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# Action Report

## Medical Board of California

IN THIS ISSUE



**Medical Board of California Meetings**

**2003**

July 31, August 1, 2
San Francisco

November 6, 7, 8
San Diego

*All meetings are open to the public.*

## Student Loan Repayment Program Awardees Begin Assignments

The California Physician Corps Loan Repayment Program, created by AB 982, Firebaugh, became law on January 1, 2003.

It allowed the Medical Board to award $3 million in educational loan repayments to qualified physicians who agree to serve in a designated medically underserved area of California for a minimum of three years (see February 2003 *Action Report*).

Over 150 recently licensed physicians applied, of whom 98 were eligible for consideration of an award. Ultimately 32 awardees were granted up to $105,000 each. Ranging between the borders of Oregon and Mexico, 42 medical facilities will be served by these physicians.

Dr. Otto Liau, who also speaks Spanish and Mandarin, is one example of the program's success. Dr. Liau is a program awardee who drives an allergy and asthma "Breathmobile," traveling to community schools in Orange County to treat medically underserved children.

The Medical Board thanks the many applicants and other parties for their interest and participation. The Board is excited to see this promising program enhance medical care to underserved communities throughout the state.

For a list of clinics that have physicians who have been selected to participate in the program, please visit the Board's Web site at www.medbd.ca.gov and select "Services for Licensees," "Loan Repayment Program."


**Dr. Stanley P. Galant, left, Asthma Program Director at the Galant and Lin Clinic, and Medical Board President Dr. Hazem Chehabi congratulate Dr. Otto Liau on his award from the Student Loan Repayment Program.**

***We hope this program can serve as a model for other state medical boards working with their licensees to improve access to healthcare in underserved communities.***

*— Medical Board President Hazem Chehabi, M.D.*

**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

I am honored to have been selected to serve as president of the Medical Board of California for 2003/04. During my period of service on this Board, I've had the pleasure to observe and learn from my predecessors. It's a great honor to follow in their footsteps.

***Hazem Chehabi, M.D.***
***President of the Board***

This Board has come a long way over the last two and a half years since I've been appointed, making tremendous progress in many areas. Much remains to be done. I hope to take the opportunity this year, as President of the Medical Board, to create the foundation for our continued success. I know as a Board member and a member of my community that solid relationships with those who share our values can be crucial in helping us achieve our goals. It is my intention to build on our relationships so that we may learn from the people we work with, in order to better serve the public.

## Relationships With the Public

The Medical Board has a proud history of protecting the public through its licensing and enforcement programs. However, it often establishes how that is done with too little input from the public that it serves. I want to increase our outreach to organizations that speak for a wider range of consumers, to learn what their needs and expectations are. These will include seniors, representatives of community health clinics and other communities of interest in the state.

It is also important that we try to be more proactive in presenting to the public the services that we offer. The Public Education Committee has addressed this issue and is already making progress in this area. I hope to advance that effort by working with them to increase our outreach around the state, to establish communication that is not merely reactive to an emerging story or issue, but is helpful in providing consumers with information that they can use to make their interaction with medicine more positive.

## Relationships With Medicine

There are two areas where opportunities compel us to work toward better communication. The first is with California's medical schools. It is important that we seek the opportunity to establish communication with our future physicians at this early point in their careers, so that we may address their questions and our expectations before that time when they are urgently seeking a license. Many of the Board's services are important to these students and our early interaction with them can be important to future patients. I will ask the Division of Licensing to consider the design of a program that includes outreach to medical schools and graduate medical educational programs for the sharing of information and support.

The other opportunity is for more open communication with the California Medical Association and its component medical societies. Despite the improved dialogue of the past few years, we must take advantage of all of the opportunities for realizing our shared interests, such as we did in establishing the medical school Student Loan Repayment Program (see February 2003 *Action Report*). I believe that both organized medicine and the Medical Board share a commitment to quality healthcare, and that goal can be advanced through cooperation better than it can be through antagonism.

## The Coming Year

Perhaps the most important undertaking in the coming year will be the work of the Enforcement Program monitor. The monitor, directed in SB 1950 of last year, will be looking at how the Board regulates the physician community, certainly the most visible of the many functions for which the Board is responsible. I believe that it is important that we take this opportunity to work closely with the monitor to develop a national model for physician regulation. There is much that we do very well, and for which we can be proud, and there is much that we can improve, if we are open to the recommendations that will be made. I will look to the Enforcement Committee, under Dr. Ronald Wender, to lead that effort.

I believe it is important that we recognize our limitations as well as our opportunities. These lean fiscal times make it critical that we spend our resources where they most benefit the public whom we serve. With our priorities established in law, we need to honestly assess that which we can and cannot do if we are to meet the mandated priorities. My goals are that the Medical Board continue to evolve into an organization that keeps focused on its mission of consumer protection through its licensing and enforcement programs, and provides support to the public and the profession in pursuit of those goals. Since becoming President, I have met with the other new Board officers to assure that we chart a course that is sustainable and consistent with our public protection mandate.

Finally, no matter how we proceed, the merits of our decisions must be recognizable to those who follow our work. I will use these pages to convey those matters with which the Board struggles and will attempt to clearly express the rationale behind some of the difficult decisions we make.

# Medical Board Member Serves in Baghdad

## Other key participants also California physicians

The Medical Board is very proud that one of its members and past Presidents, Bernard Alpert, M.D., a practicing San Francisco plastic surgeon, recently spent three weeks in Iraq, working with the International Medical Corps (IMC), a nonprofit, nonsectarian, apolitical, humanitarian organization formed in 1984 by volunteer U.S. physicians and nurses. IMC's goal is to enter regions in crisis early, assess situations, and try to help, as it is well established that early intervention saves the most lives and is the most productive.

Dr. Alpert received a phone message in late April generated from a friend, Jeff Colyer, M.D., a plastic surgeon in Kansas City, who works with IMC. The message asked Dr. Alpert to join him in Iraq in three days. Six days later, traveling alone, Dr. Alpert left for Amman, Jordan, on his way to Baghdad. He was joined in Amman by Roger Barrow, M.D., also a California physician, an internist from the San Francisco Bay Area. Since Dr. Colyer had already left Iraq, while they were there, the two Californians were the only American, nonmilitary physicians in Baghdad.

Once in Baghdad, Dr. Alpert had several assignments—assessment, medical expertise, and, ongoing, the reintegration of the Iraqi medical community with the world medical community. He assessed the medical care system of the hospitals in terms of what the impact of the war and the looting were, what the gaps in the availability of supplies and equipment were, and what the situation was with physicians and nurses and other personnel necessary to the delivery of care. The gaps were significant; Dr. Alpert chose to concentrate efforts on acute aid to two hospitals, one of which was chosen because it served the indigent of Baghdad. He performed assessments and prepared reports for IMC so they could get an idea of what the needs were and inform donors accordingly. Some shipments arrived while he was there, other supplies and equipment of which the hospitals were in dire need were delivered, such as oxygen, xylocaine for local anesthesia, and external fixators for the many orthopedic injuries.

As practicing physicians, Drs. Barrow and Alpert jumped in to help in their respective specialties. Dr. Alpert did a lot of operating, often working with general surgeons and orthopedists. He estimates he performed 15-20 operations with the other doctors while he was there, including all types of reconstructive procedures.

The physicians of Iraq have been isolated from the world for about 15 years because of the regime, and because of embargoes, physicians generally were not allowed to travel for any purpose, including for professional training. Drs. Alpert and Barrow found the Iraqi physicians eager to collaborate with other physicians.

Dr. Alpert fondly recalls his presentation to about 10 of Iraq's 35 plastic surgeons on the subject of their choice–the diagnosis, treatment, and reconstruction in cases of breast cancer in the West. They were appreciative and asked many questions during what he calls "a wonderful interchange." As another part of his integrative efforts, Dr. Alpert brought together by satellite phone Tom Russell, M.D., (a UCSF surgeon) executive director of the American College of Surgeons, and Dr. Quraish Al-Kasser, the president of the Iraqi surgical society. Dr. Russell committed to helping and welcoming the Iraqi surgical community to the world medical community. Additionally, Jim Wells, M.D., president of the American Society of Plastic Surgeons, and Dunbar Hoskins, M.D., executive director of the American Academy of Ophthalmology, both also Californians, committed to the same efforts on behalf of their societies.

**Bernard Alpert, M.D. shakes hands with Dr. Quraish Al-Kasser, the president of the Society of Iraqi Surgeons.**

Dr. Alpert hopes that this type of professional interchange will be a great pro-democracy force for the people of Iraq as they decide what kind of government they will have. An effort like this, where many Iraqi professionals immediately begin coming to the United States and other democratic countries and interacting with the rest of the world, will help in that overall goal.

Dr. Alpert's general observations include:

- The single biggest problem, at this time, is security. Without reliable supplies of water, fuel, communications, or electricity, and no security, there can be no organized society. Lawful outside activity ended after 8 p.m., because as darkness descended, the shooting began, and lasted all night long. This was being carried out by criminal elements who would sometimes shoot at coalition members, sometimes shoot at each other, and engage in robbery of the people.

*(Continued on page 7)*

# Making Recommendations for Medicinal Marijuana

Since the passage of Proposition 215 in 1996 there has been a great deal of confusion concerning the role of physicians under this law. That confusion persists today, partly because marijuana is a Schedule I controlled substance.

This designation means that, under federal law, it is deemed to have "no accepted medical use" and can only be used for research purposes. However, after Proposition 215, seriously ill patients who have the recommendation or approval of their physicians in California may use marijuana for medical purposes.

The Medical Board's position with respect to what a physician must do before he or she issues a written recommendation for marijuana was articulated as being no different than what a physician must do before recommending any other treatment option. This simple expression, however, has not been adequate to resolve the uncertainties that exist, particularly when the physician who is evaluating the patient is not also treating the patient's underlying condition.

In an attempt to resolve some of the continuing uncertainty, the Board is working with the California Medical Association to develop guidelines for physicians to follow when recommending marijuana to their patients. At its last meeting in May, the Board's Division of Medical Quality heard extensive testimony from patients and physicians on this topic. In the meantime, the Board expects physicians to follow good medical practice when recommending marijuana for patients with a legitimate medical need, as they would when recommending any other medication or other therapeutic intervention.

The January 1997 edition of the *Action Report* contained an article entitled, "Physicians, Proposition 215, and the Medical Board of California." In that article the Board cautioned that any physician who recommends the use of marijuana by a patient should have arrived at that decision in accordance with accepted standards of medical responsibility, i.e., history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent, including discussion of side effects; periodic review of the treatment's efficacy and, of critical importance, proper record keeping that supports the decision to recommend the use of marijuana. However, the Board recognizes that these principles may require further elaboration to take into account the factors that may affect the physician-patient relationship in this context.

The Board seeks to provide greater guidance to physicians to enable them to participate appropriately in the implementation of Proposition 215, while meeting their professional and ethical obligations under the relevant standard of care. Adherence to such guidance by both physicians and Medical Board enforcement staff will ensure that physicians are not investigated merely because they have issued recommendations for marijuana use to patients. Investigations must be based on information received by the Board which provides a reasonable basis to believe that the physician is not adhering to acceptable medical practice standards when making the recommendation.

PHYSICIAN ALERT

## Unauthorized Company Offering Medical Malpractice Insurance

The California Department of Insurance recently notified the Medical Board of California of an unauthorized medical malpractice insurance company that has been targeting physicians throughout the United States. The company, First Actual American Insurance Company (FAAIC), is not licensed to sell insurance in the state of California. FAAIC, in its literature, claims it can provide coverage at 30 to 50 percent below the rates charged by other insurance companies.

Insurance regulators in Georgia, Mississippi, Oregon, and Ohio have issued cease and desist orders demanding FAAIC stop marketing itself as a medical liability insurance company. The California Department of Insurance has asked the Medical Board of California to notify its licensees to determine if any California physicians have purchased or have been solicited to purchase medical malpractice insurance from FAAIC. If you have purchased insurance from FAAIC you should contact the California Department of Insurance, Consumer Communications Bureau at 1-800-HELP.

Physicians should make sure they are dealing with an authorized insurance company before purchasing insurance. Rates that are significantly lower than prevailing market rates may indicate that an insurance company is not authorized to write insurance coverage in California.

To find out if a particular company is authorized to sell insurance in California, please visit the Department of Insurance's Web site at www.insurance.ca.gov/docs/FS-Consumer.htm.

# Independent Medical Review: A New Tool for Dispute Resolution

*By the HMO Help Center, Department of Managed Health Care*

The Department of Managed Health Care (Department), launched in July 2000, has made protecting the patient our top priority. Protecting the patient means ensuring they have access to high-quality healthcare, the right doctors and specialists and making sure that the doctor-patient relationship is always secure. The Department regulates and licenses Health Maintenance Organizations (HMOs) and some Preferred Provider Organization (PPO) plans in order to promote quality healthcare for the people of California.

If you have recommended treatment for one of your patients and their HMO or PPO has denied the treatment, one of the Department's new programs, Independent Medical Review, may be able to help. The Independent Medical Review (IMR) program allows patients who have been denied treatment or medical care to have the decision reviewed by physicians or other appropriate medical professionals who have no affiliation with their health plans.

If your patient has been denied treatment, the Independent Medical Review program provides an impartial review of:

- Health plan denials, delays, or modifications of services based upon the finding that they are not medically necessary
- Health plan denials of experimental or investigational treatment (for patients with life-threatening or seriously debilitating conditions)
- Health plan denials of reimbursement for emergency or urgent medical services

The Department contracts with several Independent Medical Review Organizations to conduct Independent Medical Reviews. These Review Organizations contract with physicians and other medical professionals in all specialty areas to review health plan denials. These reviewer(s) consider patients' medical records, supporting documentation from the patient and treating physician(s), health plan denial and grievance letters, and other appropriate documents when making a decision. The health plan must comply with the decision of the Independent Medical Review Organization.

Neither patients nor their physicians pay any application or processing fees for an Independent Medical Review. However, in most circumstances, patients are required to participate in the health plan's grievance process prior to requesting an Independent Medical Review.

The Department has developed a Web site to better inform and educate physicians and other healthcare providers about California's Independent Medical Review (IMR) program. (This information is available on our Web site at http://wp.dmhc.ca.gov/imr_info/.)

The Department also provides an online database of Independent Medical Review decisions (excluding patient, provider or facility information). Searches can be conducted by diagnosis or treatment category. (This information is available on our general Web site at www.hmohelp.ca.gov.)

If one of your patients has questions or wants more information about the Independent Medical Review Program, they can contact the Department of Managed Health Care's HMO Help Center at www.hmohelp.ca.gov or at (888) HMO-2219.

# New Physician Supervisor/Physician Assistant Ratios for Medically Underserved Areas

Recent legislative changes contained in SB 1950 (Figueroa, Chapter 1085, Statutes of 2002) allow physicians who work in medically underserved areas to supervise up to four physician assistants. (Physician assistants – PAs – are healthcare professionals licensed to practice medicine with physician supervision.)

During Sunset Review hearings held in 2001, the Department of Consumer Affairs and the Joint Legislative Sunset Review Committee (JLSRC) supported a recommendation from the Physician Assistant Committee to increase the number of PAs that a physician may supervise.

Both the Department and the JLSRC noted that "As California's population continues to grow, the need for healthcare providers, particularly in hard to recruit areas, also increases. Many primary healthcare providers in these areas already rely on physician assistants to expand the number of patients they can care for on a daily basis." They also noted that implementation of this change will increase the number of Californians receiving care in these communities. The Physician Assistant Committee commented that "Given a PA's training and the fact that many PAs come from a diverse and multi-cultural background, they are particularly suited to assist physicians in medically underserved areas of California."

Legislation creating this change will be reviewed by the JLSRC at the next Sunset Review hearing for the Physician Assistant Committee in 2007.

For further information about this change, or to determine if you are in a qualifying medically underserved area, please call the Physician Assistant Committee at (916) 263-2670.

## To California Physicians:

The California Department of Health Services (DHS) and the Medical Board of California offer this reminder to California physicians regarding the statutory mandate that physicians are required to give each patient, during an annual gynecological examination, a standardized written summary describing symptoms and appropriate methods of diagnoses of gynecologic cancers.

In July 2001, the Medical Board ran an article in the *Action Report* that provided information about Health and Safety Code sections 138.4 and 109278 that require medical care providers to give written information on gynecologic cancers to their patients at the time of their annual gynecological examinations. Subsequently, in January 2002, SB 1080 (Bowen) became law, Business and Professions Code section 2249, and in addition to the previous requirement, it makes a physician subject to citation and an administrative fine upon the second and subsequent complaints of his or her failure to provide the patient with this summary.

The intent of the law is to increase awareness of gynecologic cancers and to encourage discussion between the patient and her physician about cancer screening. ***Many women are not receiving this information at their annual exams because their physicians remain unaware of this statutory mandate.***

The DHS' Office of Women's Health developed a gynecologic cancer pamphlet, "Gynecologic Cancers ... What Women Need to Know." The pamphlet is available in English, Spanish, Chinese and Vietnamese. The two-color pamphlet provides easy-to-read information on all gynecologic cancers, including signs, symptoms, risk factors, and benefits of early detection through appropriate diagnostic testing. Also, full-page fact sheets are available on cervical, ovarian and uterine cancers in the same four languages listed above. These fact sheets are for patients who may have specific questions regarding cervical, ovarian or uterine cancers and are available online at www.dhs.ca.gov/director/owh. To download a copy of the gynecologic cancers brochure, go to the Medical Board's Web site at www.medbd.ca.gov and click on "Forms and Publications."

To obtain gynecologic cancer materials in bulk quantities, fax your request for a DHS Warehouse Order form to (916) 928-1326. Be sure to provide a contact name, agency/organization name and fax number on your fax transmittal sheet. To request an order form by phone, please call (916) 928-9217. When placing your order for the materials, please be sure to specify the name of the publication, publication number and the quantity of each item you are requesting. (Please refer to the chart below.)

| | (English) | (Spanish) | (Chinese) | (Vietnamese) |
|---|---|---|---|---|
| Gynecologic Cancer Pamphlet | Pub 306 | Pub 307 | Pub 308 | Pub 309 |
| Cervical Cancer Fact Sheet | Pub 60 | Pub 64 | Pub 74 | Pub 88 |
| Ovarian Cancer Fact Sheet | Pub 62 | Pub 69 | Pub 75 | Pub 96 |
| Uterine Cancer Fact Sheet | Pub 63 | Pub 72 | Pub 77 | Pub 103 |

If you have any questions, or need additional information, please contact the DHS' Office of Women's Health at (916) 653-3330.

Sincerely,

Ron Joseph, Executive Director

## Board Member in Baghdad *(continued from page 3)*

- The old regime was much worse than has generally been reported. There has been little foreign press in Iraq for the last 10 years except for the last few months, and the atrocities which have only recently been reported have been common knowledge among the Iraqi people and were discussed with the U.S. physicians by the Iraqi physicians. Political assassinations were common, leaving no charismatic leaders to challenge Saddam. Dr. Alpert heard estimates that 20 percent of the people were informants for security, and that the regime was responsible for the deaths of some 5 million Iraqis.
- While he had never imagined the horrible impact of the sanctions on the Iraqi citizens, they were manifest in the medical world in terms of people's health. The importation of required equipment was first tested by an evaluation of its potential for dual usage, meaning that a piece of equipment, or a replacement part, could not also have a weapons-type usage. For example, many Iraqis are diabetic, and diabetic retinopathy is treated by laser. While Iraqi physicians had the knowledge and the lasers, many of the parts needed to be repaired or replaced and could not be because the lens was determined to have a dual usage and was embargoed. This resulted in many citizens going blind, because lasers were not allowed to be imported due to the sanctions. The same is true for kidney stones (another common affliction in Iraq) and lithotriptors, as the igniters were deemed dual-usage parts. The result was many teenagers with horrible kidney infections or end-stage renal failure, again because of the sanctions.
- Dr. Alpert was in Iraq after the war, and was puzzled by the nature of the injuries he saw, because so many continued to be massive traumas. It turned out they were not from the war, but from three other sources: gunshot wounds from the criminals who were looting, robbing and shooting people in the lawless streets; horrible burns from black-market "gas lines," where kids with gas cans and hoses would sell gas while smoking cigarettes; and from unexploded ordnance–land mines from the old regime, and unexploded cluster bombs dropped during the war.
- In considering whether the political outcome in Iraq will be a democracy, a theocracy, or civil war, Dr. Alpert observes that any of these is possible, and nothing is ruled out. He did not take away an impression that Iraq has a tribalistic society where people have a specifically directed, religious-based idealism to promulgate through their society. Rather, there appears to be a very definite Iraqi identity, that people feel proud of being Iraqis–a setting in which democracy could flourish.

While he acknowledges it is not for everyone, Dr. Alpert finds humanitarian work very gratifying and recommends interested physicians contact the IMC at www.imcworldwide.org, or any other of the many, long-standing international-relief organizations. Specialists can work within their own communities, assisting the ongoing reintegration efforts of Iraqi physicians, as Dr. Alpert continues to do.

## Notice: Disabled Person Placards, Plates

California Vehicle Code section 1825 requires the Department of Motor Vehicles (DMV) to conduct an annual, random audit of parking placard applications. As part of the ongoing audit DMV discovered that some of the doctors' certifications were incomplete, illegible, or the reason for the disability did not clearly meet statutory requirements. A doctor's certification of disability on the Application For Disabled Person Placard or Plates form (REG 195) must be complete and legible. As a result of the audit, DMV is revising the application form to make it clearer to determine who qualifies.

The disabled person placard and plates can only be issued for the disability reasons listed in California Vehicle Code (CVC) sections 5007(c)(1), 22511.55(b)(1) and 22511.59. Those disability reasons are listed on the REG 195 form. Individuals with disabilities that are not listed on the REG 195 are not eligible for a disabled person placard.

Some doctors are using old versions of the form. The latest revision of the REG 195 form is at www.dmv.ca.gov. Please use the latest revision, dated 6/20/02.

CVC sections 5007, 22511.55 and 22511.59 require physicians or other persons who sign a certification to retain information sufficient to substantiate that certificate and to make that information available for inspection by the Medical Board of California, if requested. CVC statutes can be found by going to "Publications" on the above Web site and then to "2003 DMV Vehicle Code Book."

### *ATTENTION PHYSICIANS*

New B&P Code §802(a) specifies information that must be reported to the Medical Board relative to malpractice settlements and awards. This reporting responsibility generally falls on malpractice carriers; however, since California does not require physicians to have malpractice insurance, there may be no company to make the report.

B&P Code §802(a) requires physicians who do *not* have malpractice insurance to report to the Medical Board within 30 days any settlement or arbitration award over $3,000. A complete report also must be sent within 45 days to the claimant or his or her counsel.

Failure to comply with this law is punishable by a fine of not less than $50 nor more than $500. Intentional failure or collusion not to comply can result in fines from $5,000 to $50,000.

# Working Together to Eliminate Childhood Lead Poisoning

## Childhood Lead Poisoning Remains a Problem

Lead, first identified as a poison in Roman times, remains a major environmental threat to children. For the year 2001, the Childhood Lead Poisoning Prevention Branch (CLPPB) of the California Department of Health Services (CDHS) identified over 2,000 California children with blood lead levels (BLLs) above 10 micrograms of lead per deciliter of blood (µg/dL), the level of concern set by the Centers for Disease Control and Prevention (CDC). This number would have been significantly higher if all children who should have been screened had been tested. CLPPB estimates that, of the California one- and two-year-olds at risk for lead poisoning, only 20-30% have ever been screened. Of all U.S. children, the General Accounting Office has noted that those served by federal healthcare programs are particularly at risk for lead poisoning.[1]

## Sources of Childhood Lead Exposure

Deteriorated paint in dwellings built before 1978, paint dust, and lead-contaminated soil remain the most commonly identified hazards. Families at all socio-economic levels, doing home improvements on older structures, frequently fail to recognize this hazard. Another common source is lead carried home on the skin and clothing of family members working in construction or other lead industries. Children who are adopted from other countries or immigrate to the United States with their families may have significantly elevated BLLs as a result of exposure to high levels of lead in their countries of origin. Other sources, including low-fired pottery, folk remedies, and certain Mexican candies are not uncommon in California.[2]

## Screening for Childhood Lead Poisoning

While primary prevention of lead hazards remains the essential public health goal, the only way to identify individual lead-poisoned children is by screening for blood lead. Children are at the greatest risk from the time they begin to crawl until six years of age. Under California law and consistent with recommendations of the CDC, children with identified risk factors should be screened at age one and again at age two.[3]

Title 17 of the California Code of Regulations, Section 37000 and following, requires healthcare providers to do the following:

- Give anticipatory guidance at each periodic health assessment visit from the age of six months until the child reaches 72 months of age.
- Screen children for blood lead at 12 and 24 months of age who are receiving services from publicly supported programs for low-income children, such as Medi-Cal, the Child Health and Disability Prevention Program (CHDP), the Special Supplemental Nutrition Program for Women, Infants and Children, and Healthy Families.
- Screen children for blood lead at 12 and 24 months of age who are not in such programs but found to be at risk because a parent or guardian answers "yes" or "don't know" to the risk assessment question: *"Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently renovated?"*
- Perform these evaluations or screenings upon learning that the child is less than 24 months old and the evaluation or screening was not done at 12 months of age or the child is from 24 months up to 72 months old and the evaluation or screening was not done at the age of 24 months.
- Screen any child up to 72 months old if changed circumstances have put the child at risk.
- If the BLL is equal to or greater than 10 µg/dL, take steps to reduce it to less than 10 µg/dL; e.g., education, clinical evaluation, follow-up BLLs, referral to the local childhood lead poisoning prevention program, and chelation when appropriate.

Of course, a child may be tested for blood lead at any age if appropriate or at the request of the parent or guardian. The healthcare provider also may choose to question the caregiver about other lead hazards known to be common in his or her community, such as the use of lead amulets in some Southeast Asian communities. Note that these regulations apply to all physicians, nurse practitioners, and physician assistants, not just Medi-Cal or CHDP providers.

## Medical Management of Childhood Lead Poisoning

The medical management of childhood lead poisoning is very briefly outlined below. The healthcare provider should consult the state CLPPB[4] or the local childhood lead poisoning prevention program for detailed information. Note that chelation is not generally considered appropriate until BLLs are at or above the level of 45 µg/dL. It is also important to remember that screening may be by capillary draw, but all subsequent tests should be on venous specimens.

*(Continued on page 9)*

| Medical Management of Lead-Poisoned Children | |
|---|---|
| **10 µg/dL** | Anticipatory guidance. |
| **10-14 µg/dL** | Guidance, nutrition evaluation, and lead-exposure history. Retest in 3 months. |
| **15-19 µg/dL** | Guidance, nutrition evaluation, and lead-exposure history. Retest in 1 to 2 months. Consider hgb/hct. Treat persistent BLLs of 15-19 µg/dL as for 20-44 µg/dL. |
| **20-44 µg/dL** | Guidance, nutrition evaluation, lead-exposure history, psychosocial and neuro-development status. Public health referral for case management and environmental investigation. Depending on BLL, retest in 1 week to 1 month. Order hgb/hct. |
| **45-69 µg/dL** | Guidance, nutrition evaluation, lead-exposure history, psychosocial and neuro-development status. Public health referral, as above. Retest 45-59 µg/dL in 48 hours and 60-69 µg/dL in 24 hours. Order hgb/hct. Consider chelation. |
| **≥70 µg/dL** | Medical emergency. Immediately hospitalize, retest, and chelate. Public health referral, as above. |

# Childhood Lead Poisoning

*(continued from page 8)*

## Blood Lead Reporting to the State of California

A healthcare provider does not have to report test results to public health officials unless, operating as a laboratory, he or she processes the lead test. Since 1986, California has had a reporting system by which laboratories report BLLs to the state, which then notifies local health departments. The previous requirement was for laboratories to report only highly elevated test results. Under legislation that became effective January 1, 2003, analyzing laboratories must report all BLLs, along with data on the test and the person tested. This will allow California to further identify areas where the screening rates are low or populations have a higher risk of lead poisoning.

For this system to work, it is important that clinicians provide complete information at the time of ordering a test for lead. The needed information includes the patient's name, address, contact phone, birth date, and gender. If the child is a teenager who is employed, also give the name, address, and phone number of his or her employer, since the lead poisoning may be coming from the workplace. A healthcare provider who performs the blood draw should provide the draw date and type (e.g., venous, capillary).[5] Complete contact information enables local and state programs to promptly initiate education, case management, and environmental investigation. Moreover, it allows public health officials to make use of newly enacted statutes that provide authority to order abatement or correction of residential lead hazards and to regulate unsafe lead-related work practices.[6]

## Summary

Lead poisoning is a preventable disease that can be conquered. Healthcare providers, by educating families, screening children, and collaborating with childhood lead poisoning prevention programs and the community, can get lead out of the environment and out of California's children.

For further information, please consult the CDHS CLPPB Web site at www.dhs.ca.gov/childlead or telephone the CLPPB at (510) 622-5000.

Submitted by Margaret Mossman, P.H.N., Health Policy Analyst, Yan Chin, M.D., M.P.H., Public Health Medical Officer, and Valerie Charlton, M.D., M.P.H., Chief, CLPPB.

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[1] See *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children,* GAO/HEHS. January 1999.

[2] See MMWR August 9, 2002/51(31); 684-686.

[3] See Centers for Disease Control and Prevention (CDC), *Managing Elevated Blood Lead Levels Among Young, Children*. Atlanta, GA: US Dept. of Health and Human Services, March 2002.

[4] Childhood Lead Poisoning Prevention Branch, (510) 622-5000.

[5] CHDP and Medi-Cal Fee for Service providers may be eligible for additional reimbursement for providing guidance and doing the blood draw.

[6] Senate Bill 460 (Chapter 931, Statutes of 2002), effective January 1, 2003. SB 460 amended Civil Code section 1941.1 and Health and Safety Code, sections 17961 and 17980. It added Health and Safety Code sections 17920.10, 105251, 105252, 105253, 105254, 105255, 105256, and 105257.

# Medicare Comes to the Mediation Table

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

This fall, the Centers for Medicare & Medicaid Services (CMS) will introduce an innovative approach to handling Medicare beneficiary complaints: mediation.

Mediation is NOT binding arbitration, because in mediation, the parties involved decide the outcome. More importantly, mediation may help prevent potential malpractice lawsuits—a laudable accomplishment for any practicing physician!

Currently, Medicare beneficiaries in California contact CMRI when they are dissatisfied with the quality of healthcare they have received. Complaints may name any type of Medicare healthcare provider or practitioner in both inpatient and outpatient settings. Until now, complaints have been handled via medical record review by a peer physician reviewer. This review process involves no interaction between the patient and the physician or provider. With the introduction of mediation, beneficiaries and practitioners such as physicians will be given the option to resolve their conflicts through direct dialogue with each other. With the assistance of a neutral party, the mediator, the two parties discuss the issues, negotiate, and try to reach an agreement.

As California's Quality Improvement Organization, CMRI will be implementing mediation as an alternative for Medicare beneficiaries.

**What does the data show?**

*Application of mediation to healthcare programs*

Nationally, a number of health centers, including Rush Memorial Hospital in Chicago, IL and the National Naval Medical Center in Bethesda, MD, have begun using mediation to address patient-provider disagreements. In a pilot program, physicians in Massachusetts also used mediation to resolve some patient complaints reported to the state Medical Board.

Let's look more closely at one of these examples—the National Naval Medical Center experience. Whenever a case that might lead to a legal claim is identified, it is referred to a full-time, experienced mediator. Since July 1, 2001, 169 cases have been mediated at this hospital—from ones involving serious medical errors to those involving poor patient-provider interactions. All have led to resolutions, and the legal claims and payout by the hospital as a result of these cases has been 0—that's right, zero. Because the results are so impressive, a large national managed care program is planning to pilot this model in a number of states beginning this summer.

*Mediation & Medicare: Pilot Study*

CMS' decision to introduce mediation to the Medicare program is based in part on the favorable findings of a six-state pilot study, led by CMRI in 1998. The study assessed the effectiveness of mediation in handling beneficiary complaints and determined how to apply mediation in the Medicare setting.

In California, seventeen quality of care complaints were handled with some form of mediation activity. All but one resulted in some constructive or positive change. Mediation participants, patients, physicians and other providers alike, were satisfied with both the process and outcomes, and were able to find closure to the situation. One provider suggested that the process of mediation was less threatening, and gave her a sense of working together to make things better.

The study concluded that mediation offered an alternative to medical record review. Additionally, mediation was found to be particularly suited to handling complaints that exhibit the very common mix of medical care issues and issues of communication and personal interaction, which account for about 80 percent of beneficiary complaints received by CMRI.

**What is it about mediation that makes it work?**

Evaluations of mediation have found that patients are generally satisfied and are no longer interested in pursuing litigation if —1) they are told directly and in understandable terms the circumstances leading to the event they experienced; 2) if indicated, they get an apology; and 3) something is put into place to make sure that similar incidents will not happen again. The Medicare Mediation Program is designed to facilitate all these outcomes.

**What does the new program mean for Medicare physicians in California?**

Under the new Medicare Mediation Program, a physician may be given the opportunity to engage in a direct dialogue with a patient who has filed a complaint against him or her. Such an opportunity can help bring resolution to a patient's complaint without resorting to the highly adversarial process of litigation.

CMRI will determine the complaint's suitability for mediation after it is received. At present, any case with what appears to be a serious departure from the expected quality of care will not be subject to mediation. If a case is suitable, CMRI will offer mediation as an option that can be chosen in lieu of the usual medical record review process.

**"Why would I want to take time out of my busy schedule for mediation?"**

Research has demonstrated that mediation is an effective alternative for resolving patient-physician conflicts. The

*(Continued on page 11)*

## Medicare Comes to Mediation Table

*(continued from page 10)*

actual mediation usually only takes a few hours, and if an agreement is reached, can significantly reduce the amount of time needed to resolve a complaint.

Mediation also gives physicians an opportunity to take charge in resolving the conflict. The medical review process includes only review of medical records with no direct communications between the two parties involved. Physicians may think their patients have misinterpreted their actions, or that their expertise is in question. When given an opportunity to discuss the issue directly with the complainant, facilitated by a mediator, the physician will often feel more in control of the outcome.

Mediation may also help prevent a complaint from progressing to litigation. Patients who feel that something wrong has happened to them can grow increasingly frustrated and look for other outlets, including legal recourse, if they are not given a satisfactory explanation. Many times, however, knowing that his or her point of view is heard and that something is being done by the provider to address the complaint assuages a beneficiary's concerns.

**What about confidentiality?**

Both federal and California laws consider all the proceedings from a mediation session to be confidential. Nothing said in the session can be recorded, is discoverable, or can be used in any future legal case. Thus, physicians don't have to worry about any adverse impact of mediation even if an agreement is not reached.

**What are the limitations or disadvantages of mediation?**

As noted above, not all beneficiary complaints are suitable for mediation. Additionally, mediation is offered only if the patient involved is willing to participate. A lack of familiarity with the process or unwillingness to come face-to-face with their physicians may make some patients hesitant to select this option for handling their complaint.

**Conclusion**

Mediation offers a number of benefits when patient complaints are addressed: 1) Any issues regarding the complaint can be considered, rather than only those documented in the medical records; 2) Both parties control the process and outcomes; 3) The parties interact throughout; and 4) The outcomes are mutually decided and may include any items important to either party and agreed to by both. The 1998 Medicare Study and subsequent experience at hospitals nationwide have shown that mediation is an effective alternative and is broadly applicable to a wide range of complaints.

Medical record review will remain an important way to resolve Medicare beneficiary complaints. Some cases are unsuitable for mediation, while some patients and physicians will not want this option. Nevertheless, the addition of mediation helps improve the efficacy of the system and allows some physicians and patients to use this more personal option to resolve their concerns.

**Reference**

*CMRI*, The Medicare Beneficiary Complaint Alternative Methods Study, *1998*

*Carole Houk*, The Internal Neutral: Why Doesn't Your Hospital Have One?

*Rush-Presbyterian-St. Luke's Medical Center News Release July 1999*, Alternative Dispute Resolution Using Mediation Proves Successful for Chicago Hospital

*Leonard J. Marcus, PhD, and Barry C. Dorn, MD*, Physicians can take charge in conflict resolution, *AMNews, November 27, 2000*

*Leonard J. Marcus, PhD, and Barry C. Dorn, MD*, Mediation can avert malpractice suits, *AMNews, June 17, 2002*

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# FDA Announces New Framework for 21st Century Patient-Safety Programs

The FDA recently announced a new framework for innovative programs to identify and manage safety problems associated with FDA-regulated medical products more effectively, using modern information technology, partnerships with healthcare organizations, and effective communication tools.

There is considerable evidence that the "spontaneous" and "mandatory" reporting systems that are used to report adverse events to FDA do not always provide timely and complete information on the safety profile of FDA-regulated medical products. These systems depend on healthcare providers taking time to complete reports about the adverse events that they observe, and consequently many adverse events go unreported. While not perfect, these systems do provide valuable information, particularly on rare serious adverse events, and the agency is working to improve their efficiency through proposed revisions to existing reporting regulations that were announced recently.

However, the FDA's new tools for identifying and addressing patient safety initiatives will increasingly supplement the traditional approach to adverse event monitoring with new, automatic reporting and electronically based risk communication with healthcare providers. As these new initiatives are expanded, they can increasingly help improve the quality of our healthcare system while reducing the unnecessary costs of preventable medical errors.

Outlined below are details about current and future initiatives that are part of FDA's 21st century approach to patient safety:

## Automatic Data Collection

Automatic, real-time transmission of safety data from healthcare systems will be an important step in improving FDA's ability to identify risks from medical product use. Two examples include:

**Connecting for Health** is a public-private partnership aimed at improving quality and patient safety through the electronic interchange of patient-safety information. Participating healthcare organizations will use clinical data standards and compatible health information systems that enable them to confidentially share selected patient-safety data with FDA. The FDA will participate in a national pilot project in conjunction with the Markle Foundation for the eHealth Initiative to demonstrate the feasibility and the value of electronic interchange of safety data. The pilot will involve several hospitals, such as New York Presbyterian, along with information technology suppliers, such as IBM, and other organizations interested in promoting patient safety and quality.

**MedSun** is FDA's Internet-based pilot program to work collaboratively with healthcare facilities to ensure the safe use of medical products. MedSun provides FDA with real-time, electronic information about problems clinicians have identified using medical devices. MedSun also uses the safety data collected to provide healthcare facilities with up-to-date information that can be used to help improve patient safety. FDA is expanding funding for this program, to allow 100 additional hospitals to participate this year, and may also expand the program to include safety analysis of certain drugs and biologics.

## Partnerships with Other Entities

FDA's efforts to expand its ability to detect and analyze adverse events also includes partnering with other government agencies, healthcare providers, and payer organizations.

FDA recently developed a partnership with a managed care organization and with the Center for Medicare and Medicaid Services which will allow FDA to access high-quality data that can be used to analyze safety concerns in large patient populations.

During the coming year, FDA expects to form similar partnerships that will provide additional, timely information from modern electronic sources to FDA on the safety of medical products.

FDA also anticipates increased collaboration with other agencies, such as the Veterans Administration, the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, to better reach our common goals of improving patient safety.

## Enhanced Communication

Although much of our focus has been on understanding the "what, why, and when" of medical errors and adverse events, FDA is now emphasizing prevention through improved communication.

The Agency is working with the National Library of Medicine to set up The DailyMed, a new way to distribute up-to-date and comprehensive medication information electronically for use in information systems that support patient care. By making current information about FDA-

*(Continued on page 13)*

# HIV Reporting by Non-Name Code

## Public Health Access to Protected Health Information

Recently, the California Department of Health Services, Office of AIDS (OA) issued a letter to healthcare providers regarding "HIV Reporting by Non-Name Code and Public Health Access to Protected Health Information." The letter addressed:

- Confidentiality restrictions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Public health disease surveillance exemption from the HIPAA Privacy Rule;
- Healthcare provider requirement to report HIV by non-name code and AIDS by name.

The HIPAA Privacy Rule allows restricted access to and permitted disclosure of protected health information under specific circumstances such as:

" (Where) a public health authority ... authorized by law to collect or receive such information for the purpose of preventing or controlling disease ... including, but not limited to, the reporting of disease ... and the conduct of public health surveillance, public health investigation, and public health interventions ..."

Healthcare providers are encouraged to contact their respective local health department HIV/AIDS Surveillance Programs to establish information-sharing agreements that will enable timely and efficient case reporting. To facilitate provider compliance, the OA has contracted with ETR Associates to deliver training and on-site technical assistance to providers and laboratories. OA suggests that office managers or nursing staff responsible for communicable disease reporting in each medical office, clinic or hospital attend training or receive site-specific instructions from one of the ETR trainers. Online training registration is accessible through the OA Web site at www.dhs.ca.gov/AIDS/.

For additional information, contact Juan Ruiz, M.D., M.P.H., Dr.P.H., Acting Chief, HIV/AIDS Epidemiology Branch at (916) 445-0700. Please contact your Local Health Department for specific instructions and protocol for HIV reporting.

*The California Department of Health Services, Office of AIDS collaborates with local health departments to assure timely and accurate reporting of HIV and AIDS data.*

### HIV Reporting Requirement

The California Code of Regulations, Title 17, Sections 2641.5-2643.2 require laboratories and healthcare providers to report specified positive HIV tests to local health officers using coded elements based on the patient's personal information. With information provided by the laboratory, the healthcare providers must complete a case report form for every HIV-infected patient under their care. Failure to submit these case reports may subject a healthcare provider to penalties including citation and fine.

## FDA Announces New Framework for 21st Century Patient-Safety Programs

*(continued from page 12)*

regulated medical products readily available to patients and healthcare providers, the DailyMed will help to reduce medication errors and improve patient safety.

FDA has developed new Web-based communication methods to better inform consumers and healthcare professionals about the risks associated with medical product use. For example, important safety updates are communicated through the Patient Safety News, a monthly, 15-minute educational television program aired on its dedicated Web site and on healthcare education networks. The Patient Safety News provides information on new drug and biological products and medical devices, FDA safety notifications and product recalls, and ways to protect patients when using medical products.

Web Notification is another new FDA initiative that disseminates safety information about medical devices to relevant professional healthcare organizations. Web Notification alerts organizations to important safety issues and asks organizations to make sure their members monitor Web Notification for up-to-the-minute updates on a particular issue.

Finally, to reduce prescribing and dispensing errors that result from product and name confusion, the Agency is developing a computer module that will evaluate medical product names, before product approval, to identify their potential for look-alike and sound-alike errors.

# ADMINISTRATIVE ACTIONS: Feb. 1, 2003 to April 30, 2003

## PHYSICIANS AND SURGEONS

ALFANO, JOSE ANGEL, M.D. (C41291)
Kindsbach, Germany
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by the U.S. Army based on misconduct due to a breach of patient confidentiality and problems in his interactions and relationships with patients. Revoked, stayed, 35 months probation with terms and conditions. March 3, 2003

AVEDIAN, VICTOR V., M.D. (A19464)
Oceanside, CA
B&P Code §2234. Stipulated Decision. Reprimanded for gross negligence and incompetence in the care and treatment of 1 patient. Public Letter of Reprimand. March 24, 2003

BARAQUE, IVAN D., M.D. (A43144)
Kew Garden Hills, NY
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by New York based on a criminal conviction for mail fraud. Revoked, stayed, 5 years probation with terms and conditions. February 10, 2003

BARTON, BROOKE M., M.D. (G43306)
Santa Monica, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts, excessive treatment or prescribing and with having a mental illness which affects and impairs her ability to practice medicine competently. Revoked, stayed, 2 years probation with terms and conditions. April 14, 2003

BERDAKIN, DANIEL G., M.D. (A35536)
Los Angeles, CA
B&P Code §§2234, 2266. Committed unprofessional conduct by failing to maintain adequate and accurate medical records in the care and treatment of 1 patient. Public Reprimand. March 28, 2003

BERTSCH, THOMAS WAYNE, M.D. (G86836)
Roseville, CA
B&P Code §§480(a)(3), 2239. Stipulated Decision. Self-use of controlled substances and alcohol in a manner dangerous to himself or others. Probationary license issued, 5 years probation with terms and conditions. March 20, 2003

## Explanation of Disciplinary Language and Actions

**"Effective date of decision"** — Example: "February 10, 2003" 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).

BIRNBAUM, LAWRENCE M., M.D. (G8502)
Beverly Hills, CA
B&P Code §§2234(b)(c), 2242. Stipulated Decision. Committed acts of gross negligence, repeated negligence, and prescribed controlled substances without a medical examination or medical indication in the care and treatment of 2 patients. Revoked, stayed, 3 years probation with terms and conditions. April 14, 2003

BODE, DAVID FAIN, M.D. (C30670)
Los Angeles, CA
B&P Code §§2052, 2234(a), 2264, 2286, 2417(a). Aided the unlicensed practice of medicine, violated the Professional Corporations Act, contracted with an unlicensed individual to work in a medical clinic to provide medical services, and failed to control or review billings using his provider number. Public Reprimand. February 13, 2003

BULLOCK, DANIEL WILLIAM, M.D. (G30957)
Mount Shasta, CA
B&P Code §§2234(e), 2236(a). Stipulated Decision. Convicted of conspiracy to defraud the government and for filing a false income tax return. Revoked, stayed, 5 years probation with terms and conditions. April 14, 2003

CHANDRA, RAVI, M.D. (A81932)
San Francisco, CA
B&P Code §§480(a)(3), 2234. Stipulated Decision. Disclosed on his application for a California physician and surgeon license that he has a mental condition which may impair or limit his ability to practice medicine with reasonable skill and safety. Probationary license issued, 5 years probation with terms and conditions. February 4, 2003

CHESKI, PETER JOSEPH, M.D. (A63634)
Beverly Hills, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts, incompetence and failure to maintain adequate and accurate records in the care and treatment of 3 plastic surgery patients, with 1 expiring after surgery from a myocardial infarction. Revoked, stayed, 2 years probation with terms and conditions. March 10, 2003

COOPER, RICHARD PAUL, M.D. (G65857)
St. James, NY
B&P Code §§2234, 2239(a), 2354. Used controlled substances in a manner dangerous to himself and others, and failed to successfully comply with or complete the California Medical Board's Diversion Program. Revoked. March 3, 2003

DRAMOV, BORINA, M.D. (G11513)
San Francisco, CA
B&P Code §2234(c)(d). Committed acts of incompetence and repeated negligence in the care and treatment of multiple patients undergoing orthopedic surgery. Revoked, stayed, 4 years probation with terms and conditions. March 5, 2003

ELLYSON, JOHN H., M.D. (G15379) Jackson, CA
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by North Dakota for providing false information on his application for a medical license. Public Reprimand. April 28, 2003

EMERY, CLYDE K., JR., M.D. (G12561)
Torrance, CA
B&P Code §§2234(e), 2236(a). Convicted in Nevada of a felony for embezzlement of funds from a homeowner's association. Revoked. April 1, 2003

ESPOSITO, MICHAEL JOSEPH, M.D. (G44189)
Long Beach, CA
B&P Code §2234. Stipulated Decision. Committed acts of negligence in the care and treatment of several patients. Public Letter of Reprimand. February 10, 2003

FLORES, LOUIS BENJAMIN, M.D. (A32929)
Glendale, AZ
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by Arizona for misdiagnosing a patient who presented to an urgent care facility for treatment. Public Reprimand. February 25, 2003

FROCHT, ALEXANDER, M.D. (A38713)
Vaucluse, Australia
B&P Code §§141(a), 2305. Disciplined by New South Wales for self-administration of morphine and inappropriate prescribing of narcotics and benzodiazepines to a patient which resulted in the patient being hospitalized for an overdose. Revoked. April 4, 2003

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

GIDDINGS, JOHN A., M.D. (A22107) Duarte, CA
B&P Code §§2234(e), 2236(a), 2239(a), 2261. Arrested twice for driving under the influence and received 1 conviction for reckless driving, failed to report either arrest to his Board probation monitor, made false statements in an application for reappointment as a qualified medical examiner, and violated the terms and conditions of his Board-ordered probation. Revoked. April 10, 2003

GLICK, DANIEL M., M.D. (A49462) Scottsdale, AZ
B&P Code §141(a). Stipulated Decision. Disciplined by Arizona for over-prescribing controlled substances to a family member, diverting some of the prescribed controlled substances for his own use, and failing to maintain medical records for his treatment. Revoked, stayed, 5 years probation with terms and conditions. April 28, 2003

GOODMAN, GEORGE A., M.D. (C28957)
Santa Rosa, CA
B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in the care and treatment of 1 patient. Revoked, stayed, 5 years probation with terms and conditions. March 3, 2003

HENDERSON, WALTER RAY, M.D. (C24144)
Palm Desert, CA
B&P Code §§2234(b)(c), 2266. Stipulated Decision. Committed acts of gross negligence, repeated negligence, and failure to keep adequate and accurate medical records in the care and treatment of 1 patient. Revoked, stayed, 3 years probation with terms and conditions. February 24, 2003

HIRSCH, ANTHONY TERRY, M.D. (G17022)
Ojai, CA
B&P Code §2234. Stipulated Decision. Engaged in unprofessional conduct in his care, treatment and management of an infant by inadequate documentation of the patient record, and failing to document discussions of differential diagnoses and therapeutic alternatives. Public Reprimand. April 2, 2003

HOGAN, WALTER L., M.D. (G8075)
Santa Barbara, CA
B&P Code §2266. Stipulated Decision. Failed to adequately record preoperative ocular status, indications for cataract surgery, surgical complications, and how the complications were treated in the medical records of 5 patients. Public Reprimand. March 18, 2003

HSU, DAVID, M.D. (A33204) Monterey Park, CA
B&P Code §2266. Stipulated Decision. Failed to maintain adequate and accurate medical records in the care and treatment of 1 patient. Revoked, stayed, 1 year probation with terms and conditions. April 2, 2003

JANDA, JOHN P.S., M.D. (A37510) Fresno, CA
B&P Code §§2234(b), 2262, 2266. Committed acts of gross negligence, alteration of medical records, and failure to maintain accurate and adequate medical records in the care and treatment of a patient when he excised the 3rd metatarsal head of the right foot instead of the 4th metatarsal head, and then altered the medical records. Suspended, stayed, 3 years probation with terms and conditions including 10 days actual suspension. April 28, 2003

KAFI, ALEX A., M.D. (A37328) West Bloomfield, MI
B&P Code §2234. Stipulated Decision. No admissions but charged with sexual misconduct with a patient, gross negligence, failure to maintain adequate and accurate medical records, and for a misdemeanor conviction for battery in the care and treatment of 1 patient. Revoked, stayed, 7 years probation with terms and conditions including 6 months actual suspension. March 21, 2003

KELLER, THOMAS McNEESE, M.D. (G27288)
Travis AFB, CA
B&P Code §2234. Stipulated Decision. Committed unprofessional conduct for the post-surgical care and treatment of a patient with leaking spinal fluid. Public Letter of Reprimand. February 19, 2003

KNAPP, DAVID PAUL, M.D. (G33943)
San Diego, CA
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by Iowa for inadequate supervision of a physician assistant and disciplined by New York for filing a false application with the New York Board. Revoked, stayed, 5 years probation with terms and conditions including 30 days actual suspension. March 10, 2003

## 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.

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Sacramento, CA 95825

KWAN, JEFFREY WAN-LI, M.D. (A81934)
Palo Alto, CA
B&P Code §480(A)(1)(2)(3)(C). Stipulated Decision. Falsified a California medical license application by failing to disclose a petty theft conviction. Probationary license issued, 2 years probation with terms and conditions. February 4, 2003

LIN, PAUL PAO-SHAN, M.D. (G41233) Irvine, CA
B&P Code §§726, 2234(b)(d), 2266. Stipulated Decision. Sexual misconduct in the care and treatment of 1 patient; committed acts of gross negligence, incompetence, and failed to maintain adequate and accurate medical records in the care and treatment of 2 patients. Revoked, stayed, 5 years probation with terms and conditions.
February 7, 2003

LUTZKER, STEVEN WAYNE, M.D. (G24190)
Thousand Oaks, CA
B&P Code §§2236(a), 2305. Stipulated Decision. Disciplined by Connecticut for submitting fraudulent insurance reimbursement claims, which resulted in a felony conviction. Revoked, stayed, 5 years probation with terms and conditions including 90 days actual suspension. February 13, 2003

NASSE, JOHN T., JR., M.D. (C29053)
Ojai, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts, incompetence, and dishonesty by failing to appropriately treat a patient's bipolar illness, failing to safeguard patient confidentiality, and violating professional boundaries. Revoked, stayed, 5 years probation with terms and conditions including 20 days actual suspension. February 24, 2003

NAVAS, RICARDO, M.D. (A38885) Los Angeles, CA
B&P Code §2234. Stipulated Decision. Performed a laparoscopic cholecystectomy in which the patient suffered a major vascular injury, occurring during the placement of a trocar, resulting in significant blood loss for the patient. Public Letter of Reprimand.
April 24, 2003

NOURMAND, AMIR DANIEL, M.D. (G80075)
Los Angeles, CA
B&P Code §2234(a)(b)(c)(d)(e). Stipulated Decision. Committed acts of gross negligence, repeated negligence, incompetence, using a non-accredited surgical site and fraudulent billing. Revoked.
February 26, 2003. Judicial review being pursued.

OPSAHL, JON STEVEN, M.D. (G79640)
Riverside, CA
B&P Code §§725, 2234(b)(c)(d)(e), 2238, 2242(1)(a). Committed acts of gross negligence, repeated negligence, repeated excessive prescribing, dishonesty, unprofessional conduct, and incompetence for engaging in illegal Internet prescribing and prescribing or dispensing drugs to patients without a good faith prior examination or medical indication. Revoked. February 21, 2003

PARHAM, FRED WALTON, M.D. (G43938)
Vacaville, CA
B&P Code §2234(c). Stipulated Decision. Committed repeated negligent acts in the care and treatment of 1 patient for pain. Revoked, stayed, 3 years probation with terms and conditions. April 2, 2003

PARK, JOHN H., M.D. (G19634) New York, NY
B&P Code §§2234, 2305. Failed to comply with his California Board-ordered probation as a result of being disciplined by the state of New York for unprofessional conduct. Revoked. March 6, 2003

PETERSON, MARK DUANE, M.D. (A82029)
Loma Linda, CA
B&P Code §§480(a)(3), 2239. Stipulated Decision. Disclosed a history of bipolar disorder and substance abuse on his application for licensure with the California Medical Board. Probationary license issued, 5 years probation with terms and conditions.
February 7, 2003

RAND, DAVID A., M.D. (C29300) Phoenix, AZ
B&P Code §§141(a), 2305. Disciplined by Arizona for unprofessional conduct in the management of 3 patients' diaphyseal femur fractures. Revoked.
February 5, 2003

SAINT-ERNE, PHILIP CHARLES, M.D. (G50009)
Kenai, AK
B&P Code §§141(a), 2234(e)(f), 2261. Failed to comply with his California Board-ordered probation in that he provided false information on his application for licensure in the state of Alaska. Revoked.
April 21, 2003

SAMIMI, FRED FOAD ROSH, M.D. (A83265)
Omaha, NE
B&P Code §480(a)(1)(2)(3)(c). Stipulated Decision. Failed to disclose a misdemeanor conviction for fraud on his application for licensure with the California Medical Board. Probationary license issued, 4 years probation with terms and conditions. April 29, 2003

SHAH, KUNVARJI GANGJI, M.D. (A25464)
Peoria, IL
B&P Code §§141(a), 2234, 2305. Stipulated Decision. Disciplined by Illinois for gross negligence by failing to supervise staff during a surgery, resulting in a burn to a patient's arm. Public Letter of Reprimand.
April 28, 2003

SHERMAN, MICHAEL, M.D. (A40995)
Beverly Hills, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with committing acts of gross negligence, repeated negligence and incompetence in the care and treatment of 8 patients, including 3 convictions for driving under the influence of alcohol, and use of alcohol in a dangerous manner. Revoked, stayed, 5 years probation with terms and conditions. February 6, 2003

SORIANO, MYRNA LOPEZ, M.D. (A38854)
Yardley, PA
B&P Code §§141(a), 2234, 2305. Stipulated Decision. Disciplined by New Jersey for altering medical records and instructing another physician to sign progress notes which she prepared. Public Letter of Reprimand. April 16, 2003

SMITH, JONATHAN, M.D. (A33287) San Diego, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts, incompetence and failure to maintain adequate and accurate medical records in the care and treatment of 4 patients. Revoked, stayed, 4 years probation with terms and conditions. February 28, 2003

STEVENS, JAMES BLAINE, M.D. (G64859)
Dallas, TX
B&P Code §§141(a), 2305. Disciplined by Texas resulting in the surrender of his Texas medical license for abusing non-prescribed drugs. Revoked. February 26, 2003

STURMAN, JOHN K., M.D. (C41528) La Habra, CA
B&P Code §2266. Stipulated Decision. Failed to obtain supporting documentation for conditions producing chronic pain, and failed to document a treatment plan for the patient's addiction to a Schedule IV controlled drug. Public Letter of Reprimand. March 28, 2003

VONDIPPE, CHRISTOPHER JOHN, M.D. (C33443)
Fallon, NV
B&P Code §§141(a), 2305. Stipulated Decision. Disciplined by Nevada for lack of timely intervention and lack of documentation in post-op notes in the care and treatment of 1 patient. Public Reprimand. February 6, 2003

WAGNER, RICHARD STEPHEN, M.D. (A33255)
Cibola, AZ
B&P Code §141(a). Disciplined by New York for professional misconduct by failing to disclose that his license had been disciplined on a hospital employment application. Revoked. February 12, 2003

WAISMAN, NORBERTO SILVIO, M.D. (A35479)
Chula Vista, CA
B&P Code §2266. Stipulated Decision. Failed to maintain adequate and accurate medical records in the care and treatment of 1 patient. Public Reprimand. March 27, 2003

WORKMAN, ALLEN EDSON, M.D. (G19120)
Tooele, UT
B&P Code §§141(a), 2310. Disciplined by Illinois for conviction of a felony for aggravated battery and engaging in unprofessional conduct by pressuring another doctor to sign a false and inaccurate affidavit. Revoked. February 24, 2003

ZYLANOFF, PHILLIPA LOUISE, M.D. (G34223)
Beverly Hills, MI
B&P Code §2305. Stipulated Decision. Failed to comply with her California Board-ordered probation in that she was disciplined by the state of Michigan for failure to participate in drug screening, which violated the terms of her Michigan Board-ordered probation. Probation extended 2 years from the expiration date of the original California Board-ordered probation with terms and conditions. March 28, 2003

## PHYSICIAN ASSISTANTS

MCKININ, MICHAEL L., P.A. (PA13460) Chico, CA
B&P Code §§2238, 2241(5), 3502(1). Wrote and/or authorized over 70 prescriptions for narcotics in his name or in the name of individuals who were not patients without the permission of his supervising physician. Revoked. March 10, 2003

STUTZMAN, LAURIE S., P.A. (PA13014)
Chino Hills, CA
B&P Code §§2238, 2241(5), 3502(1). Wrote and/or authorized over 33 prescriptions for narcotics in her name or the name of individuals who were not patients without the permission of her supervising physician. Revoked. March 10, 2003

## DOCTORS OF PODIATRIC MEDICINE

BELL, LYNN JEFFREY, D.P.M. (E3492) Payette, ID
B&P Code §2234(b)(c)(d). Committed acts of gross negligence, repeated negligence and incompetence in the care and treatment of 1 diabetic patient. Revoked, stayed, 4 years probation with terms and conditions. April 11, 2003

### *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.

BERNSTONE, MARTIN GERALD, D.P.M. (E1690)
Reseda, CA
B&P Code §§490, 2236(a). Stipulated Decision. Convicted for Medi-Cal fraud. Revoked, stayed, 5 years probation with terms and conditions.
March 3, 2003

CANADA, PAMELA J., D.P.M. (E3653)
Monterey, CA
B&P Code §2234(b). Stipulated Decision. Committed acts of gross negligence and unprofessional conduct for surgical errors made in the care and treatment of 4 patients. Revoked, stayed, 6 years probation with terms and conditions. February 10, 2003

EDWARDS, FREDERICK BART, D.P.M. (E3524)
Zenia, CA
B&P Code §2234. Stipulated Decision. No admissions but charged with gross negligence, incompetence, and unprofessional conduct in the care and treatment of 1 patient for performing a Keller bunionectomy without using more conservative surgical procedures, failing to advise the patient of the nature and extent of the surgical procedure, and failing to recognize and address the nature and cause of post-operative complications and complaints. Revoked, stayed, 3 years probation with terms and conditions.
February 10, 2003

KALHOR, NASIM, D.P.M. (EL 1539)
Woodland Hills, CA
B&P Code §§480(A)(1), 2221. Convicted of grand and petty theft and preventing a witness, who was a victim, from proceeding with prosecution. License denied, stayed, 3 years probation with terms and conditions. March 14, 2003

## SURRENDER OF LICENSE WHILE CHARGES PENDING

### PHYSICIANS AND SURGEONS

BARDOLPH, THOMAS RICHARD, M.D. (G47656)
Rancho Palos Verdes, CA
February 26, 2003

DARM, JERRY ROY, M.D. (G44187)
Lake Oswego, OR
March 13, 2003

DORAN, ANDREW, J.C., M.D. (G2718)
Inglewood, CA
February 12, 2003

EDWARDS, ARTHUR G., M.D. (C20011)
La Jolla, CA
February 7, 2003

GREENSON, DANIEL P., M.D. (A21872)
Berkeley, CA
February 14, 2003

HUBBELL, DAVID V., M.D. (A15713)
Downey, CA
February 11, 2003

LEPOFF, NORMAN JEFFREY, M.D. (G37148)
Tustin, CA
April 11, 2003

LOEB, CHARLES PHILLIP III, M.D. (G28182)
Los Angeles, CA
February 14, 2003

MALABED, LEONILO L., M.D. (A16847)
San Francisco, CA
February 27, 2003

MANTHEY, RUSSELL, M.D. (C41884)
Thousand Oaks, CA
February 3, 2003

NUVAL, GENEROSA MORENO, M.D. (A30265)
Banning, CA
April 17, 2003

OILSCHLAGER, GERALD A., M.D. (G6579)
Long Beach, CA
April 17, 2003

PAGE, GARY WAYNE, M.D. (A67353) Ogden, UT
March 31, 2003

RAVIN, JOHN M., M.D. (G14582) Torrance, CA
April 18, 2003

SALERNO, EGISTO, M.D. (A37903) San Diego, CA
April 29, 2003

THOMPSON, STEVEN HOWARD, M.D. (A64652)
Poway, CA
March 5, 2003

THORP, RICHARD H., M.D. (G14937) Fresno, CA
March 5, 2003

WISE, LESLIE EUGENE, M.D. (A32748)
Newport Beach, CA
February 6, 2003

YANNESSA, NOEL A., M.D. (G10922) Tucson, AZ
March 24, 2003

YOUNG, BING HIN, M.D. (A16561) Hayward, CA
March 19, 2003

### DOCTOR OF PODIATRIC MEDICINE

SHVARTSMAN, STANLY M., D.P.M. (E3909)
Los Angeles, CA
March 12, 2003

### LICENSED MIDWIFE

JOY, KALEEM, L.M. (LM63) Citrus Heights, CA
April 4, 2003

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

**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 — JULY 2003**
Candis Cohen, Editor (916) 263-2389

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