

Action Report

Medical Board of California

President's Report	2
Update: Pain Management and End-of-Life Mandatory CME	3
Easy Access to New Continuing Medical Education Information	3
J-1 Visa Waiver Program	4
IN THIS ISSUE	
State Warns Consumers About Prescription Drugs in Herbal Products	5
Updated Primary Care Practice Guidelines for Alzheimer's Disease Management	6-7
News From the U.S. Food and Drug Administration	8-9
Addressing Cultural Factors in Relation to Mammography Screening	10-11
Administrative Actions	14-19

Healthcare and the Nursing Home: The Role of Physicians in Improving the Quality of Care Delivered

By Cheryl Phillips, M.D., CMD
 Medical Director of Skilled Nursing and Chronic Care, Sutter Health

Taken from an anonymous letter to the Los Angeles Times, September 23, 1979:

I am an 84-year-old woman, and the only crime which I have committed is that I have an illness which is called chronic. I have severe arthritis and about five years ago I broke my hip. I wound up at a convalescent hospital (with) all kinds of people thrown together here. I sit and watch, day after day A doctor comes to see me once a month. He spends approximately three to five seconds with me, and then a few more minutes writing in the chart or joking with the nurses. (My own doctor doesn't come to convalescent hospitals, so I had to take this one.)...

I noticed that most of the physicians who come here don't even pay attention to things like whether their patients' fingernails are trimmed or whether their bodies are foul-smelling. ...

I am writing this because many of you may live to be old like me, and by then it will be too late. You, too, will be stuck here and wonder why nothing is being done, and you, too, will wonder if there is any justice in life. ...

addressing the concerns of restraint use for behaviors and other care issues. Following that report, significant changes occurred in the form of new regulations and survey oversight. There was measurable improvement in the use of physical and chemical restraints for behavior management and in the way nursing staff recognized, reported and responded to various changes of condition. However, some of the same nagging problems and issues of quality have persisted. Both advocate groups and consumers have continued to point out gaps between quality promised and quality delivered.

In July of 1998, the General Accounting Office presented a report to the Special Committee on Aging in the U.S. Senate that looked at the issues of concern in California. They concluded that of the 1,370 California nursing homes nearly three-quarters had cases of unacceptable care. The problems that they found most frequently were pressure ulcers, unplanned weight loss and dehydration. These findings were further supported by a recent (2000) report of the Institute of Medicine (IOM) on nursing home care in the U.S. The IOM acknowledged that there were improvements in the use of psychoactive medications and restraints, but that problems with pain, weight loss, incontinence management, and pressure sores persist. President Bush has joined the drive to improve the quality of care in nursing homes by committing \$67.3 million in the President's 2002 Budget for the Nursing Home Oversight Improvement Program.

The above letter was written about nursing homes over 20 years ago. Since that time there have been a number of federal and state regulatory changes in nursing home care. The Institute of Medicine issued a report in 1986

(Continued on page 12)

Medical Board of California Meetings

2002

May 9 -11	Orange County
Aug. 1-3	San Francisco
Nov. 7-9	San Diego

All meetings are open to the public.

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

The Medical Board of California currently finds itself at the hub of a statutory conflict. The issue in question, whether the Board should make public its records of malpractice settlements, raises the antithetical juxtaposition of the people's "right to know," in this case via the California Public Records Act, versus an individual's right to privacy, as guaranteed by the California Constitutional Right of Privacy, Article 1, Section 1 of our state Constitution. How is such a conundrum resolved? Fortunately, the labyrinthine ways of democracy provide both a beacon and a vehicle for navigation. The legacy of the doctrine of judicial review as established by Chief Justice John Marshall 200 years ago in *Marbury v. Madison* continues to this day to provide a framework within which to test the seeming collision of statute and the Constitution. Thus, the authority for resolution rests squarely in the courts.

At the time of this writing, the fate of a lawsuit brought against the Medical Board of California that might resolve this conflict in law lies in the mind and hands of the Honorable Morrison C. England, Judge of the Superior Court of the State of California in and for the County of Sacramento. This action was brought to prevent the Medical Board from releasing settlements in response to a request by a leading California newspaper under the California Public Records Act. In responding to the temporary restraining order, which has initially forestalled the release of the records, our Board identified and acknowledged "an inescapable tension between the pertinent statutes" and stated: "The Board does not wish to withhold from consumers information the Legislature intended them to have. At the same time, it has no wish to countermand the Legislature's directives regarding confidentiality and has no desire to violate physicians' legislatively or constitutionally conferred rights of privacy. For these reasons, the Board would welcome the courts' guidance. ..."

In making its case to the public as the situation has evolved, the newspaper has characterized the Medical Board as "routinely disregards the law"... "has done immeasurable harm to patients"... and "deliberately decided not to tell consumers about several multimillion dollar jury verdicts against doctors." In an effort to provide clarity to the aforementioned (e.g., the fact that the Board never disregards the law), an opinion editorial was offered by the Board to the paper, but was rejected, initially on the grounds that rebutting news stories was not appropriate for an op ed



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

page and subsequently, after a version to be for educational purposes only (e.g., what the Board's charges and authority are), that it was too informational.

Finally, the newspaper has filed as an "Intervener" in the lawsuit, declaring it possesses both a substantive and consequential role as an object of the action, claiming it intends to use the malpractice settlement records to demonstrate that the Medical Board is not sufficiently investigating and disciplining physicians as evidenced by their malpractice settlements, implying a direct linkage of such settlements with inappropriate medical practice. The

California Medical Association has filed an *amicus curiae* brief pointing out the perverse sequence of incentives involved in settlement decision making that are oftentimes unrelated to the quality of medical care delivered in a given case.

Although appearing as a Gordian tenet, the conflict between the right to know and the right of privacy is an important one for all citizens and deserves democracy's attention. And who is funding the resolution process? Why, those who provide the funds for the attorneys of the opposing parties, all of which, with the exception of the newspaper, are supported by fees which are paid by MDs: noble or ironic? Probably both.

The Underserved of California

In the October '01 issue of the *Action Report*, I presented the problem of the large underserved (primarily Hispanic) population of our state as well as the initial remedy being explored by the Legislature, that of a corps of physicians from Mexico coming to work in clinics in the underserved areas as part of a pilot program. This would require a modification of licensure standards. At this time I am pleased to report that the Medical Board has developed a proposal to provide the needed physician access in these areas, with a program incentivizing California-licensed physicians in the appropriate specialties (primary care) through loan relief. The program would be complemented by the creation of a new international fellowship category sponsored by the Board and created in statute. This would significantly enhance the culturally competent delivery of medical care in these areas. No relaxing or alteration of licensing standards would be required. Approximately 50

(Continued on page 4)

Update: Pain Management and End-of-Life Mandatory CME

On January 1, 2002 a new law became effective, AB 487 (Aroner, Chapter 518), that requires most physicians to take 12 credits of continuing medical education (CME) in pain management and the treatment of terminally ill and dying patients. This one-time requirement for currently licensed physicians must be completed by December 31, 2006; physicians licensed after January 1, 2002 must complete the 12 credits by the time of their second license renewal. Pathologists and radiologists are exempt from this new law.

The Board has received numerous inquiries from physicians and hospitals, asking what must be included in CME courses to qualify them for credit under this new law.

At the present time, the Board will accept programs and courses relating to pain management and end-of-life care

which qualify for Category I credit from the following organizations:

1. California Medical Association—CMA
2. American Medical Association—AMA
3. American Academy of Family Physicians —AAFP
4. Accreditation Council for Continuing Medical Education—ACCME

Physicians may choose one or several courses within the mandatory four-year period for the 12 credits. The Medical Board may develop regulations to further define the requirements to fulfill this new law, but any changes will be applied prospectively. Any new information will be provided in future *Action Reports*.

Easy Access to New Continuing Medical Education Information

The Medical Board's Web site recently has been expanded to include additional information related to Continuing Medical Education (CME) requirements.

Each option will provide you with current, up-to-date information that relates to CME. The Medical Board has received numerous inquiries from physicians regarding the recent law changes requiring courses in "Pain Management and End of Life (Palliative Care)" and also "Geriatric Medicine." The most current information available will be noted under the category, "New Laws Related to Continuing Medical Education." The information related to CME has been broadened and now provides new material that will answer many of those questions.

You may access this information on the Board's Web site at www.medbd.ca.gov. Click on "Services for Licensees," then click on "Continuing Medical Education." The following options also are available:

- [Frequently Asked Questions — Continuing Medical Education](#)
- [Continuing Medical Education Audit and Waiver Information](#)
- [Continuing Medical Education — Options Available to You](#)
- [Application for Continuing Medical Education Waiver](#)
- [New Laws Related to Continuing Medical Education](#)

CONTINUING MEDICAL EDUCATION

Cedars-Sinai Medical Center, Department of Anesthesiology sponsors:

Pain Management and End of Life Care (Fulfills California's New State Licensing Requirement)

May 18-19, 2002

Cedars-Sinai Medical Center

8700 Gracie Allen Drive

Harvey Morse Conference Center

Los Angeles

This course is a comprehensive program that encompasses all aspects of pain management for the non-pain management practitioner.

Significant materials that deal with the dying adult and child will be presented. Cedars-Sinai Medical Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing education for physicians.

Cedars-Sinai Medical Center designates this continuing medical education activity for a maximum of 12 hours in category 1 credit towards the AMA Physician's Recognition Award. For registration information contact the Office of Medical Education at (310) 423-5548 or e-mail Bari.Laner@cshs.org.

J-1 Visa Waiver Program

The “J” visa is a nonimmigrant visa category for persons participating in exchange visitor programs in the United States. The exchange visitor holds a “J-1” visa, while there are “J-2” visas for the visitor’s spouse and immediate family. The “J” exchange visitor program is designed to promote the interchange of persons, knowledge, and skills in the fields of education, arts, and sciences. Certain “J” exchange visitors, including foreign medical graduates, are required to return to their home country after completing their program in the United States and reside there physically for at least two years before they may become eligible to apply for an immigrant or temporary worker visa. However, federal law provides certain bases upon which a J-1 visitor can apply for a waiver of the two-year residence requirement.

The California Department of Health Services (DHS) has been authorized to recommend to the U.S. State Department the waiver of the two-year residence requirement for up to 20 “J-1” physicians per year (known as the Conrad State 20 Program).

Federal and state law requires any physician who provides evidence of meeting all of the following criteria to be eligible for DHS’ recommendation of a waiver:

1. The physician graduated from a medical school and is working in California pursuant to a J-1 visa;
2. The physician has an active California medical license;
3. For physicians applying for a primary care slot, the physician has a least one recommendation from his or her primary care residency program;
4. For physicians applying for a specialist or subspecialist slot, the physician has at least one recommendation from his or her fellowship/ specialty/subspecialty training program;
5. The physician has graduated from the residency program, specialty or subspecialty training program;
6. The physician has submitted to DHS copies of specified Certificate of Eligibility forms; and
7. The physician has a signed contract with a facility meeting the following criteria:
 - a) The physician’s practice will be on a full-time basis;
 - b) The practice will commence within 90 days of receipt of the waiver and will continue for a period of at least three years;
 - c) The facility is publicly funded or a private entity;
 - d) The practice is located in a federally designed shortage area;
 - e) The facility is licensed to do business in the state;
 - f) The facility offers primary healthcare services; and,
 - g) The facility services Medicare, medicaid, low-income and uninsured clients, and the population designed by the federal government.

This program has been established within the Department of Health Services. Those interested, or who have questions, should contact Susanna Torricella at storrice@dhs.ca.gov. To participate an applicant or sponsoring agency will be required to obtain forms from a local INS office. Time lines for approval of the waivers through the federal government have not been established and may take considerable time due to background verifications.

President’s Report (continued from page 2)

percent of the funding for the program would be provided by the Medical Board of California reserve funds, with a matching component from private sources such as an endowment or foundation.

At the time of this publication, the above proposal is being considered by the Board. The Board is working with multiple interested parties including the California Medical Association and involved legislators.

Interestingly enough, once again for this large public issue, it is physician licensing resources (the reserve funds mentioned) that would be getting the program started. What better use of funds than to help provide medical care to fellow residents who are currently underserved? Ultimately, all taxpaying citizens of this state would share the cost of the program, a prudent use of General Fund resources to help provide healthcare to all of our residents.

State Health Director Warns Consumers About Prescription Drugs in Herbal Products

The following is the text of a recent news release from the California Department of Health Services (www.dhs.ca.gov).

Sacramento, Calif. (Feb. 7, 2002) — Consumers should immediately stop using the dietary supplement herbal products PC SPES and SPES capsules because they contain undeclared prescription drug ingredients that could cause serious health effects if not taken under medical supervision, State Health Director Diana M. Bontá, R.N., Dr. P.H., said today. PC SPES and SPES are respectively marketed “for prostate health: and strengthening the immune system.”

BotanicLab, the Brea, Calif.-based manufacturer of the products, has voluntarily recalled PC SPES and SPES nationwide.

“Consumers should stop using these products and immediately seek medical advice, especially if they currently are using any other prescribed medication,” Bontá said. “Consumers should consult with their healthcare providers whenever they take an herbal product or a dietary supplement.”

Her warning followed an investigation and laboratory analysis of the products by the California Department of Health Services’ Food and Drug Branch that found PC SPES contains warfarin and SPES contains alprazolam, which are available only by prescription and sold either by their generic names or the trade names, Coumadin and Xanax, respectively. Warfarin is an anticoagulant or “blood thinner” used to decrease the clotting ability of the blood, and alprazolam is used to treat anxiety and panic disorders.

Warfarin can cause serious bleeding, according to the CDHS experts. This bleeding can be affected by many other different

medicines, including aspirin and other anti-inflammatory or pain medicines, antibiotics and antifungals, thyroid drugs, antidepressants and cholesterol-lowering drugs.

Alprazolam exacerbates the effects of alcohol and other central nervous system depressants. It also may be habit-forming.

PC SPES is available in 60-capsule bottles, and SPES is available in 30-capsule bottles, through mail or telephone order, Internet sales and from distributors, retailers and healthcare professionals.

PC SPES are clear capsules that contain light brown powder. The label is light brown with a blue border and the name “BotanicLab PC SPES” on the front panel. SPES are clear capsules that contain brown powder. The label is light brown with a brown border and the name “BotanicLab SPES” on the front panel.

Consumers who have unused SPES and PC SPECS capsules should return the product in its original packaging to PC SPES Recall Program, 2900-B Saturn Street, Brea, CA 92821 (1-800-458-5854). CDHS’ Food and Drug Branch is continuing to investigate these products and can be reached at 1-800-495-3232 for more information. The U.S. Food and Drug Administration is assisting in the investigation and monitoring of the recalls throughout the United States.

To view the recall notice, consumers may visit www.botaniclab.com/html/recall.html.

STD CONFERENCE

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, University of 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@rdlent.com.

Watch for registration online at www.rdlent.com.

Updated Primary Care Practice Guidelines for Alzheimer's Disease Management

By Debra L. Cherry, Ph.D., Associate Executive Director, Alzheimer's Association of Los Angeles and Jeffrey Cummings, M.D., Director, Alzheimer's Disease Center, UCLA

The California *Guidelines for Alzheimer's Disease Management*, originally released in September 1998, have been updated and are now available through the State Department of Health Services, Alzheimer's Disease Program at (916) 327-4662 (AlzheimersD@dhs.ca.gov) or downloaded from the Alzheimer's Association Web site at www.caalz.org. These evidence- and consensus-based guidelines provide support for primary care providers who are increasingly encountering this disease, with its complex post-diagnostic management issues.

The California Workgroup on Guidelines for Alzheimer's Disease Management, supported by the California Department of Health Services (DHS), the federal Administration on Aging, and the Health Resources and Services Administration's Bureau of Primary Health Care, have released an updated clinical practice guideline on the post-diagnostic management of Alzheimer's disease. The guideline is part of a statewide initiative lead by DHS and the Alzheimer's Association to improve healthcare for people with Alzheimer's disease. Implementation of the guideline is currently under way at a number of healthcare organizations.

Practice Issues in Alzheimer's Disease Management

Alzheimer's disease is a progressive, degenerative disease of the brain, and the most common form of dementia in older adults. It is estimated to afflict over 450,000 people in the State of California and its incidence doubles every five years after 60 years of age. Risk factors for this disease include increasing age, gender (more women are affected), prior head injury, and genetic predisposition. The symptom pattern is characterized by a gradual onset of continuing cognitive decline including memory impairment and at least one other cognitive deficit (aphasia, apraxia, disturbance in executive functioning or agnosia).

Alzheimer's disease is significantly under-diagnosed and often left untreated. However, once a clinical diagnosis of Alzheimer's disease has been made, a treatment strategy should be developed that includes evaluation for cholinesterase inhibitors, management of co-morbid conditions, and referral of the family to supportive and health education services.

The use of cholinesterase inhibitors can produce modest improvements in cognitive function and temporarily stabilize or reduce the rate of decline. Four cholinesterase inhibitors are currently on the market including donepezil (Aricept), galantamine (Reminyl), rivastigmine (Exelon), and tacrine (Cognex).

Management of co-morbid conditions includes assessment and treatment of a range of possible conditions that make the dementia appear worse. Treatment of depression, urinary tract infections and a host of reversible conditions can restore a person with Alzheimer's disease to a higher level of function and, in some cases, prevent premature institutionalization.

A recent survey commissioned by the Alzheimer's Association (2001) assessed the perceptions of Alzheimer's caregivers and primary care physicians about how they communicate on treatment and caregiving issues. Five hundred primary care physicians and 376 family caregivers from across the United States were interviewed in the spring of 2001. The survey found large gaps between what caregivers and physicians say they discussed at the time of diagnosis. For example: 57 percent of caregivers said they wanted information about what to expect as the disease progressed, but only 38 percent said they received such information. In contrast, 83 percent of physicians said they provide such information. Thirty-one percent of caregivers said they received recommendations from their physicians on where to find help and services, but 88 percent of physicians said they provided such advice to caregivers. In a disease where medical care is highly dependent upon family support, clear communication and education are essential.

Alzheimer's Disease Management Guideline

To improve the quality of Alzheimer's care in the primary care setting, California's *Guidelines for Alzheimer's Disease Management* recommend the following:

A periodic assessment should be conducted documenting daily function (bathing, feeding, etc.), cognitive status, other medical conditions and behavioral problems. Reassessment should occur every six months or more frequently with any sudden decline or behavioral change.

(Continued on page 9)

GUIDELINES FOR ALZHEIMER'S DISEASE MANAGEMENT

ASSESSMENT

- Conduct and document an assessment of:
 - Daily function, including feeding, bathing, dressing, mobility, toileting, continence and ability to manage finances and medications
 - Cognitive status using a reliable and valid instrument (e.g., the MMSE)
 - Other medical conditions
 - Behavioral problems, psychotic symptoms, or depression
- Reassessment should occur every 6 months or more frequently with any sudden decline or behavioral change.
- Identify the primary caregiver and assess the adequacy of family and other support systems.
- Assess the patient's decision-making capacity and whether a surrogate has been identified.
- Caregiver's needs and risks should be assessed and reassessed on a regular basis.
- Assess the patient's and family's culture, values, primary language, literacy level and decision-making process.

TREATMENT

- Develop and implement an ongoing treatment plan with defined goals. Include:
 - Use of cholinesterase inhibitors, if clinically indicated, to treat cognitive decline
 - Appropriate treatment of medical conditions
 - Referral to adult day services for appropriate structured activities, such as exercise and recreation
- Treat behavioral problems and mood disorders using:
 - Non-pharmacologic approaches, such as environmental modification, task simplification, appropriate activities, etc.
 - Referral to social service agencies or support organizations, including the Alzheimer's Association's Safe Return Program for people who may wander
 - Medications, if clinically indicated and non-pharmacologic approaches prove unsuccessful

PATIENT & CAREGIVER EDUCATION & SUPPORT

- Discuss the diagnosis, progression, treatment choices and goals of AD care with the patient and family in a manner consistent with their values, preferences and the patient's abilities.
- Refer to support organizations for educational materials on community resources, support groups, legal and financial issues, respite care, future care needs and options. Organizations include:
 - **Alzheimer's Association** **1-800-660-1993** **www.caalz.org**
 - **Family Caregiver Alliance & Caregiver Resource Centers** **1-800-445-8106** **www.caregiver.org**
 or your own social service department
- Discuss the patient's need to make care choices at all stages of the disease through the use of advance directives and identification of surrogates for medical and legal decision-making.
- Discuss the intensity of care and end-of-life-care decisions with the person with AD and the family.

REPORTING REQUIREMENTS

- Abuse: Monitor for evidence of and report all suspicions of abuse (physical, sexual, financial, neglect, isolation, abandonment) to Adult Protective Services or your local police department, as required by law (California Welfare and Institutions Code, Section 15630).
- Driving: Report the diagnosis of AD to your local health officer in accordance with California law (Sections 2800 - 2812 of Title 17, California Code of Regulations).

Prepared by the California Workgroup on Guidelines for Alzheimer's Disease Management. Supported by the California Department of Health Services and the Alzheimer's Association, Los Angeles, under Contract No. 00-91317, the federal Health Resources and Services Administration's Bureau of Primary Health Care, and the Administration on Aging. California Version-R 010102 © 2002

News From the U.S. Food and Drug Administration

Free Electronic Mailing Lists

The FDA has a variety of free electronic mailing lists to keep you up to date with news about the agency's activities and the products it regulates. Use the links on the bottom of the FDA home page (www.fda.gov) to subscribe.

- FDA News Digest — Current FDA activities, with links to press releases, talk papers and more.
- MedWatch — Receive immediate notification of safety alerts on drugs, medical devices and dietary supplements regulated by the FDA.
- FDA Consumer — A summary of, and links to, articles in the latest issue of FDA's magazine.
- FDA HIV/AIDS — FDA HIV/AIDS-related information including product approvals, significant labeling changes, safety warnings, notices of upcoming public meetings and alerts to proposed regulatory guidances for comment.
- Center for Drug Evaluation and Research — Daily or weekly notices of new additions to the CDER Web site.
- Center for Devices and Radiological Health — Separate lists for CDRH news, medical device alerts, mammography, single-use devices, and CDRH TV broadcasts.
- Dietary Supplements/Food Labeling Electronic Newsletter — Information and updates on dietary supplements, food labeling and nutrition issues.
- Food Safety Electronic Information Networks — Lists for food safety educators and for other professionals interested in food-safety issues.
- Center for Biologics Evaluation and Research — Lists for blood-product recalls and other CBER information.
- Regulatory Research Perspectives: Impact on Public Health — This FDA/National Center for Toxicological Research quarterly journal provides a vehicle for FDA scientists to communicate research that impacts current or emerging regulatory issues to FDA and the global science community.
- FDA Dockets — Includes lists for advisory committee information, FDA-related Federal Register notices (pending and current), daily Federal Register table of contents, and citizen comments.

Lotronex Availability

A letter was sent to the Irritable Bowel Syndrome (IBS) patient community January 23, 2002 in response to recent requests for information regarding the status of Lotronex (alosetron HCl) tablets.

FDA approved Lotronex in February 2000 for use in the treatment of IBS in women whose predominant bowel symptom is diarrhea. Subsequently, numerous reports of serious and fatal gastrointestinal adverse events were reported which resulted in GlaxoWellcome voluntarily withdrawing Lotronex from the market.

Discussions between the drug manufacturer and FDA were initiated to explore ways to make Lotronex available to IBS patients while limiting risks of serious and fatal gastrointestinal adverse events. The goals for a limited access program are to ensure that the drug is used as safely as currently possible, generate additional data to enable safer use of the drug, and ensure that the drug is used by patients for whom the benefits exceed the risks.

New Lotronex information has been submitted that will lead to a better understanding of the risks and benefits of this drug. A carefully designed risk-management program is essential for safe use of Lotronex for patients who need it, and to effectively discourage its use for patients where the risks are likely to exceed the benefits. Given the importance of the risk/benefit issues that surround Lotronex, an FDA Advisory Committee will convene on April 23, 2002 to address those issues. A patient representative, a person with IBS, will serve on the committee.

Changes in Accutane Risk-Management Program Approved

On October 31, 2001, the FDA advised consumers and healthcare providers about significant changes to the risk-management program for pregnancy prevention for users of isotretinoin (Accutane). The new program is called SMART (System to Manage Accutane Related Teratogenicity). The manufacturer, Roche Laboratories, developed SMART in consultation with the FDA. The program is designed to enhance safe and appropriate use of isotretinoin by strengthening the drug's existing comprehensive patient education program.

Isotretinoin is approved to treat the most serious form of acne. This form of acne is painful, permanently disfiguring and does not respond to other acne treatments. Isotretinoin

(Continued on page 9)

News From the FDA

(continued from page 8)

is very effective, but its use carries significant potential risks, including birth defects and even fetal death.

In recent years, as more women have been receiving prescriptions for isotretinoin, the risk that pregnant women may be inappropriately using the drug has increased. SMART involves prescribers, patients and pharmacists in a partnership to prevent fetal exposure to isotretinoin.

The SMART program requires prescribers to study the manufacturer's "Guide to Best Practices" and then sign and return a letter of understanding to Roche. (The manufacturer has also developed a continuing medical education course for prescribers that includes specific, practical information about pregnancy prevention.) Prescribers will then receive special self-adhesive Accutane Qualification Stickers. All prescriptions for isotretinoin should have the special yellow sticker attached to the prescriber's regular prescription form. This sticker will indicate to the pharmacist that the patient is "qualified," which means that she has had negative pregnancy tests as well as education and counseling about pregnancy prevention.

All female patients must have two negative urine or serum pregnancy tests before the initial isotretinoin prescription is written, and for each month of therapy they must have a negative pregnancy test result before receiving their next prescription, regardless of whether they are sexually active.

Patients who are, or might become, sexually active with a male partner must also select and use two forms of effective contraception simultaneously for at least one month before starting isotretinoin therapy, during therapy, and for one month following discontinuation of therapy.

They must sign a patient information and consent form about isotretinoin and birth defects, in addition to the consent form that all patients should receive about other potentially serious risks. Finally, female patients must be given the opportunity to enroll in a confidential survey that will collect data to help Roche and FDA decide if SMART is helping to prevent exposure of unborn babies to isotretinoin.

Pharmacists will dispense isotretinoin only upon presentation of a prescription with the special sticker. Pharmacists will dispense a maximum one-month supply of isotretinoin, fill prescriptions within seven days from the date of "qualification," and provide a Medication Guide for patients with each isotretinoin prescription. Requests for refills and phone-in prescriptions will not be filled.

To measure the effectiveness of the SMART program, Roche will use several independent outcome assessments, including the survey and an independent audit of pharmacies to assess the use of the qualification stickers by prescribers.

Exposure of an unborn baby to isotretinoin is a serious adverse event and should be reported to Roche, or directly to the FDA MedWatch Program.

Updated Practice Guidelines for Alzheimer's Disease (continued from page 6)

An ongoing treatment plan should be developed and implemented including the use of cholinesterase inhibitors, if clinically indicated, treatment of comorbid medical conditions, treatment of behavioral problems and mood disorders, and referral to supportive community resources such as the Alzheimer's Association. Consider prescribing vitamin E therapy.

For the treatment of behavioral problems, consider non-pharmacologic approaches, such as environmental modification and task simplification, prior to initiating pharmacologic approach.

Discuss the diagnosis, progression, treatment choices and goals of AD care with the patient and family.

Refer the patient and family to the Alzheimer's Association (800) 660-1993, and to the Caregiver

Resource Centers (800) 445-8106, for education and support.

In accordance with California law, (1) report the diagnosis of AD to your local health officer and (2) report all suspicions of abuse to Adult Protective Services or your local police department.

This statewide initiative to improve the quality of healthcare for people with Alzheimer's disease and related disorders also includes an educational component for patients and families. An educational booklet, *Working with Your Doctor When You Suspect Memory Problems*, and "A Caregiver's Workshop" are available in English and Spanish through Alzheimer's Association chapters statewide. For more information, contact your local chapter at (800) 660-1993 or visit the Web site at www.caalz.org.

Addressing Cultural Factors in Relation to Mammography Screening

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

California's population has become increasingly multicultural and diverse. However, the state's healthcare delivery systems do not always maintain pace with these changing demographics. A sober example is research showing that older minority California women are the least likely group to obtain mammograms.¹ Physicians and other medical professionals have a vital role in helping minority women understand the importance of getting a regular mammogram.

To effectively deal with patients and families who may have different cultural beliefs and health practices, physicians must become more "culturally competent." The following are key tools for effective communication with patients from different cultures:

- **Cultural Awareness** — Becoming sensitive to cultural groups and evaluating cultural biases
- **Cultural Encounters** — Direct exposure with consumers from diverse cultural backgrounds
- **Cultural Skills** — Learning about culturally sensitive assessment tools
- **Cultural Knowledge** — Learning about world views of cultures

In the case of breast health, healthcare providers can reinforce positive cultural values and recognize cultural beliefs that may encourage breast cancer screening. Culturally competent providers are able to explore a patient's health beliefs, attitudes and cultural barriers in a caring and sensitive manner.

How Can You Make a Difference?

Numerous studies have found that physician-patient discussion of breast cancer screening is one of the most important predictors of women receiving regular mammograms and clinical breast examinations.²

One UCLA study found that women who discussed breast cancer screening with their physicians were up to 12 times more likely to receive a mammogram than women who did not talk with their physicians.³

Partly due to cultural factors, your patients might be afraid or embarrassed to talk about breast care, and therefore depend on you to broach the topic. In addition, the recent controversy over mammography, which has ultimately resulted in continued support of this testing from a vast

majority of healthcare organizations, including the National Cancer Institute, may have confused older women of all ethnic backgrounds about the benefits of early detection.

Knowing your patient's cultural background and taking the appropriate steps based on that knowledge can make the difference in how your patients prioritize breast health. Below is an outline of some of the common cultural implications for various groups, as determined by research and focus groups. This is not an exhaustive list. In addition, each patient is an individual with unique perspectives and needs. However, these aspects of cultural context may be helpful in understanding the various barriers to mammography and how you might address those barriers. When treating women of all ethnic backgrounds, it is important to help your patients feel comfortable talking about breast cancer screening, and to confirm with them that they understand your recommendations.

Cultural Implications for Communication and Screening

Hispanic/Latina

- There is great diversity among and within the various Hispanic subgroups. Hispanics belong to all races including white, black, Asian and American Indian.
- Hispanic women often rely on the family, media (e.g., radio) and healthcare professionals for health information.
- Modesty, fear, embarrassment and lack of a preventive attitude have been obstacles for mammography among Hispanic women.
- "Fatalistic" attitudes and negative attitudes toward healthcare providers have also been found to be obstacles to Hispanic women obtaining mammography services.
- Individual needs are sometimes postponed to take care of family responsibilities and the needs of other family members.
- Just 42.4 percent of California Hispanic women age 65 and up enrolled in Medicare fee-for-service had a biennial mammogram during 1999-2000, compared to a rate for California Caucasian women of 54.8 percent.

(Continued on page 11)

Mammography Screening

(continued from page 10)

African-American

- Several breast cancer screening barriers have been identified among African American seniors: mistrust of the healthcare system, concerns about discrimination, fear, pain, and lack of accessibility and availability of preventive services.
- Some religious beliefs and fatalistic attitudes may be related to low screening, lack of follow-up and disregard of treatment recommendations.
- Family and faith-based networks may be helpful in the dissemination of breast cancer screening information and referral services.
- African-American women age 65 and older enrolled in fee-for-service Medicare had a low biennial mammography rate of 38.7 percent during 1999-2000.

Asian/Pacific Islander (API)

- There is great diversity among the many Asian and Pacific Islander subgroups.
- Modesty and embarrassment can be barriers to breast cancer screening among Asian and Pacific Islander women.
- Major structural, linguistic, cultural and access barriers for breast cancer screening exist for the different API communities.
- There is often a lack of understanding about breast health, mammography and the benefits of early breast cancer detection among older API women.
- Cancer myths (e.g., “cancer is contagious”), misinformation (e.g., “older women don’t need mammograms” or “API women don’t get breast cancer”), and negative attitudes (e.g., “cancer is a death sentence”) are widespread.
- Literacy and English-language proficiency are major barriers to healthcare among API women.
- The biennial mammography rate among API women age 65 and older enrolled in Medicare fee-for-service was the lowest of any group in the state at 37.4 percent from 1999-2000.

American Indian

- There are 217 native languages spoken in the U.S. and 400 federally recognized tribes; for some older native people, English may be a second language or not spoken at all. Most of these languages do not include a word for “cancer.” For the few languages

that do have a translation for “cancer,” the meanings are “the disease for which there is no cure” or “the disease that eats the body.”

- It is the belief of many native cultures that diseases such as cancer should not be discussed because such discussion invites the disease into the body. Some American Indians believe that a cancer diagnosis is synonymous with a death sentence.
- Trust is a major issue. Disclosure of information to strangers is given only after trust is established.
- American Indian women age 65 and older enrolled in Medicare fee-for-service in California have a low biennial mammography rate of 40.3 percent.

General Cultural Factors

Moreover, there are several general cultural factors that may apply to women in all ethnic and minority groups:

Family

- Women are often in charge of the health of the entire family
- Opinions of other family members are very important

Respect

- Respectful social interactions are paramount, even if you disagree
- Talking openly about sexual topics usually is considered disrespectful

Fatalism

- “Whatever will be will be”
- Belief that disease is determined by outside forces
- Breast cancer may be associated with strong fears and hopelessness

Suffering

- Stoic attitudes: “If I get breast cancer, I must endure it.”
- One must endure high levels of pain

Cultural Beliefs

- Meaning of breast cancer varies depending on the patient’s beliefs (e.g., in some cultures an offended spirit or punishment for a sin are thought to be causes of illness)
- False notion of no risk if a woman is post-menopausal or not sexually active

(Continued on page 13)

Healthcare and the Nursing Home

(continued from page 1)

Growing Numbers of Nursing Home Residents

Why do we as physicians in California worry about nursing home care? According to the 2000 census report, there are more than 3.4 million Californians over the age of 65. Using 1997 actuarial data, the overall risk of being admitted to a nursing home sometime in one's life is right around 5 percent, with the risk dramatically related to age. Of those aged 65-74, 1.1 percent will reside in a nursing home; but for those over 85 years old the number increases to 19 percent.

The Shift in Acuity

Dramatic shifts have occurred in the acuity of nursing home residents as well. Since the emergence of DRGs in the acute hospital, and particularly with the growth of managed care in the past decade, patients are discharged "quicker and sicker" from the hospital and sent to lower levels of care for rehab or ongoing care. It is common for nursing homes to provide respiratory therapy, IVs, "stat" lab and x-ray support, and many other services that most physicians once linked only with a hospital setting. The "slightly demented elderly female with mild arthritis who spent her time playing bingo" is rarely in a nursing home now. She has moved to assisted living. In her place is a patient discharged from the hospital on 13 medications, with IV antibiotics for a chronic abdominal wound, a feeding tube, respiratory treatments every four hours, and dialysis three times a week! Regardless of our specialty, it is likely that some of our patients will spend some time in the nursing home, and that you can have an impact on the quality of the service and care they receive.

A Lack of Contact

Sadly, although nursing home care impacts our patients, most physicians have no contact with the facilities or the people who provide the direct care. Ten years ago, the American Medical Association studied the practice of U.S. physicians. It reported that 65 percent of primary care physicians spent NO time in a nursing home. The American Medical Directors Association, (a national physician-based organization for long-term care), did a related study of PCPs and found that only 1 out of 10 spent two or more hours a week in long-term care. There are a number of reasons that physicians and other clinicians find it difficult to provide care to nursing home residents. In addition to logistical difficulties in even getting to a nursing home, there are burdens of additional regulations that exceed those in an

acute hospital; there are limited resources and access to the technologies of acute care; there are perceptions of limited reimbursement, (reimbursement has actually increased significantly over the past several years!); and physicians struggle with the burden of addressing chronic disease for which *cure* is rarely an option.

Staff and Litigation — Nursing Home Crises

Two additional crises are pressing hard on the nursing home industry. The first issue is staffing. Most of the issues recently raised about quality are directly or indirectly a factor of nursing and nursing-aide staffing. The work is hard, the pay is often less than other jobs with similar training, and the pool of prospective caregivers is smaller each year. Both the state of California, and the federal government, are looking hard to find solutions to improve the number and quality of long-term care providers. The second crisis is the increasing pressure of litigation. Nursing home lawsuits have reached epidemic levels in many states. Currently in Texas, almost half of all nursing homes now go without any insurance coverage. Governor Bush, of Florida, finally had to step in last year with some limits and protections in his state in order to even keep nursing homes open. Tort reform and limits to punitive damages will need to be addressed in California in order to avoid some of those same realities here.

How Physicians CAN Improve Nursing Home Care

What can I do as a physician, nurse practitioner or physician assistant? There are a number of ways that each of us can directly impact the quality of care our patients receive in long-term care:

- The first is to communicate. One problem with clinical care in the nursing home is that it is often done with little to no medical history. Often patients arrive from the hospital with only a History and Physical form, and some sketchy orders. I recently admitted a very ill gentleman who suffered a stroke following hip surgery. He was taking 14 medications and the only comment in his medical record was that he had "multiple heart and lung problems"! Take the time to communicate medical issues to the nursing home physician. Speak with the patient/family and understand their expectations and share in defining the goals of treatment. Identify specific issues of potential problems (such as abnormal labs, medication reactions, etc.). Set the expectation for you and your patient that the nursing home is part of the continuum of that patient's care, not the edge of the world as imagined in pre-Columbus time.

(Continued on page 13)

Healthcare and the Nursing Home

(continued from page 12)

- Second, be aware of the care your patients receive. If they come to your office from the nursing home, notice their overall condition. Talk with the patient/family about care needs. Be an advocate for your patients. Also, recognize that many aspects of care have improved over the past decade.
- Third, know what services can and cannot be provided in a nursing home. Have a general awareness of Medicare benefits. Become familiar with state and federal regulations that provide oversight to the clinical care. Help patients and families manage expectations. In doing so, you will be better able to respond if quality and care do fall short.
- Become directly involved in nursing home care! Long-term care is a rewarding and challenging aspect of

medicine. Look for opportunities to increase your own education in areas such as geriatric medicine, pain management, end-of-life care. (See the article on page 3 about a new continuing medical education requirement relating to pain management and end-of-life care.) Become a resource as either a direct provider or consultant, or educator for others.

We can, as physicians and healthcare providers, have a direct and powerful impact to improve the quality of nursing home care for our patients and the entire population of vulnerable elders in this country. Additional resources to give you more information about long-term care and your role:

- American Medical Directors Association: 1-800-876-2632 or www.amda.com
- California Association of Long Term Care Medicine (the California association of nursing home providers, physicians and administrators): 1-800-488-2196 or www.calctm.org.

Addressing Cultural Factors in Relation to Mammography Screening

(continued from page 11)

Distrust

- Suspicion regarding healthcare and government leads to delayed medical care
- Fear of discrimination or deportation

Folk Medicine

- Trust in lay healers and nontraditional treatment is widespread
- May delay traditional diagnosis and treatment

Lack of Preventive Attitudes

- Falsely low perceptions of breast cancer risk (perceived low vulnerability)
- Habits of accessing the healthcare system only when crises occur

CMRI, the Quality Improvement Organization (QIO) for California's four million Medicare beneficiaries, has developed a multifaceted mammography campaign to improve breast cancer screening rates among Medicare women.

CMRI can work with you, your staff, medical group or clinic to tailor system-change tools to increase mammography and other quality-of-care indicators for your patients, and can also help you understand how to better

communicate with your senior patients from diverse backgrounds. CMRI offers downloadable, culturally sensitive patient education materials developed specifically for senior women that we are glad to share with you.

For more information about CMRI's Mammography Campaign, the Quality Improvement Systems for Managed Care (QISM) 2002 Breast Cancer Screening Project, please visit CMRI's Web site at www.cmri-ca.org, or call our toll-free healthcare provider line at (877) 363-5555.

Notes:

1. Sabogal F, Merrill SS, Packel L. Mammography rescreening among older California women. *Health Care Financing Review*, 2001; 22(4): 63-75.
2. Fox SA, Siu AL, Stein JA. The importance of physician communication on breast cancer screening of older women. *Arch Intern Med* 1994 Sep 26;154(18):2058-68.
Skinner CS, Strecher VJ, Hospers H. Physicians' recommendations for mammography: Do tailored messages make a difference? *Am J Public Health* 1994; 84(1):43-9.
3. Fox SA, Murata PJ, Stein JA. The impact of physician compliance on screening mammography for older women. *Arch Intern Med* 1991;151(1):50-6.

ADMINISTRATIVE ACTIONS: NOVEMBER 1, 2001 TO JANUARY 31, 2002

PHYSICIANS AND SURGEONS

ANG, ERIBERTO C., JR., M.D. (A42030)
Chino Hills, CA
B&P Code §§810, 2234(e), 2236(a). Stipulated Decision. Convicted for failing to disclose information affecting an insurance claim. Revoked, stayed, 5 years probation with terms and conditions including 60 days actual suspension beginning January 1, 2002.
November 12, 2001

ANGEL, DAVID LEWIS, M.D. (A71316)
Los Gatos, CA
B&P Code §§822, 2234(a)(e). Charged with unprofessional conduct and dishonesty for failing to disclose a conviction for forgery on his license application, and his ability to practice his profession safely is impaired due to mental illness. Revoked.
November 14, 2001

ASSAD, HANY YOUSSEF, M.D. (A54309)
San Ramon, CA
B&P Code §2234. Stipulated Decision. Committed acts of unprofessional conduct in the treatment of 2 patients and inappropriate conduct with a patient outside of the treatment setting. Revoked, stayed, 7 years probation with terms and conditions including 90 days actual suspension. January 7, 2002

ATWAL, DAWN, M.D. (G73846)
Tustin, CA
B&P Code §§822, 725, 2239, 2242, 2234(b)(c), 2261. Stipulated Decision. Charged with gross negligence and repeated negligent acts in the care and treatment of a patient, failed to do a good faith examination, prescribed drugs for self-use by writing or calling in fraudulent prescriptions, and made threatening phone calls to a former patient. Revoked, stayed, 7 years probation with terms and conditions. December 5, 2001

Explanation of Disciplinary Language and Actions

“Effective date of decision” —
Example: “January 10, 2002” 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).

AULD, BRIAN MURRAY, M.D. (G46023)
Oakland, CA
B&P Code §141(a). Stipulated Decision. Disciplined by Colorado for unprofessional conduct for failing to keep a patient in the emergency room under observation for 12 hours when the patient had stated he had ingested antifreeze; intruded into another patient's personal life, asked inappropriate questions, and violated patient/physician trust. Public Letter of Reprimand.
January 14, 2002

BALACHANDRAN, MADHAVAN, M.D. (A31019)
Orange, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, incompetence and repeated negligent acts in the interpretation and reporting of results of neuro-diagnostic non-invasive tests of 3 patients. Revoked, stayed, 3 years probation with terms and conditions. January 7, 2002

BANISTER, STEPHEN, M.D. (G23826)
Grass Valley, CA
B&P Code §2234. Stipulated Decision. Prescribed without a good faith prior examination and without medical indication; failed to formulate a legitimate and complete treatment plan and maintain adequate and accurate medical records in the care and treatment of 3 patients. Revoked, stayed, 3 years probation with terms and conditions. November 8, 2001

BERMAN, MARSHALL LEONARD, M.D. (G22551)
Los Angeles, CA
B&P Code §2234. Stipulated Decision. Violated terms and conditions of Board-ordered probation. Revoked, stayed, 5 years probation with terms and conditions.
November 5, 2001

CECH, STEPHEN A., M.D. (G10163)
Bakersfield, CA
B&P Code §2234. Violated terms and conditions of Board-ordered probation. Revoked. January 21, 2002

CHATTMAN, MARTIN SETH, M.D.
(G24848) Scottsdale, AZ
B&P Code §§141(a), 2305. Disciplined by Arizona for writing false prescriptions and failing to maintain accurate medical records. Revoked.
November 26, 2001

CHER, JOHN B., M.D. (A38966)
Santa Monica, CA
B&P Code §§822, 2234(a)(d), 2239, 4022. Committed acts of unprofessional conduct and incompetence, self-administered controlled substances and dangerous drugs, and his ability to practice medicine is impaired due to mental illness. Revoked, stayed, 5 years probation with terms and conditions. November 26, 2001. Judicial review being pursued.

CRAWFORD, BYRON D., M.D. (A29605) Malibu, CA
B&P Code §822. Mental and physical impairment affecting competency to practice medicine. Revoked.
November 15, 2001. Judicial review being pursued.

DESILVA, CHANDRA DIANE, M.D. (A29607)
San Bernardino, CA
B&P Code §2234. Stipulated Decision. Unprofessional conduct for failing to maintain adequate and accurate records. Public Letter of Reprimand. January 21, 2002

DIXON, GERALD H., M.D. (A23796) Peoria, IL
B&P Code §141(a). Stipulated Decision. Disciplined by Oregon for unprofessional conduct with 1 patient and for prescribing without maintaining patient records and continuity of care with the patient's primary care physician. Public Letter of Reprimand.
November 28, 2001

DURANTE, JOSEPH R., M.D. (G3711)
Boulder City, NV
B&P Code §2238. Unlawfully possessed Diazepam without a DEA registration and violated a condition of a Medical Board probationary order to obey all laws. 10 days actual suspension with additional terms and conditions added to existing probation. January 7, 2002

FLETCHER, STEVEN FRANCIS, M.D.
(G71273) Greer, SC
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by South Carolina for unprofessional conduct by making crude sexual remarks and acts in the presence of colleagues, failing to respect the rights of patients and colleagues, and failing to provide competent medical service with compassion and respect for human dignity. Public Reprimand.
November 5, 2001

GOLDBERG, ARTHUR S., M.D. (G12028)
San Diego, CA
B&P Code §141(a). Stipulated Decision. Disciplined by Arizona for falling below the standard of care by performing a circumcision procedure when a penile anomaly was present and failing to obtain a specialist consultation when the abnormal outcome was realized. Public Letter of Reprimand. November 26, 2001

HAERTER, CHARLES A., M.D. (G15526)
Lake Havasu City, AZ
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by Arizona for unprofessional conduct for failing to diagnose kidney cancer with subsequent metastasis, failing to note and act on test findings with further testing, and failing to pursue a further diagnosis. Public Reprimand. November 1, 2001

HAMRICK, JONATHAN STANLEY, M.D. (A35634)
San Luis Obispo, CA
B&P Code §2234(b)(c)(d). Stipulated Decision. Committed acts of gross negligence, repeated negligence and incompetence in the care and treatment of 6 patients. Revoked, stayed, 5 years probation with terms and conditions. November 8, 2001

HASON, MICHAEL JEFFREY, M.D. (G86338)
Plantation, FL
B&P Code §§480(a)(3), 822, 2221. Stipulated Decision. Probationary license issued, 5 years probation with terms and conditions. November 21, 2001

HOSSAIN, S.M. GOLAM, M.D. (A77221)
Tujunga, CA
B&P Code §480(a)(1)(2)(3). Stipulated Decision. Convicted of welfare fraud. License granted, revoked, stayed, 5 years probation with terms and conditions. November 28, 2001

JOHNSON, KENT ROBERT, M.D. (G65573)
Riverside, CA
B&P Code §§822, 2238, 2239. Stipulated Decision. Suspended from practice until the Division of Medical Quality determines that it has received competent evidence of the absence or control of his self-use and administration of controlled substances/dangerous drugs including his mental and physical illness that impairs his ability to practice medicine safely, and until the Division is satisfied that his right to practice should be reinstated. January 17, 2002

JOHNSON, PETER BEDROS, M.D. (G54830)
Erie, CO
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by Colorado for negligent care and treatment of a patient and failure to order appropriate steroids. Public Reprimand. December 10, 2001

KONRAD-PIALA, JULIA DIANNE, M.D. (G68035)
Ramona, CA
B&P Code §2354. Stipulated Decision. No admission but charged with a violation of drug statutes and termination from the Medical Board's Diversion Program. Revoked. November 5, 2001

LATTA, GEORGE HAWORTH III, M.D. (C50705)
Provo, UT
B&P Code §§480(a)(3), 2239. Stipulated Decision. Unprofessional conduct related to a history of alcohol dependency. Probationary license issued, 5 years probation with terms and conditions. November 7, 2001

LE, KHOI MANH, M.D. (A77166) Costa Mesa, CA
B&P Code §§475(a)(1)(2)(3), 480(a)(1)(2)(3)(c), 2236(a). Stipulated Decision. Failed to disclose conviction of a crime on his license application. License granted, revoked, stayed, 2 years probation with terms and conditions. November 19, 2001

LESCH, HARRY BERNARD, M.D. (G22275)
Eureka, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with unprofessional conduct for prescribing controlled substances and dangerous drugs to his wife for several years without examining, monitoring and maintaining records. Revoked, stayed, 5 years probation with terms and conditions. November 23, 2001

MACFARLANE, ROBERT DOUGLAS, M.D. (A24835)
San Diego, CA
B&P Code §§2241, 2238, H&S Code §§11217, 11156. Prescribed controlled substances and treated 1 addict for opioid dependency at a place not approved by law. Public Reprimand. January 4, 2002

MAGRANN, JOHN J., M.D. (A28610) Anaheim, CA
B&P Code §2266. Stipulated Decision. Failed to maintain adequate records in the care and treatment of 4 patients. Revoked, stayed, 7 years probation with terms and conditions. December 3, 2001

MALLADA, DAN SODUSTA, M.D. (C43360)
Fresno, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with failing to properly manage the care and treatment of 3 patients during anesthesia procedures. Revoked, stayed, 5 years probation with terms and conditions including a 6-month actual suspension beginning on June 26, 2001 with an Interim Suspension Order. December 20, 2001

MARANS, HOWARD J., M.D. (G68911)
Fountain Valley, CA
B&P Code §§725, 2234(b). Failed to record and monitor the amount of narcotic drugs prescribed and repeated acts of clearly excessive prescribing narcotic drugs to a known drug addict. Revoked, stayed, 4 years probation with terms and conditions. January 3, 2002

MILEA, ADRIAN VALERIU, M.D. (A51493)
Salt Lake City, UT
B&P Code §141(a). Disciplined by Utah for engaging in inappropriate touching and physical contact with a patient and a co-worker. Revoked. December 6, 2001

MONTAZERI, ATA O., M.D. (A38685)
Bell Gardens, CA
B&P Code §§725, 810, 2234(b)(c)(e), 2261, 2262. Committed acts of repeated negligence and dishonesty related to billing for unnecessary medical procedures and for excessive treatment. Revoked, stayed, 7 years probation with terms and conditions including 60 days suspension. January 4, 2002

MOORES, WILLIAM YORK, M.D. (G28505)
Del Mar, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with unprofessional conduct in the care and treatment of 8 patients. Revoked, stayed, 5 years probation with terms and conditions. November 2, 2001

NOVICK, JAMES STEPHEN, M.D. (C36874)
Glendale, CA
B&P Code §2234. Violated terms and conditions of Board-ordered probation. Revoked. November 14, 2001

PEARSON, BERNARD, M.D. (G60654)
Camp Hill, AL
B&P Code §§141(a), 2234. Stipulated Decision. Disciplined by Alabama for failure to comply with continuing medical education requirements to renew his medical license. Public Letter of Reprimand. December 12, 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.

ALL CALLS ARE CONFIDENTIAL

(916) 263-2600

www.medbd.ca.gov

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

PITUCK, STEPHEN EARL, M.D. (G56100)
Santa Ana, CA
B&P Code §2266. Stipulated Decision. Failed to make adequate notations in the medical chart of a patient. Public Letter of Reprimand. January 30, 2002

POWER, WILLIAM RANDY, M.D. (G48668)
Los Angeles, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with having sexual relations with and committing sexual misconduct with a patient, prescribed psychotropic medications to a patient without conducting a physical examination, failed to discuss the risks and side effects of the medications, failed to monitor the medications and obtain medical clearance from the patient's medical doctor, failed to document the information in the medical records, and failed to manage the transference and counter-transference issues that developed while treating a patient. Revoked, stayed, 7 years probation with terms and conditions including 180 days suspension. January 22, 2002

RENTFRO, RICHARD ALLEN, M.D. (G25236)
Thorp, WA
B&P Code §§2021, 2225.5(a)(1), 2234, 2238 and H&S Code §123110(a). Stipulated Decision. Failed to report a theft of controlled substances, failed to report a change of address to the Medical Board of California, and failed to advise patients where to continue treatment or how to obtain their medical records. Public Letter of Reprimand. December 18, 2001

ROSENTHAL, MICHAEL JAY, M.D. (G17628)
Claremont, CA
B&P Code §§2234, 2234(b)(c)(d)(e), 2266. Stipulated Decision. Committed acts of gross negligence, repeated negligence, incompetence, dishonesty, unprofessional conduct, failed to maintain adequate and accurate records and violated terms and conditions of Board-ordered probation. Revoked. November 27, 2001

SALIMI, FARAMARZ, M.D. (A32780)
Morton Grove, IL
B&P Code §141(a). Stipulated Decision. Disciplined by Illinois for the inadvertent tubal ligation performed on a patient scheduled for an elective termination of early pregnancy. Public Letter of Reprimand. December 20, 2001

SHARMA, MANORAMA, M.D. (A37350)
Fountain Valley, CA
B&P Code §§2234(b)(c)(d), 2262. Committed acts of gross negligence, repeated negligence, incompetence and modification of medical records with fraudulent intent in the care and treatment of a patient. Revoked, stayed, 5 years probation with 30 days actual suspension. December 14, 2001. Judicial review being pursued.

SIMON, ROY HOWARD, M.D. (G60934)
Torrance, CA
B&P Code §2236(a). Stipulated Decision. Convicted of reckless driving with alcohol involved and convicted of lewd conduct in a public place. Revoked, stayed, 5 years probation with 30 days actual suspension. January 4, 2002

SMITH, BRIT OWEN, M.D. (A16994) Lancaster, CA
B&P Code §§2266, 4332. Stipulated Decision. Failed to maintain complete medical records in the care and treatment of a patient, and failed to record and inventory purchase of a Schedule IV controlled substance. Public Letter of Reprimand. January 16, 2002

STURCKOW, KARL, M.D. (C22009) Lakeside, CA
B&P Code §2234. Violated terms and conditions of Board-ordered probation. Revoked. January 25, 2002

WEBER, HANS E., M.D. (A29825)
Santa Monica, CA
B&P Code §2234. Stipulated Decision. Unprofessional conduct for keeping medical records for a patient's cardiac problems and family history abbreviated to the point that the records could not be relied upon to make diagnoses when the patient made repeated visits for chest pains which were not treated aggressively enough prior to the patient suffering a myocardial infarction. Public Letter of Reprimand. December 5, 2001

YAVARI, MORTEZA GHOLI, M.D. (A38292) Tax, FL
B&P Code §141(a). Stipulated Decision. Disciplined by Florida for violation of laws and regulations related to negligence while performing a procedure to remove a kidney stone. Public Letter of Reprimand. December 20, 2001

YING, LLOYD, M.D. (A28196) Canton, MI
B&P Code §141(a). Disciplined by Michigan for charges of improper record keeping, insufficient charting of patient records, and over-prescribing medications and prescribing dangerous combinations of medicines. Revoked. November 8, 2001

YOUNG, WILLIAM ISAAC, M.D. (G34511)
Los Angeles, CA
B&P Code §2234(c). Stipulated Decision. Repeated negligence in prescribing to a patient while failing to provide proper documentation, and renewing the prescription for years without evaluating the patient. Public Letter of Reprimand. January 14, 2002

YUSUFALY, IMDAD NOMAN, M.D. (A50931)
Wildomar, CA
B&P Code §726. Stipulated Decision. Engaged in sexual misconduct with a patient. Revoked, stayed, 7 years probation with 30 days actual suspension. January 25, 2002

ZACCHEO, JERALD D., M.D. (G38534) Turlock, CA
B&P Code §§2234, 2239(a). Stipulated Decision. Charged with unprofessional conduct and the use or prescribing for or administering of controlled substances in a manner dangerous to himself or others, and with use that impairs his ability to practice medicine safely. Revoked, stayed, 5 years probation with terms and conditions. November 8, 2001

ZAKY, WASSIM FOUAD, M.D. (A36981)
Huntington Park, CA
B&P Code §2234. Committed acts of negligence in the care and treatment of 2 patients. Public Reprimand. January 18, 2002

DOCTORS OF PODIATRIC MEDICINE

RELEFORD, BILL JAMES, Jr., D.P.M. (E3630)
Inglewood, CA
B&P Code §§725, 2234 (b)(c)(d)(e), 2266. Stipulated Decision. Committed acts of gross negligence, incompetence, repeated negligent acts, dishonesty and inadequate record keeping in the care and treatment of a patient. Revoked, stayed, 5 years probation with 30 days actual suspension. November 8, 2001

SERVATJOO, PARVIZ, M.D. (E3494)
Los Angeles, CA
B&P Code §§2234(b)(c)(d), 2266. Stipulated Decision. Charged with gross negligence, failure to maintain adequate medical records in the care and treatment of 2 patients and failure to obtain informed consent for a bunionectomy in the care of a patient. Suspension, stayed, 3 years probation with terms and conditions. January 17, 2002

PHYSICIAN ASSISTANTS

CANCILLA, MICHAEL ANTHONY, P.A. (PA15366)
Kelseyville, CA
B&P Code §§2234, 3527. Stipulated Decision. Admitted to unprofessional conduct and was convicted of driving while having .08 percent or more of alcohol in the blood and for inflicting corporal injury upon a spouse. Revoked, stayed, 7 years probation with terms and conditions including 7 days actual suspension. November 2, 2001

HADFIELD, GREG SEAN, P.A. (PA15366)
Bridgeport, CA
B&P Code §§480(a)(1)(3), 3527. Stipulated Decision. Convicted of being under the influence and having a concealed weapon with an expired weapon permit in his vehicle. License granted, revoked, stayed, 5 years probation with terms and conditions. January 31, 2002

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.

LINI, MEGAN NOREEN, P.A. (PA14080)
San Diego, CA
B&P Code §§2234(a)(e), 2239, 3527, 3531. Stipulated Decision. Convicted of trespassing. Committed acts of dishonesty and fraud by forging a prescription for a controlled substance, attempting to fraudulently obtain a prescription, and for self-use of drugs in prescribing and using controlled substances in a dangerous manner. Revoked, stayed, 5 years probation with terms and conditions. December 7, 2001

REGISTERED DISPENSING OPTICIAN

EYEGLOSS WORLD EXPRESS (D6312) Fresno, CA
B&P Code §2234. Stipulated Decision. Charged with improperly advertising the services of an optometrist. Revoked, stayed, 3 years probation with terms and conditions. November 28, 2001

SURRENDER OF LICENSE WHILE CHARGES PENDING

PHYSICIANS AND SURGEONS

BONE, WILLIAM DALE, M.D. (GFE63153)
San Marcos, CA
November 27, 2001

GONZALEZ, GUILLERMO F., M.D. (A14159)
Los Angeles, CA
November 28, 2001

GREEN, KENNETH S., M.D. (A49320)
San Diego, CA
December 28, 2001

HEULER, WALTER KENNETH, M.D. (G32048)
Orange, CA
December 3, 2001

MASON, ARTHUR RALPH, M.D. (A56233)
Newhall, CA
January 16, 2002

SAMADANI, SEPEHR, M.D. (G80848)
Santa Monica, CA
November 1, 2001

PHYSICIAN ASSISTANT

RICHARDSON, STEPHEN R., P.A. (PA13144)
Stockton, CA
January 4, 2002

**Business and Professions
Code Section 2021(b) &
(c) require physicians to
inform the Medical
Board in writing of any
name or address change.**



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ACTION REPORT - APRIL 2002

Candis Cohen, Editor (916) 263-2389

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