



MEDICAL BOARD OF CALIFORNIA

Newsletter



A Quarterly Publication

www.mbc.ca.gov

Vol. 104, Nov. 2007

Physician Wellness as Constrained by Burnout

by Shelton Duruisseau, Ph.D., MBC board member and Kevin Schunke, board regulations coordinator

The following are excerpts from a position paper written by Dr. Duruisseau and Mr. Schunke. The purpose of the paper was to identify, assess, and address physician burnout.

Purpose

The wellness of a person can be defined not only by the absence of disease and infirmity; a person's health is a state of complete physical, mental, and social well-being.

The focus of this review centers on the benefits that might be derived from the implementation of a program to assist with licensees' well-being. Since the mission of the board is to protect health care consumers, it must be recognized that this best can be achieved by having healthy physicians care for their patients.

Background

Through their extensive education and training, physicians are seen as the preeminent health care providers of the modern world. But the wellness of the patient relies on the wellness of the practitioner, who often gives priority to those under his care before his own well-being and that of his family. The stresses of the job are created by a broad spectrum of factors and can significantly impact the effectiveness of a physician.

Physician stress has increased dramatically over the past 20 years. In spite of achieving career and financial success, today's physicians are stressed and overworked, often losing sight of their career goals and personal ambitions. The resulting frustration, anger, restlessness, and exhaustion are known as physician burnout and adversely affect the quality and costs of patient care.

Survey results suggest that levels of professional dissatisfaction among physicians have doubled in only a few decades. In 1973, less than 15 percent of several thousand practicing physicians reported any doubts that they had made the correct career choice. In contrast, surveys administered within the past 10 years have shown that 30 to 40 percent of practicing physicians would not choose to enter the medical profession if

they were deciding on a career again, and an even higher percentage would not encourage their children to pursue a medical career.

Overall, it has been found that physicians have healthier lifestyles and generally live longer than the population at large. But the strain of the job takes its toll on members of the profession. Numerous recent studies and articles highlight the growing discontent of physicians with the increasing complexities of the medical profession. Further, physicians are frequently overloaded with the demands of caring for sick patients within the constraints of fewer organizational resources.

Physicians are challenged by both the lack of fulfillment in their careers and the effect of long hours and job stress on their personal lives. Numerous studies have confirmed the difficulties faced by today's physicians. Divorce rates

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The mission of the Medical Board of California

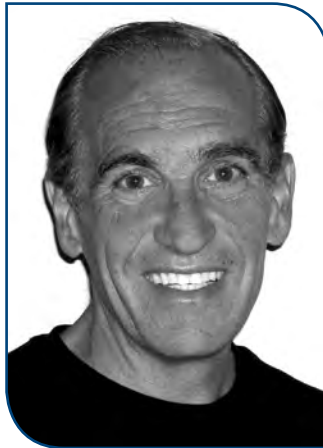
The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act.

President's Report

On July 26, 2007, the MBC voted unanimously to abolish its current Diversion Program for substance abusing licensees, effective June 30, 2008. I have had positive feedback from several individuals from within our state as well as from other states concerned about similar issues, but, because the decision has been greeted with dismay in some quarters, I would like to share with you the basis for the board's action and its plans regarding impaired physicians.

In 1980, the California Legislature enacted a law requiring the Medical Board to "seek ways and means to identify and rehabilitate physicians with impairment due to abuse of dangerous drugs or alcohol, so that physicians so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety." It needs to be noted that the public health and safety was not to be compromised as a result of this new law. In the same statute, the Legislature created within the Medical Board a new "Diversion Program" which would "divert" substance abusing physicians from the disciplinary track and instead monitor their behavior and medical practice while they recover from their addiction. Participants, most of whom participate in absolute confidentiality, enter into a contract with the program in which they agree to abstain from drugs/alcohol and to comply with program rules.

The program utilizes a number of mechanisms, including random drug testing, required attendance at group therapy meetings, and required "work site monitors," when participants are allowed to practice medicine to determine participant compliance with the terms of the contract. Since its inception, the program has been administered by board employees, assisted by a large cadre of service providers (local specimen collectors, group meeting facilitators, and testing laboratories) and volunteers across the state. The Bureau of State Audits reflected 14 full-time Medical Board staff and a budget of \$1.4 million. The real number of individuals with expertise to operate this program was more than 100, most of them providing service at no cost. If some reasonable cost was put in for those



Richard Fantozzi, M.D.
President of the board

individuals, the budget would be far more than what is seen in the audit, which shows the more true size and scope of the Diversion Program.

During the first decade of the program's existence, the State Auditor General examined the performance of the program three times and reached troubling conclusions. In 1982, 1985, and 1986, the Auditor General consistently found that the program was not adequately monitoring participants and failed to terminate the participation of physicians who did not comply with their contracts. Obviously, failure to monitor a

substance abusing physician would expose the patients of that physician to great risk. Additionally, the Auditor General found that the Medical Board had failed to establish clear standards for the program and did not adequately oversee the program.

After each audit, the board attempted to improve the program by implementing the recommendations of the Auditor General. However, 18 years elapsed before the next external audit of the Diversion Program. In November 2004, the Medical Board enforcement monitor released the findings of her investigation of the program, findings that were consistent with those of the Auditor General nearly two decades earlier. Specifically, the monitor found that:

1. The program did not adequately monitor the substance abusing physicians who are participating in it,
2. The monitoring mechanisms used particularly as drug testing programs and work site monitoring standards were ineffective and inadequately administered,
3. The Medical Board had failed to establish policies that are consistently followed by the Diversion Program in terms of consequences for relapses and criterion for termination from the program and,
4. The Medical Board did not adequately oversee the program.

Disturbingly, and very sad to me, the enforcement monitor found that the program's lax administration enabled participants to "game" its monitoring mechanisms. Drug testing was not always performed

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Board appoints new executive director



The Medical Board of California is pleased to announce the appointment of Barbara Johnston as its new executive director. As executive director, Ms. Johnston has the delegated authority to act on behalf of the 21-member Medical Board in the full range of policy and administrative duties, including all policy,

resource allocation, and personnel, and initiates licensee disciplinary matters.

Prior to her appointment, Ms. Johnston served as executive director for the California Telemedicine and eHealth Center (CTEC) from 2003–2007 and raised more than \$10 million in grant funding to support the center and the development of 10 Regional eHealth Networks that serve over 120 remote health facilities in rural areas of California. She developed a high performance collaborative partnership with medical professionals and health technology experts statewide who worked in an advisory capacity with CTEC to improve health care services for underserved communities.

She developed the Western United States eHealth Resource Center in 2006, which is the largest and most comprehensive such center in the country. There are now five new resource centers that use the California

center as a model. Ms. Johnston also served as chief operations officer for a private company in Australia, from 2001 to 2003, which developed the first virtual private health network in that country. Here, she was responsible for raising more than \$10 million in start-up capital from the private sector.

At the request of Governor Schwarzenegger's secretary of Business, Housing and Transportation, she was an invited expert to the Governor's statewide eHealth Forum in 2006. She served as faculty for the Center for Health Technology Telemedicine Learning Center at UC Davis, and has had multiple, invited presentations throughout the United States, including an address to the Joint Working Group on eHealth at the White House Conference Center in 1999.

Ms. Johnston served as the eHealth manager for the Kaiser Permanente's online disease management program for mental health with responsibilities that included coordinating a mutli-disciplinary team of physicians, researchers, technology experts, nurses, mental health advocates, and mental health service consumers. She has 16 years of expertise in the re-designing of health care delivery using innovative health technology systems such as telemedicine, online distance education and eHealth disease management systems.

She replaces former board Executive Director Dave Thornton, who retired in July.

Epidemiology and prevention of tick-borne diseases in California— New Web tutorial available from the California Department of Public Health

Fall and winter are peak seasons for encountering adult western black-legged ticks (*Ixodes pacificus*), the vector of Lyme disease in California. In addition to carrying *Borrelia burgdorferi*, the bacterial agent of Lyme disease, the western black-legged tick is the vector for *Anaplasma phagocytophilum*, the rickettsial agent of human granulocytic anaplasmosis.

Lyme disease and anaplasmosis are not the only tick-borne diseases in California. Other ticks in California carry and transmit *Rickettsia rickettsii*, the agent of Rocky Mountain spotted fever; *Borrelia hermsii*, the agent of

tick-borne relapsing fever; and *Babesia duncani*, the protozoal agent of human babesiosis in the western United States.

A tutorial on ecology, epidemiology, and prevention of tick-borne diseases in California is now available on the California Department of Public Health, Vector-Borne Disease Web site. This presentation provides health care providers with useful, up-to-date information on tick-borne diseases found in California that can prove helpful in clinical decision making.

www.cdph.ca.gov/healthinfo/discond/Pages/Tick-BorneDiseases.aspx

Medical Board of California vs. Gregory House, M.D.

by Cesar A. Aristeiguieta, M.D., FACEP

President, Division of Medical Quality, Medical Board of California

The letter from the Attorney General to the Medical Board of California read:

The Accusation against Dr. Gregory House was issued on July 10, 2007 as a result of a patient complaint. It alleges that Respondent committed violations of the Business and Professions Code sections 2234(b) (gross negligence) and 2234(c) (repeated negligent acts) in connection with the care and treatment of two patients. Additionally, Respondent was accused of violating Business and Professions Code section 2239 (excessive use of drugs and alcohol), 2238 (violation of statute regulating drugs), and 2234 (unprofessional conduct).

If the name of the physician sounds familiar, it is because he is the principal character of the popular, award-winning, television show “House,” which airs on the Fox Network. Although the above charges and Dr. Gregory House are all fictitious, the concerns raised by the show are all too real.

Ask anyone who watches the show about Dr. House and the reaction is always the same. “He is a horrible human being, and has a terrible bedside manner, but he is a brilliant doctor. He always gets the diagnosis right, no matter how tough the case is.” The answer seems to imply that health professionals and patients alike are willing to allow physicians to commit significant professional transgressions as long as they get the diagnosis right. But do the ends justify the means?

On a recent summer afternoon, I asked several staff members of the Medical Board to screen the show with me, and to comment on Dr. House’s behavior as it relates to the California Medical Practice Act. The episode was chosen at random so as to reduce the chance of commenting on any one particularly egregious show—but there are so many that are questionable. We watched “Son of Coma Guy,” which originally aired on November 14, 2006.

The episode begins with Dr. House eating his lunch in the room of a vegetative patient, Gabe. Also in the room is Dr. Wilson, who is there to confront House about stealing his prescription pad and forging a prescription for narcotics for personal use. House seems unfazed by Dr. Wilson’s accusation. He tries to encourage Dr. Wilson to continue supplying his narcotics, either by calling on

their friendship, or by blackmailing him. House suffers from debilitating chronic leg pain, but over time he has been relying more and more on narcotics. His addiction to pain killers has been a component of House’s character development.

The patient’s son, Kyle, enters the room and is surprised to see House eating lunch by his father’s bed. House has observed Kyle in the past and suspects that he suffers from akinetopsia (visual motion blindness), which is accompanied by seizures. To prove himself right, Dr. House first throws a bag of chips at Kyle, which he fails to catch, striking him in the face. House then induces a seizure by flashing the room lights. Kyle collapses to the ground and begins convulsing violently. House makes no attempt to administer aid to the now-seizing Kyle, and seems to take pleasure in proving himself right once again. Prior to this encounter, House did not have a physician-patient relationship with Kyle, and he never obtained consent to treat.

House admits Kyle to the hospital and begins evaluating both father and son. Both patients show EEG signs of cortical seizures. House orders a variety of tests, determined to find a hereditary link between the illnesses of both Gabe and Kyle. All the tests are negative, but Kyle is progressively getting sicker, finally reaching coma and hepato-renal failure.

House is at a loss to explain Kyle’s deteriorating condition, but he believes that the answer is in the history. Given that Kyle is near death and unable to communicate, he decides to do the next best thing—wake up his vegetative father. There are no other relatives that can provide a history or sign a consent.

House leads his team to the hospital pharmacy and grabs vials of L-dopa and epinephrine. Back at the bedside, House is about to inject his drug cocktail into Gabe’s IV when the department chair (Dr. Cuddy) barges in demanding that he stop. House looks at her, smirks, and goes ahead and injects anyway. Gabe immediately sits up in bed and asks for a steak. The department chair walks away and never reports House’s behavior to the hospital medical staff. No investigation is done, and no discipline is ever given to House. His behavior has again been excused by his success.

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Preventive medicine and the seven deadly sins: avoiding discipline against your medical license

by Laura Sweet, Supervising Investigator II
Los Angeles Metropolitan Area

This is the sixth of seven articles in the series, "Preventive Medicine and the Seven Deadly Sins." This quarter's issue explores the sin of greed.

Greed n. Inordinate or reprehensible acquisitiveness: avarice.

"The point is, ladies and gentlemen," Gordon Gekko pontificated in the movie "Wall Street," "that greed—for lack of a better word—is good. Greed is right. Greed works. Greed clarifies, cuts through, and captures the essence of the evolutionary spirit. Greed, in all of its forms—greed for life, for money, for love, knowledge—has marked the upward surge of mankind."

We are a conflicted society. Reprehensible acquisitiveness versus the upward surge of mankind. What a dichotomy.

The sad truth is, the sin of greed is so pervasive that it will be a challenge to find ways to surprise you with its more shameful manifestations. The more classic incarnations of greed—Medicare fraud, Medi-Cal fraud, insurance fraud, income tax evasion, mail fraud—have become so prolific that they are mundane to most investigators. During fiscal year 2005–2006, the Medical Board received 294 complaints alleging fraud. Obviously, the temptation for many to make a quick and easy buck is too great to be surmounted, but here I must warn you. Should this errant fantasy befall you, I hope you will consider that physicians who have been convicted of fraud often aren't invited to attend physician conferences in a district office. They don't come to us. We go to them. In prison, that is, since often this is the locale where we must conduct the interview to hear our subject's story about what prompted him or her to stray. Or how about having a new title to disclose on a job application, something that looks like... felon? I would hope that most of these doctors would no longer agree that "Greed is right."

According to the United States General Accounting Office and health insurance industry sources, between three percent and 10 percent of any state's Medicaid budget is lost due to fraud and abuse. The federal Office of the Inspector General's Medicaid Fraud Control Unit convicted 1,226 individuals in fiscal year 2006 and recovered more than \$1.1 billion in court-ordered restitution, fines, civil settlements and penalties.

Additionally, due to health insurance fraud, 3,425 practitioners were excluded from participation in the Medicare, Medicaid and other federal health care programs.

California's Medi-Cal losses reach billions of dollars annually. In fiscal year 2005–2006, the Bureau of Medi-Cal Fraud filed 94 criminal cases for fraud. During that same period, 65 individuals were convicted. To avoid encouraging a risk/benefit analysis, it should be noted that this disparity is due to the pendency of the remaining criminal cases. Zero individuals were acquitted during this time period. Over six million dollars was paid in criminal restitution and defendants paid \$267,854,037 in civil monetary recoveries. I would hope that these folks would no longer agree that "greed works."

For those who still might abide by Gordon Gekko's words, consider the myriad of agencies in addition to, or in conjunction with, the Medical Board, that investigate allegations of fraud: the state Department of Justice (Bureau of Medi-Cal Fraud and Elder Abuse), the Federal Bureau of Investigation, the Office of the Inspector General, the Department of Health Services, the Department of Insurance, to name but a few. Additionally, most large insurance companies have in-house investigation units dedicated to the problem of fraud. Greed may "Capture the essence of the evolutionary spirit," but it also inspires the tenacity of the just spirit, because greed impacts all of us personally. Our tax rates increase, our insurance premiums increase, our deductibles increase because of the huge losses a few greedy people impose on all of us.

Fraud cases often come to our attention after a physician has been convicted. That investigative process was described in detail for the "sin of anger" article (*Medical Board Newsletter*, April 2007). Sometimes the Medical Board receives a complaint from an insurance company, or a tip from an anonymous employee, and we work up the fraud case ourselves. For example, the Glendale Police Department once called a district office to report they had responded to

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randomly, but at times was regularly done on days that could be anticipated by participants who could adjust their behavior accordingly. The program failed to establish sufficient standards and qualifications for "work site monitors" such that a non-physician hired and fired by a participant could be approved to oversee that participant's practice of medicine. The vast majority of worksite monitors and treating psychotherapists failed to file the required reports of their observations and the program was so chronically understaffed that many of these problems were not detected, much less addressed.

In its 2005 response to the enforcement monitor's report, the California Legislature imposed a June 30, 2008 "sunset date" on the Diversion Program. In other words, the Legislature gave the board two additional years to remedy the serious deficiencies identified by the monitor. The Legislature also ordered its own auditors, the Bureau of State Audits (BSA), to examine the performance of the program during the first half of 2007, to ensure that any changes made by the board were effective in improving the program. The Medical Board, working with executive staff, hired a new program administrator and increased its budget an additional \$500,000 in 2005–06 for new staffing and resources for the Diversion Program.

The BSA audit was released on June 7, 2007. Consistent with four earlier audits, the BSA found that the program's monitoring of its substance abusing participants remained inconsistent; its oversight of the drug testing program and its service providers (especially worksite monitors) was inadequate; and the Medical Board had not properly overseen the program. In response to the BSA's survey regarding the program's drug testing system, one participant replied, "mine wasn't very common. I was able to game it for several years and almost 'graduated' while still using." This mirrored to the board the human element that would never allow us to reach a standard of zero tolerance. This was the standard set without exception by the enforcement monitor and others. Essentially, the Medical Board has to warranty to all consumers that they are completely safe to see participants in the Diversion Program, and they will not suffer from participants' addictions.

On July 26, 2007, the Medical Board met to decide the fate of the Diversion Program. We listened thoughtfully to over two hours of public comment. Physician professional associations urged us to retain the program as part of the board; while victims of botched surgeries performed by Diversion Program participants urged abolition of the program, as did the former enforcement monitor. Following another two hours of debate, the board voted unanimously to end the program as it currently exists, and I urged, and we agreed, to convene a presidential summit later this year to discuss ways to implement the "diversion" concept while protecting patients.

We, the 2007 Medical Board, inherited the problems of the Diversion Program but could not resolve them despite our best efforts. We could not ignore the results in the current BSA audit as well as previous failed audits, anymore than we could ignore the testimony of the patients who had been injured by Diversion Program participants while being denied an opportunity to protect themselves from those participants shielded by the secrecy provided by the Diversion Program.

We also could not ignore the board's statutory mission. When the Diversion Program was created in 1980, the Medical Board's highest priority (as then expressed in Business and Professions Code section 2229) was "physician rehabilitation" and the "diversion" concept seemed consistent with that priority. However, the Medical Board's statutory mandate changed with the 1990 passage of SB 2375 (Presley) and its amendments, section 2229. Public protection is the Medical Board's highest priority; the statute also says that when public protection is inconsistent with physician rehabilitation, public protection is paramount. The operation of a diversion program which demonstrably does not adequately monitor substance abusing physicians, while concealing their participation from patients, is obviously inconsistent with that mission.

Since we made our decision, I have heard expressions of dismay and bewilderment from some in the physician community who characterize the vote as a "rejection of the recognition that addiction is a disease." Our action has nothing to do with whether addiction is a disease. It has only to do with whether the Diversion Program protected patients, and five out of five external audits

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Seven deadly sins *(continued from page 5)*

a call and found an office filled with hundreds of medical charts, in varying phases of construction, being prepared for submission to Medi-Cal for false billings. Bad people sell patient identifying information and from that, data is derived to submit false claims.

Then there is the kind of greed involving physicians who receive kickbacks from laboratories or entities selling medical devices. Or there is the physician who performs one level of service but bills for a much higher level. There is “unbundling,” where the physician bills for a number of services, individually, when the services are customarily billed as one global service. There are physicians who perform unnecessary procedures. A particularly egregious recent case involved an interventional cardiologist whose fraudulent test interpretations caused patients to undergo coronary bypass procedures. There are physicians who employ staff to travel around large cities to pick up indigent “patients.” These folks are driven to a doctor’s office where numerous, unnecessary tests are run and unneeded medical services are provided and billed to Medicare or Medi-Cal. The patient is provided a meal, or a fruit basket, or \$20. Hopefully they’re returned to the same place from where they were extracted, but sometimes we receive complaints that they were abandoned and had to find their way back home.

There are drug cases that straddle greed—the physician who charges a fee for a prescription. Never mind the appropriate prior examination or medical indication: if you’ve got \$50, you can have a prescription for #30 Vicodin. The Internet has become a popular medium for greed. Apparently cyberspace does not discriminate between men and women because most of us have been inundated with electronic mail from entities proffering erectile dysfunction medications. And I know most of you never look at the back of this publication to see who’s been disciplined, but if you go back a year, you’ll note an increasing number of doctors finding themselves in trouble for Internet prescribing.

Mix greed with vanity and you might have an explanation for the cosmetic and Lasik surgery booms. Physicians who were trained in other specialties see the quick money in Lasik surgery or an untapped market in bariatrics. Many cosmetic surgeons and hair transplant physicians hire “counselors” or “assistants” to

screen prospective patients with strong-armed sales techniques reminiscent of the stereotypical used car salesman.

Mix greed with sloth and a dash of insanity, and you might understand the motivation for the three doctors who were successfully prosecuted because they substituted saline for flu vaccinations. Or the ones disciplined for using non-pharmaceutical grade Botox to save a buck or two. Or the ones disciplined for disposing of hazardous waste in conventional trash bins; or of throwing away patients’ records because proper disposal costs too much money. Physicians have fabricated clinical study records in pharmaceutical trials. In these circumstances, I would be less inclined to agree that “Greed clarifies.”

Mix greed with dishonesty, and you might discover someone like this physician—the one engaged as an expert witness who will say whatever the hiring attorney wants if the price is right. Within the last year, at least one physician was disciplined for dishonesty in testifying as an expert. I suspect we’ll be seeing a lot more of these cases since greed also seems to beget litigiousness.

Mix greed with naivete or financial desperation and you might happen upon a disturbing trend we’ve been seeing the past five years or so. A large number of newly licensed physicians and elderly physicians are being hired to “front” clinics that are actually owned and operated by lay people. Some of this involves sophisticated organized crime rings, and physicians become unwitting victims when they align with a shrewd lay person who promises a steady and generous paycheck, an office, and a source of patients. These lay people masquerade as business managers, but physicians constructively become the layperson’s employee, or should I say puppet, which translates into the unlicensed practice of corporate medicine. The layperson utilizes the physician’s license to commit fraud. Often, once the physician realizes what’s happening, and tries to exert control, they are locked out of the practice, or left fearing for their safety when they realize the gravity of what is happening with their license and want to get out of the situation. It seems newly licensed physicians are especially vulnerable to this scheme because

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Legislator profile

Assemblyman Mike Eng



Mike Eng (D-Monterey Park) was elected to the California State Assembly in 2006. Assemblyman Eng chairs the State Assembly Business and Professions Committee, which oversees a broad range of important legislation in the areas of consumer protection, the creation and elimination

of regulatory agencies, scope of practice, licensing and enforcement issues for all boards and bureaus at the Department of Consumer Affairs, and governmental efficiency and cost control.

He chairs the Select Committee on Hate Crimes and is a member of the California Asian and Pacific Islander Legislative Caucus. He is also a member of the Assembly Education, the Environmental Substance and Toxic Materials, and the Revenue and Taxation committees.

Assemblyman Eng authored two bills that directly impact the Medical Board of California. Assembly Bill 249 (2007) prohibits physicians from including a provision in settlement agreements that prohibits the other party in a dispute from contacting or cooperating with the department or board. Assembly Bill 253 (2007) reduces the board's membership from 21 to 15 and would abolish the two divisions of the board—licensing and medical quality. If the bill passes, the

board as a whole would handle the responsibilities of the divisions. At the time of this writing, both bills are pending in the Legislature.

Assemblyman Eng served three terms as a Monterey Park Library Board Trustee and chaired the successful library building campaign that raised local matching funds and qualified for state funding for an \$18 million library expansion. He was named California's Outstanding Library Trustee in 2002 for his work. He was also Monterey Park's "Volunteer of the Year" for his video that prepares viewers for the U.S. citizenship exam and which led to an Emmy award-winning production.

As a longtime community leader, Assemblyman Eng serves on the Board of Directors of the West San Gabriel Valley Boys and Girls Club, led numerous voter registration efforts, and provided free immigration legal advice to immigrant working families. In addition, he served on the Garfield Medical Center Board of Directors. He was appointed by Governor Gray Davis to the California Department of Consumer Affairs' Acupuncture Board for two terms where he served as board vice chair, and chair of the enforcement committee.

Assemblyman Eng earned his law degree from the University of California, Los Angeles, after completing bachelor's and master's degrees at the University of Hawaii while working full time at a local emergency room. He is also a part-time community college instructor.

President's Report *(continued from page 6)*

had found that it did not. That, very simply, is why the Medical Board could not continue to operate the Diversion Program.

At the upcoming summit, the board will welcome the input of interested parties including the general public, the California Medical Association, the California Society of Addiction Medicine, the California Psychiatric Association, the Center for Public Interest Law, and patient advocacy groups. We intend to re-examine the threshold issues:

1. Whether—and under what conditions—confidential "diversion" from discipline is possible within a public protection mandate; and
2. Whether such a program should be operated by a state agency or a private entity.

I also want to suggest that we consider the possibility that there be a statewide program for all healthcare professionals and possibly all professionals within our state that administers policies directed at this issue. We look forward to these challenges.

San Francisco physician receives Medical Board's Physician Humanitarian Award



Board President Richard Fantozzi, M.D. congratulates Clyde Ikeda, M.D.

At its July 27 meeting in San Francisco, the Medical Board recognized the work of Clyde Ikeda, M.D. Dr. Ikeda, a plastic and reconstructive surgeon from San Francisco, is a team leader of "Hospital de la Familia," a group

of volunteer doctors and nurses, 109 of whom are California physicians. He has been on its board of directors since 1996 and serves as its medical director and vice president. This charitable medical organization provides services four times a year to a hospital in

Guatemala. Since 1976, volunteers in this small hospital have treated nearly 290,000 patients. Dr. Ikeda performs reconstructive and plastic surgery for underserved patients, especially children.

In addition, he developed one of the foremost burn centers in Northern California (opened in 1967), the Bothin Burn Center; was on the board of the St. Vincent de Paul Society in San Francisco; and volunteers his time to teach residents in plastic surgery at St. Francis Memorial Hospital.

The Physician Recognition Committee of the Medical Board recognizes the demonstration of excellence by physicians who strive to improve access and fill gaps in health care delivery for underserved populations.

Nominations for 2008 are now being accepted. For information, please visit the board's Web site at www.mbc.ca.gov/Physician_Recognition.htm, or call the board's executive office at (916) 263-2389.

Cultural and linguistic physician competency work group update

*by Hedy Chang, Vice-President, Division of Licensing, Medical Board of California
Jill K. Silverman, CEO, MSPH, President and CEO, Institute for Medical Quality*

Over the last year and a half, the Medical Board of California, Division of Licensing, has been holding Cultural and Linguistic Physician Competency Work Group meetings to facilitate the implementation of two new laws (Business and Professions Code sections 2190 and 2198) addressing cultural and linguistic competency (CLC) of physicians in California. As a member of these work groups, I (Hedy Chang) welcome the opportunity to report that significant progress has been made.

California Assembly Bill 801 (Diaz), known as the Cultural and Linguistic Competency of Physicians Act of 2003, requires that educational classes be developed to teach foreign language proficiency and cultural beliefs and practices to California-licensed physicians. The Medical Board's Division of Licensing held work group meetings on June 26, 2007 and September, 25, 2007. It was determined that many programs of this nature have been developed since enactment of the bill. The work group will focus on identifying existing programs and determining where additional programs are still needed,

as well as developing a public resource for locating programs or classes. Anyone interested in participating in the work groups or in providing information regarding the advancement of physician cultural and linguistic competency may contact the Medical Board at (916) 263-2382 (press "4" for additional services).

California Assembly Bill 1195 (Coto) requires all continuing medical education courses (CME) to contain curriculum that includes cultural and linguistic competency in the practice of medicine. California-based CME providers' planning courses within California must comply with this law.

In 2006, the Institute for Medical Quality (IMQ) was awarded a grant by the California Endowment to provide technical assistance and other resources to providers of CME to effectively integrate CLC into the planning, development, and implementation of courses and materials offered to physicians in California. The two-year grant funds a full-time project administrator,

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Gregory House, M.D. *(continued from page 4)*

Shortly after this incident, police officer Tritter begins interviewing House's colleagues (Drs. Foreman, Cameron and Chase) about his addiction to narcotics. House has been getting prescriptions from numerous physicians, but they are all unwilling to report his drug abuse to the officer or the medical staff. They feel loyalty to House, even though he is abusive and condescending towards them. As the physicians later compare the stories they gave Tritter, Cameron appears surprised that House would steal a prescription pad, forge a prescription, and place Dr. Wilson in jeopardy with law enforcement. The simple answer: "a junkie will do whatever he has to do to get what he needs" notes Dr. Foreman.

In the meantime, House is still trying to get a complete medical history from Gabe; however, the patient has decided that he wants to spend the few hours he will be awake eating a hoagie sandwich at a special place in Atlantic City. House goes along for the ride so that he can interrogate Gabe.

Along the way, Gabe asks why House became a physician when he hates people so much. House tells the story of being a 14-year-old in Japan. A schoolmate was injured while they were rock climbing and House took him to the hospital. The friend developed a severe infection while hospitalized and the doctors didn't know what to do. They brought in the janitor, who was both a doctor and a buraku, one of Japan's untouchables, whose ancestors were slaughterers and gravediggers. Because this man was always right about patients, they had to listen to him. Nothing else mattered.

House did not become a physician to help others in need, but only to be heard. He is validation-starved. His relationship with his father is the source of his insecurity, and he only wants to hear his father say the words "you were right."

Gabe recalls for House the night when his house burned down and his wife was killed. That was the start of his vegetative state, which is believed to have been induced by smoke inhalation. Kyle had been popping corn in the fireplace and dislodged some tinder, causing the fire.

House thinks about young Kyle, who had complained that the popcorn tray was too heavy. He asks about two other relatives who died in accidents and learns that both occurred at night. House has his answer—ragged red fiber, which is an inherited condition that leads to

muscle weakness and poor night vision. Kyle's liver failure was the result of excessive drinking due to depression. House calls Foreman and instructs him to run a DNA test for ragged red fiber, but he learns that Kyle has severe alcoholic cardiomyopathy and is about to die.

After being told of Kyle's condition, Gabe decides that he wants to donate his heart to his son. Wilson tries to talk him out of it because someday they may be able to cure his vegetative condition, but Gabe is convinced. Cuddy refuses to allow this, too. House tells Wilson to leave the room. He presents Gabe with some options for suicide. Pills, he says, are the easiest, but hanging has less chance of damaging the heart. Gabe opts for strangulation.

Dr. Wilson, who went along for the ride to Atlantic City, goes down to the casino to develop an alibi for House as Gabe is killing himself. Once Gabe is dead, Wilson and House arrange to fly the body to their hospital in Princeton for the heart transplant, which, of course, is a success.

At the conclusion of the show, the Medical Board staff and I held a round table discussion of the episode and the California Medical Practice Act. The show highlighted the following concerns about Dr. House:

- Addiction to or misuse of narcotics
- Inappropriately influencing other physicians to obtain prescription narcotics
- Theft
- Forgery
- Extortion
- Physician-assisted suicide
- Treatment without consent
- Experimenting on patients without consent
- Failing to maintain patient confidentiality
- Irrational behavior

If the charges in the accusation were upheld in court, Dr. House would face revocation of his medical license. This leads us back to the original question: do the ends justify the means?

As a physician I have encountered several colleagues that fit the pattern of Dr. House. In some cases they were abusive or irrational (physically and verbally), in others they were addicted to drugs or alcohol, and in a few cases they actually engaged in illegal activities. In every circumstance, the entire medical and nursing staffs knew

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New deputy chief of enforcement

The Medical Board of California is pleased to announce the appointment of Laura Sweet as deputy chief of enforcement. As deputy chief, Ms. Sweet is responsible for planning, organizing, directing and evaluating the field investigative functions, which consist of 12 district offices staffed by supervising investigators, field investigators, investigator assistants, medical consultants and support staff. As an active member of the board's executive management staff, she will participate in policy setting on a statewide basis pertaining to the board's overall mission. She will recommend policies and/or changes in policies affecting investigative functions to improve the way business is conducted in accordance with the Medical Practice Act.

Ms. Sweet has 17 years of state service, which includes more than 14 years with the Medical Board, holding positions as senior investigator, and supervising investigator I and II. Prior to the Medical Board, she was a

special investigator and senior special investigator with the Department of Social Services, Community Care Licensing Division.

She brings years of experience as a guest lecturer for various health professions organizations, speaking on topics ranging from, "Consumer Protection: The Role of the Medical Board of California," to "Pain Management: How to arrest pain without getting arrested." You also may recognize her name from this newsletter as author of the series of articles entitled, "Preventive Medicine and the seven deadly sins: avoiding discipline against your medical license."

Ms. Sweet has been an academy instructor for both the Medical Board's Field Training Officer Program and California Statewide Agency Training, an advisor/committee member for the board's Field Training Program, and a field training officer for both the Medical Board and the Department of Social Services.

Physician wellness *(continued from cover)*

among physicians are reported to be 10–20 percent higher than those in the general population. One study showed that 31 percent would choose a different profession if given the chance to start over, while another reported that most participants had thought of leaving the profession at least once in the last 12 months and many would not want their children to go into medicine. In that latter study, by the Sacramento Medical Society, 76 percent reported that burnout affected patient satisfaction at a "medium to high" level.

Along with its emotional toll, yet to a lesser extent, prolonged job-related stress can drastically affect a physician's physical health. Constant preoccupation with job responsibilities often leads to erratic eating habits and not enough exercise, resulting in weight problems, high blood pressure, and elevated cholesterol levels.

While the general population of physicians has healthy lifestyles, it is documented that physicians have a higher rate of depression than non-physicians as well as a much higher rate of suicide, beginning in medical school and continuing throughout their lives. A study (Eva S. Schernhammer, M.D., Harvard Univ.) found that the suicide rate among male doctors is 40 percent higher

than among men in general, where the rate among female doctors is 130 percent higher than among women in general (*Am J Psychiatry* 2004;161:2295-2302). In another paper, Schernhammer suggests possible reasons for this finding, including a higher prevalence of psychiatric disorders among physicians than in the general population, drug abuse and alcoholism, the professional burden carried by doctors, and the tendency by physicians to neglect their own need for psychiatric, emotional, or medical help, stress, and burnout (*N Engl J Med* 2005;352:2473-2476).

In spite of achieving mastery of his or her specialty and, to varying degrees, financial success, something is missing: a lack of excitement, loss of meaning, and/or a feeling that there is "something else." For some, this produces a sense of ongoing frustration and anger; for others, it is a sense of melancholy or restlessness of spirit. Burnout, a term that has moved from colloquial speech into the vernacular, describes the condition, which is most frequently marked by emotional exhaustion and negative or cynical attitudes toward others and towards themselves.

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Ongoing epidemic of wound botulism in California: Obtaining antitoxin and testing through the public health system

by Charlotte Wheeler, M.D., M.P.H., California Department of Public Health, Infectious Diseases Branch

Wound botulism (WB) among injection drug users (IDUs) has been epidemic in California since the mid-1990s and California now consistently reports approximately three-quarters of the annual WB cases in the United States. Nonetheless, WB is still a rare disease; only 90 doses of botulinum antitoxin for WB were released to California physicians in 2006. Thus, many physicians are still unaware of the epidemic, of the typical presentations of WB patients, and of the protocols for obtaining antitoxin and laboratory testing through the public health system.

IDUs with WB typically present with complaints of double vision, trouble swallowing, muscular weakness and difficulty breathing. The symptoms can be mistaken for drug overdose, but on physical examination, the patients are found to have ptosis and/or other cranial nerve palsies. Paralysis is bilateral, symmetrical, and descending. Most, but not all, patients will have visibly infected wounds in locations where they have been injecting heroin subcutaneously. While the differential diagnosis for the acute onset of cranial nerve palsies includes the Miller-Fisher variant of Guillain-Barré syndrome and myasthenia gravis, California physicians should consider WB first when these signs and symptoms present in an IDU.

The diagnosis and management of WB is based initially on clinical findings. While meticulous supportive care, antibiotic administration, and wound debridement are all mainstays of patient management, the only specific treatment for WB is botulinum antitoxin. Early administration of antitoxin shortens recovery time, which can take months, so providers who suspect WB should consider treatment immediately. To obtain antitoxin in California, physicians need to contact the local health department (LHD) in the jurisdiction where the patient is hospitalized. All LHDs now have 24/7 numbers, and the California Department of Public Health (CDPH) recommends posting LHD contact numbers in emergency departments. Once contacted, LHDs and CDPH will discuss the case with the provider and arrange for the release of antitoxin.

Antitoxin is supplied free-of-charge by the public health system, but its transport from the U.S. Centers for Disease Control and Prevention (CDC) Quarantine Stations at the Los Angeles or San Francisco airports is arranged and financed by the hospital. The antitoxin is equine-derived and instructions for its administration, including de-sensitization of the patient, are included in the antitoxin packet.

Testing for circulating botulinum toxin is also provided only through the public health system. The test is a bioassay in which mice are observed for symptoms over four days following test material inoculation. Since test results are returned only after several days, treatment should never be delayed while waiting for laboratory confirmation. Prior to antitoxin administration, a full 30 mls of blood must be drawn from the patient, and this specimen is forwarded by the hospital laboratory to the local public health laboratory, which in turn forwards the specimen to the CDPH Microbial Diseases Laboratory. Results of the test are conveyed back to the hospital laboratory through the public health laboratory system.

If you are a health care provider with questions about WB or the protocol for obtaining antitoxin and testing through the public health system, please contact your LHD. General and after-hours LHD phone numbers can be found online by accessing the Web page of the California Conference of Local Health Officers through the Programs section of the CDPH Web site at www.cdph.ca.gov/programservices/programs.

Job opportunities for physicians to work with state agencies

If you are interested in learning about job opportunities with the State of California, please visit the board's Web site at www.mbc.ca.gov, click on "Licensee Information," then click on "Job Opportunities."

We just placed a new notice for psychiatrists at the California Department of Corrections and Rehabilitation. Check it out.

2007 STD Treatment Guidelines

by Ina Park, M.D., M.S. and Gail Bolan, M.D.
STD Control Branch, California Department of Public Health

In August 2006, the Centers for Disease Control and Prevention (CDC) issued updated Sexually Transmitted Disease (STD) Treatment Guidelines,¹ with modifications for the treatment of gonorrhea in April 2007.² This article highlights the major changes in these evidence-based guidelines, which were last revised in 2002. A summary table of recommended treatment regimens is included for providers as an insert in this edition of the newsletter. Providers may refer to the 2006 CDC guidelines at www.cdc.gov/std/treatment/default.htm and to the California STD treatment guidelines at: www.dhs.ca.gov/ps/dcdc/std/stdindex.htm.

Chlamydia (CT)

Treatment regimens remain unchanged and azithromycin 1 g orally in a single dose is the recommended regimen for pregnant women, adults, and adolescents with chlamydia. Partner referral for treatment is the optimal management choice but if partner follow-up is unlikely, patient-delivered expedited partner therapy (EPT) is recommended (see "Partner Management" section). Providers are encouraged to re-test women for chlamydia three months after treatment or at the next medical visit within the following 3–12 months, with some experts also recommending re-testing of men. Test-of-cure (TOC) 3–4 weeks after treatment is not routinely recommended except in pregnant women.

Gonorrhea (GC)

Prevalence of quinolone-resistant *N. gonorrhoeae* (QRNG) has continued to rise in California.³ According to the Gonococcal Isolate Surveillance Project, the prevalence of QRNG at selected sites in California was over 30 percent in 2006. Quinolone antibiotics have not been recommended for GC treatment in California since 2002 and are no longer recommended by the CDC for GC infections acquired anywhere within or outside of the US.^{2,4}

Cephalosporins remain the antibiotics of choice for uncomplicated GC infections of the cervix, urethra, rectum and pharynx and the recommended regimen is ceftriaxone 125 mg IM in a single dose.⁴ Oral treatment regimens include single-dose cefixime 400 mg (available as suspension) and cefpodoxime 400 mg though bactericidal levels with these options are not as high or sustained as with ceftriaxone. Due to high re-infection rates, clinicians should consider testing all patients with

GC for re-infection at three months. Partner referral for treatment is the optimal management choice but if partner follow-up is unlikely, patient-delivered EPT is recommended. Persons with persistent or recurrent symptoms shortly after treatment should be reevaluated by culture for *N. gonorrhoeae*; positive isolates should undergo antimicrobial-susceptibility testing.

Pelvic inflammatory disease (PID)

Testing for GC and CT prior to treatment of PID is recommended. Treatment recommendations are unchanged, though providers should only utilize fluoroquinolones as a treatment regimen when risk for GC is low. Any patient with documented gonococcal PID who received treatment with quinolone-antibiotics should undergo a test-of-cure with bacterial culture to obtain the isolate for susceptibility testing and should be re-treated with a cephalosporin-containing regimen.

Syphilis

There have been recent increases in syphilis in the U.S., especially among men who have sex with men (MSM). Syphilis and other genital ulcer diseases increase the risk of HIV acquisition and transmission. Providers should routinely screen all MSM for syphilis, and all patients with syphilis (male or female) should also be tested for HIV.

Rare cases of symptomatic neurosyphilis have been reported among HIV-infected MSM, highlighting the need for a careful neurological exam in all patients with syphilis and a syphilis test in all at-risk patients such as MSM who present with neurological symptoms.⁵ All patients with syphilis and neurologic symptoms should have a lumbar puncture. Patients with initial cerebrospinal (CSF) abnormalities should receive follow-up evaluation six months after treatment. Though a majority of HIV-infected patients respond to standard penicillin regimens, they should be evaluated clinically and serologically for treatment failure at 3, 6, 9, 12 and 24 months.

Long-acting preparations of penicillin remain the treatment of choice for all stages of syphilis, regardless of HIV status.⁶ Inappropriate use of procaine-benzathine penicillin (Bicillin-CR®) instead of benzathine penicillin G (Bicillin-LA®) has been reported, and may result in treatment failure and complications

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2007 STD Treatment Guidelines *(continued from page 13)*

such as neurosyphilis. Benzathine-procaine penicillin combinations and oral penicillin are not effective for the treatment of syphilis. Alternative therapies such as doxycycline are less efficacious and should only be used if there is a medical contraindication to benzathine penicillin G; close follow-up is essential in these patients. Use of azithromycin as an alternative treatment for syphilis in California is not recommended, as evidence of resistance has emerged.⁷

Genital herpes

In subjects with established HSV-2 infection and multiple recurrent episodes of symptomatic herpes, suppressive therapy effectively reduces frequency of recurrences, improves quality of life, and decreases the risk of genital HSV-2 transmission to susceptible partners.⁸

Although screening in the general population is not recommended, serologic testing for HSV-2 using type specific tests may be useful in patients with: 1) recurrent or atypical symptoms and negative HSV culture results, 2) a partner with a history of symptomatic genital herpes, and 3) HIV infection and no history of herpes.⁹

For recurrent episodes, new regimens for episodic therapy include: Acyclovir 800 po mg TID x 2 days or Famciclovir 1000 mg po BID x 1 day. Recommended regimens for HIV-infected persons differ slightly and are detailed in the treatment insert.

Vaginitis

Bacterial Vaginosis (BV)

Metronidazole 500 mg orally twice daily for seven days has been added as a recommended regimen for pregnant women. Clindamycin cream is not recommended for pregnant women after 20 weeks gestation due to several studies that have demonstrated an increase in adverse pregnancy outcomes when utilized in the second half of pregnancy. Single dose metronidazole (2g) is no longer recommended as an alternative regimen for treatment of BV.

Trichomoniasis

Tinidazole 2 g orally in a single dose has been added to the recommended regimens for the treatment of patients with trichomoniasis and their sexual partners. The safety of tinidazole in pregnancy has not been established (pregnancy category C); therefore, metronidazole 2 g orally in a single dose should still be used for trichomoniasis in pregnancy. For lactating women, breastfeeding should be discontinued during

treatment and for 12–24 hours following treatment with metronidazole or for three days following treatment with tinidazole.

Vulvovaginal candidiasis (VVC)

Single-dose miconazole 1200 mg vaginal suppositories have been added to the recommended regimens for treatment of VVC.

Cervicitis

Women with either: 1) mucopurulent endocervical exudate or 2) cervical friability (bleeding easily induced by passage of swab through os) should be tested for gonorrhea and chlamydia and be evaluated and treated for trichomonas and BV if present. Presumptive therapy for chlamydia should be provided in high-risk women (age <25 years, new or multiple partners, unprotected sex). Concurrent gonorrhea treatment should be provided if local prevalence is high (>5 percent) or the patient is at high risk. Empiric treatment of other women should be based on individualized risk assessment and likelihood of follow-up.

Partner management

Treatment of the partners of patients with STDs reduces risk of re-infection and may disrupt networks of STD transmission. Partners should ideally be referred to a health care provider for STD/HIV testing and counseling. If this is not feasible, another effective mechanism for partner management is expedited partner therapy (EPT), a patient-delivered therapy in which partners of infected patients are treated without prior medical examination or counseling.¹⁰ California medical providers can prescribe EPT for sexual partners of patients with gonorrhea and chlamydia. Medications or prescriptions for EPT should be accompanied by treatment instructions, warnings for pregnant women, and advice for partners to seek personal medical evaluation. Guidelines for EPT are available from the STD Control Branch of the California Department of Public Health at: www.dhs.ca.gov/ps/dcdc/std/stdindex.htm

Questions or concerns regarding these guidelines should be addressed to the STD/HIV Prevention Training Center or your local STD controller.

California STD/HIV Prevention Training Center

300 Frank H. Ogawa Plaza, Suite 520, Oakland, CA 94612-2037
tel: 510-625-6000 / e-mail: captc@cdph.ca.gov

California Department of Public Health, STD Control Branch

850 Marina Bay Parkway, Bldg P, 2nd Floor, tel: 510-620-3400

Additional copies of this article and the two-page summary table may be found at www.stdhivtraining.org or by calling the STD/HIV Prevention Training Center at (510) 625-6000.

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2007 California STD Treatment Guidelines Table for Adults and Adolescents

These guidelines for the treatment of patients with STDs reflect the 2006 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. They are intended to be a source of clinical guidance but not intended to substitute for the full 2006 STD Treatment Guidelines document. Call the local health department to report STD infections, for assistance with confidential notification of partners of patients with syphilis, gonorrhea, chlamydia or HIV, or for information on the medical management of STD patients. The CA STD/HIV Prevention Training Center provides training and consultation in the area of STD management and prevention (510) 625-6000 or www.stdhivtraining.org.

| DISEASE | RECOMMENDED REGIMENS | DOSE/ROUTE | ALTERNATIVE REGIMENS |
|--|---|--|--|
| Chlamydia (CT) | | | |
| Uncomplicated genital/rectal/pharyngeal infections ¹ | <ul style="list-style-type: none"> Azithromycin <i>or</i> Doxycycline² | <ul style="list-style-type: none"> 1 g po 100 mg po bid x 7 d | <ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d <i>or</i> Erythromycin ethylsuccinate 800 mg po qid x 7 d <i>or</i> Ofloxacin³ 300 mg po bid x 7 d <i>or</i> Levofloxacin² 500 mg po qd x 7 d |
| Pregnant women ³ | <ul style="list-style-type: none"> Azithromycin <i>or</i> Amoxicillin | <ul style="list-style-type: none"> 1 g po 500 mg po tid x 7 d | <ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d Erythromycin ethylsuccinate 800 mg po qid x 7 d |
| Gonorrhea (GC). Fluoroquinolones (FQ) are not recommended for treatment of gc infections in ca due to high levels of resistance. Routine use of azithromycin to treat gonorrhea is not recommended. Complete guidelines for treatment of GC in CA are available at www.std.ca.gov | | | |
| Uncomplicated genital/rectal infections ¹ <i>or</i> infections in pregnant women ³ | <ul style="list-style-type: none"> Ceftriaxone⁴ <i>or</i> Cefixime^{4,5} plus A chlamydia recommended regimen listed above if not ruled out by NAAT | <ul style="list-style-type: none"> 125 mg IM 400 mg po | <ul style="list-style-type: none"> Cefpodoxime⁴ 400 mg po Spectinomycin⁶ 2 g IM Azithromycin⁷ 2 g po in a single dose |
| Pharyngeal infections | <ul style="list-style-type: none"> Ceftriaxone⁴ plus A chlamydia recommended regimen listed above if not ruled out by NAAT | <ul style="list-style-type: none"> 125 mg IM | <ul style="list-style-type: none"> Azithromycin⁷ 2 g po in a single dose |
| Pelvic Inflammatory Disease^{8,9} | <p>Parenteral¹⁰</p> <ul style="list-style-type: none"> Either Cefotetan <i>or</i> Cefoxitin plus Doxycycline² <i>or</i> Clindamycin plus Gentamicin <p>IM/Oral</p> <ul style="list-style-type: none"> Either Ceftriaxone <i>or</i> Cefoxitin with Probenecid plus Doxycycline² plus Metronidazole if BV is present | <ul style="list-style-type: none"> 2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po <i>or</i> IV q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV <i>or</i> IM followed by 1.5 mg/kg IV <i>or</i> IM q 8 hrs 250 mg IM 2 g IM, 1 g po 100 mg po bid x 14 d 500 mg po bid x 14 d | <p>Parenteral¹⁰</p> <ul style="list-style-type: none"> Ampicillin/Sulbactam 3 g IV q 6 hrs plus Doxycycline² 100 mg po <i>or</i> IV q 12 hrs <p>Oral¹¹</p> <ul style="list-style-type: none"> Either Ofloxacin² 400 mg po bid x 14 d <i>or</i> Levofloxacin² 500 mg po qd x 14 d plus Metronidazole 500 mg po bid x 14 d |
| Cervicitis^{8,9,12} | <ul style="list-style-type: none"> Azithromycin <i>or</i> Doxycycline² plus Metronidazole if BV is present | <ul style="list-style-type: none"> 1 g po 100 mg po bid x 7 d 500 mg po bid x 7 d | |
| Nongonococcal Urethritis⁸ | <ul style="list-style-type: none"> Azithromycin <i>or</i> Doxycycline | <ul style="list-style-type: none"> 1 g po 100 mg po bid x 7 d | <ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d <i>or</i> Erythromycin ethylsuccinate 800 mg po qid x 7 d <i>or</i> Ofloxacin 300 mg po bid x 7 d <i>or</i> Levofloxacin 500 mg po qd x 7 days |
| Epididymitis^{8,11} | | | |
| Likely due to GC <i>or</i> CT Likely due to enteric organisms | <ul style="list-style-type: none"> Ceftriaxone plus Doxycycline Ofloxacin <i>or</i> Levofloxacin | <ul style="list-style-type: none"> 250 mg IM 100 mg po bid x 10 d 300 mg po bid x 10 d 500 mg po qd x 10 d | |
| Trichomoniasis¹³ | | | |
| Non-pregnant women | <ul style="list-style-type: none"> Metronidazole <i>or</i> Tinidazole¹⁴ | <ul style="list-style-type: none"> 2 g po 2 g po | <ul style="list-style-type: none"> Metronidazole 500 mg po bid x 7 d |
| Pregnant women | <ul style="list-style-type: none"> Metronidazole | <ul style="list-style-type: none"> 2 g po | <ul style="list-style-type: none"> Metronidazole 500 mg po bid x 7 d |
| Bacterial vaginosis | | | |
| Adults/adolescents | <ul style="list-style-type: none"> Metronidazole <i>or</i> Metronidazole gel <i>or</i> Clindamycin cream¹⁵ | <ul style="list-style-type: none"> 500 mg po bid x 7 d 0.75%, 5g intravaginally qd x 5 d 2%, 5g intravaginally qhs x 7 d | <ul style="list-style-type: none"> Clindamycin 300 mg po bid x 7 d <i>or</i> Clindamycin ovules¹⁶ 100 mg intravaginally qhs x 3 d |
| Pregnant women | <ul style="list-style-type: none"> Metronidazole <i>or</i> Metronidazole <i>or</i> Clindamycin | <ul style="list-style-type: none"> 500 mg po bid x 7 d 250 mg po tid x 7 d 300 mg po bid x 7 d | |

Footnotes

- Annual screening with nucleic acid amplification tests (NAATS) recommended for women age ≤ 25 years. Patients should be retested 3 months after treatment for CT or GC infections. Additional alternative regimens noted in the 2006 CDC STD Treatment Guidelines.
- Contraindicated for pregnant and nursing women.
- Test-of-cure (TOC) follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy.
- For patients with cephalosporin or anaphylaxis-type penicillin allergy: consider desensitization. If this is not feasible, spectinomycin or judicious use of azithromycin is a practical option.
- Cefixime tablets have not been available in the U.S. since November 2002. An oral suspension formulation is available.
- Spectinomycin has not been manufactured since January 2006, and future availability is uncertain.
- Use only if cephalosporin is contraindicated or if spectinomycin is not available. TOC is prudent because efficacy data are limited and because of concern about emerging resistance.
- Testing for GC and CT is recommended because a specific diagnosis may improve compliance and partner management, and because these infections are reportable by California state law.
- Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole.
- Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total of 14 days.
- Use FQ only if GC risk is low, NAAT for GC is performed, & close follow-up is likely. If GC is documented, obtain TOC to rule out resistant GC and retreat with patient with non-FQ regimen.
- If local prevalence of GC is greater than 5 percent, co-treat for GC infection.



California STD Treatment Guidelines Table: Adults and Adolescents 2007

| DISEASE | RECOMMENDED REGIMENS | DOSE/ROUTE | ALTERNATIVE REGIMENS |
|--|---|---|---|
| Chancroid | <ul style="list-style-type: none"> Azithromycin <i>or</i> Ceftriaxone <i>or</i> Ciprofloxacin² Erythromycin base | <ul style="list-style-type: none"> 1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d | |
| Lymphogranuloma Venereum | <ul style="list-style-type: none"> Doxycycline² | <ul style="list-style-type: none"> 100 mg po bid x 21 d | <ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 21 d <i>or</i> Azithromycin 1 g po q week x 3 weeks |
| Anogenital warts | | | |
| External genital/ Perianal warts (EGW) (Patient <i>or</i> provider applied tx) Mucosal genital warts¹⁷ (Provider applied tx only) Vaginal (V) Urethral meatus (UM) Anal (A) | Patient applied (EGW only) <ul style="list-style-type: none"> Imiquimod¹⁶ 5% cream <i>or</i> Podofilox¹⁶ 0.5% Solution <i>or</i> gel Provider applied (EGW and mucosal) <ul style="list-style-type: none"> cryotherapy (V,UM,A) <i>or</i> Podophyllin¹⁶ resin 10%-25% in tincture of benzoin (UM) <i>or</i> Trichloroacetic acid (V,A) 80%-90% Bichloroacetic acid (V,A) 80%-90% Surgical removal (A) | <ul style="list-style-type: none"> Topically qhs 3 x wk up to 16 wks Topically bid x 3 d followed by 4 d No treatment for up to 4 cycles Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks | Alternative regimen <ul style="list-style-type: none"> Intralesional interferon <i>or</i> Laser surgery |
| Anogenital herpes simplex virus (HSV)¹⁸ | | | |
| First clinical episode of Herpes | <ul style="list-style-type: none"> Acyclovir <i>or</i> Famciclovir <i>or</i> Valacyclovir | <ul style="list-style-type: none"> 400 mg po tid x 7-10 d 250 mg po tid x 7-10 d 1 g po bid x 7-10 d | |
| Established infection Suppressive therapy ¹⁹ | <ul style="list-style-type: none"> Acyclovir <i>or</i> Famciclovir <i>or</i> Valacyclovir <i>or</i> | <ul style="list-style-type: none"> 400 mg po bid 250 mg po bid 500 mg po qd <i>or</i> 1g po qd | |
| Episodic therapy for recurrent episodes | <ul style="list-style-type: none"> Acyclovir <i>or</i> Acyclovir <i>or</i> Famciclovir <i>or</i> Famciclovir <i>or</i> Valacyclovir <i>or</i> Valacyclovir | <ul style="list-style-type: none"> 400 mg po tid <i>or</i> 800 mg po bid x 5d 800 mg po tid x 2 d 125 mg po bid x 5 d 1000 mg po bid x 1 d 500 mg po bid x 3 d 1 g po qd x 5 d | |
| HIV co-infected²⁰ | | | |
| Suppressive therapy ¹⁹ | <ul style="list-style-type: none"> Acyclovir <i>or</i> Famciclovir <i>or</i> Valacyclovir | <ul style="list-style-type: none"> 400-800 mg po bid <i>or</i> tid 500 mg po bid 500 mg po bid | |
| Episodic therapy for recurrent episodes | <ul style="list-style-type: none"> Acyclovir <i>or</i> Famciclovir <i>or</i> Valacyclovir | <ul style="list-style-type: none"> 400 mg po tid x 5-10 d 500 mg po bid x 5-10 d 1 g po bid x 5-10 d | |
| Syphilis | | | |
| Primary, secondary, and early latent | <ul style="list-style-type: none"> Benzathine penicillin G²¹ | <ul style="list-style-type: none"> 2.4 Million units IM | <ul style="list-style-type: none"> Doxycycline²² 100 mg po bid x 14 d <i>or</i> Tetracycline²² 500 mg po qid x 14 d <i>or</i> Ceftriaxone²² 1 g IM <i>or</i> IV qd x 8-10 d |
| Late latent and Latent of unknown duration | <ul style="list-style-type: none"> Benzathine penicillin G | <ul style="list-style-type: none"> 7.2 Million units, administered as 2.4 Million units IM q week x 3 | <ul style="list-style-type: none"> Doxycycline²² 100 mg po bid x 28 d <i>or</i> Tetracycline²² 500 mg po qid x 28 d |
| Neurosyphilis ²³ | <ul style="list-style-type: none"> Aqueous crystalline penicillin G | <ul style="list-style-type: none"> 18-24 Million units qd, administered as 3-4 million units IV q 4 hrs x 10-14 d | <ul style="list-style-type: none"> Procaine penicillin G, 2.4 Million units IM qd x 10-14 d plus Probenecid 500 mg po qid x 10-14 d <i>or</i> Ceftriaxone²² 2 g IM <i>or</i> IV qd x 10-14 d |
| Pregnant women | | | |
| Primary, secondary and early latent | <ul style="list-style-type: none"> Benzathine penicillin G | <ul style="list-style-type: none"> 2.4 Million units IM | <ul style="list-style-type: none"> None |
| Late latent and latent of unknown duration | <ul style="list-style-type: none"> Benzathine penicillin G | <ul style="list-style-type: none"> 7.2 Million units, administered as 2.4 Million units IM q week x 3 | <ul style="list-style-type: none"> None |
| Neurosyphilis ²³ | <ul style="list-style-type: none"> Aqueous crystalline penicillin G | <ul style="list-style-type: none"> 18-24 Million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d | <ul style="list-style-type: none"> Procaine penicillin G, 2.4 Million units IM qd x 10-14 d plus Probenecid 500 mg po qid x 10-14 d |
| HIV co-infected | | | |
| Primary, secondary and early latent | <ul style="list-style-type: none"> Benzathine penicillin G | <ul style="list-style-type: none"> 2.4 Million units IM | <ul style="list-style-type: none"> Doxycycline²² 100 mg po bid x 14 d <i>or</i> Tetracycline²² 500 mg po qid x 14 d |
| Late latent and latent of unknown duration-normal CSF | <ul style="list-style-type: none"> Benzathine penicillin G | <ul style="list-style-type: none"> 7.2 Million units, administered as 2.4 Million units IM q week x 3 | <ul style="list-style-type: none"> Doxycycline²² 100 mg po bid x 28 d |
| Neurosyphilis ²³ | <ul style="list-style-type: none"> Same as general adult population | | |

Footnotes continued

¹³ For suspected drug-resistant Trichomoniasis, rule out reinfection and evaluate for metronidazole-resistance; see 2006 CDC Guidelines, Trichomonas Follow-up p. 53, for further options.

¹⁴ Safety in pregnancy has not been established; pregnancy category C.

¹⁵ Might weaken latex condoms and diaphragms because oil-based.

¹⁶ Contraindicated in pregnancy.

¹⁷ Cervical warts should be managed by a specialist.

¹⁸ Counseling about natural history, asymptomatic shedding, and transmission is an essential component of HSV management. See 2006 CDC Guidelines for additional treatment options.

¹⁹ The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission.

²⁰ If HSV lesions persist or recur during treatment, resistance should be suspected. Recommend obtaining viral isolate for sensitivity testing and consultation with an infectious disease expert.

²¹ Benzathine penicillin G is available in one long-acting formulation, Bicillin® L-A. Bicillin® C-R contains both long and short-acting penicillins and is NOT effective for treating syphilis.

²² Use only for penicillin-allergic patients because efficacy has not been established. Compliance and close follow-up are essential; otherwise penicillin desensitization is recommended.

²³ Some specialists recommend 2.4 million units of benzathine penicillin G q week for up to 3 weeks after completion of neurosyphilis treatment.



Physician wellness *(continued from page 11)*

How to Address Physician Burnout

The best prevention for burnout among physicians is to promote their personal and professional well-being on all levels—physical, emotional, psychological, and spiritual. This needs to occur throughout the professional life cycle of physicians, from medical school through retirement. It is a challenge not only for individual physicians in their own lives but for the profession of medicine and the organizations in which physicians work.

The implementation of well-being programs can be accomplished through various educational, consulting, and advisory programs and services. Recognizing that many California licensees are in geographic areas that do not lend themselves to frequent contact with their professional peers, individuals and small groups may be in the greatest need to receive educational and well-being interventions. And while larger health care facilities already may have well-being committees, they could be encouraged to expand the traditional scope of service to their physicians, not just focusing on alcohol and substance abuse issues, but to foster an all-encompassing culture of mutual concern, safety, professionalism, and confidentiality. Such efforts can lead to an improved work environment (heightened productivity, creativity, reduced turnover, improved conflict resolution, diminished intra-practice lawsuits, and uplifting of morale), improved level of care for and appreciation by patients, and more satisfying personal relationships.

Lastly, a crucial element in the successful implementation of wellness efforts best can be achieved with the involvement of spouses, significant others, and family members as a foundational element of any proposed solution.

Conclusion

Burnout is characterized by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment. Preventing burnout—a responsibility of all physicians and of the health care organizations in which they work—entails the explicit promotion of physician well-being. Physicians must be guided from the earliest years of training to cultivate methods of personal renewal, emotional self-awareness, connection with social support systems, and a sense of mastery and meaning in their work. Maintaining these values is the work of a lifetime. It is not incidental to medicine, but is at the core of the deepest values of the profession: “First, do no harm.” Harmlessness begins with oneself. If physicians hope to heal the distresses of the 21st century and lead their patients to enjoy healthy, sustainable lives, they must show that this is possible by their own lives of sustainable service that emanates from the depths of spirits that are continuously renewed.

This article can be viewed in its entirety on the board’s Web site at www.mbc.ca.gov, under “Licensee Information.”

Gregory House, M.D. *(continued from page 10)*

of the physician’s shortcomings but were unwilling to get involved. Many cited the fear of retaliation by an influential or respected member of the medical staff, while others were concerned with damaging the reputation of the physician. The physician was allowed to continue practicing unchecked until there was an adverse outcome. In some cases, patient and staff complaints went unanswered until there was actual patient harm.

Dr. House is following this same pattern. He is impaired by his constant need for validation and by his

dependence on narcotics. As long as he is right, nothing else matters. But nobody is perfect, even in a television drama. Sooner or later House will be wrong and a patient will be harmed. Clearly the ends do not justify the means.

Dr. House serves as a reminder that as a profession, physicians are responsible for reviewing and reporting the actions of their peers. Medicine cannot tolerate negligent, incompetent, impaired, illegal or irrational behavior since the result is too often patient harm.

Workers' Compensation Fraud Warning Notice

The following is a letter (warning notice) from the Department of Industrial Relations, Division of Workers' Compensation to medical providers who participate in the workers' compensation system. Please read the notice in its entirety (two pages).

STATE OF CALIFORNIA


Arnold Schwarzenegger, Governor

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
1515 Clay Street, 17th Floor
Oakland, California 94612
Telephone: (510) 286-7100



June 7, 2007

To: All California Medical Providers

From: 
Carrie Nevans, Acting Administrative Director
Division of Workers' Compensation

Subject: Workers' Compensation Fraud Warning Notice

To promote awareness of the need to eliminate fraud in the workers' compensation system, the legislature enacted Labor Code section 3822 to require the Administrative Director of the Division of Workers' Compensation to provide every employer, claims adjuster, third party administrator, physician and attorney who participates in the workers' compensation system, an annual notice warning the recipient against committing workers' compensation fraud, and advising of the penalties for such fraud.

To comply with the mandate of Labor Code Section 3822, the Administrative Director has drafted this warning notice for distribution to medical providers.

Please distribute a copy of this notice to all of your employees with responsibilities for your participation in workers' compensation.

THE FIGHT AGAINST WORKERS' COMPENSATION FRAUD

Workers' compensation fraud is a drain on California's economy. Workers' compensation fraud harms employers by contributing to the high cost of workers' compensation insurance and self-insurance and it harms employees by undermining the perceived legitimacy of all workers' compensation claims.

Workers' compensation fraud is not limited to claimant fraud. The workers' compensation program is also victimized by fraud committed by medical providers, employers, claims adjusters and attorneys.

WHAT CONSTITUTES MEDICAL PROVIDER FRAUD?

- Billing fraud
- Employing individuals to solicit new patients
- Unnecessary treatment or self-interested referrals
- Failing to report a work injury

WC Fraud Warning Notice, continued

WORKERS' COMPENSATION FRAUD IS A CRIME

Insurance Code section 1871.4 provides that it is a felony to make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in section 3207 of the Labor Code, or present or cause to be presented a knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in section 3207 of the Labor Code. It is also a crime to knowingly assist, abet, conspire with, or solicit any person in an unlawful act of workers' compensation insurance fraud.

It is also a crime to make or cause to be made a knowingly false or fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

Workers' compensation fraud may be punished by imprisonment and/or with fines. Imprisonment can be in county jail for one year, or in a state prison, for two, three, or five years. A fine may be imposed not exceeding fifty thousand dollars (\$50,000), or double the amount of the fraud, whichever is greater. In addition, if someone is convicted of workers' compensation fraud, the court is required to order restitution to be paid, including restitution for any medical evaluation or treatment services obtained or provided. A person convicted under Insurance Code section 1871.4 may be charged the costs of the investigation at the discretion of the court.

Finally, Insurance Code section 1871.5 provides that any person convicted of workers' compensation fraud pursuant to section 1871.4 or section 550 of the Penal Code shall be ineligible to receive or retain any compensation, as defined in section 3207 of the Labor Code, where that compensation was owed or received as a result of a violation of section 1871.4 or section 550 of the Penal Code for which the recipient of the compensation was convicted.

WORKERS' COMPENSATION FRAUD IS A SERIOUS MATTER

Workers' compensation fraud can increase the cost of doing business and can result in decreases (or no increases) in employee salaries, laying off employees or even going out of business. Workers' compensation fraud can also increase health care costs and the cost of insurance for all Californians.

If you would like to obtain more information about the issue of workers' compensation fraud, or would like to report an occurrence of workers' compensation fraud, please call the Department of Insurance Fraud Division's hotline number: (800) 927-4357. If you have Internet access, you can access the Fraud Division's Website at: http://www.insurance.ca.gov/FRD/Frd_main.htm to obtain more information and locate the telephone number for the Fraud Division office nearest to you.

Changes to the Reportable Disease List

California Department of Public Health, Division of Communicable Disease Control

An important function of public health is to monitor and track diseases and conditions that impact the general population. This public health surveillance function is carried out through a partnership of health care providers, laboratories, and local, state and national public health agencies. This partnership is strengthened through regulations that define the diseases and conditions to be reported, as well as the duties that each of the partners must perform. Specifically, Title 17 of the California Code of Regulations (CCR) requires health care providers and/or laboratories to report certain health conditions, listed in sections 2500 and 2505 of the CCR ("reportable disease list"), in a timely fashion to local health authorities.

California Health and Safety (H&S) Code section 120130, which is the authority for Title 17, was first published in 1945 and has been amended nine times with the intent to reflect the current needs and priorities for public health surveillance. Legislation signed into law in 2004 permits the reportable disease list to be changed by the California Department of Public Health (CDPH), previously the California Department of Health Services (CDHS), in consultation with the California Conference of Local Health Officers (CCLHO), without going through the formal regulatory process.

Several changes to the reportable disease list were filed with the Secretary of State on June 12, 2007. These changes are in Title 17, Division 1, Chapter 4, Subchapter 1, sections 2500 (reporting from providers to local health jurisdictions) and 2505 (reporting from laboratories to local health jurisdictions).

There were four disease additions to section 2500: avian influenza, chickenpox hospitalizations and deaths, Creutzfeldt-Jakob Disease and other transmissible spongiform encephalopathies (TSE), and influenza deaths in persons <18 years of age. There were also seven deletions from section 2500. There were 10 additions to section 2505. There were also paragraphs added to describe specific laboratory reporting for avian influenza (a report is required upon receipt of a specimen for testing) and hepatitis C (only those laboratory test results that meet the Centers for Disease Control and Prevention (CDC) case definition are reportable).

In addition, all shiga toxin producing *E. coli* (rather than only *E. coli* O157) infections are now reportable by both laboratories (section 2505) and providers (section 2500). Also, shiga toxin detected in feces is now reportable by both laboratories and providers. This requirement was added in the fall of 2006 in the wake of the outbreak of *E. coli* O157 infections associated with spinach because some commercial laboratories are testing for shiga toxin in addition to, or in lieu of, culturing for shiga toxin producing *E. coli*.

The full list of reportable diseases, including the allowable timeframes for reporting them, can be found at: www.dhs.ca.gov/ps/dcdc/html/publicat.htm (scroll down to "Reporting Guidelines"). Please remember that a case or suspected case of any unusual disease, even if not currently named on the list, must be reported to your local health department. Many thanks to every health care provider for your continuing efforts on the "front lines" of disease surveillance in California—you are highly valued partners with a critical role in early recognition of potentially important public health problems.

STD Treatment Guidelines References *(continued from page 14)*

- 1 Workowski KA, Berman SM. "Sexually transmitted diseases treatment guidelines, 2006," *MMWR Recomm Rep* 2006 Aug 4;55(RR-11):1-94.
- 2 CDC. "Update to CDC's sexually transmitted diseases treatment guidelines, 2006: fluoroquinolones no longer recommended for treatment of gonococcal infections," *MMWR Morb Mortal Wkly Rep* 2007 Apr 13;56(14):332-6.
- 3 Bauer HM, Mark KE, Samuel M, et al. "Prevalence of and associated risk factors for fluoroquinolone-resistant *Neisseria gonorrhoeae* in California, 2000-2003," *Clin Infect Dis* 2005 Sep 15;41(6):795-803.
- 4 "California Gonorrhea Treatment Guidelines," [cited 2007 August 1]; Available from: www.dhs.ca.gov/ps/dcdc/std/stdindex.htm
- 5 CDC. "Symptomatic early neurosyphilis among HIV-positive men who have sex with men—four cities, United States, January 2002–June 2004," *MMWR Morb Mortal Wkly Rep* 2007 Jun 29;56(25):625-8.
- 6 Rolfs RT, Joesoef MR, Hendershot EF, et al. "A randomized trial of enhanced therapy for early syphilis in patients with and without human immunodeficiency virus infection. The Syphilis and HIV Study Group [see comment]," *N Engl J Med* 1997 Jul 31;337(5):307-14.
- 7 Lukehart SA, Godornes C, Molini BJ, et al. "Macrolide resistance in *Treponema pallidum* in the United States and Ireland [see comment]," *N Engl J Med* 2004 Jul 8;351(2):154-8.
- 8 Corey L, Wald A, Patel R, et al. "Once-daily valacyclovir to reduce the risk of transmission of genital herpes," *N Engl J Med* 2004 Jan 1;350(1):11-20.
- 9 "California Guidelines for the Use of HSV-2 Serologies," [cited 2007 August 1]; Available from: www.dhs.ca.gov/ps/dcdc/std/stdindex.htm
- 10 Golden MR, Whittington WL, Handsfield HH, et al. "Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydial infection," *N Engl J Med* 2005 Feb 17;352(7):676-85.

Cultural competency *(continued from page 9)*

Alecia Robinson, dedicated to the IMQ CLC program. Priorities of this position are to work directly with CME providers and community experts to inform and facilitate the sharing of best practices.

IMQ CLC Program services include outreach efforts such as CLC Regional Workshops, one-on-one technical assistance with CME programs in person, by phone, or email, and the Annual IMQ/CMA CME Provider Conference.

Frequently asked questions about AB 1195

Does AB 1195 require a certain number of curriculum hours of continuing medical education dedicated to cultural and linguistic competency?

No. There is not a specific number of hours, but all CME activities after July 1, 2006 should include cultural and linguistic competency in their curriculum.

Does AB 1195 affect all CME activities?

No. The following educational activities are exempt: activities solely dedicated to research, other activities that do not contain patient care components, and activities offered by providers not located in California.

How do we show compliance with AB 1195?

IMQ expects each provider to make a good-faith effort to comply with the law. Program planning documentation should show evidence of efforts both to assess the need for CLC education as well as meaningfully address these needs in CME activities. Standards for AB 1195 compliance have been approved by the IMQ/CMA CME Committee and Board of Directors. Please download a copy at www.cmanet.org/upload/AB1195_standards07.doc

Is there a specific list of populations that our organization should target for improving cultural and linguistic competency in CME curriculum?

No. Studies have shown that certain populations experience significant health disparities and disease burden. Unequal access to care and services as a result

of language barriers and cultural differences can lead to poorer overall health status. Cultural competence, however, implies the ability to adapt and reinvent according to a changing environment (including demographics, socio-economics, literacy levels, and acculturation), and the expressed needs of the surrounding community.

Will IMQ provide AB 1195 related templates of speaker requirements, policies, or other materials for us to use to comply?

IMQ will provide resources to assist CME providers in drafting policies and other relevant materials specific to identified provider needs. There is no “one-size-fits-all” solution to complying with AB 1195. In fact, the spirit of AB 1195 promotes variation in how CME providers will target their educational strategies.

The IMQ CLC Program sponsors a Web site resource which houses general and specialized CLC data, journal articles, assessment tools, and CME on cultural and linguistic competency.

The IMQ CLC Program Web site is structured to address the variety of needs for CME program staff. Physicians can access CLC resources by their specialty, or select information specific to a patient population or disease state. CME coordinators may share examples of CME on CLC with their CME committees for planning purposes. Prospective CME providers may find national and state resources useful as they prepare for accreditation. Other features of the IMQ CLC Program Web site include synopses of CLC workshops and information about upcoming events. Please visit the IMQ CLC Program CLC Web site at www.imq.org/clc_index.html for more information.

Hedy Chang and Shelton Duruisseau, Ph.D., Medical Board members serving on the CLC work-group, thank the IMQ staff and countless other CLC work group participants for their continued commitment toward achieving cultural and linguistic competency in the practice of medicine in California.

Centers for Medicaid Services (CMS) releases tamper-resistant prescription pad guidance to state Medicaid directors

CMS released guidance through a state Medicaid director letter at www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf providing baseline requirements to states to define and implement tamper-resistant prescription pads as required by law. The law requires all written, non-electronic prescriptions for Medicaid outpatient drugs be executed on tamper-resistant pads for them to be reimbursable by the federal government. In the letter, CMS clarifies that to be considered tamper resistant on October 1, 2007, a prescription pad must contain at least one of the following three characteristics:

- one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; or
- one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
- one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

However, beginning October 1, 2008, a prescription pad must contain all three characteristics to be considered tamper-resistant.

In addition to the guidance outlined above, the tamper-resistant requirement does not apply when a prescription is communicated by the prescriber to the pharmacy electronically, verbally, or by fax; when a managed care entity pays for the prescription; or in most situations when drugs are provided in designated institutional and clinical settings. The State Medicaid Director Letter referenced above also allows emergency fills with a non-compliant written prescription as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours. Please visit www.cms.hhs.gov/DeficitReductionAct/Downloads/Tamper.pdf for additional information.

If a state elects to purchase compliant prescription pads for Medicaid prescriptions and provide them to prescribers at no cost or at a discounted rate, the cost of the prescription pads will be reimbursable as an administrative expense. Keep in mind that some states may need to make legislative or regulatory changes to their Medicaid pharmacy reimbursement processes. Interested parties should follow up with the appropriate state Medicaid or legislative officials for more information.

Please note: California's current tamper-resistant controlled substance prescription forms meet these requirements.

Seven deadly sins *(continued from page 7)*

of oppressive student loans and business naivete. Elderly physicians who really should have retired from the practice, but have not properly planned for retirement, are also easy marks for this form of fraud. (More information about the prohibition against the unlicensed corporate practice of medicine can be found in the April 2004 issue of the *Action Report*, page 4. You can review it on the board's Web site at www.mbc.ca.gov, click on Brochures/Publications.)

And finally, I cannot omit corporate greed as it epitomizes this sin: you know, the physician who is penalized for not seeing enough patients in a given time period so billings can be maximized? Or the

paradox of this situation—the physician who purposely over schedules him or herself to the point that laboratory results are missed and not acted upon, or other lapses in good medicine occur.

Maybe it is true that greed has marked the “upward surge of mankind,” but at whose expense? In these egregiously greedy times, it's hard not to jump on the Avarice Express, but hopefully the aforementioned scenarios, not to mention the fate of Gordon Gekko, will lead you to conclude that “Greed, for lack of a better word,” is dangerous.

Final article: Pride

Administrative actions: May 1, 2007 — July 31, 2007

Physicians and surgeons

ABDALLA, AHMAD MOHAMAD, M.D. (A32150)
Northridge, CA

Stipulated Decision. No admissions but charged with repeated negligent acts, gross negligence, incompetence, failure to maintain adequate and accurate medical records, and unprofessional conduct in the care and treatment of 1 patient. Public Reprimand. License placed in inactive status. Prior to resuming the practice of medicine, the physician must complete a clinical training program. July 19, 2007

ABELES, ERNEST D. (G11698)
New York, NY

Disciplined by New York for failure to properly evaluate and treat several patients and for failure to maintain adequate medical records. Revoked. July 16, 2007

AGUILAR, CHRISTOPHER (G83131)
Turlock, CA

Stipulated Decision. Committed acts of gross negligence and sexual misconduct in the care and treatment of 1 patient. Surrender of license. June 19, 2007

ALBERTS, LEONARD HILLEL (G36739)
Provincetown, MA

Disciplined by Massachusetts for violating a board order in which he agreed not to practice medicine until a final decision regarding a patient/physician boundary violation was resolved. Revoked. July 11, 2007

ARJMANDFARD, ABDOL RASSOL (A87931)
Philadelphia, PA

Disciplined by Arizona for having a condition affecting his ability to practice medicine safely, sexual misconduct with a patient, and violating an Interim Consent Agreement by refusing to take a polygraph test. Revoked. July 19, 2007

BABINE, SARAH ELIZABETH (G79659)
Kennebunk, ME

Disciplined by Maine for habitual substance abuse and unprofessional conduct for failing to comply with the terms of the board's decision. Revoked. July 16, 2007

Copies of public documents from 2004 to the present are available at www.mbc.ca.gov. Click on "Enforcement Public Document Search," or for copies of all public documents call the Medical Board's Central File Room at (916) 263-2525.

Explanation of disciplinary language and actions

"Effective date of decision" —
Example: "June 12, 2007" 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 pending" —
The disciplinary decision is being challenged through the court system, i.e., Superior Court, Court of Appeal, or 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.

"Public Letter of Reprimand" —
A lesser form of discipline that can be negotiated for minor violations, usually 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, five years probation on terms and conditions, including 60 days suspension" —

"Stayed" means the revocation is postponed. Professional practice

may continue so long as the licensee complies with specified probationary terms and conditions, which, in this example, includes 60 days of 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 formally negotiated and settled prior to trial.

"Surrender" — To resolve a disciplinary action, the licensee has given up his or her license — subject to acceptance by the board.

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

BENGGS, CARL M. (G2057)
Oceanside, CA

Stipulated Decision. Physician has a condition affecting his ability to practice medicine safely. Surrender of license. May 8, 2007

BENZOR, JOANNE MARIAN, M.D. (G53502)
Moreno Valley, CA

Stipulated Decision. Committed acts of repeated negligence, gross negligence, failure to maintain adequate and accurate medical records, prescribing without a good faith prior examination or medical indication, and failure to properly supervise a physician assistant in the care and treatment of 3 patients. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, prohibited from engaging in solo practice; completing a medical record keeping course, a prescribing practices course, and an educational course in addition to required CME; and obtaining a practice monitor. May 7, 2007

BLOCKER, DAVID CLINTON (G47830)
Centerville, OH

Stipulated Decision. Disciplined by the U.S. Air Force for making incorrect diagnoses and/or correct findings with inappropriate recommendations in a number of cases. Surrender of license. June 11, 2007

BRYANT, C. W., M.D. (CFE27901)
Phoenix, AZ

Disciplined by Arizona for failing to adequately address acute respiratory decompensation and for inadequate medical record keeping in the care and treatment of 1 patient. Public Letter of Reprimand. June 1, 2007

CALABRIA, RENATO, M.D. (A43041)
Beverly Hills, CA

Committed acts of repeated negligence, gross negligence, and unprofessional conduct in the care and treatment of multiple patients. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, completing a medical record keeping course and an educational course in addition to required CME. Judicial review pending. May 23, 2007

CHOPRA, RAKESH, M.D. (A40049)
Riverside, CA

Stipulated Decision. No admissions but charged with repeated negligent acts, gross negligence, and failure to

maintain adequate and accurate medical records in the care and treatment of 1 patient. Physician must complete a medical record keeping course and an educational course in addition to required CME. Public Reprimand. July 11, 2007

COBURN, WILLIAM M., JR. (C23131)
Thousand Oaks, CA

Stipulated Decision. No admissions but charged with unprofessional conduct and prescribing without a good faith prior examination by exchanging prescription drugs for a gun; and repeated negligent acts, gross negligence, excessive prescribing, and failing to maintain adequate and accurate medical records in the care and treatment of 3 patients. Surrender of license. May 30, 2007

COCCO, JOHN MICHAEL, M.D. (G18076)
Valencia, CA

Committed acts of unprofessional conduct by failing to pay a fine imposed by the board. Revoked, stayed, placed on 2 years probation with terms and conditions including, but not limited to, ordered to pay the \$500 fine. May 21, 2007

COLLIER, ROBERT H., M.D. (G10617)
Garden Grove, CA

Stipulated Decision. No admissions but charged with gross negligence in the care and treatment of 1 patient. Public Reprimand. May 29, 2007

CONRAD, BENJAMIN ERIC, M.D. (A100928)
Laguna Beach, CA

Stipulated Decision. Convicted of driving under the influence of alcohol. Probationary license issued, placed on 3 years probation with terms and conditions including, but not limited to, abstaining from the personal use or possession of controlled substances and alcohol, submitting to biological fluid testing, and providing 120 hours of free, non-medical community service. Decision effective July 5, 2007, probationary license issued July 25, 2007.

DELANO, JAMES EDWARDS, JR., M.D. (G30580)
San Francisco, CA

Committed acts of repeated negligence and gross negligence by failing to properly monitor a patient's lithium carbonate levels and failing to adequately schedule and maintain follow-up appointments. Public Letter of Reprimand. May 9, 2007

GANSSE, JOHN DIEDRICH, aka STANLEY, JOHN SLOAN, aka STANLEY, JOHN DAVID (A41508)
San Francisco, CA

Violated the terms and conditions of his board-ordered probation by failing to renew his license, failing to complete required evaluations, failing to meet with board monitors, and failing to pay cost recovery. Revoked. May 29, 2007

GARDNER, ALAN MARTIN (G48230)
Defiance, OH

Disciplined by Ohio for having a condition affecting his ability to practice medicine safely. Revoked. June 11, 2007

Board certified expert reviewers needed

The Medical Board of California established its Expert Reviewer Program in July 1994 as an impartial and professional means to support the investigative and enforcement functions of the board. Specifically, medical experts assist the board by providing expert reviews and opinions on board cases and conducting professional competency exams.

The rate of payment for expert review services is \$150/hour for conducting case reviews and \$200/hour for providing expert testimony. Experts also are reimbursed for travel expenses within the limits imposed by the state.

The board is particularly in need of physicians who are board certified and actively practicing medicine in California in the following specialties:

- **Interventional cardiology** (statewide): must be actively performing invasive/interventional cardiology (stents, balloons, cardiac catheters, etc.) and must be board certified in this subspecialty
- **Dermatology** (statewide): general dermatology and dermatologists actively performing IPL
- **Gastroenterology** (statewide): must be board certified in this subspecialty, performing various procedures and/or performing endoscopic ultrasound
- **Infectious Disease** (statewide): must be board certified in this subspecialty
- **Neurosurgery** (statewide): must be actively performing surgeries as primary surgeon
- **Neurology** (Los Angeles County)
- **Neurology** (statewide): with special qualifications in child neurology
- **Orthopaedic Surgery** (statewide): must be actively performing surgeries as primary surgeon

- **Pediatric Cardiology** (statewide)
- **Pediatric Hematology-Oncology** (statewide): must be board certified in this subspecialty
- **Pediatric Infectious Diseases** (statewide): must be board certified in this subspecialty
- **Pediatric Surgery** (statewide): must be board certified in this subspecialty
- **Obstetrics and Gynecology** (statewide)
- **Perinatology** (statewide)
- **Reproductive Endocrinology/Infertility** (statewide): must be board certified in this subspecialty
- **Spine Surgery** (statewide)
- **Thoracic Surgery** (Los Angeles County/Southern California)
- **Urology** (statewide): general and/or urologists performing organ transplant
- **Vascular & Interventional Radiology** (statewide): must be board certified in this subspecialty
- **Vascular Surgery** (statewide): must be board certified in this field of specialty and actively performing surgeries as primary surgeon

If you are interested in providing expert review services to the Medical Board, and your expertise falls under one or more of these categories, please send your application and C.V. to:

Susan Goetzinger, Program Analyst
Expert Reviewer Program
Medical Board of California
320 Arden Avenue, Suite 250
Glendale, CA 91203
(818) 551-2117
sgoetzinger@mbc.ca.gov

GOLOB, DEBORAH SUE (G69632)

La Jolla, CA

Stipulated Decision. Disciplined by Arizona for Internet prescribing, and prescribing without a physical examination or establishing a doctor-patient relationship in the care and treatment of multiple patients. Surrender of license. May 4, 2007

GOMEZ, NICOLAS PEDAZA, M.D. (AFE37700)

Chula Vista, CA

Stipulated Decision. Convicted of a felony for presenting false and fraudulent claims to Medi-Cal, committed acts of dishonesty, made or signed false documents relating to the practice of medicine, altered medical records, aided and abetted the unlicensed practice of medicine, and failed to maintain adequate and accurate medical records. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, 90 days actual suspension and completing an ethics course. Should he wish to resume the practice of medicine, physician must complete a clinical training program, pass the SPEX exam, and obtain a billing monitor. July 18, 2007

HALEVIE-GOLDMAN, BRIAN DAVID, M.D. (A38684)

Fairfield, CA

Committed acts of repeated negligence and gross negligence, failed to maintain adequate and accurate medical records, made false statements in medical documents, and prescribed without a good faith prior examination or medical indication in the care and treatment of 2 patients. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, 90 days actual suspension; prohibited from practicing, performing, or treating any condition except psychiatric conditions; completing an ethics course, a prescribing practices course, and a medical record keeping course; maintaining a record of all controlled substances ordered, prescribed, dispensed, administered, possessed, and any recommendation or approval for marijuana; and obtaining a practice monitor. May 16, 2007

HELSTON, RAYMOND HERBERT, M.D. (A23548)

Bakersfield, CA

Stipulated Decision. Committed acts of unprofessional conduct by failing to appropriately supervise a physician assistant during the care and treatment of 1 patient. Revoked, stayed, placed on 6 years probation with terms and conditions including, but not limited to, 15 days

actual suspension, completing an educational course in addition to required CME and prohibited from engaging in solo practice. June 6, 2007

HIBLER, ANITA MAE, M.D. (C36494)

Los Angeles, CA

Stipulated Decision. Failed to maintain adequate and accurate medical records in the care and treatment of 1 patient. Physician must complete a medical record keeping course. Public Reprimand. May 7, 2007

HOAK, THOMAS C., JR., M.D. (G79434)

Ripon, CA

Stipulated Decision. No admissions but charged with gross negligence in the care and treatment of 1 patient. Public Reprimand. June 1, 2007

HUANG, BENJAMIN E., M.D. (G85607)

Irvine, CA

Stipulated Decision. Committed acts of repeated negligence and failed to maintain adequate and accurate medical records in the care and treatment of 1 patient. Revoked, stayed, placed on 35 months probation with terms and conditions including, but not limited to, completing a clinical training program and obtaining a practice monitor. July 23, 2007

JELLINEK, LAWRENCE ROGER (G29482)

Santa Barbara, CA

Stipulated Decision. No admissions but convicted of a misdemeanor for driving under the influence of alcohol; and excessively used alcohol and controlled substances. Surrender of license. June 28, 2007

JOHNSON, EDDIE GLEN, III (C50439)

Shreveport, LA

Stipulated Decision. Disciplined by Louisiana for suffering from opioid dependency. Surrender of license. June 28, 2007

JONES, AARON WILSON, M.D. (A80253)

Redding, CA

Stipulated Decision. Committed acts of gross negligence, and sexual misconduct in the care and treatment of 1 patient. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, completing a professional boundaries program; prohibited from consulting, examining, or treating female patients without a third-party chaperone; and obtaining a practice monitor. June 1, 2007

KAHN, ROBERT SYLVAN (GFE32820)

Lummi Island, WA

Stipulated Decision. Disciplined by Washington for improperly removing Fentanyl from a clinic's inventory, writing fraudulent prescriptions for personal use, and sexual misconduct with a patient. Surrender of license. July 5, 2007

LASH, JEFFREY DAVID (A61336)

San Diego, CA

Stipulated Decision. Violated the terms and conditions of a board-ordered probation by committing sexual misconduct with a patient. Surrender of license. May 1, 2007

LAWRENCE, LARRY LESTER, M.D. (G16257)

Lincoln, CA

Committed acts of gross negligence by failing to correctly assess and diagnose a patient's deteriorating symptoms. Public Letter of Reprimand. May 9, 2007

LEW, BARRY GERALD (G34168)

Long Beach, CA

Violated the terms and conditions of his board-ordered probation by being convicted of a felony for grand theft and conspiracy to commit Medi-Cal fraud and money laundering; prescribing controlled substances without medical purpose, furnishing controlled substances without prescribing; and violating federal and state drug statutes. Revoked. June 11, 2007

LIFSCHUTZ, HARRY, M.D. (G42802)

Indio, CA

Stipulated Decision. No admissions but charged with repeated negligent acts, gross negligence, and incompetence in the care and treatment of 7 patients; and failure to maintain adequate and accurate medical records in the care and treatment of 1 patient. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, completing a clinical training program, an educational course in addition to required CME, a medical records keeping course; and obtaining a practice monitor. June 4, 2007

LOAIZA, AUGUSTO (C41739)

Chattanooga, TN

Stipulated Decision. No admissions but charged with violating the terms and conditions of his board-ordered probation by committing acts of repeated negligence

and gross negligence in the care and treatment of 4 patients and gross negligence in the care and treatment of 1 patient. Surrender of license. May 23, 2007

MAGBANUA, LAURIE FENETE (A23946)

Chatsworth, CA

Stipulated Decision. No admissions but convicted of a felony for presenting false/fraudulent claims and writing false insurance claims. Surrender of license. May 14, 2007

MALIK, MICHAEL YUSEF ABDUL, M.D. (A69726)

Los Angeles, CA

Stipulated Decision. No admissions but convicted of a misdemeanor for reckless driving and evading arrest, and a misdemeanor for disturbing the peace; violating a court-ordered probation; and abused alcohol. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, 16 days actual suspension, abstaining from the personal use or possession of controlled substances and alcohol, submitting to biological fluid testing, completing the Diversion Program, and 120 hours of free non-medical community service. June 22, 2007

MARTIN, ROSCOE BERNARD (A39017)

Wilton, CA

Convicted of a felony for fraudulent claims and perjury. Revoked. May 31, 2007

**Check your physician profile on
the Medical Board's Web site**

Your address of record is public.

www.mbc.ca.gov

Click on "Licensee Information" and "Check My Profile."

Signed address changes may be submitted to the board by fax at (916) 263-2944, or by regular mail to:

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

MASON, KENNETH EVERETT, M.D. (G53438)
Huntington Beach, CA

Stipulated Decision. Aided and abetted the unlicensed practice of medicine and knowingly signed medical records without examining or treating those patients. Revoked, stayed, placed on 35 months probation with terms and conditions including, but not limited to, completing a medical record keeping course, an ethics course, and obtaining a practice and billing monitor. July 12, 2007

MCMANUS, JEFFREY CRAIG, M.D. (G56160)
Ojai, CA

Stipulated Decision. Committed acts of gross negligence in the care and treatment of 1 patient and repeated negligence, and failure to maintain adequate and accurate medical records in the care and treatment of 2 patients. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, completing a clinical training program, a medical record keeping course, and an ethics course. June 15, 2007

MITTS, THOMAS FREDERICK, M.D. (G27736)
Visalia, CA

Violated drug statutes by administering Type A Botulinum Neurotoxin to 4 to 5 patients and failed to inform them that the toxin was not approved by the FDA. Public Letter of Reprimand. May 22, 2007

MOGHTADER, MEHRAN, M.D. (A62032)
Los Angeles, CA

Stipulated Decision. No admissions but charged with repeated negligent acts, incompetence, excessive treatment or prescribing, and failure to maintain adequate and accurate medical records in the care and treatment of 4 patients and gross negligence in the care and treatment of 1 patient. Revoked, stayed, placed on 3 years probation with terms and conditions including, but not limited to, completing a clinical training program, a medical record keeping course, and obtaining a practice monitor. June 8, 2007

MOINFAR, NADER, M.D. (A64834)
Longwood, FL

Stipulated Decision. Disciplined by Florida for failing to properly treat a patient with a foreign body in the patient's eye. Public Reprimand. July 5, 2007

MOON, CHAE HYUN (A32120)
Redding, CA

Committed acts of repeated negligence, gross negligence, incompetence, dishonesty or corruption, submitting fraudulent Medi-Cal insurance claims, and failure to maintain adequate and accurate medical records in the care and treatment of multiple patients. Revoked. June 8, 2007

MOSEMAN, JAMES MICHAEL, M.D. (G68447)
San Diego, CA

Stipulated Decision. No admissions but charged with gross negligence in the care and treatment of 1 patient. Physician must complete a clinical training program. Public Reprimand. June 22, 2007

NASHED, ADEL ABDELMALSK, M.D. (AFE30739)
Huntington Beach, CA

Stipulated Decision. No admissions but charged with repeated negligent acts, gross negligence, and incompetence in the care and treatment of 1 patient. Public Reprimand. July 6, 2007

NITTI, GARY JOSEPH, M.D. (G49747)
Calabasas, CA

Stipulated Decision. No admissions but charged with repeated negligent acts, gross negligence, incompetence, and failure to maintain adequate and accurate medical records in the care and treatment of 6 patients. Physician completed a medical record keeping course, an ethics course, and paid cost recovery of \$3,664. Public Letter of Reprimand. June 14, 2007

O'DONNELL, EUGENE P., M.D. (C27965)
Whittier, CA

Stipulated Decision. Violated the terms and conditions of his board-ordered probation by failing to complete a clinical training program, failing to complete an educational course, and failing to pay probation monitoring costs. Revoked, stayed, placed on 5 years probation effective March 31, 2005, with terms and conditions including, but not limited to, prohibited from the practice of medicine until successfully completing a clinical training program; prohibited from making or disseminating any false or misleading advertising concerning the practice of medicine; prohibited from practicing in the area of ENT or performing "cryosurgery;" completing an educational

course in addition to required CME, an ethics course, and a medical record keeping course; and obtaining a practice and billing monitor. June 30, 2007

PASUHUK, EDWIN HUBERT, M.D. (A39666)
Highland, CA

Stipulated Decision. Aided and abetted the unlicensed practice of medicine by allowing an unlicensed person to perform pap smears. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, 45 days actual suspension; completing an educational course in addition to required CME, a medical record keeping course, and an ethics course; and obtaining a billing monitor. June 7, 2007

PATEL, MITULKUMAR PRAVINCHANDR (G74858)
Las Vegas, NV

Stipulated Decision. Convicted of 2 misdemeanors for driving under the influence of alcohol, and has a condition affecting his ability to practice medicine safely. Surrender of license. July 19, 2007

PATEL, RAMESH R. (A40485)
Fontana, CA

Stipulated Decision. Physician has a condition affecting his ability to practice medicine safely. Surrender of license. July 3, 2007

PEARSON, GAIL LEE (G84398)
Quincy, CA

Practiced medicine while under the influence of alcohol and controlled substances. Revoked. July 27, 2007

PLUNKETT, PATRICK A., M.D. (C30729)
South Pasadena, CA

Committed an act of dishonesty by failing to report the board's investigation on his application for licensure in Alaska, and abused alcohol in a manner dangerous to himself and others. Revoked, stayed, placed on 7 years probation with terms and conditions including, but not limited to, prohibited from the solo practice of medicine and locum tenens employment, abstaining from the personal use or possession of controlled substances and alcohol, submitting to biological fluid testing, completing the Diversion Program and an ethics course, and providing 20 hours of free community service. May 4, 2007

ROBINSON, MARK DEWAYNE, M.D. (G61971)
Elk Grove, CA

Stipulated Decision. Committed acts of gross negligence and sexual misconduct in the care and treatment of a patient. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, prohibited from consulting, examining, or treating female patients without a third-party chaperone; and completing an ethics course and a professional boundaries program. July 23, 2007

SHANTHARAM, SANAGARAM S., M.D. (A52010)
Fresno, CA

Committed acts of repeated negligence and gross negligence by failing to properly perform surgery and obtain informed consent in the care and treatment of 1 patient. Public Letter of Reprimand. June 8, 2007

SHIU, TONY G. (A55151)
Pleasanton, CA

Committed acts of sexual abuse on 3 patients and sexual exploitation of no fewer than 10 adult male patients, violated federal or state drug statutes, excessively prescribed, prescribed without medical indication, corruption, and committed unprofessional conduct. Revoked. July 30, 2007

Free online CME course on domestic violence

Blue Shield Foundation of California recently launched a new Web site offering free online CME and training for California doctors treating domestic violence victims. The program provides specific information regarding California reporting laws and provides doctors the tools and information needed to help patients who may be victims of domestic violence.

Up to 16 Category 1 credits.

www.RespondtoDV.org

STARKS, D'MITRI, M.D. (G49823)**Montclair, CA**

Stipulated Decision. No admissions but charged with repeated negligent acts, gross negligence, and incompetence in the care and treatment of 2 patients. Revoked, stayed, placed on 35 months probation with terms and conditions including, but not limited to, completing a clinical training program and an educational course in addition to required CME. June 22, 2007

STRUB, IRVIN H. (C14061)**Upland, CA**

Committed acts of gross negligence, dishonesty, created false medical records, made false statements in documents related to medical procedures, and failed to maintain adequate and accurate medical records in the care and treatment of 1 patient. Revoked. Judicial review pending. May 9, 2007

SWENSON, MICHAEL ROBERT (G51605)**Louisville, KY**

Stipulated Decision. Disciplined by Kentucky for forging prescriptions on prescription pads stolen from another physician, inappropriately prescribing to his wife, and suffering from alcohol abuse. Surrender of license. June 26, 2007

TAN, BIENVENIDO, M.D. (A18536)**Newhall, CA**

Failed to maintain adequate and accurate medical records in the care and treatment of 1 patient. Public Reprimand. July 5, 2007

VAN METER, LAWRENCE RICHARD, M.D. (A26072)**Huntington Beach, CA**

Committed an act of unprofessional conduct by failing to consult with a patient's surgeon after admitting the patient who presented with post-operative complications. Public Letter of Reprimand. June 14, 2007

VENTRA, PAMELA CHRISTINE (GFE85186)**Chattanooga, TN**

Disciplined by Tennessee for practicing medicine when mentally or physically unable to do so safely. Revoked. July 2, 2007

VERBY, HARRY D., M.D. (G13395)**San Mateo, CA**

Committed acts of incompetence by issuing a letter allowing a patient to possess a hand gun knowing the patient had suicidal tendencies and failed to maintain adequate and accurate medical records. Physician completed a course in medical report writing. Public Letter of Reprimand. June 19, 2007

VONG, GAREN T., M.D. (A54155)**San Francisco, CA**

Stipulated Decision. Committed acts of repeated negligence, gross negligence, incompetence, and failure to maintain adequate and accurate medical records in the care and treatment of 3 patients. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, completing a clinical training program, a professional enhancement program, and an educational course in addition to required CME. June 3, 2007

WASHINGTON, PATRICIA A., M.D. (A43579)**Coto De Caza, CA**

Committed acts of gross negligence and incompetence in the care and treatment of 1 patient. Revoked, stayed, placed on 3 years probation with terms and conditions including, but not limited to, completing an educational course in addition to required CME. July 16, 2007

Medical Board's Subscribers' List

Are you interested in the Medical Board's latest actions?

If yes, please join the Medical Board of California's Subscribers' List to obtain e-mail updates of the MBC Newsletter; Hot Sheet; meeting agendas, notices, and minutes; and regulations. **The following actions were recently added to the list: license suspensions, restrictions, revocations, and surrenders for physicians and surgeons.**

If you wish to subscribe to this list, please go to www.mbc.ca.gov/subscribers.htm and follow the instructions for subscribing.

WILSON, EDWARD K., M.D. (A21304)
Los Angeles, CA

Committed acts of repeated negligence, unprofessional conduct, and failure to maintain adequate and accurate medical records in the care and treatment of 3 patients. Revoked, stayed, placed on 5 years probation with terms and conditions including, but not limited to, completing a clinical training program, a prescribing practices course, a medical record keeping course; and obtaining a practice monitor. June 4, 2007

WORK, WILLIAM RALPH, M.D. (A66593)
Fresno, CA

Violated drug statutes by administering Type A Botulinum Neurotoxin to 15 to 20 patients and failed to inform them the toxin was not approved by the FDA. Public Letter of Reprimand. May 22, 2007

YALE, WILLIAM SCOTT, M.D. (G21545)
Tulare, CA

Stipulated Decision. Disciplined by Washington for unprofessional conduct, negligence, aiding and abetting the unlicensed practice of medicine, failing to furnish requested documents, and not furnishing in writing a complete explanation of the matter in the complaint. Revoked, stayed, placed on 2 years probation with terms and conditions including, but not limited to, completing an ethics course. May 25, 2007

ZIMMERMAN, MARC HERBERT, M.D. (G44606)
Lake Havasu City, AZ

Disciplined by Arizona for performing wrong-site surgery on a patient. Public Letter of Reprimand. June 8, 2007

Medical consultants needed

Are you interested in being an integral part of the Medical Board of California by serving as a medical consultant? Do you have the ability to conduct effective interviews, exercise sound judgment in reviewing conflicting medical reports and preparing opinions, and analyze problems and take appropriate action? If you can work eight to 16 hours per week, we have vacancies in our Fresno and Northern California district offices. For additional information on minimum qualifications, please contact Alberto Perez at (916) 263-2582.

DOCTORS OF PODIATRIC MEDICINE

KHOSROABADY, ALIREZA, D.P.M. (E4728)
Woodland Hills, CA

Stipulated Decision. Convicted of a misdemeanor for burglary, and was convicted of driving without a license, failure to appear, and speeding. Probationary license issued, revoked, stayed, placed on 3 years probation with terms and conditions including, but not limited to, completing an ethics course and providing 80 hours of free community service. Decision effective May 16, 2007, license issued May 21, 2007.

SCIVALLY, JOHN WAYNE, D.P.M. (E4319)
Walnut Creek, CA

Stipulated Decision. No admissions but charged with repeated negligent acts, gross negligence, incompetence, and failure to maintain adequate and accurate medical records in the care and treatment of 1 patient. Revoked, stayed, placed on 3 years probation with terms and conditions including, but not limited to, completing a clinical training program, a medical record keeping course, and obtaining a practice monitor. May 28, 2007

PHYSICIAN ASSISTANTS

CATES, JOHN HARVEY, P.A. (PA10552)
Bakersfield, CA

Stipulated Decision. Committed acts of gross negligence and unprofessional conduct by exceeding the scope of his authority while treating a patient with trigger point injections. Public Reprimand. July 11, 2007

ROLENS, THOMAS A. (PA12162)
Springville, CA

Stipulated Decision. Disciplined by the U.S. Department of the Navy for inadequate documentation of patient histories and inadequate or no documentation to justify treatment or diagnostic thought processes for follow-up care. Surrender of license. July 3, 2007

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

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Business and Professions
Code section 2021(b) & (c)
require physicians to inform
the Medical Board in writing
within 30 days of any name or
address change.
See: [www.mbc.ca.gov/](http://www.mbc.ca.gov/Address_Record.htm)
[Address_Record.htm](http://www.mbc.ca.gov/Address_Record.htm)



Medical Board of California Meetings

2008

January 31-February 1: Los Angeles

May 1-2: Sacramento

July 24-25: San Francisco

November 6-7: San Diego

All meetings are open to the public.

Medical Board of California

Richard D. Fantozzi, M.D., President
vacant, Vice President
vacant, Secretary

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Barb Johnston, Executive Director

Toll-free Complaint Line: 800-Med-Bd-CA (800-633-2322)

Medical Board:

| | |
|------------------------------------|----------------|
| Applications | (916) 263-2499 |
| Complaints | (800) 633-2322 |
| Continuing Education | (916) 263-2645 |
| Diversion Program | (866) 728-9907 |
| Health Facility Discipline Reports | (916) 263-2382 |
| Fictitious Name Permits | (916) 263-2384 |
| License Renewals | (916) 263-2382 |
| Expert Reviewer Program | (818) 551-2117 |

Verification of Licensure/Consumer Information (916) 263-2382

| | |
|---------------------|----------------|
| General Information | (916) 263-2466 |
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Board of Podiatric Medicine (916) 263-2647

Board of Psychology (916) 263-2699

Affiliated Healing Arts Professions:

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| Complaints | (800) 633-2322 |
| Midwives | (916) 263-2393 |
| Physician Assistants | (916) 263-2670 |
| Registered Dispensing Opticians | (916) 263-2634 |

For complaints regarding the following, call (800) 952-5210

| | |
|------------------------|----------------|
| 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 |

MEDICAL BOARD OF CALIFORNIA NEWSLETTER — NOVEMBER 2007

Candis Cohen, Editor (916) 263-2389

The *Medical Board of California Newsletter* is available in the "Publications" section of the board's Web site: www.mbc.ca.gov. For hard copies of this report, please fax your request to (916) 263-2387 or mail to: Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.