

Action Report

Medical Board of California

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IN THIS
ISSUE

Providing Healthcare to the Uninsured: A Challenge for All

In January, the Medical Board launched the California Physician Corps Loan Repayment Program, which was created by Assembly Bill 982 (Firebaugh). The program encourages recently licensed physicians to practice in underserved locations in California by authorizing repayment of their student loans in exchange for their service in a designated medically underserved area for a minimum of three years. The Board is pleased that the program has generated widespread interest from physicians and clinics around the state.

Program participants will begin working under this program on July 1. In the following months, the Board will conduct an evaluation and report to the Legislature, addressing the achievements of the program, ways to extend the program to clinics in other medically underserved areas, and means for the provision of permanent program funding, including matching funds from various foundations.

The new law authorizes the Office of Statewide Health Planning and Development (OSHPD) to implement another loan repayment program as funding is provided. That program will enable current medical students to receive conditional warrants in advance for their service, to be redeemed upon completion. As with the Board's program, OSHPD will ensure that priority consideration will be given to applicants who are best suited to meet the cultural and linguistic needs of patients from medically underserved populations.

The Board wants to express that its commitment to improving access to healthcare for all Californians is not limited to this loan repayment program. The Board recognizes and is concerned

about the lack of adequate healthcare of the underserved, the indigent, and the uninsured. While this is not a direct statutory responsibility of the Board, the Board believes it has an obligation to participate in the growing debate about how to address the problem of access to healthcare. Board President Gary Gitnick, M.D., affirmed this position by creating a new Indigent Care Committee.

This committee will be chaired by Board Member Richard Fantozzi, M.D., who stated, "The Medical Board does not wish to see its effort to expand medical services through loan repayment stand as the sole response to the overwhelming need for medical care that we are all witnessing. The new committee has accepted the charge to be an instrument of vision and a voice in support of other responsible efforts that will emerge to confront the crisis of the uninsured."

Several bills have been introduced in the Legislature this year which seek to further the goal of improving access to the underserved. AB 948, authored by Assembly Member Fabian Nunez and sponsored by the Board, will investigate methods to enable international physicians to participate in a fellowship program in a specialty or subspecialty field in a clinic in a medically underserved area of the state. The focus would be on primary care clinics, offering services in general medicine, internal medicine, OB/GYN, family practice, and pediatrics. These fellowships would be similar to those currently allowed in hospitals under Business and Professions Code section 2112, and would enhance the connections of community clinics and clinical training programs.

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Medical Board of California Meetings

2003

May 8, 9, 10
Sacramento

July 31, August 1, 2
San Francisco

November 6, 7, 8
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 healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

President's Report

The mandate and function of the Medical Board are regulatory. However, in these difficult times with a potential for even greater reduction in access to healthcare, it is appropriate that the Board concerns itself with the milieu in which that regulatory function must be undertaken and also consider its ability to serve as advisors to healthcare policymakers and to the Legislature *without* the expenditure of Board resources.

We are now living in a time when millions of people in California have inadequate or no access to the healthcare system and where even those physicians wishing to provide care to indigents find themselves unable to do so. When the Kaiser Family Foundation looked at the issue of the uninsured, they presented interesting data regarding where Californians do receive their health insurance (see chart, page 3).

Interest in this critical issue is mounting. March 10-16 was "Cover the Uninsured" week, cosponsored by the Robert Wood Johnson Foundation, The California Endowment, the W.K. Kellogg Foundation and numerous influential national organizations. The goals of this nonpartisan project are to:

- Raise public awareness of the plight of uninsured Americans
- Demonstrate broad support for action on the issue
- Generate significant media attention to the issue
- Encourage other national organizations to join The Robert Wood Johnson Foundation and 18 partner organizations in an effort to increase attention to the issue
- Create a single rallying point for groups and individuals working to extend healthcare coverage to the uninsured

According to the California Health Care Foundation (CHCF), approximately 6.2 million Californians have no health insurance. It is not likely that this disgrace will be addressed in a meaningful manner anytime soon on the national level, where, according to CHCF, 41 million Americans have no health insurance. Some relief in the form of tax credits and direct grants from the Treasury have received support from both parties in Congress, but



Gary Gitnick, M.D.
President of the Board

are likely years away. Therefore, in the meantime, it is appropriate that members of the Board join state legislators as well as healthcare organizations in attempting to find a new road to better healthcare for all people in California, as well as to enable physicians to follow up on their dedication to the delivery of healthcare to those who are in need. John Kennedy said, "If a free society cannot help the many who are poor, it cannot preserve the few that are rich." With these thoughts in mind, let me share with you concepts which are and will be discussed by the Board and by its committees.

If we truly believe that healthcare is a *right* and that *all* people in California should have access to healthcare regardless of their income level, can we move forward with a consensus-

building effort to develop a system that will benefit the people of our state? I hope we will be able to work with concerned members of our Legislature who are now working, even with a dramatic budget deficit, to find a way to provide increased access to healthcare.

We on the Board have an important role in trying to support our legislative colleagues and others in their efforts to develop programs enabling physicians who wish to give back to do so. For example, we already have cosponsored and begun implementation of AB 982 (see February 2003 *Action Report*, lead article), the new law that provides educational loan repayment in exchange for indigent healthcare.

Other bills designed to enable physicians to provide indigent healthcare need to be moved forward. At this writing, some 15 bills already have been introduced in the state Legislature that address this issue. They range from "intent" bills that state that the Legislature should enact legislation to broaden health insurance coverage, to a comprehensive bill that would establish a State Health Care System under the control of an elected Health Care Commissioner (SB 921—Kuehl). All relevant bills will be scrutinized by this Board.

Other options must be considered. Can we harness the *vast* number of retired physicians to join those already in the new California Medical Corp to provide healthcare on a

(Continued on page 3)

New Member Appointed to Medical Board

Rehabilitation Department Director Joins Division of Medical Quality

Governor Gray Davis has appointed Catherine T. Campisi, Ph.D., to the Medical Board's Division of Medical Quality.

The Director of the Department of Rehabilitation, Dr. Campisi has more than 20 years of experience in various aspects of policy, program development and administration of programs and services to increase equality of opportunity for persons with disabilities.

Previously, she served as Dean of Student Services at the Chancellor's Office of the

California Community Colleges, Assistant Deputy Director for Transition Programs and Services, and Deputy Director of the Independent Living and Technology at the Department of Rehabilitation.

She also has served in a leadership capacity in various professional and advocacy organizations.

Dr. Campisi earned her doctoral degree in Social Psychology from the University of Missouri, Columbia.



Catherine Campisi, Ph.D.

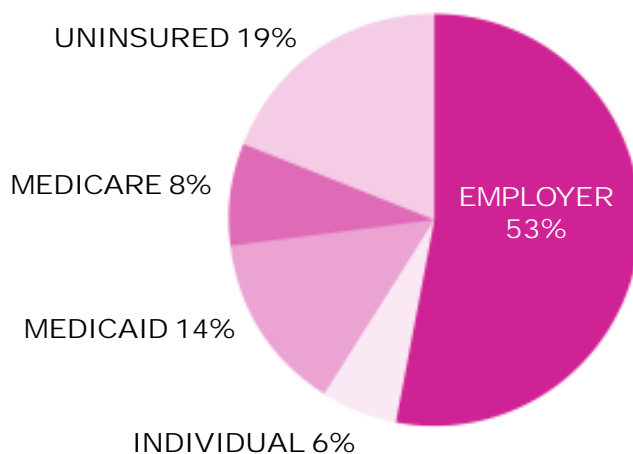
President's Report

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voluntary basis to indigent patients? Can we provide scholarship support for needy students to enable them to attain an education in exchange for providing healthcare for the underserved? Can we establish fellowships based in the community to train the willing corps of primary care physicians who will be needed to serve our growing populations?

The Medical Board will continue to examine alternatives to help address this problem from many directions, and welcomes input from the physician community and other interested parties to the Board, the Legislature and other policymakers.

California Population by Insurance Status: 2000-2001



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured

Enhanced Online Professional Licensing

As part of California's eGovernment initiative, the Medical Board has been participating in a pilot program for Online Professional Licensing. In early February 2003, the online system was unavailable while it was upgraded to include many recommended enhancements. When the system was reactivated, some users were able to access it; however, problems were identified that severely impacted the renewal process.

As a result of those system problems, the Online Professional Licensing system was deactivated, preventing physicians from renewing their licenses via the Internet. System enhancements have been completed and online licensing is once again available to licensees and applicants who wish to submit their fees by credit card.

The Board has long sought to make its services available in a paperless, online environment and sincerely apologizes for any inconvenience encountered by applicants and licensees during the time this service was unavailable. If you encountered any problems with the system that you believe have yet to be rectified, please contact Board staff at (916) 263-2382.

Liposuction Regulations Now In Effect

In 1999, the Legislature passed SB 450 (Speier, Chapter 631), mandating the Board to adopt regulations for liposuction procedures. As introduced, it would have required all procedures exceeding 5,000 ccs to be performed in a hospital, but after much objection from the profession, the bill was amended to require the Board to promulgate regulations.

To fulfill its mandate, the Board's Committee on Plastic and Cosmetic Surgery worked for two years to develop language that the Board's Division of Medical Quality adopted.

The Board worked with the profession, including specialty boards, medical schools, accreditation agencies, specialty societies, and malpractice insurers to develop regulations

that protect patients and meet the legal regulatory standards while not being overly burdensome to physicians responsible for patient care.

In summary, the regulations require all procedures done under IV sedation or general anesthesia, or those of volumes over 5,000 ccs, to be performed in a hospital, a certified or an accredited facility. Procedures under 5,000 ccs done by purely tumescent technique, without any IV sedation or general anesthesia, may be performed in unaccredited settings, as long as certain safeguards are followed.

The regulations went into effect on February 20, 2003. Physicians performing liposuction in settings that are not accredited or certified should pay particular attention to regulatory requirements to be in full compliance. The actual regulations are below.

§1356.6. Liposuction Extraction and Postoperative Care Standards.

(a) A liposuction procedure that is performed under general anesthesia or intravenous sedation or that results in the extraction of 5,000 or more cubic centimeters of total aspirate shall be performed in a general acute-care hospital or in a setting specified in Health and Safety Code Section 1248.1.

(b) The following standards apply to any liposuction procedure not required by subsection (a) to be performed in a general acute-care hospital or a setting specified in Health and Safety Code Section 1248.1:

(1) **Intravenous Access and Emergency Plan.** Intravenous access shall be available for procedures that result in the extraction of less than 2,000 cubic centimeters of total aspirate and shall be required for procedures that result in the extraction of 2,000 or more cubic centimeters of total aspirate. There shall be a written detailed plan for handling medical emergencies and all staff shall be informed of that plan. The physician shall ensure that trained personnel, together with adequate and appropriate equipment, oxygen, and medication, are onsite and available to handle the procedure being performed and any medical emergency that may arise in connection with that procedure. The physician shall either have admitting privileges at a local general acute-care hospital or have a written transfer agreement with such a hospital or with a licensed physician who has admitting privileges at such a hospital.

(2) **Anesthesia.** Anesthesia shall be provided by a qualified licensed practitioner. The physician who is performing the procedure shall not also administer or maintain the anesthesia or sedation unless a licensed person certified in advanced cardiac life support is present and is monitoring the patient.

(3) **Monitoring.** The following monitoring shall be available for volumes greater than 150 and less than 2,000 cubic centimeters of total aspirate and shall be required for

volumes between 2,000 and 5,000 cubic centimeters of total aspirate:

- (A) Pulse oximeter
- (B) Blood pressure (by manual or automatic means)
- (C) Fluid loss and replacement monitoring and recording
- (D) Electrocardiogram

(4) **Records.** Records shall be maintained in the manner necessary to meet the standard of practice and shall include sufficient information to determine the quantities of drugs and fluids infused and the volume of fat, fluid and supranatant extracted and the nature and duration of any other surgical procedures performed during the same session as the liposuction procedure.

(5) **Discharge and Postoperative-care Standards.**

- (A) A patient who undergoes any liposuction procedure, regardless of the amount of total aspirate extracted, shall not be discharged from professionally supervised care unless the patient meets the discharge criteria described in either the Aldrete Scale or the White Scale. Until the patient is discharged, at least one staff person who holds a current certification in advanced cardiac life support shall be present in the facility.
- (B) The patient shall only be discharged to a responsible adult capable of understanding postoperative instructions.

NOTE: Authority cited: Sections 2018 and 2259.7, Business and Professions Code. Reference: Section 2259.7, Business and Professions Code.

HISTORY:

1. New section filed 1-21-2003; operative 2-20-2003 (Register 2003, No. 4)

Colorectal Cancer Screening Saves Lives— But Too Few Get Tested

By Diane Fink, M.D., Chief Cancer Control Officer for the American Cancer Society, California Division

Colorectal cancer, commonly referred to as colon cancer, is the third-most commonly diagnosed cancer and the second-leading cause of cancer deaths in the United States. According to the California Department of Health Services, 14,083 Californians were diagnosed with colorectal cancer in 1999, and 5,121 died.¹

The fact is that colorectal cancer is one of the most preventable cancers. We in the physician community could see an enormous improvement in colorectal cancer prevention, early detection, and survival if we discussed the disease with all of our patients 50 and older—and those at increased risk—and referred them, as appropriate, for testing. Testing options currently exist to find and remove precancerous polyps before they develop into a serious health problem. Colorectal cancer almost always starts with a polyp; therefore, screening can actually prevent the disease from occurring.

The American Cancer Society recommends one of these five screening options for all people beginning at age 50:

- Yearly fecal occult blood test (FOBT); or
- Flexible sigmoidoscopy every five years; or
- A yearly FOBT and flexible sigmoidoscopy every five years (preferred over either option alone); or
- Double-contrast barium enema every five years; or
- Colonoscopy every ten years.

Preventing colorectal cancer altogether through testing is the ideal outcome, but early detection of the disease also yields important health benefits. In California, patients whose colon and/or rectum cancers are found at an early stage—before the cancer has extended beyond the intestinal wall—have five-year survival rates of 90 percent. However, only about 40 percent of colon cancers are detected in the earliest stages, compared to 70 percent for prostate cancers and 68 percent for breast cancers.²

Although it is less common than either breast or prostate cancer, colorectal cancer has a poorer prognosis due in part to lower rates of screening. The five-year survival rate for colorectal cancer is only 61 percent, compared to 87 percent for breast cancer and 94 percent for prostate cancer.³

In spite of the unequivocal evidence that colorectal cancer screening saves lives, only 42 percent of California adults ages 50 and over report having had sigmoidoscopy or colonoscopy within the last five years. The proportion is even lower among persons in poverty (28 percent) and among Asian/Pacific Islanders (28 percent).⁴

To raise survival rates, all primary-care physicians should bring up screening options with their patients in the appropriate age and risk ranges. Patients may not raise the issue until they have symptoms such as rectal bleeding or blood in their stool. Some may find colorectal cancer an embarrassing conversation topic, even with their physicians.

One way to initiate these conversations is by using patient-education materials designed to break through barriers and encourage and facilitate screenings. The American Cancer Society has free brochures, posters, detailed guidelines and others materials available for physicians. We offer these tools as a way to discuss a choice of tests with your patients and help them choose a screening strategy from the options listed above, all of which reduce the risk of death from colorectal cancer.

The Society is also using a humorous approach to raise awareness with patients and to cut through cultural taboos such as discussing “private” parts of the body. Working with the Advertising Council, the Society recently unveiled a new round of television, radio, and print ads featuring a polyp (a character in a red suit) who is a nuisance until doctors catch him and haul him away. The ads grab viewers’ attention through humor, but convey a serious message: “Colon Cancer: Get the test. Get the polyp. Get the cure.”

Factors associated with increased risk for colon cancer, as well as information on prevention, early detection, and treatment of the disease can be found on the American Cancer Society’s Web site at www.cancer.org or by calling the Society toll-free at (800) ACS-2345. Telling your patients about these resources may help you save valuable time during face-to-face interactions with your patients.

The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.

¹ American Cancer Society, California Division, and Public Health Institute, California Cancer Registry. California Cancer Facts and Figures 2003.

² Ibid.

³ Ibid.

⁴ Ibid.

Smallpox Vaccination is Now Every Provider's Business

The following informational letter, dated March 2003, submitted by the Immunization Branch, California Department of Health Services, has been edited slightly to fit the available space.

After a 30-year hiatus, smallpox vaccination is again being administered in California. Initial recipients of the vaccine are public health and healthcare personnel who would be available to initiate hospital care and field investigation should a smallpox case appear. Vaccination may be expanded in the future to emergency responders, including police, fire, and EMS personnel, as well as additional healthcare providers. Everyone in these positions is at high risk of exposure if smallpox cases were to appear.

Physicians must make a personal decision whether or not to receive the vaccine. Some colleagues and others in your community will be vaccinated. Regardless of your ultimate decision or of your personal belief regarding the benefits of this vaccination program, smallpox vaccination and its related adverse reactions will again become a part of your medical practice. We know that California physicians are committed to maintaining clinical excellence in emerging diseases and therapies. We urge you to devote the necessary time to develop your knowledge of smallpox vaccine, its effects, and management of its adverse reactions. (More information can be obtained at www.cdc.gov/smallpox.)

Since smallpox was eradicated worldwide, appearance of any case outside the laboratory would be considered a terrorist attack. Although the risk of an attack is unknown, the vaccination program was announced by President Bush because an attack is considered a possibility. The vaccination program is being undertaken as a preparedness measure to improve our capacity to respond quickly and safely to any reappearance of smallpox disease, and to provide optimal protection to those persons integral to the response. The ultimate extent of vaccination is not yet known. The vaccination program is voluntary for public health, healthcare, and emergency personnel. Vaccination is mandatory only for certain military personnel and reservists called to active duty. At this time vaccination is **not** recommended for the public, although the federal government has stated their plan to make vaccination available to those intent on receiving it.

Smallpox vaccine does **not** contain smallpox virus. The vaccine contains vaccinia, a virus closely related to cowpox. The vaccine being used currently is Dryvax[®], the identical vaccine used in the U.S. when smallpox vaccination was routine. Essentially everyone over 30 years of age has been vaccinated with this same vaccine.

For this initial vaccination program, vaccinees will be encouraged to direct questions to the clinic where they were vaccinated and to be evaluated by clinicians designated by the hospital or local health department.

However, in the event of a reaction, it is likely that patients will present to their regular providers, emergency departments and urgent care centers, especially after hours.

As with any medical problem, first evaluate and stabilize the patient, if necessary. Most patients will need only reassurance for minor reactions. Very few reactions will be immediately life threatening or truly emergent. Encephalitis is likely to present with the most urgency.

Vesicular, pustular, or open lesions at the vaccination site **do** contain live vaccinia virus. The virus is spread by direct contact, not by aerosolization. Unlike smallpox disease, lesions are not likely to occur on the oral mucosa. Contact isolation and precautions are advised, but respiratory isolation is not necessary, unless the presentation is an unknown febrile rash illness.

If you need advice or consultation for a potential adverse reaction, first try contacting your local health department. The patient should have been provided with a list of phone numbers, including the local health departments, at the time of vaccination. If unable to reach a consultant through your local health department, or through your hospital call roster, you may call the clinical advice line at the Centers for Disease Control (CDC) at (877) 554-4625.

Patients with adverse reactions who need hospitalization can be cared for in a local medical facility unless the required level of care (e.g., intensive care) cannot be provided. For serious adverse reactions, complex or unclear cases, a network of physician consultants has been established in California. These consultants will be contacted by the CDC clinical consultation group, your local health department, or any of the local providers who have volunteered to act as initial consultants.

The state network consultants will also facilitate access to Vaccine Immune Globulin (VIG), if it is considered necessary. For distance consultation, digital photographs will be extremely helpful. Most of these consultants will have access to telemedicine video transmission through established networks. There are currently operational telemedicine sites throughout California, especially in rural counties. In most instances, the patient could be referred to these centers for consultation the following day. To find the closest telemedicine site, contact UC Davis Telemedicine Center at (916) 734-8858.

For more information, visit the CDC Web site at www.cdc.gov/smallpox, "Clinicians Resources."

Clinicians with a special interest in this area or willing to act as a local consultant should contact their local health department and hospital.

News From the U.S. Food and Drug Administration

Rapid Group B Strep Test for Pregnant Women

Recently, the FDA announced the clearance of a new rapid Group B strep test for screening pregnant women. This test can provide results in as little as one hour, as compared to 18 to 48 hours for culture testing. The new test is called the IDI-Strep B Assay and it is made by Infectio Diagnostic, Inc. Instead of using a standard culture method to grow the bacteria, the new test uses a special instrument to detect the DNA of Group B Strep in swab samples from the vagina and rectum.

Group B Strep is a leading cause of illness and death among newborns in the U.S. About 10 to 30 percent of pregnant women have Group B Strep, which can be transmitted to their newborns during birth if the women are not given antibiotic treatment. Pregnant women are typically screened for Group B strep two to four weeks before labor begins, using the standard culture method. If the test is positive for Group B Strep, the woman is given four hours of antibiotic treatment during labor. Although culture results are reliable, they are available too late to be useful for women who have pre-term labor or who have not had prenatal care. This rapid test may be particularly useful for these women, and may help avoid unnecessary antibiotic use.

The IDI-Strep B test is the first non-culture test that meets the performance criteria recommended by CDC guidelines—at least 85% as sensitive as culture methods. Because of this, it can be used instead of the standard culture method.

Additional information:

FDA Talk Paper: www.fda.gov/bbs/topics/ANSWERS/2002/ANS01172.html

www.fda.gov/bbs/topics/ANSWERS/2002/ANS01172.html

New Device Clearance: IDI-Strep B Assay:
www.fda.gov/cdrh/mda/docs/k022504.html

New Labeling and Advice on Hormone Therapies for Postmenopausal Women

Data from the landmark Women's Health Initiative study showed that postmenopausal women taking estrogen plus progestin have an increased risk of heart attack, stroke, breast cancer, and blood clots. FDA is working with manufacturers of estrogen and estrogen plus progestin products to incorporate this new information in professional and patient labeling. FDA's labeling changes include a new boxed warning that highlights the increased risks of MI,

stroke, breast cancer and venous thromboembolism, and it emphasizes that these products should not be used to prevent cardiovascular disease. The revised labeling also clarifies that these drugs should only be used when the benefits clearly outweigh risks. Of the three indications, two have been revised to include consideration of other therapies:

- Treatment of moderate to severe vasomotor symptoms (such as "hot flashes") associated with the menopause. (This indication has not changed.)
- Treatment of moderate to severe symptoms of vulvar and vaginal atrophy associated with the menopause. When these products are being prescribed solely for the treatment of symptoms of vulvar and vaginal atrophy, topical vaginal products should be considered.
- Prevention of postmenopausal osteoporosis. When these products are being prescribed solely for the prevention of postmenopausal osteoporosis, approved non-estrogen treatments should be carefully considered, and estrogens and combined estrogen-progestin products should only be considered for women with significant risk of osteoporosis that outweighs the risks of the drug.

To minimize the potential risks and to accomplish the desired treatment goals, the new labeling also advises healthcare providers to prescribe estrogen and combined estrogen with progestin drug products at the lowest dose and for the shortest duration for the individual woman. Women who choose to take estrogens or combined estrogen and progestin therapies after discussing their treatment with their doctor should have yearly breast exams by a healthcare provider, perform monthly breast self-examinations, and receive periodic mammography examinations scheduled based on their age and risk factors.

Women should also talk to their healthcare provider about other ways to reduce their risk factors for heart disease (e.g., controlling high blood pressure, improving diet, tobacco use) and osteoporosis (e.g., eating an appropriate diet, using Vitamin D and calcium supplements, and doing weight-bearing exercise).

FDA will update guidances to provide advice on studies needed to demonstrate safety and effectiveness of new products for these indications and provide recommendations on labeling for estrogen and estrogen with progestin products used in postmenopausal women.

For more information:

www.fda.gov/cder/drug/infopage/estrogens_progestins/default.htm

Buprenorphine Offers New Options for Treatment of Opioid Dependency

By Susan McCall, M.D.

Medical Director, Oregon Board of Medical Examiners Health Professionals Program (HPP)

The federal Drug Addiction Treatment Act of 2000 established a waiver allowing qualified physicians (as defined below) to use Schedule III, IV and V medications in their offices to treat opioid-dependent patients. Medications must be approved for this purpose by the U.S. Food and Drug Administration (FDA).

On October 8, 2002 the FDA announced the approval of buprenorphine for the treatment of opioid addiction. Buprenorphine, a Schedule III medication, is the first medication to be available for use in detoxification or maintenance of opioid dependent patients in office-based practice.

The use of medication to treat opioid dependence has traditionally been restricted to a limited number of physicians working in federally regulated opioid treatment programs. In contrast, office-based opioid treatment (OBOT) is a new model that allows qualified physicians to treat opioid dependence in their practices.

OBOT provides a major new treatment modality for many opioid-dependent patients who have been unable or unwilling to access methadone treatment. OBOT places the treatment of opioid dependence in the context of standard medical care, under the regulation of state medical boards.

Buprenorphine is a partial opiate agonist eliciting a maximal response, which cannot be exceeded with increasing doses. This characteristic provides an improved safety profile over full agonists such as methadone, and makes buprenorphine more appropriate for use with less restriction.

Buprenorphine is formulated as sublingual tablets with naloxone, marketed as Suboxone, and without naloxone, marketed as Subutex.

Naloxone has minimal oral bioavailability and is used to prevent the tablet being dissolved for intravenous use. The formulation, Subutex without naloxone, is available for initiation of treatment and in cases where naloxone use is contraindicated such as during pregnancy.

The partial agonist quality of buprenorphine may precipitate withdrawal symptoms in patients with an established high requirement for opiates. Caution in initiating treatment of patients with an unusually high

tolerance to opiates is advised, and the initial dose of buprenorphine may need to be delayed until withdrawal symptoms are significant in these patients.

Comprehensive information about buprenorphine is available on the FDA Web site, www.fda.gov/cder/drug/infopage/subutex_suboxone/default.htm.

Minimal training requirements have been established to ensure that physicians authorized to use this new treatment option have adequate training in the diagnosis and treatment of opioid dependence.

Qualified physicians are defined as those with certification in addiction medicine by the American Society of Addiction Medicine (ASAM) or the American Osteopathic Association (AOA).

Other possible qualifiers include a Certificate of Additional Qualifications in Addiction Psychiatry, or completion of eight hours of training in the treatment of opioid dependent patients. Such training may be sponsored by ASAM, the AOA, The American Academy of Addiction Psychiatry (AAAP) or the American Medical Association (AMA).

Physicians utilizing OBOT must have the capacity to refer patients for counseling and appropriate ancillary services. Regulations specifically prohibit physicians from delegating the prescribing of opioids for detoxification/maintenance to non-physicians. Each physician or practice is allowed to treat a maximum of 30 OBOT patients simultaneously.

To obtain a waiver to utilize buprenorphine for OBOT, qualified physicians must notify the Substance Abuse Mental Health Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT) of their intent to provide office-based opioid treatment (OBOT) and certify their qualifications. CSAT has 45 days to act on waiver applications.

If a physician finds it necessary to begin OBOT for an individual patient in an emergency, prior to approval of the waiver application, he or she must notify CSAT and the U.S. Drug Enforcement Administration (DEA) of such intent. The waiver application is available on CSAT's Web site, www.buprenorphine.samhsa.gov, and

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Buprenorphine

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may be completed and submitted online. Physicians considering OBOT have many resources available for detailed information.

CSAT's Web site, www.buprenorphine.samhsa.gov, is a user-friendly site packed with all the pertinent information. It also provides information on, and links for, Web-based and on-site training programs. Information on training opportunities may also be found on specialty society Web sites: www.asam.org, www.aaap.org, www.psych.org.

The efficacy and safety of OBOT will be under more intense scrutiny than other medical treatments. It is subject to being discontinued with 60 days' notice at any time it is determined to be unsafe or ineffective. The ability to retain this powerful treatment option will depend on appropriate patient selection and the use of sound medical judgment in the prescribing of buprenorphine by well-trained physicians.

The Federation of State Medical Boards (FSMB) has published *Model Guidelines for Opioid Addiction Treatment in the Medical Office*. The *Guidelines* are available at www.fsmb.org under "Policy Documents."

CORRECTION

In the February 2003 issue of the *Action Report*, a description of SB 1950 stated a requirement that "attorneys at the time of filing a civil complaint serve a copy of the complaint or demand upon the Medical Board, which shall be treated as a complaint."

This provision was contained in an earlier draft and was **not** passed in the final version of the bill.

Requirements for HIV/AIDS Case Reporting

There are new, non-name reporting procedures for patients with HIV. The following letter was sent to healthcare providers by the California Conference of Local Health Officers (CCLHO). It is being reprinted here as a timely reminder for physicians who encounter HIV/AIDS in their patients. (A similar article was included in the July 2002 Action Report.)

Dear Healthcare Provider:

As you are probably aware, on July 1, 2002, the California Department of Health Services, Office of AIDS (OA) implemented new regulations establishing a non-name HIV surveillance system to capture prevalent and incident HIV cases throughout California. During the first seven months of the system, 12,762 cases were reported out of an estimated 80,000 cases statewide. The purpose of this letter is to alert you of your responsibility to report all HIV positive patients to the local health department.

In California, diagnosed AIDS cases are reported by name from the healthcare provider to the local health department (LHD) on an HIV/AIDS Case Report form. In contrast, the new HIV surveillance system is a dual reporting system, with both laboratories and healthcare providers reporting to the LHD. HIV case reports utilize a non-name code to distinguish cases from each other. The code is comprised of the soundex (an alphanumeric code based on consonants in the patient's last name), the patient's date of birth, gender, and the last four digits of the patient's Social Security Number. For each (non-AIDS) HIV positive patient for whom you receive laboratory notification of a confirmed HIV test, it is your responsibility to assure that one HIV/AIDS Case Report form is completed and sent to your LHD. The LHD forwards unduplicated HIV case reports to the OA. It is critical that all parties involved fulfill their reporting obligations in order for the system to succeed.

It is understandable that some individuals may experience challenges with the new HIV reporting requirements during the first year of implementation. Fortunately, there are a number of resources available for assistance. The OA's Web site, www.dhs.ca.gov/aids, has a number of resources including the text of the regulations, information for both online and in-person training, frequently asked questions, and contact information for local HIV/AIDS surveillance staff. Your local surveillance staff is available to provide technical assistance, so please contact them to enlist their help in complying with the regulations.

It is important that HIV and AIDS data are reported in an accurate and timely manner, as future state and federal funds will be allocated based on the number of HIV cases as well as the number of AIDS cases within jurisdictional boundaries. These data will also assist the OA to more effectively target resources for prevention and care services to best meet the needs of our communities.

Thank you very much for your continuing efforts to control HIV disease.

(Original letter signed by Poki Namkung, M.D., M.P.H., President, CCLHO)

Providing Healthcare to the Uninsured

(continued from page 1)

The Board is also interested in AB 621 and will be working on the bill with its author, Assembly Member Alan Nakanishi. AB 621 would expand the current provisions for physicians who are licensed under a fee-exempt status while providing voluntary, unpaid medical services to indigent patients in medically underserved or critical-need population areas.

There are numerous other important avenues to consider. Working with interested parties, the Board will take a role in seeking ways to support existing and additional volunteerism within the medical community. The Board also is considering ways to use its Web site to provide valuable linkage; for example, a list of those volunteer physicians willing to offer their services, a list of volunteer organizations providing services, and a list of practice settings in underserved areas where need for these services exists.

Other ideas may prove too costly, given the state's current revenue shortfalls. Nevertheless, the Board plans to discuss ideas with healthcare advocates—bringing these concepts forward may help generate program ideas that have not yet been discussed. Our goal is to improve access to healthcare for all Californians, regardless of economic status, through the use of physicians who are already licensed in California or who advance the goal of expanded healthcare and who meet the legal qualifications of education, examination, and training to become licensed physicians.

CME

California Physicians — Fulfill AB 487 Mandate

A Clinician's Approach to Pain Management

June 7 and 8, 2003

Hilton Costa Mesa

12-hour CME event

Hosted by Pioneer Medical Group, Inc.

Contact: Cynthia Castillo, CME Coordinator
(562) 936-0053

Physician Knowledge Assessment on Lyme and other Tick-Borne Diseases

Thank you for responding

The California Department of Health Services (DHS) thanks you for responding to the questionnaire on tick-borne diseases published in the last issue of the Action Report. To date DHS has received 279 responses. An analysis of the results and a discussion will be presented in the next Action Report.

Until then, DHS reminds physicians that spring is the season when the tiny immature nymphal stage of the western black-legged tick (*Ixodes pacificus*) is most common. *Ixodes pacificus* is the tick vector in California for two bacterial diseases, Lyme disease and granulocytic ehrlichiosis. The nymphs of *I. pacificus* are found in low, moist vegetation, particularly in leaf litter in mixed hardwood forests.

Where studied in certain north coastal California counties, the average infection prevalence of the agent that causes Lyme disease in nymphal ticks can range from 0-15%. More than half of the Lyme disease cases are contracted during the spring and summer months.

Because of the small size of the nymphal tick, frequent tick inspections while in tick habitat and daily, thorough checking of the entire body should be encouraged for people who live or recreate where ticks occur.

More information on tick avoidance tips and Lyme disease diagnosis, treatment and epidemiology in California can be found at the DHS Web site: www.dhs.ca.gov/ps/dcdc/disb/disbindex.htm.

TDD NUMBERS

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

Division of Licensing
(916) 263-2687

Central Complaint Unit
(916) 263-0935

Free Prostate Cancer Treatment Available for Men

A new statewide program that provides free prostate cancer treatment to California men with little or no health insurance is now available. The program, called IMPACT (Improving Access, Counseling and Treatment for Californians with Prostate Cancer), began in June 2001, and is administered throughout the state by the University of California, Los Angeles, under the direction of Program Director Mark S. Litwin, M.D., and Medical Director James R. Orecklin, M.D.

IMPACT is the largest state funded-effort to provide comprehensive cancer care to low-income men with little or no health insurance, many of whom are from communities of color and other communities that have been medically underserved. In 2001, nearly 2 million California men were without health insurance.

IMPACT will help men who have little or no health insurance, are not enrolled in Medi-Cal, do not have Medicare and have incomes under 200 percent of the federal poverty level. IMPACT will provide free prostate cancer treatment for an initial 18 months to men who qualify.

In addition to offering treatment, the new program is designed to increase patient education and promote awareness about the importance of early prostate cancer treatment.

The program has four regional offices: Los Angeles-Irvine, Sacramento, San Diego, and San Francisco. Each regional center works with local health departments, community hospitals and physicians to establish a growing network of providers who will help patients receive evaluation and treatment in their local communities.

Patients can receive prostate cancer treatment from IMPACT at many community hospitals and physician offices throughout California. To receive the free treatment from IMPACT, patients must use a contracted physician or hospital. Treatments for prostate cancer paid for by IMPACT include: radical prostatectomy, external beam radiation therapy, hormone therapy, chemotherapy and watchful waiting. Along with treatment, IMPACT provides each patient with the services of a nurse case manager who acts as the patient's advocate and interacts with physicians throughout the course of therapy. IMPACT patients also receive free personalized nutritional counseling.

For more information or to refer patients for treatment call: (866) 549-4819 or log on to: www.california-impact.org.

ADMINISTRATIVE ACTIONS: Dec. 1, 2002 to Jan. 31, 2003

PHYSICIANS AND SURGEONS

ALWAN, MOUHANAD M., M.D. (A44569)
Claremont, CA
B&P Code §§2234(e), 2236(a). Committed acts of dishonesty and convicted of crimes substantially related to the practice of medicine. Six months suspension, stayed, 3 years probation with terms and conditions. January 13, 2003. Judicial review being pursued.

BIRSNER, JOHN W., M.D. (C9250) Bakersfield, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts, incompetence, and unprofessional conduct by misinterpreting mammograms for 4 patients. Revoked, stayed, 5 years probation with terms and conditions. December 18, 2002

DIBBLE, TIMOTHY DANIEL, M.D. (G80511)
Coeur D'Alene, ID
B&P Code §2234. Stipulated Decision. Failed to properly document some of the medical care provided. Public Reprimand. December 16, 2002

ELKJER, JAMES DWIGHT, M.D. (C33589)
Gardena, CA
B&P Code §§725, 810, 2234(b)(c)(d)(e), 2266. Stipulated Decision. Committed acts of gross negligence, repeated negligence, incompetence, dishonesty or corruption, excessive treatment, insurance fraud, and failed to maintain adequate and accurate medical records in the care and treatment of 5 patients. Revoked, stayed, 7 years probation with terms and conditions including 90 days actual suspension. December 18, 2002

GERGANS, GREGORY ALAN, M.D. (G47499)
Evanston, IL
B&P Code §§141(a), 2305. Disciplined by Illinois for failure to implement and follow recommendations to ensure the competent and safe practice of medicine. Revoked. January 16, 2003

GERSTEN, DENNIS JOHN, M.D. (G32898)
Encinitas, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, incompetence, dishonesty or corruption, and practicing under a false name in the care and treatment of 1 patient by using questionable lab and stool tests to convince the patient of the need for vitamins supplied by a store in which he had a financial interest. Revoked, stayed, 5 years probation with terms and conditions.
December 18, 2002

HYMAN, MARK HOWARD, M.D. (G55008)
Los Angeles, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence and sexual misconduct for engaging in acts of sexual abuse, sexual misconduct, and sexual relations with a patient. Revoked, stayed, 5 years probation with terms and conditions including 30 days actual suspension.
January 13, 2003

JEYARANJAN, THAMBIMUTTU, M.D. (A32442)
Los Angeles, CA
B&P Code §2234(c). Stipulated Decision. Failed to maintain adequate and accurate medical records and committed repeated negligent acts by failing to note a patient's abnormal kidney function in a consultation report or notes. Revoked, stayed, 2 years probation with terms and conditions. January 17, 2003

KIRKLAND, PURNELL ALEXIS, M.D. (G39834)
Inglewood, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts, excessive treatment or prescribing, failure to maintain adequate medical records, alteration of medical records, and acts of incompetence by recommending or performing diagnostic arthroscopy and lavage of the knee in 3 patients. Public Letter of Reprimand.
January 15, 2003

KRUGLIK, GERALD DAVID, M.D. (G34085)
Hollywood, FL
B&P Code §§141(a), 2305. Disciplined by Florida for failure to correctly interpret a mammogram and to recommend appropriate follow-up procedures in the care and treatment of 1 patient. Public Reprimand.
January 15, 2003

LANNON, RICHARD ANDREW, M.D. (A23592)
San Francisco, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, incompetence, failing to maintain adequate and accurate medical records, excessive treatment or prescribing, and prescribing without a medical examination by failing to properly diagnose and treat a patient's psychiatric illness. Revoked, stayed, 2 years probation with terms and conditions. December 9, 2002

Explanation of Disciplinary Language and Actions

“Effective date of decision” —
Example: “December 9, 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).

LIGHTFOOTE-YOUNG, BRENDA J., M.D. (A43548)
Big Bear Lake, CA
B&P Code §2234. Failed to comply with Board-ordered probation terms and conditions. Revoked. December 5, 2002

LUSMAN, JULES MARK, M.D. (A47985)
Los Angeles, CA
B&P Code §§725, 2234(a)(b)(c)(d), 2238, 2241, 2242(a), 2266. Committed gross negligence, repeated negligent acts, incompetence, excessive prescribing or administration of drugs, dispensing dangerous drugs without a good faith examination and medical indication, prescribing, furnishing or administering dangerous drugs to addicts, failing to maintain records showing the pathology and purpose for prescribing a schedule II controlled substance, failing to maintain adequate and accurate records related to services provided to patients, failing to maintain required inventory of controlled substances, and failing to maintain a required inventory and records of controlled substances in the care and treatment of 8 patients. Revoked. December 6, 2002

MICHEL, JAMES WESLEY, M.D. (G46554)
Carmel, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with prescribing without conducting a medical examination, gross negligence, and incompetence for prescribing excessive amounts of narcotics to multiple patients without medical justification or maintaining adequate and accurate records. Revoked, stayed, 5 years probation with terms and conditions. December 26, 2002

MILLS, WALTER WARREN, II, M.D. (G45945)
Rohnert Park, CA
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct by prescribing excessive doses of narcotic and psychoactive medications for 2 patients without appropriate monitoring or referral, and failing to maintain adequate and accurate records related to the provisions of services and prescribing of controlled substances. Public Reprimand. December 16, 2002

MINKOFF, DAVID IRA, M.D. (G30196)
Clearwater, FL
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by Florida for prescribing Valium and chloral hydrate without conducting a good faith physical examination and without establishing a proper patient/physician relationship, including obtaining a medical history. Revoked, stayed, 5 years probation with terms and conditions. December 26, 2002

MOGENSEN, THOMAS KEITH, M.D. (G79090)
Colton, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with unprofessional conduct, gross negligence, repeated negligent acts, incompetence, excessive treatment, inadequate records, prescribing without indication, and aiding and abetting unlicensed practice by using a fictitious name without having a fictitious name permit in the care and treatment of 8 patients. Revoked, stayed, 7 years probation with terms and conditions including 20 days actual suspension. January 6, 2003

MONDKAR, AVINASH MADHUKAR, M.D. (A35142)
Beverly Hills, CA
B&P Code §§2234(b)(d), 2262. Stipulated Decision. Committed acts of gross negligence and incompetence for failing to document the patient's history, physical examination and diagnostic plan, failing to obtain a hematological evaluation, failing to maintain adequate records and altering the medical record in the care and treatment of 1 patient. Revoked, stayed, 3 years probation with terms and conditions. January 16, 2003

NAZARIAN, IRADJ H., M.D. (A43573)
Beverly Hills, CA
B&P Code §2266. Stipulated Decision. Failed to maintain adequate and accurate records in the care and treatment of multiple patients. Revoked, stayed, 4 years probation with terms and conditions including 30 days actual suspension. December 26, 2002

OAKES, CECIL EVERETT, JR., M.D. (C43319)
Vacaville, CA
B&P Code §§2021, 2052, 2053, 2234(b)(c)(e), 2238, 2242(a), 2263, 2266. Practiced medicine without a valid license after his license had expired, prescribed

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www.medbd.ca.gov

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

without a good faith examination or medical indication, failed to maintain adequate medical records, committed acts of dishonesty, gross negligence, repeated negligent acts, and violated the professional confidence of patients. Revoked. December 19, 2002

RAMOS, DOUGLAS JAN, M.D. (G69214)
Omaha, NE
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by Nebraska for unprofessional conduct during contact with another physician. Public Letter of Reprimand. December 2, 2002

RINCON, FRANCISCO I., M.D. (A45411)
Los Angeles, CA
B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in the care and treatment of an infant with pediatric herpes. Revoked, stayed, 3 years probation with terms and conditions. January 3, 2003

RODRICKS, PAUL, M.D. (G84064)
Sherman Oaks, CA
B&P Code §§141, 2305. Stipulated Decision. Disciplined by New York for repeated negligence during the provision of anesthesia services to a patient during surgery. Revoked, stayed, 2 years probation with terms and conditions. December 5, 2002

ROSS, HOWARD D., M.D. (C17421)
Los Angeles, CA
B&P Code §§820, 822. Stipulated Decision. Ability to practice medicine safely impaired due to mental illness. Revoked, stayed, 5 years probation with terms and conditions. January 3, 2003

SAUNDERS, SCOTT DAVID, M.D. (G78847)
Solvang, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence and incompetence for failure to diagnose and treat appendicitis. Revoked, stayed, 2 years probation with terms and conditions. December 2, 2002

SHARMA, MANORAMA, M.D. (A37350)
Fountain Valley, CA
B&P Code §§2234(b)(c)(d), 2262. Committed acts of gross negligence, repeated acts of negligence, incompetence, and fraudulent alteration of medical records in the care and treatment of 1 patient undergoing a laser procedure. Revoked, stayed, 4 years probation with terms and conditions. January 20, 2003

SISON, RENATO FERNANDEZ, M.D. (A48516)
Riverside, CA
B&P Code §§2234(e), 2236. Convicted of a felony for enticing prostitution of a minor and for carrying a concealed weapon in a vehicle. Revoked. January 8, 2003

SJAARDA, JOHN R., M.D. (A20766) Merced, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence and incompetence for failure to properly respond to a patient's respiratory distress after lacerating the patient's heart during a sternal bone marrow biopsy. Revoked, stayed, 5 years probation with terms and conditions including 30 days actual suspension. December 2, 2002

SUTTON, PATRICK MARK, M.D. (G53929)
Pasadena, CA
B&P Code §2266. Stipulated Decision. Failed to maintain adequate medical records in the care and treatment of 1 patient. Revoked, stayed, 4 years probation with terms and conditions. December 2, 2002

Drug or Alcohol Problem?

If you are concerned about a fellow physician who may be abusing alcohol or other drugs or suffering from a mental illness, you can get assistance by contacting the Medical Board's confidential Diversion Program.

Physicians are not required by law to report a colleague to the Medical Board. However, the American Medical Association Code of Ethics indicates that 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, confidential program for impaired physicians.

Your call 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**

VERHOEVE, PAUL EDWARD, M.D. (A45358)
El Cajon, CA
B&P Code §§2234(a)(e)(f), 2236(a). Stipulated Decision. Convicted of federal mail fraud and aiding and abetting mail fraud. Revoked, stayed, 5 years probation with terms and conditions including 90 days actual suspension. January 2, 2003

WEISBLATT, JEFFREY HOWARD, M.D. (G74694)
Los Angeles, CA
B&P Code §2266. Stipulated Decision. Failed to maintain adequate and accurate records of his care and treatment of a surgery patient under anesthesia. Public Reprimand. December 2, 2002

WESTPHAL, LOUETTA KANNENBERG, M.D. (G43635) Beverly Hills, CA
B&P Code §§2234(a)(e), 2261, 2264, 2415.
Committed acts of unprofessional conduct, aided and abetted unlicensed practice, committed dishonest or corrupt acts by providing false statements in documents, and violated the fictitious name permit requirements by entering into an oral agreement to work in a medical clinic for an individual she knew was not a licensed physician. Revoked, stayed, 5 years probation with terms and conditions including 60 days actual suspension. December 9, 2002

WHANG, CHULL, M.D. (C40630) Gallup, NM
B&P Code §2234(a). Stipulated Decision. Falsely billed surgery time and services for procedures covered by insurers when working with other surgeons and anesthesiologists who performed non-covered cosmetic services and other surgeries. Revoked, stayed, 5 years probation with terms and conditions, including 60 days actual suspension. December 2, 2002

WHANG, CHULL, M.D. (C40630) Gallup, NM
B&P Code §2234(c). Stipulated Decision. Failed to personally inspect anesthesia-related equipment to ensure proper functioning of the equipment prior to commencing 2 surgical procedures in which patient harm occurred. Public Letter of Reprimand. December 2, 2002

ZANDER, ALLA, M.D. (A61985) Laguna Hills, CA
B&P Code §§2234, 2236(a). Stipulated Decision. Convicted of 3 charges of petty theft and 1 commercial burglary. Revoked, stayed, 5 years probation with 20 days actual suspension. December 20, 2002

DOCTOR OF PODIATRIC MEDICINE

LARKINS, PHILIP EDWARD, D.P.M. (E4457)
San Diego, CA
B&P Code §§480(a)(1)(2)(3), 2236(a), 2261, 2475(a). Stipulated Decision. Convicted of disorderly conduct in 1992 and battery in 1995, and practiced in a residency program without a limited license after denial of licensure in California. License granted, revoked, stayed, 10 years probation with terms and conditions. January 9, 2003

PHYSICIAN ASSISTANT

ROBERTS, WILLIAM ALTON, JR., P.A. (PA15005)
Avenal, CA
B&P Code §§498, 2234(e)(f), 3527(a), 3531.
Stipulated Decision. Committed acts of dishonesty or corruption, licensure by fraud, and unprofessional conduct by failing to disclose a conviction of domestic violence on his California application for licensure. Revoked, stayed, 5 years probation with terms and conditions. December 20, 2002

REGISTERED DISPENSING OPTICIAN

LANGTON, DAVID LEE (SL711) Clovis, CA
B&P Code §§490, 498. Failed to disclose a misdemeanor conviction on an application for a Registered Spectacle Lens Dispenser Certificate. Revoked. January 23, 2003

SURRENDER OF LICENSE WHILE CHARGES PENDING

PHYSICIANS AND SURGEONS

ABRAMO, ARNOLD A., M.D. (G5989)
Orchard Park, NY
December 4, 2002

HEISS, RICHARD JAMES, II, M.D. (G69342)
Bakersfield, CA
December 11, 2002

HILDE, REUBEN LYNN, JR., M.D. (G22770)
Whittier, CA
December 4, 2002

PINNAS, JACOB LOUIS, M.D. (G17839)
Tucson, AZ
December 3, 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.

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

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Code Section 2021(b) &
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Applications	(916) 263-2499
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Verification of Licensure/

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Board of Podiatric Medicine	(916) 263-2647
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Board of Psychology	(916) 263-2699
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Complaints	(800) 633-2322
Midwives	(916) 263-2393
Physician Assistant	(916) 263-2323
Registered Dispensing Opticians	(916) 263-2634

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Acupuncture	(916) 263-2680
Audiology	(916) 263-2666
Hearing Aid Dispensers	(916) 327-3433
Physical Therapy	(916) 263-2550
Respiratory Care	(916) 323-9983
Speech Pathology	(916) 263-2666

ACTION REPORT — APRIL 2003
Candis Cohen, Editor (916) 263-2389

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