagnostic clues and patterns of illness that might indicate an unusual infectious disease associated with intentional release of a biological agent. They should report any unusual diseases or clusters of illness to their local health department. The agents of highest concern, as defined by the Centers for Disease Control and Prevention (CDC) are *Bacillus anthracis* (anthrax), *Yersinia pestis* (plague), *Variola major* (smallpox), *Clostridium botulinum* toxin (botulism), *Francisella tularensis* (tularemia), and the hemorrhagic fever viruses (e.g., Ebola, Lassa, Marburg). In California, brucellosis has been included in this high-priority group.

These agents have the potential to be used as weapons, based on ease of dissemination or transmission, potential for major public health impact (e.g., high mortality), potential for public panic and social disruption, and requirements for public health preparedness such as antibiotic and vaccine stockpiling.

The following summary of the clinical features of these diseases was adapted from the October 19, 2001 edition of the Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report (www.cdc.gov/mmwr) and other resources listed at the end of this article.

Anthrax: Nonspecific prodromal symptoms of **inhalational anthrax** include fever, malaise, headache, myalgias, nonproductive cough, and chest discomfort. Nausea or abdominal pain may be present. Approximately 2-4 days after initial symptoms, sometimes after a brief period of improvement, respiratory failure and hemodynamic collapse ensue. Meningitis and altered mental status may also occur. A widened mediastinum and/or pleural effusion may be seen on chest radiograph. Gram-positive bacilli may be cultured from blood or cerebrospinal fluid, usually 2-3 days after onset of illness. **Cutaneous anthrax** follows deposition of the organism onto the skin, occurring particularly on exposed areas of the hands, arms, or face. A pruritic macule or papule enlarges and ulcerates after 1-2 days. Small, 1-3 mm satellite vesicles may surround the ulcer. The ulcer develops a painless, depressed, black eschar, usually with surrounding local edema.

Lymphangitis, tender lymphadenopathy, and systemic symptoms of fever, malaise, or headache may also occur.

Plague: Clinical features of pneumonic plague include fever, cough with mucopurulent sputum (gram-negative rods may be seen on gram stain), hemoptysis, and chest pain. A chest radiograph will show evidence of bronchopneumonia.

Botulism: Clinical features include symmetric cranial neuropathies (e.g., drooping eyelids, blurred vision, difficulty swallowing or speaking) followed by symmetric descending weakness and respiratory failure from respiratory muscle paralysis. No sensory deficits are present. Inhalational botulism that may occur from an intentional aerosol release of botulinum toxin would have a similar clinical presentation as foodborne botulism, but the gastrointestinal symptoms that accompany foodborne botulism may be absent.

Smallpox (variola): The acute clinical symptoms of smallpox resemble other acute viral illnesses, such as influenza, beginning with a 2-4 day nonspecific prodrome of fever, malaise, prostration, cough, headache, and backache before onset of a rash. The lesions of the rash begin as small macules, progress to firm papules, then vesicles, which are usually multiloculated and soon become opaque and pustular. The vesicles are typically raised and firm to the touch, and 8 to 9 days after onset of the rash, they become pit-like and dimpled. Varicella (chickenpox) may be differentiated from smallpox by the distribution and evolution of the rash. The rash of varicella is most prominent on the trunk and develops in successive groups of lesions over several days, resulting in lesions in various stages of development and resolution. In comparison, the rash of smallpox is typically most prominent on the face and distal extremities, and lesions on any one part of the body are at the same stage of development.

Inhalational tularemia: Inhalation of *F. tularensis* causes an abrupt onset of an acute, nonspecific febrile illness beginning 3-5 days after exposure, with pleuropneumonitis developing in a substantial proportion of cases during subsequent days.

Hemorrhagic fever (e.g., illness caused by Ebola or Marburg viruses): After an incubation period of usually

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Bioterrorism Recognition

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5-10 days (range: 2-19 days), illness is characterized by abrupt onset of fever, myalgia, and headache. Other signs and symptoms include nausea and vomiting, abdominal pain, diarrhea, chest pain, cough, and pharyngitis. A maculopapular rash, prominent on the trunk, develops in most patients approximately 5 days after onset of illness. Bleeding manifestations, such as petechiae, ecchymoses, and hemorrhages, occur as the disease progresses.

Brucellosis: The insidious onset of irregular fever, chills, malaise, headache, profound fatigue, weakness, and weight loss occurs from 5-60 days after exposure. Musculoskeletal manifestations include arthralgias, sacroiliitis, and paravertebral abscesses. Anorexia, nausea, vomiting, diarrhea, and hepatosplenomegaly may be seen. Cough and pleuritic chest pain may occur. The organism is a tiny, slow-growing, gram-negative coccobacillus that may be isolated in blood or bone marrow culture. Anemia and thrombocytopenia are possible, and chest radiograph findings are variable (bronchopneumonia, abscesses, single or military nodules, enlarged hilar nodes, effusions, or no abnormalities).

Unusual patterns of illness: Clinicians should consider the possibility of an intentional release of a biological agent if they observe: a) multiple patients presenting with the same clinical syndrome, clustered in time and/or geography, especially occurring in otherwise healthy individuals (e.g., several persons who work in the same building who present over two or three days with fever, gram-negative pneumonia, and rapid progression to sepsis); b) an unusual age distribution for common diseases (e.g., many cases of chickenpox-like illness among adults might represent misdiagnosed smallpox); c) an unusual seasonal distribution of illness (e.g., an increase in influenza-like illness in the summer, outside of the usual flu transmission season in the Northern Hemisphere).

New reporting requirements

Emergency amendments to the California Code of Regulations concerning reportable diseases and conditions became effective November 5, 2001. The diseases/conditions/agents that pose the most serious threat for bioterrorism are immediately reportable by healthcare providers and clinical laboratory directors to the local health department.

The diseases/conditions that healthcare providers must report *immediately* (including nights, weekends, and holidays) by telephone to the local health department are suspected or confirmed cases of:

- Anthrax
- Botulism
- Brucellosis
- Smallpox (variola)
- Tularemia
- Varicella deaths
- Viral hemorrhagic fevers
- Occurrence of any unusual disease
- Outbreaks of any disease

Healthcare providers are defined as physicians, surgeons, veterinarians, podiatrists, nurses, nurse practitioners, nurse midwives, school nurses, infection control practitioners, physician assistants, dentists, coroners, and medical examiners. The requirement for laboratories to report these diseases does **not** replace the healthcare provider's legal obligation to report.

More importantly, public health action to find the source and implement preventive treatment should not be delayed until a definitive laboratory diagnosis is reached, which may take several days, depending on the organism. Therefore, healthcare providers should immediately report even **suspected** cases or conditions to their local health department prior to receiving laboratory confirmation. Detailed information about the amended regulations may be found at the California Department of Health Services Web site, www.dhs.ca.gov.

Once notified, the local health department will arrange for specialized laboratory testing; provide a guidelines for treatment, prophylaxis, and infection control; begin a public health investigation; and activate local, state, and federal emergency response systems as appropriate.

A complete list of selected references and resources are posted along with this article on the Board's Web site at: www.medbd.ca.gov.

More Valuable Bioterrorism Updates

Because of public and professional concerns regarding biological terrorism, the Board has added links on its Web site to the California Department of Health Services (DHS) and Centers for Disease Control and Prevention (CDC) Web sites.

This will facilitate ready access to timely information on prevention and response to anthrax and other forms of bioterrorism. Toll-free numbers with recorded non-emergency anthrax-related information are available at the DHS site. Anthrax information and public health emergency preparedness and response are available at the CDC site.

Routinely check these sites as the information provided is updated on a daily basis.

FDA Message to Physicians and Health Practitioners on Medications for Anthrax

Ciprofloxacin Hydrochloride

Cipro (ciprofloxacin hydrochloride) is indicated for inhalational anthrax (post-exposure), to reduce the incidence or progression of disease following exposure to aerosolized *Bacillus anthracis*. Drug administration should begin as soon as possible after suspected or confirmed exposure to aerosolized *Bacillus anthracis* spores.

Cipro (ciprofloxacin hydrochloride) therapy should not be begun in the absence of suspected or confirmed exposure to aerosolized *Bacillus anthracis*. Cipro reduces the risk of severe disease following exposure, but does not prevent exposure to aerosolized *Bacillus anthracis*.

If a person is exposed to *B. anthracis*, the risk of adverse events caused by Cipro (ciprofloxacin hydrochloride) therapy may be acceptable because of the severity of this disease. However, in the absence of exposure, the risk of these side effects may not be acceptable. Possible adverse events and other concerns include:

- CNS effects (dizziness, confusion, tremors, hallucinations, depression, increased risk of seizures)
- Drug Interactions – (Cipro may increase levels of theophylline and caffeine, other vitamin and drug products may reduce availability of Cipro)
- Hypersensitivity
- Pseudomembranous colitis
- Tendonitis/Tendon rupture
- Photosensitivity

Use of an antibiotic inappropriately (for example when exposure has not been confirmed) can lead to the emergence of resistant strains of bacteria. The usefulness of Cipro (ciprofloxacin hydrochloride) as an antibiotic may be lost if widespread use occurs.

The safety and effectiveness of Cipro in patients less than 18 years of age is not established except for use post-exposure in inhalational anthrax. Ciprofloxacin causes arthropathy in juvenile animals.

Fluoroquinolones are not generally recommended during pregnancy because of their known association with arthropathy in adolescent animals and small numbers of children. However, animal studies have not shown evidence of teratogenicity related to exposure to Cipro. While there are no controlled studies of Cipro use in pregnant women to show safety and efficacy, a 1999 review of published data on experiences with Cipro use during pregnancy by TERIS—the Teratogen Information System—concluded that therapeutic doses of Cipro during pregnancy are unlikely to

pose a substantial teratogenic risk, but the data are insufficient to state that there is no risk.¹ In addition, a 1999 consensus statement by the Working Group on Civilian Biodefense recommends that Cipro be used at usual adult doses in pregnant women for therapy and postexposure prophylaxis following anthrax exposure.² For more information, please see www.fda.gov/cder/drug/infopage/cipro/default.htm and the Cipro label.

¹ Friedman JM and Polifka JE. *Teratogenic Effects of Drugs. A Resource for Clinicians (TERIS)*. Baltimore, MD: The Johns Hopkins University Press; 2000:149-150.

² Inglesby TV, et al. Anthrax as a biological weapon: medical and public health management. Working Group on Civilian Biodefense. *JAMA* 1999 May 12;281(18):1735-45. [Erratum in: *JAMA* 2000 Apr 19;283(15):1963]

Doxycycline and Penicillin G Procaine Drug Products

The Food and Drug Administration issued a *Federal Register* notice to clarify that the antibiotics doxycycline and penicillin G procaine are currently approved for use in treating all forms of anthrax infections—cutaneous (skin), inhalational and gastrointestinal.

The notice also includes explicit dosing and other useful information on the use of doxycycline and penicillin G procaine to treat inhalational anthrax (post-exposure) in adults and children. FDA is encouraging companies to update labeling of these products with this previously unspecified information.

FDA developed the dosing information for inhalational anthrax (post-exposure) based on its review of published scientific literature and the separate doxycycline and penicillin G procaine arms of the same rhesus monkey study used to support the August 2000 approval of Cipro (ciprofloxacin) for the same use. The doxycycline and penicillin G arms of the rhesus monkey study showed a survival advantage over placebo.

Doxycycline has been approved for the treatment of anthrax in all its forms. The FDA is providing additional information concerning the dosing regimen for the treatment of anthrax, including cutaneous and inhalational anthrax (post-exposure). The currently recommended dosage regimen of doxycycline for severe disease is 100 mg every 12 hours for adults and 1mg per pound (2.2 mg per kilogram) every 12 hours for children less than 100 pounds.

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Medications for Anthrax

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These dosage regimens are appropriate for use in patients who have been exposed to anthrax (*Bacillus anthracis*) regardless of the route of exposure.

Doxycycline and other members of the tetracycline class of antibiotics are not generally indicated for the treatment of any patients under the age of 8 years because of their negative effects on teeth and bone development. However, FDA believes the benefits of doxycycline for the treatment of inhalational anthrax (post-exposure) outweigh these risks.

The full-text of the *Federal Register* notice is available at: www.fda.gov/OHRMS/DOCKETS/98fr/cd01156.pdf and other health authorities strongly discourage individuals from taking any antibiotic for prevention of anthrax without the specific advice of a physician and a clear indication that exposure may have occurred.

Unnecessary antibiotic use exposes patients to serious risks without any potential benefit. Moreover, the indiscriminate use of antibiotics could speed up the development of drug-resistant organisms and may cause the usefulness of an antibiotic to be lost.

To obtain information from the Centers of Disease Control and Prevention on Public Health Emergency Preparedness and Response go to www.bt.cdc.gov. The following videos can be downloaded with the proper software:

- Response to Bioterrorism: Video 1: Overview and Clinical Aspects of Critical Biological Agents
- Response to Bioterrorism: Video 2: The Laboratory Response Network and Agents of Bioterrorism
- Anthrax: What every clinician should know, CDC, October 18, 2001
- CDC Anthrax update, Interview with Dr. Jeffrey P. Koplan, Director of the Centers of Disease Control and Prevention, October 18, 2001

The October issue of the *Morbidity & Mortality Weekly Report (MMWR)* with Interim Guidelines for Exposure Management and Antimicrobial Therapy is also available at this link.

In addition, a collection of the articles addressing bioterrorism published in *JAMA* and the *Archives Journals* are available free of charge at: <http://pubs.ama-assn.org/bioterr.html>.

Information for Health Professionals: Another Good Web link

Every day, health professionals use or prescribe for their patients a host of products regulated by the Food and Drug Administration (FDA)—everything from prescription medicines to vaccines, blood products, and the most advanced medical and surgical devices.

The FDA Web site has a wealth of resources for health professionals about regulated products and agency policies of interest to the medical community. To get to this site go to www.fda.gov and click on “Information for Health Professionals.” This page provides links to many resources.

- Adverse Reactions/Safety Issues
- Advisory Committees
- Biologics
- Clinical Trials
- Controlled Substances
- Dietary Supplements
- Drugs
- Food Safety
- Health & Human Services
- Interacting with FDA
- International Health
- Medical Devices
- Orphan Products

If you can't find what you're looking for here, try one of the following:

- Search the FDA Web site.
- Check the FDA Web site index.
- Refer to the site map.

If you prefer calling, some important contact numbers are listed below:

MedWatch:

1-800-FDA-1088 (1-800-332-1088)

Vaccine Adverse Event Reporting System:

1-800-822-7967

Advisory Committees: 1-800-741-8138

Biologics: 301-827-2000

Institutional Review Board:

301-594-0020

Drugs: 301-827-4573

**Fraudulent Advertising
of FDA-regulated products:**

301-827-2828 or 1-800-332-1088

Medical Devices: 301-827-3990

Orphan Products: 301-827-3666

New State Data Show Antibiotic Resistance On the Rise in California

Anthrax Antibiotic Abuse Threatens Effectiveness of Antibiotics

The California Medical Association Foundation has initiated a long-term, statewide effort to promote the appropriate use of antibiotics called, Alliance Working for Antibiotic Resistance Education, or AWARE. AWARE is the largest and most diverse partnership of its kind in the country that includes physician organizations, healthcare providers, health systems, health plans, public health agencies, consumer and community based health organizations, federal, state and local government representatives and the pharmaceutical industry. The following is a reprint of a news release that was prepared and recently distributed by AWARE. More information about AWARE can be found by logging on to www.aware.md.

While many people are concerned about anthrax, it is far more likely they are going to be prescribed antibiotics for more common—yet still potentially deadly—infections. These infections, which have been tamed to date by existing antibiotics, are showing increased signs of antibiotic resistance in California—a trend which is likely to be fueled by the current climate of continuing antibiotic abuse.

Recently released figures show that two of the three main classes of antibiotics are already losing their effectiveness in the state.

The data compiled from California Department of Health Services statistics shows the overall level of antibiotic resistance for *Streptococcus pneumoniae*, the most common bacterial cause for illnesses such as meningitis, middle ear infections, and community-acquired pneumonia is increasing in the state. Across the country, *Streptococcus pneumoniae* causes an estimated 700,000 to 1 million middle-ear infections in children a year, 50,000 cases of pneumonia, hundreds of cases of meningitis and blood stream infections, and 4,000 deaths per year.

The three main classifications of antibiotics tested for effectiveness against *Streptococcus pneumoniae* were: penicillins, macrolides, and fluoroquinolones. In California, penicillins show a 30% resistance level, macrolides 22% resistance and fluoroquinolones 1%. This means that for one in three people who receive a penicillin-type antibiotic, it may not work. Depending upon the nature of the infection, the individual may require a stronger antibiotic.

The California Department of Health Services, along with the Alliance Working for Antibiotic Resistance Education (AWARE), a project initiated by the California Medical Association Foundation, compiled the data showing the level of antibiotic resistance for many important medications, including those used against anthrax and many other more common bacteria infections, is on the rise in the state.

“This first of its kind snapshot of California’s resistant diseases shows that we must stop the misuse of antibiotics, so we can continue to have them available when we truly need them,” said State Health Director Diana M. Bontá. “California’s level of resistance to penicillin is of particular concern. The resistance is growing and soon it may no longer be an effective treatment. There are behaviors each of us can and should change to slow the resistance of these diseases and improve public health.”

Penicillin, once considered a ‘wonder drug’ for *Streptococcus pneumoniae*, now has a level of resistance in California of 30%—nearly one-third of all cases. And, one-third of those cases which resist the antibiotic are high resistant. High-level resistance was extremely rare in California just eight years ago. Drug resistance is also appearing in a second class of antibiotics, referred to as macrolide drugs. California has seen the level of resistance with these drugs increase from 18% in 1998 to 22% in 2000—from nearly one out of five cases, to nearly one out of four cases.

“I hope this data finally helps people see that we can no longer take an antibiotic ‘just in case’ and believe there is no harm done if the antibiotics were not truly necessary,” said President and CEO California Medical Association Foundation, Carol Lee. “This new surveillance data confirms our fears. Antibiotic resistance is growing in California, often times the result of our own inappropriate behaviors while using them.”

These behaviors contribute to antibiotic-resistant bacterial infections that are more difficult to treat, and cause more infections which are potentially fatal as well as causing infections which result in longer and costlier hospitalizations. These infections must be treated with stronger antibiotics that may cause more serious side effects.

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Antibiotic Resistance

(continued from page 10)

Current Scares Could Taint Future Use

With the threat of bioterrorism and heightened awareness of anthrax in the news, there is an increased risk of future antibiotic resistance through the inappropriate use of antibiotics, abuse which is jeopardizing a third class of antibiotics.

Resistance to first and second line drugs for respiratory, ear, urinary tract, and some hospital-acquired infections is at critical levels in California. For many of these infections the fluoroquinolone class of antibiotics, including Cipro, are the next and sometimes last line of defense. Resistance to this class of antibiotics, which is beginning to appear in some bacteria, could result in a return to the Dark Ages of antibiotics—the days prior to penicillin.

“Cipro prescriptions were up as high as 20 percent over the last month, but are now at normal levels,” said Jeff Kamil, Senior Vice President at Wellpoint Health Networks, the parent of Blue Cross of CA. “Like other organizations, ours and other health plans are also very concerned about the growing public health threat posed when bacteria become resistant to antibiotics.”

“Misusing or inappropriately using antibiotics not only increases the risk of antibiotic resistance, but it also may cause antibiotics like Cipro to ultimately become ineffective,” said Dr. Joseph Silva, Dean of the U.C. Davis School of Medicine and a member of the AWARE steering committee. “Taking Cipro without a bacterium exposure is not risk-free. It has side effects, some of which can be life threatening, including—allergic reactions, medication interactions, and a serious form of diarrhea. Quite frankly, the likelihood of contracting an antibiotic resistant infection is likely to be much greater than the risk of being exposed to anthrax, in most cases.”

“During these anxious days with the fear of bioterrorism, physicians have the opportunity to be a voice of reason for their patients and express to them what physicians already know, that antibiotics must be used appropriately,” said Frank Stagers, M.D., President of the California Medical Association. “This report reinforces the fact that if we use antibiotics inappropriately by stockpiling or self-medicating, they won’t be available when we actually need them.”

FDA MedWatch Program Update: Managing Risk of Use of Medical Products—The Zyvox Example

MedWatch, the FDA Safety Information and Adverse Event Reporting Program, serves both healthcare professionals and the medical-product-using public and provides timely safety information on the drugs and other medical products regulated by the U.S. Food and Drug Administration.

A good example of how the MedWatch program plays a role in the risk-management process is a labeling change that was placed on the linezolid (Zyvox) package in March 2001. Zyvox is an antibiotic that is especially effective for vancomycin-resistant *Enterococcus faecium*, a serious infection that has been hard to treat.

“Once it was on the market spontaneous reports of suspected serious adverse events came in from a few sources, maybe a half-dozen reports of effects on blood cells—myelosuppression,” said Norman Marks, M.D., medical director of the MedWatch program. “That was enough of a signal for our safety evaluators to go back and contact the reporters, get specific information on the timing of patient exposure to the product and hematological changes.”

The manufacturer, Pharmacia, and the FDA then worked together to change the labeling so that the warning of possible myelosuppression was added.

“This is at least a short term success story in that a product came on the market with a lot of potential efficacy, but these rare adverse events show up only once it was used in a wider population. The problem was found within the first year of marketing and we were able to get the new safety information out to those who need to know it,” said Marks.

Not only was a “Dear Health Professional” letter mailed out by the manufacturer, the traditional method of notification, according to Marks, but the information was available immediately on the MedWatch Web site and broadcast by e-mail to 10,000 individuals and 190 Partner organizations. The risks of use of Zyvox could be balanced against the benefits of this potentially lifesaving drug by the widespread distribution of this type of timely safety information, made available to clinicians and their patients at the point of care.

To see it for yourself, go to www.fda.gov/medwatch, click on “Safety Information”; look for “Safety Alerts for Drugs, Biologics, Devices, and Dietary Supplements” and click on “2001”; go to mid-page, click on “Drugs”; scroll down to “Zyvox” and click. Click on letter pdf format to see the manufacturer’s “Dear Health Care Professional” letter.

Syphilis: Ancient Nemesis

By Robert Settlage, M.D., M.P.H., Deputy Medical Director, County of Los Angeles, STD Program and Giannina Donatoni, Ph.D., M.T., Laboratory Surveillance Coordinator, STD Program

Once thought to be on the path to extinction because of the development of Penicillin, the number of reported syphilis cases has risen and fallen in 10-year cycles over the last half century. Cases dropped to an historic low in 1999, when the Centers for Disease Control and Prevention announced a nationwide effort to eliminate it entirely.

Within months came the sobering recognition that much still needs to be done to render the spirochete *Treponema pallidum* an endangered species. Between 1999 and 2000, primary and secondary cases in California rose 9 percent, the first increase since 1988. By comparison, primary and secondary cases among MSM (men who have sex with men) increased 145 percent statewide during the same period.

So what is the danger? Most MSM with syphilis also have HIV, which increases the likelihood of acquiring and transmitting *both* diseases. And some MSM also have sex with women. And women may become pregnant. Pregnant women with untreated syphilis may infect their unborn children at any stage of their disease. Approximately 25 percent of untreated cases may end in intrauterine death; up to 25 percent more may die in the perinatal period. Undiagnosed disease can also lead to permanent birth defects and syphilitic brain disease that may not become obvious until adolescence.

Over 80 percent of congenital syphilis cases recorded in 2000 can be linked to women who lacked verifiable or adequate treatment during or before their pregnancies. The Western U.S. reported one of the highest rates of congenital disease in the nation. California state law requires that all pregnant women who plan to carry their pregnancies to term have a serologic test for syphilis as soon as possible. In communities where syphilis is more common, tests are usually repeated at 32 weeks gestational age. The Los Angeles County STD Program recently uncovered instances of carelessness, where laboratories failed to report results; where providers failed to find and review laboratory reports; and where clinics failed to find patients with positive tests who had not returned for scheduled visits.

This is a good time to review how your practice deals with prenatal syphilis tests and the management of syphilis in pregnancy:

- Do you take medical histories that facilitate an assessment of sexual health?
- Who reviews laboratory results?
- Who charts results?
- Who makes sure the ordering physician reviews the results without delay?
- Who makes certain that cases are diagnosed, treated, and reported to the County STD Program with a Confidential Morbidity Report (CMR) containing complete diagnostic and demographic information?

The physician's CMR, which is *entirely confidential*, is uniquely important because it is the *only* documented verification of a patient's diagnosis and treatment. Many healthcare providers associate the identification and treatment of sexually transmitted disease with public health departments; the fact is that private physicians identified more than 40 percent of infectious syphilis cases in California in 2000. Physicians have a critical role to play in protecting the unborn child from syphilis, and in the elimination of syphilis cases in the general population.

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Report Targets Best Practices for Postpolio Syndrome

Difficult-to-Diagnose Ailment Has Surfaced as Harsh Reminder of Polio Epidemic that Swept Nation in 1950s

The Board shares the following article to inform physicians of this emerging but little understood, secondary illness.

**By Susan J. Landers
American Medical News Staff**

Washington—Patients who survived polio many years ago may now be arriving in doctors' offices complaining of new progressive muscle weakness, fatigue and pain in muscles and joints.

Postpolio syndrome is a little understood, secondary illness now confronting thousands of polio survivors and their physicians.

In a new report, the March of Dimes estimates that up to 250,000 polio survivors in the United States face the threat of new disabilities 15 to 40 years after contracting their original illness.

The disease is difficult to diagnose, in part because there are no definitive tests for the condition. As a result, the report finds that many physicians fail to recognize the illness. To correct this situation, the March of Dimes has identified best practices in diagnosis and care in a report specifically targeted to doctors.

"The causes of PPS are not thoroughly understood," said Lewis P. Rowland, MD, professor of neurology at Columbia University College of Physicians and Surgeons in New York City.

"In the initial acute polio episode, patients can lose up to 60% or 70% of their motor nerve cells," said Dr. Rowland, who also heads the March of Dimes' Steering Committee on Post-Polio Syndrome. Surviving nerve cells attach themselves to muscle fibers that still work, and a patient's motor function is restored.

However, 15 to 40 years later, "the ability to maintain function seems to be lost," Dr. Rowland said. "But no one is certain why this happens."

One theory holds that the motor nerves that sprouted new connections years earlier to make up for other nerves killed by polio simply wear out prematurely under the added load.

The normal aging process and the overuse or disuse of muscles may be contributing factors in the development of PPS, according to the report.

PPS first came to the widespread attention of the nation's medical community during the 1980s—three decades after the worst polio epidemic swept the country. More than 50,000 people were affected in 1952 alone.

Among them was Lauro S. Halstead, MD, director of the postpolio program at the National Rehabilitation Hospital in Washington, D.C. Dr. Halstead had polio when he was a college student in the 1950s. The disease temporarily paralyzed his right arm, and he needed an iron lung to help him breathe.

"I made a good recovery, finished college and medical school," Dr. Halstead said. "But I began experiencing new weakness in the early 1980s. Doctors had no idea what I had, with some suggesting multiple sclerosis and others, Lou Gehrig's disease [amyotrophic lateral sclerosis]."

A physician who was studying postpolio syndrome finally made the diagnosis, Dr. Halstead said.

Disease management

Management of the illness requires a multifaceted and interdisciplinary approach that focuses on the symptom, according to the report.

Muscle weakness can be managed with a judicious exercise program or the use of braces, crutches or wheelchairs. Excessive fatigue may respond to lifestyle changes, regular rest periods or medications such as antihistamines, valerian and melatonin to improve sleep.

Postpolio muscle pain may be helped by first reducing activities and then introducing a program of individually designed exercises. Treatment could include physical therapy, nonsteroidal anti-inflammatory drugs or orthoses.

Treatment for joint and soft tissue pain also may include physical therapy and strengthening exercises, splinting for carpal tunnel syndrome or shoe lifts and back supports for patients with low back pain.

Respiratory muscle weakness also may be a problem for patients who required assistance with breathing at the time of their initial infection with polio. In PPS, breathing can be assisted with ventilators or supplemental oxygen.

Difficulty in swallowing, caused by weakness of pharyngeal or laryngeal muscles, may require restricting patients' diets to pureed foods and thickened liquids.

In addition to the report issued for physicians, the March of Dimes has released a second report on PPS for patients.

American Medical News granted permission to reprint this article.

New Law Regarding Emergency Contraception

There are an estimated 300,000 unintended pregnancies each year in California. Many of these could be prevented by the use of Emergency Contraceptive Pills (EC). EC products are progestin-only or combined estrogen/progestin pills, which if taken within 72 hours of unprotected intercourse, greatly reduce the chance of pregnancy.

Because of this short time frame for efficacy of EC, many organizations and individuals have encouraged increased access to EC.

With the support of the California Medical Association and the American College of Obstetrics and Gynecology, the California Legislature enacted SB 1169 (Alpert), which takes effect January 1, 2002. This law allows pharmacists, operating under written protocols with a physician, to provide emergency contraception directly to customers who request EC.

In addition to having a written protocol with a physician, pharmacists wishing to provide EC directly to their customers must first complete a training program on Emergency Contraception from an American Council of

Pharmaceutical Education provider. The law also specifies that women obtaining EC from a pharmacist must receive an EC fact sheet approved by the California State Board of Pharmacy.

More than 70 demonstration projects were implemented during the past year to pave the way for this legislation. Participants included physicians in private practice, local health departments, managed care plans, Planned Parenthood, and community clinics. These projects showed that many women were able to gain timely access to EC.

Under the new law, it is expected that many of the women served will not have an ongoing source of care, and that the participating pharmacists will be able to make referrals for ongoing care.

The Pharmacy Access Partnership maintains a registry of physicians who are interested in participating in protocols with local pharmacists. Physicians wishing to obtain more information, or to view a sample protocol, can call the Pharmacy Access Partnership at (510) 272-0150.

President's Report (continued from page 2)

to providers.”¹ The irreconcilable condition of these two notions has resulted in 25 years of increasing agitation by all stakeholders (which is everyone). And again, it is the recipient of healthcare services who is disadvantaged by the inefficiencies of the policy approach that is selected.

A legislative review of the quarter century under the Knox-Keene Act reveals an ever and exponentially increasing number of reactive legislative efforts attempting to counteract side effects of the mother statute. This phenomenon rose to a crescendo in 1996 when the Legislature created a task force to spend a year of investigation and analysis to culminate in a report to the Governor with problems delineated and suggestions for remedies for the ills discovered. Over 100 bills relating to this alone were authored and then bottlenecked for the year of review. An entire new government agency was created in one reactive adaptation. Currently one law “might force (the) state to regulate doctor fees.”² In a CMA “lawsuit against the seven major health plans ... the court of Appeal ruled that physicians have no legal recourse when they get paid nothing for millions of dollars of necessary medical care provided to health plan enrollees when the health plans’ intermediaries go bankrupt.”³ And yet, with all of the above reactive chaos, the competition among health plans remains on cost, not quality. So, as a “Sunset Reviewer” of 25 years of the Knox-Keene Act, I would ask whether a threshold amount of reactivity might have been crossed as to trigger a new look at the original legislation.

Timely, constructive, critical review is a good thing. Perhaps the Legislature should use it more.

¹ Knox-Keene Act. (Health & Safety Code section 1342 (d)).

² *The Sacramento Bee*, Nov. 11, 2001, pg. 5L, “Other Views,” Daniel Weintraub.

³ CMA Alert, Dec. 2001.

REMINDER

Effective Jan. 1, 2002, the data collection requirement for outpatient surgeries that result in the patient requiring transfer to an acute-care facility for medical care or treatment, is being transferred to the Office of Statewide Health Planning and Development (OSHPD).

Accordingly, effective immediately, the Patient Transfer Reporting Form developed by the Medical Board should be mailed to:

Office of Statewide
Health Planning and
Development Patient
Discharge Data Section
Attn: Physician
Reporting—Transfers
818 K Street, Suite 100
Sacramento, CA 95814

Joint Commission Issues Alert:

Simple Steps by Patients, Healthcare Practitioners Can Prevent Surgical Mistakes

The following is the text of a recent news release from the Joint Commission on Accreditation of Healthcare Organizations, reported in its entirety. The actual "Alert," and other useful information, is available at www.jcaho.org.

Oakbrook Terrace, IL - December 5, 2001—Surgeries on the wrong site, or on the wrong patient, or performance of the wrong procedure on a patient are completely preventable and should never happen, according to a special alert issued by the Joint Commission on Accreditation of Healthcare Organizations to nearly 18,000 healthcare facilities nationwide.

The Joint Commission alert calls on the healthcare community to take specific safety steps and seeks to enlist patients to help to eliminate these tragic mistakes.

"Healthcare experts are unanimous in their belief that these types of errors should never happen," says Dennis S. O'Leary, M.D., president, Joint Commission. "The know-how to create systems that prevent wrong site surgeries has existed for years, yet the number of errors has not decreased. Even one wrong site surgery is one too many."

To help avoid these surgical errors, the Joint Commission encourages patients to make one basic request: ask to have the surgical site marked with a permanent marker. "This simple step really will help," Dr. O'Leary said. "And it is an important way in which patients can play an active role in improving safety."

The Joint Commission alert also recommends that healthcare facility staff:

- Mark the surgical site—Sometimes referred to as "signing your site," doctors place their initials on the surgical site with a permanent marking pen in a way that cannot be overlooked and then actually operate through or next to the initials.
- Orally verify the surgery—In the operating room just before starting the operation, each member of the surgical team should confirm that they have the correct patient, the correct surgical site and the correct procedure.
- Take a 'time out' in the operating room—This gives the surgical team one last chance to double check amongst themselves about the impending procedure, check charts, and corroborate information with the patient.

"It is most important that there be cooperative openness between the surgeon and the nurses," says Tom Russell, M.D., executive director, American College of Surgeons. "The two groups must both take responsibility, and if there are questions, they should stop to be sure everyone is on the same page. No one should make assumptions."

During its on-site quality evaluations, the Joint Commission will ask accredited healthcare facilities how they are protecting patients from wrong-site surgeries. The Joint Commission's error reporting database includes more than 150 such cases collected since 1996.

The Joint Commission first drew attention to the issue more than three years ago when it issued its first alert on the subject. The American Academy of Orthopaedic Surgeons and the New York State Department of Health have also independently issued recent recommendations on prevention of wrong site surgeries.

"Although the wrong site surgery problem has been addressed on the local level in many areas of the country, there has been no organized national effort to eliminate wrong site surgery," says S. Terry Canale, M.D., immediate past president, American Academy of Orthopaedic Surgeons.

"Healthcare experts are unanimous in their belief that these types of errors should never happen."

Dennis S. O'Leary, M.D.

The new warning about surgical mistakes is the latest in a series of patient safety alerts issued by the Joint Commission. Previous alerts have focused on deadly medication mix-ups, patient suicides, infant abductions and fatal falls among the elderly.

Making patient safety its top priority, the Joint Commission has established one of the nation's most comprehensive voluntary reporting systems for healthcare errors. The resulting database includes detailed information about the causes of the errors, and has enabled the Joint Commission to both warn healthcare facilities about dangers and share solutions to prevent these tragedies. The complete list and text of past issues of Sentinel Event Alert can be found on the Joint Commission's Web site at www.jcaho.org.

Finding Solutions to Clinical Issues Through Collaboration

By Mary Giammona, M.D., M.P.H., Medical Director, California Medical Review, Inc.

California Medical Review, Inc. (CMRI), the federally funded Medicare Quality Improvement Organization for California, is collaborating with physicians and other clinical staff to boost performance on key quality indicators, and to improve patient care, by offering free and simple system change tools. The Centers for Medicare & Medicaid Services (CMS, formerly HCFA) published research in 2000 in the *Journal of the American Medical Association* evaluating the quality of healthcare delivered to Medicare beneficiaries in each state. In this study of widely accepted quality indicators, California ranked in the bottom quartile. The low ranking was a call to action for the healthcare community in California.

In Partnership

Along with partners such as the California Medical Association, the American Heart Association and CMS, CMRI focuses on the diseases that pose the most risk to seniors: heart disease, stroke, breast cancer, diabetes, flu and pneumonia. CMRI brings together different parts of the healthcare system—nonprofit, public and commercial-sector organizations—under the common goal of raising the level of health in our communities. Every hospital, health plan, health system, physician, medical group, nursing home, and home health agency is part of the solution. We have found that the best, most effective solutions to ensure better quality and reduce medical errors are process or system changes, such as patient and provider reminder systems.

Inpatient and Outpatient Quality Improvement Projects

With your help, we implement clinical quality improvement projects in California hospitals and health systems. CMRI data analysts compare clinical practice patterns to evidence-based guidelines to assess the quality of clinical treatment. We then provide each hospital the data on how they compare with similar organizations statewide. When CMRI or a hospital identifies an opportunity to improve care, we work with our collaborators to develop and implement improvement plans and measure results. Together, we have achieved positive, measurable results with our projects in a number of clinical areas, such as heart attack treatment and stroke prevention.

In addition to our efforts to raise hospital performance, CMRI focuses on improving outpatient preventive care across diverse communities, especially those high-risk or underserved; promoting the use of proven, effective therapies, and ensuring appropriate medical care.

CMRI Resources

CMRI offers free services to help improve quality of care within hospitals. These include:

- **Benchmarking.** Aggregate data on processes and outcomes of care to compare your hospital's performance with peer institutions.
- **Data analysis.** Confidential analytic reports to evaluate your hospital's performance and improvement.
- **Individual Consultation.** Our quality improvement staff is available to help you develop customized strategies for your institution and to make educational presentations.
- **Best practices.** Information and ideas on implementing effective intervention strategies to improve hospital performance.
- **Toolkits.** Informational packets containing the most recent updates to the evidence-based guidelines, algorithms, tip sheets, and reminder and patient education materials.
- **Recognition of achievement.** Collaborating hospitals that demonstrate measurable improvement can receive special recognition.

CMRI has developed interactive tools, including CD-ROMs of data abstraction tools and clinical guidelines that can be easily downloaded to personal digital assistants (PDAs). CMRI has also instituted online conferencing in order to quickly and easily share information. Utilizing these simple, time-saving tools, providers in any setting can make "leaps" in improving care for their patients.

- **Performance Measurement Tools CD-ROM.** CMRI designed a performance measurement tool CD-ROM to make it easy and economical for hospitals to abstract data from and analyze their medical records as part of a quality improvement project. Hospitals can measure their performance against CMS-approved quality indicators for congestive heart failure, atrial fibrillation, stroke/TIA, community-acquired pneumonia, and acute myocardial infarction. These tools allow hospitals to utilize real time data, determine baseline measurements, compare their rates to national, statewide and county rates, and implement rapid cycle quality improvement. Instead of having to send charts to be abstracted and wait for the results to be analyzed, hospitals can now abstract and re-measure their data at their convenience to monitor progress against their goals.

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Solutions to Clinical Issues

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- **Online Data Abstraction Training and Sample Size Calculator.** To maintain the quality of abstracted data, CMRI has developed quality assurance tools, including online data abstraction training and a sample size calculator. These tools help abstractors meet recommended standards for accurate abstraction before abstracting data at their hospitals; and, help determine an adequate sample size and reasonable estimate of performance, based on the number of patients with the disease of interest.
- **Online Conferencing.** By providing hospitals with the best means in accurately abstracting data, it is our goal to help hospitals improve their rates and achieve higher quality indicator rates for the entire state. We intend to move forward in this effort, by providing online conferencing and further training on the performance measurement tools.

CMRI is ready to assist you with your quality improvement goals. View and order our system change and other intervention tools online at www.cmri-ca.org or call the California toll-free provider line 1-877-363-5555.

Reminder Systems for Preventive Care

*By Allison Meyer-Oaks, M.D.
CMRI Physician Consultant*

A reminder system does not need to be complex. There are simple tools that can help facilitate system change in your office.

- **Physician Reminder Systems Remind the physician to order preventive care**
 - Flow Sheets
 - Chart Flags/Stickers
- **Patient Reminder Systems Remind patients to schedule and receive preventive care**
 - Reminder Post Cards
 - Reminder Letters
 - Wallet Cards
- **Motivating Staff to Implement System Change**
 - At the beginning of a staff meeting, describe the goal of the system changes and elicit input from staff on the efforts needed to make these changes.
 - Assign specific roles to individual staff members.
 - Carry out the tasks and identify measurable outcome (i.e., “We will mail reminder cards to patients to have their annual flu shot one month before it is due”).
 - Always give positive feedback to encourage staff to continue to work as a team.

Identifying Tasks for Members of the Prevention Team

• The Medical Assistant

- Ask about preventive care at patient check-in.
- Help track and chart your patients’ preventive care information when they come in for an office visit for any reason.

Tip: Think of it as a “Preventive Vital Sign”. Ask Medicare patients if they have ever had a pneumococcal vaccination, when they last underwent colorectal cancer screening, and questions regarding other preventive services such as flu shots and mammograms.

Tip: Doctors can help decide which prevention questions staff should routinely ask.

Tip: If patients are overdue for a service, there should be a method for the staff to alert the physician.

- Help highlight preventive services deficiencies by using:

- * Preventive care flow sheets at the front of the chart and/or
- * Chart stickers or highlighted reminder post-it notes on the front of the chart, and/or
- * Pre-printed orders to provide immunizations or filling out requisitions for missing or overdue preventive screening tests

• The Receptionist

- Facilitate future notification of preventive care at checkout by doing one or all of the following:

*Send postcards or letters to remind patients that it is time to receive a preventive service.

Tip: If you cannot afford a computerized system, you can create a simple reminder system. Have the patient fill out the address side of the reminder postcard and file the card by the month prior to the preventive service anniversary. Once a month, pull out the postcards or letters from your filing box and mail them to your patients

- *Place Reminder Stickers in the front of the chart (note the date that the service is due).
- *Give patients wallet cards to track their care and remind them when they need exams and tests.
- *Track patient compliance with preventive services recommendations.
- *Track patient compliance using a “Tickler File” document in which you: log the date patient reminders are mailed; log the date when preventive test results are ordered; and log the date when preventive test results are received

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News From the U.S. Food and Drug Administration

Consumers Needed

The U.S. Food and Drug Administration (FDA) is seeking people with strong ties to consumer and community-based organizations to serve as consumer representatives on its advisory committees. Consumer representatives are included on all advisory committees, which provide the FDA with independent opinions and recommendations from outside experts on regulated products and Agency policies.

For more information on becoming a consumer representative, visit www.fda.gov/oc/advisory/default.htm or contact the FDA's Office of Consumer Affairs at (301) 827-5006.

For information on upcoming FDA Advisory Committee meetings and transcripts from previous meetings, visit www.fda.gov/cdrh/panelmtg.html.

Recall Information

Medical Device Recalls—The following new Web site provides information on Class I medical device recalls and some Class II and III recalls with general public interest: www.fda.gov/cdrh/recalls/index.html.

“Hip Implants Recalled; Potential Fracture Problem”—(September 14, 2001) A zirconia ceramic femoral head manufactured by St. Gobain Desmarquest was recalled due to a potential problem with the component. Further details can be found at www.fda.gov/cdrh/recalls/irconiahip.html and www.fda.gov/bbs/topics/ANSWERS/2001/ANS01102.html.

Public Health Advisory

“Potential for Injury from Medical Gas Misconnections of Cryogenic Vessels”—(July 20, 2001) This is to alert you to the potential injury when cryogenic vessels containing medical gas are misconnected to oxygen delivery systems: www.fda.gov/cdrh/safety/medical-gas-misconnect.html.

Clinical Trials—Provides patients, family members and the public with current information about clinical research studies at the National Institutes of Health (NIH) Web site: www.clinicaltrials.gov.

Buying Medical Devices from the Internet

“Buying Diagnostic Tests from the Internet: Buyer Beware!”—(October 2001) Important information for consumers to read prior to buying diagnostic tests such as tests for pregnancy, cholesterol, blood sugar, and drugs of abuse over the Internet: www.fda.gov/cdrh/consumer/buyer beware.html.

“Agencies Team Up in War Against Internet Health Fraud”—(September/October 2001) Federal and State government organizations have united in an effort dubbed “Operation Cure All” to crack down on marketers who use the Internet to prey on vulnerable consumers. For information on this effort, please visit: www.fda.gov/fdac/features/2001/501_war.html.

Reuse Information

“Changes in Enforcement of FDA’s Requirements on Reprocessing of Single-Use Devices”—(September 25, 2001) Letter to alert hospitals of a change in FDA’s policy on how it intends to enforce requirements on the reuse of single-use devices: www.fda.gov/cdrh/reuse/reuse-letter-092501.html.

Device Approvals

The most recent medical device approvals are listed on our Medical Device Approvals Web site at: www.fda.gov/cdrh/mda/index.html.

Some recently approved devices include:

- **Biotronic Home Monitoring System**—A new type of pacemaker that contains a tiny transmitter that automatically sends data on the patient’s heart condition to the doctor between office visits: www.fda.gov/bbs/topics/ANSWERS/2001/ANS01108.html.
- **30-Night Continuous Wear Contact Lenses**—Soft contact lenses that can be worn up to 30 nights of continuous wear: www.fda.gov/bbs/topics/ANSWERS/2001/ANS01109.html.
- **RapidScreen RS-2000**—A computer-aided detector used when viewing chest x-rays of patients at high risk of lung cancer: www.fda.gov/cdrh/mda/index.html.
- **AquaFlow Collagen Glaucoma Drainage Device**—A small cylinder made of collagen used to treat open-angle glaucoma: www.fda.gov/cdrh/mda/docs/p000026.html.
- **UBIS 5000 Ultrasound Bone Sonometer**—A portable device that uses ultrasound to measure the strength of the heel bone: www.fda.gov/cdrh/mda/docs/p000055.html.
- **Given Diagnostic Imaging System**—A capsule that contains a tiny video camera. When swallowed, it passes through the digestive tract taking pictures of the small intestines: www.fda.gov/cdrh/mda/docs/k010312.html.

(Continued on page 19)

News From the FDA (continued from page 18)

- **Medtronic InSync Cardiac Pacing System**—A pulse generator that delivers electrical impulses to stimulate the heart. Used to help treat patients with congestive heart failure: www.fda.gov/cdrh/mda/docs/p010015.html.
- **Avanta Joint Finger Implant Finger Prosthesis**—This device is approved under the Humanitarian Device Exemption (HDE) program. It is an artificial finger joint used to replace the metacarpal phalangeal (MPC) joint of the hand: www.fda.gov/cdrh/mda/docs/h010001.html.
- **Dermagraft**—A skin substitute used to help in the wound closure of diabetic foot ulcers: www.fda.gov/cdrh/mda/docs/p000036.html.

Updated Web Sites

Recent Additions to Center for Devices and Radiological Health Web site: www.fda.gov/cdrh/newpg.html.

LASIK Eye Surgery: www.fda.gov/cdrh/lasik.

Over-the-Counter In Vitro Diagnostic Devices List: www.fda.gov/cdrh/ode/otclist.html.

FDA Press Releases and Talk Papers: www.fda.gov/opacom/hpnews.html.

Recent Federal Register Notices: www.fda.gov/cdrh/fedregin.html.

Request for Nominations for Voting and Nonvoting Consumer Representatives on Public Advisory Committees and Panels: www.fda.gov/OHRMS/DOCKETS/98fr/102301d.htm.

FDA Consumer Magazine: www.fda.gov/fdac/default.htm.

“Vision Correction: Taking a Look Into What’s New” September/October 2001: www.fda.gov/fdac/features/2001/501_eyes.html.

Growing Bones: Bone Expansion Treats Facial Deformities” July/August 2001: www.fda.gov/fdac/features/2001/401_bone.html.

Radiological Health

The Radiological Health Web site at www.fda.gov/cdrh/radhealth.html has valuable information on items such as radiation-emitting devices, mammography and mobile phones.

FDA’s Consumer Staff welcomes your feedback. Send your comments and suggestions via e-mail to dsma@cdrh.fda.gov. If you prefer to speak directly with staff, call 1-888-463-6332. When prompted, press 1, press 3, press 2, press 4, press 1 and press 5 to talk with a Public Health Advisor.

FDA encourages you to visit its Consumer Web site for updates at: www.fda.gov/cdrh/consumer/index.shtml and the Center for Devices and Radiological Health home page at www.fda.gov/cdrh.

Solutions to Clinical Issues

(continued from page 17)

*Call patients who have not yet received their screening tests or set up a doctor’s appointment for them.

• The Physician

- Educate and inform your patients about preventive services.
- Affirm to patients that preventive screening tests can save lives.
- Explain to patients that early detection of cancer is usually a result of preventive screening tests.
- Reassure patients that vaccines don’t cause the flu or pneumonia.
- Determine the frequency and timeliness of preventive services offered to your Medicare patients and train office staff accordingly.
- Medicare now pays for annual mammograms, annual flu shots, and annual hemoccult blood and every 4-year flexible sigmoidoscopy, once every 48 months. These periodic screening time limits have been found to reduce mortality.
- Take a look at a valuable publication about preventive healthcare services and counseling for non-Medicare and Medicare patients, the US Preventive Services Task Force Report. This report examines the efficacy and scientific evidence for various preventive care services and counseling for all age groupings.
- Customize the use of CMRI materials to suit your practices’ needs.

Peer Reviewers Needed

CMRI also needs additional peer reviewers for our case review work. If you would like to become a peer reviewer for Medicare and are board certified in a medical specialty, in active practice and have hospital privileges, we would like to talk to you. Please contact Dr. Mary Giammona, Medical Director, CMRI at (415) 677-2110 or e-mail her at capro.mgiammona@sdps.org for more information.

Community Water Fluoridation in California

By David F. Nelson, D.D.S., M.S., Fluoridation Consultant, California Department of Health Services

In accordance with Chapter 660, Statutes of 1995 and Sections 4026.7 and 4026.8 of the Health and Safety Code, Assembly Bill 733 (Speier), the Department of Health Services (DHS) has adopted regulations that require, under specific conditions, the fluoridation of the water of any public water system that has at least 10,000 service connections. The Department is also charged with the identification of funding to support the implementation of AB 733.

At the present time, California ranks at about the 40th percentile in the numbers of its citizens having access to fluoridated water. Approximately 30% of our residents live in areas that have fluoridated drinking water compared with 62% of the national population. This is a vast improvement from five years ago when California ranked 48th in the country and had only 17% of its residents drinking fluoridated water.

In communities without fluoridated water, physicians and dentists in many California communities have prescribed sodium fluoride tablets to appropriate patients, consistent with sound medical and dental practice. These prescriptions may soon no longer be necessary for patients in several California cities as these communities become fluoridated.

Currently, the City of Los Angeles, the City of San Francisco, the East Bay Area counties served by East Bay Municipal Utility District, portions of Marin County, Beverly Hills, Long Beach, Huntington Beach, Port Hueneme, Yuba City, Daly City, Mountain View, certain select portions of Bay Area Peninsula cities as well as certain military installations are fluoridated.

Because the regulations require DHS to seek funding from outside sources, the Fluoridation 2010 Workgroup, composed of representatives from DHS, the California Dental Association (CDA), the Dental Health Foundation (DHF), the Fluoridation Task Force (FTF), Delta Dental, the California Medical Association (CMA) and the American Academy of Pediatrics (AAP) are working to identify foundations and grants to fluoridate California.

The collaboration has been awarded \$15 million from the California Endowment to fluoridate certain of California's public drinking water systems. As additional funds are obtained and communities fluoridated, physicians can expect to receive notification from a variety of sources, including the local water system, DHF, DHS and professional publications such as the *Action Report*, when fluoridation is to begin.

Currently, the Helix Water District in San Diego County is under construction and is the only jurisdiction expected to fluoridate in the near future. **Fluoride supplements prescribed for caries prevention should be discontinued when community water fluoridation is instituted.**

Water fluoridation in the United States has enjoyed over 55 years of success as a valuable public health measure. CDC has recently selected fluoridation as "one of the ten greatest public health achievements of the twentieth century." Many of the world's major health organizations endorse water fluoridation. These include: the American Medical Association, American Dental Association, U.S. Public Health Service, Centers for Disease Control and Prevention, American Cancer Society, World Health Organization and every Surgeon General for the past 50 years. In spite of widespread professional and public acceptance of community water fluoridation, a small percentage of California residents remain opposed to the intervention.

Fluoridation began in Grand Rapids, Michigan in 1945. Eleven years later, scientists reported the decay rate had fallen 60 percent. Since 1970 there have been over 3,700 peer reviewed articles on the safety and efficacy of fluoridation. Water fluoridation is the safest, most economical and effective way to prevent tooth decay, especially among children. However, it benefits adults as well by preventing root surface decay.

Projections indicate that tooth decay for children will decrease as much as 30% within five years of water fluoridation, and in areas where children have little access to preventive care the reduction in decay may be even higher. The reduction of tooth decay in adults may run as high as 40% and even higher in our senior population. Within the same five years, preventing just one cavity in each school-aged child in California will save taxpayers an estimated \$385 million. DHS will be providing updates on the status of community water fluoridation in future issues of the *Action Report*.

Primary care physicians, by prescribing fluoride supplements when indicated, have improved the oral health of California's children. Community water fluoridation, as it becomes available to more California residents in the near future, will also assure a healthier California. Should you have any further questions concerning community water fluoridation, you may contact Ron Chapman, M.D., M.P.H. or David F. Nelson, D.D.S., M.S. at the California Department of Health Services, Medicine and Public Health Section, (916) 323-0852.

MEETINGS

The Medical Board has been notified of the following upcoming meetings, which may be of interest:

The California STD/HIV Prevention Training Center presents:

STDs in the 21st Century

May 17, 2002

The Westin Hotel, San Francisco Airport

An STD conference on the latest advances and most up-to-date information designed specifically for clinicians who already have a working knowledge of STDs. National STD experts:

Gail Bolan, M.D., Chief, STD Control Branch, California Department of Health Services

Connie Celum, M.D., M.P.H., Associate Professor of Medicine, Univ. of WA

Edward "Ned" Hook, III, M.D., Professor of Medicine/ Epidemiology, UC Alabama

Anna-Barbara Moscicki, M.D., Professor in Residence, Dept. of Pediatrics, UC San Francisco

Anna Wald, M.D., M.P.H., Assistant Professor, Division of Infectious Disease, Univ. of WA

To receive a registration packet, contact RDL enterprises at (916) 443-0218, or e-mail: Alex@RDLe.com. Watch for registration online at www.RDLe.com.

The American Academy of Pain Medicine presents:

AAPM 18th Annual Meeting

February 26-March 3, 2002

Hyatt Regency, San Francisco
(in Embarcadero Center)

Colleagues are invited to participate in the first annual Skills Course for Pain Physicians to be held prior to the 18th Annual Meeting (February 26-27). In this course, physicians interested in the diagnosis and management of pain problems will learn the assessment and treatment skills that are necessary tools for pain physicians.

Physicians in California will benefit from attending this meeting in two ways: 1) they will fulfill the AB 487 educational requirement and 2) they will receive an outstanding educational experience presented by the most respected experts in the field of Pain Medicine.

To receive a registration packet, contact aapm at (847) 375-4731, or e-mail: aapm@amctec.com. Download an Annual Meeting Brochure online at www.painmed.org.

Fictitious Name Permit Applications Now Available Online

Physicians who advertise with a name other than their own must first obtain a Fictitious Name Permit (FNP) from the Medical Board.

Applications for FNPs are now available on the Medical Board's Web site. To download an application from our Web site, go to www.medbd.ca.gov. Applications may be printed from the Web site. Please note that some copies received are illegible and, if so, will be returned.

If you are unable to obtain access to our Web site but would like a copy of the application, please contact the Consumer Information Unit at (916) 263-2382.

Online Licensing (continued from page 1)

Those physicians with active or inactive licenses who wish to request a duplicate pocket identification card or wall certificate due to a name change or a lost or destroyed license, may initiate the process over the Internet when paying by credit card. However, this feature will require supporting documentation. The licensee will need to complete and submit to the Medical Board the Application for Duplicate Certificate before the duplicate license can be issued. The Application for Duplicate Certificate can be downloaded and printed from the Medical Board's Web site (click on "Services for Licensees"), or it can be obtained by calling the Board's Consumer Information Unit at (916) 263-2382.

Similarly, first-time applicants who begin the initial process online also will need to complete and submit some application forms. Detailed information describing the initial application process is available on the Board's Web site (click on "Services for Applicants") or from the Board's Consumer Information Unit.

In our continuing efforts to maintain the cost of our renewal and application fees, the expense of providing this service will not result in increased fees but will be paid as a surcharge by those who choose to use the system. Therefore, a \$10 convenience charge will be added to each renewal and initial applicant transaction. The charge for processing each duplicate license will be \$1.

Legislative Update (continued from page 1)

authorized to do so by a written protocol prepared or approved by the referring physician and surgeon, medical laboratory tests related to nutritional therapeutic treatments and to accept or transmit verbal orders consistent with established protocol.

AB 1490 (Thomson, Chapter 529) This bill permits test results to be delivered in electronic form if requested by the patient and if deemed appropriate by the healthcare professional who requested the test. It requires that patient consent be obtained to receive laboratory results by Internet posting or other electronic form. The bill also prohibits the disclosure of specific laboratory test results by Internet posting or other electronic manner regardless of authorization by the patient.

SB 111 (Alpert, Chapter 358) This bill authorizes a physician assistant, nurse practitioner and a nurse midwife to supervise a medical assistant in the absence of a physician in specified clinics when standardized procedures are in place and specified tasks are assigned to the medical assistant.

SB 680 (Figueroa, Chapter 898) This bill requires every organization that owns a health facility to file specified reports containing various financial and patient data with the Office of Statewide Health Planning and Development. This bill would revise the type of data required to be filed with the office.

SB 1192 (Figueroa, Chapter 224) This bill prohibits a person who is required to register as a sex offender, where the victim was a minor under the age of 16, from serving as an employee or volunteer with any person, group, or organization, where the registrant would be working directly and in an unaccompanied setting with minor children.

Enforcement

AB 1616 (Wright, Chapter 617) This Board-sponsored bill extends the statute of limitations for sexual misconduct cases from seven years to 10 years. It also adds a provision to toll the statute during an ongoing criminal investigation for specified reasons.

SB 16 (Figueroa, Chapter 614) This bill revises and amends the law regarding the peer review reporting requirements as follows:

- Clarifies time limits for the filing of reports;
- deletes the need for duplicate filing of reports;
- adds that withdrawal or abandonment of an application for privileges upon notification on an impending investigation is grounds for reporting;
- increases the penalty for intentional failure to file an 805 report from \$10,000 to \$100,000;

- increases the penalty for the failure to file an 805 report from \$5,000 to \$50,000;
- allows for mitigating circumstances in setting the penalty;
- tolls the disclosure period while a case is pending;
- requires an electronic notification system for 805 filings;
- increases the data that is required to be collected;
- requires the Board to examine a pilot program for the remediation of physicians;
- directs the Board to contract for a study of the peer review process.

SB 455 (Committee on Insurance, Chapter 328) This bill requires the Department of Insurance to report a suspected violation by physicians and surgeons, and organizations being operated in violation of provisions governing clinics, professional corporations, and physicians and surgeons, relative to potential insurance fraud. It also requires the permanent revocation of the license of a physician and surgeon who practices medicine with a business organization that violates specified fraud laws.

SB 502 (Ortiz, Chapter 579) This bill requires the Office of Criminal Justice Planning to cooperate with various agencies to establish medical forensic forms fulfilling specified criteria, instructions, and examination protocol for victims of domestic violence and elder and dependent adult abuse and neglect.

SB 724 (Committee on Business and Professions, Chapter 728) This bill carried various technical provisions for the Board including requiring a name and license number on the 802 and 803 reports (see Licensing, below, for additional provisions).

SB 1080 (Bowen, Chapter 730) This bill allows the Board to issue a citation and administrative fine to a physician for the second and any subsequent occurrence of not providing gynecological cancer information during an annual gynecological examination.

Licensing

AB 487 (Aroner, Chapter 518) This legislation's intent is to broaden the knowledge base of physicians relating to the appropriate care and treatment of patients suffering from pain. It adds to the continuing education requirements a mandatory 12 credits of continuing education in pain management and the treatment of terminally ill and dying patients.

- Twelve credits are a one-time only requirement for currently licensed physicians;
- those 12 credits must be completed by December 31, 2006;

(Continued on page 23)

Legislative Update (continued from page 22)

- physicians licensed in California after January 1, 2002 must complete the 12 credits by their second renewal cycle;
- the Board may exempt by regulation physicians by practice status category if the physician does not engage in direct patient care, provide patient consultations or reside in California;
- physicians practicing in pathology or radiology specialty areas are exempted by law.

These provisions will be implemented through the self-certification process that currently exists during the renewal process. The Board will provide more information regarding the implementation and sources for courses in future *Action Reports*.

The bill requires the Division of Medical Quality to develop standards before June 2002 to assure the competent review of cases regarding pain management. The Division will be discussing these standards at its February and May 2002 meetings. Lastly, the bill amended Business and Professions Code section 2313 to add reporting requirements regarding actions taken relating to the undertreatment or undermedication of pain.

AB 1586 (Negrete McLeod, Chapter 509) This bill requires physicians to report, at time of renewal, their practice status and specialty board certification and they may report cultural background and any language proficiencies. This information may be placed on the Board's Web site and shall be implemented by July 1, 2003. This information will be incorporated into the renewal process, and more information regarding the implementation of this new data collection requirement will be provided in future *Action Reports*.

SB 724 (Committee on Business and Professions, Chapter 728) This bill carried various technical provisions for the Board (see Enforcement, page 22, for additional provisions):

- authorizes the Board to require a resident to cease participation in a training program if that person's application is denied;
- clarifies that an application for exemption from licensure during postgraduate education must be approved by the Board;
- repeals the undergraduate science requirements prior to entry into medical school;
- repeals an obsolete provision regarding verification of citizenship.

Managed Care

AB 207 (Matthews, Chapter 622) This bill requires certain healthcare service plans and disability insurers offering coverage for prescription drug benefits and issuing identification cards to enrollees and insureds to process claims for prescription drug benefits by a specified date.

AB 532 (Cogdill, Chapter 208) This bill requires the Legislative Analyst to study the operation of healthcare service plans in rural areas of this state and to report to the Legislature and the Department of Managed Health Care (DMHC) on or before July 1, 2002, regarding the reasons plans have discontinued operating in those areas and incentives for plans to resume operating there.

AB 938 (Cohn, Chapter 817) This bill requires healthcare service plans to use disclosure forms to include any limitations on the patient's choice of a non-physician healthcare practitioner, to include any general authorization requirements for referral by a primary care physician to a non-physician healthcare practitioner, and to provide enrollees a list of contracting providers and information concerning their medical education, board certification, and subspecialty training.

AB 1503 (Nation, Chapter 531) This bill requires, on or before July 1, 2002, that a written policy be filed with the DMHC describing how a health plan would facilitate continuity of care for new enrollees who have been receiving services for acute, serious, or chronic conditions from a nonparticipating psychiatrist, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker, when the enrollee's employer has changed health plans.

SB 1219 (Romero, Chapter 380) This bill requires a healthcare service plan issued, amended, or renewed on or after January 1, 2002, that includes coverage for the treatment or surgery of cervical cancer, to provide coverage for an annual cervical cancer screening test in accordance with deductible or co-payment provisions contained in the plan contract or policy that includes the conventional Pap test and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the patient's healthcare provider.

Public Health

AB 284 (Jackson, Chapter 550) This bill requires the California Research Bureau, in consultation with the Department of Health Services (DHS), to perform a study of fungal contamination in indoor environments, and to organize meetings of a review panel to review content for the study, which is to be submitted no later than January 1, 2003.

(Continued on page 24)

Legislative Update (continued from page 23)

AB 480 (Pacheco, Chapter 246) Urgency, September 5, 2001. This bill requires the Cancer Research Fund for the Cancer Research Program to consist of money accepted by the DHS from grants and donations from private entities and of public monies transferred to the Fund. Monies in the Fund will be made available for expenditure by DHS only upon appropriation by the Legislature.

AB 1263 (Migden, Chapter 324) This bill authorizes the DHS Office of AIDS to participate in a rapid HIV test research program conducted with the federal Centers for Disease Control and Prevention (CDC) and specifically authorizes an HIV counselor who is trained by the Office of AIDS and works in an HIV counseling and testing site to perform any HIV test that is classified as waived under Clinical Laboratory Improvement Act (CLIA) provided certain specified conditions exist, and order and report HIV test results to patients without authorization from a licensed healthcare professional. Provides that patients with indeterminate or positive test results shall be referred to a specified licensed healthcare provider for further evaluation.

AB 1452 (Cox, Chapter 372) This bill requires the DHS to develop information regarding meningococcal disease and make the information available to requesting school districts and degree-granting postsecondary educational institutions. It requires that the information be provided by each institution that provides on-campus housing to each incoming freshman who has been accepted for admission and will be residing in on-campus housing, and to adopt a policy to notify all incoming students about meningococcal disease and the availability of the vaccination, beginning with the 2002-03 school year. Each public postsecondary institution is required by this bill to maintain records of compliance in the same manner as it maintains other confidential student records. This bill applies to the University of California only to the extent that the regents make it applicable.

SB 212 (Oller, Chapter 374) Urgency, October 1, 2001. This bill requires the DHS to develop a Meningococcal Disease Strategic Prevention Plan. This bill also requires the department to involve and receive input from victims of meningococcal disease and their families in the development of the plan. This bill requires the department to have the plan completed and made available to the Legislature on or before June 30, 2002. It appropriates \$100,000 from the General Fund to the DHS for the purposes of the bill.

SB 702 (Escutia, Chapter 538) This bill declares legislative intent to establish an Environmental Health Surveillance System (EHSS), in accordance with the recommendations of the working group created pursuant to the bill. It provides that the purpose of the EHSS shall be to establish an ongoing surveillance of environmental exposures and the diseases afflicting Californians. The bill requires the division and the office, in cooperation with the Regents of the University of California, to create a working group of technical experts with specified duties, including the development of possible approaches to establishing the EHSS, and expresses legislative intent that legislation be enacted adopting one of these approaches.

Miscellaneous

AB 68 (Migden, Chapter 242) This bill establishes licensing requirements for private duty nursing agencies, that provide skilled nursing services on a shift basis at the patient's place of residence.

AB 192 (Canciamilla, Chapter 243) This bill requires that all meetings of a state body be open and public and all persons be permitted to attend any meeting of a state body. This bill reorganizes and recasts the definition in the Bagley-Keene Open Meeting Act of "state body" by deleting the phrase "state agencies" and replacing it with "any board, commission, committee, or similar multimember body." This bill, with the exception of teleconferencing, prohibits any use of direct communication, personal intermediaries, or technological devices employed by a majority of the members of the state body to develop a collective concurrence as to action to be taken on an item by the members of the state body.

AB 213 (Nation, Chapter 37) This bill adds licensed marriage and family therapists to the list of providers who may approve the disclosure of information and records relating to services provided to mentally disordered and developmentally disabled patients in instances in which the provider's patient designates persons to whom information or records may be released.

AB 289 (Oropeza, Chapter 321) This legislation exempts Narcotic Treatment Programs regulated by the Department of Alcohol and Drug Programs from the bar on Corporate Practice of Medicine. Although the program is exempted, the law clearly states that the program shall not interfere with, control, or otherwise direct a physician's professional judgment.

AB 548 (Runner, Chapter 520) This bill requires the Office of Statewide Health Planning and Development, in consultation with the DHS, to establish, until January 1, 2007, a specialty care access program in underserved areas.

(Continued on page 25)

Legislative Update (continued from page 24)

The bill declares legislative intent that the program be funded by private gifts and grants. Under this program, private funding obtained by the office will be deposited into the Specialty Care Fund, and used to reimburse participating out-of-area providers in underserved areas for the cost of care provided to low-income persons, upon appropriation by the Legislature.

AB 652 (Horton, Chapter 459) This bill requests the Regents of the University of California, on or before January 15, 2003, to report to the Legislature concerning the university's existing and planned efforts to recruit students to its schools of medicine, dentistry, and optometry from communities and populations that are dentally and medically underserved. The bill also requests the regents to use existing resources to establish dental, medical, and optometric health professions outreach and exposure programs for elementary, high school, and undergraduate students, including community college students.

AB 809 (Salinas, Chapter 310) This bill authorizes an automated drug delivery system to be located in those specified clinics that are licensed by the Pharmacy Board to buy and dispense drugs under a physician's direction.

AB 1075 (Shelley, Chapter 684) This bill requires the DHS to develop regulations establishing staff-to-patient ratios with regard to direct caregivers working in a skilled nursing facility and requires a skilled nursing facility to post information about staffing levels.

AB 1205 (Ashburn, Chapter 751) This bill appropriates \$500,000 to the Valley Fever Vaccine Project for purposes of extending the project.

AB 1589 (Simitian, Chapter 464) This bill requires the Board to commission a study on the electronic transmission of prescriptions by physicians. This report is due to the Legislature on January 1, 2003.

SB 26 (Figueroa, Chapter 615) Urgency, October 9, 2001. This bill requires the Board to commission a study of the peer review process to be conducted by the Institute for Medical Quality to be completed and delivered to the Legislature by November 1, 2002.

SB 108 (Speier, Chapter 740) This bill enacts the Organ and Tissue Donor Registry Act of 2001, and requires the Department of Motor Vehicles to provide information and a standardized form containing specified information, to be completed by driver's license and identification card applicants who desire to be organ donors.

SB 129 (Burton, Chapter 71) This bill specifies that no physician or any other person invited to attend an execution, whether or not employed by the California Department of Corrections, shall be compelled to attend.

SB 340 (Speier, Chapter 631) This bill authorizes a pharmacist to substitute a drug product with a different form of medication having the same active chemical ingredients of equivalent strength and duration of therapy as the prescribed drug product, when the change would improve the ability of the patient to comply with the prescribed drug therapy. The bill requires that the patient be notified of the substitution, does not permit a substitution if the prescriber indicates that no substitution may be made, and does not permit a substitution between long-acting and short-acting forms of a medication with the same chemical ingredients or between one drug product and two or more drug products with the same chemical ingredients.

SB 341 (Perata, Chapter 361) This bill expands the modalities available for use by a licensed acupuncturist and authorizes the use of heat, cold, diet, magnets, plant, animal, and mineral products, and dietary supplements to promote, maintain, and restore health. The bill defines magnet, plant, animal, mineral products, and dietary supplement.

SB 716 (Machado, Chapter 142) This bill redefines the term "psychotherapist" to provide that communication between a patient and a registered or licensed professional (or his or her trainee or intern) whom the patient reasonably believes is a "psychotherapist" would be confidential and privileged.

SB 802 (Perata, Chapter 349) Urgency, September 27, 2001. This bill enacts the Toxic Mold Protection Act, intended to protect the public from adverse health effects related to the presence of molds in residential and commercial properties.

SB 1169 (Alpert, Chapter 900) This bill authorizes a pharmacist to initiate emergency contraception drug therapy in accordance with standardized protocols developed by the pharmacist and an authorized prescriber acting within his or her scope of practice. The bill requires a pharmacist who initiates emergency contraception drug therapy pursuant to these provisions to provide the recipient with a standardized fact sheet developed by the California State Board of Pharmacy, in consultation with the State Department of Health Services, the American College of Obstetricians and Gynecologists, the California Pharmacists Association, and other healthcare organizations. The bill also requires that prior to performing this procedure a pharmacist complete a specified training program. (See page 14 for more information.)

SB 1174 (Polanco, Chapter 640) This bill exempts certified emergency medical technicians and licensed paramedics from California clinical laboratory regulation for performing blood glucose tests while providing basic or advanced life support services.

ADMINISTRATIVE ACTIONS: AUGUST 1, 2001 TO OCTOBER 31, 2001

PHYSICIANS AND SURGEONS

ALAPATI, RAVINDRA, M.D. (A45634)
Anaheim, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with dishonesty for conspiring to disseminate insider information and securities trading on the NASDAQ exchange. Public Letter of Reprimand. August 23, 2001

ASHOKAN, ANNAMALAI, M.D. (A43142)
Monterey, CA
B&P Code §§726, 2234, 2236. Stipulated Decision. Committed acts of unprofessional conduct and sexual misconduct in the care and treatment of a patient. Convicted of sexual exploitation of a patient. Revoked, stayed, 5 years probation with terms and conditions including 60 days actual suspension. September 24, 2001

BENNETT, VINCENT JOSEPH, M.D. (G75983)
Paramount, CA
B&P Code §2264. Stipulated Decision. Aided and abetted the unlicensed practice of medicine in an employment relationship with a board and care facility. Public Reprimand. September 26, 2001

BLOOM, JOSEPH, M.D. (G7184) La Jolla, CA
H&S Code §11217. Stipulated Decision. Prescribed excessive quantities of methadone to a patient with a history of drug addiction and chronic use of methadone. Public Letter of Reprimand. September 26, 2001

CHI, ANDREW YINTAH, M.D. (A76299)
Manhattan Beach, CA
B&P Code §480(a)(1)(3). Stipulated Decision. Failed to disclose conviction of a crime on his license application. License issued, revoked, stayed, 5 years probation with terms and conditions. August 22, 2001

Explanation of Disciplinary Language and Actions

“Effective date of decision” — Example: “October 10, 2001” at the bottom of the summary means the date the disciplinary decision goes into operation.

“Gross negligence” — An extreme deviation from the standard of practice.

“Incompetence” — Lack of knowledge or skills in discharging professional obligations.

“Judicial review is being pursued” — The disciplinary decision is being challenged through the court system— Superior Court, maybe Court of Appeal, maybe State Supreme Court. The discipline is currently in effect.

“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.

“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.

“Public Letter of Reprimand” — A lesser form of discipline that can be negotiated for minor violations before the filing of formal charges (accusations). The licensee is disciplined in the form of a public letter.

“Revoked” — The license is canceled, voided, annulled, rescinded. The right to practice is ended.

“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.

“Stipulated Decision” — A form of plea bargaining. The case is negotiated and settled prior to trial.

“Surrender” — Resignation under a cloud. While charges are pending, the licensee turns in the license — subject to acceptance by the relevant board.

“Suspension from practice” — The licensee is prohibited from practicing for a specific period of time.

“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).

CLOUD, THOMAS CALVIN, III, M.D. (G41210)
Los Angeles, CA
B&P Code §§802.1, 2052, 2054, 2234(a)(e),
2236(a), 2306. Failed to comply with conditions of a
Medical Board probationary order, failed to report a
felony conviction and sentencing, represented
himself as a physician and practiced medicine while
license was suspended. Revoked.
September 26, 2001

CHERMANSKY, CHRISTOPHER JOHN, M.D.
(A76588) San Francisco, CA
B&P Code §§480(a)(1)(3), 2239. Stipulated
Decision. Two convictions for driving under the
influence of alcohol. Probationary license issued,
5 years probation with terms and conditions.
September 21, 2001

FELDMAN, ARNOLD ERWIN, M.D. (G85449)
Natchez, MS
B&P Code §§141(a), 2305. Stipulated Decision.
Disciplined by Mississippi for violation of laws and
regulations relating to prescribing, dispensing, and
administering controlled substances. Public
Reprimand. September 24, 2001

FROME, BRUCE M., M.D. (G8667)
Beverly Hills, CA
B&P Code §2234(b)(c)(d). Stipulated Decision.
Committed acts of gross negligence, incompetence
and repeated negligent acts in failing to obtain/use
appropriate medical tests and results in the care
and treatment of 3 patients. Revoked, stayed, 6
years probation with terms and conditions.
August 24, 2001

GARDNER, JAMES DONALD, M.D. (G51158)
Fresno, CA
B&P Code §2234. Violated terms and conditions of
Board-ordered probation. Revoked.
October 15, 2001

GRAY, TERENCE B., M.D. (G57450)
Petaluma, CA
B&P Code §2234. Stipulated Decision. No
admissions but charged with unprofessional
conduct in the care and treatment of a patient.
Public Reprimand. October 18, 2001

HEMPHILL, DONALD W., JR., M.D. (A22062)
Garden Grove, CA
B&P Code §§2234, 2266. Stipulated Decision.
Failed to maintain adequate and accurate records
in the care and treatment of a patient. Public Letter
of Reprimand. August 13, 2001

HILDEBRAND, JOHN FRANCIS, M.D. (C35182)
Elk Grove, CA
B&P Code §§726, 2234(b). Committed acts of
sexual misconduct and gross negligence with a
patient. Revoked. September 20, 2001

HUYEN, TRAN TIEN, M.D. (A31920)
Santa Ana, CA
B&P Code §§2234, 2266. Stipulated Decision.
Failed to maintain adequate and accurate records
in the care and treatment of a patient. Revoked,
stayed, 2 years probation with terms and conditions.
September 3, 2001

HWANG, DAVID YI-FONG, M.D. (A40132)
Anaheim, CA
B&P Code §§725, 2234(b)(c)(d), 2238, 2242, 2266.
Stipulated Decision. Committed acts of gross
negligence, repeated negligence and
incompetence, failed to maintain adequate and
accurate medical records, and prescribed
dangerous drugs and controlled substances without
prior examinations or medical indication in the care
and treatment of 3 patients. Revoked, stayed, 3
years probation with terms and conditions.
October 12, 2001

KING, WILLIAM S., M.D. (A26006)
San Diego, CA
B&P Code §2234, 2234(e). Violated terms and
conditions of Board-ordered probation by testing
positive for controlled substances and committed
acts of dishonesty. Revoked. September 24, 2001

KNOX, DALE GARFIELD, M.D. (G25182)
San Clemente, CA
B&P Code §2234(b). Stipulated Decision.
Committed acts of gross negligence by allowing
unlicensed persons to provide medical care to a
patient. Revoked, stayed, 7 years probation with
terms and conditions. September 6, 2001

KORMI, TOURAJ, M.D. (A48807) Pinole, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with unprofessional conduct due to the self-use of controlled substances. Revoked, stayed, 5 years probation with terms and conditions. October 29, 2001

LAWSON, DAVID GERALD, M.D. (A41446)
Mesa, AZ
B&P Codes §§141(a), 726, 2234, 2305. Disciplined by Missouri for sexual relations with 2 female patients. Revoked. October 25, 2001

LEHMANN, LANCE JOSEPH, M.D. (G75590)
Las Vegas, NV
B&P Code §141(a). Disciplined by Florida based on inappropriate care and treatment of a patient. Revoked. October 15, 2001

LIBUNAO, JOSE PABLO, III, M.D. (A39794)
Anaheim, CA
B&P Code §§141(a), 2234. Stipulated Decision. Disciplined by Pennsylvania for failure to provide patients with adequate access to their medical records. Public Letter of Reprimand. September 17, 2001

MAKAM, RAVIPRAKASH, M.D. (A40900)
Anaheim, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with dishonesty for conspiring to disseminate insider information and securities trading on the NASDAQ exchange. Public Letter of Reprimand. August 15, 2001

MATSUMOTO, KENNETH K., M.D. (C16161)
Beverly Hills, CA
B&P Code §2234. Stipulated Decision. Charged with gross negligence, incompetence and unprofessional conduct in the care and treatment of a patient after diagnosing and continuing to diagnose esophagitis throughout treatment period without performing or referring the patient for a diagnostic study or endoscopy, even after detection of a submucosa mass. Public Letter of Reprimand issued and license is placed on inactive (non-practice) status. If license is reactivated, then it will be revoked, stayed, placed on 10 years probation with terms and conditions. October 26, 2001

MCCANNE, MONTE O., M.D. (A28758)
San Juan Capistrano, CA
B&P Code §§2234, 2266. Stipulated Decision. Failed to maintain complete and accurate records and prescribed Antabuse to a patient after determination that the patient was jaundiced and may have had hepatitis. Public Letter of Reprimand. October 15, 2001

McCOURT, KATHY MAUREEN, M.D. (A46539)
Ventura, CA
B&P Code §2234. Stipulated Decision. Failed to release medical records for 35 patients. Revoked, stayed, 5 years probation with terms and conditions. October 5, 2001

MYERS, JEFFREY MARTIN, M.D. (A49094)
Bradenton, FL
B&P Code §§141(a), 2234. Stipulated Decision. Disciplined by Florida for requiring and receiving full payments from a patient at the time of service, then submitting claims to the patient's insurance company for payment of those same charges, and failing to refund the overpayment amount to the patient. Public Letter of Reprimand. August 1, 2001

MODI, KANAN ANIL, M.D. (A38793)
San Dimas, CA
B&P Code §2266. Stipulated Decision. Failed to maintain adequate and accurate records. Current probation extended for an additional 3 years with terms and conditions. August 23, 2001

NUNEZ, OSCAR GARCIA, M.D. (G47907)
Milpitas, CA
B&P Code §§726, 2234(b). Committed gross negligence and sexual misconduct while treating a female patient. Revoked. September 3, 2001

PANAHI, GHAROON, M.D. (A34894)
Fountain Valley, CA
B&P Code §§2234(b)(c)(d), 2266. Committed acts of negligence, incompetence and repeated negligent acts and failed to maintain adequate medical records in the care and treatment of a patient. Revoked, stayed, 5 years probation. October 26, 2001

PANGULURI, RANGARAO, M.D. (A52987)
Baldwin Park, CA

B&P Code §2234. Stipulated Decision. No admissions but charged with dishonesty for conspiring to disseminate insider information and securities trading on the NASDAQ exchange. Public Letter of Reprimand. August 10, 2001

PARAGAS, RODNEY ROMINE, M.D. (C36467)
Santa Barbara, CA

B&P Code §2242. Stipulated Decision. Prescribed dangerous drugs to a patient without conducting a physical examination. Public Letter of Reprimand. August 15, 2001

RASHEED, AMJAD ADNAN, M.D. (A76606)
Redding, CA

B&P Code §480(a)(1)(2)(3), 480(c). Stipulated Decision. Failed to disclose a criminal conviction on his application for a physician and surgeon's license. Probationary license issued, 3 years probation with terms and conditions. September 21, 2001

REITER, ALVIN, M.D. (G24550) Beverly Hills, CA
B&P Code §§810, 2234, 2234(e)(f), 2236(a). Stipulated Decision. Convicted of 4 counts of mail fraud and aiding and abetting the submission of false and fraudulent medical claims. Revoked, stayed, 7 years probation with terms and conditions. August 20, 2001

SHAHEEN, RUBINA, M.D. (A56311) Anaheim, CA
B&P Code §§2234(e), 2261. Stipulated Decision. Committed dishonest acts by failing to disclose information regarding prior dismissal and termination from a residency program on an application for membership to an HMO program. Public Reprimand. October 1, 2001

SHELL, WILLIAM ELSON, M.D. (C32361)
Los Angeles, CA

B&P Code §2234. Stipulated Decision. No admissions but charged with violation of terms and conditions of Board-ordered probation. Current probation period extended until December 31, 2001 or until the terms and conditions of the decision are completed. October 10, 2001

Drug or Alcohol Problem?

If you are concerned about a fellow physician who you think is abusing alcohol or other drugs or is mentally ill, you can get assistance by asking the Medical Board's Diversion Program to intervene.

Physicians are not required by law to report a colleague to the Medical Board. However, according to the American Medical Association Code of Ethics, physicians have an ethical obligation to report a peer who is impaired or has a behavioral problem that may adversely affect his or her patients or practice of medicine to a hospital well-being committee or hospital administrator, or to an external impaired physicians program such as the Diversion Program.

Your referral may save a physician's life and can help ensure that the public is being protected.

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www.medbd.ca.gov

**Medical Board of California
Physician Diversion Program
1420 Howe Avenue, Suite 14
Sacramento, CA 95825**

SIMPSON, GEORGE TRUE, II, M.D. (G28083)
Buffalo, NY

B&P Code §§141(a), 2305. Disciplined by New York for gross negligence in the care and treatment of a patient. Public Reprimand. October 29, 2001

SMARS, GUNNAR ANDERS, M.D. (G43985)
Redlands, CA

B&P Code §§2234(b)(c)(e), 2236(a). Convicted of falsely representing his name in a passport application and failed to comply with court-ordered probation. Revoked. October 9, 2001

SULLIVAN, TERENCE RAYMOND, M.D. (G25099) San Jose, CA
B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in the care and treatment of a patient during a hernia repair. Revoked, stayed, 5 years probation with terms and conditions. September 28, 2001

SWANSON, KARL ERIC, M.D. (G60534) Fort Walton Beach, FL
B&P Code §§2236(a), 2305. Stipulated Decision. Disciplined by Florida for conviction of 1 count of conspiracy to possess drugs with intent to distribute. Revoked, stayed, 5 years probation with terms and conditions. September 24, 2001

SYAL, PARVIN, M.D. (A37754) Northridge, CA
B&P Code §§2234, 2234(e), 2236(a). Stipulated Decision. Criminal conviction for filing false or fraudulent Medi-Cal claims. Revoked, stayed, 3 years probation with terms and conditions. October 29, 2001

TENNANT, FOREST SEARLS, JR., M.D. (G22141) West Covina, CA
B&P Code §§490, 810, 2234(a)(e), 2236(a), 2261, 2262. Stipulated Decision. Criminal conviction for filing false or fraudulent Medi-Cal claims. Revoked, stayed, 4 years probation with terms and conditions. September 24, 2001

TOTH, JOHN P., M.D. (A17586) Concord, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with repeated departure from the standard of care in the treatment of a patient. Public Reprimand. October 17, 2001

VESCO, DAVID MICHAEL, M.D. (A43384) Calabasas, CA
B&P Code §§725, 2234, 2234 (b)(c)(d), 2238, 2241, 2242. 2242(a). Stipulated Decision. Prescribed excessive controlled substances to a patient with a history of drug abuse without attempting to treat chronic pain by methods other than medication. Revoked, stayed, 2 years probation with terms and conditions. September 6, 2001

VESPE, JOHN ROBERT, M.D. (G72675) Tempe, AZ
B&P Code §2234, 2234(a)(e). Violated terms and conditions of probation, including failure to notify the Medical Board that he was practicing in California. Revoked. August 15, 2001

WALL, WENDELL ALAN, M.D. (G68245) Wahpeton, ND
B&P Code §141(a). Stipulated Decision. Disciplined by North Dakota for unprofessional conduct and not providing appropriate documentation in medical records. Public Reprimand. August 31, 2001

WELLS, ROBERT N., M.D. (A22094) Fresno, CA
B&P Code §2234(e). Stipulated Decision. Committed dishonest or corrupt acts by communicating, via the Internet, explicit sexual matter with an undercover officer posing as an underage female. Revoked. October 31, 2001

ZAKI, ALY ATEF ABEL RAHMAN AHNEO, M.D. (A37358) San Jose, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with purchase and subsequent resale of a dangerous drug for overseas distribution and sale. Public Letter of Reprimand. August 1, 2001

PHYSICIAN ASSISTANTS

CRAWFORD, THOMAS WILLIAM, P.A. (PA14580) San Leandro, CA
B&P Code §§ 2234, 2234(f), 2239(a), 2266. Stipulated Decision. Failed to chart or account for controlled medications administered to 6 patients while on duty as a registered nurse. Revoked, stayed, 3 years probation with terms and conditions. August 13, 2001

RINSET, GUNDER SIGVALD, II, P.A. (PA10122) Georgetown, CA
B&P Code §725. Stipulated Decision. Performed excessive number of examinations on a 30-month-old child without medical indication, at the request of the child's parent. Public Reprimand. August 1, 2001

SPENCER, BRIAN EARL, P.A. (PA12373)
Las Vegas, NV
B&P Code §§ 2234, 2236(a), 2237, 2239. Stipulated Decision. Criminal conviction for possession of a controlled substance, possession of marijuana, being under the influence of controlled substance and possession of drug paraphernalia. Revoked, stayed, 3 years probation with terms and conditions. October 18, 2001

SUHR, DANIEL AUGUST, P.A. (PA14016)
Mission Viejo, CA
B&P Code §§ 490, 2239(a), 2234, 3531. Stipulated Decision. Criminal conviction for driving under the influence of alcohol, and having a measurable amount of marijuana in his bloodstream while at work. Revoked, stayed, 5 years probation with terms and conditions, including 7 days actual suspension. August 30, 2001

DOCTOR OF PODIATRIC MEDICINE

WEBER, GAREY LEE, D.P.M. (E1371)
Studio City, CA
B&P Code § 2234, 2234(a) Violated terms and conditions of Board-ordered probation and treated 3 patients while his license was suspended. Revoked. October 19, 2001

SURRENDER OF LICENSE WHILE CHARGES PENDING

PHYSICIANS AND SURGEONS

BURACK, NEIL DAVID, M.D. (G54550)
September 21, 2001 (No accusation was filed in this case.)

CADAG, SANTIAGO TOPACIO, M.D. (A39899)
August 30, 2001

CHEN, SAMUEL PAN, M.D. (A38456)
August 7, 2001

HENRIQUES, GAVIN ANTHONY, M.D. (A62781)
October 4, 2001

HARRIS, HENRY DAVIS, M.D. (A39781)
October 3, 2001

LEE, SUN KUN, M.D. (A30787)
October 9, 2001

MONT, HALLIE B., M.D. (A12865)
August 31, 2001

SCOTTI, STEPHEN DOUGLAS, M.D. (G84593)
October 18, 2001

WALKER, SAMUEL R., M.D. (C25783)
August 22, 2001

YAGODA, CHARLES LAWRENCE, M.D. (G29486)
September 11, 2001

YOUNG, JOSEPH D., M.D. (G10679)
October 5, 2001

For further information...

Copies of the public documents attendant to these cases are available at a minimal cost by calling the Medical Board's Central File Room at (916) 263-2525.

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ACTION REPORT - JANUARY 2002
Candis Cohen, Editor (916) 263-2389

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