



FINAL REPORT

MEDICAL BOARD OF CALIFORNIA ENFORCEMENT PROGRAM MONITOR

Julianne D'Angelo Fellmeth

MBC Enforcement Program Monitor
Administrative Director/Supervising Attorney
Center for Public Interest Law
University of San Diego School of Law

Thomas A. Papageorge

Principal Consultant
Head Deputy District Attorney, Consumer Protection Division
Los Angeles District Attorney's Office

November 1, 2005

TABLE OF CONTENTS

<u>Chapter</u>		<u>Page</u>
	Acknowledgments	iii
	Executive Summary	ES-1
I.	Introduction	1
II.	Overview of the Medical Board of California	5
III.	Summary of the <i>Initial Report of the MBC Enforcement Program Monitor</i>	11
IV.	2005 Reform Legislation Addressing the Monitor's Recommendations	17
V.	MBC's Enforcement Program: General Description and Threshold Concerns	33
VI.	Complaint Receipt and Screening: Central Complaint Unit	49
VII.	Field Investigations: District Offices	79
VIII.	Expert Reviewer Program	103
IX.	Prosecutions: Health Quality Enforcement Section	109
X.	Hearings: Medical Quality Hearing Panel	121
XI.	Decisions: Division of Medical Quality	129
XII.	Judicial Review of DMQ Decisions	145

XIII.	Public Disclosure	151
XIV.	Public Education and Outreach	157
XV.	MBC's Diversion Program	163
XVI.	Other Areas of Monitor Inquiry	189
XVII.	Conclusion and Recommendations for the Future	201

ACKNOWLEDGMENTS

The Medical Board Enforcement Monitor project, now concluded, was at all times a joint effort of many contributors, whom we gratefully acknowledge here.

First, neither the Enforcement Monitor project nor the fundamental reform legislation resulting from the project would exist but for the efforts of Senator Liz Figueroa, the longtime and dedicated chair of both the Senate Committee on Business, Professions and Economic Development and the Joint Committee on Boards, Commissions and Consumer Protection. Special thanks were earned by Joint Committee Chief Consultant Ed Howard, who spearheaded the negotiation of SB 231 (Figueroa). We also thank Senate Business and Professions Committee Chief Consultant Bill Gage, Joint Committee Consultant David Link, Assembly Business and Professions Committee Chief Consultant Jay Greenwood, and Assembly Business and Professions Committee Principal Consultant Ross Warren for their valuable input and assistance in the extraordinary legislative effort required to secure the passage of SB 231.

The Monitor is grateful to Governor Arnold Schwarzenegger for signing SB 231 (Figueroa), and to Charlene Zettel, Director of the Department of Consumer Affairs, for her support of the Monitor project.

The Monitor thanks the current members of the Medical Board — led by 2004–05 President Mitch Karlan, M.D., and 2005–06 President Ron Wender, M.D. — for their leadership and unwavering support for the vast majority of the Monitor’s recommendations. Dr. Wender’s presence and testimony at all the legislative hearings on SB 231 demonstrate his firm commitment to improving the Medical Board’s enforcement program. The Monitor is grateful to the many past Medical Board presidents who spoke out in strong support of SB 231 and its vertical prosecution goal — including 1993–94 President Bruce Hasenkamp, J.D.; 1994–95 President Robert del Junco, M.D.; 1995–96 President Alan Shumacher, M.D.; 1996–97 President Stewart Hsieh, J.D.; 1997–99 President Tom Joas, M.D.; 1999–2000 President Karen McElliott; and 2000–01 President Ira Lubell, M.D. Additionally, the Monitor thanks former MBC Executive Director Dixon Arnett and former Department of Consumer Affairs Director Jim Conran for supporting the bill and its reforms.

In researching and writing both reports, the Monitor was greeted with full and complete cooperation from management and staff across the state at both the Medical Board of California and the Health Quality Enforcement Section of the Attorney General’s Office. At the Medical Board, we are especially thankful to Executive Director Dave Thornton, Deputy Executive Director Kim Kirchmeyer, and Enforcement Chief Joan Jerzak for their long careers in public service and for their candor and receptiveness toward this project. We similarly acknowledge Senior Assistant Attorney General Carlos Ramirez and the many fine attorneys at the Health Quality Enforcement Section. We owe special thanks in advance to Dave Thornton, Joan Jerzak, and Carlos Ramirez for leading their respective troops toward full and successful implementation of the vertical prosecution model. As stated by the Federation of State Medical Boards in its support letter on SB 231, “the Federation is eager to follow how this early coordination and close partnership between attorneys and investigators is realized as it may create a model for other licensing boards to follow.” MBC and HQE are in the hands of dedicated public servants who are making a daily commitment to bettering the Board’s enforcement program on behalf of all Californians. We salute them all.

We are grateful to former University of San Diego School of Law Dean Daniel B. Rodriguez, Interim Dean Kevin Cole, and Los Angeles County District Attorney Steve Cooley for permitting us to undertake this important project along with the demands of our permanent posts.

Although this report is written primarily by us, it is based upon the invaluable research and other work conducted by other members of the Monitor’s team. Ben Frank, Director of the NewPoint Group in Sacramento, performed all data-gathering and analysis and the extensive and insightful business process analysis of the Diversion Program. Ben’s statistical analyses and agency insights are featured prominently in both the *Initial Report* and the *Final Report*, and we thank him for contributing his experience and skills to this project. We thank Hanna Gibson, third-year law student at the University of San Diego School of Law, for her meticulous proofreading, cite-checking, and editing of the *Final Report*. Once again, Elisa Weichel of the Children’s Advocacy Institute took our raw work, performed her usual magic, and turned it into something fit to print on paper and online. And we are grateful to Professor Robert C. Fellmeth — Price Professor in Public Interest Law at the University of San Diego School of Law, former State Bar Discipline Monitor, and primary author of *Physician Discipline in California: A Code Blue Emergency* — for pioneering the “enforcement monitor” concept and for his extraordinary contributions to the fields of administrative law, public interest advocacy, and professional discipline.

Finally, on a personal note, the Monitor once again extends her deepest thanks to Sol and Helen Price, who have generously endowed the Center for Public Interest Law at the University of San Diego School of Law. Without them, CPIL would not exist.

Julianne D’Angelo Fellmeth
Thomas A. Papageorge

© Copyright 2005 by the Center for Public Interest Law
University of San Diego School of Law
5998 Alcalá Park ■ San Diego, CA 92110
(619) 260-4806 ■ Fax: (619) 260-4753
www.cpil.org

EXECUTIVE SUMMARY

INTRODUCTION

As a result of the Legislature's 2001–02 sunset review of the Medical Board of California (MBC), Senate Bill 1950 (Figueroa) added section 2220.1 to the Business and Professions Code.¹ Section 2220.1 provides for the appointment of an independent Medical Board Enforcement Program Monitor for a two-year period, and charges the Monitor with evaluating “the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board’s enforcement program and operations and the improvement of the overall efficiency of the board’s disciplinary system.” The statute tasks the Monitor with several specific analyses, including a required evaluation of the Board’s Diversion Program for substance-abusing physicians, and requires the Monitor to publish two reports during the two-year appointment period.

Following a year of research, data gathering and analysis, and extensive interviews, the Monitor released the *Initial Report of the Medical Board Enforcement Program Monitor* on November 1, 2004. The report made hundreds of findings and 65 specific recommendations for reform; some of them required legislation, while others could be implemented administratively by MBC. The Medical Board and the Health Quality Enforcement (HQE) Section of the Attorney General’s Office quickly embraced nearly all of the Monitor’s recommendations, and immediately began to implement those that did not require legislation or additional resources. Commencing in April 2005, many of the Monitor’s most important recommendations were amended into Senate Bill 231 (Figueroa), which was signed by Governor Arnold Schwarzenegger on October 7, 2005.

This *Final Report of the Medical Board Enforcement Program Monitor* describes the details of this fundamental reform legislation and its impacts on the various components of the Medical Board’s enforcement program. Additionally, it includes updated enforcement program data for fiscal year 2004–05 and documents MBC/HQE implementation of other Monitor recommendations that did not require legislation. The efforts of MBC, HQE, and the Legislature to implement each of the Monitor’s 65 recommendations are documented in the matrix in Chapter XVII. Lastly, the *Final Report* includes final recommendations for future consideration by the Medical Board, the Attorney General’s Office, the Legislature, and the Schwarzenegger administration.

¹ Unless otherwise noted, all further statutory references in this Executive Summary are to the California Business and Professions Code.

OVERVIEW OF MBC AND ITS ENFORCEMENT PROGRAM

Created in the Medical Practice Act, the Medical Board of California is a semi-autonomous occupational licensing agency within the state Department of Consumer Affairs (DCA). MBC consists of 21 members: twelve California-licensed physicians and nine non-physician “public members,” all serving four-year terms. Uniquely, MBC is comprised of two autonomous divisions — the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). DOL, which consists of four physicians and three public members, focuses on the licensure of physicians and the regulation of several non-physician health care professions. DMQ, which consists of fourteen members (eight physicians and six public members), is the Board’s enforcement arm. DMQ is responsible for reviewing the quality of medical practice carried out by California physicians; conducting disciplinary proceedings in cases of unprofessional conduct; and generally enforcing the disciplinary and criminal provisions of the Medical Practice Act, other relevant statutes and regulations, and applicable professional standards. The Legislature has declared that, in exercising its disciplinary authority, “[p]rotection of the public shall be the highest priority for the Division of Medical QualityWhere [physician] rehabilitation and protection are inconsistent, protection shall be paramount.”

MBC’s enforcement program is large, complex, expensive, and fragmented across three state agencies. DMQ oversees a large enforcement staff that receives, screens, and investigates complaints and reports of physician misconduct and negligence. These staff are based at headquarters in Sacramento and at eleven district offices throughout California. Once a Medical Board investigator (assisted by physician employees called “medical consultants” and often external expert physician reviewers) has determined that sufficient evidence exists to take disciplinary action, the matter is transmitted to a separate agency — the Health Quality Enforcement Section of the Attorney General’s Office; HQE has six offices throughout the state. A deputy attorney general (DAG) from HQE then files an “accusation,” a written statement of formal charges, which triggers a panoply of due process rights for the subject physician. Absent settlement, the charges then become the subject of an evidentiary hearing presided over by an administrative law judge (ALJ) from another separate agency — the Medical Quality Hearing Panel of the Office of Administrative Hearings (OAH) — at which each side presents its case. After the case is “submitted,” the ALJ drafts a proposed decision, including findings of fact, conclusions of law, and recommended discipline. That proposed decision is referred back to DMQ, where it is reviewed by one of two “panels” of DMQ, each consisting of seven members (four physicians and three public members). The assigned DMQ panel makes MBC’s final disciplinary decision, which is then subject to potentially three levels of review by the courts. Contested MBC disciplinary matters often consume five to eight years, during which time most respondent physicians are free to continue practicing medicine.

The Business and Professions Code sets forth grounds for MBC disciplinary action, including gross negligence (an extreme departure from applicable professional standards); repeated negligent acts; incompetence; the commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician; and the violation of any provision of the Medical Practice Act. In MBC disciplinary matters, the burden of proof is on the Board, and MBC must prove its case by “clear and convincing evidence to a reasonable certainty.” The Code also sets forth an array of sanctions that DMQ may impose on a licensee for a disciplinable violation, including license revocation, suspension, probation on specified terms and conditions, public reprimand, citations, fines, and civil penalties.

In 2004–05, MBC regulated over 120,000 physicians, of which 93,000 reside and practice medicine in California. The Medical Board receives no funding or support from the state’s general fund. MBC is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a “special-fund agency.” MBC’s fiscal year 2004–05 budget was \$41 million, of which \$30 million — or 75% — was spent on enforcement.

SUMMARY OF THE *INITIAL REPORT*

On November 1, 2004, the Monitor team released its initial findings and recommendations in the *Initial Report of the Medical Board Enforcement Program Monitor*.² These findings highlight significant limitations on the Board’s ability to protect the public through its enforcement and diversion programs. Some of them are within the Medical Board’s control; others are beyond its control. The Monitor’s major findings and recommendations can be summarized as follows:

1. The structure of the Board’s enforcement program is inefficient and outdated. The current structure of MBC’s enforcement program and process used to handle serious complaints against physicians — which places Medical Board investigators and HQE’s specialized prosecutors in separate agencies — is fragmented, inefficient, and outdated. Currently, a Medical Board investigator with little or no legal guidance works up a case and then “hands it off” to a DAG who has had no involvement in the planning or direction of the investigation and then has no investigative assistance thereafter. Most other similar law enforcement agencies use a “vertical prosecution” model in which (1) investigators and prosecutors work for the same entity; (2) an investigator/prosecutor team is assigned to each case as soon as it warrants formal investigation; and (3) that team handles the case as a team through its ultimate conclusion. In the *Initial Report*, the Monitor proposed the transfer of the Medical Board’s investigators from the jurisdiction of the

² Fellmeth and Papageorge, *Initial Report of the Medical Board Enforcement Program Monitor* (Nov. 1, 2004) (hereinafter “*Initial Report*”). The 294-page report is available on the Medical Board’s Web site at www.medbd.ca.gov and on the Web site of the University of San Diego School of Law’s Center for Public Interest Law at www.cpil.org.

politically appointed Board to HQE, and recommended full adoption of the vertical prosecution model for improved enforcement efficiency and effectiveness.

The Monitor noted other structural infirmities in MBC's enforcement program. Specifically, existing venue statutes that govern the location of the administrative hearing and the court challenge to any resulting MBC disciplinary action are unnecessarily expensive to the Board and its licensees, and are inconvenient and inefficient for those who must participate in Medical Board disciplinary proceedings — including HQE prosecutors and OAH ALJs. The Monitor recommended amendments to the statutory provisions governing the venue of MBC administrative hearings and judicial challenges to Medical Board disciplinary decisions.

2. The Medical Board has woefully inadequate resources for its important enforcement function. For over a decade, the Medical Board has been starved for budgetary resources: Physicians' license fees have not been increased since January 1994, notwithstanding a 28% increase in the California Consumer Price Index during those eleven years. In addition, the Board has been starved for human resources: Since 2001, MBC has lost 29 enforcement program positions (a 16.2% reduction) and the Attorney General's Office has lost six HQE DAGs (a 15% reduction) due to the state's 2001–04 hiring freeze — contributing greatly to chronic case processing delays. The Monitor called for an increase in physician licensing fees from \$610 biennially to at least \$800 biennially. These added resources would enable the Board to reinstate investigator/prosecutor positions lost as a result of the hiring freeze, implement vertical prosecution, reform and sufficiently staff its Diversion Program for substance-abusing licensees, reinstate critical programs it was forced to abandon during the eleven-year financial drought, and maintain an adequate reserve fund as required by state law.

3. MBC case processing times are unacceptably high. The Medical Board's enforcement process simply takes too long to protect the public. Although section 2319 requires the Board to set a goal of completing an investigation within 180 days from receipt of the complaint (one year for complex cases), during 2003–04 an average of 340 days elapsed from MBC's receipt of a serious quality of care complaint to the conclusion of the investigation. One reason for this delay is that many physicians refuse to honor lawful MBC requests for patient medical records, and neither MBC investigators nor HQE prosecutors aggressively enforced existing laws governing medical records procurement. Similar delays plague other steps in the long enforcement process, including initial complaint processing, securing physician interviews during an investigation, and the procurement of an expert opinion necessary to prove a violation. The Monitor recommended that MBC and HQE develop and consistently apply new policies to enforce existing medical records procurement laws and to end other frequent delays in obtaining physician interviews and expert witness testimony.

4. Failure to exchange expert opinion delays and impedes the enforcement process. The MBC/HQE enforcement process is routinely delayed and frustrated because, whereas MBC requires

its expert witnesses (physicians) to put their expert opinions in writing and shares them with the other side, defense counsel do not require their medical experts to put their expert opinions in writing and exchange them with MBC or HQE prior to the administrative hearing. This practice stifles the settlement process and often disadvantages the DAG at the hearing. In the *Initial Report*, the Monitor recommended that the Medical Practice Act be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the administrative hearing.

5. Many of MBC’s most important detection mechanisms are failing it. Despite the extensive “mandatory reporting scheme” set forth in section 800 *et seq.*, the Medical Board is not receiving information to which it is statutorily entitled about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law — information that enables MBC to detect possible physician wrongdoing, investigate, and take disciplinary action as appropriate. Further, physicians themselves routinely conceal information about their own misconduct from the Board through the insertion of so-called “regulatory gag clauses” — provisions that prohibit an injured plaintiff from complaining to or cooperating with the Medical Board — into civil malpractice settlement agreements. To ensure that the Medical Board is informed of events indicating potential physician incompetence or impairment, the Monitor proposed a number of new reporting requirements and the enhancement of several existing reporting requirements — including a DCA-sponsored educational program for courtroom clerks regarding their duty to report criminal convictions and civil judgments; the completion of a study of the hospital peer review process mandated in 2001, so that loopholes and problems in peer review reporting to MBC can be identified and closed; the imposition of penalties on insurance companies and physician employers that fail to report medical malpractice payouts as required by law; and a statutory ban on “regulatory gag clauses” in civil settlement agreements.

6. The Medical Board’s public disclosure policy is insufficient. The Board’s complex public disclosure statutes and regulations — which have evolved in patchwork-quilt style over the past decade — do not allow the Board to disclose sufficient information about physician conduct and history to enable patients to make informed decisions about their physicians. The Monitor recommended that the statutes governing public disclosure be streamlined to eliminate inconsistencies, redundancies, and drafting errors; and called for the required public disclosure of medical malpractice settlements over \$30,000, misdemeanor criminal convictions against physicians that are “substantially related” to the duties of a physician, and significant terms and conditions of probation imposed by MBC.

7. The Board’s Diversion Program — charged with monitoring substance-abusing physicians — is significantly flawed: Its most important monitoring mechanisms are failing,

it is chronically understaffed, and it exposes patients to unacceptable risks posed by physicians who abuse drugs and alcohol. The Monitor examined the Diversion Program’s most important monitoring mechanisms — random drug testing, case manager attendance at group meetings of participants, and regular reporting by worksite monitors and treating psychotherapists — and found that all were failing. Further, the Diversion Program — due in part to severe understaffing — failed to detect or address these critical failures. Participants in the Program were not drug-tested as often as they should be; they were not terminated from the Program even after repeated violations; and no standards exist to guide the functioning of “worksite monitors” who purportedly oversee Program participants when they practice medicine. The Monitor found that the Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held; the Medical Board has failed to adequately supervise the Program; and the Program improperly operates in a vacuum that prevents MBC management from detecting breakdowns in its functioning.

The Monitor called on the Medical Board to reevaluate whether the “diversion” concept is feasible, possible, and consistent with MBC’s “paramount” public protection priority. If the concept is deemed viable, the Monitor recommended that DMQ spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that have limited the Program’s effectiveness in assisting participant recovery and in protecting the public. This overhaul must include not only additional staffing for the Program but also the adoption and enforcement of standards and criteria to which both Program participants and staff are consistently held. Additionally, the Monitor recommended that MBC more fully integrate and incorporate Diversion Program management into overall Board and enforcement program management, and ensure that the *Diversion Program Manual* — which is so outdated that it has become obsolete — is completely rewritten. Finally, the Monitor recommended that the Diversion Program — if it is continued and once its problems are addressed — be required to undergo a full performance audit by the Bureau of State Audits.

2005 REFORM LEGISLATION ADDRESSING THE MONITOR’S RECOMMENDATIONS

Most of the Monitor’s *Initial Report* recommendations requiring legislation were amended into three bills considered by the California Legislature during 2005:

Senate Bill 231 (Figueroa). Most of the key recommendations contained in the Monitor’s *Initial Report* were incorporated into SB 231 (Figueroa), which was introduced on February 15, 2005, and was substantively amended five times before it was finally signed by the Governor on October 7 (Chapter 674, Statutes of 2005). As enacted, SB 231 contains a mix of provisions. Many of them directly implement the Monitor’s recommendations. Some of them only partially implement a Monitor recommendation; the compromise reflects the give-and-take of the political process as the bill moved through various committees and both houses of the Legislature and was ultimately

negotiated with the Schwarzenegger administration late in the process. Other provisions in SB 231 did not originate with the Monitor at all, but reflect the desires of MBC, the California Medical Association (CMA), or the Schwarzenegger administration.

As described in detail below, SB 231 (1) fundamentally restructures MBC/HQE investigations and prosecutions by implementing the vertical prosecution model, and paves the way for the prospective transfer of MBC's investigators to HQE after a transition period and legislative review in 2007; (2) enhances MBC's enforcement resources by increasing MBC licensing fees by 30%; (3) addresses excessive delays in the medical records procurement process by authorizing MBC to issue citations and fines for noncompliance with lawful MBC requests for medical records; (4) requires parties in MBC disciplinary proceedings to exchange expert witness opinion information prior to the evidentiary hearing; (5) improves MBC's ability to detect physician negligence and misconduct by enhancing several of its mandatory reporting requirements; (6) strengthens MBC's public disclosure policy and requires the Little Hoover Commission to study the effectiveness of MBC's public disclosure statutes and regulations; and (7) requests a thorough performance audit of MBC's Diversion Program and establishes a sunset date on which it will cease to exist if the Medical Board does not substantially improve it.

As MBC's "sunset bill," SB 231 also extends the existence of the Medical Board and its executive director position until July 1, 2010. Finally, although the Enforcement Monitor project ends on November 1, 2005, SB 231 requires a number of additional studies, hearings, and reports on various issues related to MBC's enforcement program. Chapter IV contains a chart outlining numerous post-Monitor activities related to MBC's enforcement program.

AB 446 (Negrete McLeod). In the *Initial Report*, the Monitor urged the Legislature to ban regulatory gag clauses — provisions included in civil settlement agreements that prohibit an injured victim from filing a complaint about the physician with MBC or otherwise cooperating with an MBC investigation, or requiring the victim to withdraw a complaint pending before MBC. AB 446 (Negrete McLeod), introduced during 2005, would have replicated a 20-year-old statutory precedent applicable to attorneys and banned the use of gag clauses by all DCA licensees — including physicians. Although AB 446 was fully supported by MBC and other agencies, the Governor vetoed the bill on September 29.

Senate Bill 1111 (Committee on Business, Professions and Economic Development), which was passed by the Legislature and signed by the Governor (Chapter 621, Statutes of 2005), is a technical clean-up bill that amends section 2230 to correctly reflect the number of members on DMQ's panels.

MBC'S ENFORCEMENT PROGRAM: THRESHOLD CONCERNS

In the *Initial Report*, the Monitor identified several threshold concerns about MBC's enforcement program. The following summarizes those concerns and documents the responses implemented by MBC, HQE, and the Legislature during 2005.

1. The enforcement process simply takes too long to protect the public. During 2003–04, the average length of time for a serious complaint to reach its disciplinary conclusion was 2.63 years. During 2004–05, MBC cut that overall average time slightly to 2.5 years, even without the addition of new monetary resources or staffing. Although MBC should be commended for its efforts, 2.5 years is excessive in light of the risk of irreparable harm posed by incompetent physicians, and the Board's investigative time still exceeds the 180-day goal established in section 2319.

2. MBC resources are inadequate. In the *Initial Report*, the Monitor noted that physician licensing fees — which support MBC's enforcement program — had not been increased since January 1994, working a 28% decrease in spending power since that time. In addition to the loss of budgetary resources, MBC's human resources were hit hard by staffing cuts required by the state's 2001–04 hiring freeze. In 2004, MBC estimated that it would need an increase in licensing fees from \$610 to \$800 biennially to support the reinstatement of lost enforcement positions and a restoration of service levels comparable to 1994; the Monitor agreed.

SB 231 increases MBC's initial and biennial renewal licensing fees to a base fee of \$790 (\$395 per year). At the request of CMA, the bill eliminates MBC's "cost recovery" authority under section 125.3 but requires this change to be "revenue neutral" to MBC. Thus, SB 231 permits MBC to increase licensing fees above the \$790 base to compensate for the loss of cost recovery revenue, and to cover any "uptick" in investigative and other enforcement costs that accompanies the elimination of cost recovery. SB 231 also permits MBC to increase licensing fees by an additional \$20 per biennial renewal period if its investigators are transferred to HQE after 2007.

SB 231's fee increase will enable the Board to restore fifteen investigator positions, six DAG positions, and MBC's Medical Director position — all of which were lost in the hiring freeze; implement vertical prosecution; augment the staffing of the chronically understaffed Diversion Program; maintain an adequate budget for the payment of qualified expert reviewers; restore lost medical consultant hours; and maintain a two-month reserve fund as required by law.

The resources battle is only halfway won. Armed with the fee increase, MBC and HQE must now submit budget change proposals (BCPs) to restore their lost positions and spend the new money in a way that not only restores 1994 service levels but significantly improves on them. The Monitor

urges the Department of Consumer Affairs, the Department of Finance, and other control agencies to approve these vitally important BCPs.

3. MBC and HQE's management structure and information systems need improvement. During 2005, MBC and HQE addressed several *Initial Report* concerns about MBC/HQE management structure and information systems:

■ ***Medical Director position.*** As noted above, MBC lost its Medical Director position in the hiring freeze, and the Monitor urged the Board to reinstate the position. MBC agreed, and can fund the new position with SB 231's fee increase. The Monitor urges the Administration to approve the reinstatement of this important position.

■ ***Diversions Program management.*** In the *Initial Report*, the Monitor observed that MBC has traditionally permitted its Diversion Program to effectively function in a vacuum, separate from overall MBC management. Because this separation resulted in breakdowns in key Diversion functions that pose a risk not only to the public but also to the physicians participating in the Program, the Monitor recommended that the administration of the Diversion Program be more fully integrated into MBC management. MBC has made progress on this issue. Since the issuance of the *Initial Report*, MBC management has hired a new program administrator who has strong enforcement and impairment program credentials, added a new case manager supervisor position to the Program, and expanded its vitally necessary Collection System Manager position into a full-time position. Additionally, MBC has created a new Diversion Committee and charged it with addressing longstanding policy issues that have plagued the Diversion Program.

■ ***Relationship between MBC and HQE.*** MBC's investigations and prosecutions are inefficiently fragmented between two agencies, whereas most other comparable law enforcement agencies employ both investigators and prosecutors who work together in "vertical prosecution" teams under the direction of the prosecutor to gather evidence, assess the strength of the case, and quickly close weak cases while focusing expedited attention on meritorious cases. SB 231 imposes the essential elements of vertical prosecution on MBC and HQE — early assignment of an attorney/investigator team, continuity of teamwork throughout the life of a case, and early designation of trial counsel under whose direction the investigation proceeds. While SB 231 did not succeed in transferring MBC's investigators into HQE for full implementation of vertical prosecution, it has set the stage for the transfer (including the funding), and the Monitor anticipates that transfer will occur in 2008 after completion of this transition period.

■ ***Enforcement policy/procedure manuals.*** In researching the *Initial Report* during 2004, the Monitor scoured a dozen MBC policy and procedure manuals, and found that several had not been updated to reflect 2002 legislative changes. MBC has made progress in this area as well. MBC

has revised its *Expert Reviewer Guidelines*, *Enforcement Program General Operations Manual*, *Enforcement Operations Manual*, *Central Complaint Unit Procedure Manual*, *Probation Operations Manual*, and *Investigation Activity Report Intranet Users' Guide*. MBC's *Citation and Fine Program Procedure Manual* was completely rewritten, and an overhaul of the *Diversion Program Manual* is under way.

■ **Management information systems.** Although MBC continues to struggle with DCA's "Consumer Affairs System" (CAS) mainframe computer program, it is fortunate to have an in-house Information Systems Branch (ISB) that is capable of designing new software to accommodate specialized programs. For example, after the release of the *Initial Report*, ISB revamped the Diversion Tracking System (DTS) into a Web-based real-time program that was operational by July 1, 2005.

HQE now has one year of experience with its new ProLaw case management system. HQE and its prosecutors appear to have mastered the case tracking system aspect of ProLaw in that all HQE attorneys (since July 14, 2004) now track their time and tasks performed on MBC cases on ProLaw. Additionally, HQE managers have begun to request and receive simple reports. However, HQE appears to have made less effective use of other important capabilities of this system. The Monitor recommends that HQE take full advantage of its new ProLaw system by learning its capabilities, adding a field that will identify "priority cases" under section 2220.05, ensuring that ProLaw's calculation function is activated, and ensuring the data needed to calculate desired averages or totals are properly input by HQE staff on all cases.

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

In the *Initial Report*, the Monitor identified several concerns about MBC's Central Complaint Unit, which receives and screens complaints and reports about physicians — both "quality of care" (QC) and "physician conduct" (PC) cases — to determine whether they merit formal investigation. The following summarizes those concerns and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. CCU's average complaint processing time is longer than historically reported. In the *Initial Report*, the Monitor noted that MBC had been counting as "complaints" several categories of information that should not be counted as complaints — including "notices of intent (NOI) to sue" under Code of Civil Procedure (CCP) section 364.1, copies of insurer reports of malpractice payouts sent to the National Practitioner Data Bank (NPDB), and "change of address citations." As a result, CCU's reported complaint total was artificially high and its reported average complaint processing time was artificially low. During 2003–04, MBC discontinued counting NOIs and NPDB reports as complaints; during 2004–05, MBC discontinued counting change of address citations as

complaints. Thus, MBC has fully implemented the Monitor's recommendations and is accurately reporting both its complaint/report intake and its average case cycle times. Related to this issue, the Monitor recommended that CCP section 364.1 be repealed, as these reports provide MBC with information that is of little or no use. Effective January 1, 2006, section 20 of SB 231 (Figueroa) repeals section 364.1.

2. CCU's complaint processing takes too long. During 2003–04, it took CCU an average of 79 days (2.63 months) from receipt of a complaint to its closure or referral to the field for investigation — 12 days longer than it took CCU to process complaints in 2002–03. During 2004–05, CCU lowered its overall average complaint processing time to 66 days (2.2 months) — an encouraging 16% decrease.

CCU also lowered the average time it takes to process QC complaints — which involve the request, receipt, and analysis of medical records — from 140 days in 2003–04 to 122 days in 2004–05, a 13% decrease. CCU accomplished this reduction by working with its assigned DAG to revise the *CCU Procedure Manual* to emphasize the statutory timeframes for production of requested medical records; CCU also revamped the request letters it sends to physicians and medical facilities to include a citation to the relevant statute, a copy of the statute, and a reference to possible penalties for noncompliance. CCU's focus on prompt medical records procurement has cut last year's average medical records procurement delay in QC cases from 66 days to 48 days.

Although the Monitor suggested an expansion of the role of the assigned CCU DAG, that was not achieved during 2004–05. HQE's staffing losses and overall workload required HQE, in May 2005, to return the assigned CCU DAG to its Sacramento office for accusation filing and trial work. HQE hopes to reinstate the DAG in CCU by January 1, 2006, and also hopes — with the fee increase in SB 231 — to assign a DAG full-time to CCU (or to assign two DAGs half-time to CCU) to assist with case disposition review, medical records procurement, and stubborn issues related to malpractice payout reporting by insurance companies and physician employers.

3. CCU's implementation of the specialty review requirement for QC complaints has caused a number of problems. In the *Initial Report*, the Monitor found that MBC's implementation of section 2220.08 — which requires CCU to ensure that QC complaints have been reviewed by a physician with expertise in the same specialty as the complained-of physician — was causing substantial delay in the processing of QC cases in certain specialties. The Monitor made three recommendations relating to specialty review, two of which were implemented during 2005. First, MBC has developed a protocol for utilizing a qualified alternative medical reviewer in some cases where a subspecialist cannot be found to review a complaint after a 30-day good faith search. Second, section 12 of SB 231 (Figueroa) exempts from the section 2220.08 specialty review requirement new complaints against physicians who are already under investigation, the subject of a pending accusation, or on probation.

MBC postponed consideration of the Monitor’s third recommendation — a statutory exemption from the specialty review requirement for cases where MBC is unable to locate a specialist after a good-faith 30-day search — based on representations by enforcement staff that CCU was developing the protocol described above, and that CCU had successfully recruited and trained a sufficient number of specialty reviewers such that the average time delay had declined significantly. However, new data indicate that the delay due to the specialty review requirement — an average of 45 days in 2003, sharply increasing to 67 days in 2004, and easing back to 53 days in 2005 to date — is still significant. MBC should continue to focus efforts on reducing the delay due to the specialty review requirement.

4. The codification of mandatory case processing priorities is resulting in unintended consequences. Section 2220.05 requires MBC to “prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously.” The statute says that complaints falling into one of five stated categories (coded “U1–U5” by MBC) — which attempt to capture physicians “representing the greatest threat of harm” — should be handled on a priority basis. Although no one quarrels with this sound goal, the *Initial Report* documented several unintended consequences related to this requirement, including overuse of the U1 priority; lower enforcement priority for cases posing imminent risk (such as complaints regarding sexual misconduct and drug/alcohol abuse), and very low priority for economic harm cases (such as fraud and deceptive business practices). Although the Monitor recommended a collaborative effort to redraft the language of section 2220.05 to address these issues, MBC’s Enforcement Committee deferred this issue for at least a year. In the meantime, the Committee directed staff to (1) gather data on the impact of section 2220.05; (2) develop a policy statement on staff’s interpretation and implementation of the statute; (3) attempt to define the statutory term “serious bodily injury”; and (4) recommend whether additional categories of priority cases should be added to the statute.

5. Many of MBC’s most important detection mechanisms are failing it. The *Initial Report* described several important “mandatory reporting requirements” intended to ensure that MBC is apprized of and can detect physician negligence, incompetence, dishonesty, and impairment so that it might investigate and take disciplinary action if appropriate. However, several of these detection mechanisms are failing the Board and the public.

■ **Malpractice Payouts.** Although sections 801 and 801.1 require insurance carriers and employers of physicians to notify the Board of malpractice payouts, many reports are not filed within the required 30-day time period, are incomplete, are useless to the Board (for example, many fail to identify the plaintiff in the malpractice action or the physician(s) whose conduct resulted in the payout), or are not filed at all. Further, MBC and HQE contend that malpractice action documents required to be forwarded to MBC under section 804 are often destroyed. In the *Initial Report*, the

Monitor noted that, unlike section 805 applicable to hospitals' reporting of peer review disciplinary actions against physicians, sections 801/801.1 contain no penalty whatsoever for failure to report, and recommended that they be amended to include substantial penalties for noncompliance.

This is one of the few Monitor recommendations requiring legislation that was neither addressed in SB 231 (Figueroa) nor meaningfully discussed by the Medical Board in the past year. The *Final Report* documents a 31% decrease in insurer/employer reporting of malpractice payouts to MBC over the past six years, and analyzes numerous examples of insurer/employer reports that are late, incomplete, or that blatantly violate the letter and/or the spirit of the reporting requirement. Both the Monitor and CCU staff have alerted MBC and HQE to this problem for over one year, but the loss of MBC enforcement staff, the recent absence of the assigned CCU DAG (although required by Government Code section 12529.5), and the separation of MBC and HQE have combined to contribute to the stalemate on this issue.

Insurer/employer failure or refusal to provide MBC with this statutorily-required information is a serious and undeniable problem which has been tolerated for too long by the Board and HQE. The Monitor recommends that MBC and HQE formulate a working group to (1) review the examples described in this report and other examples that can readily be produced by CCU staff; (2) review and draft revisions to the statutory language to close loopholes, identify mandated reporters at insurance companies and physician employers of all types, and add substantial penalties for noncompliance to sections 801, 801.1, and 803.2; and (3) sponsor legislation enacting those amendments.

■ **Coroner's Reports.** Although section 802.5 requires a coroner to file a report with MBC whenever the coroner "receives information" that a death may be the result of a physician's gross negligence or incompetence, MBC receives few coroner's reports — never more than 40 in a given year. In response to the Monitor's recommendation that MBC educate coroners about their reporting responsibilities, the Board's public information officer sent informational letters about section 802.5 to all coroners' offices. Additionally, MBC's enforcement chief made an hour-long presentation on MBC's enforcement program and the importance of compliance with section 802.5 at the annual meeting of the California State Coroners' Association.

■ **Physician Self-Reporting of Criminal Convictions.** Although many misdemeanor criminal convictions are "substantially related to the qualifications, functions, or duties" of a physician and are grounds for disciplinary action, section 802.1 limits physician self-reporting of criminal convictions to felonies. In response to the Monitor's recommendation that physicians be required to self-report misdemeanor criminal convictions to MBC, section 5 of SB 231 amends Business and Professions Code section 802.1 to require physicians to self-report misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a

physician. This self-reporting requirement will be triggered after MBC compiles, and the Legislature enacts, a list of such substantially related criminal convictions.

■ ***Court Clerk Reporting.*** Although section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC, few court clerks comply with these requirements. The Monitor recommended that DCA, on behalf of all of its agencies with mandatory reporting statutes, join with the Judicial Council to design an educational program for courtroom clerks to enhance their familiarity and compliance with these reporting requirements. During 2005, DCA's Public Affairs Office drafted an informative article regarding the various court clerk reporting requirements in the Business and Professions Code for publication in the Judicial Council's *Court News Online* electronic newsletter; additionally, DCA has created a "universal reporting form" that can be used by any court clerk to report criminal convictions and civil judgments against any DCA licensee to the Department. DCA is preparing to publish the article and post the reporting form on its Web site.

Related to the reporting of civil malpractice judgments, section 4 of SB 231 (Figueroa) amends section 802 to require physicians to self-report civil judgments in any amount to MBC.

■ ***Hospital Reporting of Adverse Peer Review Action.*** Although section 805 reporting by hospitals, health care facilities, and HMOs about internal disciplinary action taken against physicians is one of the most valuable source of complaints resulting in investigation, prosecution, and disciplinary action, it is the greatest area of failure. In 2003–04, MBC received only 157 section 805 reports — and fully one-third of those were for actions taken by hospitals against a physician's privileges *after* the Medical Board disciplined the physician's license. The data for 2004–05 are similar: Of the 110 section 805 reports received, 23 reported peer review actions taken after MBC had disciplined the license of the physician. In the *Initial Report*, the Monitor recommended that a comprehensive study of the peer review process mandated in a 2001 statute be funded and completed as soon as possible, so that section 805 might be amended to conform its reporting requirements to the actual conduct of peer review in California. Section 6 of SB 231 (Figueroa) amends section 805.2 to require MBC to contract with an external entity to conduct the study mandated in 2001 by July 31, 2007. Under SB 231, "[c]ompletion of the peer review study . . . shall be among the highest priorities of the Medical Board of California."

■ ***Regulatory Gag Clauses.*** In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians through the inclusion of "regulatory gag clauses" in civil settlement agreements. In the *Initial Report*, the Monitor recommended that regulatory gag clauses be statutorily banned for all regulated trades and professions — and particularly for physicians in light of the irreparable harm doctors can cause. During 2005, Assemblymember Gloria Negrete McLeod introduced the Monitor's

recommendation as AB 446. Although the Legislature passed AB 446, the Governor vetoed it on September 29. Unfortunately, this veto preserves a discredited practice and undermines the purpose of occupational licensing agencies — which is to protect future unsuspecting consumers who were not a party to the settlement.

6. The staffing allocations of CCU’s sections should be revisited. In the *Initial Report*, the Monitor noted that the staffing of CCU’s QC and PC sections was based on the projection that MBC would receive more QC cases than PC cases. Because the reverse is true, the Monitor suggested that CCU revisit its staffing allocations and cross-train analysts so that certain kinds of urgent PC complaints that warrant immediate attention (*e.g.*, complaints of sexual misconduct and drug/alcohol abuse) do not get lost in the massive caseloads handled by the one CCU analyst trained to handle such matters. CCU has implemented the Monitor’s recommendations by redirecting one analyst position from the QC Section to the PC Section, and by assigning that redirected analyst to urgent PC matters (such that two PC analysts now handle urgent PC complaints).

7. Detection of repeated negligent acts has improved, but could be enhanced. In the *Initial Report*, the Monitor noted that CCU had instituted a review process for QC complaints recommended for closure based on a “simple departure” finding. Under the review process, CCU determines whether the complained-of physician has been the subject of prior similar “simple departure” closures — such that the physician might be disciplined for repeated negligent acts under section 2234(c). The Monitor recommended that this review process be extended to PC cases as well, particularly cases alleging sexual misconduct or drug/alcohol abuse. During 2005, CCU implemented the Monitor’s recommendation.

8. CCU should ensure that subject physicians are notified when complaints are closed. In the *Initial Report*, the Monitor suggested that MBC ensure that subject physicians are notified when complaints are closed, and that its procedure manuals reflect this policy. CCU has implemented this recommendation.

9. CCU should regularly review and update its procedure manuals. In the *Initial Report*, the Monitor recommended that CCU ensure that its procedure manuals are regularly reviewed and revised to conform to changes in the law and MBC policy, and that HQE personnel are involved in these revisions. CCU has implemented the Monitor’s recommendation; during 2005, the Monitor received five sets of revisions to the *CCU Procedure Manual*.

FIELD INVESTIGATIONS: DISTRICT OFFICES

Through MBC district offices, investigators gather evidence concerning alleged violations, analyze that evidence with the assistance of MBC medical consultants and external expert witnesses,

and recommend whether the Board should institute disciplinary action. The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's investigative process, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. MBC investigations are plagued by delays and excessive case cycle times. The Medical Board has consistently failed to comply with section 2319's statutory goals for the investigative process, including an average of six months total time from receipt of complaints to completion of investigations (one year for complex matters). Even with MBC investigator caseloads at a near-record low of 19 cases per investigator, MBC remains unable to comply with the six-month and one-year processing goals. The average elapsed time for an MBC investigation during 2004–05 was 259 days, up from a similarly-calculated 243 days in 2002–03, and down slightly from the 2003–04 figure of 261 days. Over 26% of these investigations still take an average of twelve months or more.

The *Initial Report* documented the multiple personnel and process issues contributing to these long cycle times, including the general difficulty of MBC cases; reductions in district office staff; losses of other valuable resources (such as medical consultant time); chronic investigator recruitment and retention challenges; a changed case mix toward greater complexity; and increased use of defense counsel by physicians. As recommended by the Monitor, the Medical Board has addressed both resource/structural problems and process weaknesses in order to significantly reduce the stubbornly long case cycle times in MBC investigations. As described below, the internal reforms already undertaken by MBC are beginning to bear fruit. Coupling these efforts with the even greater changes to be wrought by SB 231 — most notably the 30% increase in fee revenues and the advent of the vertical prosecution system of case processing, there is reason for optimism that case processing will be speeded. But there is still much to be done before MBC case delays are reduced to the levels set by statute.

2. Attorney/investigator coordination and teamwork is inadequate. As documented in the *Initial Report*, MBC investigators in the present system typically function without true, close coordination with the trial prosecutor who will ultimately handle the case. This system of limited investigator/trial attorney teamwork and cooperation — the “hand-off prosecution model” — stands in sharp contrast to the “vertical prosecution model” (where investigators and attorneys work together as a team throughout the life of a case) widely used in complex white collar crime and regulatory matters by many state, federal, and local agencies. In the *Initial Report*, the Monitor recommended that MBC's investigators be transferred to HQE and suggested that MBC and HQE convert to the vertical prosecution model.

The implementation of a contemporary vertical prosecution system — bringing MBC investigators and HQE prosecutors together into investigation and trial teams — is a centerpiece of

SB 231 (Figueroa). As amended on August 30, SB 231 would have transferred the Medical Board's investigators into HQE to enable full implementation of the vertical prosecution model. Although that version of the bill was supported by MBC, HQE, CMA, Kaiser Permanente, defense attorneys whose practices concentrate on physician defense, seven former Medical Board presidents, one former Medical Board executive director, Governor Pete Wilson's Department of Consumer Affairs Director, and the Federation of State Medical Boards, the Schwarzenegger administration opposed the transfer of MBC's investigators to HQE. Thus, the final language of SB 231 implements vertical prosecution without the immediate transfer of investigative staff. However, the bill envisions legislative reconsideration of the transfer during 2007, and contains funding for full implementation of vertical prosecution including the transfer.

Specifically, SB 231 adds new section 12529.6 to the Government Code, which makes legislative findings that because of the critical importance of MBC's enforcement function, "using a vertical prosecution model . . . is in the best interests of the people of California." Section 12529.6(b) requires that, as of January 1, 2006, each MBC complaint that is referred for investigation be "simultaneously and jointly" referred to an investigator/prosecutor team (including the prosecutor who will ultimately file and try the case) which will handle the matter for its duration. Under the direction of the prosecutor, the investigator will gather evidence that enables the prosecutor to advise MBC whether and how to proceed with formal disciplinary proceedings. MBC must report to the Legislature on the progress of the vertical prosecution model mandated in SB 231 by July 1, 2007, and all of the newly added provisions relating to vertical prosecution sunset on July 1, 2008 — meaning that during 2007, the Legislature will have another opportunity to evaluate the feasibility of the transfer of MBC's investigators to HQE and enact legislation mandating it.

In the meantime, SB 231 prepares MBC and HQE for the eventual transfer of MBC's investigators to HQE and full implementation of the vertical prosecution model. It transfers the investigative function to HQE; redefines "MBC investigations" as "HQE investigations"; eliminates the "deputy in district office" (DIDO) program under which HQE has been required to place prosecutors onsite at MBC district offices to provide legal guidance to investigators — this program will be unnecessary when MBC investigators are transferred to HQE; and authorizes MBC to increase its licensing fees to cover the additional costs of transferring its investigators to HQE.

If fully and successfully implemented, SB 231 will work a comprehensive change in the entire process through which MBC and HQE develop and resolve these disciplinary cases. In anticipation of the January 1, 2006 start of the vertical prosecution system, MBC and HQE officials have met and begun to comprehensively plan its implementation. The Monitor urges MBC and HQE to make full use of their opportunity to prove the value of the team approach. By doing so, they will earn the full and final implementation of this advantageous system of investigation and prosecution.

3. Delays in medical records procurement are chronic. In the *Initial Report*, the Monitor identified the medical records procurement step as one of the lengthiest components of the screening and investigative process. In fiscal year 2003–04, the average timeframe from a request for records by MBC investigators to the receipt of all records was 74 days (or 2.5 months), despite the statutory 15-day timeframe in Business and Professions Code sections 2225 and 2225.5. Combining the district offices’ 74-day average with CCU’s average 66-day records-gathering period, medical records procurement at MBC during 2003–04 consumed an average of 140 days — or 77% of the 180-day goal in section 2319. The Monitor found that lengthy delays by physicians in complying with medical records requests were being tolerated by both MBC investigators and HQE prosecutors; and urged MBC and HQE to agree upon, implement, and strictly enforce a new medical records procurement policy.

In response, MBC management amended *Enforcement Operations Manual* section 6.14 in January 2005 to advise all sworn staff that a “zero tolerance” policy had been initiated and that Board staff would no longer tolerate delays by physicians or hospitals in producing medical records requested pursuant to section 2225.5. The manual sets new deadlines for MBC investigators to secure patient releases and serve requests for records in person; requires close tracking of deadlines for production; and mandates expedited follow-up where records are not produced on time. As a direct result of these policy changes (which were communicated to the physician community and defense bar by HQE), MBC’s 2004–05 average timeframe from a request for patient records by an MBC investigator to the receipt of those records was 44 days, down from 74 days in 2003–04 (a reduction of over 40%). Although this is significant improvement, the average timeframe is still more than twice the allowable statutory time period, so further reductions are important.

SB 231 (Figueroa) will assist in medical records procurement. The bill amends section 2225(d) to define the term “good cause” for delay and to extend the time within which physicians must produce requested medical records to 15 business days from the date of MBC’s request. Thereafter, SB 231 authorizes MBC to use its existing citation and fine authority to penalize physicians immediately when they fail to produce requested medical records within 15 business days and without good cause. SB 231 specifies that the citation and fine remedy is in addition to other remedies available to MBC.

4. Subject interview policies are inconsistent and ineffective. MBC investigators must conduct subject interviews as a key part of the district office investigative process. In the *Initial Report*, the Monitor found that — during 2003–04 — an average of 60 days elapsed between MBC’s request for an interview and the physician’s appearance or refusal to appear, and recommended that MBC and HQE agree upon and consistently enforce a new policy requiring prompt physician cooperation with interview requests and regular tape-recording of interviews. In January 2005, enforcement staff revised *Enforcement Operations Manual* section 6.2 to institute new subject

interview policies and deadlines. Implementation of these new policies has somewhat reduced the interview delay: In 2004–05, the average time between initial request and actual subject interview was 57 days; the average time between request and interview refusal was 49 days. These figures are down slightly from the overall average of 60 days in 2003–04. However, they still represent a large portion of the undesirable 259-day average investigative timeframe.

5. Medical consultant availability, training, and utilization are inadequate. In the *Initial Report*, the Monitor noted that the availability of medical consultants is central to the speed and quality of QC case processing at the district office level; however, MBC budget constraints caused a 15% reduction in available medical consultant hours agencywide during 2003–04. This reduction has meant that medical consultants are often unavailable for or are greatly delayed in reviewing expert opinions and participating in decisions to transmit cases. The Monitor urged MBC to expand and improve its medical consultant program. As noted above, SB 231 (Figueroa) increases initial and biennial renewal fees by 30%. MBC management staff plans to use some of these additional funds to increase medical consultant hours.

6. Expert witness availability and use are systemic weaknesses. In the *Initial Report*, the Monitor found that MBC investigations continue to be delayed by the unavailability of experts (particularly highly specialized ones), inadequate training provided to new experts, and inconsistent performance by experts. These concerns are addressed in detail below.

7. Ongoing training of investigators, medical consultants, and experts is inadequate. During recent years, MBC — which in the past had an exemplary training program — was forced to substantially reduce formal training for investigators, medical consultants, experts, and others, to accommodate pressing budgetary concerns. The Monitor recommended that MBC continue to pursue the resources necessary to reinstate and improve its sequential training programs for which the agency was justifiably recognized in previous years. During 2004–05, MBC management has maintained and modestly expanded its training regimen. However, full implementation of the Monitor’s training recommendations will require funds from the SB 231 budget augmentation. Especially worthy of consideration is the reinstatement of the senior-level training supervisor position which was a casualty of the 2001–04 budget cuts.

8. Coordination with state and local prosecutors is underutilized. Many of MBC’s peace officer investigators have substantial knowledge of the criminal and civil law enforcement options available to the agency as potential tools to address complaints against medical practitioners involving both quality of care and physician conduct issues. However, the *Initial Report* noted the concerns of state and local prosecutors over the need for greater early communication and consistent coordination between MBC investigators and state and local law enforcement agencies in cases where non-administrative enforcement tools (such as Penal Code section 23 orders or civil unfair

competition actions) may be appropriate. The Monitor recommended that MBC make every effort to improve cooperation and case referrals between its enforcement staff and state and local prosecutors. MBC management and staff have implemented the Monitor's recommendation by actively participating in conferences and consumer protection roundtable meetings conducted by the California District Attorneys Association's Consumer Protection Committee; working on interagency enforcement cases with local, state, and federal authorities; and reaching out to numerous allied investigative and prosecution agencies in a wide variety of settings.

9. Recruitment and retention problems exacerbate MBC personnel shortages. Compounding the loss of 19 sworn investigator positions during the 2001–04 hiring freeze, MBC continues to lose highly trained and experienced investigators and well-qualified applicants to other agencies because of disparities between MBC investigator salaries and those at other agencies hiring peace officers. The Monitor urged MBC to continue its efforts to reinstate its lost enforcement program positions and to upgrade the salaries of its investigators commensurate with the competition.

The fee increase in SB 231 (Figueroa) satisfies the essential pre-condition for the restoration of these necessary MBC investigator positions — which are central to the successful implementation of the vertical prosecution system now declared in state law to be in the best interests of the public. The proposal to restore MBC investigator positions represents not a net growth in state government but a return to the 2001 level of staffing previously found to be essential. However, MBC cannot return to this minimally necessary staffing level without the cooperation of the Department of Consumer Affairs, the State and Consumer Services Agency, and the Department of Finance, which must ultimately approve budgets or BCPs for the hiring of MBC staff and the reinstatement of lost positions. The Monitor urges all those with authority over the budget process to permit the Medical Board to use these earmarked special funds for the purposes for which they are intended, including the restoration of the MBC investigative positions lost in recent years.

The related problems of investigator recruitment and retention can ultimately be addressed by full implementation of the integrated vertical prosecution system envisioned in SB 231. Upon a showing of the success of the vertical prosecution system, and with the Legislature's affirmative approval after review of the 2007 report, the transfer of the MBC investigators to HQE will eventually result in special agent status for MBC's sworn personnel and a concomitant increase in pay and career recognition. Morale and productivity will be boosted, and MBC's ability to recruit and retain highly qualified investigators will be dramatically improved.

10. Procedural and training manuals must be updated continuously. The *Initial Report* expressed concern that MBC investigations and other enforcement processes were frequently guided by policy and procedure manuals that had not been consistently reviewed or approved by HQE —

MBC's legal counsel and enforcement partner. In addition, at least some of those manuals had not been adequately updated by MBC management and were, in at least a few cases, inaccurate as to Board policy. MBC has made progress in addressing this concern. The Board has continuously updated its *Enforcement Operations Manual* during this reporting period. Of equal significance, MBC has shared copies of its *Enforcement Operations Manual* with HQE management and supervisors for the first time in at least a decade, permitting an ongoing dialogue on enforcement policies and guidelines.

11. Investigators need full and easy access to law enforcement databases. The *Initial Report* noted that — due to budget woes — MBC investigators sometimes lack convenient access to law enforcement databases that are essential to modern police work. In response to the Monitor's recommendation that MBC improve investigator access to law enforcement information systems, the Board is exploring enhanced access to a number of databases. Some of these efforts and expenditures will become unnecessary following the proposed transfer of MBC investigators to HQE, where access to these systems is more readily available. This is one of the numerous efficiencies which would be realized by full integration of the MBC investigators and HQE prosecutors.

EXPERT REVIEWER PROGRAM

Through MBC's Expert Reviewer Program, the Board identifies and utilizes external physician experts to review evidence (including medical records) gathered in quality of care cases and opine whether the subject physician's conduct departed from applicable professional standards. The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's Expert Reviewer Program, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. Average expert reviewer times are excessive. Once an expert is chosen for a given QC case and has received the investigative file (including medical records and other documentary evidence), the expert is expected to review the materials, draft a memorandum in a specified format, and return the file within 30 days. In the *Initial Report*, however, the Monitor found that the average 2003–04 turnaround time for expert opinions was 69 days. According to recent data from the Expert Reviewer Program, the average turnaround time in 2004–05 was also 69 days — over two times MBC's goal.

This delay occurs because most California physicians who provide expert review services to MBC are actively practicing medicine, and must find time to provide services to MBC outside their busy practices. It may also occur because MBC is able to pay only \$100 per hour for records review and report preparation and \$200 per hour for testimony at hearings — while physicians who

testify for the defense or in civil malpractice proceedings are routinely paid \$500–\$750 per hour, depending on the specialty. Although MBC could never pay its experts the equivalent of what they earn in medical practice, a growing number of experts indicate that MBC should attempt to increase the hourly rates. If the fee increase in SB 231 can accommodate an increase in the hourly rate paid for records review and report preparation, MBC should consider it as it may assist in the recruitment of qualified experts — who are essential to the Board’s ability to prove a quality of care case — and may prompt experts to review cases in a more timely fashion.

2. There is a lack of qualified experts in many specialties, and the CCU specialty review requirement is siphoning off some experts who would otherwise review cases in the field. In the *Initial Report*, the Monitor noted that MBC lacks a sufficient number of experts in certain subspecialties, and that some of those experts are now being utilized by the Central Complaint Unit for the specialty review required by section 2220.08. The Monitor recommended that MBC undertake a vigorous recruitment effort and that — resources permitting — it should consider reinstating in-person training sessions for expert reviewers. During 2005, MBC enforcement staff implemented both of the Monitor’s recommendations. Staff engaged in a concerted effort to recruit expert reviewers through an *Action Report* article and through presentations to physician groups and organizations. Additionally, staff identified specialties and subspecialties in which MBC lacks a sufficient number of experts — including dermatology, neurosurgery (especially spine surgery), pediatric surgery, pediatric cardiology, and gastric bypass surgery — and has engaged in a targeted outreach effort to hospital administrators and individual physicians in these specialties. Finally, MBC and HQE staff reinstated in-person training sessions for expert reviewers which have been held in MBC district offices all over the state.

3. There is no requirement that expert testimony be reduced to writing and/or exchanged before the hearing. In the *Initial Report*, the Monitor explained that MBC requires its experts to reduce their expert opinions to writing, which written opinions are discoverable by the defense as soon as the accusation is filed. However, defense counsel frequently instruct their experts not to reduce their opinions to writing. Because of the Administrative Procedure Act’s limitations on discovery in administrative proceedings, the HQE DAG frequently has no idea of the substance of defense counsel’s expert opinion until that expert takes the stand at the evidentiary hearing. This practice results in the unfair “sandbagging” of the DAG at the hearing, and stifles the possibility of prehearing settlement. The Monitor urged that the Medical Practice Act be amended to provide that any party to a Medical Board enforcement matter that wishes to rely on expert testimony must reduce that testimony to writing and provide it to the other party well in advance of the hearing.

SB 231 (Figueroa) adds new section 2334 to the Business and Professions Code, which requires a party to a Medical Board disciplinary proceeding who wishes to rely on expert testimony to exchange certain information in writing with counsel for the other party: (1) a curriculum vitae

of the expert; (2) a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis; (3) a representation that the expert has agreed to testify at the hearing; and (4) a statement of the expert's hourly and daily fee for providing testimony. The exchange of this information must occur at least 30 days prior to the commencement of the administrative hearing or as ordered by the ALJ. OAH is authorized to adopt regulations to implement section 2334.

4. The expert reviewer handbook contained errors. In the *Initial Report*, the Monitor noted that MBC's *Expert Reviewer Manual* provided to the Monitor team in 2003 had not been revised to conform to the changes in 2002's SB 1950 (Figueroa) and contained several legal errors. That manual was revised and corrected in late 2004.

PROSECUTIONS: HEALTH QUALITY ENFORCEMENT SECTION

The Health Quality Enforcement Section of the Attorney General's Office houses the prosecutors who represent MBC in disciplinary actions against its licensees; they review investigations, prepare and file accusations and other pleadings, try cases at evidentiary hearings, and represent DMQ if its disciplinary decision is challenged. The following summarizes the Monitor's *Initial Report* findings about the performance of HQE, and documents the responses to those findings implemented by the Attorney General's Office, the Medical Board, and the Legislature during 2005.

1. HQE cycle times remain lengthy, including recent increases in the filing phase. Without increased staff or improved process efficiency, HQE continues to experience lengthy case processing times, notwithstanding the efforts of a group of experienced and hardworking DAGs and supervisors. MBC statistics for fiscal year 2004–05 reveal an average 116-day period between transmittal of the completed investigation by MBC and the filing of the accusation, up from 107 days last year and 60–70 days in 2001, before HQE staffing shortages took hold. The Monitor's primary recommendation to address long case cycle times and case efficiency concerns — the successful implementation of the vertical prosecution system, beginning January 1, 2006 — is discussed above in "Field Investigations."

2. HQE attorney staffing is insufficient to meet its statutory and operational requirements. Although Government Code section 12529(c) requires HQE to be "staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions," HQE's six offices suffered a 15% loss of attorney positions in the past four years, and no remedy has been forthcoming. HQE's staffing losses are now exacerbated by a number of vacancies in established attorney positions. In a September 2005 letter to Attorney General Bill Lockyer, Medical Board President Ronald Wender, M.D., directed attention

to the vacancies in HQE which are “causing delays in filing accusations and setting matters for hearing, and therefore, impacting public protection.” Dr. Wender urged the Attorney General to “move quickly to fill all vacant positions in this vital section of the Attorney General’s Office.” The Monitor fully endorses that recommendation, and adds that success in implementing vertical prosecution, and in reducing disciplinary delays generally, will almost certainly depend on filling vacant attorney positions and ending HQE understaffing. As noted above, SB 231 increases physician licensing fees by 30%, and a portion of those increased revenues has been earmarked for reinstatement of lost DAG positions. The Monitor urges relevant control agencies to approve the creation of these positions which are now vital to the success of vertical prosecution.

3. Attorney/investigator coordination and teamwork is inadequate. As described above, the traditional system linking HQE prosecutors with MBC investigators has been and still is characterized by inadequate coordination and teamwork. HQE prosecutors still generally receive “hand-off” cases which have been investigated and assembled by MBC investigators with little or no input from the HQE trial prosecutor who will handle the case. Most HQE prosecutors complain that they do not play a role in shaping the cases they receive or the investigative plans and strategies behind them, often resulting in last-minute changes of case direction, amended pleadings, and delays as cases are reinvestigated. Equally critical, HQE DAGs today frequently have little or no investigator assistance at the hearing itself. In the *Initial Report*, the Monitor called for a sweeping reform of the basic model of MBC and HQE disciplinary interaction with the implementation of the vertical prosecution system. The enactment of SB 231 (Figueroa), detailed above, mandates the implementation of the vertical prosecution model by January 1, 2006, and provides the mechanism for full integration of MBC’s investigators and supervising investigators into HQE by 2008 if the initial implementation is adjudged successful by the Legislature.

4. Attorney assistance is not used sufficiently in MBC’s medical records procurement process. The *Initial Report* expressed concern that HQE prosecutors seldom file subpoena enforcement actions or motions for sanctions for failure to produce medical records, contributing to the laxity in physician and institutional responses to MBC requests for medical records. The Monitor urged MBC and HQE to revise their medical records procurement and enforcement policies to ensure prompt compliance with records requests.

HQE management has embraced these recommendations, supported MBC’s policy of rigor with regard to records production, and encouraged its staff attorneys to make more frequent and aggressive use of existing sanctions and procedures to ensure records production. In March 2005, following MBC’s formulation of its vigorous new “zero tolerance” policy, HQE management sent letters to defense counsel and various professional organizations advising them of the Board’s new policy requiring adherence to sections 2225 and 2225.5. HQE staff has also responded with increased enforcement actions. Subpoena enforcement actions for medical records sought in fiscal

year 2003–04 totaled only four statewide; HQE increased this figure to nine in 2004–05. No motions for sanctions for failure to produce were brought by HQE attorneys in 2003–04; HQE staff filed three such motions in 2004–05. HQE’s high-visibility enforcement notices and increased case activity no doubt played a role in the reduction of average document production times in the MBC district offices from 74 days in 2003–04 to 44 days in 2004–05.

5. HQE and MBC make inadequate use of ISO/TRO powers and the Penal Code section 23 authority. The *Initial Report* called attention to the relatively modest use of legal tools available to MBC and HQE when a physician is an imminent danger to the public and continues to practice medicine. The use of important expedited proceedings — including interim suspension orders (ISOs), temporary restraining orders (TROs), and probation order proceedings under Penal Code section 23 — has declined in recent years. The Monitor recommended that MBC and HQE make more extensive use of these potent tools. In response to this recommendation, HQE stepped up its use of these proceedings. Motions for ISO/TRO increased to 40 in fiscal year 2004–05 — a 50% increase. Although the number of Penal Code section 23 probation orders sought decreased to nine (of which seven were successful), this decline was largely due to the new procedural requirements imposed by the appellate court decision in *Gray v. Superior Court*. The Monitor believes that early trial attorney involvement in the investigation — an integral part of the new vertical prosecution system under SB 231 — will result in increased use of these important tools for public safety.

6. Needed improvements in HQE case tracking and management information systems have begun and must be properly implemented. During the summer of 2004, HQE implemented the long-awaited ProLaw management information system. HQE supervisors report that the system works well for basic case tracking and management review. However, several desirable capabilities are not yet in place, including the ability to perform calculations of key data for management purposes (such as case cycle times and average caseloads), the ability to trace referrals to other prosecuting agencies, and a method of noting case priorities under section 2220.05. Further development of ProLaw should continue to be a priority for HQE.

7. HQE has no formal policy and procedure manual to ensure uniformity and assist in training. The *Initial Report* noted that HQE has no formal policy/procedure manual or operations manual in place to clearly reflect its functions and processes, leading to diverging policies, inconsistent practices, and a weakened training process. In response to the Monitor’s recommendation, HQE management began a process aimed at outlining and then drafting an HQE operations manual. However, the supervening enactment of SB 231 provides a tremendous opportunity to advance this project in the broader context of the vertical prosecution system — and the Monitor now recommends that MBC and HQE develop a joint operations manual implementing vertical prosecution. The Monitor believes the distribution of this joint manual would have

immediate practical and symbolic significance, and should be among the highest priority projects for HQE and MBC in the near term.

8. The current venue statute for adjudicative hearings results in substantial and unnecessary costs for HQE, OAH, MBC and — ultimately — disciplined physicians and the physician population generally. In the *Initial Report*, the Monitor found that Government Code section 11508 — which generally assigns the venue for administrative hearings to the judicial district in which the transaction in question occurred or where the respondent resides — has frequently required the costly scheduling of administrative hearings in cities in which HQE and OAH have no office or hearing facilities. The Monitor urged the amendment of section 11508 to require adjudicative hearings to be held in large cities in which HQE has offices and OAH has courtroom facilities. Section 22 of SB 231 amends Government Code section 11508(a) to require that MBC administrative hearings be held at the OAH facility closest to the location where the transaction occurred or the respondent resides. Defense concerns are fairly addressed, in that section 11508(c) retains the respondent’s ability to move for change of venue and the ALJ’s discretion to order a venue change. However, absent good cause to the contrary identified in writing by the ALJ, hearings must now take place in a facility maintained by OAH. This will significantly change the wasteful practice under prior section 11508 and yield a clear public benefit.

HEARINGS: MEDICAL QUALITY HEARING PANEL

The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state and local agency adjudicative hearings in a variety of areas. In 1993, a special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH; ALJs appointed to the MQHP are permitted to specialize in physician discipline matters. The law requires an MQHP ALJ to preside over MBC evidentiary hearings. In the *Initial Report*, the Monitor made no findings regarding OAH’s performance. However, the Monitor promised to look into the following issues.

1. OAH was impacted by the hiring freeze and budget cuts. In the *Initial Report*, the Monitor noted that OAH was not immune from the October 2001 hiring freeze or the subsequent position “sweeps” and budget cuts. OAH lost two ALJ positions and a number of support staff positions. Although these losses affected OAH as a whole, they did not directly impact the MQHP which provides services to MBC. The MQHP remains staffed with 13 line ALJs, which appears sufficient to handle MBC’s workload.

2. The time it takes to schedule and conduct evidentiary hearings is lengthy. In July 2004, OAH adopted a new policy requiring it to calendar hearings to start within 90 days of the date both parties are available; in no event will the first day of the hearing be scheduled more than 210

days from the date OAH receives the request for hearing. Despite this new policy, an average of 382 days elapsed between the filing of the accusation and the conclusion of the evidentiary hearing during 2004–05 (down from 448 days in 2003–04). Some of these hearings are one- or two-day matters; others should last days or weeks but — due to the schedules of the attorneys, respondent, and judge — must be conducted in non-contiguous blocks over the course of many months. It appears that the delay in scheduling and conducting MBC hearings is not due to a shortage of judges or bureaucratic limitations on OAH’s part; instead, the understaffing in HQE’s Los Angeles office (which normally files approximately 60% of all accusations in California) and the limited number of defense counsel who regularly defend physicians in MBC disciplinary matters account for much of the delay in scheduling and holding hearings. In OAH’s view, it has sufficient MQHP ALJs to hear cases more rapidly than they are being heard — but they can’t, due to a shortage of attorneys in HQE and the limited number of defense attorneys who handle MBC cases.

3. DMQ members perceive that MQHP ALJs are not following MBC disciplinary guidelines. During 2001–02 and 2002–03, DMQ nonadopted an unusually high number of proposed ALJ decisions: 25% in 2001–02 and 28% in 2002–03. However, the nonadoption rate declined to 16% in 2003–04, and further decreased to only 11% in 2004–05. According to the OAH director, DMQ nonadopts a larger percentage of proposed decisions than do other agencies, which generally nonadopt approximately 5% of proposed decisions. The reasons for this higher nonadoption rate are unclear. Although DMQ members have at times voiced concerns that ALJs do not follow the Board’s disciplinary guidelines when recommending discipline in physician cases, it is clear that DMQ agrees with the ALJs’ proposed decisions in the vast majority of cases.

4. Whether ALJs are receiving medical training as authorized by Government Code section 11371 is unclear. According to the OAH director, MQHP ALJs receive medical training in a variety of ways. In November 2004, the director convened a three-day annual statewide training session for OAH ALJs, and more than one-third of it related to medical issues (including participation and presentations by Medical Board staff). In addition, every month, every OAH office has a staff meeting which often includes a training component; some of those training components relate to Medical Board issues. Finally, MBC staff has visited all four OAH offices in the past year to engage in half-day training sessions with MQHP ALJs. While MBC staff members are prohibited from addressing issues raised in specific or ongoing cases, they provide valuable information on a list of topics of interest to MQHP ALJs.

5. ALJs rarely make use of their authority to call their own expert witnesses. Under Government Code section 11371(d), MQHP ALJs — if confronted with diametrically opposed expert witnesses paid by the parties — are authorized to call their own expert to the stand “to testify on the record about any matter relevant to a proceeding and subject to cross-examination by all

parties.” According to the OAH director, this procedure is rarely used, primarily because the judges depend on the parties to produce relevant expert testimony and generally feel comfortable relying on it. Further, if the judge were to select his/her own expert, the use of that expert would delay the proceeding by several additional months. For these reasons, this mechanism is seldom used.

6. Should ALJs be authorized to enforce administrative subpoenas? As noted throughout the *Initial Report*, medical records procurement and MBC/HQE’s tolerance of lengthy delays by physicians in producing requested medical records are serious issues confronting MBC and HQE. One time-consuming aspect of the existing process is that subpoena enforcement is available only in superior court. In the *Initial Report*, the Monitor suggested that some thought be given to authorizing MQHP ALJs to enforce subpoenas issued by MBC, as a means of expediting medical records procurement. While this is a possibility, enabling legislation would be required and it is not clear whether the MQHP is sufficiently staffed to undertake such a function. Hopefully, MBC’s new medical records procurement policy and SB 231’s expansion of the citation and fine sanction to noncompliance with lawful requests for records will substantially shorten the timeframe necessary for medical records procurement and obviate the need for subpoena enforcement proceedings by either superior courts or OAH ALJs.

DECISIONS: DIVISION OF MEDICAL QUALITY

MBC’s 14-member Division of Medical Quality is divided into two seven-member panels that review proposed ALJ decisions and stipulated settlements negotiated between MBC/HQE and respondent physicians. The following summarizes the Monitor’s *Initial Report* findings and concerns about DMQ review of proposed disciplinary dispositions, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. The added value of DMQ review of proposed decisions is unclear. In the *Initial Report*, the Monitor noted that, on three prior occasions, legislation has been attempted that would eliminate DMQ review of proposed decisions in favor of permitting the ALJ to make the final agency decision based on the agency’s disciplinary guidelines and subject to a petition for judicial review by either side. According to the Monitor, the prior attempts to eliminate DMQ review of proposed decisions were intended to achieve two goals: (1) streamline the decisionmaking process to expedite it for the benefit of both the respondent and the public; and (2) create a limited number of decisionmakers who have both (a) subject matter expertise and (b) independence from the profession — as opposed to the current time-consuming and expensive system where layer after layer after layer of decisionmakers are required to sequentially learn the details of a disciplinary matter.

The Monitor then examined the “qualifications” of the various decisionmakers in the existing process. The MQHP ALJ — a professional judge who is trained in the law and experienced in the

judicial process — is present at the evidentiary hearing, has seen and heard the witnesses, has received all the documentary evidence, and has heard the expert testimony submitted by both sides. The judge specializes in physician discipline matters and is familiar with the rules of procedure and evidence in administrative proceedings. Thus, the judge has both knowledge of the evidence and is independent of the profession. On the other hand, DMQ members are physicians and other professionals who meet once every three months for two days; they are generally not lawyers or judges, and may have no familiarity with the rules of evidence or administrative procedure. When DMQ members receive a proposed decision in the mail, that is all they have — they have no access to the transcript of the hearing or the evidence presented at the hearing. Unlike jurors in a civil or criminal trial, DMQ members are not present at the hearing. They have had no opportunity to observe the witnesses or judge their credibility and demeanor. They may not have any familiarity with the subject matter of the particular case; usually have no idea how similar cases have been decided in the past; and often hold the same license as the accused licensee — such that they may have (or may be perceived to have) empathy for or bias against their accused colleague. While DMQ physician members may have medical expertise in a particular specialty, it may not be relevant to the case at hand; in any event, DMQ is confined to the evidence in the record — including the expert testimony of physicians who practice in the same specialty as the accused, have thoroughly examined the evidence, and have been subject to cross-examination.

In the *Initial Report*, the Monitor questioned the value of DMQ review and noted that the cost of the current system — including time, money, and lost opportunity costs — seems to outweigh the system's output: the nonadoption of very few proposed decisions (only 7 out of 63 in 2004–05) and the rejection of very few stipulations (only 18 out of 223 in 2004–05). The Monitor recommended that DMQ engage in a public dialogue on the value and costs of DMQ review of proposed decisions.

At its April 22, 2005 meeting, the Board's Enforcement Committee commenced a very preliminary discussion of this issue. The Committee received a background paper from staff outlining possible options, and heard brief public comment on the matter. Finding that this issue does not appear to require urgent action, the Committee voted to defer this matter until 2006.

2. The consistency of DMQ decisionmaking is unclear. In the *Initial Report*, the Monitor noted that the fragmented structure of MBC's enforcement program makes it difficult to evaluate the consistency of decisionmaking at any point in the process, including DMQ review. Investigations are handled from eleven different MBC offices; they are funneled into one of six HQE offices and thereafter into one of four OAH offices. Decisionmaking occurs at each of these steps — decisions to close cases, to move them further in the process, to seek disciplinary action, to impose disciplinary action. DMQ decisionmaking is superimposed on all the decisionmaking that occurs below, and it is also plagued with fragmentation. DMQ is split into two panels, neither of which knows of the other's decisionmaking in similar cases. DMQ membership is constantly

shifting and changing. There is little or no *stare decisis* — the legal doctrine under which courts adhere to precedent (prior decisionmaking in similar cases) on questions of law in order to ensure certainty, consistency, and stability in the administration of justice — in administrative agency proceedings.

Compounding this problem of is DMQ's failure to utilize Government Code section 11425.60's "precedent decision" mechanism. Although this ten-year-old mechanism is intended to promote consistency in decisionmaking, encourage settlements, and avoid costly litigation, DMQ has made no use of it other than to discuss its existence at its July 2004 meeting. The Monitor suggested that DMQ more fully explore its "precedent decision" authority and begin to utilize it. In response to this recommendation, DMQ staff says it continuously reviews each final disciplinary decision to determine whether it may be appropriate for designation as a precedent decision.

3. The procedure used at DMQ oral arguments is flawed. When DMQ nonadopts a proposed decision, it is required to afford the parties an opportunity for oral argument before making its final decision. DMQ's oral argument proceedings are most unusual. The primary reason for a nonadoption is that DMQ is considering a harsher penalty than that recommended by the ALJ; thus, the respondent physician is turned into a petitioner. That respondent must be mystified when he arrives at the hearing to find that the Board is represented by its own counsel — HQE. In effect, the "client" hears argument from its own counsel, with which it frequently interacts and upon whom it depends for legal advice on a myriad of matters.

MBC regulations require an ALJ to preside over oral arguments, to ensure that someone legally trained is available to rule on evidentiary objections, require counsel and the respondent to stick to evidence that was admitted at the hearing, and control the proceeding. However, the ALJ presiding over oral argument cannot be the same ALJ who presided over the hearing and whose decision was nonadopted in the matter at issue; so the ALJ presiding at oral argument necessarily has little or no knowledge of the sometimes voluminous record in the underlying matter. The required presence of the ALJ adds more expense to this process, and interrupts the hearing schedule of that MQHP ALJ. The respondent must be given an opportunity to address DMQ; however, neither the statute nor the regulations require that the respondent be put under oath when he makes a statement or answers questions. Respondents sometimes stray from the record and/or the topic at hand, and are subject to objections. Well-meaning DMQ panel members often ask questions outside the record, and are subject to more objections.

To the outside observer, the entire DMQ review process seems fraught with (1) apparent conflict of interest; (2) delay in a context where delay may cause irreparable harm; (3) extraordinary expense to the Board, the respondent physician, and the physician population whose license fees support the Board's enforcement program; and (4) uncertainty and potential unfairness that can result

when non-judges with no assured knowledge of the evidence and who function under no defined standard of review are asked to second-guess the findings and conclusions of a professional judge in a profoundly significant legal proceeding. As noted above, the Monitor recommended that DMQ discuss the value of its review of proposed decisions (including the procedure it utilizes to review those matters), which was deferred during 2005.

Since the publication of the *Initial Report*, a superior court issued a decision illuminating the errors that can result from these unusual procedures designed to accommodate adjudicative decisionmaking by non-judges. In its decision, the court found that certain procedural aspects of the DMQ review process denied one physician a fair hearing, vacated DMQ's decision revoking that physician's license, and remanded the matter to the Division for further proceedings. The court took no position on the merits of the matter — that is, the court did not decide whether MBC sustained its burden of proof and/or whether the physician should be disciplined; neither does the Monitor. However, the court's ruling points out significant procedural flaws in the DMQ review process that have occurred because the prosecutorial and judicial functions are not sufficiently separated at the Medical Board, and because non-judges who have no assured familiarity with the evidence are permitted to assume the role of a judge in a momentous legal proceeding; those flaws could be avoided if the ALJ's decision were deemed final.

The Monitor again urges DMQ to meaningfully evaluate the value of its review of proposed ALJ decisions and stipulations, and of the procedure it utilizes to review those matters. The Monitor is aware that many Board members wish to retain their authority to review ALJ recommendations and make disciplinary decisions. However, this is not the universal model. The State Bar Board of Governors does not make disciplinary decisions. The Contractors State License Board does not make disciplinary decisions. If freed from having to spend excessive amounts of time on a function to which they are not necessarily well-suited, and to which others are better suited, MBC members may be able to make greater contributions to public protection by focusing on their important rulemaking, oversight, and general policymaking functions.

4. DMQ's procedures on motions for a stay in order to seek reconsideration appear unfair. In the *Initial Report*, the Monitor noted that either party may seek reconsideration of a DMQ decision, and that Government Code section 11521(a) permits either side to request a short stay of the effective date of the decision to enable counsel to prepare a motion for reconsideration. While MBC's *Discipline Coordination Unit Procedure Manual* is clear that a motion for reconsideration must be decided by a DMQ panel, it allows MBC enforcement staff to rule on a request for stay (and contains criteria to guide staff's decision whether to grant a stay). The Monitor agreed with defense counsel that this procedure — wherein an agent of MBC's executive director (technically the prosecutor in MBC enforcement actions) is able to make decisions affecting the final outcome of a disciplinary matter — appears one-sided and unfair, and recommended that DMQ address this

procedural issue. In response, MBC staff declined to end its role in ruling on motions for stay. Instead, it is in the process of amending its *Discipline Coordination Unit Procedure Manual* to amplify the criteria to guide staff's decision whether to grant the stay.

The Monitor disagrees with this approach. In the Monitor's view, this appears to be another example of the lack of sufficient separation between the prosecutorial and judicial functions at the Medical Board. As illustrated in the recent superior court decision discussed above, agents of the executive director/prosecutor should not even participate in judicial decisionmaking much less engage in it. A recently-adopted DMQ regulation permitting the submission of *amicus curiae* briefs in disciplinary cases requires two panel members to consider and rule on any request to submit an *amicus* brief. If panel members can rule on *amicus* requests within a tight timeframe, there is no reason they cannot similarly rule on requests for stays. The Monitor urges DMQ to properly address this issue and devise a method whereby a panel member is designated to rule on motions for stay.

5. DMQ does not notify both parties if it rejects a stipulated settlement. In the *Initial Report*, the Monitor noted complaints from defense counsel that DMQ does not always notify both counsel if it rejects a stipulation. In October 2005, MBC staff amended section 32 of the *Discipline Coordination Unit Procedure Manual* to require DMQ notice to both sides when it rejects a stipulated settlement.

JUDICIAL REVIEW OF DMQ DECISIONS

A physician whose license has been disciplined may seek judicial review of MBC's decision by filing a petition for writ of mandate in superior court under Code of Civil Procedure (CCP) section 1094.5. The following summarizes the Monitor's *Initial Report* findings and concerns about judicial review of DMQ disciplinary decisions, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. MBC's venue statute is encouraging "forum-shopping" and inefficient use of judicial resources, and is unnecessarily costing HQE and MBC substantial amounts of money each year. In the *Initial Report*, the Monitor noted that Business and Professions Code section 2019 governs venue for the filing of a petition of writ of mandate challenging a DMQ disciplinary decision. Under section 2019 (which is unique to MBC), a respondent unhappy with a DMQ disciplinary decision may file a petition for writ of mandate in San Diego, Los Angeles, Sacramento, or San Francisco — regardless of where the administrative hearing was held and regardless of where the HQE DAG who prosecuted the case works. This statute has led to apparent "forum-shopping" on the part of defense counsel in search of a sympathetic judge, and requires HQE to fly its DAGs all over the state for writ hearings. Additionally, this practice disrupts the efficient operation of the Attorney General's Office; unfairly overburdens one court funded by the taxpayers of a single

county, while other courts are relatively unused by MBC petitioners; and undermines the integrity of the process. The Monitor recommended that section 2019 be amended to require legal proceedings challenging DMQ decisions to be instituted in the large city closest to where the administrative proceeding was held. Until August 30, SB 231 contained an amendment to section 2019 that would have implemented the Monitor's recommendation. However, the amendment was opposed by CMA and various defense attorneys who represent physicians before MBC; they raised questions regarding the Monitor's "forum-shopping" conclusion. Because this matter warrants further discussion, the amendment was eventually dropped from the bill.

2. MBC is inappropriately subsidizing the cost of the preparation of administrative hearing transcripts for writ proceedings. When a licensee files a CCP section 1094.5 petition for writ of mandate challenging a DMQ disciplinary decision, that petitioner must request the record of the administrative proceeding from the Office of Adminstrating Hearings. Under section 1094.5, "[e]xcept when otherwise prescribed by statute, the cost of preparing the transcript shall be borne by petitioner." However, due to the interaction of CCP section 1094.5 and Government Code section 69950, the petitioner generally pays only about one-half of the actual cost of the preparation of the transcript, and MBC is billed for the rest. MBC's underwriting or cross-subsidization of the cost of the preparation of the record in writ of mandate proceedings — to the tune of thousands of dollars per transcript and many more thousands of dollars each year — is unnecessary and particularly inappropriate in light of its current financial plight. The Monitor recommended the amendment of section 11523 to require the petitioner to pay the entire cost of the transcript up front.

Section 23 of SB 231 amends Government Code section 11523 to require a petitioner to pay the full cost of hearing transcript preparation to OAH. The amendment preserves the petitioner's right to full reimbursement of this cost if the petitioner prevails in the writ proceeding, and does not affect the right of *in forma pauperis* (indigent) petitioners to a free copy of the transcript under Code of Civil Procedure section 1094.5 and Government Code section 68511.3.

PUBLIC DISCLOSURE

In addition to removing incompetent, negligent, dishonest, and impaired physicians from the marketplace through its enforcement program, another way in which MBC implements its "paramount" public protection priority is by disclosing licensee information to the public, to enable consumers to make informed choices when selecting a health care practitioner. MBC's disclosure of information about physicians is accomplished primarily through its Web site, which is statutorily required and closely governed by several state laws. The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's public disclosure policy and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. The fragmented tangle of overlapping statutes — including drafting errors and inconsistencies — frustrates the purpose of MBC’s Web site, unnecessarily exposes MBC to litigation, and results in the disclosure of different information depending on the mode of inquiry. In the *Initial Report*, the Monitor found that the purpose of MBC’s Web site — to provide the public with easy access to public information about California physicians — has been frustrated by the language of the statutes. As a result of the interaction of many statutory provisions, there are essentially four categories of “information” on physicians and three ways to obtain some (but not all) of it — and one receives different information depending on how and who one asks. In the *Initial Report*, the Monitor outlined several specific inconsistencies and apparent drafting errors in the statutes, and suggested that sections 2027 and 803.1 be consolidated and harmonized to achieve the laudable purposes behind MBC’s public disclosure statutes.

SB 231 corrects a drafting error in section 2027(a)(2), and now clearly authorizes MBC to post its own prior disciplinary actions. SB 231 also addresses the public disclosure issue more generally by requiring the Little Hoover Commission, an independent and respected watchdog agency, to “study and make recommendations on the role of public disclosure in the public protection mandate of the board. This study shall include, but not be limited to, whether the public is adequately informed about physician misconduct by the current laws and regulations providing for disclosure.” The study must be completed by July 1, 2008.

2. SB 1950’s civil settlement disclosure provision has had minimal effect. Prompted by a number of high-profile California cases and precedent in ten other states, section 803.1(b)(2)(A) — added by SB 1950 (Figueroa) in 2002 — authorized MBC to disclose multiple civil malpractice settlements over \$30,000 for the first time. However, the statute has had limited effect: Since the bill’s effective date of January 1, 2003 to August 10, 2005, the settlements of only eleven physicians have been disclosed on MBC’s Web site. In the *Initial Report*, the Monitor recommended that MBC be required to disclose on its Web site all medical malpractice settlements over \$30,000 with the disclaimer currently required in section 803.1(c). Rather than reviving this controversial issue so soon after SB 1950 was enacted, Senator Figueroa opted to delegate it to the neutral Little Hoover Commission (see above).

3. MBC is not authorized to disclose misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician. In the *Initial Report*, the Monitor noted that, while MBC discloses felony criminal convictions against physicians for an indefinite period, it discloses no misdemeanor criminal convictions no matter their number or seriousness — including misdemeanor convictions that were originally charged as straight felonies and/or “wobblers” but were pled down to misdemeanors. The Monitor echoed the Joint Legislative Sunset Review Committee, the Medical Board, and the Federation of State Medical Boards in calling for the required disclosure of misdemeanor criminal convictions that are substantially related to the qualifications, duties, and functions of a physician.

Section 11 of SB 231 requires MBC to post on its Web site all substantially related misdemeanor criminal convictions against physicians for ten years from the date of the conviction. This new disclosure requirement is not effective until MBC presents to the Legislature, and the Legislature enacts, a list of misdemeanor convictions that are “substantially related.” Thus, additional legislation is required, but MBC will soon be permitted to disclose additional criminal convictions that are relevant to consumers when choosing health care providers.

4. MBC is not disclosing all significant terms and conditions of probation on its Web site. Although state law requires MBC to post information about “probations” and “limitations” on its Web site, the *Initial Report* found that MBC does not consistently do so — due in part to limitations imposed by its CAS computer system. In response to the Monitor’s recommendation that MBC disclose all significant terms and conditions of public probation orders on its Web site, MBC added a new “enforcement public document search” feature to its Web site as of November 2004. Since then, the Board has posted almost 500 enforcement-related documents — including accusations, disciplinary decisions (including stipulations), public letters of reprimand, and citations — from September 2004 forward. These documents are now available in their entirety on MBC’s Web site. As additional resources and staffing become available, MBC will attempt to backload all public enforcement-related documents on its Web site; in the meantime, they are available upon request.

PUBLIC EDUCATION AND OUTREACH

Under the general direction of its Public Education Committee, MBC engages in outreach and public education to various stakeholders, including patients, licensees, mandated reporters, prospective expert reviewers, and the media. MBC’s enforcement program is responsible for communicating with complainants and subject physicians during complaint processing and investigations. The following summarizes the Monitor’s *Initial Report* findings and concerns about MBC’s public education efforts and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. Physicians are not required to provide patients with information about the existence of the Board and its disciplinary jurisdiction. In the *Initial Report*, the Monitor noted that many other regulatory agencies — including health care-related agencies — require their licensees to provide customers or clients with information about their licensing board, its regulatory authority, and its contact information. The Medical Board has never imposed a similar requirement on physicians. The Monitor suggested that MBC sponsor legislation requiring physicians to inform patients about the Medical Board’s existence, disciplinary jurisdiction, address, and toll-free complaint number. Neither MBC nor the Legislature took action on this recommendation during 2005. Although this is understandable due to the press of other higher-priority issues (including the

needed fee increase and the fundamental structural change to a vertical prosecution model), this issue should find its way onto the agendas of MBC and its Public Education Committee during 2006. Many California agencies manage their caseloads while still meeting their obligation to help the public seek redress of legitimate grievances. The Monitor believes that, as a matter of sound public policy, the Medical Board should likewise make better efforts to meet its obligation to assist victims of medical wrongdoing in understanding how to be involved with its enforcement program.

2. The Board does not communicate consistently with physicians during the complaint review and investigative process. In the *Initial Report*, the Monitor noted defense counsel complaints that MBC does not always contact subject physicians when complaints against them are closed, and found that its various policy and procedure manuals were inconsistent on this point. In response, MBC revised its *CCU Procedure Manual* and its *Enforcement Operations Manual* to require CCU and its district offices to notify a subject physician who has been contacted by CCU or field staff during complaint processing of the closure of that complaint.

3. MBC should communicate with local county medical societies about their obligations under Civil Code section 43.96. This provision requires medical societies, hospitals, and local government agencies that receive a written complaint against a physician to affirmatively notify the complainant that they have no jurisdiction over the physician's license, and that only MBC may discipline a physician's license. Further, the local entity must "provide to the complainant the address and toll-free telephone number" of the Board. The Monitor suggested that MBC periodically communicate with local county medical societies and remind them of their obligations under section 43.96. During March 2005, MBC's public information officer (PIO) checked the Web sites and/or otherwise contacted all 58 local county medical societies. According to MBC, all but two societies are in compliance with section 43.96. The PIO sent letters to those two societies setting forth the requirements of section 43.96.

MBC'S DIVERSION PROGRAM

The purpose of MBC's Diversion Program is to monitor substance-abusing physicians while they attempt to recover from the disease of addiction. Participants in the Diversion Program include physicians who voluntarily seek help ("self-referrals"), physicians who are referred by the Board's enforcement program during investigation of a complaint ("Board-referred"), and physicians who are ordered to participate by DMQ as a term of probation in a formal disciplinary order ("Board-ordered"). Overseen by a standing Diversion Committee composed of Board members, the Diversion Program is run by MBC employees and is advised by regional Diversion Evaluation Committees (DECs) and by the Liaison Committee to the Diversion Program. In the *Initial Report*, the Monitor — as did the Auditor General in a series of audits over twenty years ago — identified and documented numerous significant deficiencies in the functioning of the Diversion Program. The

following summarizes the Monitor's *Initial Report* findings and concerns about the Diversion Program and documents the responses to those findings implemented by MBC and the Legislature during 2005.

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are: (1) random urine screening requirements; (2) case manager attendance at required group therapy meetings; (3) required worksite monitoring; and (4) regular reporting to the Program by psychotherapists who are treating participants. In the *Initial Report*, the Monitor found — as did the Auditor General during the 1980s — that all of these monitoring mechanisms were failing the Program and the public, and that the Program lacked internal quality controls that would otherwise enable staff to detect these failures. Following is a brief summary of the Monitor's *Initial Report* findings about each of the Diversion Program's monitoring mechanisms.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means of monitoring participants' sobriety and detecting relapses. More than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major objective measure of participant compliance with the terms of the contract and with the Program's requirements. Although two levels of Program staff — specifically, the Program's regional case managers (CMs) and the Sacramento-based Collection System Manager (CSM), who establishes a random schedule for testing and is charged with overseeing the overall integrity of the system — were in a position to monitor participant compliance with the Program's urine collection requirements, neither were overseeing the system. Local urine collectors were essentially unsupervised and were free to adjust the random schedule to suit their convenience. They often unilaterally shifted collections to dates that could be anticipated by the participants, or skipped scheduled tests altogether and failed to make them up. These failures went undetected by Program staff. The Monitor found that many Diversion Program participants were tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there was a problem. In 60% of the case files reviewed by the Monitor, testing did not occur on the random dates generated by the CSM; when it occurred, it

occurred with frequency on dates that could be anticipated by the participant. In many cases, test results (including positive test results that indicate relapse) were not promptly communicated from the lab to the Program. When test results were received, they were sometimes appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there was a problem. The Monitor found numerous errors, gaps, and inconsistencies in the Program's recordkeeping on these physicians — recordkeeping that must be available, correct, and reliable in the event of a relapse.

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The *Diversion Program Manual* requires CMs to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants. CMs are required to report their group meeting attendance in monthly reports to the program administrator. However, the Monitor — like the Auditor General in the 1980s — found that few case managers filed monthly reports as required, so there was no documentation as to whether they had attended group meetings as required by Program policy.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are “monitored” by non-impaired physicians. However, since its inception, the Program has set forth no workable definition of the duties, qualifications, or expectations of a “worksite monitor.” No statute, regulation, or procedure manual contains a definition of or standards for a “worksite monitor,” or even requires the monitor to be a physician. The Monitor also found that people functioning as worksite monitors were not consistently filing quarterly reports as required by the Program. Yet DEC's were recommending that participants be permitted to increase their work hours or resume full-time practice notwithstanding the absence of worksite monitor reports.

(4) Treating psychotherapist reporting is deficient. The Diversion Program also assures the public that impaired physicians are monitored by treating psychotherapists who are required to file quarterly written reports with the Program. However, this monitoring requirement was not being satisfied. Neither the case managers, the program administrator, nor the DEC's (which annually review all Program participants) were ensuring that quarterly psychotherapist reports were filed.

b. The Program is so understaffed that staff could not correct the failures in its monitoring mechanisms even if they knew about them. In the *Initial Report*, the Monitor found significant understaffing of the Diversion Program at all levels: program management, case management, and analytical/clerical support staff. The Monitor recommended that — if the Medical Board chooses to continue administering the Diversion Program — DMQ must spearhead a comprehensive overhaul of the Program to correct longstanding deficiencies that limit the Program's effectiveness. This overhaul must include an influx of additional staff if the Program is to adequately

monitor its participants. However, the Monitor emphasized that the mere addition of staff alone will not solve the Diversion Program's problems. In addition, the Program must install and staff sufficient and significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. Finally, any restructuring of the Diversion Program must include the resolution of significant and longstanding policy issues by the Diversion Committee and DMQ.

To address fundamental flaws in the Program's monitoring mechanisms, MBC Executive Director Dave Thornton — who personally stepped in and served as Acting Diversion Program Administrator from August 2004 through February 2005 — announced in January 2005 his intent to “deconstruct and reconstruct” the Diversion Program, and has taken several initial steps toward that goal. The following improvements have occurred since the release of the *Initial Report*:

■ ***Diversion Program staffing.*** Effective February 17, 2005, MBC hired a new Diversion Program Administrator who has significant experience in both enforcement and in impairment programs. On February 8, 2005, MBC added a new management position to the Diversion Program — a supervisor for the case managers. Under the direction of the new program administrator and CM supervisor, the case managers have been moved out of their former home offices and now work from Medical Board district offices. Significantly, on March 1, 2005, the Program formally expanded its existing Collection System Manager position to a full-time position devoted almost entirely to overseeing the operations and integrity of the Program's urine collection system; additionally, another Program analyst has been cross-trained to handle CSM duties when the CSM is on vacation or otherwise out of the office. Finally, MBC has submitted a BCP for additional Diversion Program case managers and the conversion of a seasonal clerical position to a permanent position. The additional CM positions are of particular importance; if approved, average CM caseloads will decrease from over 50 cases to approximately 40 cases each — and should enable CMs to adequately monitor participants and greatly improve the public protection afforded by the Diversion Program. Funding for these positions was included in the Board's calculation of the fee increase in SB 231 (Figueroa) — now passed by the Legislature and signed by the Governor. The Monitor urges all applicable control agencies to approve the creation of these new positions for the Diversion Program.

■ ***Improvements to the Program's urine testing system.*** As noted above, the Medical Board has finally devoted a full-time analyst position to the Diversion Program's critical CSM function. The new CSM is in the process of rebuilding the Program's urine collection system from the ground up, and has instituted policies and procedures to ensure that: (1) all active participants are included in the master collection schedule maintained by the CSM; (2) each participant is scheduled for the required number of tests, per the Diversion Program's “frequency of testing” policy; (3) collections are actually completed on the random dates assigned by the CSM; (4) the same number of collections

is completed as is scheduled for each participant; (5) collected specimens are received at and processed by the laboratory; and (6) test results are correctly downloaded and appended to each participant's record in the DTS.

In late 2004, MBC management commissioned the Board's Information Systems Branch (ISB) to create a new DTS to electronically track data (including all results of urine tests) on all Diversion Program participants. ISB created a new system that was up and running as of July 1, 2005; the DTS is now a Web-based real-time system that is accessible to Program case managers at MBC district offices.

■ ***Case manager attendance at group meetings.*** The new case manager supervisor now requires and reviews monthly reports filed by case managers that document their compliance with the Program's policy of CM attendance at each group meeting in their region at least once monthly. Most CMs are able to comply with that requirement now.

■ ***Worksite monitoring standards and reporting.*** Under the supervision of the new case manager supervisor, CMs are now beginning to address issues related to the timely filing of quarterly worksite monitor reports. Program staff is working with ISB to develop a program whereby a list of participants who are not in compliance with the worksite monitor requirement is generated. Although worksite monitor reporting has improved, the Diversion Committee has yet to flesh out required qualifications for worksite monitors and the parameters of worksite monitoring.

■ ***Treating psychotherapist reporting.*** Under the supervision of the new case manager supervisor, CMs are also beginning to address issues related to the timely filing of quarterly treating psychotherapist reports.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held. In the *Initial Report*, the Monitor found that the Diversion Program is plagued by an almost complete lack of enforceable rules, standards, or expectations to which participants or staff are consistently held. The Diversion Program's statutes and regulations are skeletal at best. None of the monitoring mechanism described above are even mentioned in, much less governed by, statute or regulation. All of the monitoring mechanisms and other Program "rules" and "policies" are contained in an unenforceable "procedure manual" that has not been updated since 1998 and is effectively obsolete. Despite statutory requirements to the contrary, the Program has no meaningful criteria for admission to the Program or termination from the Program. It has no clear standards regarding consequences for or response to relapse. In the *Initial Report*, the Monitor recommended that DMQ adopt meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse. The Monitor also suggested that DMQ establish enforceable standards and consistent expectations

of Diversion Program participants and staff through legislation or the rulemaking process, and oversee a complete revision of the *Diversion Program Manual*. Program staff has commenced an overhaul of the *Diversion Program Manual*—that project is under way. During 2006, the Diversion Committee and DMQ must address the fundamental policy issues identified by the Monitor.

SB 231 did not amend substantive law governing the Diversion Program. However, the bill sunsets the whole program effective July 1, 2008, thus requiring the Legislature to pass and the Governor to sign extension legislation in 2007. For inclusion in that extension legislation, the Diversion Committee and DMQ should submit any substantive policies they have developed—for example, meaningful criteria for termination from the Program; and/or a Penal Code section 1000-type mechanism applicable to Board-ordered and Board-referred participants, which may excise repeat offenders from the Program and result in the revocation of their license without further procedure.

3. Contrary to statute, the Division of Medical Quality has never taken “ownership” of or responsibility for the Diversion Program. State law requires DMQ to administer the Diversion Program and oversee its functioning. However, both the Auditor General in the 1980s and the Monitor in 2004 found that the Division has failed to adequately supervise and oversee the Diversion Program. One reason for DMQ’s failure to adequately oversee the Diversion Program lies in MBC’s 1982 creation of the “Liaison Committee to the Diversion Program” (LCD)—a committee which has no statutory existence or authority but was formed and funded by the California Medical Association, the California Society of Addiction Medicine, and (recently) the California Psychiatric Association. Although the LCD was intended to be an advisory body that could offer clinical expertise on addiction issues to DMQ and MBC staff who administer the Diversion Program, over the years it has been delegated responsibility for or has inserted itself into operational, legal, and other issues that do not require clinical expertise. The Monitor recommended that DMQ abolish the Liaison Committee as it currently exists; determine whether there is a need for external clinical expertise; and—if so—convert the Liaison Committee into a workable advisory panel that both serves the needs of DMQ (as determined by DMQ) and makes the very best use of the skills, expertise, and time of Liaison Committee members.

In response, MBC President Ronald Wender, M.D., has appointed a new Diversion Committee headed by DMQ member Martin Greenberg, Ph.D. Dr. Greenberg and the Committee are actively reconsidering the purpose and role of the Liaison Committee, and ways in which volunteer addiction professionals can best provide input to the Program on issues that require clinical expertise.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC

management. For many years, the Medical Board — both the Board and its staff — permitted the Diversion Program to effectively function in a vacuum. In the Monitor’s view, this separation resulted in the breakdowns in overall Diversion Program functioning and in the key monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which were not communicated to MBC management so they might be addressed. The Monitor recommended that MBC more effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management — especially concerning Board-ordered and Board-referred participants who are participating in Diversion in lieu of being disciplined.

MBC has responded to this recommendation positively by hiring a new program administrator who has extensive experience in both enforcement and impairment programs. Both the new program administrator and the new case manager supervisor have been actively interacting with MBC’s enforcement program and its probation monitors with respect to Board-ordered and Board-referred participants. As described above, the program administrator has moved the Diversion Program’s case managers from their home offices into Medical Board district offices. The CMs now function from MBC offices, where they can access the DTS and interact with MBC investigators. Finally, the Diversion Program is actively working to revamp the obsolete *Diversion Program Manual* — a key management function that was ignored for many years.

5. The Program’s claim of a “74% success rate” is misleading. In the *Initial Report*, the Monitor noted that the Diversion Program periodically calculates and advertises a “success rate” which — in the Monitor’s view — is misleading. The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Program has no idea whether it is successful in rehabilitating physicians over the long term. At the very least, such a “success rate” claim should not be made without fully explaining its meaning.

The current management and staff of the Diversion Program have ceased making a “success rate” claim. Although no concrete plans have been developed, staff is discussing the possibility of arranging for an external long-term study of both “successfully terminated” and “unsuccessfully terminated” Diversion Program participants in an attempt to determine whether the Program is effective in assisting physicians to recover from addiction. Such an assessment would provide invaluable information and enable informed decisionmaking to guide future Diversion program structure and operations.

OTHER AREAS OF MONITOR INQUIRY

During the first year of the MBC Enforcement Monitor project, the Monitor was unable to examine several components of MBC's enforcement program that deserve mention.

Citation and Fine Program. Business and Professions Code section 125.9 authorizes MBC to implement, by regulation, a system for the issuance of citations, fines, and orders of abatement for minor or technical violations of the Medical Practice Act or the Board's regulations. In 1994, MBC implemented its citation and fine authority by adopting section 1364.10 *et seq.*, Title 16 of the California Code of Regulations. Section 1364.10 permits various board officials to determine when and against whom a citation should be issued, and to issue citations including orders of abatement and fines. Section 1364.11 identifies statutory and regulatory provisions whose violation may justify the issuance of a citation, fine, and/or order of abatement. Section 1364.14 sets forth the procedure for challenging a citation. A cited licensee may request, within ten days after service of the citation, an informal conference with the board official who issued the citation. At the conclusion of the informal conference, the board official may affirm, modify, or dismiss the citation, including any fine levied or order of abatement issued. Thus, the Board's implementation of section 125.9 affords the licensee four levels of procedural due process protection — informal conference, ALJ hearing, DMQ review of ALJ decision, and court review of DMQ's decision — both as to sanction generally and as to the degree of sanction.

In 2004, MBC's handling of citation and fine cases changed significantly — largely as a result of the assignment of a deputy attorney general and a supervising investigator to the Central Complaint Unit; these individuals examined MBC's citation and fine program and prompted several important policy changes that have since been codified in MBC's various procedure manuals. Whether a citation case arises in CCU or in a district office during investigation, MBC's procedure manuals now clarify that a citation will not be issued unless staff has first contacted the subject physician for information, an explanation, and an attempted resolution. Further, citation cases are now subject to review by a supervising investigator and an HQE attorney to determine whether the file includes sufficient evidence of the violation (including documentation of MBC's written contact with the physician and the physician's response, if any).

MBC's recent citation and fine activity indicates a significant decline in the number of citations and fines issued in recent years. MBC insists that it is utilizing the citation and fine remedy judiciously, and mostly in an attempt to educate physicians about their legal responsibilities and encourage compliance with the law. The numbers appear consistent with this claim. The vast majority of citations issued over past three years are citations (with no fines) for failure to notify the Board of a change of address. Many (if not most) citations are withdrawn when compliance is achieved. During 2004–05, CCU issued 59 advisory and educational letters (40 of which were in

quality of care cases) to physicians in lieu of citations and fines — which accounts (in part) for the dramatic decrease in the number of citations issued in 2004–05.

Citations are not considered “disciplinary actions” because they have not been issued by the Division of Medical Quality. However, citations are public information, and are required to be posted on MBC’s Web site. In May 2004, CMA questioned the fairness of MBC’s posting of the citations on its Web site upon “issuance,” before the physician has had an opportunity to request and participate in the informal conference and the “full due process hearing” before the ALJ. The Monitor is informed that MBC representatives met with CMA in March 2005 and offered to institute a procedure whereby MBC will formally notify all physicians ten days in advance of “issuance” and posting that they are about to be cited — in a last attempt to elicit information and cooperation from the physician; according to MBC, CMA has not responded to that offer. The Monitor finds that offer reasonable and is not prepared to recommend other changes in MBC’s practice regarding the posting of citations upon their “issuance.”

MBC’s Probation Unit. Business and Professions Code sections 2227(a)(3) and 2228 authorize DMQ to place the license of a physician on probation subject to specified terms and conditions. In its 2003 disciplinary guidelines, DMQ has identified approximately 35 standard and optional terms and conditions of probation that it may include in a disciplinary order depending on the circumstances of the case. Through probation, DMQ may restrict a license or condition continued practice on fulfillment of a condition; require a physician to take and pass coursework or examinations; and/or require participation in the Physician Assessment and Clinical Education (PACE) program (see below).

Since 1992, MBC has maintained a centralized Probation Unit whose purpose is to protect the public by ensuring that any physician whose license has been placed on probation complies with the terms and conditions imposed in the probationary order. The Unit’s investigators monitor an assigned caseload of probationers to ensure that imposed probationary terms and conditions are met; additionally, they investigate new complaints filed against one of their assigned probationers. When a physician’s license is put on probation, the assigned probation investigator conducts an intake interview with the physician to secure his signature on various acknowledgment forms and to explain each term and condition of probation to ensure that the physician understands DMQ’s expectations. Thereafter, the probation investigator is expected to meet with the probationer at least quarterly; these visits may be scheduled or unannounced. Probation investigators may also meet with any required practice monitor of the probationer, and must generally ensure that the probationer is fulfilling all required terms and conditions of the probationary order.

Recent Probation Unit data indicate that, at any given time during the past four fiscal years, the Probation Unit has monitored approximately 526 probationers. Probation investigators carry an

average caseload of 40 probationers, plus an additional five investigations of new complaints filed against existing probationers; these high caseloads sometimes preclude quarterly in-person meetings between probationer and probation investigator. Collectively, the Probation Unit refers an average of 26 probation violations to HQE, and HQE files an average of 23 petitions to revoke probation every year. According to MBC, HQE DAGs have traditionally been hesitant to file petitions to revoke probation for relatively minor noncompliance with probationary terms; however, MBC has had no other remedy to address that noncompliance. To fill that loophole, MBC is in the process of amending its citation and fine regulations to authorize it to utilize that sanction to address probation violations that do not warrant a petition to revoke probation.

Physician Assessment and Clinical Education Program (PACE). When inserted into a formal disciplinary order, optional condition #19 of DMQ’s disciplinary guidelines requires a respondent physician to “enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education (PACE) Program at the University of California San Diego School of Medicine.” Founded in 1996 by UCSD Professor William A. Norcross, M.D., PACE offers a relatively unique service — it provides clinical competency assessment for physicians and delivers remedial education for detected deficiencies in the core clinical competency areas identified by the American Council on Graduate Medical Education. Although the PACE staff is small, it can call upon the full resources of the UCSD School of Medicine to assist in the assessment, evaluation, and remedial education of program participants.

Currently, the basic PACE program consists of Phase I (a comprehensive assessment of the physician participant and his/her clinical skills) and Phase II (a five-day clinical education program onsite at the UCSD Medical Center). While PACE participants do not have direct responsibility for patient care, they are integrated into the full spectrum of specialty-specific educational opportunities offered at a busy teaching hospital, including outpatient clinics, inpatient ward rounds, grand rounds and other conferences, and observation of procedures. To the greatest extent possible, PACE customizes Phase II to the results of the Phase I assessment, the perceived deficiency which has resulted in the physician’s referral to PACE, and the instructions of DMQ. At the conclusion of Phase II, a PACE faculty member prepares a report on the participant’s performance, which is reviewed by a multidisciplinary group. Thereafter, PACE submits a detailed report to DMQ which indicates whether the physician has successfully completed the program, as required by the DMQ probation order. Most physicians who have enrolled in PACE have successfully passed the program.

Over the past nine years, PACE has modified its basic assessment and clinical education program significantly, and has added new programs that can occur subsequent to completion of Phases I and II. PACE has also developed and offers numerous courses that are often required by DMQ as a condition of probation. Finally, PACE is working with MBC and HQE on the creation of a program to assess and remediate surgical skills.

MBC, its licensees, and California patients are fortunate that MBC has ready access to the professionals at PACE and the assessment and education programs that PACE has developed in its nine-year existence. Although optional condition #19 of MBC's disciplinary guidelines allows a physician to complete PACE or an "equivalent" clinical assessment and education program, not all such programs are created equal. DMQ should ensure that any alternative program claiming to be "equivalent" administers the same assessment techniques, demands the same remedial education, and is as responsive to DMQ as PACE has been.

CONCLUSION AND RECOMMENDATIONS FOR THE FUTURE

During the pendency of the Enforcement Monitor project, major reform of MBC's enforcement program has successfully begun and significant improvements in the efficiency of the Board's disciplinary system are being achieved as the result of the collaborative efforts of a broad coalition of stakeholders. The long-term prospects for further improvement are excellent.

The Medical Board and the Health Quality Enforcement Section of the Attorney General's Office have embraced most of the Monitor's 65 recommendations for reform, and the initial results are praiseworthy. Through the combined efforts of the Medical Board, its staff, HQE management and staff, the Legislature, and many others, the following improvements have been realized:

- MBC will soon benefit from a 30% increase in operating revenues to dramatically boost enforcement program resources.
- The vertical prosecution system, the modern paradigm for complex regulatory casework of this kind, will be employed by MBC and HQE staff working together in case teams, starting January 1, 2006.
- MBC's processes for gathering medical records and obtaining physician interviews have been streamlined and strengthened, and key indicators of delay are already on the decline.
- Timely exchange of expert opinions in MBC administrative actions will soon be the rule, increasing informed case evaluation and earlier case disposition.
- Operations manuals and training efforts have been extensively updated and enhanced.
- The Central Complaint Unit's structure and process have been improved, and relevant complaint processing times have dropped by 16% already.

■ The Board's Diversion Program has undergone a dramatic change of direction with the intent of "reconstructing" the program to better protect the public, and significant operational improvements have been implemented despite continuing resource shortages.

■ The long-overdue study of the peer review process will soon commence, and hopefully lead to amendments to section 805 that improve MBC's ability to detect physician incompetence and misconduct.

■ MBC's program of public disclosure of physician information to improve informed consumer choice has been upgraded and will now be reevaluated by a respected oversight agency.

The matrix included in Chapter XVII, which summarizes the status of the Monitor's 65 recommendations, demonstrates that MBC, HQE, and the Legislature have implemented (in whole or in part) or will soon implement 50 of the Monitor's 65 recommendations, and others are under active consideration. The Monitor applauds the commitment to improvement and the gratifying efforts to bring about that change by the Medical Board, HQE, the Legislature, and many other stakeholders. However, a great deal of work remains before the Medical Board's enforcement program fulfills its potential as a model of public protection. The *Final Report* contains a number of recommendations for future action, including the following:

- Full and immediate access to the new enforcement program resources from SB 231.
- Full and effective implementation of the vertical prosecution system, ultimately resulting in the transfer of MBC's investigators to HQE after 2007, including the prompt development of operating protocols and implementation of the case team process; rapid retraining of MBC and HQE staff in the new procedures; a jointly-developed operations manual for MBC and HQE staff; and expanded use of ProLaw by HQE and the earliest feasible shift-over to the ProLaw system by MBC.
- Continued enforcement of the vigorous new "zero tolerance" policies on medical records procurement and investigative interviews.
- Greater use of expedited disciplinary tools, including ISO/TRO powers, Penal Code section 23 authority, and subpoena enforcement.
- Full staffing of HQE, as required by Government Code section 12529(c), and increased HQE assistance for CCU, as required by Government Code section 12529.5(b).
- Improved insurer/employer reporting of malpractice payouts.

- Increased hourly rates for records review and report preparation by expert reviewers.
- Evaluation of the costs and benefits of DMQ review of proposed case dispositions.
- New DMQ procedure on requests for stay.
- Development of the required list of disclosable “substantially related” misdemeanor criminal convictions.
- Required notice to consumers regarding the Board’s existence and disciplinary jurisdiction.
- Full resolution of longstanding policy issues affecting the Diversion Program, including the development of standards for termination from the Program and consequences for relapse; an examination of options for Program funding to ensure adequate monitoring; the development of standards for worksite monitors; and revamped governance of the program.

The many process improvements now under way, and the important reforms coming soon as the result of SB 231 (Figueroa), point to a brighter future for MBC and its disciplinary process. MBC’s enforcement program has demonstrated strong new momentum and clear improvement, but further progress is needed for this agency to fully meet its vital public safety obligations.

The Monitor calls upon every stakeholder in the healthcare system — MBC, HQE, OAH, the Department of Consumer Affairs, the Legislature, organized medicine and the healthcare industry, physicians, and patients — to embrace the cause of a better Medical Board enforcement program. An ongoing collaborative effort to continue MBC’s recent progress will result in greater protection for every Californian who relies on the healthcare system.

Chapter I

INTRODUCTION

A. An Overview of the Medical Board Enforcement Program Monitor Project

As a result of the Legislature’s 2001–02 sunset review of the Medical Board of California (MBC), Senate Bill 1950 (Figueroa) added section 2220.1 to the Business and Professions Code. Section 2220.1 provides for the appointment of an independent Medical Board Enforcement Program Monitor for a two-year period. The “enforcement monitor” concept is not new. The California Legislature has created enforcement monitor positions at four other occupational licensing agencies in the past two decades.¹ The concept is similar to that of an external independent auditor — independent of the board to be studied, and independent of the profession regulated by that board. Under all enforcement monitor legislation, the agency must cooperate with the monitor, who is delegated significant investigative authority and charged with conducting a lengthy in-depth study of a particular regulatory program, making findings and recommendations, and proposing legislative, regulatory, or administrative changes to improve the efficiency, effectiveness, and quality of the program and its decisionmaking.

Section 2220.1 charges the Medical Board Enforcement Monitor with evaluating “the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board’s enforcement program and operations and the improvement of the overall efficiency of the board’s disciplinary system.” The statute tasks the Monitor with several specific analyses, including a required evaluation of the Board’s Diversion Program for substance-abusing physicians, and requires the Monitor to publish two reports during the two-year appointment period.

¹ SB 1543 (Presley) (Chapter 1114, Statutes of 1986) enacted Business and Professions Code section 6086.9, which created a State Bar Discipline Monitor charged with evaluating and recommending improvements to the State Bar’s attorney discipline system. SB 2029 (Figueroa) (Chapter 1005, Statutes of 2000) enacted Business and Professions Code section 7092, which created the Contractors State License Board (CSLB) Enforcement Monitor position to study and recommend changes to CSLB’s contractor enforcement program. SB 26 (Figueroa) (Chapter 615, Statutes of 2001) enacted Business and Professions Code section 1601.3 to create the Dental Board Enforcement Monitor post at the Dental Board of California. SB 1542 (Figueroa) (Chapter 572, Statutes of 2004) created a Bureau of Automotive Repair Administration and Enforcement Monitor, which commenced in January 2005. In addition, SB 1544 (Figueroa) (Chapter 740, Statutes of 2004) created an “operations and administrative monitor” for the Bureau of Private Postsecondary and Vocational Education, also commencing in January 2005.

Following a competitive bidding process and the selection of the Monitor by the Department of Consumer Affairs (DCA) Director, the MBC Enforcement Monitor project began in late October 2003. During the first year of the project, the Monitor and her colleagues studied the history of six major legislative enactments that have shaped the structure and purpose of MBC's enforcement program over the past thirty years; surveyed twenty previous studies and reports on MBC's enforcement and diversion programs; reviewed MBC-generated documents and procedure manuals relevant to its enforcement and diversion programs; interviewed more than 90 experts and witnesses representing all stakeholder groups; gathered and analyzed statistical data; and identified numerous issues and developed recommendations relating to the Board's enforcement and diversion programs.

On November 1, 2004, the Monitor released the *Initial Report of the Medical Board Enforcement Program Monitor*. The report — summarized in Chapter III below — made hundreds of findings and 65 specific recommendations for reform. The Monitor team unveiled the *Initial Report* to the Medical Board at its regularly-scheduled November 4, 2004 quarterly meeting in San Diego. Thereafter, the Board convened a special meeting on January 21, 2005 in Burbank. This meeting was devoted exclusively to the Monitor's findings and recommendations, and involved an extensive discussion of the concept of "vertical prosecution" as recommended in Chapters VII and IX of the *Initial Report*, other Monitor recommendations, and the increased costs of enforcement over the prior eleven years during which physician licensing fees had stagnated. Following the Monitor's presentation and Board discussion, MBC unanimously voted to support the concept of vertical prosecution and a fee increase to \$800 per biennial renewal cycle.

On January 25, 2005, the *Initial Report* was the subject of a four-hour "sunset review hearing" convened by the Joint Committee on Boards, Commissions and Consumer Protection chaired by Senator Liz Figueroa. Present to testify on the *Initial Report* were representatives of the Monitor team, the Medical Board, several physician organizations, and interested members of the public.

Commencing in April 2005, many of the Monitor's most important recommendations were amended into Senate Bill 231 (Figueroa). Throughout the summer of 2005, the bill was amended several times to include additional provisions and streamlined to eliminate opposition. At its May and July 2005 meetings, the Medical Board — led by Board President Ronald Wender, M.D., and Executive Director Dave Thornton — continued to focus attention on the issues raised in the *Initial Report* and pledged support for SB 231 and nearly all of the Monitor's recommendations. In addition, the staff of the Medical Board's enforcement program and the Health Quality Enforcement (HQE) Section of the Attorney General's Office began to implement Monitor recommendations that did not require legislative change. In short, both MBC and HQE embraced almost all of the Monitor's recommendations; this support is reflected in the matrix of MBC/HQE responses to the

65 recommendations contained in Chapter XVII below. On October 7, 2005, Governor Arnold Schwarzenegger signed SB 231 (Figueroa), which is summarized in Chapter IV below and described in detail throughout this report.

Under section 2220.1, the Medical Board Enforcement Program Monitor project ends on November 1, 2005. This *Final Report of the Medical Board Enforcement Program Monitor* describes the details of this fundamental reform legislation and its impacts on the various components of the Medical Board's enforcement program. Additionally, it includes updated enforcement program data for fiscal year 2004–05 and documents the efforts of MBC and HQE to implement other Monitor recommendations that do not require legislation. Lastly, it includes final recommendations for future consideration by the Medical Board, the Attorney General's Office, the Legislature, and the Schwarzenegger administration.

B. Data Issues

As in the *Initial Report*, we present two *caveats* about the data presented in this *Final Report*. The first concerns the scope of the data. The Medical Board's enforcement program serves not only the Medical Board, but also several so-called "allied health licensing programs" (AHLPs) which regulate non-physician health care practitioners and which were previously committees of the Medical Board and subject to its jurisdiction. In recent years, most AHLPs have successfully sought legislation separating themselves from the jurisdiction of MBC; however, some of them still contract for the use of components of MBC's enforcement program to varying degrees. Because SB 1950 (Figueroa) and the Enforcement Monitor statute reveal the Legislature's intent to strengthen MBC's *physician* discipline program, the data presented in this report focus on MBC's handling of cases against physicians. We have generally excluded AHLP enforcement data — which in any event constitute only a small proportion of overall MBC enforcement program workload.

A second caveat about the data presented in this report involves the presence of minor differences between some of the statistics included in this report and comparable statistics published by MBC and/or DCA. In order to properly complete analyses of all of the issues contained in our scope of work, a number of special compilations of statistical data from the MBC complaint tracking system were prepared for us by MBC staff. In most cases, these special compilations were prepared within a few weeks of MBC's compilation of comparable statistical data for MBC's and DCA's published reports. However, MBC's complaint tracking system is dynamic in the sense that it is continuously updated to reflect the status of every individual complaint. Sometimes, after being closed, a complaint or investigation may be reopened. Also, reopened complaints and investigations will, at some point, be re-closed. These types of changes can marginally impact the results of various statistical compilations produced from the complaint tracking system at slightly different points in

time. Except where otherwise noted in this report, minor differences between the statistics shown in this report and comparable statistics published by MBC and/or DCA are attributable to legitimate changes that were made to complaint tracking system data between the dates when the statistical data used in the different reports were compiled.

Chapter II

OVERVIEW OF THE MEDICAL BOARD OF CALIFORNIA

A. MBC Generally

Created in the Medical Practice Act,² the Medical Board of California is a semi-autonomous occupational licensing agency within the state Department of Consumer Affairs (DCA). MBC consists of 21 members who serve four-year terms. By law, twelve of MBC's members must be California-licensed physicians; the remaining nine members are so-called "public members" (non-physicians). Nineteen of MBC's members (including all of the physician members and seven of the public members) are appointed by the Governor; the remaining two public members are appointed by the Assembly Speaker and Senate Rules Committee, respectively.

MBC is semi-autonomous in that, pursuant to Business and Professions Code section 109(a), its members make final licensing and enforcement decisions (subject to judicial review). Uniquely, MBC is comprised of two autonomous divisions — the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). MBC members are not merely appointed to the Board; they are specifically appointed to one of the two divisions. Comprised of seven members (four physicians and three public members), DOL focuses on the licensure of physicians and the regulation of several non-physician health care professions.³ DMQ, which consists of fourteen members (eight physicians and six public members), is the Board's enforcement arm; it oversees a large enforcement staff and adopts final decisions in disciplinary matters against its licensees. The Legislature rarely directs "the Medical Board" to do anything; instead, it aims its directives expressly at one of the divisions. Neither division reviews or ratifies the decisions of the other. No other DCA agency is structured this way.

² Bus. & Prof. Code § 2000 *et seq.*

³ In addition to physicians, DOL licenses registered dispensing optician firms (including contact lens dispensers and spectacle lens dispensers), research psychoanalysts, and licensed midwives; it also regulates unlicensed medical assistants.

The Medical Board is authorized to select an executive director, who serves at its pleasure.⁴ In turn, the executive director hires staff to head the Board’s licensing and enforcement divisions, and other important management, investigative, analytical, and support staff.

In 2004–05, MBC regulated over 120,000 physicians, of which almost 93,000 reside and practice in California. The Medical Board receives no funding or support from the state’s general fund. MBC is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a “special-fund agency.” In 2004–05, MBC’s annual budget was \$41 million — up from its \$38 million budgets during 2003–04, 2002–03, and 2001–02, when a state hiring freeze forced both budget and staffing constrictions on the Board.

B. MBC’s Enforcement Program

As noted above, MBC is responsible not only for licensing physicians, but also for reviewing the quality of medical practice carried out by California physicians; conducting disciplinary proceedings in cases of unprofessional conduct; and generally enforcing the disciplinary and criminal provisions of the Medical Practice Act, other relevant statutes and regulations, and applicable professional standards.⁵ MBC accomplishes this latter function through its Division of Medical Quality.

MBC’s enforcement program is large, complex, and fragmented across three state agencies. DMQ oversees a large enforcement staff that receives, screens, and investigates complaints and reports of physician misconduct and negligence. These staff are based at headquarters in Sacramento and at eleven district offices throughout California. Complaints and reports of physician misconduct are received at the Sacramento-based Central Complaint Unit, where they are screened and — if meritorious — shipped out to one of the regional district offices for formal investigation. Once a Medical Board investigator (assisted by physician employees called “medical consultants” and often by external expert physician reviewers) has determined that sufficient evidence exists to take disciplinary action, the matter is transmitted to a separate agency — the Health Quality Enforcement Section of the Attorney General’s Office; HQE has six offices throughout the state. A deputy attorney general from HQE then files an “accusation,” a written statement of formal charges, which triggers a panoply of due process rights for the subject physician. Absent settlement, the charges then become the subject of an evidentiary hearing presided over by an administrative law judge (ALJ) from another separate agency — the Medical Quality Hearing Panel of the Office of Administrative Hearings — at which each side presents its case. After the case is “submitted,” the ALJ drafts a proposed decision, including findings of fact, conclusions of law, and recommended

⁴ Bus. & Prof. Code § 2020.

⁵ *Id.* § 2004.

discipline. That proposed decision is referred back to MBC's Division of Medical Quality, where it is reviewed by one of two "panels" of DMQ, each consisting of seven members (four physicians and three public members). The assigned DMQ panel makes MBC's final disciplinary decision, which is then subject to potentially three levels of review by the courts. Contested MBC disciplinary matters often consume five to eight years, during which time most respondent physicians are free to continue practicing medicine.

Business and Professions Code section 2234 sets forth grounds for MBC disciplinary action, including gross negligence (an extreme departure from applicable professional standards); repeated negligent acts; incompetence; the commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician; and the violation of any provision of the Medical Practice Act. In MBC disciplinary matters, the burden of proof is on the Board, and MBC must prove its case by "clear and convincing evidence to a reasonable certainty."⁶

Business and Professions Code section 2227 sets forth an array of sanctions that DMQ may impose on a licensee for a disciplinable violation, including license revocation, suspension, probation on specified terms and conditions, and the issuance of a public reprimand. Through probation, DMQ may restrict a license (for example, it may prohibit a physician from prescribing certain types of controlled substances, practicing without a third-party chaperone, or engaging in solo practice) or condition continued practice on participation in the Board's Diversion Program for substance-abusing licensees; require a physician to take and pass a professional competency exam, psychiatric examination, ethics and/or other continuing education courses, or to undergo psychotherapy or other medical evaluation and treatment; and/or require participation in the Physician Assessment and Clinical Education (PACE) program. Additionally, section 2233 permits DMQ to issue a "public letter of reprimand"; section 125.9 allows Division staff to impose citations and fines on physicians for minor violations of the Medical Practice Act; and other Code sections permit DMQ to assess civil penalties against physicians for specified misconduct.

Theoretically, both the ALJ's recommendation and DMQ's imposition of specific disciplinary sanctions are based on "disciplinary guidelines" formulated by DMQ. These guidelines, which are regularly reviewed and updated by MBC enforcement staff and the Division, are incorporated by reference in DMQ regulation⁷ and represent DMQ's preferred range of sanctions for every given violation of the Medical Practice Act and applicable professional standards. They are intended to promote statewide consistency in disciplinary decisionmaking to ensure that similarly situated physician respondents are treated similarly — an important component of due process and equal protection.

⁶ See, e.g., *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

⁷ 16 CAL. CODE REGS. § 1361.

MBC’s enforcement program is enormously important to California consumers, who depend on it to rid the marketplace of physicians who are negligent, incompetent, dishonest, or impaired. MBC is the only entity in the state authorized to revoke, suspend, or restrict the license of a California physician in order to protect “the public at large, *i.e.*, all consumers of medical services in California.”⁸ Most California consumers visit a physician regularly, and most physicians see and treat dozens of patients per day. Negligence or misconduct by a physician can easily cause the “irreparable harm” that justifies the existence of most state licensing programs. Even one moment of negligence or impairment by a physician can result in serious injury to or the death of a patient. Thus, the importance of the effective, efficient, and decisive functioning of MBC’s enforcement program cannot be overstated.

MBC’s enforcement program is also important to physicians who practice medicine in California. Those who become licensed as physicians have spent many years in and many dollars on medical school, clinical education and postgraduate training programs, and often additional training and examinations necessary to become certified by national specialty boards; the law views their license as a property right which may not be taken by the state absent substantive and procedural due process. All segments of society need competent and qualified physicians to assist in preventing, detecting, and treating disease and other medical conditions. Thus, trained physicians should not be barred from the marketplace for insignificant reason. In this era of managed care, the impact of MBC investigative and disciplinary activity can have momentous ramifications for a physician’s ability to practice medicine. Thus, the fairness, consistency, and quality of MBC disciplinary decisionmaking are of significant import to California’s physician population.

These sometimes competing priorities of consumer protection and physician marketplace access have been reflected in the Legislature’s evolving definition of the paramount goal of MBC’s enforcement program. Prior to 1990, Business and Professions Code section 2229 directed MBC, in exercising its disciplinary authority, to “take such action as is calculated to aid in the rehabilitation of the licensee” — for example, by ordering additional education or restricting (rather than revoking) the license. In 1990, however, the Legislature amended section 2229 to unambiguously declare that “[p]rotection of the public shall be the highest priority for the Division of Medical Quality”⁹ Physician rehabilitation is still recognized as a goal for DMQ in exercising its disciplinary authority; however, “[w]here rehabilitation and protection are inconsistent, protection shall be paramount.”¹⁰

⁸ *Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 10.

⁹ Bus. & Prof. Code § 2229(a), added by 1990 Cal. Stat. 1597.

¹⁰ Bus. & Prof. Code § 2229(c). This declaration of legislative intent was later replicated for MBC generally in AB 269 (Correa) (Chapter 107, Statutes of 2002), which added section 2001.1 to the Business and Professions Code. Section 2001.1 declares that “[p]rotection of the public shall be the highest priority of the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent

Enforcement is expensive. Consistent with prior years dating back to the early 1990s, MBC spent 75% of its \$41 million budget — over \$30 million — on enforcement in fiscal year 2004–05.

C. MBC’s Diversion Program

The Medical Board’s Diversion Program was created in 1980 legislation that enacted Business and Professions Code section 2340 *et seq.* In the enabling legislation, the Legislature stated its intent “that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.”¹¹ Consistent with MBC’s chief priority of public protection, this language thus requires the Board to “identify and rehabilitate” impaired physicians and return them to the practice of medicine, but only if this can be done “in a manner which will not endanger the public health and safety.”

Although the enabling language makes reference to physicians with mental or physical illness, the Diversion Program has historically been structured to monitor substance-abusing physicians. Participants in the Diversion Program include physicians who voluntarily seek help (“self-referrals”), physicians who are referred by the Board’s enforcement program during investigation of a complaint (“Board-referred”), and physicians who are ordered to participate by DMQ as a term of probation in a formal disciplinary order (“Board-ordered”). Regardless of method of entry, each participant is required to enter into a contract with the Program. In the contract, the participant agrees to abstain from the use of drugs and alcohol, submit to random bodily fluids testing, attend support group meetings with similarly impaired physicians, undergo psychotherapy and/or substance abuse treatment, retain a “worksite monitor,” and cease practicing medicine if so instructed by the Program due to relapse or other noncompliance with the terms of the contract.

The Division of Medical Quality is statutorily responsible for overseeing the Diversion Program,¹² which is administered by a staff of twelve MBC employees. Although several of the Program’s components (including bodily fluids collection, laboratory testing, and facilitation of support group meetings) have been contracted to the private sector, the “case management” function of the program and overall Program administration have been housed within the Medical Board since the Program’s inception in 1981. The overhead costs of the Program — almost \$1.2 million in

with other interests sought to be promoted, the protection of the public shall be paramount.”

¹¹ Bus. & Prof. Code § 2340.

¹² *Id.* § 2346.

2004–05 — are subsidized entirely through licensing fees paid by all California physicians. As of June 30, 2005, 232 physicians were admitted to and participating in the Diversion Program.

Chapter III

**SUMMARY OF THE
INITIAL REPORT OF THE
MBC ENFORCEMENT
PROGRAM MONITOR**

On November 1, 2004, the Monitor team released its initial findings and recommendations in the *Initial Report of the Medical Board Enforcement Program Monitor*.¹³ The 294-page report is available on the Medical Board's Web site at www.medbd.ca.gov and on the Web site of the University of San Diego School of Law's Center for Public Interest Law at www.cpil.org.

A. Principal Findings of the *Initial Report*

In the *Initial Report*, the Monitor presented a number of major findings about the Medical Board's enforcement and diversion programs. These findings highlight significant limitations on the Board's ability to protect the public through its enforcement and diversion programs. Some of them are within the Medical Board's control; others are beyond its control. For summary purposes, these findings may be grouped and described as follows:

1. The structure of the Board's enforcement program is inefficient and outdated. The current structure of MBC's enforcement program and process used to handle serious complaints against physicians — which places Medical Board investigators and HQE's specialized prosecutors in separate agencies — is fragmented, inefficient, and outdated. Currently, a Medical Board investigator with little or no legal guidance works up a case and then "hands it off" to a deputy attorney general (DAG) who has had no involvement in the planning or direction of the investigation and then has no investigative assistance thereafter. Most other similar law enforcement agencies on the federal, state, and local levels use a "vertical prosecution" model in which (1) investigators and prosecutors work for the same entity; (2) an investigator/prosecutor team is assigned to each case as soon as it warrants formal investigation; and (3) that team handles the case as a team through its

¹³ Fellmeth and Papageorge, *Initial Report of the Medical Board Enforcement Program Monitor* (Nov. 1, 2004) (hereinafter "*Initial Report*").

ultimate conclusion, whether that conclusion is a quick closure for lack of evidence or a presentation to the California Supreme Court on appeal. The vertical prosecution model is a team approach that encourages early coordination — often leading to faster decisions, filings, and results — and eliminates redundant reviews and conflicting efforts by investigators, attorneys, and supervisors.¹⁴

The Monitor noted other structural infirmities in MBC’s enforcement program. Specifically, existing venue statutes that govern the location of the administrative hearing and the court challenge to any resulting MBC disciplinary action are unnecessarily expensive to the Board and its licensees, and are inconvenient and inefficient for those who must participate in Medical Board disciplinary proceedings (including prosecutors and administrative law judges).

2. The Medical Board has woefully inadequate resources for its important enforcement function. For over a decade, the Medical Board has been starved for budgetary resources: Physicians’ license fees have not been increased since January 1994, notwithstanding a 28% increase in the California Consumer Price Index during those eleven years.¹⁵ In addition, the Board has been starved for human resources: Since 2001, MBC has lost 29 enforcement program positions (a 16.2% reduction) and the Attorney General’s Office has lost six HQE DAGs (a 15% reduction) due to the state’s hiring freeze¹⁶ — contributing greatly to the chronic case processing delays.¹⁷

3. MBC case processing times are unacceptably high. The Medical Board’s enforcement process simply takes too long to protect the public. This delay in justice — which is significant in the context of the irreparable harm threatened by an incompetent or impaired physician — has many causes. For example, although state law requires the Board to set a goal of completing an investigation within 180 days from receipt of the complaint,¹⁸ the Monitor found that an average of

¹⁴ For a complete discussion of this issue, *see id.* at Chapters VII (Field Investigations: District Offices) and IX (Prosecutions: Health Quality Enforcement Section).

¹⁵ *Id.* at 64–65.

¹⁶ Due to unprecedented deficits in the state’s general fund, then-Governor Gray Davis imposed a statewide hiring freeze on October 23, 2001. Governor Arnold Schwarzenegger continued the hiring freeze shortly after he was sworn in on November 17, 2003, and allowed it to end effective June 30, 2004. Despite the facts that (1) MBC is a “special fund” agency funded solely by licensing fees paid by physicians; (2) MBC receives no money from the general fund; (3) any salary savings to the Medical Board by virtue of the hiring freeze does not assist the general fund deficit in any way whatsoever; and (4) in fact, Business and Professions Code section 2445 prohibits the transfer of any MBC funds to the general fund, the hiring freeze (including its subsequent automatic loss of vacant positions) was imposed on MBC as if it were funded solely by the general fund. *Id.* at 65–67.

¹⁷ *Id.*

¹⁸ Business and Professions Code section 2319(a), enacted in 1990, requires MBC to establish a goal that “an average of no more than six months will elapse from the receipt of complaint [sic] to the completion of an investigation.” Section 2319(b) sets a one-year goal for the completion of investigations in cases involving “complex medical or fraud issues or complex business or financial arrangements.”

340 days elapses from MBC's receipt of a serious quality of care complaint to the conclusion of the investigation. One reason is that many physicians refuse to honor lawful MBC requests for medical records of complaining patients or otherwise delay in producing requested records, and neither MBC investigators nor HQE prosecutors aggressively enforced existing laws governing medical records procurement. Similar delays plague other steps in the long enforcement process, including initial complaint processing,¹⁹ securing physician interviews during an investigation,²⁰ and the procurement of an expert opinion necessary to prove a violation.²¹ Overall, there is an unacceptable 2.63-year average time lag between the filing of a serious complaint and a conclusion or decision by the Medical Board, and an average of 3.75 years elapses if superior court review of a Medical Board disciplinary decision is involved.²² A regulatory result which takes three or four years is a denial of substantive justice for all concerned.

4. Failure to exchange expert opinion delays and impedes the enforcement process. The MBC/HQE enforcement process is routinely delayed and frustrated because, whereas MBC requires its expert witnesses (physicians) to put their expert opinions in writing and shares them with the other side, defense counsel do not require their medical experts to put their expert opinions in writing and exchange them with MBC or HQE prior to the administrative hearing. This practice stifles the settlement process and often disadvantages the DAG at the hearing. If each side had access to the other side's expert opinions (as occurs in civil medical malpractice cases), it is likely that fewer hearings would be required and more settlements would be reached — saving time and money, and resolving the matter more quickly for the benefit of both the physician and the public.²³

5. Many of MBC's most important detection mechanisms are failing it. Despite the extensive "mandatory reporting scheme" set forth in Business and Professions Code section 800 *et seq.*, the Medical Board is not receiving information to which it is statutorily entitled about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law — information that enables MBC to detect possible physician wrongdoing, investigate, and take

¹⁹ *Initial Report, supra* note 13, at 99 (average overall CCU complaint processing time was 79 days in 2003–04), 100 (average CCU complaint processing time for quality of care complaints was 140 days in 2003–04).

²⁰ *Id.* at 142 (average time between MBC's request for a physician interview and either completion of the interview or refusal by the physician to be interviewed was 60 days in 2003–04).

²¹ *Id.* at 160 (average time between MBC delivery of medical records to an expert witness and expert's return of an expert opinion was 69 days in 2003–04).

²² *Id.* at 63–64 and Ex. V-D.

²³ *Id.* at 160–61.

disciplinary action as appropriate.²⁴ Further, physicians themselves routinely conceal information about their own misconduct from the Board through the insertion of “regulatory gag clauses” — provisions that prohibit an injured plaintiff from complaining to or cooperating with the Medical Board — into civil malpractice settlement agreements.²⁵

6. The Medical Board’s public disclosure policy is insufficient. The Board’s complex public disclosure statutes and regulations — which have evolved in patchwork-quilt style over the past decade — do not allow the Board to disclose sufficient information about physician conduct and history to enable patients to make informed decisions about their physicians.²⁶

7. The Board’s Diversion Program — charged with monitoring substance-abusing physicians — is significantly flawed: Its most important monitoring mechanisms are failing, it is chronically understaffed, and it exposes patients to unacceptable risks posed by physicians who abuse drugs and alcohol. In a series of audits of the Diversion Program beginning in the early 1980s, the Auditor General’s Office found that participants in the Program are not drug-tested as often as they should be and are not terminated from the Program even after repeated violations; additionally, no standards exist to guide the functioning of “worksites monitors” who purportedly oversee Program participants when they practice medicine. Overall, the Auditor General found that the Program — due in part to severe understaffing — generally fails to adequately monitor substance-abusing physicians while permitting them to practice medicine, and that the Medical Board has inadequately supervised the Program. Despite repeated findings by the Auditor General and repeated promises by the Board to address the problems identified, the *Initial Report* documents that all of these deficiencies continue to exist today — almost 25 years later.²⁷

B. Recommendations in the *Initial Report*

In the *Initial Report*, the Monitor presented a total of 65 recommendations for improvement to the Medical Board’s enforcement program. Some of these recommendations require legislative and structural change; others may be addressed internally by the Board through regulatory, administrative, or procedural change. The Monitor’s major recommendations may be grouped into seven categories for purposes of summary:

1. Structural reform of the enforcement program. The Monitor recommended adoption of the vertical prosecution model for improved enforcement efficiency and effectiveness. The

²⁴ *Id.* at 109–12.

²⁵ *Id.* at 112–14.

²⁶ *Id.* at 212–23.

²⁷ *Id.* at 254–85.

Monitor proposed the transfer of the Medical Board’s investigators from the jurisdiction of the politically appointed Board to the Attorney General’s Office — and specifically into HQE — so investigators and prosecutors could work together in the team approach of vertical prosecution that is widely used at other law enforcement agencies. This structural proposal would improve the efficiency of investigations and prosecutions, assist the Medical Board in addressing its chronic inability to recruit and retain experienced investigators, and address a perception on the part of the public that investigators “work for a board dominated by doctors” and have no incentive to protect the public from those doctors.²⁸

The Monitor also recommended amendments to statutory provisions governing the venue of MBC administrative hearings and judicial challenges to Medical Board disciplinary decisions.

2. Ensuring adequate MBC enforcement resources. The Monitor called for an appropriate increase in the statutory ceiling on physician licensing fees from \$610 biennially (in 2003–04, physicians actually paid \$300 per year in licensing fees, while lawyers paid \$390 and podiatrists paid \$450 per year) to at least \$800 biennially (that is, from \$300 per year to \$400 per year). These added resources would enable the Board to reinstate investigator/prosecutor positions lost as a result of the hiring freeze, implement vertical prosecution, reform and sufficiently staff the Diversion Program, reinstate critical programs it had to abandon during the eleven-year financial drought, and maintain an adequate reserve fund as required by state law.²⁹

3. Reduction of investigative delays. The Monitor recommended that MBC and HQE develop and consistently apply new policies to enforce existing medical records procurement laws and to end other frequent delays in obtaining physician interviews and expert witness testimony.³⁰

4. Timely exchange of expert opinions. The *Initial Report* recommended that the Medical Practice Act be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the administrative hearing. This procedural change would promote earlier and more informed case evaluation and negotiations, leading to quicker and more frequent settlements to the benefit of physicians and the public alike.³¹

²⁸ *Id.* at 129–40, 149 (Recommendation #22), 170–71, 176 (Recommendation #33).

²⁹ *Id.* at 64–67, 72 (Recommendations #1 and #2).

³⁰ *Id.* at 100–01, 117 (Recommendation #7), 140–41, 149 (Recommendation #23), 171–72, 176 (Recommendation #34).

³¹ *Id.* at 160–62 (Recommendation #30).

5. Improved detection of physician misconduct. The Monitor proposed a number of new reporting requirements to ensure that the Medical Board is informed of events indicating potential physician incompetence or impairment. To improve required reporting by court clerks of criminal convictions and civil judgments, the Monitor suggested that the Department of Consumer Affairs initiate a comprehensive educational program for courtroom clerks on behalf of all of its agencies with reporting requirements. In addition, the *Initial Report* (1) called on the Board to expedite and complete a study of the hospital peer review process that was mandated in a 2001 law (but never completed due to budgetary constraints), so that loopholes and problems in peer review reporting to MBC can be identified and closed; (2) suggested the imposition of penalties on insurance companies that fail to report medical malpractice payouts as required by law; and (3) urged the Legislature to statutorily ban so-called “regulatory gag clauses” contained in civil settlement agreements.³²

6. Enhanced public disclosure. The Monitor recommended that the statutes governing public disclosure be streamlined to eliminate inconsistencies, redundancies, and drafting errors. The Monitor also called for the required public disclosure of (1) medical malpractice settlements over \$30,000; (2) misdemeanor criminal convictions against physicians that are “substantially related” to the duties, qualifications, and functions of a physician; (3) significant terms and conditions of probation imposed by MBC; and (4) the resignation or surrender of hospital privileges after a hospital has notified a physician of an impending investigation.³³

7. Diversion Program reform. The Monitor called on the Medical Board to reevaluate whether the “diversion” concept is feasible, possible, and protective of the public interest. If the concept is deemed viable, the Monitor recommended that MBC’s Division of Medical Quality spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that have limited the Program’s effectiveness in assisting participant recovery and in protecting the public. This overhaul must include not only additional staffing for the Program but also adoption and enforcement of standards and criteria to which both Program participants and staff are consistently held. Additionally, the Monitor recommended that MBC more fully integrate and incorporate Diversion Program management into overall Board and enforcement program management, and ensure that the *Diversion Program Manual* — which is so outdated that it has become obsolete — is completely rewritten. Finally, the Monitor recommended that the Diversion Program — if it is continued and once its problems are addressed — be required to undergo a full performance audit by the Bureau of State Audits (formerly the Auditor General).³⁴

³² *Id.* at 109–14, 118–20 (Recommendations #12–#19).

³³ *Id.* at 212–24 (Recommendations #48–#52).

³⁴ *Id.* at 254–89 (Recommendations #56–#65).

Chapter IV

2005 REFORM LEGISLATION ADDRESSING THE MONITOR'S RECOMMENDATIONS

A. Senate Bill 231 (Figueroa)

Many of the key recommendations contained in the Enforcement Monitor's *Initial Report* were incorporated into Senate Bill 231 authored by Senator Liz Figueroa, who chairs both the Senate Committee on Business, Professions and Economic Development and the Joint Committee on Boards, Commissions and Consumer Protection (formerly called the "Joint Legislative Sunset Review Committee"). During the summer of 2005, SB 231 passed both houses of the Legislature; the bill was signed into law by Governor Schwarzenegger on October 7, 2005 (Chapter 674, Statutes of 2005). SB 231 will become effective on January 1, 2006.

SB 231 was introduced on February 15, 2005, and was substantively amended five times before it was finally enrolled to the Governor as a 30-part bill on September 12, 2005. As enacted, SB 231 contains a mix of provisions. Many of them directly implement the Monitor's recommendations. Some of them only partially implement a Monitor recommendation; the compromise reflects the give-and-take of the political process as the bill moved through various committees and both houses of the Legislature, and was ultimately negotiated with the Schwarzenegger administration late in the process. Other provisions in SB 231 did not originate with the Monitor at all, but reflect the desires of the Medical Board, the California Medical Association, or the Schwarzenegger administration.

The provisions of SB 231 may be grouped into the same seven categories of Monitor recommendations described in Chapter III (with two additional categories relating to sunset provisions and technical amendments):

1. Structural reform of the enforcement program. In the *Initial Report*, the Monitor identified several structural issues that cause delay, inefficiency, or unnecessary cost to the Medical Board, its licensees, and the public. Some of these structural issues have been addressed in SB 231:

■ *Investigations/prosecutions.* In Chapters VII and IX of the *Initial Report*,³⁵ the Monitor criticized the inefficiency inherent in the fragmented relationship between the Medical Board’s investigators and the Attorney General’s prosecutors. Currently, a professional investigator employed by the Medical Board must work up a disciplinary matter with little or no legal guidance, no input on the design of the investigation from the prosecutor who will file and try that case, and no ability to assist that prosecutor at the resulting administrative hearing. The investigator then “hands off” that investigative file to a professional prosecutor who works for a different agency (the Health Quality Enforcement Section of the Attorney General’s Office), has had no input into the design of the investigation or the selection of the expert (much less the documents given to that expert), and thereafter lacks vitally important investigative assistance. In Recommendations #22 and #33, the Monitor called for full implementation of the “vertical prosecution” model widely used at similar law enforcement agencies at the state, local, and federal levels, in which an investigator/prosecutor team is assigned to work a case together from its inception through its ultimate closure. The Monitor stated that the optimum way to implement vertical prosecution is to merge investigators and prosecutors into the same agency, but noted that the model can be applied — although somewhat less easily — to personnel working for different agencies so long as both agencies are committed to the key components of vertical prosecution.³⁶

As amended on August 30, SB 231 would have transferred the Medical Board’s investigators into HQE to enable full implementation of the vertical prosecution model, and transferred the responsibility to “investigate” cases from MBC to HQE. That version of the bill was supported by MBC, HQE, the California Medical Association (CMA), Kaiser Permanente, two prominent defense attorneys whose practices concentrate on physician defense, eight former Medical Board presidents, one former Medical Board executive director, Governor Pete Wilson’s Department of Consumer Affairs Director, and the Federation of State Medical Boards. Despite this strong showing of support, the Schwarzenegger Administration opposed the transfer of MBC’s investigators to HQE. Thus, the final language of SB 231 implements vertical prosecution without the immediate transfer of investigative staff. However, the bill envisions legislative reconsideration of the transfer during 2007, and contains funding for full implementation of vertical prosecution including the transfer.

Specifically, SB 231 adds new section 12529.6 to the Government Code, which — in subdivision (a) — makes a legislative finding that because of the critical importance of MBC’s

³⁵ *Initial Report*, *supra* note 13, at 129–40, 170–71.

³⁶ *Id.* at 136. The Monitor identified these components as “(1) early coordination of the efforts of attorneys, investigators, and other staff; (2) continuity of teamwork throughout the life of a case; (3) mutual respect for the importance of the professional contributions of both attorneys and investigators, and the value of having both available in all stages of the case; and (4) early designation of trial counsel, recognizing that the prosecutor who ultimately puts on the case must be assigned from the case’s inception to help shape and guide it because the purpose of any investigation is the *preparation of a case for trial.*” *Id.* at 135–36 (emphasis original).

enforcement function, “using a vertical prosecution model . . . is in the best interests of the people of California.” Section 12529.6(b) requires that, as of January 1, 2006, each complaint that is referred for investigation be “simultaneously and jointly” referred to an investigator/prosecutor team (including the prosecutor who will ultimately file and try the case) which will handle the matter for its duration. Under the direction of the prosecutor, the investigator will gather evidence that enables the prosecutor to advise MBC whether and how to proceed with formal disciplinary proceedings.

SB 231 also adds new Government Code section 12529.7 which requires the Medical Board — in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration — to report and make recommendations to the Legislature by July 1, 2007 on the vertical prosecution model created in Government Code section 12529.6.

In the meantime, SB 231 prepares MBC and HQE for the eventual transfer of MBC’s investigators to HQE and full implementation of vertical prosecution. SB 231 amends Government Code section 12529(a) to transfer the investigative function to HQE; adds new section 2006 to the Business and Professions Code to redefine “MBC investigations” as “HQE investigations”; amends Government Code section 12529.5(b) to eliminate the “deputy in district office” (DIDO) program under which HQE has been required to place prosecutors onsite at MBC district offices to provide legal guidance to investigators³⁷ — this program will be unnecessary when MBC investigators are transferred to HQE; and adds new section 2435.3 to the Business and Professions Code to authorize MBC to increase its licensing fees to cover the additional costs of transferring its investigators to HQE.

As noted above, MBC must report to the Legislature on the progress of the vertical prosecution model mandated in SB 231 by July 1, 2007, and all of the newly added provisions relating to vertical prosecution sunset on July 1, 2008 — meaning that during 2007, the Legislature will have another opportunity to evaluate the feasibility of the transfer of MBC’s investigators to HQE and enact legislation mandating it.

■ ***Venue for administrative hearings.*** In Chapter IX of the *Initial Report*,³⁸ the Monitor found that Government Code section 11508 — the statute that governs the venue (location) of adjudicative hearings and that allows hearings to be held anywhere in the state — results in substantial and unnecessary costs for MBC, HQE, the Office of Administrative Hearings (OAH, which supplies the administrative law judges (ALJs) who preside over MBC disciplinary hearings), and the physician population as a whole. In Recommendation #39, the Monitor suggested that section 11508 be amended to require most hearings to be held in large cities in which both HQE and OAH have existing offices and hearing facilities.

³⁷ See *id.* at 131–34 for a description of the DIDO program.

³⁸ *Id.* at 175–76.

SB 231 amends Government Code section 11508 to require Medical Board administrative hearings to be held at the OAH facility that is closest to the location where the transaction occurred or the respondent physician resides. The amendments to section 11508 preserve the ability of the parties to agree to a different venue; they also preserve the ability of the respondent to move for a change of venue and the discretion of the ALJ to order a change of venue. However, unless good cause is identified in writing by the ALJ, the hearing shall be held in a facility maintained by OAH. Thus, SB 231 imposes a presumption that most MBC adjudicative hearings will be held at secure OAH facilities.

■ ***Venue for writs of mandate.*** After MBC issues a formal disciplinary decision against a physician, that physician is entitled to challenge MBC’s decision by filing a petition for writ of mandate in a superior court. In Chapter XII of the *Initial Report*,³⁹ the Monitor found that Business and Professions Code section 2019 — the statute that currently governs the venue (location) for the filing of a petition for writ of mandate and allows a disciplined physician to file a petition in superior court in Sacramento, San Francisco, Los Angeles, or San Diego (regardless of where the administrative hearing was held and where the prosecutor who must defend the writ is located) — appears to be encouraging “forum-shopping” and inefficient use of judicial resources, and is unnecessarily costing HQE and MBC substantial amounts of money every year. In Recommendation #46, the Monitor called for the amendment of section 2019 to require a disciplined physician to file a petition for writ of mandate in the superior court in the large city (either Sacramento, San Francisco, Los Angeles, or San Diego) closest to where the administrative hearing was held.

Until August 30, SB 231 contained an amendment to section 2019 that would have implemented Recommendation #46. However, the amendment was opposed by CMA and various defense attorneys who represent physicians before MBC; they raised questions regarding the Monitor’s “forum-shopping” conclusion. Because this matter warrants further discussion, the amendment was eventually dropped from the bill.

2. Adequate resources for MBC enforcement. In Chapter V of the *Initial Report*,⁴⁰ the Monitor noted that MBC is a “special fund” agency that is funded solely by physician licensing fees, and that — despite the 1975 promise of the medical profession to support a vigorous enforcement program⁴¹ — those fees have not been increased since January 1994. Due to this funding freeze (which worked a 28% cut in MBC spending power between 1994 and 2004), MBC was forced to cut proactive enforcement programs, reduce the hours worked by its physician employee “medical

³⁹ *Id.* at 201–02.

⁴⁰ *Id.* at 64–67.

⁴¹ *Id.* at. 19–22, 65.

consultants” who assist MBC investigators in deciphering medical records and issues, and eliminate training programs for its investigative staff. Additionally, and as noted above,⁴² MBC lost 29 enforcement positions (and HQE lost six prosecutor positions) due to the imposition of the state’s 2001–04 hiring freeze. In Recommendations #1 and #2, the Monitor stated that MBC’s initial and biennial renewal licensing fees should be increased to \$800 (\$400 per year) to enable the Board and HQE to reinstate lost enforcement positions, fully implement vertical prosecution, resume training programs, provide sufficient funding for medical consultants, and cover the increased costs of doing business.

SB 231 enhances the funding available to MBC so that it can rebuild and strengthen its enforcement program:

■ ***Increased license fees.*** SB 231 amends subsections (c) and (d) of Business and Professions Code section 2435 to increase, respectively, MBC’s initial and biennial renewal licensing fees to a base fee of \$790 (\$395 per year). Further, the bill codifies these fees in statute. In the past, the Legislature established a “fee ceiling” and permitted the Board to adjust fees beneath that ceiling through the rulemaking process (which is subject to review by the Department of Consumer Affairs and the Office of Administrative Law). SB 231 establishes the base fee of \$790 in statute, and amends section 2435(h) to state the Legislature’s intent that MBC fees should always be set to ensure that the Board can cover its annual budget and also maintain two months’ worth of operating expenses in its reserve fund.

■ ***Compensation for the elimination of cost recovery.*** Under Business and Professions Code section 125.3, the Medical Board — like all other DCA agencies — was authorized to request reimbursement of some of its investigative and enforcement costs against disciplined licensees. For over a decade, MBC’s implementation of this so-called “cost recovery” statute was the object of intense criticism by CMA and other physician groups, who frequently offered to agree to a fee increase in exchange for a cap on or elimination of MBC’s cost recovery ability.⁴³ At the request of CMA, SB 231 adds new subsection (k) to section 125.3 to eliminate MBC’s ability to request and receive cost recovery from its licensees. Section 125.3(k) specifies that the change must be “revenue-neutral” to MBC, meaning that license fees must be increased above the \$790 base fee to make up for the loss to MBC of approximately \$850,000 per year in cost recovery. SB 231 thus amends Business and Professions Code section 2435(e) to allow the Board — via the rulemaking process — to increase its base initial and renewal fees above \$790 to compensate for (a) the loss of cost recovery revenue, and (b) any “uptick” in investigative and other enforcement costs that accompanies the elimination of cost recovery.

⁴² See *supra* Ch. III.A.2.

⁴³ *Initial Report*, *supra* note 13, at 39, 43–46.

■ **Covering the costs of the transfer of MBC investigators to HQE.** As noted above, SB 231 requires MBC and HQE to immediately implement a form of vertical prosecution without physically transferring MBC's investigators to HQE. That transfer will be evaluated by the Legislature in 2007. If the investigators are transferred, their salaries will likely increase to conform with the salaries of other investigative staff within the Attorney General's Office. SB 231 anticipates that eventuality by adding new section 2435.3 to the Business and Professions Code, which allows MBC to increase initial and renewal licensing fees by an additional \$20 above the base fee of \$790 if its investigators are transferred to HQE after 2008.

■ **Eliminating the MBC cross-subsidy of hearing transcript costs.** Under Code of Civil Procedure section 1094.5, a disciplined physician who wishes to challenge MBC's decision by filing a petition for writ of mandate must first request the preparation of the hearing transcript by OAH. If the physician petitioner prevails, section 1094.5 requires MBC to reimburse him for the cost of the transcript. Although section 1094.5 expressly states that "the cost of preparing the transcript shall be borne by petitioner," two sections of the Government Code cap the amount that must be paid by the petitioner and require the agency (here, MBC) to pay the rest. In Chapter XII of the *Initial Report*,⁴⁴ the Monitor found that Government Code section 11523 forces the Medical Board to improperly cross-subsidize the cost of preparing hearing transcripts to the tune of thousands of dollars per transcript. In Recommendation #47, the Monitor urged the amendment of section 11523 to require the petitioner to pay the entire cost of the transcript up front.

SB 231 amends Government Code section 11523 to require a petitioner to pay the full cost of hearing transcript preparation to OAH. The amendment preserves the petitioner's right to full reimbursement of this cost if the petitioner prevails in the writ proceeding, and does not affect the right of *in forma pauperis* (indigent) petitioners to a free copy of the transcript under Civil Procedure Code section 1094.5 and Government Code section 68511.3.

3. Reduction of investigative delays. In Chapters VI and VII of the *Initial Report*,⁴⁵ the Monitor found that MBC takes an average of 340 days to screen and investigate a serious case of physician misconduct — almost double the 180-day goal established in statute since 1991.⁴⁶ The Monitor identified the medical records procurement step as one of the lengthiest components of the screening and investigative process. Whereas Business and Professions Code section 2225 requires physicians to turn over lawfully requested medical records of a patient (where the patient has signed a release) to the Medical Board within 15 days (except for "good cause"), the Monitor found that it

⁴⁴ *Id.* at 202–03.

⁴⁵ *Id.* at 100–01, 125–29, 140–41.

⁴⁶ Business and Professions Code section 2319 establishes as the goal for the MBC discipline system that "an average of no more than six months will elapse from the receipt of the complaint to the completion of the investigation."

takes MBC's Central Complaint Unit and district office investigators an average of 140 days to collect medical records that are essential to proving a quality of care case — or 77% of the 180-day goal established in state law for the investigative process.⁴⁷ In the Monitor's estimation, both MBC personnel and HQE prosecutors have demonstrated inappropriate tolerance for these lengthy delays. In Recommendations #7, #23, and #34, the Monitor called on MBC and HQE to revise their medical records procurement policies with an eye toward zero tolerance of unnecessary delays, and suggested a number of statutory mechanisms to stimulate physician compliance with requests for medical records.

SB 231 amends section 2225(d) to define the term “good cause” and to extend the time within which physicians must produce requested medical records to 15 business days from the date of MBC's request. Further, SB 231 authorizes MBC to utilize its existing citation and fine authority⁴⁸ to immediately penalize physicians who fail to produce requested medical records within 15 business days and without good cause. SB 231 specifies that the citation and fine remedy is in addition to other remedies available to MBC (including subpoenas and subpoena enforcement proceedings, certain warrantless searches, and the use of administrative inspection warrants under Code of Civil Procedure section 1822.50 in appropriate cases).

SB 231 also streamlines another component of the complaint screening process required by Business and Profession Code section 2220.08. That section requires quality of care complaints to undergo “specialty review” in the Central Complaint Unit before their transfer to the field for formal investigation. In Recommendation #10, the Monitor urged that new complaints against physicians who are already under investigation, the subject of a filed accusation, or who are on probation should be exempt from the specialty review requirement and forwarded immediately to the field. SB 231 amends section 2220.08 to that effect.

4. Timely exchange of expert opinions. In Chapter VIII of the *Initial Report*,⁴⁹ the Monitor noted that MBC requires its expert witnesses to reduce their expert opinions to writing — such that they are immediately discoverable by the defense once an accusation is filed. However, many defense counsel instruct their expert witnesses not to reduce their opinions to writing, so that the HQE prosecutor often has no idea of the substance of defense counsel's expert opinion until that expert takes the stand at the administrative hearing. The Monitor noted that this practice results in the unfair “sandbagging” of the prosecutor and greatly reduces the prospects for settlement prior to the costly hearing. In Recommendation #30, the Monitor suggested that the Medical Practice Act

⁴⁷ *Initial Report*, *supra* note 13, at 140.

⁴⁸ See Bus. & Prof. Code § 125.9.

⁴⁹ *Initial Report*, *supra* note 13, at 160–61.

be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the hearing.

SB 231 adds new section 2334 to the Business and Professions Code, which requires a party to a Medical Board disciplinary proceeding who wishes to rely on expert testimony to exchange certain information in writing with counsel for the other party: (1) a curriculum vitae of the expert; (2) a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis; (3) a representation that the expert has agreed to testify at the hearing; and (4) a statement of the expert's hourly and daily fee for providing testimony and consultation. The exchange of this information — which will benefit both sides — must occur at least 30 days prior to the commencement of the administrative hearing or as ordered by the OAH ALJ. OAH is authorized to adopt regulations to implement this section.

5. Improved detection of physician misconduct. In Chapter VI of the *Initial Report*,⁵⁰ the Monitor noted that Business and Professions Code section 800 *et seq.* sets forth an extensive “mandatory reporting scheme” intended to enable MBC to detect physician negligence, incompetence, dishonesty, and impairment so that it might investigate and take action as appropriate. A variety of actors — including medical malpractice insurance companies, court clerks, hospitals and health plans, employers of physicians, physicians themselves, and even counsel for physicians — are required to report certain events to the Medical Board. However, the Monitor found that many of MBC's most important detection mechanisms are failing. In response to several Monitor recommendations, SB 231 strengthens a few of these reporting requirements:

■ ***Self-reporting of civil malpractice judgments.*** Business and Professions Code section 802(b) currently requires uninsured physicians to self-report to MBC arbitration awards in any amount and civil malpractice settlements over \$30,000. SB 231 amends section 802(b) to require physicians to additionally self-report to MBC civil judgments in any amount.

■ ***Self-reporting of misdemeanor criminal convictions.*** Section 802.1(a)(2) currently requires physicians to self-report to MBC felony criminal convictions. SB 231 amends that section to require physicians to self-report misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician. This self-reporting requirement will be triggered after MBC compiles, and the Legislature enacts, a list of such substantially related criminal convictions.

■ ***Health facility “peer review” reporting.*** Business and Professions Code section 805 requires hospitals, health care facilities, and HMOs to file a report with MBC when they take certain

⁵⁰ *Id.* at 109–14.

internal disciplinary actions against the admitting privileges of a physician. As documented in the *Initial Report*, section 805 reporting is one of the most valuable sources of complaints resulting in the investigation, prosecution, and disciplinary action in high-priority cases against physicians.⁵¹ However, the number of section 805 reports filed each year has steeply declined — and 2004–05 is no exception.⁵² In 2001, the Legislature added section 805.2 to the Business and Professions Code, requiring MBC to contract with an external entity to engage in a comprehensive study of the way in which peer review is actually conducted in California today, and to compare that with the reporting language in section 805. Specifically, the statute instructs the independent contractor to assess the need to amend sections 805 *et seq.* “to ensure that they continue to be relevant to the actual conduct of peer review,” and to determine “whether the current reporting requirement is yielding timely and accurate information to aid licensing boards in their responsibility to regulate and discipline healing arts practitioners when necessary, and to assure that peer review bodies function in the best interests of patient care.” Due to MBC’s budget constraints, that study has never been conducted, section 805’s reporting requirements have never been amended, and section 805 reporting continues to decline — to the detriment of the patients it is supposed to benefit.

SB 231 amends section 805.2 to require MBC to contract with an external entity to conduct the study mandated in 2001 by July 31, 2007. Under SB 231, “[c]ompletion of the peer review study . . . shall be among the highest priorities of the Medical Board of California.”

6. Enhanced public disclosure. In Chapter XIII of the *Initial Report*, the Monitor noted the importance of MBC’s public disclosure policy — especially in light of the legal, structural, staffing, and resource limitations on MBC’s enforcement program: “It is thus reasonable to expect MBC, as a complement to its enforcement program, to provide consumers with true, accurate, and complete information about its licensees so they can make informed choices and protect themselves from physicians with whom they would prefer not to deal.”⁵³ However, the Monitor found that the complex tangle of existing statutes and regulations that forms MBC’s “public disclosure policy” does not permit the Board to disclose all information about physician histories that consumers might deem relevant and important — including public information that is known to the Medical Board. In Recommendations #48–#52, the Monitor suggested that the existing statutes be consolidated and harmonized to eliminate drafting errors, inconsistencies, and confusion, and that certain additional events — including civil malpractice settlements over \$30,000 and misdemeanor criminal convictions against physicians — be publicly disclosed on MBC’s Web site.

⁵¹ *Id.* at 86–87 and 90–93.

⁵² See *infra* Ch. VI.B.5. for the number of section 805 reports filed with MBC in fiscal year 2004–05.

⁵³ *Initial Report*, *supra* note 13, at 205.

SB 231 makes several immediate changes to MBC's public disclosure policy and directs that an in-depth study of the role of public disclosure within MBC's public protection mandate be undertaken by a respected oversight agency:

■ ***Board posting of past disciplinary actions.*** Business and Professions Code section 2027(a)(2) previously contained language that appeared to preclude MBC from posting its own prior disciplinary actions against physicians on its Web site. That language was found to be a legislative drafting error in a recent decision in *Szold v Medical Board of California*,⁵⁴ and SB 231 amends section 2027(a)(2) to correct the error.

■ ***Board posting of substantially related misdemeanor criminal convictions.*** Although MBC is authorized to post felony criminal convictions on its Web site for an indefinite period of time,⁵⁵ it is not authorized to post any misdemeanor criminal convictions — no matter their seriousness, their relationship to the practice of medicine, or their number, and despite the fact that all criminal convictions are public information. SB 231 adds new subdivision (a)(7) to section 2027, which requires MBC to post on its Web site misdemeanor criminal convictions that are “substantially related to the qualifications, functions, or duties of a physician and surgeon.” Under amended section 2027(b)(1), such criminal convictions will be posted for ten years. Under new section 2027(d), this new disclosure requirement is not effective until MBC presents to the Legislature, and the Legislature enacts, a list of misdemeanor convictions that are “substantially related.”

■ ***Little Hoover Commission study of public disclosure.*** Rather than adding more public disclosure requirements in piecemeal fashion, SB 231 adds new section 2026 to the Business and Professions Code, which requires — to the extent MBC funding is available — the Milton Marks Commission on California State Government Organization and Economy (also known as the “Little Hoover Commission”), an independent watchdog agency, to “study and make recommendations on the role of public disclosure in the public protection mandate of the board. This study shall include, but not be limited to, whether the public is adequately informed about physician misconduct by the current laws and regulations providing for disclosure.” Section 2026 requires the study to be completed by July 1, 2008.

7. Reform of the Diversion Program. MBC's Diversion Program “diverts” substance-abusing physicians into a program that is intended to monitor them while they attempt to recover from the disease of addiction. Because Program participants often retain an unrestricted license to practice medicine, substance-abusing physicians pose a risk of grave harm to patients, and

⁵⁴ 127 Cal. App. 4th 591 (2005).

⁵⁵ Bus. & Prof. Code § 2027(a)(3); *see also id.* § 2027(b)(2).

participation in the Diversion Program is often concealed from patients and from MBC's enforcement program, the proper functioning of the Diversion Program is indispensable to protecting patients from potentially dangerous physicians. In Chapter XV of the *Initial Report*,⁵⁶ the Monitor undertook the first external audit of the Medical Board's Diversion Program in 18 years, and found significant deficiencies in its operations — many of which had been identified in the 1980s by the Auditor General. Twenty years later, the Monitor found that (1) the Program's monitoring mechanisms are inadequate; (2) the Program's internal quality controls are insufficient; (3) the Program is chronically understaffed; (4) the Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held; (5) the Medical Board has failed to adequately supervise the Program; and (6) the Diversion Program improperly operates in a vacuum that prevents MBC management from detecting breakdowns in its functioning.

Monitor's Recommendations #56–#65 present a series of challenges to the Medical Board ranging from the conceptual to the operational. MBC is asked to reevaluate the whole concept of “diversion” — whether it is feasible, whether it is consistent with the Board's overall public protection mandate, and whether it should be operated by the Medical Board or contracted to a private entity. If MBC desires to keep the Program, the Monitor recommended that DMQ spearhead a comprehensive overhaul of the Program to correct longstanding and fundamental deficiencies identified by the Auditor General in the 1980s and again by the Monitor in 2004.

SB 231 gives the Medical Board more than two years to fully and finally address the problems that plague this critically important program. The bill adds new section 2358 to the Business and Professions Code. Section 2358 sunsets the provisions creating the Diversion Program as of July 1, 2008 — thus abolishing the Program within the Medical Board on that date. Prior to that date, however, the Board and its Diversion Committee may make internal and administrative changes, adopt regulatory changes, and propose statutory changes to strengthen the functioning of the Program. Additionally, under legislative intent language contained in Section 1 of SB 231, the Joint Legislative Audit Committee will be asked during 2006 to direct the Bureau of State Audits (formerly the Auditor General) to conduct a thorough performance audit of the Diversion Program by June 30, 2007. These audit results, along with the Board's internal changes and legislative suggestions, will be available to the Legislature when it decides (during 2007) whether to extend the existence of the Diversion Program beyond July 1, 2008.

Additionally, SB 231 adds new subdivision (b) to Business and Professions Code section 2343, which requires the Diversion Program Manager to account for all expenses and revenues of the Diversion Program and separately report this information to the Board on a quarterly basis. This provision relates to Monitor's Recommendations #60–#61, which call on MBC to earmark and

⁵⁶ *Initial Report*, *supra* note 13, at 254–85.

separate the Diversion Program's budget from the rest of MBC's budget and limit participation in the Program to that which Program staff can reasonably and effectively monitor.

8. Medical Board “sunset” provisions. Under California's “sunset review” process, the necessity and performance of state occupational licensing boards are reviewed every four years by the Joint Committee on Boards, Commissions and Consumer Protection; these reviews are triggered by the insertion of a “sunset date” (the date on which the board will cease to exist) into the statutory provision creating the board. The Medical Board's “sunset date” is July 1, 2006, as established in Business and Professions Code section 2001. SB 231 amends section 2001 to extend the existence of the 21-member Medical Board to July 1, 2010. SB 231 also amends section 2020 to authorize the Medical Board to employ an executive director until July 1, 2010. Finally, SB 231 adds new section 473.16 to the Business and Professions Code, which requires the Joint Committee to examine the composition of the Medical Board and its initial and renewal licensing fees and report to the Governor and Legislature by July 1, 2008.

9. Miscellaneous technical clean-up provisions. SB 231 also makes several technical clean-up changes recommended by the Monitor:

■ **“Notices of intent.”** Code of Civil Procedure (CCP) section 364 requires any person who intends to sue a physician for medical malpractice to provide the physician with a “notice of intent to sue” at least 90 days prior to filing the lawsuit. CCP section 364.1 requires those persons to furnish MBC with a copy of the 90-day notice of intent (NOI) as well, ostensibly to alert MBC that a civil malpractice action may soon be filed against one of its licensees. In Chapter VI of the *Initial Report*,⁵⁷ the Monitor found that the information contained in NOIs is essentially useless to the Board, and that their inclusion as “complaints” in MBC enforcement data artificially skewed MBC's complaint totals upward and its complaint processing timeframes downward. The Monitor recommended that MBC discontinue counting NOIs as complaints, and further recommended the repeal of CCP section 364.1 in Recommendation #6. SB 231 repeals CCP section 364.1.

■ **“Medical Discipline Report.”** Government Code section 11371(c), enacted in 1993, required the Office of Administrative Hearings to publish ALJ proposed decisions to the Medical Board, “together with court decisions reviewing those decisions, and any court decisions relevant to medical quality adjudications,” in a quarterly *Medical Discipline Report*. The intent of the journal was to inform all parties — including licensees, HQE, respondent's counsel, and DMQ — of prior DMQ disciplinary decisionmaking in order to promote consistency and encourage settlements.⁵⁸ However, OAH never published the journal, and its intended “precedential” impact was superseded

⁵⁷ *Id.* at 97–98.

⁵⁸ *Id.* at 36, 193.

by the enactment of Government Code section 11425.60 in 1995. Therefore, the Monitor recommended that section 11371(c) be repealed (Recommendation #43). SB 231 repeals that section.

10. Future studies and reports. While the Enforcement Monitor project ends on November 1, 2005, SB 231 requires a number of additional studies, hearings, and reports on various issues related to MBC's enforcement program. The following table sets forth these post-Monitor activities:

DUE DATE	TOPIC
Early 2006	MBC must contract for the study of the peer review process. [Bus. & Prof. Code § 805.2]
Early 2006	The Joint Legislative Audit Committee (JLAC) is asked to assign the Bureau of State Audits (BSA) to perform a thorough performance review of MBC's Diversion Program. [SB 231 § 1 intent language]
Jan. 1, 2007	JLAC must appoint an external entity to review the Board's financial status, financial projections, and overall bookkeeping. [Bus. & Prof. Code § 2435(i)]
June 30, 2007	If authorized by JLAC during 2006, BSA must complete its audit of the Diversion Program. [SB 231 § 1 intent language]
July 1, 2007	MBC — in consultation with HQE, DCA, and the Department of Finance — must report to the Legislature on the progress of SB 231's version of vertical prosecution. [Gov't Code § 12529.7]
July 31, 2007	Peer review study must be completed. [Bus. & Prof. Code § 805.2]
2007	Legislature must pass legislation extending the Diversion Program and extending/refining vertical prosecution — or both will sunset as of July 1, 2008. [Bus. & Prof. Code § 2358; Gov't Code §§ 12529, 12529.5, 12529.6]
Jan. 1, 2008	The JLAC-selected auditor must complete its audit of MBC's finances/fees. [Bus. & Prof. Code §2435(i)]
July 1, 2008	The Joint Committee on Boards, Commissions and Consumer Protection must report to the Legislature on MBC's composition and its licensing fees. [Bus. & Prof. Code § 473.16]
July 1, 2008	The Little Hoover Commission must release its report on the role of public disclosure within MBC's public protection mandate. [Bus. & Prof. Code § 2026]
December 2008	The Joint Committee on Boards, Commissions and Consumer Protection must hold a sunset review hearing on MBC. [Bus. & Prof. Code § 2001]
2009	The Legislature must pass legislation continuing the existence of the Medical Board and its executive director — or both will sunset on July 1, 2010. [Bus. & Prof. Code §§ 2001, 2020]

B. Assembly Bill 446 (Negrete McLeod)

In Chapter VI of the *Initial Report*,⁵⁹ the Monitor decried a common practice that affirmatively deprives MBC of information about physician misconduct, and of cooperation by patients who have been injured by physicians. When a patient sues a physician for medical malpractice, the physician may decide to settle with the patient. However, as a condition of settlement, the physician demands that the consumer agree not to contact the Medical Board, not to cooperate with the Medical Board (should the Board contact the patient upon receiving the section 801 report of the settlement), and/or to withdraw a complaint pending before the Board.

These so-called “regulatory gag clauses” cause many serious problems — both for the Medical Board that is being deprived of information about its own licensees by its own licensees and for unsuspecting patients who continue to be exposed to unscrupulous and/or incompetent physicians because MBC cannot take appropriate disciplinary action against them — the very antithesis of the purpose of all regulatory agencies and especially the Medical Board. During 2004, the Medical Board documented some of the costs of regulatory gag clauses.⁶⁰ The Board described a dozen recent cases from throughout the state in which regulatory gag clauses hindered or prevented investigations and/or prosecutions. These cases documented the considerable time CCU must spend attempting to persuade reluctant patients that the use of regulatory gag clauses by physicians has been invalidated by the courts⁶¹ — which court decision seems not to have deterred physicians from inserting gag clauses into settlement agreements. If CCU cannot persuade the patient to sign a release for medical records (which records are otherwise privileged), it can request HQE to subpoena the records and then enforce the subpoena through a motion before the courts. This process takes considerable time — and some cases in which gag clauses were used had to be closed because the accusation could not be filed within the Board’s statute of limitations.⁶² This process also costs money — in one case arising out of San Jose, the existence of a gag clause in a civil settlement agreement cost MBC an additional 24 months in investigative time and \$25,000 in attorneys’ fees for the preparation and enforcement of a subpoena.

In Recommendation #17, the Monitor stated that regulatory gag clauses should be statutorily banned for all regulated trades and professions and particularly for physicians in light of the

⁵⁹ *Id.* at 112–14.

⁶⁰ Medical Board of California, *Investigation of Impact of Regulatory Gag Clauses: Preliminary Findings* (January 13, 2004).

⁶¹ *Mary R. v. Division of Medical Quality of the Board of Medical Quality Assurance* (1983) 149 Cal. App. 3d 308.

⁶² Bus. & Prof. Code § 2230.5.

irreparable harm they can cause if they are incompetent, negligent, dishonest, or impaired. Recommendation #17 became the subject of AB 446 (Negrete McLeod), 2005 legislation that proposed to ban the inclusion of regulatory gag clauses in civil settlement agreements. During the summer of 2005, AB 446 passed both houses of the Legislature. Regrettably, the Governor vetoed AB 446 on September 29, finding that the bill would have a “negative effect” on the California economy. According to the Governor, “[w]hen parties who are in dispute agree to settle, there should be some assurances that the dispute has been resolved in a satisfactory and final manner for both parties.”

This veto reflects a misunderstanding of the purpose of executive branch agencies, which is not to rubberstamp private dispute resolution but to protect future consumers from future injury caused by licensees of the State of California. The civil tort system and the administrative process have very different purposes. An outcome in one system should not necessarily dictate the outcome in the other. Concealment from a regulator should not be “on the table” during civil settlement negotiations. Regulated licensees should not be able to unilaterally deprive their own regulators of information about their own misconduct committed in the course and scope of the regulated business, and agencies should never be deprived of the discretion to investigate complaints or the cooperation of injured victims. Unfortunately, this veto undermines the purpose of occupational licensing agencies — which is to protect future unsuspecting consumers who were not a party to the settlement.

C. Senate Bill 1111 (Committee on Business, Professions and Economic Development)

Senate Bill 1111 (Committee on Business, Professions and Economic Development), which was passed by the Legislature and signed by the Governor (Chapter 621, Statutes of 2005), contains one technical clean-up change proposed by the Monitor. As suggested in Monitor's Recommendation #45, SB 1111 amends Business and Professions Code section 2230 to correctly reflect the number of members on DMQ's panels.

Chapter V

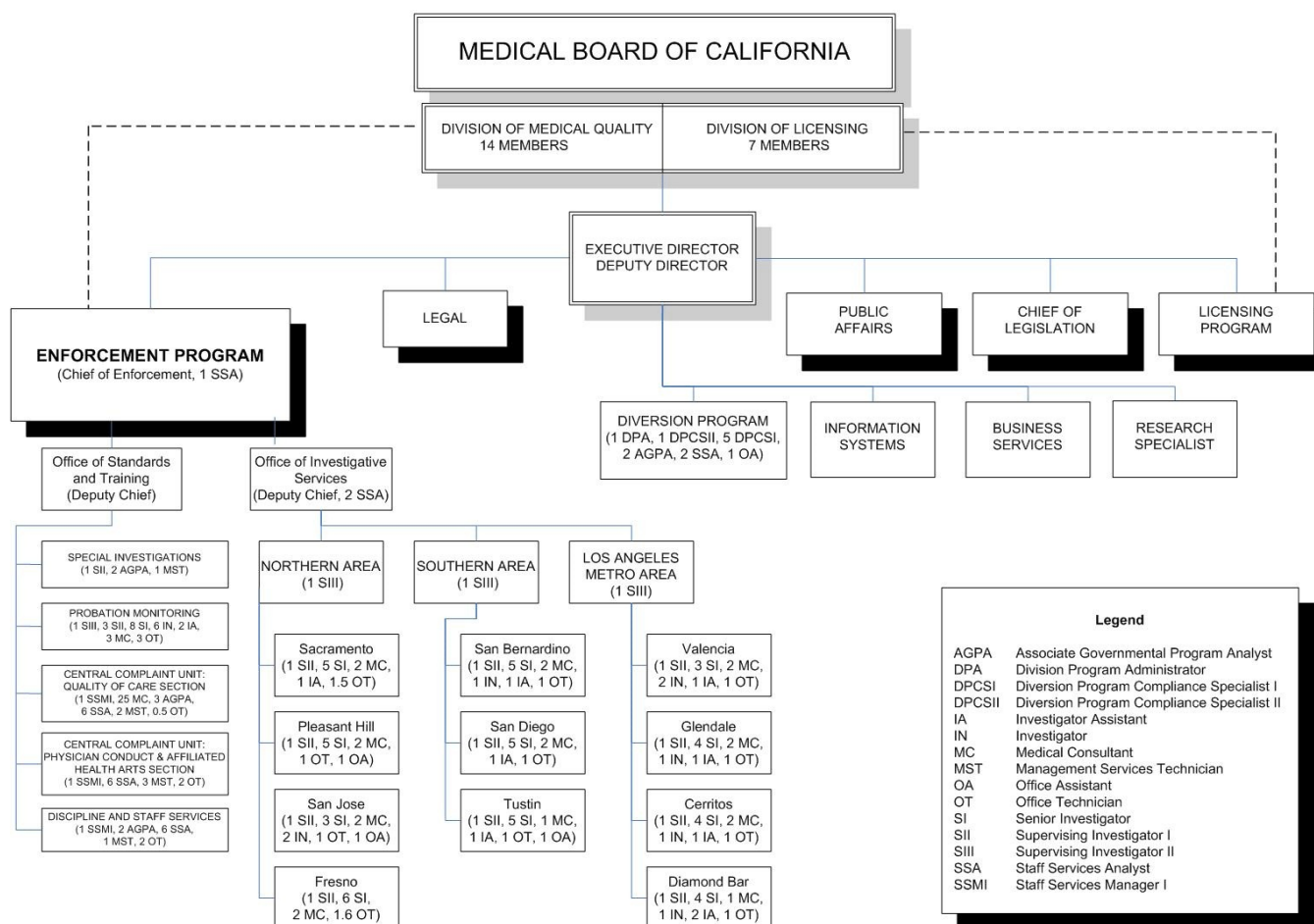
MBC's ENFORCEMENT PROGRAM: GENERAL DESCRIPTION AND THRESHOLD CONCERNS

A. Overview of Function and Updated Data

The Medical Board's enforcement program is complex, fragmented, and expensive. Individuals from three separate agencies participate in its proceedings, and it cost the Board \$30 million in 2004–05. Presented here is a brief overview of the various steps of the process — along with an updated enforcement program organizational chart, a flowchart of the pathway of a complaint through the process, and detailed data to give the reader a sense of the complexity of the process and the number of complaints handled by the various participants. We recap several Monitor concerns identified in the *Initial Report* that cut across the entirety of the enforcement program, and discuss steps taken to address those concerns in 2004–05.

Central Complaint Unit. MBC's complaint intake function is centralized in the Central Complaint Unit (CCU) in Sacramento. As reflected in Exhibit V-A below, CCU is presently divided into two sections — the Quality of Care Section (which handles complaints related to diagnosis and/or treatment provided by a physician to a patient in the context of the physician/patient relationship) and the Physician Conduct Section (which handles all other complaints). In most quality of care cases, CCU procures the medical records of the complainant and requests a response or explanation from the subject physician. The medical records and explanation are reviewed by a CCU "medical consultant" (a physician practicing in a similar specialty as the complained-of physician) who recommends whether the matter warrants formal investigation. In non-quality of care cases, CCU may procure medical records and forward them for medical consultant review (if applicable), and/or request a response or explanation from the subject physician; CCU then processes the case as appropriate depending on the type of case and sufficiency of the evidence. Cases that survive CCU screening are referred for formal investigation.

Ex. V-A. MBC Enforcement Program Organizational Chart (September 2005)



Source: Medical Board of California

Field investigations. MBC currently maintains eleven field offices (called “district offices”) staffed by professional peace officer investigators, district office medical consultants, and supervising investigators. A case that has survived CCU screening is referred “to the field” in the geographical area where the subject physician practices and is assigned to one of MBC’s investigators. Assisted by a medical consultant, the supervising investigator, and a deputy attorney general from the Health Quality Enforcement (HQE) Section of the Attorney General’s Office, the investigator develops an investigative plan appropriate to the type of case and conducts the investigation. Investigations typically include the gathering of additional medical records; interviews with the complainant(s), witnesses, and the subject physician; and — in quality of care cases — review of the entire investigative report and the evidence by an “expert reviewer” (again, a licensed physician in the same or similar specialty as the complained-of physician) who opines on the standards of care applicable to the particular matter, whether the subject physician’s conduct fell below those standards, in what way(s), and to what degree. If the investigative report and the expert

review indicate that the subject physician has committed a serious and disciplinable violation, the matter is referred to HQE for the drafting of formal charges against the physician's license, and/or (in appropriate cases) to local prosecutors for the filing of criminal charges.

Administrative prosecutions. Once a Medical Board investigator completes an investigative report recommending the filing of disciplinary charges in a given case and that recommendation (often supported by expert testimony) is approved, the matter is transferred to HQE where it is assigned to a deputy attorney general (DAG). The DAG reviews the investigative file and determines whether it is complete and sufficient to prove a disciplinary violation. If so, the DAG prepares an "accusation" (a formal written statement of charges)⁶³ and returns it to the Medical Board's executive director for approval.⁶⁴ The accusation is deemed "filed" when the executive director signs it. The accusation is then served on the subject physician, who is called the "respondent."⁶⁵

The filing of the accusation triggers the adjudication process governed by the Administrative Procedure Act (APA),⁶⁶ which is designed to ensure that an accused licensee is afforded appropriate procedural due process before his or her property right (the license) is taken.⁶⁷ According to caselaw interpreting the APA, the agency is the moving party, has the burden of proof, and must prove a disciplinary violation by "clear and convincing proof to a reasonable certainty."⁶⁸

Once the accusation is filed, the respondent may file a notice of defense.⁶⁹ If such a notice is filed, MBC transfers the case file back to the DAG, who secures a hearing date from the Office of Administrative Hearings (see below). Thereafter, the parties engage in limited discovery⁷⁰ and — barring a settlement that is approved by MBC enforcement staff and the Division of Medical Quality — present their respective cases at a public evidentiary hearing presided over by an

⁶³ Gov't Code § 11503.

⁶⁴ In less serious cases not warranting license revocation, suspension, or probation, MBC may issue a citation and fine, Bus. & Prof. Code § 125.9, or opt to offer the physician a "public letter of reprimand" in lieu of filing or prosecuting an accusation. *Id.* § 2233.

⁶⁵ Gov't Code § 11500(c).

⁶⁶ *Id.* § 11370 *et seq.*; *see also* Bus. & Prof. Code § 2230(a).

⁶⁷ *See, e.g.*, Gov't Code § 11425.10.

⁶⁸ *See, e.g., Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

⁶⁹ Gov't Code § 11506.

⁷⁰ *Id.* § 11507.6.

administrative law judge (ALJ) from the Office of Administrative Hearings. At the hearing and throughout any post-hearing proceedings, the HQE DAG represents the Medical Board; the respondent may be represented by private counsel at his/her own expense.

Office of Administrative Hearings' Medical Quality Hearing Panel. The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state and local agency adjudicative hearings in a variety of areas. In 1993, a special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH; ALJs appointed to the MQHP are permitted to specialize in physician discipline matters.⁷¹ The law requires an MQHP ALJ to preside over MBC evidentiary hearings.⁷²

During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument.⁷³ Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline.⁷⁴ The ALJ's ruling is a "proposed decision"⁷⁵ that is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision (see below).

In filing charges and recommending discipline, the DAG and the ALJ are guided by a set of "disciplinary guidelines" approved by DMQ; these guidelines set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.⁷⁶

Division of Medical Quality review. Following completion of the evidentiary hearing, the ALJ's proposed decision is transmitted to MBC headquarters for review by DMQ. For purposes of reviewing ALJ proposed decisions, the fourteen-member DMQ divides into two seven-member panels (Panel A and Panel B); a proposed decision is assigned to one of the panels for review.⁷⁷ Within 90 days of receipt of the proposed decision, the assigned DMQ panel must review the ALJ's

⁷¹ *Id.* § 11371.

⁷² *Id.* § 11372.

⁷³ *Id.* § 11513.

⁷⁴ *Id.* § 11425.50.

⁷⁵ *Id.* § 11517.

⁷⁶ Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board's disciplinary guidelines.

⁷⁷ Bus. & Prof. Code § 2230(b).

ruling and decide whether to “adopt” it as the final agency decision for purposes of judicial review, or “nonadopt” it because it is defective or inappropriate in some way.⁷⁸ If the panel nonadopts the ALJ’s proposed decision because it believes the penalty should be more severe than that recommended by the ALJ, the panel must order a record of the evidentiary hearing, make it available to both parties,⁷⁹ and afford the parties an opportunity for oral argument before the panel prior to deciding the case.⁸⁰ In imposing disciplinary sanctions, the DMQ panel must consider the Division’s “disciplinary guidelines,” which set forth the Division’s preferred range of sanctions for every given violation of the Medical Practice Act and the Board’s regulations.⁸¹

Judicial review of DMQ’s decision. A physician whose license has been disciplined by DMQ may seek judicial review of the Division’s decision by filing a petition for writ of mandate in superior court under Code of Civil Procedure section 1094.5.⁸² Generally, the focus of the court’s review is to determine whether DMQ’s factual findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency’s discretion or constitutes an abuse of that discretion.⁸³ Following its review, the superior court may affirm DMQ’s decision, or may reverse and/or vacate it and remand it to DMQ for further proceedings.

Either side may challenge the superior court’s decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal.⁸⁴ If the court believes the petition is meritorious, it will grant an alternative writ, order full briefing, entertain oral argument, and issue a written decision. If the court believes the petition is nonmeritorious, it may summarily deny the writ, thus obviating the need for oral argument and a written opinion in the matter.

If the appellate court affirms the superior court’s decision, either party may petition the California Supreme Court to review the case. Such review is entirely discretionary and is rarely attempted or granted.

⁷⁸ *Id.* § 2335(c)(3).

⁷⁹ Gov’t Code § 11517(c)(2)(E).

⁸⁰ Bus. & Prof. Code § 2335(c)(4).

⁸¹ *See supra* note 76.

⁸² Gov’t Code § 11523.

⁸³ Civ. Proc. Code § 1094.5(b).

⁸⁴ Bus. & Prof. Code § 2337.

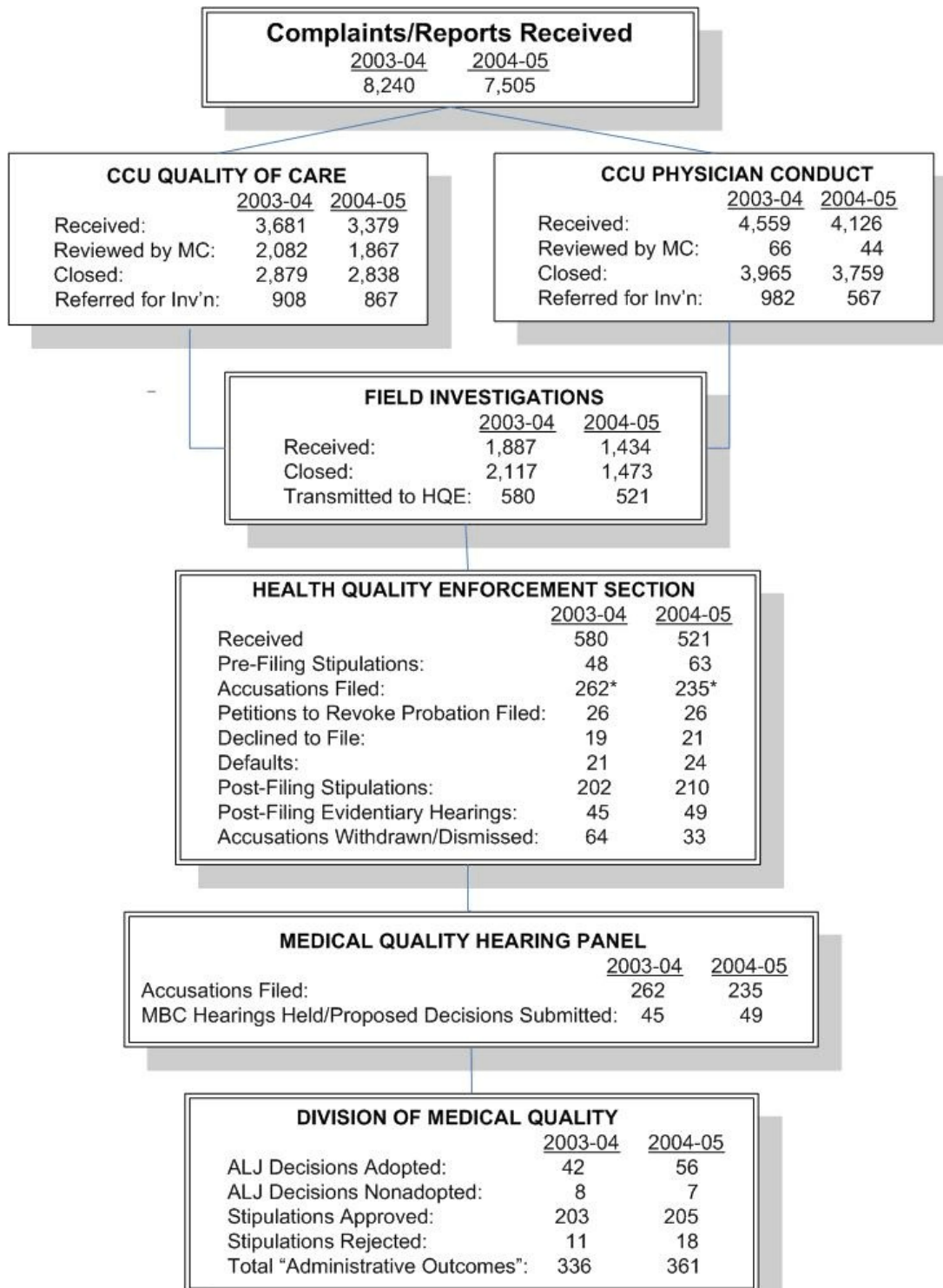
MBC enforcement program flowchart. Exhibit V-B below presents the pathway of a complaint or report of physician misconduct through the MBC enforcement program described above. Additionally, it presents MBC's fiscal year 2003–04 and 2004–05 “throughput” — the number of cases that entered each step and their overall disposition. Exhibit V-C below presents MBC enforcement data from 1991–92 (the year in which HQE was created) to the present.

Exhibit V-B indicates a significant decline in the number of complaints and reports received by MBC and a lower volume of output on the part of MBC and HQE staff during 2004–05. However, a number of variables may be in play, and some explanations are in order:

■ **Complaint/reports received.** On its face, Exhibit V-B indicates a 9% decline in the number of complaints received in 2004–05 (from 8,240 in 2003–04 to 7,505 in 2004–05). However, MBC adopted one of the Monitor's recommendations and has — in its reported 2004–05 enforcement data — ceased counting so-called “change of address citations” as complaints and investigations.⁸⁵ Of the 8,240 complaints and reports received in 2003–04, 327 were change of address citations. Thus, MBC received 7,913 complaints and reports during 2003–04, and there has been an actual 5.2% decrease in the number of complaints received in 2004–05. While this may not be a statistically significant decrease, Exhibit V-C indicates that the decrease reflects a trend occurring over the past three or four years, and it is occurring across almost all sources of complaints and reports, including the valuable reports mandated in Business and Professions Code section 800 *et seq.* Obviously, a downward trend in the number of complaints and reports received helps MBC and its decreased staff — but it may also reflect inadequate public outreach, especially to mandated reporters. These issues are discussed in more detail in Chapters VI and XIV.

⁸⁵ A “change of address citation” occurs when MBC's Licensing Unit mails a physician his/her license renewal notice and it is returned to the Board because the address is incorrect — the physician has moved but failed to notify MBC in a timely manner as required by law. When this occurs (and it occurs 300–400 times per year), a complaint is initiated by CCU and it is immediately (on the same day) referred to the Board's Citation and Fine Unit for the issuance of a citation. For some reason, these were counted as both “complaints” and “investigations,” although neither CCU nor investigations handled them. The inclusion of “change of address citations” as complaints and investigations artificially skewed MBC's complaint total upward and — because they are opened and closed on the same day — skewed the case cycle times of both CCU and investigations downward. In the *Initial Report*, the Monitor suggested that MBC discontinue counting “change of address citations” as complaints and investigations. *Initial Report*, *supra* note 13, at 98–100 and Recommendation #5. MBC has eliminated them from its 2004–05 reported complaint totals. Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at v.

Ex. V-B. FY 2003-04 and 2004-05 MBC Enforcement Program Throughput



* Multiple cases against the same physician are frequently combined into one accusation.

Source: Medical Board of California

Ex. V-C. Enforcement Program Statistical Profile (Physicians and Surgeons)

Workload Measure	3-Year Averages			2000-01	2001-02	2002-03	2003-04	2004-05	
	1991-92 through 1993-94	1994-95 through 1996-97	1994-95 through 1999-00						
Active Licensees	102,680	103,266	106,835	109,289	112,273	115,354	117,806	120,027	
Complaint Intake and Review	Complaints Received - B&P Code, Section 800 and 2240(a) Reports	1,010	1,191	1,441	1,538	1,454	1,385	1,240	1,107
	Complaints Received - Govt. & Law Enforcement	NA	1,844	1,855	1,953	1,996	1,737	1,593	1,266
	Complaints Received - Profession	NA	153	270	279	264	295	283	256
	Complaints Received - Public & Other	5,730	3,800	4,046	4,450	4,845	5,478	5,124	4,874
	Total Complaints Received (Excl. NOI and NPDB Reports)	6,740	6,988	7,612	8,220	8,559	8,895	8,240	7,503
	Complaints Closed Without Investigation	4,289	5,616	5,608	5,011	6,818	6,072	6,837	6,603
	Complaints Referred for Investigation (Including Change of Address Citations)	2,608	2,026	2,125	2,320	2,608	2,138	1,887	1,443*
	Total Complaints Closed/Referred for Investigation	6,897	7,642	7,734	7,331	9,426	8,210	8,724	8,046
	Pending Complaints (End of Period)	3,397	1,555	1,279	2,229	1,403	2,019	1,566	1,011
	Investigations Closed or Referred (Including Change of Address Citations)	2,066	2,095	2,304	2,374	2,449	2,361	2,117	1,475*
Investigations	Referrals to District Attorney (DA) Offices	80	63	70	58	82	47	37	34
	Referrals to Attorney General's Office (AGO)	460	497	595	510	589	494	580	521
	Pending Investigations (End of Period, Excluding Legal Actions)	2,303	1,824	1,406	1,346	1,531	1,251	1,060	1,054
	Pending Investigations Per Investigator (Including AHLP Cases)	33	26	21	18	20	21	18	19
Probation	Active, In-State Cases (End of Period)	475	569	500	503	498	516	547	545
	Cases Per Investigator	53	63	42	39	36	40	46	39
	Pending Investigations (End of Period)	69	94	13	35	78	73	43	45
	Pending Legal Action Cases (End of Period)	77	18	37	46	53	39	42	52
Locations	Pending Investigations & Legal Actions Per Investigator	17	12	1	3	6	6	4	7
	TROs/ISOs Ordered	25	28	28	17	26	12	22	29
	Accusations Filed	282	289	327	238	329	258	262	235
	Petitions to Revoke Probation Filed	10	15	31	18	21	18	26	26
	Accusations Withdrawn/Dismissed	33	75	88	54	48	45	64	33
	Pending Legal Actions (End of Period; Including AHLP; Excluding Probation)	584	572	496	547	655	608	494	503
Discipline	Pending Legal Actions Per Investigator (Including AHLP Cases)	23	8	7	7	9	10	8	9
	Citations and Administrative Fines Issued	NA	141	290	513	520	532	423	307
	Revocation	51	59	50	39	38	40	37	43
	Surrender	29	67	77	49	47	67	65	82
	Suspension	0	1	2	5	6	4	2	0
	Suspension and Probation	29	30	16	16	19	27	31	17
	Probation Only	51	127	109	91	69	87	98	93
	Public Reprimand	NA	44	50	50	52	58	51	75
	Total, Excluding Citations	162	328	304	250	231	283	284	310
	B&P Mandated Reports	Sections 801/801.1/803.2 - Malpractice Reporting by Insurers & Employers	746	894	1,024	921	872	872	787
Section 802 - Malpractice Self-Reporting		79	130	232	391	313	281	228	212
Section 803 - Malpractice Reporting by Courts		10	21	26	25	30	16	3	9
Section 802.5 - Coroner Reports of Gross Negligence		16	9	32	33	38	24	18	23
Sections 802.1/803.5 - Criminal Charges and Convictions		0	18	26	37	38	24	33	20
Section 805 - Health Care Facilities (Competence)		159	119	101	124	151	162	157	110
Section 2240(a) - Self-Reported Surgical Death/Complications		0	0	0	7	12	6	14	11
Total B&P Mandated Reports		1,010	1,191	1,441	1,538	1,454	1,385	1,240	1,107

* Effective in FY 2004-05, change of address citations are no longer counted as complaints or investigations.

Sources: Medical Board of California Annual Reports, California Department of Consumer Affairs Annual Statistical Profiles, and MBC Complaint Tracking System data.

■ **Cases referred for investigation.** Once again, Exhibit V-B indicates a 24% decrease in the number of complaints referred for investigation (from 1,887 in 2003-04 to 1,434 in 2004-05). However, the 2003-04 figure includes 327 change of address citations, so that number should be adjusted to 1,560. In 2004-05, there was an actual 8% decrease in the number of cases sent to the field. The reasons for this decline are unclear. For example, CCU (including the relatively recent additions of a half-time deputy attorney general and supervising investigator, who are reviewing proposed dispositions of many cases) may be doing a better job of screening weak cases away from MBC's depleted investigative staff. It appears that the new "specialty review" requirement mandated

by Business and Professions Code section 2220.08 is not the reason for this decline; this issue is discussed in more detail in Chapter VI.

■ **Physician conduct cases referred for investigation.** At first look, Exhibit V-B indicates a 42% decrease in the number of physician conduct cases referred to the field in 2004–05 (from 982 to 567). However, the 2003–04 figure must be adjusted to exclude 327 change of address citations. Thus there was an actual decrease of 13% in the number of physician conduct cases referred for investigation.

■ **Cases closed by investigators.** The number of cases closed by investigators dropped by 317 in 2004–05 (from 1,790 in 2003–04 to 1,473 in 2004–05, when the 2003–04 total is properly adjusted for 327 change of address citations — see above), reflecting a 17.7% decrease.

■ **Cases forwarded to HQE and accusations filed.** Exhibit V-B reflects a 10% decrease in number of cases sent to HQE (from 580 to 521) and a 10% decrease in the number of accusations filed (from 262 to 235) during 2004–05.

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes several threshold concerns about the overall enforcement program discussed in the *Initial Report*, and documents the responses to those findings implemented by the Medical Board, the Attorney General's Office, and the Legislature. More detail on each of the findings is available in Chapter V of the *Initial Report*.⁸⁶

1. The enforcement process simply takes too long to protect the public.

During 2003–04, the average length of time for a serious complaint to reach its disciplinary conclusion was 2.63 years. This is an average, and does not include time consumed by judicial review of MBC's decisions. As reflected in Exhibit V-D below, during 2004–05 MBC cut that overall average time slightly to 2.5 years, even without the addition of new monetary resources or staffing; for that, MBC should be commended. However, 2.5 years is still excessive in light of the risk of irreparable harm posed by incompetent or impaired physicians, and the Board's investigative time still far exceeds the 180-day goal established in statute.⁸⁷

⁸⁶ *Initial Report*, *supra* note 13, at 63–72.

⁸⁷ Bus. & Prof. Code § 2319; *see supra* note 18.

Ex. V-D. FY 2003–04 / 2004–05 Average Complaint Processing Time

	FY 2003–04	FY 2004–05
CCU processing	79 days ⁸⁸	66 days ⁸⁹
Field investigations (including expert review)	261 days ⁹⁰	259 days ⁹¹
HQE prior to accusation filing	107 days ⁹²	116 days ⁹³
HQE post-filing/ OAH hearing and proposed decision/ DMQ review and decision	513 days ⁹⁴	473 days ⁹⁵
TOTAL TIME TO FINAL DMQ DECISION	960 days = 2.63 years	914 days = 2.5 years

Source: Medical Board of California

2. MBC resources are inadequate.

In the *Initial Report*, the Monitor described the devastating combination of blows suffered by the Medical Board’s enforcement program over the past decade, including an outdated license fee structure wherein its fees have been frozen for twelve years, the higher costs of staff salaries (including benefits, pensions, and workers’ compensation) and other enforcement-related services (including an increase in the Attorney General’s hourly rate) during that time, and significant staffing losses endured by both MBC and HQE as a result of the 2001–04 state hiring freeze. These financial losses and staffing cuts required MBC to disband two promising proactive enforcement programs, cut employee training, reduce work hours for its district office medical consultants, and impose caseloads on some of its supervising investigators. In 2004, MBC estimated that it would need an increase in licensing fees from \$610 to \$800 biennially to support a restoration of service levels comparable to 1994, and the Monitor agreed.⁹⁶

⁸⁸ *Initial Report*, *supra* note 13, at 99 (Ex. VI-H).

⁸⁹ *See infra* Ex. VI-C.

⁹⁰ *Initial Report*, *supra* note 13, at 125 (Ex. VII-A).

⁹¹ *See infra* Ex. VII-A.

⁹² *Initial Report*, *supra* note 13, at 167 (Ex. IX-B).

⁹³ Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at vi.

⁹⁴ Medical Board of California, *2003–04 Annual Report* (Oct. 1, 2004) at vi.

⁹⁵ Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at vi.

⁹⁶ *Initial Report*, *supra* note 13, at 72 (Recommendation #2).

In SB 231 (Figueroa), the Legislature responded by amending Business and Professions Code section 2435 to increase MBC's initial and biennial renewal licensing fees to a base of \$790 (or \$395 per year). Additionally, and as described above in Chapter IV, the Legislature has authorized MBC to exceed the \$790 base to recoup lost cost recovery revenue (approximately \$850,000 per year, or about \$18 per licensee) and to cover increased enforcement activity due to the absence of cost recovery. Finally, in anticipation of the transfer of MBC's investigators to HQE in 2008, new section 2435.3 authorizes MBC to increase licensing fees by an additional \$20 per biennial renewal period to cover the costs of the transfer. In order to increase fees above the base of \$790 for these reasons, MBC must engage in the public rulemaking process.

According to MBC Executive Director Dave Thornton, SB 231's fee increase will enable the Board to restore fifteen investigator positions, six DAG positions, and MBC's Medical Director position — all of which were lost in the hiring freeze. The fee increase will also allow MBC to implement vertical prosecution, augment the staffing of the chronically understaffed Diversion Program, maintain an adequate budget for the payment of qualified expert reviewers, restore lost medical consultant hours, and maintain a two-month reserve fund as required by law.

The resources battle is only halfway won. Collecting increased licensing fees is one thing; being authorized to spend them is quite another. Armed with the fee increase, MBC and HQE must now submit budget change proposals (BCPs) to restore their lost positions and spend the new money in a way that not only restores 1994 service levels but significantly improves on them. Although MBC has achieved slight improvements in certain categories during 2004–05, the status quo is still unacceptable. Today, MBC's enforcement program staff consists of 20 fewer positions than it had in 1991–92, when it received 22% fewer complaints and took 75% fewer disciplinary actions. As reflected in Exhibit V-D above, the case processing times of MBC and HQE are simply too long to protect the public from dangerous physicians who pose a risk of irreparable harm. Since the hiring freeze ended on June 30, 2004, the number of state employee positions — including those funded by the general fund and by special funds — has grown by an estimated 3.2%.⁹⁷ MBC is a special fund agency that requires no money from the general fund, that now has sufficient funding to reinstate its lost enforcement positions and make the other reforms suggested by the Monitor, and that — according to the Legislature and Governor who enacted SB 231 (Figueroa) — “performs one of the most critical functions of state government.”⁹⁸ The Monitor urges the Department of Consumer Affairs, the Department of Finance, and other control agencies to approve these vitally important BCPs.

⁹⁷ Office of the Governor, *Governor's Budget Summary 2005–06* (Jan. 10, 2005) at Schedules 4 and 6.

⁹⁸ Gov't Code § 12529.6(a), as added by SB 231 (Figueroa), 2005 Cal. Stat. 674, § 28.

3. MBC and HQE's management structure and information systems need improvement.

In the *Initial Report*, the Monitor expressed concerns about several aspects of MBC's management structure and information systems. Some of these concerns have been addressed in 2005:

- **Medical Director position.** As noted above, MBC lost its Medical Director position in the hiring freeze. The most recent occupant of that position played an important role by assisting the Board and its staff in policy and program development, serving as a liaison to health care constituencies, and working with those constituencies to define issues of importance. In the *Initial Report*, the Monitor urged MBC to reinstate the Medical Director position. MBC agrees, and can fund the new position with SB 231's fee increase. The Monitor urges the Administration to reinstate this important position.

- **Diversion Program management.** In Chapters V and XV of the *Initial Report*, the Monitor noted that, for many years, the Medical Board permitted its Diversion Program to effectively function in a vacuum, separate from overall MBC management. This separation resulted in breakdowns in key Diversion functions that pose a risk not only to the public but also to the physicians participating in the Program — breakdowns of which MBC management was not aware and thus could not address. The Monitor recommended that the administration of the Diversion Program be more fully integrated into MBC management. MBC has made progress on this issue. Since the issuance of the *Initial Report*, MBC management has hired a new program administrator who has strong enforcement and impairment program credentials, added a new case manager supervisor position to the Program, and expanded its essential Collection System Manager position into a full-time position. Additionally, new Board President Ronald Wender has created a new Diversion Committee chaired by Martin Greenberg, Ph.D., and Dr. Greenberg is committed to addressing longstanding policy issues that have plagued the Diversion Program. These positive developments are described more fully in Chapter XV below.

- **Relationship between MBC and HQE.** As described in the *Initial Report*, MBC's investigations and prosecutions are inefficiently fragmented between two agencies, whereas most other comparable law enforcement agencies employ both investigators and prosecutors who work together in "vertical prosecution" teams under the direction of the prosecutor to gather evidence, assess the strength of the case, and quickly close weak cases while focusing expedited attention on meritorious cases. The 1991 addition of Government Code section 12529 *et seq.* was the first attempt at vertical prosecution; SB 231 goes a step further by imposing the essential elements of vertical prosecution on MBC and HQE — early assignment of an attorney/investigator team, continuity of

teamwork throughout the life of a case, and early designation of trial counsel under whose direction the investigation proceeds. While SB 231 did not succeed in transferring MBC's investigators into HQE for full implementation of vertical prosecution, it has set the stage for the transfer (including the funding), and the Monitor expects the transfer to occur in 2008 after completion of this transition period. These issues, and the precise way in which MBC/HQE plan to implement SB 231's version of vertical prosecution during the transition period, are discussed more fully in Chapters VII and IX below.

■ **Enforcement policy/procedure manuals.** In researching the *Initial Report* during 2004, the Monitor scoured a dozen MBC policy and procedure manuals, and found that several had not been updated to reflect 2002 legislative changes. The *Diversion Program Manual* had not been revised since 1998, and HQE had no policy and procedure manual whatsoever. MBC has made progress in this area as well. In late 2004, MBC's *Expert Reviewer Guidelines* were revised to correct several factual and legal errors. During 2005, the Monitor has received numerous updates to the Board's *Enforcement Program General Operations Manual*, *Enforcement Operations Manual*, *Central Complaint Unit Procedure Manual*, *Probation Operations Manual*, and *Investigation Activity Report Intranet Users' Guide*. MBC's *Citation and Fine Program Procedure Manual* was completely rewritten and an overhaul of the *Diversion Program Manual* is under way.

HQE has drafted an outline of a policy and procedure manual. However — as described more fully in Chapter VII below — the Monitor believes the better course is for a special working group of MBC and HQE managers to convert MBC's *Enforcement Operations Manual* (EOM), which guides all investigative procedures, into a joint MBC/HQE policy and procedure manual which implements vertical prosecution — both as it is currently mandated by SB 231 and in preparation for the eventual transfer of MBC investigators into HQE. The production of a joint manual would be an excellent first step in encouraging MBC/HQE teamwork and coordination, and would address the *Initial Report's* concern that many MBC policy and procedure manuals — of which the EOM is the most important — are not systematically reviewed or approved by HQE.⁹⁹ MBC has taken a significant step toward achievement of this necessary and important goal by sharing its EOM with HQE management.

■ **Management information systems.** Like all Department of Consumer Affairs agencies, MBC continues to struggle with DCA's "Consumer Affairs System" (CAS) mainframe computer program, which is so antiquated that the Department is reluctant to support further upgrades to it. Because CAS fails to meet its needs, MBC is forced to track some information manually or with additional small database programs.

⁹⁹ *Initial Report*, *supra* note 13, at 120 (Recommendation #21), 148, 152 (Recommendation #27).

MBC is fortunate to have an in-house Information Systems Branch (ISB) that is capable of designing new software to accommodate specialized programs. After the Monitor expressed concerns in the *Initial Report* about the error-ridden Diversion Tracking System (DTS) utilized by the Diversion Program, ISB revamped the DTS into a Web-based real-time program that was operational by July 1, 2005. This issue is discussed in more detail in Chapter XV below.

HQE now has one year of experience with its new ProLaw case management system, which is used to track attorney time and tasks performed on MBC cases, produce itemized billings for client agencies, and produce various types of reports that enable HQE managers to better supervise line DAGs and their movement of cases. HQE and its prosecutors appear to have mastered the case tracking system aspect of ProLaw in that all HQE attorneys (since July 14, 2004) now track their time and tasks performed on MBC cases on ProLaw. Additionally, HQE managers have begun to request and receive simple reports (for example, detailed billing reports by case and/or by prosecutor, and detailed case aging reports that provide clear and helpful information regarding key dates in the life of any case) that enable them to better supervise their staff.

However, HQE appears to have made less effective use of other important capabilities of this system. For example, ProLaw has a calculation function which would allow HQE to track sectionwide average time from its acceptance of cases to accusation filing, average time from filing to the date of stipulation and/or first date of hearing, and average caseloads of HQE DAGs. However, either HQE has not requested that the calculation function be activated or its external ProLaw contractor has not provided that service. As a result, HQE managers either don't know these calculated averages or must compute them on standalone databases in Access or Excel. Additionally, ProLaw does not classify cases by priority pursuant to Business and Professions Code section 2220.05; although the Monitor was told in 2004 that the addition of this field would be an "easy fix," it has not been accomplished. The Monitor recommends that HQE take full advantage of its new ProLaw system by learning its capabilities, activating the calculation function, and ensuring the data needed to calculate desired averages or totals are properly input by HQE staff on all cases.

Additionally, the Monitor recommends — as described more fully in Chapter VII below — that MBC purchase ProLaw, train its investigators in its use, and require investigators to track their time and activities on ProLaw as of January 1, 2006 (or as soon as is practicable thereafter). As vertical prosecution goes online as of January 1, 2006, and in preparation for the transfer of MBC's investigators to HQE in 2008, both sets of professionals should use the same computer system to track their time and activities on MBC cases. Both sets of professionals should be consistently trained in the use of that system, and both agencies should agree to and begin to use the same terminology and methodology in describing activities, events, and timeframes in their jointly-worked

cases. As described in Chapter IX below, MBC and HQE still count cases differently, and they count various timeframe intervals within cases differently.¹⁰⁰ As frustrating as that is for an external auditor like the Monitor, it must be maddening for those who actually work in the system. These two agencies — especially as they begin a process that is intended to integrate key MBC and HQE staff — must begin to work as one, utilizing the same tracking system, terminology, and methodology of counting case cycle times.

C. Recommendations for the Future

- ***Integrated policy/procedure manual.*** As described above and in Chapter VII below, HQE and MBC should work together to convert MBC's excellent *Enforcement Operations Manual* into a joint policy and procedure manual incorporating vertical prosecution.

- ***Expanded use of ProLaw by HQE.*** HQE should master all of the capabilities of ProLaw and ensure that the system is being utilized to its full capacity.

- ***Use of ProLaw by MBC investigators.*** As soon as possible after vertical prosecution goes online on January 1, 2006, MBC investigators should convert to the use of ProLaw. Both agencies should use the same case tracking system, be trained consistently on the use of that tracking system, and begin to count cases and case timeframes in the same way.

¹⁰⁰ See *infra* Ch. IX.B.1. for a discussion of this issue.

Chapter VI

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

A. Overview of Function and Updated Data

The Medical Board's Central Complaint Unit (CCU) is responsible for receiving, acknowledging, screening, and processing all complaints and reports the Medical Board receives about the medical care provided by and conduct of California physicians.

CCU is located in Sacramento, and is currently staffed by two managers, 15 analysts, four management services technicians, and a number of support staff. CCU is supported by a cadre of physicians ("medical consultants" or "MCs") under contract with the Unit who review complaints and medical records to assist in determining whether complaints should be referred for formal investigation. As of October 2003, a deputy attorney general from the Health Quality Enforcement Section of the Attorney General's Office and a supervising investigator from MBC's field investigations staff joined CCU; their roles are described below.

As noted in Chapter V, CCU is presently divided into two sections — the Quality of Care Section (which handles complaints related to diagnosis and/or treatment provided by a physician to a patient in the context of the physician/patient relationship) and the Physician Conduct Section (which handles all other complaints).

Quality of care cases. In order to analyze a quality of care (QC) complaint, CCU must procure the medical records of the patient from the complained-of physician (and often other treating physicians and institutions), which are subject to the physician-patient privilege and may not be released by the physician absent the patient's permission. Thus, CCU must secure the signature of the patient on a "release" or waiver of the privilege and request all relevant medical records on the patient, which may include charts, X-rays, laboratory test results, photographs, invoices, and correspondence. CCU may also request that the physician provide a summary or explanation of the care and treatment provided to the patient. Once CCU receives those medical records and other documents, the entire file is reviewed by one of CCU's medical consultants, who determines whether

there has been a departure from the applicable standard of care and recommends whether the case should be closed (because it reveals no violation or involves conduct that does not merit disciplinary action) or referred to the appropriate regional field office for formal investigation.

Physician conduct cases. Non-quality of care cases (also called “physician conduct” or “PC” cases) may involve alleged sexual misconduct, drug or alcohol abuse, false advertising, fraud, or criminal activity (among others). If the proper analysis of these cases requires patient medical records, CCU will secure a waiver, request the records, and turn the matter over to a medical consultant for a recommendation on whether the case should be closed or go forward. If not, CCU will process the case as appropriate depending on the type of case and sufficiency of the evidence.

Recent changes to CCU. The *Initial Report* provides a detailed description of CCU’s complaint processing function which is not repeated here.¹⁰¹ However, the reader is reminded of several relatively new changes to CCU functioning:

■ **Case processing priorities.** Effective January 1, 2003, SB 1950 (Figueroa) enacted section 2220.05, which declares that “[i]n order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

- (1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.
- (2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.
- (3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. . . .¹⁰²

¹⁰¹ See *Initial Report*, *supra* note 13, at 75–83.

¹⁰² Business and Professions Code section 2220.05(a)(3) emphasizes that a physician prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing practices shall not be prosecuted for excessive prescribing.

- (4) Sexual misconduct with one or more patients during a course of treatment or an examination.
- (5) Practicing medicine while under the influence of drugs or alcohol.”

Thus, effective January 1, 2003, CCU staff who initiate complaints into MBC’s computer system assign a priority code to each case according to the section 2220.05 priorities. In MBC parlance, section 2220.05 “priority cases” are called “U1” or “U3” or “U5,” depending on which subsection of 2220.05(a) is applicable. For cases not falling into a section 2220.05 priority category, CCU continues to utilize the pre-existing prioritization categories of “urgent,” “high,” and “routine.” In addition, U1–U5 priority cases are physically “red-tagged” so that CCU analysts can visually distinguish them from the rest of their caseload.

■ **“Specialty review” requirement.** Also effective January 1, 2003, SB 1950 (Figueroa) added section 2220.08, which prescribes a specific review process for quality of care cases in CCU. The statute requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been “reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required.” Section 2220.08 specifies that such “specialty review” must include a review of relevant patient records, a statement or explanation of the care and treatment provided by the subject physician, any additional expert testimony or literature provided by the subject physician, and any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care. The specialty review requirement has required CCU to recruit and train new medical consultants in a number of different specialties and subspecialties so that QC complaints and reports can be reviewed by a physician with relevant expertise.

■ **Additions to CCU.** Effective October 1, 2003, two persons were newly assigned to CCU. The half-time assignment of an HQE deputy attorney general (DAG) to CCU represents MBC/HQE’s long-overdue implementation of Government Code section 12529.5(b)’s requirement that HQE “assign attorneys to assist the division . . . in intake Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.”¹⁰³ At the same time,

¹⁰³ Government Code section 12529 *et seq.* was enacted in 1990 and became effective on January 1, 1991. It creates the Health Quality Enforcement Section in the Attorney General’s Office and requires the Attorney General to “ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against licensees” of the Medical Board. Section 12529.5 requires HQE to station deputies attorney general on location at every major intake

MBC assigned a supervising investigator to work full-time at CCU — such that CCU now has built-in legal and investigative expertise to assist in the processing and review of complaints.

Initially, the skills of these two professionals were not well integrated into the Unit. By September 2004, however, their roles had expanded considerably. The CCU DAG reviews all medical consultant-reviewed quality of care cases in which a simple departure has been found and all medical consultant-reviewed cases in which there is a split of opinion between MCs, has become involved in a few cases in which subject physicians or health care institutions have failed to produce requested medical records, and has reviewed and assisted in revising the *CCU Medical Consultant Procedure Manual* and various CCU forms. The CCU supervising investigator now reviews QC complaints that are proposed for closure without being reviewed by a medical consultant, PC cases being recommended for referral to investigation, and complaints being recommended for closure due to insufficient evidence. In addition, he assists with medical records procurement issues, performs undercover investigations of suspected Internet prescribing violations, serves as a liaison between MBC and other health care agencies, designs and teaches training courses for CCU analysts and MBC investigators, reviews proposed updates to various MBC procedure manuals, and assists in the recruitment of new medical consultants and expert reviewers. Both MBC and HQE agree that the addition of this expertise has had a beneficial effect on the functioning of CCU.

Detection of physician misconduct: sources of complaints and reports. Unlike other occupational licensing agencies, MBC is not solely dependent on consumers for information about physician misconduct. For many years, the California Legislature has mandated that other institutions — including medical malpractice insurance carriers, courts, hospitals, coroners, and physicians themselves — file reports with MBC about events that may indicate a problem physician. Exhibit V-C above presents an itemized breakdown of “B&P Mandated Reports” — reports that are required to be filed by the “mandatory reporting scheme” in Business and Professions Code section 800 *et seq.*¹⁰⁴

Exhibit VI-A below presents a breakdown of all complaints received by MBC in 2004–05, by referral source, and the percentage of complaints submitted by each source that was referred for investigation and prosecution (either by HQE or by local prosecutors).

and investigatory unit of MBC. Due to staffing shortfalls and budget constraints, HQE did not post any DAGs at MBC’s investigative offices until January 1, 1997. Although a brief and limited effort to provide DAG guidance to CCU was attempted in 1991–93, HQE did not assign any DAG to work in CCU until October 1, 2003 — shortly before the MBC Enforcement Monitor project began. *Initial Report*, *supra* note 13, at 31, 40–41, 54, 81–82.

¹⁰⁴ See *id.* at 84–86 for a detailed description of MBC’s mandatory reporting scheme.

**Ex. VI-A. FY 2004–05 Physician Complaint Processing
and Investigations by Referral Source**

Referral Source	FY 2004–05								
	Complaints Received	Reviewed By Medical Consultant	Complaints Closed By CCU	Referred to Investigation		Non-Legal Closures	Legal Closures		
				Number	Percent		Attorney General*	District Attorney*	Percent
Patient, Patient Advocate, Family Member or Friend	4,360	1,016	4,216	412	9%	322	111	9	27%
Out of State Medical/Osteopathic Boards	438	0	328	97	23%	5	95	0	95%
Section 801, 801.1 & 803.2 (Insurers & Employers)	725	576	597	193	24%	150	55	0	27%
Section 805 (Health Facilities)	112	0	29	83	74%	67	33	0	33%
Department of Health Services	103	12	75	38	34%	24	12	1	35%
M.D. Licensees	208	9	190	44	19%	35	7	0	17%
DOJ - Criminal Identification & Information Bureau (CII)	230	1	226	56	20%	40	16	0	29%
Other Governmental Agencies	69	10	50	40	44%	17	7	2	35%
Anonymous	270	2	257	32	11%	35	9	2	24%
Insurance Company	48	0	36	7	16%	10	2	0	17%
Police/Sheriff Departments	42	0	17	26	60%	11	8	3	50%
Section 802 & 802.1 (Self-Reporting)	207	218	192	67	26%	38	8	0	17%
Other	80	0	64	16	20%	17	3	1	19%
Newsclipping	7	1	2	6	75%	5	2	0	29%
Section 803 & 803.5 (Courts)	22	11	20	3	13%	1	0	0	0%
Employee or Co-worker of Subject	55	1	37	22	37%	11	6	1	39%
Pharmacist or Employee	18	0	11	6	35%	7	2	1	30%
Attorney General & Dept. of Justice	7	0	2	5	71%	3	0	0	0%
Coroner (including Section 802.5)	23	21	18	10	36%	11	2	0	15%
Confidential Informant	26	0	17	7	29%	3	2	1	50%
B&P 2240(A) - Self-Reported Surgical Complications	11	9	7	5	42%	2	1	0	33%
District Attorney	11	0	3	8	73%	3	3	0	50%
Allied Health Licensee	10	0	7	3	30%	1	0	0	0%
Other DCA Boards and Bureaus	16	4	24	5	17%	6	0	1	14%
Other Healing Arts Licensee	14	1	15	0	0%	1	2	1	75%
Hospital (Non-805 Report)	6	4	6	3	33%	3	0	0	0%
Jury Verdict Weekly	2	1	1	2	67%	1	0	0	0%
Court Clerk - Non-Felony Conviction	9	0	9	0	0%	1	0	0	0%
WE Tip	21	0	18	1	5%	1	0	0	0%
Medical Society or Association	12	0	11	1	8%	0	0	0	0%
Total, Excluding Medical Board	7,162	1,897	6,485	1,198	16%	831	386	23	33%
Medical Board	343	14	112	236	68%	121	135	11	55%
Total, Including Medical Board	7,505	1,911	6,597	1,434	18%	952	521	34	37%

* May include dual referrals.

Source: Medical Board of California

The data in Exhibit VI-A are consistent with similar data presented in the *Initial Report*,¹⁰⁵ and — once again — we can draw several conclusions from them. First, the predominant source of complaints is patients, their advocates, and their families. However, those complaints are rarely referred for investigation — only 9% of patient complaints went to investigation during 2004–05, which is consistent with 2003–04 (9% of patient complaints referred for investigation) and 2002–03 (11% of patient complaints referred for investigation). During 2004–05, the principal sources of complaints referred for investigation were mandatory reports required by Business and Professions Code section 800 *et seq.*, especially section 805 reports of adverse peer review action taken by

¹⁰⁵ *Id.* at 87.

hospitals (74% of section 805 reports were referred for investigation), section 802.5 reports by coroners (36% referred), section 802/802.1 self-reporting by physicians (26% referred), and section 801/801.1/803.2 reports by insurers and employers regarding malpractice payouts (24% referred). Other high-yield sources are medical and osteopath boards in other states, other government agencies, and local police or sheriff departments.

Disciplinary actions taken in section 2220.05 priority cases. As described above, SB 1950 (Figueroa) imposed mandatory case processing priorities on MBC. It also required the Monitor to assess “the relative value to the board of various sources of complaints or information available to the board about licensees in identifying licensees who practice substandard care causing serious patient harm”¹⁰⁶ In the *Initial Report*, the Monitor was required to present “an analysis of the sources of information that resulted in each disciplinary action imposed since January 1, 2003, involving priority cases, as defined in Section 2220.05.”¹⁰⁷ The Monitor presented that analysis for the period of January 1, 2003 through June 30, 2004 in the *Initial Report*; those figures are reproduced in Exhibit VI-B below. The exhibit provides the total number of disciplinary actions taken in both section 2220.05 priority categories and in MBC’s pre-existing “urgent/high/routine” categories which are still used to prioritize cases not falling within section 2220.05. Exhibit VI-B indicates that, during the 18-month period surveyed in the *Initial Report*, 24% of MBC disciplinary actions taken were in priority cases under section 2220.05, and that — in raw numbers — patients were the top source of section 2220.05 priority complaints resulting in disciplinary action.

Exhibit VI-B also supplements the 18-month period described in the *Initial Report* with another year’s worth of data. Between July 1, 2004 and June 30, 2005, 29% of MBC disciplinary actions taken were in section 2220.05 priority cases — representing an upward trend since the period charted in the *Initial Report*. As during the first reporting period, patients were once again — in raw numbers — the top source of priority complaints resulting in disciplinary action.

The Business and Professions Code section 800 *et seq.* “mandatory reporting statutes” continue to be high-yield sources of information leading to disciplinary actions in priority cases. Of the 218 disciplinary actions taken in section 2220.05 priority cases during the 30-month period covered in Exhibit VI-B, 31% resulted from mandatory reporting. This is consistent with the data in Exhibit VI-A above.

¹⁰⁶ Bus. & Prof. Code § 2220.1(c)(2).

¹⁰⁷ *Id.* § 2220.1(d).

Ex. VI-B. Disciplinary Actions by Referral Source by Priority

Referral Source	1/1/03 through 6/30/04			7/1/04 through 6/30/05			Total		
	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total
Out-of-State Medical/Osteopathic Boards	0	109	109	0	83	83	0	192	192
Medical Board	15	69	84	9	51	60	24	120	144
Patient, Patient Advocate, or Family Member	24	44	68	27	26	53	51	70	121
B&P 801 and 801.1 Reports (Insurers)	14	23	37	24	20	44	38	43	81
B&P 805 Reports (Health Care Facilities)	17	27	44	7	19	26	24	46	70
Department of Health Services	5	20	25	3	17	20	8	37	45
M.D., Other Healing Arts Licensee, Medical Assoc.	4	13	17	9	8	17	13	21	34
Other Government Agencies	3	12	15	3	6	9	6	18	24
Anonymous	5	7	12	6	3	9	11	10	21
Other (confidential informant, coworker, employee, other)	7	10	17	3	1	4	10	11	21
DOJ CII Report	0	8	8	0	12	12	0	20	20
Insurance Company	3	8	11	1	4	5	4	12	16
Police/Sheriff's Department	6	3	9	3	2	5	9	5	14
B&P 802 Reports (Self-Reporting)	2	8	10	2	0	2	4	8	12
Drug Enforcement Administration	4	2	6	1	0	1	5	2	7
B&P 803 Reports (Courts)	1	3	4	1	0	1	2	3	5
Pharmacist or Employee	2	1	3	1	1	2	3	2	5
Department of Justice	0	0	0	1	2	3	1	2	3
District Attorney	2	1	3	0	0	0	2	1	3
2240(a) Self-Reported Surgical Complications	0	0	0	1	1	2	1	1	2
Coroner's Office	0	0	0	1	1	2	1	1	2
Court Clerk - Non-felony	0	0	0	1	0	1	1	0	1
Total	114	368	482	104	257	361	218	625	843
Percent	24%	76%	100%	29%	71%	100%	26%	74%	100%

Source: Medical Board of California

Of the 843 disciplinary actions taken during this 30-month period, 218 (26%) were taken in section 2220.05 priority cases, and 625 (74%) were taken in nonpriority cases. However, this does not support a conclusion that “74% of MBC’s disciplinary actions were taken in cases where there was no patient harm.”

As noted in the *Initial Report*, MBC is taking disciplinary action in more patient harm cases than the data indicate. The most fruitful source of complaints in which disciplinary action was taken during the 30-month period was out-of-state medical boards and osteopathic medical boards. Twenty-three percent (23%) of the 843 disciplinary actions taken by MBC resulted from out-of-state disciplinary action. However, none of these cases was classified as a section 2220.05 priority case.

This is a function of the way MBC codes incoming reports of out-of-state physician discipline. Even though many out-of-state disciplinary actions upon which MBC's subsequent disciplinary action was premised involved "death or serious bodily injury" to a patient (such that they conceivably could have been classified as U1 priorities), technically MBC is not reopening those cases, rehearing the evidence, and taking disciplinary action for death or serious bodily injury — instead, it is basing its own disciplinary action on the other state's disciplinary action.¹⁰⁸ As such, all 192 cases were coded as "routine." Although MBC might have coded those out-of-state disciplines involving death or injury as U1 in order to "pad" its statistics, it did not. This decision is probably appropriate. Many of the physicians disciplined in this category do not reside in California and pose little threat to California consumers; they reside in another state (where they committed the act resulting in discipline) but also have a California license.

The Medical Board itself was the second most productive source of complaints leading to all disciplinary actions taken since January 1, 2003. The Medical Board is considered the "source" of complaints leading to disciplinary action in a number of different scenarios — several of which portend likely patient harm: (1) CCU or a district office investigator is investigating a case against Dr. X, obtains medical records and — based on the records — realizes that Dr. Y is equally or more culpable, and initiates a complaint against Dr. Y; (2) when an investigator is looking into a case, she will often run a "Civil Index" check (a check on all civil malpractice actions filed against the subject physician) and may find additional victims of the subject physician who have not filed a complaint with MBC, whereupon the investigator will initiate a new complaint against that physician; (3) if a physician whose license is on probation violates the terms of that probation and MBC files a petition to revoke the probation, MBC is listed as the source of the complaint leading to the petition; (4) when a physician whose license has been revoked petitions for reinstatement of his license, the physician's post-revocation conduct and rehabilitation is the subject of an investigation by a district office investigator, and MBC is listed as the source of that investigation; (5) when a self-referred participant in the Diversion Program is terminated for failure to comply with his/her Diversion contract, MBC is listed as the source of that action; (6) if a physician who is on probation decides to simply surrender his/her license, MBC is listed as the source of that surrender; and (7) occasionally, when MBC is investigating an allegation of unlicensed practice, it finds a physician who is aiding and abetting the unlicensed practice and initiates a complaint against that physician. Thus, in addition to taking disciplinary action in section 2220.05 priority cases, MBC is also taking disciplinary action in "patient harm" cases that fall outside section 2220.05's categories.

¹⁰⁸ See *id.* § 2305 (most disciplinary actions taken by another state or jurisdiction are grounds for disciplinary action in California).

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes the Monitor's *Initial Report* findings and concerns about CCU's performance, and documents the responses to those findings implemented by the Medical Board, the Attorney General's Office, and the Legislature during 2005. More detail on each of the findings is available in Chapter VI of the *Initial Report*.¹⁰⁹

1. CCU's average complaint processing time is longer than historically reported.

In the *Initial Report*, the Monitor noted that MBC had been counting as "complaints" several categories of information that should not be counted as complaints — including "notices of intent (NOI) to sue" under Code of Civil Procedure (CCP) section 364.1, copies of insurer reports of malpractice payouts sent to the National Practitioner Data Bank (NPDB), and "change of address citations."¹¹⁰ As a result, CCU's reported complaint total was artificially high and its reported average complaint processing time was artificially low. The Monitor recommended that MBC discontinue counting all three types of notices as "complaints."¹¹¹

In 2003–04, MBC discontinued counting NOIs and NPDB reports as complaints.¹¹² In 2004–05, MBC discontinued counting "change of address citations" as complaints.¹¹³ Similarly, they have been excluded from MBC's calculation of CCU's average complaint processing time. Thus, MBC has fully implemented the Monitor's recommendations and is accurately reporting both its complaint/report intake and its average case cycle times.

Related to this issue, the Monitor recommended (Recommendation #6) that CCP section 364.1 be repealed, as these reports provide MBC with information that is of little or no use. Effective January 1, 2006, section 20 of SB 231 (Figueroa) repeals section 364.1.

2. CCU's complaint processing takes too long.

In the *Initial Report*, the Monitor excluded NOIs, NPDB reports, and change of address citations from the calculation of CCU's average complaint processing, and found that it took CCU

¹⁰⁹ *Initial Report*, *supra* note 13, at 97–117.

¹¹⁰ *See supra* note 85.

¹¹¹ *Initial Report*, *supra* note 13, at 117 (Recommendation #5).

¹¹² *Id.* at 98.

¹¹³ Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at v.

an average of 79 days (2.63 months) from receipt of a complaint to its closure or referral to the field for investigation during 2003–04 — 12 days longer than it took CCU to process complaints in 2002–03.¹¹⁴ Exhibit VI-C below indicates that during 2004–05, CCU lowered its average complaint processing time to 66 days (2.2 months) — an encouraging 16% decrease.

**Ex. VI-C. FY 2004–05 CCU Physician Complaint Processing
Timeframes by Disposition and Day Range**

Day Range	Closed By CCU ¹		Referred to Investigation ²		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	2,660	41.0%	699	48.7%	3,359	42.4%
1 to 2 Months	1,275	19.6%	195	13.6%	1,470	18.6%
2 to 3 Months	901	13.9%	133	9.3%	1,034	13.0%
3 to 4 Months	575	8.9%	94	6.6%	669	8.4%
4 to 6 Months	664	10.2%	171	11.9%	835	10.5%
More than 6 Months	415	6.4%	142	9.9%	557	7.0%
Total, Excluding Change of Address Citations	6,490	100.0%	1,434	100.0%	7,924	100.0%
Average Timeframe	64 Days		68 Days		66 Days	

¹ Includes 26 complaints that took longer than a full year.

² Includes 12 complaints that took longer than a full year.

Source: Medical Board of California

Also in the *Initial Report*, the Monitor examined the time it takes CCU to process quality of care complaints — the thrust of SB 1950 (Figueroa). As described above, QC complaint processing generally involves (1) a CCU request for the patient’s signature on a release; (2) a CCU request for the patient’s medical records; and (3) review of those medical records and other materials submitted by the subject physician by a “specialty reviewer” under Business and Professions Code section 2220.08. In 2003–04, the average time from receipt of a QC complaint to completion of the medical consultant’s review was 140 days (4.66 months). Approximately ten of these days were consumed by complaint receipt and initiation, medical records procurement took 66 days, and the time consumed by the “specialty reviewer” was 64 days.¹¹⁵

Monitor’s Recommendations #7, #23, and #34 focused on one of the most pervasive and unnecessary delays in the enforcement program — the excessive amount of time it takes MBC and HQE to request and receive medical records which are indispensable in proving a quality of care case — and the apparent toleration of that delay in physician compliance with medical records laws on the part of both MBC and HQE personnel. These recommendations urged MBC and HQE to agree to and strictly enforce a new medical records procurement policy that encourages prompt production of requested medical records. For its part, CCU consulted with its assigned deputy attorney general in April 2005 and revised section 5.5 of the *CCU Procedure Manual* in July 2005. The manual

¹¹⁴ *Initial Report*, *supra* note 13, at 99 (Ex. VI-H).

¹¹⁵ *Id.* at 100–01.

revisions emphasize the statutory timeframes for production of requested medical records and revamp the request letters sent by CCU to physicians and medical facilities to include a citation to the relevant statute, a copy of the statute, and reference to possible penalties for noncompliance.¹¹⁶

CCU's emphasis on prompt medical records procurement appears to have worked. In 2004–05, CCU's average QC complaint processing time dropped to 122 days — a 13% decrease from 2003–04. Whereas the complaint initiation and specialty reviewer components remained approximately the same, the medical records procurement component of CCU processing was cut from 66 days to 48 days.

Thus, in the past year, CCU's overall complaint processing time has dropped by 16% to 66 days, and its QC complaint processing time has dropped 13% from 140 days to 122 days. While laudable, these timeframes — especially the QC complaint timeframe — are still excessive in the context of Business and Professions Code section 2319's statutory goal of 180 days from receipt of a complaint until completion of the investigation. CCU should continue to work hard on reducing the time spent on medical records procurement and specialty review (discussed in more detail below).

Related to medical records, Monitor's Recommendation #8 suggested an expansion of the role of the assigned CCU DAG, and encouraged MBC to make better use of the DAG to assist with medical records procurement issues. Both MBC and HQE agree that the assigned DAG's presence in and contributions to CCU have been valuable. Regrettably, however, HQE's staffing losses and overall workload required HQE, in May 2005, to return the assigned CCU DAG to its Sacramento office for accusation filing and trial work. HQE hopes to reinstate the DAG in CCU by January 1, 2006, and also hopes — with the fee increase in SB 231 — to assign a DAG full-time to CCU (or to assign two DAGs half-time to CCU) to assist with case disposition review, medical records procurement, and stubborn issues related to malpractice payout reporting by insurance companies and physician employers (see below).

3. CCU's implementation of the specialty review requirement for QC complaints has caused a number of problems.

As described above, SB 1950 (Figueroa) added section 2220.08 to the Business and Professions Code, which requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been “reviewed by one or more medical experts with the

¹¹⁶ As described in Chapters VII and IX below, MBC's *Enforcement Operations Manual* was also revised to include a new “zero tolerance” policy on the part of investigators and prosecutors toward noncompliance with medical records statutes, and HQE mailed dozens of letters to defense attorneys and physician organizations announcing the new policy.

pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required.” As noted above, this mandate required CCU to recruit and train a number of new reviewers in niche subspecialties — not an easy task when CCU is able to pay only \$75 per hour.

In the *Initial Report*, the Monitor found that the specialty review requirement was being implemented rather strictly by CCU, and that method of implementation was causing substantial delay in the processing of QC cases in certain specialties (including neurology, radiology, and cardiology). Specifically, we compiled data on all reviews completed by CCU medical consultants during calendar year 2003, and separated our analysis into two categories: (1) “high-volume specialties” — those specialties that are often the subject of complaints and in which CCU has a number of trained and experienced reviewers, and (2) “low-volume specialties” — specialties and subspecialties in which relatively few physicians practice and/or are less often the subject of complaints, and in which CCU has no (or very few) trained and experienced reviewers. We found that specialty reviews in high-volume specialties during calendar year 2003 were completed in an average of 35 days, while reviews in low-volume specialties were completed in an average of 69 days. Further, we found a large and growing backlog of pending and unassigned cases — portending a significant delay in the processing of QC cases.

Finally, the Monitor found that the specialty review requirement was costly in other ways — (1) CCU was “raiding” MBC’s expert reviewer list to find specialists qualified to perform a specialty review (thus depriving district offices of their use later on in the proceeding); (2) CCU was forced to pay physicians on the expert reviewer list \$100 per hour for reviewing CCU cases instead of its usual \$75 per hour salary; and (3) it was not clear that either the quality of the reviews or fairness to physicians had improved due to the use of specialty reviewers. Between 2000 and 2003, fewer reviews were accomplished in a longer time, yet approximately the same proportion of cases was referred for formal investigation each year, and MBC district office medical consultants found little or no improvement in the quality of the CCU reviews.¹¹⁷

In the *Initial Report*, the Monitor made three recommendations relating to specialty review: (1) MBC should revisit its implementation of section 2220.08 and identify alternative specialists who are also qualified to review cases in a narrow subspecialty; (2) section 2220.08 should be amended to permit MBC to refer a given case to a generalist reviewer if it is unable to locate a specialty reviewer after a 30-day good faith search; and (3) section 2220.08 should be amended to exempt from the specialty review requirement new complaints against physicians who are already the subject of a formal investigation, a filed accusation, or on probation (Recommendations #9 and #10). These recommendations have been implemented as follows:

¹¹⁷ *Initial Report*, *supra* note 13, at 101–06.

■ **Alternative specialists.** In a memo dated June 21, 2005, MBC informed the Monitor that CCU has developed a protocol for utilizing a qualified alternative medical reviewer in some cases where a subspecialist cannot be found to review a complaint after a 30-day good faith search. CCU's protocol was reviewed and approved by its lead medical consultant, a district office medical consultant, MBC's enforcement chief, and MBC's executive director, and it provides CCU with a reasonable approach to securing qualified medical review of QC cases without undue delay. The protocol includes the following chart listing recommended alternative specialists where a QC complaint focuses on a particular specialty.

Ex. VI-D. CCU Protocol Regarding Alternative Specialist Reviewers

Medical Specialty	Recommended Alternate MC Review
Allergy and Immunology	Internal Medicine, Family Practice
Anesthesiology	General Surgery
Cardiology - Medication Management Only	Internal Medicine, Family Practice
Cardiology - Surgical care	General Surgery
Cardiothoracic Surgery	General Surgery
Dermatology	Internal Medicine, Family Practice
Emergency Medicine	Family Practice
Endocrinology	Internal Medicine
ENT/Otolaryngology	Internal Medicine or General Surgery (depending on issue)
Facial, Plastic, Reconstructive Surgery	General Surgery
Gastroenterology	Internal Medicine, Family Practice
Hematology / Oncology	Internal Medicine
Internal Medicine	Family Practice
Nephrology	Internal Medicine
Neurological Surgery	General Surgery
Neurology	Internal Medicine
OB/ GYN	Family Practice
Ophthalmology	Family Practice (if not surgical case)
Orthopedic Surgery	General Surgery
Orthopedic	Family Practice
Pain Medicine	Internal Medicine, Family Practice
Pathology	No Recommendation
Perinatal / Neonatology	Pediatrics
Physical / Rehabilitation Medicine	Internal Medicine, Family Practice
Psychiatry	Internal Medicine (medication issues)
Pulmonary / Critical Care	Internal Medicine
Radiology	No Recommendation
Rheumatology	Internal Medicine
Spine Surgery	Orthopedic Surgery/General Surgery
Thoracic Surgery	General Surgery
Urology	Internal Medicine, Family Practice

Source: Medical Board of California (11/1/05)

■ *Amendment of section 2220.08 to exempt complaints from specialty review after 30-day search.* Both the Medical Board and the Monitor agreed to postpone consideration of this recommendation based on representations by enforcement staff at MBC's February 2005 meeting that (1) CCU was developing the protocol described above, and (2) CCU had successfully recruited and trained a sufficient number of specialty reviewers such that the average time delay had declined significantly. We gathered additional data on the time consumed by specialty review during calendar years 2004 and 2005 (through September 15, 2005); these data are reflected in Exhibit VI-E below.

Ex. VI-E. CCU Medical Consultant Reviews

Specialty	CY2003				CY2004				2005 (through September 15)			
	Total Cases	Days Unassigned (Average)	Days Assigned (Average)	Total Days (Average)	Total Cases	Days Unassigned (Average)	Days Assigned (Average)	Total Days (Average)	Total Cases	Days Unassigned (Average)	Days Assigned (Average)	Total Days (Average)
Allergy and Immunology				0	1	7	29	36	19	23	42	65
Anesthesiology	28	32	39	71	47	67	21	88	19	23	42	65
Cardiology	52	60	28	88	54	87	49	136	24	51	46	97
Cardiothoracic/Thoracic Surgery	0	0	0	0	11	61	28	79	6	15	9	24
Colon and Rectal Surgery	0	0	0	0	0	0	0	0	1	4	11	15
Dermatology	18	71	20	91	35	43	25	68	17	26	50	76
Endocrinology	2	87	30	117	2	63	33	96	3	10	32	42
ENT/Otolaryngology	25	49	16	65	6	55	28	83	10	29	20	49
Gastroenterology	21	22	21	43	28	16	31	47	21	16	30	46
Hematology/Oncology	10	52	22	74	67	79	69	148	12	61	46	107
Internal/General Medicine	798	12	21	33	727	40	28	68	276	11	20	31
Midwife	0	0	0	0	6	56	35	91	0	0	0	0
Nephrology	3	0	31	31	2	62	16	78	2	14	14	27
Neurological Surgery	10	23	14	37	26	65	24	89	8	28	13	41
Neurology	3	61	22	83	24	78	19	97	7	62	21	83
Obstetrics and Gynecology	177	16	28	44	197	12	24	36	83	9	29	38
Ophthalmology	54	27	23	50	75	48	34	82	31	36	28	64
Orthopedic and Spine Surgery	45	58	26	84	161	26	15	41	54	9	8	17
Orthopedics	48	43	21	64	62	25	8	33	32	9	8	17
Pain Medicine	7	55	8	63	18	28	48	76	4	27	43	70
Pathology	2	80	14	94	4	97	112	209	2	90	11	101
Pediatrics	67	15	23	38	70	30	31	61	35	11	25	36
Perinatal/Neonatal	3	82	38	120	7	69	28	97	4	22	27	49
Physical Medicine and Rehabilitation	11	111	15	126	4	54	26	80	4	23	39	62
Plastic/Reconstructive Surgery	52	30	20	50	116	36	28	64	56	20	40	60
Psychiatry	84	10	20	30	42	46	41	87	15	35	41	76
Pulmonology	8	24	30	54	8	59	29	88	8	17	17	34
Radiology	54	41	26	67	75	76	27	103	35	40	23	63
Rheumatology	2	40	28	68	2	76	42	118	2	33	22	55
Surgery	147	25	16	41	195	13	10	23	99	5	10	15
Urology	25	68	21	89	58	77	24	101	23	43	29	72
Total	1,756	23	22	45	2,130	40	27	67	912	27	26	53

Source: Medical Board of California

As is clear from Exhibit VI-E, the specialty review requirement is still causing significant delay in a large number of specialties. The overall 2003 average of 45 days sharply increased to 67 days in 2004, and has eased back to 53 days in 2005 to date. Additionally, the data do not shed light on whether specialty review is improving the quality of medical review of QC cases and/or fairness to physicians. Exhibit VI-F below reveals that, although the number of cases referred for specialty review has declined dramatically, the proportion of complaints referred for formal investigation between 2000 and 2004 has not declined at all; if anything, it has increased (but not to a significant degree).

**Ex. VI-F. CCU Disposition of Physician Complaints
Following Medical Consultant Review**

Disposition	3-Year Average for CYs 00, 01, 02		CY 2003		CY 2004	
	Number	Percent	Number	Percent	Number	Percent
Closed (no violation)	1,852	61.5%	1,460	61.3%	1,201	57.4%
Closed (insufficient evidence)	486	16.1%	354	14.9%	338	16.2%
Closed (info on file)	49	1.6%	61	2.6%	83	4.0%
Closed - Other	29	1.0%	30	1.3%	13	0.6%
Subtotal	2,415	80.2%	1,905	79.9%	1,635	78.2%
Referred to INV	596	19.8%	478	20.1%	457	21.8%
Total	3,011	100.0%	2,383	100.0%	2,092	100.0%

Source: Medical Board of California

■ **Other exemptions from specialty review.** As recommended by the Monitor, section 12 of SB 231 (Figueroa) exempts from the section 2220.08 specialty review requirement new complaints against physicians who are already under investigation, the subject of a pending accusation, or on probation.

4. The codification of mandatory case processing priorities is resulting in unintended consequences.

As noted above, SB 1950 (Figueroa) added section 2220.05 to the Business and Professions Code, which requires MBC to “prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously.” The statute says that complaints falling into one of five stated categories (coded “U1–U5” by MBC) — which attempt to capture physicians “representing the greatest threat of harm” — should be handled on a priority basis. No one quarrels with this sound goal. However, as noted in the *Initial Report*, the statute has caused unintended consequences:

■ **Overuse of U1 priority.** One net effect of the statute has been the elevation of all cases where there has been a death or “serious bodily injury”¹¹⁸ to a patient to U1 status (“gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public”). Exhibit VI-G below arrays the 7,505 complaints and reports against physicians by referral source and by priority as assigned by CCU:

Ex. VI-G. FY 2004–05 Physician Complaints Received by Priority by Referral Source

Referral Source	U1 Death or Serious Injury	U3 Excessive Prescribing	U4 Sexual Misconduct	U5 Prctng. Under the Influence	Subtotal Priority U1–U5	Urgent	High	Routine	Total
Patient, Patient Advocate, Family Member or Friend	651	86	91	2	830	474	798	2,258	4,360
Section 801, 801.1 & 803.2 (Insurers & Employers)	718	0	3	0	721	0	4	0	725
Section 802 & 802.1 (Self-Reporting)	199	0	0	0	199	5	0	3	207
Anonymous	11	8	8	6	33	71	6	160	270
M.D. Licensees	11	5	4	2	22	33	11	142	208
Department of Health Services	11	2	1	0	14	18	17	54	103
Coroner (including Section 802.5)	21	0	0	0	21	2	0	0	23
Police/Sheriff Departments	2	5	14	0	21	14	2	5	42
Other Governmental Agencies	7	12	0	0	19	36	12	0	67
B&P 2240(A) - Self-Reported Surgical Complications	11	0	0	0	11	0	0	23	34
Employee or Co-worker of Subject	0	2	3	3	8	14	1	32	55
Section 803 & 803.5 (Courts)	14	0	0	0	14	6	2	0	22
Section 805 (Health Facilities)	3	0	2	0	5	93	0	14	112
Insurance Company	0	4	1	0	5	4	5	34	48
Attorney General & Department of Justice	1	1	0	0	2	1	2	2	7
Pharmacist or Employee	0	6	0	0	6	3	3	6	18
Other	1	5	1	0	7	0	7	46	60
Out of State Medical/Osteopathic Boards	0	0	2	0	2	6	0	430	438
Newsclipping	0	0	0	0	0	2	4	1	7
Confidential Informant	3	2	0	0	5	11	0	10	26
Other Healing Arts Licensee	0	1	1	0	2	2	1	9	14
WE Tip	0	1	0	0	1	10	1	9	21
Other DCA Boards and Bureaus	1	0	0	0	1	9	0	5	15
District Attorney	1	2	0	0	3	5	2	1	11
DOJ-Criminal Identification & Information Bureau (CII)	0	0	0	0	0	72	156	2	230
Allied Health Licensee	1	0	0	0	1	2	3	4	10
Medical Society or Association	0	0	0	0	0	0	0	12	12
Hospital (Non-805 Report)	0	0	0	0	0	2	3	1	6
Court Clerk - Non-Felony Conviction	0	0	0	0	0	0	9	0	9
Jury Verdict Weekly	2	0	0	0	2	0	0	0	2
Total, Excluding Medical Board	1,669	142	131	13	1,955	895	1,049	3,263	7,162
Medical Board	45	15	14	1	75	101	25	142	343
Total, Including Medical Board	1,714	157	145	14	2,030	996	1,074	3,405	7,505

Source: Medical Board of California

Thus, of 7,505 complaints received in 2004–05, 2,030 (27%) were classified as section 2220.05 priority complaints. And of the 2,030 priority complaints, 1,714 (84%) were classified as

¹¹⁸ The term “serious bodily injury” is not defined in section 2220.05 or any other California statute; thus, CCU’s classification of complaints involving injury is necessarily subjective. In an attempt to comply with the intent of the statute, CCU assigns a U1 priority to almost every complaint or report involving injury to a patient.

U1 complaints.¹¹⁹ In 2004–05, most section 2220.05 priority cases were U1; as in 2003–04, there were no U2s (because the U2 category is subsumed by U1), and relatively few U3s, U4s, and U5s.¹²⁰ Not everything can be assigned a U1 priority. If everything is a U1 priority, in effect we have no priority system. But almost every priority case is classified as a U1 priority in the present system.

■ ***Lower priority for cases posing imminent harm.*** Both the language of the statute and the way in which MBC has implemented the section 2220.05 priorities have elevated *patient outcome* over factors which may be as or more important in enforcement circumstances, including imminence of harm, strength of evidence, and culpability. Patient injury or death is always tragic. Sometimes it is the fault of the doctor; many times it is not. But the mere presence of a tragic outcome should not necessarily dictate prioritization of enforcement activity. A good argument can be made that it is more important for MBC to move quickly on a complaint of recent egregious sexual misconduct (U4) or practicing while impaired (U5) rather than a section 801 report of a civil settlement involving the death of a patient five years ago (U1). A good argument can likewise be made that a felony conviction, aiding and abetting unlicensed practice in backroom clinics, and even some probation violations — none of which are included in section 2220.05’s list of priorities deserve more expedited treatment than a stale 801 report of a civil settlement stemming from a death five years ago.

■ ***No priority for economic harm cases.*** Adequate protection of the California public also requires an enforcement presence in other important areas of medical misconduct. No one disputes that a death is a greater tragedy than economic harm or non-fatal unlicensed practice, but a system which inhibits MBC from bringing at least some actions to stop economic harm or unlicensed conduct sends a dangerous signal that such misconduct is tolerated in California. Today, fraud (including egregious insurance fraud that does critical systemic damage to our health care system) and deceptive business practices which injure honest practitioners and consumer victims are relegated to a very low priority by MBC in its current interpretation of its mandate.

In the *Initial Report*, the Monitor noted the good intentions behind the statute, and the extraordinary difficulty of transferring those intentions into words. The Monitor also noted that —

¹¹⁹ These figures are almost identical to MBC’s 2003–04 statistics, when 28% of incoming complaints were classified as section 2220.05 priority complaints, and 85% of them were assigned a U1 priority. *Initial Report, supra* note 13, at 106–09.

¹²⁰ Further, 917 of the 1,714 U1 complaints (53%) are section 801/801.1/802/803.2 reports of civil malpractice settlements, which often occur several years after the event that prompted the lawsuit. In cases where three or four years have elapsed since the event and the physician has not been the subject of any subsequent complaint or report, it is not appropriate to classify the complaint as U1 because the physician is not “a danger to the public” as required in section 2220.05(a)(1). However, that is a judgment call and MBC has chosen to err on the side of caution and demonstrate absolute compliance with the letter and spirit of the statute.

contrary to frequent arguments by defense counsel — the statute does not say that MBC may investigate, prosecute, and take disciplinary action only in cases falling into one of the five priority categories; nor does it say that MBC may not investigate, prosecute, and take disciplinary action in cases falling outside the five categories. In Recommendation #11, the Monitor suggested that all stakeholders in MBC’s enforcement program collaborate to refine the language of section 2220.05’s “mandatory case processing priorities” to effectuate the intent of SB 1950 (Figueroa) — “ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously.”

At its April 22, 2005 meeting, MBC’s Enforcement Committee discussed Recommendation #11 and decided to defer this issue for at least a year, rather than attempting a possibly premature legislative amendment of the statute. In the meantime, the Committee directed staff to (1) gather data on the impact of section 2220.05; (2) develop a policy statement on staff’s interpretation and implementation of the statute; (3) attempt to define the statutory term “serious bodily injury”; and (4) recommend whether additional categories of priority cases should be added to the statute. At its May 6, 2005 meeting, the Division of Medical Quality approved the Enforcement Committee’s recommendation.

5. Many of MBC’s most important detection mechanisms are failing it.

As described above, Business and Professions Code section 800 *et seq.* sets forth an extensive “mandatory reporting scheme” intended to enable MBC to detect physician negligence, incompetence, dishonesty, and impairment so that it might investigate and take disciplinary action if appropriate. Several of these statutes have been on the books for decades — indicating strong legislative intent that MBC be notified of these events so that its discretion to investigate and its public protection mandate are furthered. As reflected in Exhibits VI-A and VI-B above, section 800 reports are valuable sources of information to the Board leading to investigation, prosecution, and disciplinary action — including disciplinary action taken in section 2220.05 priority cases. However, many of these mechanisms are failing the Board and the public.

■ **Malpractice payouts.** Sections 801 and 801.1 require insurance companies and employers of physicians that self-insure to report to MBC specified judgments, settlements, and arbitration awards against physicians within 30 days of the event. Under section 804(b), the reports must be “complete” in that they must include eight specified items of information — including “the name and last known business and residential addresses of every physician or provider of health care services who was claimed or alleged to have acted improperly, whether or not that person was a named defendant and whether or not any recovery or judgment was had against that person.” Section 804(d) further provides that insurers and self-insured employers of physicians that have received “a copy of any written medical or hospital records prepared by the treating physician or the staff of the

treating physician or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the claim prompting the Section 801 or 801.1 report, or a copy of any depositions in the matter that discuss the care, treatment or medical condition of the person shall provide with the report copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California to the insurer” Section 804(d) further requires insurers and self-insured governmental agencies to “maintain the records and depositions referred to in this subdivision for at least one year from the date of the Section 801 or 801.1 report.”

In researching the *Initial Report*, the Monitor looked at a number of section 801 and 801.1 reports. Hardly any of them were filed within the required 30-day time period, and most of them were incomplete to the point of being almost useless to the Board (for example, many failed to identify the plaintiff in the malpractice action or the physician(s) whose conduct resulted in the payout). During our interviews of dozens of MBC and HQE staff, we were consistently told that the materials required to be forwarded to MBC by section 804 are not forwarded; in fact, on many occasions, they are destroyed as soon as the settlement is reached, making it difficult if not impossible for MBC to proceed in such a matter.

Unlike section 805 applicable to hospitals, sections 801 and 801.1 contain no penalty for failure to file the required report, failure to file a complete report, and/or failure to produce the records that are required to be produced and kept for one year from the date of the report. In Recommendation #12, the Monitor suggested that these sections be amended to include penalties for noncompliance.¹²¹

This is one of the few Monitor recommendations requiring legislation that was neither addressed in SB 231 (Figueroa) nor meaningfully discussed by the Medical Board in the past year. As indicated in Exhibits VI-A and VI-B above, insurer/employer reports of malpractice payouts under sections 801 and 801.1 are a reliable source of information leading to investigations and disciplinary action. In other words, proper and timely filing of these reports is an important detection mechanism for MBC. However, a number of problems beset this reporting requirement. Since the release of the *Initial Report*, CCU staff has forwarded to the Monitor numerous examples of insurer/employer reports that are late, incomplete, or that blatantly violate the letter and/or the spirit of the reporting requirement and even affect MBC’s public disclosure of multiple settlements now required by Business and Professions Code section 803.1(b)(2)(A). These examples, included below, illustrate several problems that are exacerbated due to the absence of a penalty for noncompliance.

¹²¹ The Monitor noted that the Joint Committee on Boards, Commissions and Consumer Protection (then the Joint Legislative Sunset Review Committee) also recommended penalties on insurers “up to a \$50,000 fine for a negligent failure to file, and up to a \$100,000 fine for a willful failure to file” during its 2001–02 sunset review of the Medical Board. *Initial Report*, *supra* note 13, at 110.

(1) *Insurers and employers are simply not complying with the reporting requirement.* According to MBC annual reports, the number of section 801/801.1 reports filed by insurers/employers with MBC pursuant to these statutes has declined annually as follows:

Ex. VI-H. Insurer/Employer Reports of Malpractice Payouts

Fiscal Year	Number of 801/801.1 Reports Filed
1998–99	1,041
1999–00	982
2000–01	921
2001–02	872
2002–03	872
2003–04	787
2004–05	722

Source: Medical Board of California

While the number of MBC-licensed physicians residing and practicing in California grew from 80,341 in 1998 to 92,852 in 2005, Exhibit VI-H above reflects a 31% decrease in the number of these important reports filed since 1998 — and it is not because reportable events have declined or are not occurring. CCU staff often receives notices of malpractice judgments and settlements from plaintiffs, plaintiffs’ attorneys, and other non-mandated reporters on events for which no report has been received from the physician’s insurer or employer. CCU staff also spends a considerable amount of time reviewing newspaper articles, weekly publications, and court Web sites for information about civil judgments and settlements, and routinely finds reportable events that have not been reported.

It is clear that not all insurers and employers are reporting all settlements that must be reported. MBC staff is convinced that the public disclosure requirement for multiple malpractice settlements contained in SB 1950 (Figueroa)¹²² is one significant factor that has negatively impacted settlement reporting. Additionally, several of the reporting statutes contain language that has created confusion or prompted noncompliance, as described below.

(2) *The statutory language is not always clear.* Prior to 2002, sections 801(b), 801.1(b), and 802 required reporting by insurers or employers on malpractice payouts against physicians, but contained a glaring loophole that was frequently exploited. Settlements were offered but only on the

¹²² See Bus. & Prof. Code § 803.1(b)(2)(A).

condition that individually-named defendant physicians were dropped from the case; insured facilities or medical groups — which were generally not subject to settlement reporting requirements — then became the only settling defendants, and no report to MBC about a defendant physician was required. SB 1950 (Figueroa) attempted and intended to close this loophole by additionally requiring that “a settlement over thirty thousand dollars (\$30,000) shall also be reported if the settlement is based on the licensee’s negligence, error, or omission in practice, or by the licensee’s rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee.” However, the new language does not expressly require such a report to identify the physician whose conduct is the reason for the payout.¹²³

Predictably, insurers and employers have interpreted SB 1950’s addition narrowly. For example, on April 8, 2005, an insurer reported a \$250,000 malpractice settlement but announced that the physician named in the complaint had been “dismissed early in the pretrial phase of litigation.” The settlement was against the physician’s medical group and the insurer refused to identify the physician.

(3) *The absence of any penalty for failure to report encourages abuse and neglect.* As noted in the *Initial Report*, sections 801 and 801.1 fail to include any penalty whatsoever for insurers and employers that fail to file required reports. The following examples illustrate why the statutes should be clarified and a substantial penalty for noncompliance added:

- The carrier that insured four physicians involved in the widely-publicized events at Redding Medical Center filed one report on each physician — even though each physician settled with hundreds of plaintiffs in a “mass tort global settlement.” One of these physicians settled with 654 plaintiffs, including 389 plaintiffs in excess of \$30,000; although his Medical Board Web site screen should list 389 settlements, it lists none. Another Redding physician settled with 15 plaintiffs, ten of whom received in excess of \$30,000; although his MBC Web site screen should list ten settlements, it lists none. Much of the information required by the statute and requested on the reporting forms — including the identities of any of the plaintiffs involved in these matters — was omitted, and both forms were filed two months late.

- The same carrier reported that two of the Redding physicians settled with multiple plaintiffs for a total of \$5 million each; however, the company claims they did not settle with any individual claimant for more than \$6,460 per claimant such that their settlements need not even be

¹²³ The drafters of SB 1950 may have believed that language expressly requiring these settlement reports to identify the physician was unnecessary because Business and Professions Code section 803.2, which incorporates by reference reports filed pursuant to sections 801, 801.1, and 801.2, already states that “[t]his report shall include the name and license number of the physician and surgeon.”

reported. Again, no plaintiff identifying information was included, and the forms were filed two months late.

- A self-insured physician employer reported two settlements of \$175,000 and “\$1,000,000 cash + periodic payments,” respectively, but refused to identify the physician whose conduct led to the payout.

- According to the Medical Board, Los Angeles County — a self-insured government agency subject to section 801.1 — has not filed any settlement reports on physician employees in over two years because it objects to the language in section 803.2 requiring it to identify the physician whose conduct led to the settlement. Recently, the County notified MBC that it has finally settled on a process by which it believes it can fairly apportion fault to individual physicians and identify them for MBC, and that it may forward to MBC its backlog of over 80 unfiled settlement reports dating back to 2003. At this writing, MBC has received none of them — and may be unable to investigate or take disciplinary action in many of them because the statute of limitations has run.

- A liability insurance carrier recently discovered that approximately 50 settlements against insured obstetrician/gynecologists dating back to 2001 have not been forwarded to MBC due to the negligence of an employee. The carrier has promised to forward them to MBC immediately; once again, however, MBC may be unable to investigate or take disciplinary action in many of them because of the statute of limitations.

(4) *Staffing and budget cuts at MBC and HQE have precluded both from promptly and comprehensively addressing this problem.* As noted above, these and other examples have been forwarded to the Monitor by CCU staff, which is well aware of this problem. However, staff is not always able to analyze the underlying problems and develop solutions — and is certainly not able to assert a remedy that does not exist. For over one year, staff has alerted MBC management of the problem, but nothing has been done about it. The loss of MBC enforcement staff, the absence of the assigned CCU DAG (although required by Government Code section 12529.5), and the separation of MBC and HQE all contribute to the stalemate on this issue.

Were there a meaningful penalty for failure to file these required reports, insurers and other mandated reporters would treat their reporting responsibilities more seriously, err on the side of caution, and file reports. Section 805, which is applicable to hospitals and their reporting of “peer review” decisionmaking, contains hefty penalties for failure to file — up to \$50,000 for a negligent failure to file an 805 report, and up to \$100,000 for an intentional failure to file a required report. While it is debatable whether these enhanced penalties have stimulated compliance (see below), the absence of any penalty at all renders insurers and employers absolutely unaccountable and free to do as they please — as illustrated by the examples above.

The Monitor has discussed this issue and Recommendation #12 with MBC management, who believe that tackling the problem of insurer/employer nonreporting is more difficult than hospital nonreporting. In the hospital setting, peer review is centralized within certain identifiable hospital committees and personnel, and section 805 charges those personnel (for example, “the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body”) with filing the required report and explicitly subjects them to the penalty if they fail to do so. According to MBC, section 801 reports from insurance companies are not always coordinated through any single identifiable company officer, but rather come in (if they come in) from various “claims representatives.” However, most companies charge a specific officer with responsibility for ultimate decisionmaking on health care liability claims, and that person could and should be identified in section 801, charged with ensuring compliance with its reporting requirement, and penalized in the event of noncompliance. Additionally, insurer noncompliance with these laws should be reported to the Insurance Commissioner and should be grounds for disciplinary action against the insurer’s license.

The Monitor recognizes and appreciates the fact that MBC and HQE have expended significant time and energy addressing the vast majority of the Monitor’s recommendations — both internally and in the Legislature — during 2005. However, insurer/employer failure or refusal to provide MBC with this statutorily-required information is a serious and undeniable problem which has been tolerated for too long by the Board and HQE. The Monitor recommends that MBC and HQE formulate a working group to (1) review the examples described in this report and other examples that can readily be produced by CCU staff; (2) review and draft revisions to the statutory language to close loopholes, identify mandated reporters at physician insurers and employers of all types, and add substantial penalties for noncompliance with sections 801, 801.1, 803.2, and 804; and (3) sponsor legislation enacting those amendments.

■ ***Coroner’s reports.*** Section 802.5 requires a coroner to file a report with MBC whenever the coroner performs an autopsy or otherwise “receives information” from a board-certified pathologist indicating that a death may be the result of a physician’s gross negligence or incompetence. MBC receives very few coroner’s reports — never more than 40 in a given year. In Recommendation #14, the Monitor suggested that MBC educate coroners about their reporting responsibilities. In response, MBC’s public information officer sent informational letters about section 802.5 to all coroners’ offices. Additionally, on September 21, 2005, MBC’s enforcement chief made an hour-long presentation on MBC’s enforcement program and the importance of compliance with section 802.5 to 125 members at the annual meeting of the California State Coroners’ Association.

■ ***Physician self-reporting of criminal convictions.*** In the *Initial Report*, the Monitor noted that section 802.1 limits physician self-reporting of criminal convictions to felonies, and questioned

why misdemeanor criminal convictions are not also required to be reported. Many misdemeanor convictions are the result of a felony charge which is pled down to a misdemeanor; others are the result of a “wobbler” charge (a crime that may be charged either as a felony or a misdemeanor in the discretion of the prosecutor) that is pled down to a misdemeanor. Many misdemeanor criminal convictions are “substantially related to the qualifications, functions, or duties” of a physician and are grounds for disciplinary action.¹²⁴ In Recommendation #13, the Monitor suggested that physicians be required to self-report all misdemeanor criminal convictions to MBC.

Section 5 of SB 231 amends Business and Professions Code section 802.1 to require physicians to self-report to MBC misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician. This self-reporting requirement will be triggered after MBC compiles, and the Legislature enacts, a list of such substantially related criminal convictions.

■ **Court clerk reporting.** Business and Professions Code sections 803(a)(2) and 2236(c) require court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC. In the *Initial Report*, the Monitor found a very low level of court clerk reporting under these statutes, primarily because (1) court clerks are unaware the reporting requirements exist; and (2) even if they know of the reporting requirement, they may not know that a criminal defendant is a physician. The Monitor noted that many other Department of Consumer Affairs agencies have similar court clerk reporting requirements, and reporting of other regulated professionals by court clerks is similarly low at other agencies. In Recommendation #15, the Monitor suggested that DCA — on behalf of all of its regulatory agencies with mandatory reporting requirements — join with the Judicial Council to design an educational program for courtroom clerks to enhance their familiarity and compliance with these reporting requirements.

During 2005, DCA’s Public Affairs Office drafted an informative article regarding the various court clerk reporting requirements in the Business and Professions Code for publication in the Judicial Council’s *Court News Online* electronic newsletter. Published monthly, this newsletter is widely distributed to all California courts and courtrooms. Additionally, DCA created a “universal reporting form” that can be used by any court clerk to report criminal convictions and civil judgments against any DCA licensee to the Department. DCA is preparing to publish the article and post the reporting form on its Web site. Hopefully, the article will be revised as necessary and published in the Judicial Council’s newsletter at least annually, so as to improve court clerk compliance with the reporting requirements about licensees of the State of California.

¹²⁴ Bus. & Prof. Code §§ 490, 2236.

Related to reporting of civil malpractice judgments, section 4 of SB 231 (Figueroa) amended Business and Professions Code section 802 to require physicians to self-report civil judgments in any amount to the Medical Board.

■ ***Hospital reporting of adverse peer review action.*** Since 1975, Business and Professions Code section 805 has required hospitals, health care facilities, and HMOs to file reports with MBC when they take certain internal disciplinary actions against physicians. The California Supreme Court has articulated the importance of the conduct of internal peer review at health care facilities and the reporting of adverse peer review actions to the Medical Board of California — whose duty is to protect “all consumers of medical services in California.” The Court found that MBC’s public protection mandate outweighs a hospital’s interest in protecting only its own patients, and trumps a hospital’s “private purpose of reducing the exposure of the hospital to potential tort liability.”¹²⁵ In other words, the Court demanded compliance with section 805 because one of the purposes behind private peer review is to support MBC’s public enforcement program — not the other way around.

As reflected in Exhibits VI-A and VI-B, section 805 reporting by hospitals, health care facilities, and HMOs is one of the most valuable source of complaints resulting in investigation, prosecution, and disciplinary action. However, section 805 reporting is the greatest area of failure. According to the Office of Statewide Health Planning and Development, there are 515 hospitals in California; additionally, there are numerous other health care facilities and managed care organizations that are subject to the reporting requirements of section 805. The *Initial Report* noted that, in 2003–04, MBC received only 157 section 805 reports.¹²⁶ Unfortunately, 2004–05 reporting was even lower: Only 110 section 805 reports were filed with MBC this year.¹²⁷

To add insult to injury, the evidence indicates that compliance with section 805 is lower than it appears. In 2003–04, the Board received 157 reports — but fully one-third of those actions were taken by hospitals against a physician’s privileges *after* the Medical Board disciplined the physician’s license. The data for 2004–05 are similar: Of the 110 section 805 reports received, 23 reported peer review actions taken after MBC had disciplined the license of the physician. Thus, rather than peer review assisting MBC in detecting dangerous physicians as commanded in *Dal Cielo*, the tail is wagging the dog and MBC is prompting hospitals to finally take peer review action against physicians.

In 2001, SB 16 (Figueroa) attempted to stimulate compliance with section 805 in several ways. The bill increased the maximum fine for willful failure to file an 805 report from \$10,000 to

¹²⁵ *Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 12.

¹²⁶ *Initial Report*, *supra* note 13, at 111.

¹²⁷ *See supra* Ex. V-C; *see also* Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at vi.

\$100,000, and from \$5,000 to \$50,000 for other failures to file. The bill also made failure to file an 805 report by a physician reporter unprofessional conduct and grounds for disciplinary action. Importantly, SB 16 also added section 805.2, which states the Legislature’s intent “to provide for a comprehensive study of the peer review process as it is conducted by peer review bodies . . . in order to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusive, and their relevance to the conduct of peer review in California.” In his signing message, then-Governor Davis indicated his expectation that MBC would come up with the \$300,000 needed to conduct the study within its existing resources. Because the Legislature failed to increase MBC’s license fees since 1994 and due in part to the 2001 budget cuts, that study has never been funded and never been conducted.

In Recommendation #16, the Monitor stated that the peer review study required by SB 16 should be funded and completed as soon as possible, so that section 805 might be amended to conform its reporting requirements to the actual conduct of peer review in California. Section 6 of SB 231 (Figueroa) amends section 805.2 to require MBC to contract with an external entity to conduct the study mandated in 2001 by July 31, 2007. Under SB 231, “[c]ompletion of the peer review study . . . shall be among the highest priorities of the Medical Board of California.”

■ **Regulatory gag clauses.** In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians by those very physicians when they include a “regulatory gag clause” in a civil malpractice settlement agreement. When a patient sues a physician for medical malpractice, the physician may decide to settle with the patient. However, as a condition of settlement, the physician demands inclusion of a regulatory gag clause that prohibits the patient from contacting or cooperating with the Medical Board, and/or requires the patient to withdraw a complaint pending before the Board.

Regulatory gag clauses cause many serious problems — both for the Medical Board that is being deprived of information about its own licensees by its own licensees and for unsuspecting patients who continue to be exposed to unscrupulous and/or incompetent physicians because MBC cannot take appropriate disciplinary action against them — the very antithesis of the purpose of all regulatory agencies and especially the Medical Board. Gag clauses delay the efficient processing and investigation of cases, force agencies to spend additional money to subpoena records and testimony, and have prevented some disciplinary actions altogether because the statute of limitations runs before an accusation can be filed. Regulatory gag clauses also encourage an irresponsible business model that affirmatively injures people: Despite repeated malpractice actions and repeated settlements, physicians are able to gag their victims so they cannot contact or cooperate with MBC, leaving the doctors free to turn right around and do it again — with MBC unable to do anything about it because it doesn’t have a cooperative victim.

In Recommendation #17, the Monitor urged the Legislature to ban the practice of including regulatory gag clauses in civil settlement agreements. Assemblymember Gloria Negrete McLeod, Chair of the Assembly Business and Professions Committee, introduced Recommendation #17 as AB 446 (Negrete McLeod) during 2005. AB 446 replicated a 20-year-old statutory precedent applicable to attorneys,¹²⁸ and codified strong judicial precedents already applicable to teachers, physicians, and investment advisers.¹²⁹ Throughout 2005, California newspapers and national journals documented the frequency of and harm caused by regulatory gag clauses,¹³⁰ and a dozen consumer groups and state agencies (including the Medical Board and the Attorney General's Office) expressed support for the bill.

Although the Legislature passed AB 446, the Governor vetoed the bill on September 29. As noted in Chapter IV, this veto reflects a misunderstanding of the purpose of executive branch agencies, which is not to rubberstamp private dispute resolution but to protect future consumers from future injury caused by licensees of the State of California. Unfortunately, this veto perpetuates a legal loophole that is antithetical to the underlying purpose of occupational licensing agencies.

6. The staffing allocations of CCU's sections should be revisited.

In the *Initial Report*, the Monitor described the 2002 division of the Central Complaint Unit into the Quality of Care (QC) Section (consisting of a manager and seven analysts) and the Physician Conduct (PC) Section (consisting of a manager and six analysts), and noted that the initial assignment of analysts was based on the projection that MBC would receive more QC cases than PC cases.¹³¹ As illustrated in Exhibit V-B, the reverse has been true: MBC receives more PC than QC complaints. In Recommendation #18, the Monitor suggested that CCU revisit its staffing allocations to even out caseloads, and cross-train analysts so that certain kinds of urgent PC complaints that warrant immediate attention (*e.g.*, complaints of sexual misconduct or drug/alcohol abuse) do not get lost in the massive caseloads handled by the one CCU analyst trained to handle such matters.

CCU has implemented the Monitor's recommendations. In January 2005, one analyst position was redirected from the Quality of Care Section to the Physician Conduct Section — a move

¹²⁸ Bus. & Prof. Code § 6090.5 (originally enacted in 1986).

¹²⁹ See, *e.g.*, *Cariveau v. Halferty* (2000) 83 Cal. App. 4th 126; *Picton v. Anderson Union High School District* (1996) 50 Cal. App. 4th 726; *Mary R. v. Division of Medical Quality of the Board of Medical Quality Assurance* (1983) 149 Cal. App. 3d 308.

¹³⁰ See, *e.g.*, Jordan Rau, *Bill Would End Gag Clauses that Stifle Victims Who Sue*, L.A. TIMES (Apr. 19, 2005); Molly McDonough, *Second Effort Seeks to Life Contract Gag Rule*, AMER. BAR ASS'N J. (Apr. 29, 2005); *Cloaking Complaints*, RIVERSIDE PRESS-ENTERPRISE (Apr. 19, 2005); Fox News, *Hush Money for Malpractice Settlements?* (Jul. 13, 2005).

¹³¹ *Initial Report*, *supra* note 13, at 79.

which evens out caseloads of all CCU analysts to approximately 30 new cases received each month. In addition, the redirected analyst was assigned to urgent PC matters, such that two PC analysts now handle urgent PC complaints.

7. Detection of repeated negligent acts has improved, but could be enhanced.

In the *Initial Report*, the Monitor noted that — in response to concern expressed by the Joint Legislative Sunset Review Committee during MBC’s 2001–02 sunset review — CCU had instituted a review process for QC complaints that were recommended for closure because the medical consultant found only a “simple departure” from applicable standards. Under the review process, CCU’s senior program analyst, lead medical consultant, and assigned CCU DAG review these cases to determine whether the complained-of physician has been the subject of prior similar complaints that were also closed as “simple departures” — such that the physician might be disciplined for repeated negligent acts under Business and Professions Code section 2234(c). In Recommendation #19, the Monitor suggested that this review process be extended to physician conduct cases as well, particularly cases alleging sexual misconduct or drug/alcohol abuse.

CCU has implemented the Monitor’s recommendation. In July 2005, the Unit expanded its review process to PC cases and amended the *CCU Procedure Manual* to reflect the change. Unfortunately, the assigned CCU DAG is no longer present to participate in this review process.

8. CCU should ensure that subject physicians are notified when complaints are closed.

In the *Initial Report*, the Monitor found that CCU has done a good job of communicating with complainants throughout the screening process, but — according to the defense bar — does not always notify the subject physician that a complaint has been closed. The Monitor also found that MBC’s various procedure manuals were inconsistent on this point. In Recommendation #20, the Monitor suggested that MBC ensure that physicians are notified when complaints are closed and that its procedure manuals reflect this policy.

The *CCU Procedure Manual* had always stated CCU’s policy that if the subject physician has been contacted during the course of CCU’s review of a complaint, the subject should be notified of its closure. In February 2005, CCU drafted new closure letters to be sent to subjects of MBC complaints that are being closed. MBC’s amendment of its *Enforcement Operations Manual* on this point is discussed in Chapter VII below.¹³²

¹³² See *infra* note 152.

9. CCU should regularly review and update its procedure manuals.

In the *Initial Report*, the Monitor recommended that CCU ensure that its procedure manuals are regularly reviewed and revised to conform to changes in the law and MBC policy, and that HQE personnel are involved in these revisions (Recommendation #21). CCU has implemented the Monitor's recommendation; during 2005, the Monitor received five sets of revisions to the *CCU Procedure Manual*.

C. Recommendations for the Future

■ **HQE support for CCU.** MBC and HQE must come into compliance with Government Code section 12529.5(b) by ensuring that CCU is properly staffed with attorneys “to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.” Both MBC and HQE agree that the contributions of the assigned CCU DAG have been valuable to the functioning of CCU, and the Monitor recommended an enhanced role for the CCU DAG in the *Initial Report*. The findings in this *Final Report* emphasize that the assistance of a DAG in CCU would be invaluable to assist not only with complaint disposition review but also with medical records procurement and mandatory reporting issues.

■ **Insurer/employer reporting of malpractice payouts.** Insurer/employer compliance with the reporting requirements in Business and Professions Code sections 801, 801.1, and 803.2 is declining, and the absence of a penalty for failure to report surely encourages abuse and neglect — as described above. The Monitor recommends that MBC and HQE formulate a working group to (1) review the examples described in this report and other examples that can readily be produced by CCU staff; (2) review and draft amendments to the statutory language to close loopholes, identify mandated reporters at physician insurers and employers of all types, and add substantial penalties for noncompliance with sections 801, 801.1, 803.2, and 804; and (3) sponsor legislation enacting those amendments.

Chapter VII

FIELD INVESTIGATIONS: DISTRICT OFFICES

A. Overview of Function and Updated Data

Complaints and reports about California physicians which have passed through the screening process of the Central Complaint Unit are referred to MBC’s district offices for investigation. MBC maintains eleven field offices (“district offices”) staffed by peace officer investigators, supervising investigators, and medical consultants (physician employees). A complaint that warrants additional scrutiny after CCU screening is referred the district office in the geographical area where the subject physician practices. The case is assigned to an MBC investigator who — assisted by the medical consultant, supervising investigator, and sometimes an HQE attorney — reviews the existing file and conducts the investigation. This process includes the gathering of medical records or evidence; locating and interviewing complainants and other witnesses; interviewing the subject physician; and, in quality of care cases, securing review of the investigative report and the evidence by a physician “expert reviewer.”

As reflected in Exhibit V-C above, in 2003–04, Medical Board investigators opened 1,887 investigations, closed 2,117 investigations, referred 580 matters to HQE for administrative enforcement action, and referred 37 cases for criminal action. In 2004–05, using new definitions of the terms “complaint” and “investigation,”¹³³ Medical Board investigators opened 1,443 investigations, closed 1,475 investigations, referred 521 matters to HQE for administrative enforcement action, and referred 34 cases for criminal action.

Business and Professions Code section 2319 requires MBC to establish a goal that “an average of no more than six months will elapse from the receipt of the complaint to the completion

¹³³ As a result of findings and recommendations in the *Initial Report*, MBC discontinued counting notices of intent to sue under Code of Civil Procedure section 364.1 and reports of malpractice payouts sent to the National Practitioner Data Bank as “complaints” and “investigations” in its 2003–04 enforcement data. *Initial Report, supra* note 13, at 97–100. Also in response to *Initial Report* recommendations, MBC has discontinued counting so-called “change of address citations” as either complaints or investigations in its 2004–05 data. *See supra* Chapter VI.B.1. Care should be exercised in comparing prior data (which included these categories) with 2004–05 data (which do not).

of the investigation.” Cases involving “complex medical or fraud issues or complex business or financial arrangements” should be investigated within one year.¹³⁴ As indicated in Exhibit VII-A below, in fiscal year 2004–05, the average timeframe for the completion of only the investigative portion of MBC case processing was 259 days, down slightly from the 2003–04 figure of 261 days.¹³⁵ These cycle times, while comparing favorably with even longer averages in the recent past (e.g., 315 days in 1991), continue to call for vigorous action to improve investigative efficiency and speed, if there is to be any realistic chance of meeting MBC’s statutory goals.

Ex. VII-A. FY 2004–05 Investigation Timeframes By Disposition and Day Range

Day Range	Non-Legal Closure		Referred for Legal Action ¹		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	37	4.0%	145	26.8%	182	12.3%
1 to 3 Months	88	9.4%	41	7.6%	129	8.7%
3 to 6 Months	216	23.1%	72	13.3%	288	19.5%
6 to 9 Months	201	21.5%	53	9.8%	254	17.2%
9 to 12 Months	173	18.5%	61	11.3%	234	15.9%
12 to 18 Months	165	17.7%	109	20.1%	274	18.6%
18 to 24 Months	41	4.4%	40	7.4%	81	5.5%
More than 24 Months	13	1.4%	21	3.9%	34	2.3%
Total	934	100.0%	542	100.0%	1,476	100.0%
Average Timeframe	264 Days		251 Days		259 Days	

¹ Includes both AGO and DA referrals. Dual referred cases are counted once.

Source: Medical Board of California

B. The Monitor’s Findings and MBC/Legislative Responses

The following summarizes the Monitor’s *Initial Report* findings and concerns about MBC’s investigative process, and documents the responses to those findings implemented by the Medical Board, the Attorney General’s Office, and the Legislature. More detail on each of the findings is available in Chapter VII of the *Initial Report*.¹³⁶

1. MBC investigations are plagued by delays and excessive case cycle times.

The Medical Board has consistently failed to comply with the statutory goals set by the Legislature for the investigative process, including an average of six months total time from receipt of complaints to completion of investigations (one year for complex matters). As noted above, the

¹³⁴ Bus. & Prof. Code § 2319(a) and (b).

¹³⁵ *Initial Report*, *supra* note 13, at 125.

¹³⁶ *Id.* at 125–48.

average elapsed time for an MBC investigation in FY 2004–05 was 259 days, up from a similarly-calculated 243 days in 2002–03, and down slightly from the 2003–04 figure of 261 days. Over 26% of MBC investigations still take an average of twelve months or more. Chapter VII of the *Initial Report* documented the multiple personnel and process issues contributing to these long cycle times, including the general difficulty of MBC cases; reductions in district office staff; losses of other valuable resources (such as medical consultant time); investigator recruitment and retention challenges; a changed case mix toward greater complexity; and increased defense counsel use by physicians. Many of these factors are outside the control of district office staff, and most will not change significantly until the resource and procedural changes of SB 231 (Figueroa) take full effect.

MBC’s cadre of investigators are competent and dedicated, and they are doing a good job of maintaining the volume and quality of casework despite challenges. However, even with MBC investigator caseloads at a near-record low of 19 cases per investigator,¹³⁷ MBC remains unable to comply with the six-month and one-year processing goals. Despite a commitment to improvement here, MBC still suffers from investigations that take too long.

As described in the *Initial Report*, MBC investigations are characterized by a “hurry up and wait” phenomenon. Although some progress has been made as the result of MBC internal process improvements during 2004–05, investigators must still wait an average of 44 days to get complete medical records (even after CCU has already spent 66 days in the same effort); then wait for the medical consultant to assist with records analysis; then wait for the subject to agree to be interviewed (an average of 57 days in 2004–05); then wait for the medical consultant’s memo and identification of the essential expert reviewer; and then wait for the expert review (an average of 69 days — more than twice MBC’s goal of 30 days).

The Monitor’s *Initial Report* recommendations called on the Medical Board to address both resource/structural problems and process weaknesses in order to significantly reduce the stubbornly long case cycle times in MBC investigations. The Medical Board considered and adopted nearly all of those recommendations at its 2005 meetings, and the Board and its staff have diligently worked to implement the internal changes and support the legislative efforts described throughout this report. As described below, the internal reforms already undertaken by MBC are beginning to bear fruit. Coupling these efforts with the even greater changes to be wrought by SB 231 — most notably the 30% increase in fee revenues and the advent of the vertical prosecution system of case processing, there is reason for optimism that case processing will be speeded. But there is still much to be done before MBC case delays are reduced to the levels set by statute.

¹³⁷ Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at vi.

2. Attorney/investigator coordination and teamwork is inadequate.

Notwithstanding dedicated work by MBC and HQE staff, the current system linking MBC investigators and HQE prosecutors continues to suffer from inadequate coordination and teamwork, and will do so until the new and more modern vertical prosecution system is fully implemented as mandated by SB 231 (Figueroa).

As documented in the *Initial Report*,¹³⁸ MBC investigators in the present system typically function without true, close coordination with the trial prosecutor who will ultimately handle the case. Despite the existing Deputy in District Office (DIDO) program,¹³⁹ most MBC investigators still receive only limited legal support, rarely work directly with the trial counsel during the critical formative phases of the case, and seldom play a significant role in the pre-hearing and hearing process to which their work is directed. This system of limited investigator/trial attorney teamwork and cooperation — the “hand-off prosecution model”— stands in sharp contrast to the “vertical prosecution model” (where investigators and attorneys work together as a team throughout the life of a case) widely used in complex white collar crime and regulatory matters by many state, federal, and local agencies. In Recommendations #22 and #33, the Monitor suggested that MBC and HQE convert to the vertical prosecution model.

The implementation of a contemporary vertical prosecution system — bringing MBC investigators and HQE prosecutors together into investigation and trial teams — is a centerpiece of SB 231 (Figueroa).¹⁴⁰ If fully and successfully implemented, SB 231 will work a comprehensive change in the entire process through which MBC and HQE develop and resolve disciplinary cases.

Specifically, SB 231 adds new section 12529.6 to the Government Code, which makes legislative findings that because of the critical importance of MBC’s enforcement function, “using a vertical prosecution model . . . is in the best interests of the people of California.” This new section implements the fundamental reform needed to begin vertical prosecution by mandating the use of teams of investigators and prosecutors who are brought together early in each case and remain together throughout the life of the case. Section 12529.6(b) requires that, as of January 1, 2006, each MBC complaint that is referred for investigation be “simultaneously and jointly” referred to an investigator/prosecutor team (including the prosecutor who will ultimately file and try the case) which will handle the matter for its duration. Under the direction of the prosecutor, the investigator will gather evidence that enables the prosecutor to advise MBC regarding the disciplinary proceeding and whether to take legal action.

¹³⁸ *Initial Report*, *supra* note 13, at 129–40.

¹³⁹ *See id.* at 131–34 for a description of the DIDO program.

¹⁴⁰ SB 231 (Figueroa), 2005 Cal. Stat. 674, §§ 24–28.

As described more fully in Chapter IV above, SB 231 provides for fully integrated implementation of vertical prosecution (including funding for the transfer of MBC investigators to the Department of Justice), but only after an initial 18-month experience with this system has been evaluated.¹⁴¹ SB 231 adds new Government Code section 12529.7 which requires the Medical Board — in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration — to report and make recommendations to the Legislature by July 1, 2007 on the vertical prosecution model as created in Government Code section 12529.6. (All of the newly added provisions relating to vertical prosecution sunset on July 1, 2008, unless affirmatively acted upon by the Legislature.) Thus, in the latter half of 2007, the Legislature will evaluate the merits of the new system and will determine its future. MBC and HQE have 18 months to demonstrate the effectiveness of the team approach in order to earn full structural implementation of the system, including the transfer of MBC investigators to the Department of Justice.

SB 231 prepares MBC and HQE for fully integrated implementation of vertical prosecution through several provisions. Specifically, SB 231 (1) amends Government Code section 12529(a) to transfer the investigative function to HQE; (2) adds new section 2006 to the Business and Professions Code to redefine “MBC investigations” as “HQE investigations”; (3) amends Government Code section 12529.5(b) to eliminate the DIDO program under which HQE has been required to place prosecutors onsite at MBC district offices to provide legal guidance to investigators — this program will be unnecessary when MBC investigators are transferred to HQE; and (4) adds new section 2435.3 to the Business and Professions Code section to authorize MBC to increase its licensing fees to cover the costs associated with transfer of its investigators to HQE.

In anticipation of the January 1, 2006 start of the vertical prosecution system, MBC and HQE officials have met and begun to comprehensively plan its implementation. The Monitor’s recommendations for implementing vertical prosecution, and the plans and efforts already made by MBC and HQE, are detailed in Chapter VII.C below. As more fully described there, the Monitor urges MBC and HQE to make full use of their opportunity to prove the value of the team approach. By doing so, they will earn the full and final implementation of this advantageous system of investigation and prosecution.

¹⁴¹ As described in Chapter IV.A above, the full implementation of the vertical prosecution system, including a prompt transfer of MBC’s investigators and their supervisors to HQE, was ultimately supported by MBC, HQE, organized medicine, and a wide range of stakeholders and experts, without significant opposition. However, the Schwarzenegger administration opposed the transfer, and the final version of the bill provides for the multi-stage process described here.

3. Delays in medical records procurement are chronic.

The lengthy waiting time for the procurement of essential medical records has been among the greatest problems facing MBC's district offices and among the principal sources of overall case processing delays. In fiscal year 2003–04, the average timeframe from a request for records by MBC investigators to the receipt of all records was 74 days (or 2.5 months), despite the statutory 15-day timeframe in Business and Professions Code sections 2225 and 2225.5. Combining the district offices' 74-day average with CCU's average 66-day records-gathering period, medical records procurement at MBC during 2003–04 consumed an average of 140 days — or 77% of the 180-day goal in section 2319. These daunting statistics were in part the result of both MBC investigators and HQE prosecutors demonstrating apparent tolerance for physicians' lengthy delays in complying with medical records requests. MBC requests for HQE assistance in obtaining these records were comparatively infrequent, and actual enforcement actions were even less frequent.¹⁴² In Recommendations #7, #23, and #34, the Monitor urged MBC and HQE to agree upon, implement, and strictly enforce a new medical records procurement policy.

In response, MBC management amended *Enforcement Operations Manual* section 6.14 in January 2005 to advise all sworn staff that a “zero tolerance” policy has been initiated and that Board staff will no longer tolerate delays by physicians or hospitals in producing medical records requested pursuant to Business and Professions Code section 2225.5. This section of the manual advises investigators of their responsibility to obtain authorization for release of a patient's medical records within 30 days of case assignment and to serve the release to the appropriate facility within 10 days. A new cover letter which accompanies the release advises the physician, hospital, or other facility of the civil penalties applicable for failure to produce the records in the allotted time.

To ensure that physicians and institutions clearly understand the nature of the request and the time interval imposed by law, a procedural change was instituted requiring that these letters not be sent by mail or fax. Instead, the new policy requires a Board investigator or investigative assistant to serve the letter and medical release in person. The Board representative must complete a declaration of service confirming the date, location, and person who received the request, as this information is required if civil penalties for noncompliance are sought. MBC investigators report that in-person service of the letters and releases has improved understanding and cooperation with certain facilities and their representatives.

MBC staff also instituted a tracking system so that each investigator can readily monitor the dates for pending records requests. Within one day of an overdue request, the investigator must contact the physician/facility to inquire about the records and to advise of potential penalties which

¹⁴² *Initial Report*, *supra* note 13, at 140–41.

may accrue on the specified due date. This contact also serves to determine whether the physician or facility is experiencing any “good cause” delays. MBC supervisors and HQE staff must review such explanations to evaluate their sufficiency.

MBC has taken steps to publicize its vigorous new policy on records procurement. The Board published an article in the January 2005 issue of its *Action Report* newsletter advising the medical community of this change in policy. In March 2005, HQE management sent letters to defense counsel and various professional organizations advising them of the Board’s change in requiring adherence to sections 2225 and 2225.5.

As a direct result of the Medical Board and its staff committing to internal process improvements, MBC’s fiscal year 2004–05 statistics show encouraging signs of reduction in medical records procurement delays. During 2004–05, the average timeframe from a request for patient records by an MBC investigator to the receipt of those records was 44 days, down from 74 days in 2003–04 (a reduction of over 40%). This is a significant improvement, in both nominal and percentage terms, and MBC investigators and supervisors should be commended. However, despite this substantial improvement, the average timeframe is still more than twice the allowable statutory time period, so further reductions are important.

SB 231 (Figueroa) will assist in medical records procurement by improving the tools available to ensure prompt physician and institutional responses to record requests. The bill amends section 2225(d) to define the term “good cause” for delay and to extend the time within which physicians must produce requested medical records to 15 business days from the date of MBC’s request.¹⁴³ Thereafter, SB 231 authorizes MBC to use its existing citation and fine authority¹⁴⁴ to penalize physicians immediately when they fail to produce requested medical records within 15 business days and without good cause. SB 231 specifies that the citation and fine remedy is in addition to other remedies available to MBC (including subpoenas and subpoena enforcement proceedings, certain warrantless searches, and the use of administration inspection warrants under Code of Civil Procedure section 1822.50 in appropriate cases).

Past delays in medical records procurement have been attributed in part to reliance on the subpoena enforcement process as the principal remedy for noncompliance. This process typically requires attorney and sometimes superior court involvement, and thus entails a considerable

¹⁴³ Section 13 of SB 231(Figueroa) amends Business and Professions Code section 2225(d) to define “good cause” justification for a physician’s failure to turn over medical records, including but not limited to “physical inability to access the records in the time allowed due to illness or travel,” and extends the time for production of records from “15 days” to “15 business days.”

¹⁴⁴ See Bus. & Prof. Code § 125.9.

investment of time and resources. As documented in the *Initial Report*, MBC investigators found that “jawboning” respondents was easier than the process of requesting and obtaining subpoenas and then enforcing them.¹⁴⁵ SB 231’s new authority to use the citation and fine process gives MBC staff a first enforcement option that is fast and simple to use, leaving the more elaborate subpoena enforcement process for more serious or complex matters. Cite-and-fine will become an important tool for an immediate and measured response to physician or institution delays.

Delays in investigator procurement of medical records have been significantly reduced and further real progress is within reach with the new policies and tools at hand. However, MBC investigators (and their HQE teammates) must ensure those reductions by institutionalizing the new organizational value: *Unexcused delays in producing medical records will not be tolerated.*

4. Subject interview policies are inconsistent and ineffective.

Medical Board investigators must conduct subject interviews as a key part of the district office investigative process. In the *Initial Report*, the Monitor found that the delay inherent in this interview process — in 2003–04, an average 60-day delay between MBC’s request for an interview and the physician’s appearance or refusal to appear¹⁴⁶ — contributed to the overall 259-day average investigative timeframe. Interview delays reflected, in part, an inconsistency among district offices regarding the process of arranging and conducting the interviews. Some investigators relied on persuasion to obtain physician interviews; others pursued stricter policies utilizing subpoenas for attendance and tape-recording. The more permissive policy of informal persuasion, voluntary requests, and waiting for cooperation contributed significantly to the problem of excessive case cycle times. The vigorous use of the administrative subpoena authority, after a reasonable interval for cooperation, worked well in certain district offices and was the subject of Recommendation #24 by the Monitor in the *Initial Report*, which stressed the importance of clarified authority, consistent policies of requiring prompt physician cooperation, and regular tape-recording of interviews.

MBC management took prompt steps to implement these policy change recommendations. In January 2005, enforcement staff revised *Enforcement Operations Manual* section 6.2 to advise all investigators of a change in the policy governing the scheduling of physician interviews. MBC investigators are now directed to contact the physician to request an interview and give the physician 72 hours to respond with a date for the interview, which date must be within the next 15 calendar days. If the physician fails to respond within 72 hours or fails to appear at the scheduled appointment, the investigator must prepare an investigational subpoena to appear and testify. In addition, section 6.2 now specifies that all physician interviews should be tape-recorded. If the

¹⁴⁵ *Initial Report*, *supra* note 13, at 140–41.

¹⁴⁶ *Id.* at 141–43.

physician arrives at the interview and refuses to proceed because of the tape recording, the physician is advised that subpoena enforcement action will be instituted by the Office of the Attorney General.

In a January 2005 article in the *Action Report*, MBC publicized these new interview policies for the medical community; in March 2005, HQE management sent letters to defense counsel and professional organizations advising of the policy changes.

MBC management reports initial resistance among some physicians and their counsel regarding these changes. But MBC supervisors have discussed with field investigators the appropriate handling of unusual circumstances, and this has apparently improved the level of understanding between Board staff and physicians and their attorneys. MBC indicates that there has not been a need to request a subpoena enforcement action by HQE since the announcement of the new policies in early 2005. Implementation of these new policies has somewhat reduced the interview delay: In 2004–05, the average time between initial request and actual subject interview was 57 days; the average time between request and interview refusal was 49 days. These figures are down slightly from the overall average of 60 days in 2003–04. However, they still represent a large portion of the undesirable 259-day average investigative timeframe.

5. Medical consultant availability, training, and utilization are inadequate.

In the *Initial Report*, the Monitor noted that the medical consultant's (MC) function is central to the speed and quality of QC case processing at the district office level; however, problems regarding medical consultant availability, training, and proper use contribute significantly to lengthy investigations and inefficient operations.¹⁴⁷ Specifically, budget constraints caused a 15% reduction in available medical consultant hours agencywide during 2003–04, and this shortfall has not yet been corrected. Shortages of medical consultant time have made it continuously difficult for investigators to obtain sufficient medical consultant assistance, exacerbating a situation of reduced investigative and support staff, and requiring unproductive down time in cases waiting for consultant attention. In particular, these reductions have often meant that medical consultants are unavailable for or are greatly delayed in reviewing expert opinions and participating in the decision to transmit cases. In Recommendation #28, the Monitor urged MBC to expand and improve its medical consultant program.

As described in Chapter IV, SB 231 (Figueroa) increases initial and biennial renewal fees by 30%. MBC management staff plans to use some of these additional funds to increase medical consultant hours. The Monitor concurs that budgets in 2006 and thereafter must restore the 15% cut imposed during 2003–04; if possible, the medical consultant budget should be increased beyond that

¹⁴⁷ *Id.* at 144–45.

level, because the marginal benefit of small increases in MC funding is likely to be very high in reducing district office investigative delays.

6. Expert witness availability and use are systemic weaknesses.

In the *Initial Report*, the Monitor found that MBC investigations continue to be delayed by the unavailability of experts (particularly highly specialized ones), inadequate training provided to new experts, and inconsistent performance by experts. These concerns are addressed in detail in Chapter VIII below.

7. Ongoing training of investigators, medical consultants, and experts is inadequate.

During recent years, MBC — which in the past had an exemplary training program — was forced to substantially reduce formal training for investigators, medical consultants, experts, and others, to accommodate pressing budgetary concerns. If MBC is to significantly improve its case cycle times and efficiency, a systematic and professionalized training program for its field investigators, medical consultants, and expert reviewers is required. For this reason, the Monitor's Recommendation #27 suggested that MBC reinstate and improve its sequential training programs for which the agency was justifiably recognized in previous years, and extend its efforts to coordinate training with other agencies.

MBC management has maintained and modestly expanded its training regimen in 2004–05, to the extent consistent with the limited existing funding. Training courses, most of which are POST-certified, have been offered in areas such as new MBC investigator training (72 hours); drug awareness recognition (8 hours); interviews and interrogation (8 hours); probation investigator training (26 hours); pain management issues (6 hours); SB 151–CURES electronic prescribing (2 hours); Proposition 115 preliminary hearing testimony (2 hours); and others. In addition to formal certified training courses, supervising investigators have provided on-the-job training to investigators, and field training officer materials have been developed for assistance in training new sworn staff. POST training videos are also used to supplement training classes with in-person presenters.

However, full implementation of the Monitor's training recommendations will require funds from the SB 231 budget augmentation. Especially worthy of consideration is the reinstatement of the senior-level training supervisor position which was a casualty of the 2001–04 budget cuts.

8. Coordination with state and local prosecutors is underutilized.

Many of MBC's peace officer investigators have substantial knowledge of the criminal and civil law enforcement options available to the agency as potential tools to address complaints against

medical practitioners involving both quality of care and physician conduct issues. However, the *Initial Report* noted the concerns of state and local prosecutors over the need for greater early communication and consistent coordination between MBC investigators and state and local law enforcement agencies in cases where non-administrative enforcement tools (such as Penal Code section 23 orders or civil unfair competition actions) may be appropriate.¹⁴⁸ In Recommendation #25, the Monitor suggested that MBC make every effort to improve cooperation and case referrals between its enforcement staff and state and local prosecutors.

MBC management and staff have taken to heart the Monitor's recommendation that it improve communication and coordination with state and local criminal and civil prosecutors, including district attorneys, city attorneys, and deputies attorney general in non-HQE sections. MBC staff now regularly participates in the bi-monthly consumer protection roundtable meetings conducted by the California District Attorneys Association (CDAA) Consumer Protection Committee in both southern and northern California. In May 2005, MBC Enforcement Chief Jerzak gave a well-received presentation to a plenary session of the CDAA Consumer Protection Prosecution Conference in Santa Barbara, the largest annual gathering of state and local economic and regulatory crime officials in California. Chief Jerzak's presentation focused on cases which typically lead to criminal referrals to local prosecutors, with emphasis on Penal Code section 23 filings, unlicensed practice of medicine, pain management, medical marijuana, Internet prescribing, and sexual misconduct cases.

In addition to its significant new relationship with CDAA, during 2004–05 the Medical Board reached out to other allied investigative and prosecution agencies in a wide variety of settings. MBC representatives participated in the November 2004 training conference sponsored by California Narcotics Officers' Association; Drug Enforcement Agency (DEA) and U.S. Justice Department investigator training on pain management issues; and monthly meetings with regional Drug Diversion Task Forces, the Professional Diversion Information Network, the FBI Healthcare Fraud Task Force, the Medical/Legal Fraud Task Force associated with the U.S. Department of Health and Human Services, the RxNet Task Force associated with the California Department of Insurance, DEA, and the Bureau of Narcotics Enforcement, and local police departments, among others. Chief Jerzak has also met with and begun initiatives with the California Department of Corrections and the California State Coroners' Association.

Also during 2004–05, MBC investigative staff worked on a number of significant interagency enforcement cases, including cases involving the Orange County and San Diego County District Attorneys' Fraud Task Force; a DEA and U.S. Attorney case yielding \$545,000 in asset forfeiture; a U.S. Food and Drug Administration (FDA) criminal investigation involving Botox and non-FDA

¹⁴⁸ *Id.* at 146–47.

approved drugs; and several major cases worked in conjunction with county coroners and sheriff's departments involving drugs, sex crimes, and fatalities.

In March 2005, MBC sent more than 500 letters to law enforcement administrators, police departments, sheriff's departments, county district attorneys, U.S. attorneys, and state law enforcement agencies. These letters provided information about MBC's increased commitment to interagency cooperation in appropriate cases.

These outreach efforts have increased interagency contacts. An informal survey by MBC management shows that, during 2004–05, a wide range of local, state, and federal law enforcement agencies made requests for information and education from Medical Board staff to share specialized expertise in areas such as pain management, medical marijuana, Internet prescribing, prescription drugs, corporate practice of medicine, unlicensed practice of medicine, and sexual misconduct.

The Medical Board's efforts to implement the Monitor's recommendation regarding relationships with other agencies — undertaken during a year when many other challenges were being addressed — are highly commendable. The Monitor notes a genuine MBC management commitment to these efforts, and a significant improvement in interagency communications and coordination between MBC investigators and state and local prosecutors. However, special attention to early case contacts with civil and criminal prosecutors — especially district attorneys, city attorneys, and relevant sections of the Attorney General's Office — is needed to ensure that the full benefits of teamwork and coordination of efforts are realized. The building of these vital relationships is not a one-time activity, but an ongoing process which requires a clear and continuing message from Medical Board management that MBC is a steadfast teammate and partner with all its sister agencies.

9. Recruitment and retention problems exacerbate MBC personnel shortages.

The dramatic losses in investigative personnel suffered by MBC during the 2001–04 hiring freeze and budget crisis have not yet been restored, despite the Medical Board's repeated requests for hiring authority through the budget change proposal (BCP) process. At this time (and prior to any additional resources from the SB 231 fee increase), the Medical Board investigative staff remains 19 sworn investigators (or almost 20%) short of its 2001 staffing level. In addition, recruitment and retention problems continue to plague personnel management at MBC. Highly trained and valuable investigators continue to be lost and well-qualified applicants go elsewhere because of disparities between investigative salaries at MBC and those at other agencies hiring peace officers. In Recommendation #26, the Monitor urged MBC to continue efforts to reinstate lost enforcement program positions.

The fee increase in SB 231 (Figueroa) satisfies the essential pre-condition for the restoration of these necessary MBC investigator positions. MBC management has projected the replacement of these lost investigator positions as one of the first uses of the 30% increase in fees. These investigators are also central to the successful implementation of the vertical prosecution system, which state law now declares to be in the best interests of the public.¹⁴⁹ However, the Medical Board cannot return to this minimally necessary staffing level without the cooperation of the Department of Consumer Affairs, the State and Consumer Services Agency, and the Department of Finance, which must ultimately approve budgets or BCPs for the hiring of MBC staff and the reinstatement of lost positions.

Any realistic hope of meeting the state's longstanding statutory goals for MBC disciplinary investigations hinges on an improved HQE/MBC team process and on the personnel necessary to make that process work. The Medical Board, the organized medical community, health maintenance organizations, consumer advocates, law enforcement, the Legislature, and virtually all other stakeholders supported the fee increase in SB 231 as a means of supplying the funds to improve the Medical Board's enforcement program without using any general fund monies. The proposal to restore MBC investigator positions represents not a net growth in state government but a return to the 2001 level of staffing previously found to be essential. The Monitor urges all those with authority over the budget process to permit the Medical Board to use these earmarked special funds for the purposes for which they are intended, including the restoration of the MBC investigative positions lost in recent years.

The related problems of investigator recruitment and retention, discussed in detail in the *Initial Report*,¹⁵⁰ can ultimately be addressed by full implementation of the integrated vertical prosecution system envisioned in SB 231. Upon a showing of the success of the vertical prosecution system, and with the Legislature's affirmative approval after review of the 2007 report, the transfer of the MBC investigators to the Health Quality Enforcement Section will eventually result in special agent status for MBC's sworn personnel and a concomitant increase in pay and career recognition. Morale and productivity will be boosted, and MBC's ability to recruit and retain highly qualified investigators will be dramatically improved. The Monitor fully expects that the results of the initial vertical prosecution effort will justify this important improvement in the Medical Board's human resources.

10. Procedural and training manuals must be updated continuously.

The *Initial Report* expressed concern that MBC investigations and other enforcement processes were frequently guided by policy and procedure manuals that had not been consistently

¹⁴⁹ Bus. & Prof. Code § 12529.6(a), added by SB 231 (Figueroa), 2005 Cal. Stat. 674, § 28.

¹⁵⁰ *Initial Report*, *supra* note 13, at 147–48.

reviewed or approved by HQE — MBC’s legal counsel and enforcement partner.¹⁵¹ In addition, at least some of those manuals had not been adequately updated by MBC management and were, in at least a few cases, inaccurate as to Board policy.

The Monitor is pleased to report material progress in addressing this concern. As described in Chapter V of this report, the *Enforcement Operations Manual* has been substantially updated in a series of efforts during this reporting period, as have other manuals and guides essential to the activities of the MBC investigators.¹⁵² Of equal significance, copies of the *Enforcement Operations Manual* have now been shared with HQE management and supervisors for the first time in at least a decade, permitting an ongoing dialogue on enforcement policies and guidelines.

This latter event is the beginning of the next phase in the development of a new operations manual reflecting the fundamental changes in HQE/MBC teamwork brought about by SB 231. As discussed in Chapter V and below, development of a single operations manual guiding the joint investigation and prosecution of MBC disciplinary matters is an essential step toward successful implementation of the vertical prosecution system to be used starting January 1, 2006.

11. Investigators need full and easy access to law enforcement databases.

The *Initial Report* noted that MBC investigators sometimes lack convenient access to law enforcement databases that are essential to modern police work. Budgetary limitations reportedly prevent investigators from easier access to these law enforcement systems, and from using commercial databases, such as Merlin, Westlaw/Dialog, and similar systems, which investigators in other California agencies are funded and permitted to use. In Recommendation #29, the Monitor suggested that MBC improve investigator access to law enforcement information systems.

In response to this recommendation, MBC managers have obtained cost estimates to determine whether enhancements to current information systems are feasible. For example, access to the “DMV Direct” system would allow for DMV data to be available via each investigator’s computer terminal. Currently, DMV data are available to MBC enforcement staff only via three California Law Enforcement Telecommunications System (CLETS) terminals located in Sacramento, Rancho Cucamonga, and Cerritos. Board staff trained on the CLETS system and its rules respond to requests for these data, but the turnaround time is often 48 hours and sometimes

¹⁵¹ *Id.* at 148.

¹⁵² *See supra* Ch.V.A.3. One of MBC’s revisions to its *Enforcement Operations Manual* responded to Monitor’s Recommendation #20, which found that MBC’s various procedure manuals were inconsistent on the issue of whether and when physicians who are the subject of complaints should be notified that those complaints have been closed. In late 2004, MBC amended sections 7.1, 8.7, and 9.1 of the EOM to require CCU and its district offices to notify any physician who has been contacted by CCU or field staff during complaint processing of the closure of that complaint.

longer. This two-day lag time disrupts the continuity of new investigations; MBC investigators should have more convenient and immediate access to this information.

MBC management reports that a link via the existing Teale Data Network lines would allow for DMV information to be available to each investigator at a cost of \$1 per month per investigator (or an annual cost of \$920 to MBC). MBC plans to implement this system for DMV data access right away. The Monitor views this as just one of several small investments in information systems which would, in the aggregate, significantly improve district office performance.

In interviews with the Monitor, MBC investigators requested that CLETS terminals be made available in every MBC office (currently eleven district offices and three probation offices). CLETS terminals are leased, and the costs for installation and for monthly use are relatively modest — estimated at about \$30,000 for installation of eleven new terminals, and total agencywide operating costs of about \$14,000 per year. This would be another wise use of a small part of the SB 231 revenue increase, and the Monitor unequivocally endorses it and similar information system improvements.

In addition, MBC management is now exploring the feasibility of access to private commercial data systems, including Lexis/Nexis and Pro E Access, which systems are useful for individual and business background information of all kinds. Presently, MBC management is inclined to implement the Pro E Access system (which provides person/business searches at \$5 per search) if ready access to HQE's Lexis/Nexis account cannot be conveniently arranged.

The Monitor notes that some of these information system efforts and expenditures will become unnecessary following the proposed transfer of MBC investigators to HQE, where access to these systems is more readily available. This is one of the numerous efficiencies which would be realized by full integration of the MBC investigators and HQE prosecutors.

C. Recommendations for the Future

Introduction. The enactment of SB 231 (Figueroa) signals the start of a new era for the Medical Board enforcement program generally, and for the MBC investigative process in particular. A fundamental paradigm shift is envisioned by the Legislature, which concluded that because of the critical health and safety importance of MBC's enforcement function, "using a vertical prosecution model . . . is in the best interests of the people of California."¹⁵³ As of January 1, 2006, the era of arm's-length working relationships and "hand-off" investigations is giving way to the vertical prosecution model, in which the MBC investigator and HQE prosecutor work together as a team throughout the life of a case.

¹⁵³ Bus. & Prof. Code § 12529.6(a), added by SB 231 (Figueroa), 2005 Cal. Stat. 674, § 28.

As discussed in Chapter IV above, the Monitor, Senator Figueroa, and MBC and HQE management originally proposed in SB 231 that vertical prosecution be implemented in a fully integrated manner, with the transfer of MBC's peace officer investigators and supervisors to HQE to best facilitate the operation of a single system with closely-knit case teams. This version of the bill was consistent with Monitor's Recommendation #22, which stated: "The Monitor believes the vertical prosecution system could best be implemented by merging existing MBC investigators and supervisors into HQE."¹⁵⁴ The final version of the bill provides instead for multi-stage implementation, including an initial period of joint case assignments and supervision, followed by a July 2007 report and subsequent evaluation. The mechanism and funding for the transfer are present in the law but await the Legislature's affirmative evaluation of the initial phase.

While immediate integration would have improved the efficiency of the vertical prosecution system, the Monitor is convinced that the teamwork model will readily prove superior to the hand-off model and will be affirmed by the Legislature in its 2007 review. What remains in the immediate future is a full commitment to the new model by both MBC and HQE, which in turn will earn the full integration of the staffs as originally envisioned.

Keys to the long-term success of the vertical prosecution system. Vertical prosecution is a new paradigm for the MBC investigative process and the disciplinary system as a whole. The traditional model of separate investigation and hand-off is now replaced with a more appropriate model of partnership and teamwork throughout the life of each case. Given the fundamental nature of this change, success in implementing vertical prosecution will involve more than new case assignments and new names for old activities — it will in fact require significant changes to the organizational cultures of both MBC and HQE.

Based on other agencies' experiences with vertical prosecution, full implementation should take place in three dimensions: *structural*, *operational*, and *attitudinal*.

■ ***The structural dimension of vertical prosecution.*** To be successful with this new system, MBC and HQE should oversee significant changes in the structure and resources of their agencies, including:

(1) *Sufficient staff and financial resources* must be allocated to operate the new system of case teams and supervisors. A vertical system without enough staff is just as likely to fail as any other understaffed work process.

¹⁵⁴ *Initial Report*, *supra* note 13, at 149.

(2) *A logical and workable system of case assignments* for the new case teams must be devised and installed, with sufficient flexibility to adapt to differing case needs and staffing circumstances.

(3) *Design and implementation of an appropriate supervisory structure* to provide sufficient management and supervision for peace officer investigators and attorneys now working together in a single system. Any such system must clarify the supervisory chain of command, so that no team member is uncertain who to look to for guidance and decisions.

(4) *Short- and long-term decisions on physical plant and equipment* must be made so as to guide the resolution of logistical issues. Included here must be decisions on office space to house the respective staffs (bearing in mind long-term lease commitments and related issues) and short- and long-term questions about shared equipment and information systems (such as management information systems, information database systems, computer and communications systems, and others).

(5) *Decisions on long-term structural reform, including potential staff transfer*, must ultimately be made to guide the permanent implementation of vertical prosecution. The Monitor believes that full integration of attorney and investigator personnel is optimal, and a primary goal of the initial phase of implementation should be to demonstrate the viability of the team system and the added value of full integration.

■ ***The operational dimension of vertical prosecution.*** The successful changeover to the vertical prosecution model calls for many operational and process changes:

(1) *Joint and mutual agreement on goals and operational procedures* — including a system of management cooperation and coordination of decisionmaking — must take place at the outset of this process.

(2) *Consistent, but flexible, application of the new teamwork system* must be planned and put in place, including new protocols and policies for case assignments, supervision of the two types of staff, team communications, travel and joint work issues, and resolution of disputes.

(3) *A jointly developed operations manual and other training materials* must be drafted and distributed in order to bring about the unification of two previously separate processes.

(4) *Joint (and separate) retraining for existing staff and training for new personnel* will be necessary for the long-term development of a unified casework process.

(5) *Coordination of management information systems* into a single unified system is essential to effective case management and staff supervision.

(6) *Standards of evaluation and mechanisms for course correction* must be developed as early as possible to enable managers to identify problems, fine-tune and improve the new process, and prepare to defend the system in subsequent evaluations.

■ ***The attitudinal dimension of vertical prosecution.*** No work process succeeds if the managers and employees do not believe in it and support it. MBC and HQE management and employees should bring a constructive and committed attitude to the vertical prosecution system, and should come to believe — as so many other professionals have learned — that being a valued and respected member of a successful team is the surest path to job satisfaction. This aspect of the proposed change should include:

(1) *Management commitment to the full and successful implementation of vertical prosecution* is the first requisite for a successful transition to the new system. Leadership in this context requires developing and sharing the new strategic vision for these organizations, and demonstrating that management is entirely committed to the successful change to vertical prosecution.

(2) *Staff commitment to the full and successful implementation of vertical prosecution* is equally important to this change. Staff commitment begins with seeing management's commitment, but also requires an understanding of the new process and how it will benefit everyone. MBC investigators and HQE attorneys must understand how the new teamwork system will improve their daily work lives, their careers, and their personal satisfaction.

(3) *Working relationships built on mutual respect, professionalism, and courtesy* are essential to successful teams of any kind. Law enforcement teams are no different. In the vertical prosecution system, there must be a consistent respect for the importance of the professional contributions of both attorneys and investigators, and the value of having both available in all stages of the case. The differing professional roles of members of the State Bar and peace officers can and must be preserved, but an environment of mutual consideration, professionalism, and courtesy must be fostered.

(4) *The teamwork ethos must replace the old attorney/client ethos* if vertical prosecution is to succeed. Understanding the advantages and satisfactions of teamwork is key, as is understanding that individual success is dependent on team success.

Ultimately, teamwork in a vertical prosecution system is, more than anything else, an *attitude* — an individual and collective commitment to mutual goals and an agreed-upon system to achieve

them. The vertical prosecution system has proven consistently successful at other agencies with similar regulatory duties. But it is a system which requires its participants to be committed to the team concept and the team's goals — and this means commitment to treating all colleagues as valued teammates, not as clients, subordinates, or outsiders.

Issues for the successful implementation of vertical prosecution. In light of these three dimensions of change, the Monitor recommends that MBC and HQE address the following issues to facilitate the successful transition to vertical prosecution. The Monitor notes that these recommendations are suggestions based on the experiences of other agencies in operating vertical prosecution programs. These concepts can and should be modified appropriately to meet the unique circumstances of implementation in this context. The Monitor's recommendations include:

■ ***Management coordination and planning for the implementation of SB 231.*** MBC and HQE management must meet together continuously during the period preceding January 1, 2006 to plan and coordinate the implementation of the new system. The blending of two different institutions into a single process is a complex task with all the stresses and strains inherent in any profound organizational change. MBC and HQE managers are, as a group, unusually dedicated and experienced public servants, but negotiating and implementing such changes are daunting tasks. Consideration might be given to the use of a third-party facilitator, ideally with consulting experience in managing organizational change, to assist in this transitional period.

MBC and HQE management are already well on their way to accomplishing this task. Discussions between HQE Senior Assistant Attorney General (SAAG) Carlos Ramirez and MBC Executive Director Dave Thornton, and other senior managers of both agencies, during September and October of 2005 resulted in a preliminary plan to implement the new vertical prosecution system, as mandated by SB 231, beginning January 1, 2006.

■ ***Installation of the basic system of case teams.*** MBC and HQE managers must devise and install the new system of required simultaneous and joint assignments of MBC investigators and HQE prosecutors to the new case teams. (As indicated in the *Initial Report*,¹⁵⁵ in most circumstances these teams would be formed around individual cases, and thus most investigators and attorneys would work with a number of different colleagues on different teams.) HQE and MBC should agree on the role of attorney and investigator supervisors, advice/consultation attorneys, and others in the new vertical system.

Successful implementation of vertical prosecution will require immediate efforts to acquire the minimally necessary number of investigators and attorneys to staff and supervise the new case

¹⁵⁵ *Id.* at 134.

teams. This will entail, at a minimum, the reinstatement of 15 sworn investigators and six HQE attorneys lost to recent budget constraints.

MBC Executive Director Thornton and HQE SAAG Ramirez report the following tentative plans for installation of the new case teams system:

(1) *Revised attorney and investigator assignments.* HQE and MBC envision the end of the DIDO program as it currently exists, and the replacement of it with a team of deputies attorney general assigned to each Medical Board district office. One of the deputies assigned to each location will be the team leader whose responsibilities will be similar, in some respects, to those of the previous DIDO attorney. The team leader and the district office supervisor (DOS) will work together to ensure that all incoming complaints that are reasonably expected to result in administrative action (a judgment call based on the combined knowledge and experience of the team leader and the DOS) are immediately assigned to an investigator and a prosecutor who will function as the investigative team and will handle the investigation and prosecution until completion of the matter.

(2) *Team leaders and case assignments.* The deputy attorney general assigned as team leader will be available as an advice and consultation deputy (ACD) on those matters that do not require input from the deputy assigned to the complaint(s). Additionally, incoming complaints that are not reasonably expected to result in administrative action will initially be assigned to an investigator and the ACD. However, if it appears at any point that the case may result in administrative action, it will then be reassigned to a trial deputy (preselected when the initial complaint assignment is made) who will participate on the investigative team.

(3) *Anticipated staffing challenges.* At the January 2006 outset, and before new personnel has arrived, HQE and MBC management must implement the new case assignment system with existing staff. HQE and MBC anticipate few problems with implementing the new assignments in northern California. Each HQE office in northern California currently works closely with only one Medical Board district office (MBC San Jose and HQE San Francisco, MBC Pleasant Hill and HQE Oakland, and MBC and HQE Sacramento). The only concern is with the Medical Board's Fresno office, where HQE staff will have to be augmented as there is currently only one deputy attorney general assigned there.

HQE and MBC management face a challenge in the Los Angeles metropolitan area. As noted above, HQE lost six Los Angeles DAGs in the recent hiring freeze, and currently has a number of additional attorney vacancies. As such, HQE does not currently have sufficient staff in its Los Angeles office to provide more than two deputies plus a team leader/ACD in each of the Medical Board's Los Angeles-area district offices. With current staffing levels in the Los Angeles HQE office, the team leader/ACD may have to cover two MBC district offices.

However, HQE management is working hard to fill the Los Angeles attorney vacancies, and plans are under way to seek approval for the reinstatement of the six Los Angeles office attorneys lost in the hiring freeze. The success of the vertical prosecution system will be tied closely to full staffing of both HQE and the MBC district offices.

■ ***Resolution of immediate and longer-term logistics issues.*** Immediate logistical issues should be addressed to implement vertical prosecution, including but not limited to issues relating to communications among team members, team meetings and related travel issues, and joint or separate use of shared equipment and information systems (such as management information systems, information database systems, computers, communications systems, and others).

In the longer term, HQE and MBC management must plan to address office space issues (including present and future office leases) and other co-location logistics which must be resolved if the proposed transfer of MBC investigators to HQE is ultimately approved.

■ ***Development of joint operations protocols and an operations manual.*** Operational protocols and procedures must be worked out jointly by the management staffs of MBC and HQE right away, well in advance of the January 2006 implementation date. The Monitor believes that these protocols must be ultimately reduced to a single jointly-produced operations manual, equivalent in relevant respects to MBC's current *Enforcement Operations Manual*. Ultimately, few activities will have greater impact on the success of this new system — and on the acceptance of the new system by all concerned — than the work of HQE and MBC colleagues in developing this joint operations manual.

MBC and HQE senior managers have been meeting on an ongoing basis to develop the necessary joint procedures. In order to ensure that each member of the investigative team, the trial attorney, the ACD, and the DOS understand their respective roles in the investigative process, HQE and MBC managers are now discussing and drafting joint operating protocols.

HQE and MBC executives intend the system protocols to clearly define the role and responsibilities of each team member and supervisor, always keeping in mind the ultimate goal of a quality investigation. MBC and HQE plan to have drafted the operational protocols by November 2005, well in advance of the January 1, 2006 implementation date, permitting senior management from both agencies to meet to discuss and finalize the procedural protocols before they are distributed. MBC and HQE managers have expressed support for the concept of a single joint operations manual to be drafted and distributed in the near future as the continuing guide for the new joint investigation/prosecution process.

■ ***Training of staffs in the vertical prosecution system; provisions for ongoing training.*** Implementation of a new operating system in a short timeframe requires immediate arrangements

for adequate retraining of existing staff in the new process. And ongoing training is vital for organizations dealing with complex issues such as those involved in highly technical regulatory activities.

To accomplish this task, and as soon as the basic operational protocols are developed and approved by MBC and HQE, the agencies will hold joint meetings of all MBC investigators and supervisors, and all deputies and supervising deputies, to provide orientation and training in the new vertical prosecution system. MBC and HQE report that training sessions are planned in San Diego, Los Angeles, and Oakland during the first two weeks of December. MBC managers and HQE executives have expressed independent commitment to an ongoing program of investigator and attorney training, conducted jointly and separately as appropriate.

■ ***Integration of management information systems.*** The present system features two unrelated management information systems (MIS) — DCA’s antiquated CAS system used by MBC and the relatively new ProLaw system at HQE — neither of which has the capacity to interact with the other. A jointly operated management information system is essential to the effective management and case tracking for the new vertical prosecution system. The Monitor recommends that MBC acquire appropriate licenses for the proprietary ProLaw system and use that platform to develop a unified management data system. MBC is actively inquiring into that solution now. A unified MIS will also be important in the evaluation of the new teamwork system for purposes of continuous improvement and to meet the oversight requirements of the July 2007 report.

■ ***Development of a process for ongoing evaluation and system improvements.*** MBC and HQE should work together early in the transitional process to establish a set of standards for the evaluation of the new vertical prosecution system, and a mechanism for self-evaluation and course correction during the implementation of the system. The Monitor recommends that a standing committee or working group of MBC and HQE senior managers, attorneys, and investigators be formed to identify transitional problems, agree on process improvements, and assist with the July 2007 program evaluation. Evaluation standards of both a qualitative and quantitative nature should be identified for use in internal process critiques and the July 2007 report.

■ ***Preparation of the July 2007 report to assist the required legislative evaluation.*** SB 231 mandates that MBC — in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration — prepare and submit to the Legislature a report and recommendations on the vertical prosecution model by July 1, 2007.¹⁵⁶ As indicated immediately above, the Monitor recommends that MBC and HQE work together to identify qualitative and quantitative standards and to gather results to allow for a full and

¹⁵⁶ Gov’t Code § 12529.7, as added by SB 231 (Figueroa), 2005 Cal. Stat. 674, § 29.

fair evaluation of the new system. To the extent that vertical prosecution has succeeded in its initial application, and the Monitor is confident that it will, then the July 2007 report must demonstrate this success in measurable ways.

The drafting of the July 2007 report essentially starts now. By developing evaluative criteria and setting up systems to capture needed data, MBC and HQE will put in place the process necessary to provide a meaningful analysis of the impact of vertical prosecution in the July 2007 report.

■ ***Full integration of investigator and attorney staffs in the long term.*** The initial implementation of vertical prosecution under SB 231 poses a challenge because it does not take place in an environment of full staff integration. Although many of the benefits of vertical prosecution can and will be obtained through the initial phase of the SB 231 process, there remain significant advantages to the full integration of these personnel in a single agency, which can be accomplished most directly by transfer of the MBC investigators and their supervisors to HQE. Co-location of all staff within one agency, and each individual team within one office, would facilitate direct communications and joint work, greatly ease the process of mutual policymaking and training, and improve the rapport and sense of team among the involved staff. A single, simplified management structure — whether it uses a fully unified supervisory system or a dual system for attorneys and investigators — would make every decision and every task of implementation easier and quicker.

As they set up their new vertical prosecution system, HQE and MBC face unique circumstances which will shape the supervisory framework of that system, and these cannot be fully anticipated at this stage of the process. In the long term, the agencies may choose to adopt a single unified supervisory process, with appropriate accommodation of the differing staff categories, or they may choose to maintain separate supervisory chains for the different classes of professionals (leading ultimately to senior management within the Attorney General's Office), or some other variation on these themes. New Government Code section 12529.6 specifies that the investigators work "under the direction of the deputy attorney general" handling the matter, but leaves the issue of other supervisory functions to be determined by the agencies.

Whichever system HQE and MBC adopt, a number of important supervisory functions for investigative staff remain. During the initial phase of vertical prosecution, and even after the proposed transfer, the investigators of MBC will continue to need supervisors and managers to perform critical functions, including but not limited to investigator recruitment and training, case assignments, guidance on specialized technical or procedural issues (such as how to conduct complex interviews, undercover operations, search warrant preparation, etc.), investigator performance evaluation, discipline and promotion functions, budgetary and administrative functions, and establishment of investigator policies and procedures (and the drafting and constant revision of

operations manuals to implement them). Those functions must be clearly addressed in the supervisory process that the two agencies ultimately select.

The ultimate transfer of MBC's investigators and supervisors to HQE would have a dramatic impact on the salary, benefits, and career recognition for those investigators, as they would attain special agent status, yielding a minimum 5–7% pay increase and other benefits. The continuing morale, recruitment, and retention concerns described in the *Initial Report*¹⁵⁷ would be addressed in a single organizational change. Finding and keeping talented sworn investigators would become a much easier job.

MBC and HQE managers understand and agree with this perspective on the short- and long-term prospects for vertical prosecution. MBC and HQE executives share the view that implementation of vertical prosecution with investigators and prosecutors working in separate agencies is less than optimal and will entail challenges which full integration would have avoided. However, MBC and HQE management see the initial system as an important first phase of this process, whereby a basic version of vertical prosecution is put in place to demonstrate (on a limited basis) what could be accomplished on a larger scale with the full integration of the staffs through the transfer of the MBC investigators and their supervisors to HQE.

To facilitate the best possible working relationship between the agencies and to help address an aspect of change in organizational culture, authority for the settlement of MBC disciplinary cases would be shifted from enforcement program management to MBC's executive director and deputy executive director. Executive Director Thornton has implemented this measure to help eliminate the present perception of an attorney/client relationship, as opposed to the partnership intended in the Monitor's recommendations and by the Legislature in SB 231.

¹⁵⁷ *Id.* at 147–48.

Chapter VIII

EXPERT REVIEWER PROGRAM

A. Overview of Function and Updated Data

In a quality of care disciplinary matter against a physician, expert opinion testimony is required to prove or disprove that the physician performed in accordance with the prevailing standard of care.¹⁵⁸ Because the burden of proof is on the Board, it must produce one or more physician witnesses with experience and expertise in the specialty or procedure at issue. That expert witness must review all the evidence in the case, testify to the standard of care applicable to each procedure performed, opine as to whether the subject physician's conduct departed from that standard of care and to what degree, and explain the justification or basis for his opinion. This burden requires MBC to recruit, train, and select expert witnesses who are willing to review disciplinary investigations against other physicians, write detailed memoranda and opinions, and — if necessary — testify orally at an evidentiary hearing.

As described in detail in the *Initial Report*,¹⁵⁹ the Medical Board overhauled its Expert Reviewer Program in 1994, adopting minimum qualifications for expert reviewers¹⁶⁰ and establishing procedures for the appointment, training, oversight, evaluation, and reappointment of a pool of expert reviewers who would be available when investigations reach a point where independent and objective expert input is essential. In the past decade, MBC's Expert Reviewer Program has recruited and trained a list of approximately 900 expert reviewers in all specialties throughout the state. The Board recruits experts in a variety of ways, but primarily through its *Action Report* licensee newsletter, speeches and presentations made by Board members and staff to hospital

¹⁵⁸ *Hanson v. Grode* (1999) 76 Cal. App. 4th 601, 606–07; *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal. 4th 992, 1001.

¹⁵⁹ *Initial Report*, *supra* note 13, at 155–59.

¹⁶⁰ MBC generally requires its experts to have a current California license in good standing, with no prior discipline, no pending accusation, no current complaints, and no complaints closed within the past five years for insufficient evidence. They must be board certified in a specialty approved by the American Board of Medical Specialties and must have at least three years of experience (beyond board certification) in that specialty. Additionally, MBC expert reviewers must be actively practicing medicine or, if retired, not more than two years out of practice.

personnel and medical societies, and recruitment efforts by district office medical consultants in their local communities.

The *Initial Report* also described methods by which MBC investigators, medical consultants, and HQE DAGs evaluate the performance of experts in reviewing records, drafting well-reasoned expert opinions, and — if applicable — testifying at hearings. Further, since July 2003, MBC's experts have been invited to evaluate their experience as an expert and provide feedback directly to the Chair of MBC's Enforcement Committee. Through this mutual evaluation process, Board staff is better able to determine whether to reuse a given expert in a future proceeding,¹⁶¹ and experts provide invaluable feedback to the Board about their experience with the process, MBC staff, HQE DAGs, and ways in which MBC can better attract, train, and retain qualified experts.

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's Expert Reviewer Program, and documents the responses to those findings implemented by the Medical Board, the Attorney General's Office, and the Legislature during 2005.

1. Average expert reviewer times are excessive.

Once an expert is chosen for a given case, the investigator and medical consultant — sometimes assisted by the DIDO DAG in the district office — assemble the investigative file, medical records, and other documentary evidence, determine which materials to forward to the expert, and send the package to the expert with a cover letter. Experts are expected to review the materials, draft a memorandum in a specified format,¹⁶² and return the file within 30 days. In the *Initial Report*, however, the Monitor found that the average 2003–04 turnaround time for expert opinions was 69 days.¹⁶³ According to recent data from the Expert Reviewer Program, the average turnaround time in 2004–05 was also 69 days — over two times MBC's goal.

¹⁶¹ In the *Initial Report*, the Monitor commented on the fact that MBC has no standards or policy on the reuse of experts. *Initial Report, supra* note 13, at 159. In February 2005, MBC Enforcement Chief Joan Jerzak announced a new policy governing expert reuse. Once a given expert is used five times within a 12-month period, his/her name is flagged on MBC's expert witness database, and investigators and medical consultants are encouraged to seek an alternative expert.

¹⁶² The expert opinion must (1) describe the records reviewed; (2) summarize the case; (3) state the standard of care at the time of the event(s) in question; (4) determine if the care in question was or was not a deviation from the standard of practice; (5) define the deviation from the standard in terms of no departure, simple departure, or extreme departure; and (6) summarize the review.

¹⁶³ *Initial Report, supra* note 13, at 160.

Quality of care cases are often complex and involve boxes of medical records and other evidence. Most California physicians who provide expert review services to MBC are actively practicing medicine, and they must find time to provide services to MBC outside their busy practices. MBC is able to pay only \$100 per hour for records review and report preparation, and \$200 per hour for testimony at hearings. MBC's experts know that physicians who testify for the defense or in civil malpractice proceedings are routinely paid \$500–\$750 per hour, depending on the specialty, and properly view their work for MBC as community service. On their evaluation forms, MBC's experts state that it is often difficult to find time to review investigatory files and draft opinions within the time constraints of their busy practices. Although MBC could never pay these physicians the equivalent of what they earn in medical practice, a growing number of experts indicate that MBC should attempt to increase the hourly rates for experts. In 2003–04, 49% of the physicians who returned MBC's expert reviewer survey said they weren't paid enough for their services.¹⁶⁴ In 2004–05, 51% of the 250 physicians who responded to the survey stated that MBC's hourly rate is not high enough. If the fee increase in SB 231 can accommodate an increase in the hourly rate paid for records review and report preparation, MBC should consider it as it may assist in the recruitment of qualified experts — who are essential to the Board's ability to prove a quality of care case — and may prompt experts to review cases in a more timely fashion.

2. There is a lack of qualified experts in many specialties, and the CCU specialty review requirement is siphoning off some experts who would otherwise review cases in the field.

In the *Initial Report*, the Monitor noted that MBC lacks a sufficient number of experts in certain subspecialties, and that some of those experts are now being utilized by the Central Complaint Unit for the specialty review required by Business and Professions Code section 2220.08. In Recommendation #32, the Monitor suggested that MBC undertake a vigorous recruitment effort and that — resources permitting — it should consider reinstating in-person training sessions for expert reviewers. During 2003–04, veteran MBC investigators told us that, in years past, district office supervisors, medical consultants, and DAGs conducted training sessions for experts in which they would review examples of well-written expert reports, discuss the guidelines for writing an expert report, and answer the experts' questions. According to the investigators, these training sessions served to enhance the quality of the experts' work and promoted a collegial relationship between MBC/HQE personnel and the experts — which in turn encouraged retention of qualified experts.

During 2005, MBC enforcement staff has engaged in a concerted effort to recruit expert reviewers whenever they give presentations to physician groups and organizations. Further, the

¹⁶⁴ *Id.* at 162.

Expert Reviewer Program analyst has identified specialties and subspecialties in which MBC lacks a sufficient number of experts — including dermatology, neurosurgery (especially spine surgery), pediatric surgery, pediatric cardiology, and gastric bypass surgery — and has engaged in a targeted outreach effort to hospital administrators and individual physicians in these specialties. Finally, MBC’s enforcement chief drafted an article on the role of physicians in MBC investigations for publication in the October 2005 issue of the Board’s *Action Report* licensee newsletter.

Additionally, MBC and HQE staff have reinstated in-person training sessions for expert reviewers which have been held in MBC district offices all over the state. These two-hour sessions¹⁶⁵ include separate presentations by a supervising investigator, a medical consultant, and a deputy attorney general. The sessions cover a range of material designed to supplement the expert reviewer guidelines and the videotaped presentation that are mailed to each expert at the start of his/her two-year tenure. In the training sessions, MBC and HQE staff place special emphasis on the all-important expert opinion to ensure that the experts understand how it must be drafted, how it is used, and how it may result in the filing of administrative charges and become subject to scrutiny and cross-examination.

3. There is no requirement that expert testimony be reduced to writing and/or exchanged before the hearing.

In the *Initial Report*, the Monitor explained that MBC requires its experts to reduce their expert opinions to writing — and under the Administrative Procedure Act (APA), those written expert opinions are discoverable by the defense as soon as an accusation is filed. However, defense counsel frequently instruct their experts not to reduce their opinions to writing. Because of the APA’s limitations on discovery in administrative proceedings (and especially its limitations on witness depositions), the HQE DAG frequently has no idea of the substance of defense counsel’s expert opinion until that expert takes the stand at the evidentiary hearing. This practice results in the unfair “sandbagging” of the DAG at the hearing, and stifles the possibility of prehearing settlement. While defense counsel may perceive some short-term adversarial advantage in depriving the trial DAG of full knowledge of the weaknesses of MBC’s case, litigation surprise over expert testimony is very costly to respondents, as it often means unnecessary trial preparation and hearing expenses because potential early case dispositions — including possible dismissals of accusations — cannot take place (in the absence of expert views raising doubts about MBC’s case). This surprise is equally costly to MBC and the public, as scarce investigator and attorney resources are often allocated to preparation and trial of matters which could have been resolved more expeditiously. In

¹⁶⁵ During 2005, expert reviewer training sessions were held on March 24 and April 18 in Glendale, May 19 in Valencia, June 21 in Tustin, June 27 in San Diego, June 29 in Pleasant Hill (two sessions), and September 28 in Santa Monica.

Recommendation #30, the Monitor urged that the Medical Practice Act be amended to provide that any party to a Medical Board enforcement matter that wishes to rely on expert testimony must reduce that testimony to writing and provide it to the other party well in advance of the hearing.

SB 231 (Figueroa) adds new section 2334 to the Business and Professions Code, which requires a party to a Medical Board disciplinary proceeding who wishes to rely on expert testimony to exchange certain information in writing with counsel for the other party: (1) a curriculum vitae of the expert; (2) a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis; (3) a representation that the expert has agreed to testify at the hearing; and (4) a statement of the expert's hourly and daily fee for providing testimony and consultation. The exchange of this information must occur at least 30 days prior to the commencement of the administrative hearing or as ordered by the administrative law judge. The Office of Administrative Hearings is authorized to adopt regulations to implement section 2334.

4. The expert reviewer handbook contained errors.

In the *Initial Report*, the Monitor noted that MBC's *Expert Reviewer Manual* provided to the Monitor team in 2003 had not been revised to conform to the changes in 2002's SB 1950 (Figueroa) and contained several legal errors. That manual was revised and corrected in late 2004.

C. Recommendations for the Future

■ ***Increased expert reviewer hourly rates for records review and report preparation.*** If the fee increase in SB 231 can accommodate an increase in the hourly rate paid to Medical Board experts for records review and report preparation, MBC should consider it as it may assist in the recruitment of qualified experts — who are essential to the Board's ability to prove a quality of care case — and may prompt experts to review cases in a more timely fashion.

Chapter IX

PROSECUTIONS: HEALTH QUALITY ENFORCEMENT SECTION

A. Overview of Function and Updated Data

After a Medical Board district office has completed an investigation yielding sufficient evidence of chargeable physician misconduct, the case is transmitted to the Attorney General's Health Quality Enforcement (HQE) Section for administrative action, and/or to the appropriate state or local prosecutor for criminal or civil enforcement action. Under Government Code section 12529 *et seq.*, HQE is responsible for prosecuting disciplinary proceedings against MBC licensees; it is also charged with assisting MBC with complaint intake and investigation activities in support of those prosecutions. To implement its responsibility to assist with investigations, HQE created the Deputy in District Office (DIDO) program in 1997. To assist with complaint intake, HQE formally assigned a deputy attorney general to MBC's Central Complaint Unit on October 1, 2003.

As of the 2003–04 fiscal year, HQE was staffed by a Senior Assistant Attorney General, six supervising deputies attorney general (SDAGs), and 36 deputies attorney general (DAGs) stationed in six offices across the state. In 2003–04, HQE received 580 cases transmitted from MBC investigators (on par with the previous three-year average), filed 262 accusations (down from a 2001–02 high of 329 but about average for the past five years), obtained 48 prefiling stipulations and 202 post-filing stipulations, and conducted 45 administrative hearings.

As of fiscal year 2004–05, HQE staffing remained static, with 36 DAGs, six SDAGs, and the HQE chief. In the absence of major additional resources or process changes, its enforcement throughput — reflected in Exhibit IX-A below — also remained essentially the same in 2004–05. HQE received 521 cases transmitted from MBC, filed 235 accusations (down 10% from the prior year), obtained 63 prefiling stipulations (up 30% but entirely attributable to increased public letters of reprimand) and 210 post-filing stipulations, and conducted a comparable 49 administrative hearings.¹⁶⁶

¹⁶⁶ The Monitor again notes that each complex disciplinary case is different and urges caution in comparisons of one year's caseload with that of another. See *Initial Report, supra* note 13, at note 209.

Ex. IX-A. Health Quality Enforcement Section: Enforcement Throughput

	Activity	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05
HQE	Cases transmitted to HQE by MBC	491	510	589	494	580	521
	Pre-filing public letters of reprimand	19	17	19	17	29	49
	Other pre-filing stipulations	15	15	14	12	19	14
	Cases in which HQE declined to file	31	24	25	34	19	21
HQE/ OAH	ISO/TRO sought (can be pre- or post-filing of accusation)	21	34	40	24	26	40
	Full ISOs/TROs granted	13	10	17	12	19	26
	Partial restriction granted	6	7	9	0	3	3
	Stipulations not to practice (can be pre- or post-filing of accusation)	2	3	5	5	0	2
	Accusations filed	262	238	329	258	262	235
	Petitions to revoke probation filed	28	18	21	18	26	26
	Post-filing public letters of reprimand	14	10	13	11	12	5
	Other post-filing stipulations	242	185	158	206	202	210
	Accusations withdrawn	71	45	32	35	44	25
	Evidentiary hearings held	49	44	39	44	45	49
	Accusations dismissed after hearing	12	9	16	10	20	8
	Defaults (respondent failed to appear)	30	14	15	22	21	24

Source: Medical Board of California

Exhibits IX-B and IX-C below and MBC's 2004-05 *Annual Report* reflect the present pattern of HQE cycles times as calculated by MBC,¹⁶⁷ with particular emphasis on the time it takes to file accusations in the six HQE offices. The average time between HQE's receipt of a fully investigated case and the filing of the accusation is once again on the rise, from the 60-70 day level reported by HQE in the 2001-03 period, to 107 days average in 2003-04, to the 2004-05 average of 116 days (see Exhibit IX-B below). In particular, the average filing time of the Los Angeles office (in excess of five months, as before) reflects the continuing critical staffing shortage in that office.

As indicated in Exhibit IX-C below, the age of pending cases with no pleading filed gives a similar insight into the backlog issue. In all the high-volume offices except Sacramento (including Los Angeles, San Diego, and San Francisco), the age of pending cases averages about five months or more, and four of the six offices show greater case aging in 2004-05 than the prior year.

Although greatly reduced from historical highs of as much as 365 days to filing, the current filing statistics show a generally static or worsening picture in case cycle times at HQE. A significant component of the average 2.5 year disciplinary processing time is still the HQE filing

¹⁶⁷ As observed in the *Initial Report*, *supra* note 13 at 168, MBC and HQE presently use wholly separate case tracking systems and significantly different definitions of case events. As a result, HQE statistics — which define not filing but "transmittal" to MBC's executive director — show significantly shorter "filing" times than do MBC statistics. Discussed further below and in Chapters V and VII above, this disconnect between closely related systems illustrates yet again why the investigative and prosecutorial functions must be united into a single teamwork system.

process. As explained in the *Initial Report*,¹⁶⁸ the filing of the accusation turns a confidential investigation into a matter of public record which is posted on MBC’s Web site, and a delay in accusation filing means a delay in notice to the public about a potentially dangerous physician.

**Ex. IX-B. Attorney General’s Office Case Cycle Times:
Processing Time to Filing of Pleading (FY 2004–05)**

HQE Office	Total number of pleadings filed	Total number of days pending in AG’s office before pleading filed	Average age when pleading filed
Fresno	2	475	237.50 (7.92 months)
Los Angeles	71	11,194	157.66 (5.26 months)
Oakland	12	1,193	99.42 (3.31 months)
Sacramento	32	3,131	97.84 (3.26 months)
San Diego	65	7,191	110.63 (3.69 months)
San Francisco	79	7,106	89.95 (3 months)
TOTALS	261	30,290	116.05 (3.87 months)

Source: Medical Board of California

**Ex. IX-C. Attorney General’s Office Case Cycle Times:
Age of Pending Cases with No Pleading Filed (6/30/2005)**

HQE Office	Total number of unfiled cases	Total number of days pending as of 6/30/05	Average days per unfiled case
Fresno	3	290	96.67 (3.22 months)
Los Angeles	53	7,680	144.91 (4.83 months)
Oakland	1	154	154 (5.13 months)
Sacramento	11	1,112	101.09 (3.37 months)
San Diego	38	7,380	194.21 (6.47 months)
San Francisco	19	2,851	150.05 (5 months)
TOTALS	125	19,467	155.74 (5.19 months)

Source: Medical Board of California

Updating the status of a key vehicle for prompt disciplinary action, Exhibit IX-D shows the trends in HQE Penal Code section 23 appearances and orders. As described in the *Initial Report*, Penal Code section 23 permits HQE to appear in any criminal proceeding against an MBC licensee “to furnish pertinent information, make recommendations regarding specific conditions of probation,

¹⁶⁸ *Id.* at 168.

or provide any other assistance necessary to promote the interests of justice and protect the interests of the public.” HQE continues an impressive batting average of success in orders sought. The reduction in the number of appearances reflects, at least in part, the brief uncertainty surrounding this process following the limiting appellate court decision in *Gray v. Superior Court*.¹⁶⁹ However, this tool remains underutilized in a state with 120,000 licensed physicians and surgeons.

Ex. IX-D. HQE Penal Code § 23 Appearances

Activity	FY 1999–00	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04	FY 2004–05
Total PC 23 Appearances	9	10	10	9	16	9
Total PC 23 Orders Issued	11	11	12	8	15	7

Source: Medical Board of California

B. The Monitor’s Findings and HQE/Legislative Responses

The following summarizes the Monitor’s *Initial Report* findings and concerns about the performance of HQE, and documents the responses to those findings implemented by the Attorney General’s Office, the Medical Board, and the Legislature during 2005. More detail on each of the findings is available in Chapter IX of the *Initial Report*.¹⁷⁰

1. HQE cycle times remain lengthy, including recent increases in the filing phase.

Without increased staff or improved process efficiency, HQE continues to experience lengthy case processing times, notwithstanding the efforts of a group of experienced and hardworking DAGs and supervisors. HQE is seeing further erosion of earlier progress in the filing phase — the one aspect over which the Attorney General has primary (although not exclusive) control. MBC statistics for fiscal year 2004–05 reveal an average 116-day period between transmittal of the completed investigation by MBC and the filing of the accusation, up from 107 days last year and 60–70 days in 2001, before HQE staffing shortages took hold.

As noted in the *Initial Report*,¹⁷¹ HQE and MBC management use different statistical definitions of key events, and HQE reports shorter “filing times.” HQE measures the average time from its acceptance of an investigated case to the transmittal of the draft accusation to MBC — as opposed to

¹⁶⁹ 125 Cal. App. 4th 629 (2005).

¹⁷⁰ *Initial Report*, *supra* note 13, at 168–76.

¹⁷¹ *Id.* at 168; *see supra* Ch. V.B.3.

filing — and reports a range of 29 to 92 days during 2004–05, depending on the HQE office. However, HQE management readily acknowledges that the average time to file pleadings has doubled in the past three or four years — an increase HQE attributes to the 2001–04 reductions in attorney staff in the high-volume Los Angeles office. Discussed below is the Monitor’s primary recommendation to address long case cycle times and case efficiency concerns — the successful implementation of the vertical prosecution system, beginning January 1, 2006.

2. HQE attorney staffing is insufficient to meet its statutory and operational requirements.

Government Code section 12529(c) requires HQE to be “staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions.” In the *Initial Report*, the Monitor found that HQE’s six offices suffered a 15% loss of attorney positions since early 2002.¹⁷² No remedy has been forthcoming. As noted above, current HQE staffing remains identical to its reduced size during November 2004. Senior managers report that HQE lacks a sufficient number of DAGs to meet the statutory mandate of Government Code section 12529(c), especially in HQE’s Los Angeles office.

The overall HQE staffing picture is a principal factor in MBC’s inability to move its disciplinary cases rapidly to conclusion statewide. The reduced staff level contributes to the growing delays in case pleading, and leaves little time for remaining DAG and SDAG staff to adequately train newer attorneys, perpetuating a cycle of lowered efficiency. In Recommendation #35, the Monitor called on the Attorney General’s Office to come into full compliance with Government Code section 12529(c) by adequately staffing HQE to restore lost attorney positions and to fulfill all missions required by the statutes that created HQE.

Over the past three years, the Department of Justice has submitted budget change proposals (BCPs) to obtain permission to add four new DAG positions, but these have been rejected because no available MBC funding could be identified. As recently as September 2005, DOJ submitted another BCP for four additional DAGs for fiscal year 2006–07, but this proposal was withdrawn pending the enactment of SB 231 (Figueroa). HQE’s staffing woes are now exacerbated by a number of vacancies in established attorney positions. In his September 20, 2005 letter to Attorney General Bill Lockyer, Medical Board President Ronald Wender, M.D., directed attention to the vacancies in HQE which are “causing delays in filing accusations and setting matters for hearing, and therefore, impacting public protection.” Dr. Wender urged the Attorney General to “move quickly to fill all vacant positions in this vital section of the Attorney General’s Office.” The Monitor fully endorses that recommendation, and adds that success in implementing vertical

¹⁷² *Initial Report*, *supra* note 13, at 169.

prosecution, and in reducing disciplinary delays generally, will almost certainly depend on filling vacant attorney positions and ending HQE understaffing.

As noted above, SB 231 increases physician licensing fees by 30%, and a portion of the increased revenues has been earmarked for reinstatement of lost DAG positions.¹⁷³ The Monitor urges relevant control agencies to approve the creation of those positions which are vital to the success of vertical prosecution.

3. Attorney/investigator coordination and teamwork is inadequate.

Notwithstanding diligent staff efforts, the traditional system linking HQE prosecutors with MBC investigators has been and still is characterized by inadequate coordination and teamwork. HQE prosecutors still generally receive “hand-off” cases which have been investigated and assembled by MBC investigators with little or no input whatsoever from the HQE trial prosecutor who will handle the case. Most HQE prosecutors complain that they do not play a role in shaping the cases they receive or the investigative plans and strategies behind them, often resulting in last-minute changes of case direction, amended pleadings, and delays as cases are reinvestigated. Equally critical, HQE DAGs today frequently have little or no investigator assistance at the hearing itself.

The principal discussion of the present HQE and MBC case coordination relationship is found in the *Initial Report*¹⁷⁴ and in Chapter VII above, and that analysis is incorporated here. In *Initial Report* Recommendations #22 and #33, the Monitor called for a sweeping reform of the basic model of MBC and HQE disciplinary interaction with the implementation of the vertical prosecution system (described at length in the *Initial Report* and in Chapter VII.C. above), in which an attorney/investigator team is formed at the inception of an investigation and works together to the case’s conclusion.¹⁷⁵ The enactment of SB 231 (Figueroa), detailed in Chapters IV and VII above, mandates the implementation of the vertical prosecution model by January 1, 2006, and provides the mechanism for full integration of MBC’s investigators and supervising investigators into HQE by 2008 if the initial implementation is adjudged successful by the Legislature.

Vertical prosecution will call for a number of significant structural, operational, and attitudinal changes in both HQE and MBC, including the addition of sufficient staff to operate the new system, the creation of a workable system of case assignments within the team concept, the adoption of an appropriate supervision system for peace officer investigators and HQE attorneys,

¹⁷³ See *supra* Ch. V.B.2.

¹⁷⁴ *Initial Report*, *supra* note 13, at 129–40.

¹⁷⁵ *Id.* at 149, 176.

decisionmaking on physical plant and equipment, joint agreement on operational protocols and the drafting of an operations manual to reflect them, joint retraining, coordination of management information systems, and development of new evaluative standards and methods of course correction. The Monitor's recommendations for each aspect of the implementation of vertical prosecution are presented in detail in Chapter VII.C. above.

Carlos Ramirez, Senior Assistant Attorney General (SAAG) in charge of HQE, and his supervisory staff are already working closely with MBC managers to plan the transition to the vertical prosecution system. Extensive discussions in September and October 2005 resulted in a general consensus on the basic process and the essential transitional details of implementation. A series of staff training programs is planned for early December 2005, and HQE is prepared to go forward under the new system in January 2006.

The enactment of SB 231 will change the HQE enforcement process profoundly, and HQE leadership has supported and embraced this change. The Monitor applauds the constructive approach and energetic efforts of HQE management and staff in beginning the changeover to this new and different team-based process. As noted in the implementation recommendations in Chapter VII.C., the attitudinal component of any such change is key, and clear leadership commitment to the new system is a prerequisite for success. That prerequisite is met in both HQE's and MBC's management today.

Based on the experiences of other regulatory and law enforcement agencies that utilize the vertical prosecution model, HQE attorneys will soon operate in a wholly different and more efficient environment, in which attorneys and investigators (and other staff) work together throughout the process, each professional bringing unique expertise and skills to each case team. HQE attorneys will direct the investigative plan and process, will be able to shape the cases they take to hearing, and will enjoy the invaluable benefits of a case partner in the prehearing and hearing phases of the disciplinary process. The positive impact of these changes on HQE attorneys and management will be immediate and profound. The Monitor predicts that in years to come HQE prosecutors will wonder how it was possible to use any other approach to this complex disciplinary process.

4. Attorney assistance is not used sufficiently in MBC's medical records procurement process.

The *Initial Report* expressed concern that HQE prosecutors seldom file subpoena enforcement actions or motions for sanctions for failure to produce medical records, contributing to the laxity in physician and institutional responses to MBC requests for medical records.¹⁷⁶ Monitor's

¹⁷⁶ *Id.* at 171–72.

Recommendations #7, #23, and #34 urged MBC and HQE to revise their medical records procurement and enforcement policies to ensure prompt compliance with records requests.

HQE management has embraced these recommendations, supported MBC's publicly disclosed policy of rigor with regard to records production, and encouraged its staff attorneys to make more frequent and aggressive use of existing sanctions and procedures to ensure records production. In March 2005, following MBC's formulation of its vigorous new "zero tolerance" policy, HQE management sent letters to defense counsel and various professional organizations advising them of the Board's new policy requiring adherence to Business and Professions Code sections 2225 and 2225.5.

HQE staff has responded with increased enforcement actions. Subpoena enforcement actions for medical records sought in fiscal year 2003–04 totaled only four statewide; HQE increased this figure to nine in 2004–05. No motions for sanctions for failure to produce were brought by HQE attorneys in 2003–04; HQE staff filed three such motions this past year. While these absolute numbers remain modest in light of the scope of the records production problem, such an increase in enforcement activity can have an impact disproportionate to the raw numbers. The attorneys representing doctors and institutions in these matters are a small group, and the word of a new enforcement policy and additional enforcement efforts spreads rapidly and can achieve a significant deterrent effect.

HQE's high-visibility enforcement notices and increased case activity no doubt played a role in the reduction of average document production times in the MBC district offices from 74 days in 2003–04 to 44 days in 2004–05.¹⁷⁷

SB 231 and its vertical prosecution reforms should also significantly assist in the medical records procurement process. The presence of an HQE trial attorney on the investigation team — ready and able to assist with prompt subpoena or sanction motions as needed — should only improve physician and institutional compliance with records requests.

5. HQE and MBC make inadequate use of ISO/TRO powers and the Penal Code section 23 authority.

The *Initial Report* called attention to the relatively modest use of legal tools available to MBC and HQE when a physician is an imminent danger to the public and continues to practice medicine.¹⁷⁸ The use of important expedited proceedings — including interim suspension orders (ISOs), temporary restraining orders (TROs), and probation order proceedings under Penal Code

¹⁷⁷ See *supra* Ch. VII.B.3.

¹⁷⁸ *Initial Report*, *supra* note 13, at 172–73.

section 23 — has declined in recent years. For example, ISOs/TROs sought by HQE on behalf of the Medical Board diminished from a high of 40 in 2001–02 to 26 in 2003–04 (a decline of 35%). Monitor’s Recommendation #37 called on MBC and HQE to make more extensive use of these potent tools.

In response to this recommendation, HQE stepped up its use of these proceedings significantly. Motions for ISO/TRO increased to 40 in fiscal year 2004–05 — a 50% increase. Exhibit IX-D above indicates that the number of Penal Code section 23 probation orders sought decreased to nine (of which seven were successful), largely due to the new procedural requirements imposed by the appellate court decision in *Gray v. Superior Court*.¹⁷⁹ The *Gray* opinion, which vacated and remanded a section 23 bail order prohibiting a doctor’s continued practice, found insufficient due process where the physician defendant was not given advance notice and an opportunity to research and present an informed opposition. Although *Gray* imposes a clarified system of procedural requirements for the section 23 process, it is the view of HQE management that these requirements can be readily met in most relevant instances. The new procedure should not prevent increased use of this expedited method of achieving an early public safeguard in appropriate cases.

The Monitor believes that early trial attorney involvement in the investigation — an integral part of the new vertical prosecution system under SB 231 — will result in increased use of these important tools for public safety. The Monitor urges HQE to continue its heightened emphasis on these procedures.

6. Needed improvements in HQE case tracking and management information systems have begun and must be properly implemented.

The Attorney General’s Office as a whole has long been subject to criticism for its outdated and antiquated management information system (MIS), as noted in the *Initial Report*.¹⁸⁰ To address these concerns, the Attorney General has finally installed and begun to use the long-awaited ProLaw management information system.

Implementation of ProLaw began at HQE in the summer of 2004 and — to some extent — the system is still in its developmental stage. HQE supervisors report that the system works well for basic case tracking and management review. The system allows them to track docket events accurately, and an increasingly deep pool of historical case data is being compiled. The change to

¹⁷⁹ 125 Cal. App. 4th 629 (2005).

¹⁸⁰ *Initial Report*, *supra* note 13, at 173–74.

an entirely new MIS is a major undertaking, and HQE and DOJ as a whole merit recognition for getting this system up and running successfully.

However, in its early implementation ProLaw still has limitations as a management tool. HQE managers responsible for the system report that several desirable capabilities are not yet in place, including the ability to generate data for client reports, the ability to perform calculations of key data for management purposes (such as case cycle times and average caseloads), the ability to trace referrals to other prosecuting agencies, and a method of noting case priorities under Business and Professions Code section 2220.05. HQE is exploring these capabilities with the vendor and information systems staff, but the process is reported to be slow.

The advent of ProLaw represents an important step toward modernizing HQE's management information process. However, the system is a work in progress and is not yet capable of all the functions of an optimum management tool. Further development of ProLaw should continue to be a priority for HQE.

The enactment of SB 231 presents yet another opportunity for overall improvement of the MBC and HQE disciplinary process — the development of a jointly-operated management information system unifying the data capabilities of the two agencies. An integrated MIS is essential to the effective management and case tracking for the new vertical prosecution system. Although multiple options are available, the Monitor recommends that MBC acquire appropriate licenses for ProLaw and use that software to develop a unified management data system. MBC management is inquiring into this solution now. A unified MIS will also be important in the evaluation of the new teamwork system for purposes of continuous improvement and to meet the oversight requirements of the July 2007 report.

7. HQE has no formal policy and procedure manual to ensure uniformity and assist in training.

The *Initial Report* noted with dismay that HQE has no formal policy/procedure manual or operations manual in place to clearly reflect its functions and processes, leading to diverging policies, inconsistent practices, and a weakened training process.¹⁸¹ In Recommendation #38, the Monitor urged HQE to develop a formal policy and procedure manual to improve consistency of practice and to assist in prosecutor training.

HQE management readily agreed, and began a process aimed at outlining and then drafting an HQE operations manual. The Monitor has reviewed the resulting outline and is confident that

¹⁸¹ *Id.* at 174.

HQE is well on its way to completion of the requisite manual. However, the supervening enactment of SB 231 provides a tremendous opportunity to advance this project in the broader context of the vertical prosecution system by generating a joint operations manual for the newly combined efforts of MBC investigators and HQE attorneys.

Operational protocols and procedures for the new vertical prosecution system are now being worked out jointly by the management staffs of MBC and HQE in anticipation of the January 2006 implementation date. The Monitor recommends that these protocols be brought together into a single jointly-produced operations manual, equivalent in relevant respects to MBC's current *Enforcement Operations Manual*. A joint committee of appropriate supervisors and staff from both agencies should undertake this task and should remain in place to update and improve the manual continuously.

MBC and HQE managers have expressed support for the concept of a single operations manual (reflecting, at the very least, those aspects of activities undertaken together), to be drafted and distributed in the near future as the continuing guide for the new joint investigation/prosecution process. The Monitor believes the distribution of this joint manual would have immediate practical and symbolic significance, and should be among the highest priority projects for HQE and MBC in the near term.

8. The current venue statute for adjudicative hearings results in substantial and unnecessary costs for HQE, OAH, MBC and — ultimately — disciplined physicians and the physician population generally.

Prior to the changes brought about by SB 231, Government Code section 11508 generally assigned the venue for administrative hearings to the judicial district in which the transaction in question occurred or in which the respondent resides. The statute frequently required the costly scheduling of administrative hearings in cities in which HQE and OAH have no office facilities. Requiring adjudicative hearings to be held in cities in which HQE has an office and OAH has hearing facilities would substantially lessen costs for MBC, and in many cases for the respondent as well.¹⁸² In Recommendation #39, the Monitor urged amendment of this statute to end these costly venue results.

Section 22 of SB 231 amends Government Code section 11508(a) to require that MBC administrative hearings be held at the OAH facility closest to the location where the transaction occurred or the respondent resides. Defense concerns are fairly addressed, in that revised section 11508(b) preserves the possibility of parties stipulating to a different venue, and section 11508(c)

¹⁸² *Id.* at 175–76.

retains the respondent's ability to move for change of venue and the ALJ's discretion to order a venue change. However, absent good cause to the contrary identified in writing by the ALJ, hearings must now take place in a facility maintained by OAH. This will significantly change the wasteful practice under prior section 11508 and yield a clear public benefit.

C. Recommendations for the Future

- ***Full implementation of vertical prosecution.*** Numerous recommendations for the full and successful integrated implementation of the vertical prosecution system under SB 231 are presented above in Chapter VII.C., and are incorporated here.

- ***Adequate staffing of HQE.*** MBC and HQE must come into compliance with Government Code section 12529(c) (“[t]he Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions”). The success of vertical prosecution hinges on the proper staffing of HQE.

Chapter X

HEARINGS: MEDICAL QUALITY HEARING PANEL

A. Overview of Function and Updated Data

Housed within the Department of General Services, the Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over adjudicative hearings in a variety of areas for over 150 state and 800 local agencies. OAH is headed by a director (also called the chief administrative law judge) appointed by the Governor. Currently, the Office employs the director, five presiding judges, and approximately 50 ALJs based in four California cities (Sacramento, Oakland, Los Angeles, and San Diego).¹⁸³

In the early 1990s, the Legislature enacted Government Code section 11371 *et seq.*, which created a special panel of ALJs — the Medical Quality Hearing Panel (MQHP) — within OAH.¹⁸⁴ MQHP ALJs specialize in physician discipline matters; the statute limits the number of ALJs who may be appointed to the MQHP by the OAH director,¹⁸⁵ and generally requires an MQHP ALJ to preside over MBC adjudicative hearings.¹⁸⁶ The purpose of the creation of the MQHP is to enhance the expertise and independence of the ALJs who preside over physician discipline hearings. The statute declares that the MQHP ALJs “shall have medical training as recommended by the Division

¹⁸³ In the *Initial Report*, we reported that OAH employed approximately 35 ALJs throughout the state. Effective July 1, 2005, OAH entered into an agreement with the Department of Education which requires OAH ALJs to preside over special education hearings for the Department. As a result of this additional responsibility, OAH is in the process of doubling in size. OAH’s Special Education Unit alone will eventually include three presiding ALJs, 40 line ALJs, and will require the Office to add two more hearing facilities in southern California and an additional hearing facility in Sacramento.

¹⁸⁴ The MQHP was originally created in SB 2375 (Presley) (Chapter 1597, Statutes of 1990); its composition was refined in SB 916 (Presley) (Chapter 1267, Statutes of 1993). See *Initial Report*, *supra* note 13, at 30, 36, 179.

¹⁸⁵ Gov’t Code § 11371(a)-(b). These sections provide that the OAH director must appoint at least five full-time ALJs but not more than 25% of the total number of ALJs in OAH to the MQHP. Currently, 13 full-time ALJs serve on the MQHP.

¹⁸⁶ *Id.* § 11372.

of Medical Quality . . . and approved by the Director of the Office of Administrative Hearings.”¹⁸⁷ Additionally, the statute requires the OAH director, with the advice of MBC, to appoint “panels of experts” to provide assistance to ALJs who may have difficulty with the expert witnesses paid by the parties. “These panels of experts may be called as witnesses by the administrative law judges of the panel to testify on the record about any matter relevant to a proceeding and subject to cross-examination by all parties.”¹⁸⁸ With the creation of the specialized ALJ panel, the Legislature — for the first time — felt comfortable authorizing those judges to entertain motions for and issue interim suspension orders restricting or suspending the license of a physician pending the conclusion of the disciplinary matter, as an alternative to the temporary restraining order remedy in superior court.¹⁸⁹

Once an accusation has been filed by MBC and the respondent files a notice of defense, the parties approach OAH for a hearing date.¹⁹⁰ Effective July 1, 2004, OAH adopted a new policy requiring it to calendar hearings to start within 90 days of the date both parties are available; in no event will the first day of the hearing be scheduled more than 210 days from the date OAH receives the request for hearing.¹⁹¹ Prior to the evidentiary hearing, the assigned ALJ may entertain and rule on discovery disputes¹⁹² and hold prehearing conferences to clarify issues, make rulings on witnesses and objections to proffers of evidence, establish the order of presentation of evidence and witnesses, require the exchange of witness lists and exhibits or documents to be offered in evidence at the hearing, and explore the possibility of settlement.¹⁹³ OAH may also conduct formal settlement conferences prior to the hearing in an effort to avoid litigation.¹⁹⁴

¹⁸⁷ *Id.* § 11371(a).

¹⁸⁸ *Id.* § 11371(d).

¹⁸⁹ *Id.* §§ 11372(b), 11529.

¹⁹⁰ OAH usually conducts an immediate telephonic trial-setting conference with the parties in order to schedule a hearing date, and the hearing is usually preceded by one or two scheduled settlement conferences.

¹⁹¹ OAH’s July 1, 2004 policy replaced a prior policy requiring it to calendar hearings to start within 120 days of the date that both parties are available; there was no outer limit.

¹⁹² *See* Gov’t Code § 11507.7.

¹⁹³ *See id.* § 11511.5.

¹⁹⁴ *See id.* § 11511.7. The ALJ who is assigned to the matter may not conduct the settlement conference unless the parties so stipulate.

Evidentiary hearings on accusations filed by MBC are presided over by an MQHP ALJ. During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument.¹⁹⁵ Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline.¹⁹⁶ The ALJ’s ruling is a “proposed decision”¹⁹⁷ which is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision (see Chapter XI).

In recommending discipline, the MQHP ALJ is guided by a set of “disciplinary guidelines” approved by DMQ; these guidelines set forth the Division’s preferred range of sanctions for every given violation of the Medical Practice Act and the Board’s regulations.¹⁹⁸

Exhibit IX-A above reflects the “throughput” of MBC investigations into HQE, and HQE accusations into OAH. In the past six years, HQE has filed an annual average of 264 accusations and 23 petitions to revoke probation. Due to the large number of post-filing settlements (many of which are assisted through settlement conferences conducted by OAH ALJs), the MQHP has presided over an average of 45 MBC disciplinary hearings annually for the past six years. Government Code section 11517(c)(1) requires ALJs to submit a proposed decision to DMQ within 30 days of submission of all the evidence. Exhibit X-A below indicates that, over the past four years, it took MQHP ALJs an average of 34 days to submit proposed decisions. In 2004–05, OAH improved on its 2003–04 record by lowering its average to 31 days.

Ex. X-A. HQE/OAH/DMQ Average Cycle Times

	Activity	FY 2001–02	FY 2002–03	FY 2003–04	FY 2004–05
HQE	MBC transmittal → HQE filing of accusation	103 days	91 days	107 days	116 days
HQE/ OAH	Estimated time from filing of accusation → conclusion of hearing/ submission of stipulation ¹⁹⁹	351 days	379 days	448 days	382 days
OAH	Case submission to ALJ → submission of proposed decision to DMQ	35 days	36 days	35 days	31 days
DMQ	Receipt of proposed decision → DMQ final decision	51 days	56 days	30 days	60 days

Source: Medical Board of California

¹⁹⁵ *Id.* § 11513.

¹⁹⁶ *Id.* § 11425.50.

¹⁹⁷ *Id.* § 11517.

¹⁹⁸ Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board’s disciplinary guidelines.

¹⁹⁹ We generated this estimated figure by subtracting average ALJ proposed decision drafting time (presented above) and average DMQ decision time (presented above) from the *MBC Annual Report’s* calculation of the average length of time from accusation filing to final case disposition.

B. The Monitor's Findings and MBC/Legislative Responses

In the *Initial Report*, the Monitor made no findings regarding OAH's performance. However, the Monitor promised to look into the following issues.

1. OAH was impacted by the hiring freeze and budget cuts.

In the *Initial Report*, the Monitor noted that OAH was not immune from the October 2001 hiring freeze or the subsequent position "sweeps" and budget cuts. OAH lost two ALJ positions and a number of support staff positions. Although these losses affected OAH as a whole, they did not directly impact the MQHP which provides services to MBC. The MQHP remains staffed with 13 line ALJs, which appears sufficient to handle MBC's workload.

2. The time it takes to schedule and conduct evidentiary hearings is lengthy.

Exhibit X-A above indicates an estimated average 382-day period between the filing of the accusation and the conclusion of the evidentiary hearing during 2004–05 — down from 448 days in 2003–04, but still almost 13 months. As we explained in the *Initial Report*, some of these hearings are one- or two-day matters; others should last days or weeks but — due to the schedules of the attorneys, respondent, and judge — must be conducted in many non-contiguous blocks over the course of many months. Based on a limited review, it seems that the delay in scheduling and conducting MBC hearings is not due to a shortage of judges or bureaucratic limitations on OAH's part. Instead, it appears that the understaffing in HQE's Los Angeles office (which normally files approximately 60% of all accusations in California) and the limited number of defense counsel who regularly defend physicians in MBC disciplinary matters account for much of the delay in scheduling and holding hearings. In short, there are too few attorneys on both the prosecution and defense sides, and all of these attorneys are "booked" many months in advance. OAH believes that it is setting hearings well within the timelines established in its July 1, 2004 policy, but is forced to postpone scheduled hearings because the parties request continuances. In OAH's view, it has sufficient MQHP ALJs to hear cases more rapidly than they are being heard — but they can't, due to a shortage of attorneys in HQE and the limited number of defense attorneys who handle MBC cases.

3. DMQ members perceive that MQHP ALJs are not following MBC disciplinary guidelines.

Exhibit XI-A below indicates that, during 2001–02 and 2002–03, DMQ nonadopted an unusually high number of proposed ALJ decisions: 25% in 2001–02 and 28% in 2002–03. However, the nonadoption rate declined to 16% in 2003–04, and further decreased to only 11% in 2004–05.

According to the OAH director, DMQ nonadopts a larger percentage of proposed decisions than do other agencies, which generally nonadopt approximately 5% of proposed decisions. The reasons for this higher nonadoption rate are unclear, and cannot be determined or even intelligently speculated within the context of a Monitor project funded at this level and charged with reviewing the entirety of MBC's enforcement and diversion programs. Further, the Monitor — despite the broad investigative authority delegated in Business and Professions Code section 2220.1 — is not privy to DMQ's closed-door sessions following oral arguments on nonadoptions, such that the Monitor has no way of knowing DMQ members' thought processes on individual cases. Although DMQ members have at times voiced concerns that ALJs do not follow the Board's disciplinary guidelines when recommending discipline in physician cases, it is clear that DMQ agrees with the ALJs' proposed decisions in the vast majority of cases.

4. Whether ALJs are receiving medical training as authorized by Government Code section 11371 is unclear.

As noted above, one of the ways in which SB 2375 (Presley) and SB 916 (Presley) sought to enhance the expertise of MQHP ALJs was to provide them with medical training “as recommended by the Division of Medical Quality . . . and approved by the Director of the Office of Administrative Hearings.”²⁰⁰

According to the OAH director, MQHP ALJs receive medical training in a variety of ways. For example, in November 2004, the director convened a three-day annual statewide training session for OAH ALJs, and more than one-third of it related to medical issues (including participation and presentations by Medical Board staff). In addition, every month, every OAH office has a staff meeting which often includes a training component; some of those training components relate to Medical Board issues. Finally, MBC staff has visited all four OAH offices in the past year to engage in half-day training sessions with MQHP ALJs. While MBC staff members are prohibited from addressing issues raised in specific or ongoing cases, they provide valuable information on a list of topics of interest to MQHP ALJs.

5. ALJs rarely make use of their authority to call their own expert witnesses.

Another way in which SB 2375 (Presley) sought to enhance both the expertise and independence of the MQHP ALJs was to provide them with a panel of expert witnesses. If confronted with diametrically opposed expert witnesses paid by the parties, this mechanism enables the ALJ to call his/her own expert to the stand “to testify on the record about any matter relevant to

²⁰⁰ Gov't Code § 11371(a).

a proceeding and subject to cross-examination by all parties.”²⁰¹ According to the OAH director, this procedure is rarely used, primarily because the judges depend on the parties to produce relevant expert testimony and generally feel comfortable relying on it. Further, if the judge were to select his/her own expert, the use of that expert would delay the proceeding by several additional months (as noted in Chapter VIII, the average period required for an expert to review medical records and draft an expert opinion is 69 days). For these reasons, this mechanism is seldom used.

6. Should ALJs be authorized to enforce administrative subpoenas?

As noted throughout the *Initial Report*, medical records procurement and MBC/HQE’s tolerance of lengthy delays by physicians in producing requested medical records are serious issues confronting MBC and HQE. One time-consuming aspect of the existing process is that subpoena enforcement is available only in superior court. In the *Initial Report*, the Monitor suggested that some thought be given to authorizing MQHP ALJs to enforce subpoenas issued by MBC, as a means of expediting medical records procurement. On this issue, the OAH director offered several comments: (1) the Legislature would have to specifically authorize OAH to enforce subpoenas, as OAH has no such authority currently; (2) if the Legislature authorizes OAH to enforce subpoenas, it should also authorize judges to impose a penalty for noncompliance, such as a fine or evidentiary sanctions; (3) it is unclear how many subpoena enforcement motions would be filed and whether OAH is sufficiently staffed to handle them; and (4) from a bureaucratic standpoint, it is also unclear to whom, and under which case number, OAH would bill the time its judges spend hearing and ruling on these motions — as, by definition, no accusation has yet been filed and OAH has no existing case number for the matter.

Hopefully, MBC’s new medical records policy and SB 231’s expansion of the citation and fine sanction to noncompliance with lawful requests for records — described in Chapters IV and VII — will substantially shorten the timeframe for medical records procurement and obviate the need for subpoena enforcement proceedings by either superior courts or OAH ALJs.

7. The venue statute governing the location of adjudicative hearings results in substantial and unnecessary costs for HQE, OAH, MBC, and — ultimately — the physician population generally.

In the *Initial Report*, the Monitor examined Government Code section 11508, which governs the venue for adjudicative hearings under the Administrative Procedure Act — including MBC hearings presided over by an OAH ALJ. The Monitor found that the antiquated statute permitted

²⁰¹ *Id.* § 11371(d).

hearings to be held anywhere in the state, frequently causing HQE, OAH, and/or respondent's counsel to suffer significant costs and inconvenience, and leaving established OAH hearing facilities empty and unused. In Recommendation #39, the Monitor suggested that section 11508 be amended to require most hearings to be held in large cities in which both HQE and OAH have offices and hearing facilities.²⁰²

As described in Chapters IV and IX above, section 22 of SB 231 amends Government Code section 11508 to require Medical Board administrative hearings to be held at the OAH hearing facility that is closest to the location where the transaction occurred or the respondent physician resides. The amendments to section 11508 preserve the ability of the parties to agree to a different venue; they also preserve the ability of the respondent to move for a change of venue and the discretion of the ALJ to order a change of venue. However, unless good cause is identified in writing by the ALJ, the hearing must be held in a facility maintained by OAH. Thus, SB 231 imposes a presumption that most MBC adjudicative hearings will be held at secure OAH facilities.

²⁰² *Initial Report*, *supra* note 13, at 175–77.

Chapter XI

DECISIONS: DIVISION OF MEDICAL QUALITY

A. Overview of Function and Updated Data

The Medical Board’s Division of Medical Quality (DMQ), which consists of fourteen of MBC’s 21 members (eight physicians and six public members), is the Board’s enforcement arm. As described in prior chapters, it oversees a large enforcement staff and adopts final adjudicative decisions in disciplinary matters against its licensees.

Adjudicative or “quasijudicial” decisionmaking is generally governed by the Administrative Procedure Act (APA).²⁰³ It differs fundamentally from all other types of agency decisionmaking, and the courts and Legislature have adopted special rules to ensure that the due process rights of the respondent — who stands to lose a vested constitutional property right — are preserved. Of import, the burden is on the agency to prove a disciplinable violation by “clear and convincing evidence to a reasonable certainty.”²⁰⁴ Under the APA and constitutional law, the respondent has a right to a written statement of the charges (the “accusation”) that sets forth the acts or omissions with which she has been charged with sufficient specificity to enable her to prepare a defense.²⁰⁵ Thereafter, the respondent is entitled to some discovery rights,²⁰⁶ a noticed and public hearing²⁰⁷ at which the respondent may be represented by counsel (at his/her expense), testimony under oath,²⁰⁸ the right to

²⁰³ Gov’t Code § 11370 *et seq.*

²⁰⁴ *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

²⁰⁵ Gov’t Code § 11503.

²⁰⁶ *Id.* § 11507.6. APA discovery is not as expansive as civil discovery, in that interrogatories and depositions are generally not allowed.

²⁰⁷ *Id.* §§ 11425.10(a)(3), 11509.

²⁰⁸ *Id.* § 11513(a).

cross-examine and confront witnesses,²⁰⁹ the issuance of a formal decision,²¹⁰ and judicial review of the agency's decision.²¹¹ Of critical importance, the respondent is also entitled to a decisionmaker who is neutral and unbiased,²¹² and who decides the matter based upon evidence that has been lawfully gathered and admitted at a public hearing.²¹³

Another mechanism utilized by DMQ and other adjudicative bodies attempts to protect the constitutional rights of the respondent. In imposing disciplinary sanctions, the DMQ panel must consider the Division's "disciplinary guidelines," which set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.²¹⁴ While not binding standards, these disciplinary guidelines attempt to ensure consistency in DMQ decisionmaking — an important component of equal protection.

DMQ is the final decisionmaker in all MBC disciplinary matters in which an accusation has been filed. However, as described above, DMQ does not personally preside over or even attend APA evidentiary hearings; that responsibility is delegated to an administrative law judge (ALJ) from the Office of Administrative Hearings' Medical Quality Hearing Panel (MQHP), who prepares a proposed decision (PD) for DMQ's review. Nor does DMQ negotiate the terms of stipulated settlements that avoid an evidentiary hearing; that responsibility is delegated to its counsel (HQE) and its staff, who negotiate proposed settlements with the respondent and his/her counsel and present them to DMQ for review. DMQ reviews all proposed case dispositions that follow the filing of an accusation — including all PDs (including ALJ recommendations that an accusation be dismissed),

²⁰⁹ *Id.* § 11513(b).

²¹⁰ *Id.* §§ 11425.10(a)(6), 11425.50, 11517, 11518.

²¹¹ *Id.* § 11523; *see also* Civ. Proc. Code § 1094.5.

²¹² Gov't Code §§ 11425.10(a)(5), 11425.40. *See also* *Gibson v. Berryhill* (1973) 411 U.S. 564; *State Board of Dry Cleaners v. Thrift-D-Lux Cleaners, Inc.* (1953) 40 Cal. 2d 436; *Allen v. California Board of Barber Examiners* (1972) 25 Cal. App. 3d 1014; and the long series of cases involving the New Motor Vehicle Board, including *American Motor Sales Corp. v. New Motor Vehicle Board* (1977) 69 Cal. App. 3d 983; *Chevrolet Motor Division v. New Motor Vehicle Board* (1983) 146 Cal. App. 3d 353; *Nissan Motor Corp. v. New Motor Vehicle Board* (1984) 153 Cal. App. 3d 109; *University Ford Chrysler-Plymouth v. New Motor Vehicle Board* (1986) 179 Cal. App. 3d 796.

²¹³ Decisions must be made based on evidence lawfully admitted at the public hearing, and not on off-the-record "ex parte" communications with either the presiding officer at the hearing, Gov't Code § 11430.10, or the governmental official or body entrusted with making the ultimate decision, Gov't Code § 11430.70. *See also* Bus. & Prof. Code § 2335(c)(2).

²¹⁴ Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board's disciplinary guidelines.

stipulated settlements, license surrenders, and default judgments.²¹⁵ In APA jargon, DMQ is authorized to “adopt” or “nonadopt” proposed case dispositions; in so doing, it is the final judge in the disciplinary matter. It makes the final agency decision which is then subject to judicial review.

For purposes of reviewing PDs, stipulated settlements, and other proposed case dispositions, DMQ divides into two seven-member panels (called “Panel A” and “Panel B”); a proposed case disposition is randomly assigned to one of the panels for review.²¹⁶ As presented in Exhibit XI-A below, DMQ panels have reviewed and acted upon an average total of 56 PDs and 200 stipulated settlements each year for the past six years.

Generally, Government Code section 11517 — part of the APA — governs a board’s review of a PD. However, special rules apply to a DMQ panel’s review of a proposed decision:

(1) A DMQ panel must give “great weight to the findings of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence.”²¹⁷ This “great weight” requirement was added in 1995, and is based on the fundamental premise of American jurisprudence that the “trier of fact” should be the one who sees and hears the witnesses, has an opportunity to observe how they say what they say, and observe their credibility and demeanor.

Despite this “great weight” requirement, it is important to understand that DMQ does not function under any defined standard of review. The ALJ’s proposed decision is merely a “recommendation” to Board members serving on the Division. As a matter of law, they may ignore it entirely.

(2) Once MBC receives the PD, it is assigned to a DMQ panel and sent by mail to each panel member within ten calendar days of receipt. Each member must vote whether to “approve the decision, to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel . . . as a whole, or to nonadopt the decision.”²¹⁸ Four votes are needed to adopt a decision, approve a decision with an altered penalty, refer the case back to the ALJ for the taking of additional evidence, or nonadopt the decision. Two votes will effectively “hold” the proposed

²¹⁵ DMQ does not review interim suspension orders issued by MQHP ALJs; those are final when issued, Bus. & Prof. Code § 2335(b), subject to judicial review, Gov’t Code § 11529(h). DMQ also does not review pre-filing public letters of reprimand, license surrenders while on probation, or withdrawn accusations (unless they are part of a stipulated settlement).

²¹⁶ Bus. & Prof. Code § 2230(b).

²¹⁷ *Id.* § 2335(c)(1).

²¹⁸ *Id.* § 2335(c)(2).

decision for discussion of the case at the panel's next meeting. DMQ panel members must return their votes by mail to the Board within 30 days from receipt of the proposed decision.²¹⁹

(3) The DMQ panel must take action on the proposed decision — that is, adopt it or nonadopt it — within 90 calendar days of the date it was received by the Board.²²⁰ If two panel members vote to “hold” a proposed decision for discussion at the panel's next meeting (see above), that meeting must take place within the 90-calendar-day period.²²¹ If the panel takes no action on the PD within the 90-calendar-day period, the PD becomes final and subject to judicial review.²²²

(4) If the panel believes that the penalty should be more severe than that recommended by the ALJ, the panel must nonadopt the decision within the 90-calendar-day period. Thereafter, it must order a record of the entire administrative proceeding (including a transcript of the hearing and all the documentary evidence), make it available to both parties,²²³ and afford the parties an opportunity for oral argument before the panel prior to deciding the case.²²⁴ Following oral argument, four votes are required to increase the penalty proposed by the ALJ, and “no member of the . . . panel . . . may vote to increase the penalty except after reading the entire record and personally hearing any additional oral argument and evidence presented to the panel . . .”²²⁵

Once a DMQ panel has adopted a final decision and mailed it to the parties, that decision is subject to reconsideration by DMQ “on its own motion or on petition of any party,” within specified time limits prior to the effective date of the decision. Thereafter, the decision may be reconsidered by the panel itself or may be assigned to an ALJ.²²⁶

²¹⁹ *Id.* § 2335(c)(3).

²²⁰ *Id.*

²²¹ *Id.* § 2335(c)(2).

²²² *Id.* § 2335(c)(3).

²²³ Gov't Code § 11517(c)(2)(E).

²²⁴ Bus. & Prof. Code § 2335(c)(4). Under the APA, an agency that considers the penalty proposed by the ALJ too harsh may simply lower it and adopt the decision with the lowered penalty. Gov't Code § 11517(c)(2)(B). An agency that nonadopts a proposed decision because it does not believe the penalty recommended by the ALJ is sufficiently harsh must afford the parties “the opportunity to present either oral *or written* argument before the agency itself.” Gov't Code § 11517(c)(2)(E)(ii) (emphasis added). However, a DMQ panel that is nonadopting a proposed decision must afford the respondent an opportunity for oral argument. Bus. & Prof Code § 2335(c)(4).

²²⁵ *Id.* § 2335(c)(5).

²²⁶ Gov't Code § 11521.

Exhibit XI-A below presents recent DMQ activity in two areas — DMQ panel review of proposed decisions and stipulated settlements. It reveals that DMQ adopts most PDs (89% in 2004–05) and approves most stipulations (92% in 2004–05). When it nonadopts a decision, it generally increases the penalty recommended by the ALJ. Recall, however, that increasing the penalty is the only reason a panel must nonadopt a proposed decision — such that a harsher penalty after nonadoption is the expectable result. If the panel believes the recommended penalty is too harsh, it can simply reduce the penalty and approve the decision.²²⁷

**Ex. XI-A. Division of Medical Quality Review of
ALJ Proposed Decisions and Stipulations**

Activity	FY 1999–2000	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04	FY 2004–05
Total ALJ decisions reviewed	53	60	52	57	50	63
ALJ decisions adopted	45 (85%)	49 (82%)	39 (75%)	41 (72%)	42 (84%)	56 (89%)
ALJ decisions nonadopted	8 (15%)	11 (18%)	13 (25%)	16 (28%)	8 (16%)	7 (11%)
Subsequent disposition of nonadoptions	7 increased 1 upheld	8 increased 2 upheld 1 decreased	11 increased 2 upheld	13 increased 2 upheld	6 increased 2 pending	2 increased 1 decreased 1 upheld 2 remanded 1 pending
Total stipulations submitted	198	182	162	218	214	223
Stipulations approved	184 (93%)	171 (94%)	145 (90%)	205 (94%)	203 (95%)	205 (92%)
Stipulations rejected	14 (7%)	11 (6%)	17 (10%)	13 (6%)	11 (5%)	18 (8%)

Source: Medical Board of California

Exhibit XI-B below presents recent DMQ decisions on petitions for reconsideration under Government Code section 11521.

Ex. XI-B. Rulings on Petitions for Reconsideration

	FY 1999–2000	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04	FY 2004–05
Petitions filed by Respondent	18	17	9	17	14	20
Petitions Granted	1	1	1	1	1	0
Petitions Denied	17	16	8	16	13	20
Petitions filed by DAG	2	4	4	4	5	3
Petitions Granted	1	3	1	1	4	3
Petitions Denied	1	1	3	3	1	0

Source: Medical Board of California

²²⁷ See *supra* note 224. DMQ rarely reduces a proposed penalty.

Finally, Exhibit X-A above presents DMQ's average cycle time from receipt of a PD to DMQ decision. In 2004–05, DMQ reviewed and reached a final decision on most PDs within 60 days — double its 2003–04 rate of 30 days.²²⁸

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes the Monitor's *Initial Report* findings and concerns about DMQ review of proposed disciplinary dispositions, and documents the responses to those findings implemented by the Medical Board, the Attorney General's Office, and the Legislature during 2005. More detail on each of the findings is available in Chapter XI of the *Initial Report*.²²⁹

1. The added value of DMQ review of proposed decisions is unclear.

In the *Initial Report*, the Monitor noted that, on three prior occasions, legislation has been attempted that would eliminate DMQ review of proposed decisions in favor of permitting the ALJ to make the final agency decision based on the agency's disciplinary guidelines and subject to a petition for judicial review by either side. According to the Monitor, the prior attempts to eliminate DMQ review of proposed decisions were intended to achieve two goals: (1) streamline the decisionmaking process to expedite it for the benefit of both the respondent and the public; and (2) create a limited number of decisionmakers who have both (a) subject matter expertise and (b) independence from the profession — as opposed to the current time-consuming and expensive system where layer after layer after layer of decisionmakers are required to sequentially learn the details of a disciplinary matter.

The Monitor then examined the “qualifications” of the various decisionmakers in the existing process — the administrative law judge who presides over the hearing and receives the evidence (including expert testimony) vs. the DMQ panel that reviews the proposed decision of the ALJ.

The MQHP ALJ is present at the evidentiary hearing, has seen and heard the witnesses, has received all the documentary evidence, and has heard the expert testimony submitted by both sides. This individual is a professional judge — trained in the law and experienced in the judicial process — whose daily job is to preside over evidentiary hearings and draft decisions following those hearings. The judge specializes in physician discipline matters and is familiar with the rules of procedure and evidence in administrative proceedings. Thus, the judge has both knowledge of the evidence and is independent of the profession.

²²⁸ Medical Board staff speculate that DMQ's average increased in 2004–05 because of the large number of PDs that were mailed to DMQ panel members but “held” for discussion and decision at the next regularly-scheduled meeting of DMQ.

²²⁹ *Initial Report*, *supra* note 13, at 190–98.

DMQ members — volunteers who receive no salary for being on the Medical Board — are physicians and other professionals who meet once every three months for two days. When DMQ members receive a proposed decision in the mail, that is all they have — they have no access to the transcript of the hearing or the evidence presented at the hearing. Unlike jurors in a civil or criminal trial, DMQ members are not present at the hearing. They have had no opportunity to observe the witnesses or judge their credibility and demeanor. They are generally not lawyers or judges, and may have no familiarity with the rules of evidence or administrative procedure. They may not have any familiarity with the subject matter of the particular case; usually have no idea how similar cases have been decided in the past; and often hold the same license as the accused licensee — such that they may have (or may be perceived to have) empathy for or bias against their accused colleague. While DMQ physician members may have medical expertise in a particular specialty, it may not be relevant to the case at hand; in any event, DMQ is confined to the evidence in the record — including the expert testimony of physicians who practice in the same specialty as the accused, have thoroughly examined the evidence, and have been subject to cross-examination.

While volunteer members of occupational licensing boards — which meet infrequently and whose composition changes as terms of board members expire and new members are appointed — may be well-suited to overseeing regulatory programs and adopting “quasilegislative” regulations to govern the practice of a trade or profession, they are less well-suited to making “quasijudicial” decisions that call for intense exposure to and understanding of the evidence in a given matter. DMQ members have full-time jobs and busy lives. The burden of having to read multiple proposed decisions and — when they nonadopt a proposed decision — boxes of hearing transcripts and evidence for each quarterly meeting may be too much to realistically ask of these volunteers. There is no guarantee that all DMQ members read and/or fully understand the proposed decisions or hearing transcripts before voting on disciplinary action. And the time DMQ must spend on fact-finding in individual disciplinary matters leaves less time for other kinds of decisionmaking and activities that are vitally needed and to which the members are better suited, such as rulemaking, policymaking, and oversight of important mechanisms such as the Diversion Program (see Chapter XV).

According to the Monitor, the questionable value of DMQ review and the cost of the current system — including time, money, and lost opportunity costs — seem to outweigh the system’s output: the nonadoption of very few proposed decisions (only 7 out of 63 in 2004–05) and the rejection of very few stipulations (only 18 out of 223 in 2004–05). In Recommendation #40, the Monitor suggested that DMQ engage in a public dialogue on the value and costs of DMQ review of proposed decisions.

At its April 22, 2005 meeting, the Board’s Enforcement Committee commenced a very preliminary discussion of this issue, and received a background paper from staff outlining possible

options: (1) preserve the status quo; (2) eliminate DMQ review of PDs and allow ALJs to make the final agency decision; (3) require DMQ to review stipulations but not ALJ proposed decisions; (4) require DMQ to review ALJ proposed decisions but not stipulations; (5) adopt the Contractors' State License Board model, wherein the executive director (not appointed board members) reviews and decides whether to adopt proposed decisions and stipulations; and (6) adopt the State Bar's model, wherein proposed decisions drafted by hearing judges are reviewed by a three-member panel of appellate judges within the agency (and not by appointed board members).

The Enforcement Committee entertained brief public comment on this issue. The Attorney General's Office registered strong opposition to the notions of allowing ALJ decisions to become final and eliminating DMQ review. The California Medical Association urged the Committee to conduct further research into the matters raised by the Monitor. Finding that this issue does not appear to require urgent action, the Committee voted to defer this matter until 2006.

2. The consistency of DMQ decisionmaking is unclear.

In the *Initial Report*, the Monitor noted that the fragmented structure of MBC's enforcement program makes it difficult to evaluate the consistency of decisionmaking at any point in the process, including DMQ review. Investigations are handled from eleven different MBC offices; they are funneled into one of six HQE offices and thereafter into one of four OAH offices. Decisionmaking occurs at each of these steps — decisions to close cases, to move them further in the process, to seek disciplinary action, to impose disciplinary action. DMQ decisionmaking is superimposed on all the decisionmaking that occurs below, and it is also plagued with fragmentation. DMQ is split into two panels, neither of which knows of the other's decisionmaking in similar cases. DMQ membership is constantly shifting and changing. There is little or no *stare decisis* — the legal doctrine under which courts adhere to precedent (prior decisionmaking in similar cases) on questions of law in order to ensure certainty, consistency, and stability in the administration of justice — in administrative agency proceedings.

To promote *stare decisis* and consistent decisionmaking over time and across the shifting membership of DMQ panels, Government Code section 11371(c) — enacted in 1993 — required the Office of Administrative Hearings to publish the decisions of the Medical Quality Hearing Panel, “together with any court decisions reviewing those decisions,” in a quarterly *Medical Discipline Report*. The intent of the journal was to inform all parties — including licensees, HQE, respondent's counsel, and DMQ itself — of prior DMQ disciplinary decisionmaking in order to promote consistency and encourage settlements. A similar journal instituted at the State Bar in the early

1990s has accomplished precisely that.²³⁰ However, the *Medical Discipline Report* has never been published. Because it has not been published, and because it has been effectively superseded by Government Code section 11425.60 (which precludes a party from relying on or citing to a prior DMQ decision unless the Division has designated it as a “precedent decision”), the Monitor recommended that Government Code section 11371(c) be repealed (Recommendation #43). Section 21 of SB 231 (Figueroa) repeals section 11371(c).

In the *Initial Report*, the Monitor commented on Government Code section 11425.60’s “precedent decision” mechanism. Although this ten-year-old mechanism is intended to promote consistency in decisionmaking, encourage settlements, and avoid costly litigation, DMQ has made no use of it other than to discuss its existence at its July 2004 meeting. In Recommendation #41, the Monitor suggested that DMQ more fully explore its “precedent decision” authority and begin to utilize it. In response to this recommendation, DMQ staff says it continuously reviews each final disciplinary decision to determine whether it may be appropriate for designation as a precedent decision.

3. The procedure used at DMQ oral arguments is flawed.

In the *Initial Report*, the Monitor also commented on the unusual procedure employed at DMQ oral arguments on nonadoption — and the Monitor has attended literally hundreds of DMQ oral arguments since 1986. The scenario is as follows: A DMQ panel has nonadopted a proposed decision. The only reason a DMQ panel needs to nonadopt a PD is to consider a harsher penalty than that recommended by the ALJ. So the respondent physician turns into a petitioner — pleading with the panel to either leave the ALJ’s proposed penalty alone or lower it, but certainly not to increase it. That respondent must be mystified when he arrives at the hearing to find that the Board is represented by its own counsel — HQE. In effect, the “client” agency hears argument from its own counsel, with which it frequently interacts and upon whom it depends for legal advice on a myriad of matters — which must strike the respondent physician as unfair.

Procedurally, the respondent is usually permitted to argue first. The HQE DAG is given equal time to respond, and each side is afforded a brief rebuttal. In making oral argument, the lawyers are required to confine themselves to evidence that is “in the record” — that is, evidence that has been presented at the evidentiary hearing and admitted by the ALJ. The DMQ members have

²³⁰ Rule 310 of the State Bar’s Rules of Procedure requires the Bar to compile final disciplinary decisions of the Bar’s Review Department (an appellate review body within the Bar) into a *California State Bar Court Reporter*; these decisions are binding on the Bar’s hearing judges who preside over evidentiary hearings in attorney discipline matters. Note that the State Bar is not subject to the APA and does not use OAH ALJs at attorney discipline hearings; the Bar has its own staff of hearing and appellate judges who specialize in attorney discipline matters. Note also that the State Bar Board of Governors does not review final disciplinary decisions made by the appellate Review Department; those are reviewable only by the California Supreme Court.

all of this evidence, because in nonadoption cases the entire transcript and record of the evidentiary hearing are ordered and delivered to all panel members, and by law all of them are required to read the entire record and personally hear any additional oral argument and evidence presented to the panel before voting on the nonadoption.²³¹ However, counsel do not always confine themselves to the record, and an objection to the argument may be voiced — requiring a legal ruling on the objection.

Historically, the chair of the DMQ panel — usually a physician, usually (and understandably) not well-versed in litigation procedures or accustomed to responding instantly to evidentiary challenges — presided over these oral arguments and was expected to rule on objections. On those occasions, in-house MBC lawyers would attempt to assist the panel chair in ruling on objections. Inasmuch as those individuals generally report to the prosecutor in the matter (MBC's executive director), that procedure left something to be desired. Due to these problems and the considerable mischief that resulted, 1995's SB 609 (Rosenthal) required MBC to adopt regulations governing the procedure at oral arguments,²³² and those regulations now require an ALJ to preside at oral argument.²³³ Of course, this cannot be the same ALJ who presided over the hearing and whose decision was nonadopted in the matter at issue, so the ALJ presiding at oral argument necessarily has little or no knowledge of the sometimes voluminous record in the underlying matter. As opposed to the panel chair, this judge might be somewhat more successful in controlling the proceeding, ruling on objections, and requiring counsel to cite to the record when there is a question as to whether argument is based on the record. However, the required presence of the ALJ adds more expense to this process, and interrupts the hearing schedule of that MQHP ALJ.

Then, in what is by far the most unusual aspect of the proceeding, the respondent himself must be given an opportunity to personally address the panel,²³⁴ and members of the DMQ panel are permitted to question either counsel or the respondent. Neither the statute nor the regulation requires that the respondent be put under oath when he makes this statement or answers questions. Respondents sometimes stray from the record and/or the topic at hand, and are subject to objections. Well-meaning DMQ panel members often ask questions outside the record, and are subject to more objections.

To the outside observer, the entire DMQ review process seems fraught with (1) apparent conflict of interest; (2) delay in a context where delay may cause irreparable harm; (3) extraordinary

²³¹ Bus. & Prof. Code § 2335(c)(5).

²³² *Id.* § 2336.

²³³ 16 CAL. CODE REGS. § 1364.30.

²³⁴ *Id.* § 1364.30(e).

expense to the Board, the respondent physician, and the physician population whose license fees support the Board's enforcement program; and (4) uncertainty and potential unfairness that can result when non-judges with no assured knowledge of the evidence and who function under no defined standard of review are asked to second-guess the findings and conclusions of a professional judge in a profoundly significant legal proceeding.

Since the publication of the *Initial Report*, a superior court has issued a decision illuminating the errors that can result from these unusual procedures designed to accommodate adjudicative decisionmaking by non-judges. In its decision, the court found that certain procedural aspects of the DMQ review process denied one physician a fair hearing, vacated DMQ's decision revoking that physician's license, and remanded the matter to the Division for further proceedings.²³⁵ The court took no position on the merits of the matter — that is, the court did not decide whether MBC sustained its burden of proof and/or whether the physician should be disciplined; neither does the Monitor. The Medical Board does not intend to appeal the court's ruling. The Monitor discusses the case here because it points out significant procedural flaws in the DMQ review process that could be avoided if the ALJ's decision were deemed final.

In this matter, MBC charged a physician with quality of care violations relating to sixteen different patients and one count of unprofessional conduct based on a federal criminal conviction for tax evasion. After a lengthy hearing, the ALJ issued a proposed decision dismissing all of the patient care allegations as unfounded and recommending no discipline for the criminal conviction. A DMQ panel nonadopted the ALJ's decision. In its notice of nonadoption, the panel accepted the dismissal of the patient care allegations but invited argument on “the appropriate penalty for the conviction that was charged in the case, taking into consideration any rehabilitation or mitigating factors.”

As is customary after a nonadoption, MBC staff ordered the entire administrative record of the hearing before the ALJ, including the transcripts and the exhibits; received the record; and prepared to mail it to the panel members. However, an attorney for the Board (not the Attorney General's Office but an attorney advisor to the Board) determined that — because the nonadoption had been narrowly limited to the appropriate penalty for the criminal conviction — it was not necessary for the panel to review the entire administrative record. She apparently attempted to isolate the portions of the transcript dealing with “rehabilitation and mitigating factors” for submission to the panel. In so doing, she withheld all of the physician's exhibits from the panel and provided only about 165 pages of the 3,305-page transcript to the panel; she did not advise the physician's counsel that she had redacted the record. This same attorney was present at the panel's

²³⁵ *Kawesch v. Medical Board of California*, No. 04CS00760 (Sacramento County Superior Court; Sept. 14, 2005).

oral argument on the nonadoption, and at the panel's subsequent closed-door deliberation on the matter. During that executive session, panel members instructed her how to rewrite the ALJ's decision. Thereafter, she redrafted the decision pursuant to the instructions given. The redrafted decision indicated that the panel had reviewed "the entire record," including two exhibits that had been redacted from that portion of the record provided to the panel. The attorney forwarded the redrafted decision to the chair of the seven-member panel. The chair reviewed the decision, signed it, and mailed it to the physician. In the decision, the panel revoked the physician's license based on the criminal conviction.

In his petition for writ of mandate, the physician argued that he had been denied a fair trial because the panel had (among other things): (1) improperly delegated its duty to take final disciplinary action to the chair of the panel when multiple statutes require the entire panel to make that decision; (2) revoked his license without reviewing the entire administrative record and without giving him notice that it was not reviewing the entire administrative record, when statute clearly requires the reviewing panel to review the entire record; and (3) permitted the attorney — arguably an agent of the prosecutor — to be present during closed-door deliberations and to engage in *ex parte* communications with panel members acting as judges in a final disciplinary matter.²³⁶ The court agreed that these "significant procedural errors" deprived the physician of a fair hearing, vacated the revocation decision, and remanded the matter to DMQ for further proceedings (from which the panel members who had originally heard the matter, the advising attorney, and the HQE DAG have been disqualified).

Regardless of the eventual disposition of this matter, these are serious procedural issues which occurred because the prosecutorial and judicial functions are not sufficiently separated at the Medical Board. In the Monitor's view, this lack of sufficient separation is not unique to the Medical Board, nor is it confined to these particular issues.²³⁷ These problems also arose because non-judges who have no assured familiarity with the evidence are permitted to assume the role of a judge in a momentous legal proceeding. With all due respect to the intelligence, skills, and good intentions of DMQ members, they are not judges. They do not judge for a living. They have had no training in the process and art of judging. The agency within which they function is not within the judicial branch. In fact, the agency within which they function houses the prosecutor in the proceedings they

²³⁶ The court noted that MBC, citing Business and Professions Code section 2335(c)(2), disputes this issue because the attorney is not an "employee" of MBC. However, section 2335(c)(2) is not the only provision applicable to *ex parte* communications with agency members acting in a judicial capacity. Government Code section 11430.10 *et seq.*, which appears fully applicable here, prohibits any "communication, direct or indirect, regarding any issue in the proceeding, to the presiding officer from an employee *or representative* of an agency that is a party or from an interested person outside the agency, without notice and opportunity for all parties to participate in the communication" (emphasis added). The court did not address whether any of the exceptions to that statute contained in Government Code section 11430.30 apply here; neither does the Monitor.

²³⁷ See *infra* Chapter XI.B.4.

adjudge — the Medical Board executive director; further, they directly hire and may fire that prosecutor for any or no reason. In conducting the business of the Board, they routinely interact with counsel for the prosecutor (HQE) and with Board employees and advisors who may fairly be called (or perceived to be) agents of the executive director/prosecutor. Apparent conflicts plague this process. In the Monitor's view, it is inappropriate for DMQ members — who lack assured knowledge and understanding of the evidence, a defined standard of review, and independence from the profession they regulate — to participate in adjudicative decisionmaking affecting the legal rights of a state licensee.

The Medical Board has several options. It may choose to retain its existing decisionmaking authority and simply address the procedural flaws identified by the Monitor and in the recent court decision. For example, a Board-sponsored amendment to Business and Professions Code section 2335(c)(4) to allow written argument after nonadoption (in lieu of required oral argument) may put an end to the circus-like atmosphere surrounding some oral arguments. And, theoretically, it is easy to address two of the three bases for the court's decision: MBC must simply follow existing law requiring all panel members to (1) review the entirety of the administrative record following a nonadoption, regardless of the scope of the review upon nonadoption, and (2) review decisions following a nonadoption. It is unclear, however, how MBC will address the issue of who will redraft final agency decisions after nonadoption and oral argument. Obviously, no employee of the prosecutor may interact *ex parte* with the decisionmakers on any matter of substance related to the case²³⁸; it is not clear whether non-employee attorney advisors may do so.²³⁹ It may be that the ALJ who presides over the oral argument will have to take on this drafting task — at considerable additional expense and delay.

In the alternative, the Board could meaningfully implement Recommendation #40 and — especially in light of the recent decision — engage in an intelligent, public, informed discussion of the costs and value of DMQ review of ALJ decisions together with the advantages and disadvantages of alternative models. The Monitor is aware that many Board members wish to retain their authority to review ALJ recommendations and make disciplinary decisions. However, this is not the universal model. The State Bar Board of Governors does not make disciplinary decisions. The Contractors State License Board does not make disciplinary decisions. If freed from having to spend excessive amounts of time on a function to which they are not necessarily well-suited, and to which others are better suited, MBC members may be able to make greater contributions to public protection by focusing on their important rulemaking, oversight, and general policymaking functions.

²³⁸ Bus. & Prof. Code § 2335(c)(2); Gov't Code § 11430.10.

²³⁹ See *supra* note 236.

4. DMQ's procedures on motions for a stay in order to seek reconsideration appear unfair.

In the *Initial Report*, the Monitor discussed DMQ's procedures when a party wishes to seek reconsideration of a final decision, as permitted in Government Code section 11521. Exhibit XI-B above reveals DMQ's 2004–05 record on motions for reconsideration: While it rejected all 20 motions filed by respondents, it granted all three motions filed by HQE. Once again, these results appear unfair. However, as discussed in the *Initial Report*,²⁴⁰ they are also somewhat expectable and unsurprising. One expects the prosecution to win most of the time a case goes to hearing; an experienced prosecutor with a weak case will settle prior to hearing, while a respondent with a weak case may decide to “roll the dice,” go to hearing, and hope for the best rather than stipulating to discipline. One also expects a respondent to “exhaust his administrative remedies” by challenging every order adverse to his interests (which is why respondents petitioned for reconsideration four times more than did HQE over the past six years). Finally, one does not expect DMQ to revisit these matters often — the DMQ panel has already reviewed the PD, perhaps held oral argument on it, and ruled on it. In the absence of serious procedural or substantive error, DMQ will be content to let the matter proceed to court.

The Monitor also discussed Government Code section 11521(a), which permits either side to request a short stay of the effective date of the decision to enable counsel to prepare a motion for reconsideration. While MBC's *Discipline Coordination Unit Procedure Manual* is clear that a motion for reconsideration must be decided by a DMQ panel, it allows MBC enforcement staff to rule on a request for stay (and contains criteria to guide staff's decision whether to grant a stay). In the *Initial Report*, the Monitor agreed with defense counsel that this procedure — wherein an agent of the executive director/prosecutor is able to make decisions affecting the final outcome of a disciplinary matter — appears one-sided and unfair. In Recommendation #42, the Monitor stated that MBC enforcement staff should not rule on those motions and suggested that DMQ address this procedural issue.

In response, MBC staff declined to end its role in ruling on motions for stay. Instead, it is in the process of amending its *Discipline Coordination Unit Procedure Manual* to amplify the criteria to guide staff's decision whether to grant the stay.

The Monitor disagrees with this approach. In 2004–05, MBC received 15 requests for stays. Of those, 14 were filed by respondent's counsel; 12 were denied and two were granted. One was filed by a DAG; it was granted. In other words, MBC's track record on motions for stay is similar to its record on motions for reconsideration generally — motions filed by respondents are usually

²⁴⁰ See *Initial Report*, *supra* note 13, at 196.

denied, while motions filed by HQE are usually granted. But here, agents of the executive director/prosecutor are making the decision. In the Monitor's view, this appears to be another example of the lack of sufficient separation between the prosecutorial and judicial functions at the Medical Board. As illustrated in the recent superior court decision (see above), agents of the executive director/prosecutor should not even participate in judicial decisionmaking much less engage in it. A recently-adopted DMQ regulation permitting the submission of *amicus curiae* briefs in disciplinary cases requires two panel members to consider and rule on any request to submit an *amicus* brief.²⁴¹ If panel members can rule on *amicus* requests within a tight timeframe, there is no reason they cannot similarly rule on requests for stays. The Monitor urges DMQ to properly address this issue and devise a method whereby a panel member is designated to rule on motions for stay.

5. DMQ does not notify both parties if it rejects a stipulated settlement.

In the *Initial Report*, the Monitor noted complaints from defense counsel that DMQ does not always notify both counsel if it rejects a stipulation. It notifies the HQE DAG and expects the DAG to notify defense counsel, which does not always happen promptly. In Recommendation #44, the Monitor suggested that DMQ notify counsel for both HQE and the respondent when it rejects a stipulated settlement. In October 2005, MBC staff amended section 32 of the *Discipline Coordination Unit Procedure Manual* to require this dual notification.

C. Recommendations for the Future

■ ***The costs and value of DMQ review.*** The Medical Board should engage in an intelligent, public, informed discussion of the costs and value of DMQ review of ALJ decisions, together with the advantages and disadvantages of alternative models.

■ ***Procedure on requests for stay.*** DMQ should adopt a regulation governing rulings on requests for a stay — which regulation ensures that a DMQ member or members rule on those requests, not MBC enforcement staff.

²⁴¹ 16 CAL. CODE REGS. § 1364.31(c).

Chapter XII

JUDICIAL REVIEW OF DMQ DECISIONS

A. Overview of Function and Updated Data

A physician whose license has been disciplined may seek judicial review of MBC's decision by filing a petition for writ of mandate (also called a "writ of administrative mandamus") in superior court under Code of Civil Procedure (CCP) section 1094.5.²⁴² The physician may also seek a court order staying MBC's decision pending the conclusion of the superior court's review. Under MBC's unique venue statute, a writ challenging DMQ's disciplinary decision may be filed in any city in which the Board has an office.²⁴³

In conducting its review of the agency's decision, the superior court sits alone, without a jury, and reviews the record of the administrative hearing (including the transcripts of the testimony that was presented at the hearing and the exhibits that were introduced). The court does not call witnesses, nor does it consider new evidence that was not introduced at the administrative hearing (except under very narrow statutory circumstances). Generally, the focus of the court's review is to determine whether the agency's findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency's discretion or constitutes an abuse of that discretion.²⁴⁴ The court exercises its independent judgment and reviews the administrative record as a whole in determining these issues. There is a presumption that the agency's decision is correct,²⁴⁵ and the petitioner (the disciplined licensee or applicant denied a license) has the burden of demonstrating how the decision is invalid.

²⁴² Gov't Code § 11523.

²⁴³ Business and Professions Code section 2019 requires the Board to have an office in Sacramento, authorizes it to have offices in Los Angeles, San Diego, and San Francisco, and states that "legal proceedings against the board shall be instituted in any one of these four cities."

²⁴⁴ Civ. Proc. Code § 1094.5(b).

²⁴⁵ *Fukuda v. City of Angels* (1999) 20 Cal. 4th 805, 812.

If the court determines that the findings and conclusions are supported by the weight of the evidence and that the Board acted within its discretion, the court will uphold MBC's decision and deny the petition. If not, the court can grant the petition in part (with respect to those findings it does not find supported) and deny the petition in part (affirming those portions of the decision which it concludes are supported by the weight of the evidence). The court can also grant the petition altogether, explaining how the findings are not supported by the evidence, the conclusions are not supported by the findings, or how — in its opinion — the penalty constitutes an abuse of discretion. Whenever a petition is granted in whole or in part, the matter is remanded to the Board for further proceedings (the issuance of a new decision) consistent with the court's ruling. The court may not tell the Board how to exercise its discretion (in other words, it cannot specify a penalty it prefers).

Either side may challenge the superior court's decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal.²⁴⁶ Unlike a direct appeal, this procedure requires the party filing the petition to promptly file papers supporting the claim, and file the entire administrative and superior court record with the court. The appellate court has three options. If it concludes the petition lacks merit on its face and does not believe additional briefing would be helpful, it may summarily deny the writ on the merits, thus obviating the need for oral argument and a written opinion. In most instances, however, the court issues an alternative writ. When an alternate writ is issued, the parties engage in full briefing, the court entertains oral argument, and it issues a written decision. The court also has the option of summarily granting the writ (reversing the lower court's decision without further input from the parties), but this has not yet been done by a court reviewing a superior court's decision concerning physician discipline. Although the procedure for judicial review of physician discipline has been expedited by this "extraordinary writ" process, the appellate court still uses the same standard of review it does for direct appeals: It determines whether the superior court's findings are supported by substantial evidence and are correct on matters of law.²⁴⁷

The appellate court's decision may be appealed to the California Supreme Court. Such review is entirely discretionary and is rarely attempted or granted.

Exhibit XII-A below presents the number of DMQ disciplinary decisions appealed to a court in each year indicated. It also reveals the number of decisions issued in those years in which either MBC prevailed or the respondent prevailed.²⁴⁸

²⁴⁶ Bus. & Prof. Code § 2337.

²⁴⁷ The constitutionality of the "extraordinary writ" mechanism, which was added by SB 609 (Rosenthal) in 1995, was upheld by the California Supreme Court in *Leone v. Medical Board of California* (2000) 22 Cal. 4th 660.

²⁴⁸ Note that the number of decisions upholding DMQ orders or reversing/remanding them in a given year does not match the number appealed during that year. The number of court rulings on DMQ decisions applies to a different universe of cases that were appealed in prior years. We present these figures only to give the reader an idea of how MBC fares when its disciplinary decisions are reviewed by the courts.

Ex. XII-A. Judicial Review of DMQ Decisions

	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05
DMQ decisions appealed to:				
Superior Court	23	24	19	20
Court of Appeal	5	8	6	5
Supreme Court	2	3	2	2
DMQ decisions upheld by:				
Superior Court	16	16	5	12
Court of Appeal	5	4	5	3
Supreme Court	1	2	2	2
DMQ decisions reversed/remanded/vacated by:				
Superior Court	16	13	12	6
Court of Appeal	1	1	0	1
Supreme Court	0	0	1	0

Source: Medical Board of California

Exhibit XII-B below presents the average number of days from the filing of a petition for writ of mandate in a superior court until the superior court's decision; it also indicates the number of DMQ decisions that were stayed by the superior court — that is, their effective date was postponed — pending the conclusion of superior court review.

Ex. XII-B. Cycle Time and Stay Rate: Superior Court Review of DMQ Decisions

	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05
Percentage of writ cases in which superior court stayed DMQ decision	34.7%	37.5%	47.3%	23%
Average days from filing of petition → superior court ruling	357 days	375 days	409 days	270 days

Source: Medical Board of California

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes the Monitor's *Initial Report* findings and concerns about judicial review of DMQ decisions, and documents the responses to those findings implemented by the Medical Board and the Legislature. More detail on each of the findings is available in Chapter XII of the *Initial Report*.²⁴⁹

Note also that the source of these figures is the Medical Board, whose Discipline Coordination Unit (DCU) closely tracks the status and disposition of every matter transmitted from MBC to HQE. DCU must undertake this tracking function because — as mentioned repeatedly above — the computer systems of MBC and HQE are separate (and HQE's ProLaw system does not reliably contain data on events occurring before July 2004). Thus, DCU tracks these cases, and DCU depends on the HQE DAG handling a writ matter to inform DCU that a writ has been filed and its subsequent disposition. These data represent the number and disposition of writs transmitted to DCU.

²⁴⁹ *Initial Report*, *supra* note 13, at 201-03.

1. MBC’s venue statute is encouraging “forum-shopping” and inefficient use of judicial resources, and is unnecessarily costing HQE and MBC substantial amounts of money each year.

In the *Initial Report*, the Monitor noted that Business and Professions Code section 2019 governs venue for the filing of a petition of writ of mandate challenging a DMQ disciplinary decision. Under section 2019 (which is unique to MBC), a respondent who is unhappy with a DMQ disciplinary decision may file a petition for writ of mandate in San Diego, Los Angeles, Sacramento, or San Francisco — regardless of where the administrative hearing was held and regardless of where the HQE DAG who prosecuted the case works.

This statute has led to apparent “forum-shopping” on the part of defense counsel in search of a sympathetic judge. The *Initial Report* revealed that, of 24 writs filed in 2002–03, only eight were filed in the same city where the administrative hearing was held and the HQE DAG works; the remaining 16 (66%) of them were filed in different cities. Eleven of those 16 cases were filed in Sacramento. During 2003–04, of 19 writs filed, only five were filed in the same city where the administrative hearing was held and the HQE DAG works; the remaining 14 (74%) were filed in different cities. Ten of those 14 writ cases were filed in Sacramento. The 2004–05 data are no different: Of 20 writs filed, only six were filed in the same city where the hearing was held. Fourteen writs (70%) were filed in different cities, and eight of those were filed in Sacramento.

Section 2019 requires HQE to fly its DAGs all over the state for writ hearings. In the Monitor’s view, this practice disrupts the efficient operation of the Attorney General’s Office; unfairly overburdens one court funded by the taxpayers of a single county, while other courts are relatively unused by MBC petitioners²⁵⁰; and undermines the integrity of the process. In Recommendation #46, the Monitor suggested that section 2019 be amended to require legal proceedings challenging DMQ decisions to be instituted in the large city closest to where the administrative proceeding was held.

As noted in Chapter IV above, until August 30, 2005, SB 231 contained an amendment to section 2019 that would have implemented Recommendation #46. However, the amendment was

²⁵⁰ See *In re Roberts* (2005) 36 Cal. 4th 575. In this case, the California Supreme Court determined that the proper venue for writs of habeas corpus filed by prisoners is the county in which they were convicted, not the county of confinement. The court held that locating venue in the county of confinement would require courts in small counties in which correctional facilities happen to be located to “process a disproportionate number of petitions for writ of habeas corpus relative to their population and their number of felony commitments. . . . By contrast, certain other counties — large in population and in their number of felony convictions, but having comparatively few (or no) prison facilities — resolve a fraction of the habeas corpus petitions filed statewide by inmates in state custody that is small in relation to their share of the state’s population and total felony convictions. Thus, such counties do not share proportionately in expending the court resources required to adjudicate these petitions.” *Id.* at 591–92.

opposed by CMA and various defense attorneys who represent physicians before MBC; they raised questions regarding the Monitor's "forum-shopping" conclusion. Because this matter warrants further discussion, the amendment was eventually dropped from the bill.

2. MBC is inappropriately subsidizing the cost of the preparation of administrative hearing transcripts for writ proceedings.

Under Code of Civil Procedure section 1094.5, a disciplined physician who wishes to challenge MBC's decision by filing a petition for writ of mandate must first request the preparation of the hearing transcript by OAH. If the physician petitioner prevails, section 1094.5 requires MBC to reimburse him for the cost of the transcript. Although section 1094.5 expressly states that "the cost of preparing the transcript shall be borne by petitioner," two sections of the Government Code cap the amount that must be paid by the petitioner and require the agency (here, MBC) to pay the rest. In the *Initial Report*,²⁵¹ the Monitor found that Government Code section 11523 forces the Medical Board to improperly cross-subsidize the cost of preparing hearing transcripts to the tune of thousands of dollars per transcript. In Recommendation #47, the Monitor urged the amendment of section 11523 to require the petitioner to pay the entire cost of the transcript up front.

Section 23 of SB 231 amends Government Code section 11523 to require a petitioner to pay the full cost of hearing transcript preparation to OAH. The amendment preserves the petitioner's right to full reimbursement of this cost if the petitioner prevails in the writ proceeding, and does not affect the right of *in forma pauperis* (indigent) petitioners to a free copy of the transcript under Code of Civil Procedure section 1094.5 and Government Code section 68511.3.

²⁵¹ *Initial Report*, *supra* note 13, at 202–03.

Chapter XIII

PUBLIC DISCLOSURE

A. Overview of Function

In addition to removing incompetent, negligent, dishonest, and impaired physicians from the marketplace through its enforcement program, another way in which MBC implements its “paramount” public protection priority²⁵² is by disclosing licensee information to the public, to enable consumers to make informed choices when selecting a health care practitioner.

The Board’s public disclosure policy is an important complement to its enforcement program. The preceding chapters have described many limitations on the Board’s ability to protect the public through its enforcement program — including limitations that are within its control (for example, lengthy delays due in part to its failure to demand compliance with medical records procurement laws) and others that are beyond its control (for example, its limited resources, the recent staffing losses at both MBC and HQE, and the failure of many of its most important sources of information to report physician misconduct as required by law). As a result of these flaws, it is unreasonable to expect that MBC will be able to promptly remove all dangerous physicians from the marketplace. Even assuming these flaws are resolved, consumers are still entitled to information about the people to whom they are entrusting their lives and health. It is thus reasonable to expect MBC, as a complement to its enforcement program, to provide consumers with true, accurate, and complete information about its licensees so they can make informed choices and protect themselves from physicians with whom they would prefer not to deal.

Further, and as astutely noted by the Joint Legislative Sunset Review Committee in 2002, “poor public disclosure is worse than no public disclosure.” In its final report and recommendations on MBC’s 2001–02 sunset review, the JLSRC stated: “A public program of disclosure that purports to provide information a patient might find relevant about the history and record of a physician, but which for whatever reason falls short, is worse than no disclosure program at all. An inadequate program leads a diligent patient into erroneously believing that their physician was trouble-free,

²⁵² Bus. & Prof. Code §§ 2001.1, 2229(a) and (c).

when the physician may in fact have an extensive record of problems. An inadequate program of public disclosure leads a patient into an incorrect belief that no further investigation of their physician is warranted.”²⁵³

In the *Initial Report*, the Monitor described the gradual evolution of MBC’s public disclosure policy over the past twelve years, and noted that the policy is currently embodied in Business and Professions Code sections 803.1 and 2027, and in section 1354.5 of Title 16 of the California Code of Regulations. The very complex confluence of these laws creates four categories of “information” on physicians and three ways to obtain some (but not all) of it:

■ **“Public information” that is specifically described in sections 803.1 and 2027 and required to be posted on MBC’s Web site** — this includes information on the status of a license (whether it is in good standing or subject to an ISO, TRO, or any of the enforcement actions set forth in section 803.1), prior disciplinary actions, “current” accusations,²⁵⁴ some felony convictions known to the Board, any civil malpractice judgment or arbitration award and a limited number of civil malpractice settlements (described in more detail below), some hospital disciplinary actions, and other information required to be posted.²⁵⁵ Under section 2027(b), MBC’s disclosure of much of this information may be posted for only ten years from the date of the event and then must be purged from the Web site.

■ **“Public information” that is disclosed by MBC but is not available on its Web site** (because it is not listed in sections 803.1 or 2027, but is nevertheless public information under the California Public Records Act and must be disclosed upon request) — this includes events that are otherwise-disclosable but are more than ten years old,²⁵⁶ MBC disciplinary actions taken before

²⁵³ Joint Legislative Sunset Review Committee, *Final Recommendations of the Joint Legislative Sunset Review Committee on the Medical Board of California* (May 2002) at 4.

²⁵⁴ Under Business and Professions Code section 2027(a)(4), a “current” accusation is one that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an ALJ and MBC (unless an appeal of that decision is pending).

²⁵⁵ Business and Professions Code subsections 803.1(b)(3) and (b)(4) require MBC to post approved specialty board certification and approved postgraduate training, respectively. These subsections were added by SB 1950 (Figueroa) in 2002. However, DCA maintains MBC’s Web site, and DCA does not have the resources to add these fields and data to MBC’s Web site at this time. MBC has petitioned to take over maintenance of its Web site, at which time it will add the fields and post approved specialty board certification and postgraduate training.

²⁵⁶ Under Business and Professions Code section 2027(b), only felony convictions and permanent revocations of hospital privileges may be posted indefinitely; all other items of information required to be posted on MBC’s Web site must be purged after ten years.

1990,²⁵⁷ and filed accusations that have been withdrawn, dismissed, settled, or are no longer “current” under section 2027(a)(4).²⁵⁸

■ **“Public information” that is known to MBC but is not disclosed at all** — including criminal arrests, misdemeanor criminal convictions (see Chapter XIII.B.3. below for further discussion), civil malpractice filings, and civil malpractice settlements that do not qualify for disclosure under section 803.1(b)(2) (discussed in greater detail in Chapter XIII.B.2. below).

■ **“Non-public information” known to MBC that is not disclosed** — this includes complaints, pending investigations, and hospital disciplinary actions that did not result in termination or revocation of a physician’s hospital privileges.

B. The Monitor’s Findings and MBC/Legislative Responses

The following summarizes the Monitor’s *Initial Report* findings and concerns about MBC’s public disclosure policy, and documents the responses to those findings implemented by the Medical Board and the Legislature during 2005. More detail on each of the findings is available in Chapter XIII of the *Initial Report*.²⁵⁹

1. The fragmented tangle of overlapping statutes — including drafting errors and inconsistencies — frustrates the purpose of MBC’s Web site, unnecessarily exposes MBC to litigation, and results in the disclosure of different information depending on the mode of inquiry.

In the *Initial Report*, the Monitor found that the purpose of MBC’s Web site — to provide the public with easy access to public information about California physicians — has been frustrated by the language of the statutes. Consumers who check MBC’s Web site will be given only information specifically authorized by sections 2027 and 803.1. Consumers who call the Board’s Central File Room or submit a Public Records Act request will be given a different set of information. And consumers who consult their county courthouses — or perhaps many of them in large communities such as Los Angeles and the Bay Area — may receive even more information. Although most of this information is technically “public information,” is known to the Medical Board, and could easily be loaded onto its Web site, the complexities of the statutes and the

²⁵⁷ MBC began to use its current computer system in 1990, and actions taken before that date and recorded on the Board’s prior system could not be “imported” onto its Web site.

²⁵⁸ See *supra* note 254.

²⁵⁹ *Initial Report*, *supra* note 13, at 212–23.

understandable unwillingness of MBC to expose itself to more expensive litigation²⁶⁰ over its public disclosure policy mean that disclosure varies based on how (and who) the consumer asks for information. The Monitor outlined several specific inconsistencies and apparent drafting errors in these statutes and, in Recommendation #48, suggested that sections 2027 and 803.1 be consolidated and harmonized to achieve the laudable purposes behind MBC's public disclosure statutes.

SB 231 corrects a drafting error that became the subject of *Szold v. Medical Board of California*.²⁶¹ Prior to SB 231, section 2027(a)(2) authorized MBC to post “prior discipline . . . by the board of another state or jurisdiction,” suggesting that MBC was not permitted to post its own prior disciplinary actions. In *Szold*, the Fourth District Court of Appeal examined the legislative history of the bill that added section 2027(a)(2) to the Business and Professions Code, and determined that the legislature intended to permit MBC to disclose “prior discipline . . . by the board or another state or jurisdiction.” Section 11 of SB 231 corrects section 2027(a)(2) to conform to the court's decision in *Szold*.

Section 10 of SB 231 also addresses the public disclosure issue more generally by adding new section 2026 to the Business and Professions Code. Section 2026 requires the Little Hoover Commission, an independent and respected watchdog agency, to “study and make recommendations on the role of public disclosure in the public protection mandate of the board. This study shall include, but not be limited to, whether the public is adequately informed about physician misconduct by the current laws and regulations providing for disclosure.” Section 2026 requires the study to be completed by July 1, 2008.

2. SB 1950's civil settlement disclosure provision has had minimal effect.

Prompted by a number of high-profile California cases and precedent in ten other states, Business and Professions Code section 803.1(b)(2)(A) — added by SB 1950 (Figueroa) in 2002 — authorized MBC to disclose multiple civil malpractice settlements over \$30,000 for the first time. However, MBC's disclosure of malpractice settlements is limited by the following formula:

(1) MBC must classify medical specialties as “high risk” or “low risk,” and may disclose the civil settlements of a physician in a “low risk” specialty only if the physician has three or more settlements in the past ten years. MBC may disclose the civil settlements of a physician in a “high risk” specialty only if the physician has four or more settlements in the past ten years.²⁶² The Board

²⁶⁰ MBC has had to defend its public disclosure policy in a number of lawsuits. See *Initial Report, supra* note 13, at note 329.

²⁶¹ 127 Cal. App. 4th 591 (2005).

²⁶² MBC has identified neurological surgery, orthopedic surgery, obstetrics, and plastic surgery as “high risk” specialties. 16 CAL. CODE REGS. § 1355.31.

may disclose only settlements occurring and reported to the Board after SB 1950's effective date — January 1, 2003.

(2) When it discloses civil malpractice settlements, the Board is not permitted to disclose the actual dollar amount of a settlement. Instead, the Board must calculate (1) the number of physicians practicing in every given specialty; (2) the number of malpractice settlements suffered by all physicians practicing in every given specialty over the past ten years; and (3) the average amount of malpractice settlements suffered by all physicians in every given specialty over the past ten years. When it discloses the settlements of a particular physician, MBC must indicate the number of physicians practicing in the same specialty; the number and date of each settlement suffered by the physician at issue; and whether each settlement is below average, average, or above average for that specialty during the most recent ten-year period.²⁶³

(3) When it discloses civil settlements, the Board is required to attach a lengthy disclaimer mandated in section 803.1(c).

Although SB 1950 came in response to vocal public outcry over the Board's prior public disclosure policy which had permitted the disclosure of no civil settlements whatsoever,²⁶⁴ and although MBC itself unanimously voted to support public disclosure of all settlements over \$30,000 in May 2002, SB 1950's complex formulation has not yielded much additional disclosure. Since the bill's effective date of January 1, 2003 to August 10, 2005, the settlements of only eleven physicians are being disclosed on MBC's Web site. In Recommendation #49, the Monitor suggested that MBC be required to disclose on its Web site all medical malpractice settlements over \$30,000 with the disclaimer currently required in section 803.1(c). Rather than reviving this controversial issue so soon after SB 1950 was enacted, Senator Figueroa opted to delegate it to the neutral Little Hoover Commission through new Business and Professions Code section 2026 (see above).

3. MBC is not authorized to disclose misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician.

In the *Initial Report*, the Monitor noted that, while MBC discloses felony criminal convictions against physicians for an indefinite period, it discloses no misdemeanor criminal convictions regardless of their number or seriousness — including misdemeanor convictions that were originally charged as straight felonies and/or “wobblers”²⁶⁵ but were pled down to

²⁶³ Bus. & Prof. Code § 803.1(b)(2)(B).

²⁶⁴ See *Initial Report*, *supra* note 13, at 48–53, 207, 215–16.

²⁶⁵ A “wobbler” is a crime that may be charged as either a felony or misdemeanor based on the facts of the case and in the discretion of a public prosecutor. See Penal Code § 17.

misdeemeanors. In Recommendation #50, the Monitor echoed the Joint Legislative Sunset Review Committee, the Medical Board, and the Federation of State Medical Boards in calling for the required disclosure of misdemeanor criminal convictions that are substantially related to the qualifications, duties, and functions of a physician.

Section 11 of SB 231 adds section 2027(a)(7) to the Business and Professions Code, which requires MBC to post on its Web site all substantially related misdemeanor criminal convictions against physicians for ten years from the date of the conviction. This new disclosure requirement is not effective until MBC presents to the Legislature, and the Legislature enacts, a list of misdemeanor convictions that are “substantially related.” Thus, additional legislation is required, but MBC will soon be permitted to disclose additional criminal convictions that are relevant to consumers when choosing health care providers.

4. MBC is not disclosing all significant terms and conditions of probation on its Web site.

In the *Initial Report*, the Monitor noted that, although required by sections 803.1 and 2027 to post on its Web site information about “revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement,” MBC was not consistently disclosing all significant terms and conditions of public probation orders on the Internet — including restrictions on practice or prescribing, a requirement to have a third-party chaperone present when examining or treating patients, and requirements to participate in the Board’s Diversion Program and to abstain from the use of controlled substances and/or alcohol. In Recommendation #51, the Monitor urged MBC to disclose all significant terms and conditions of public probation orders on its Web site.

MBC has responded positively to this recommendation. Beginning in November 2004, MBC added a new “enforcement public document search” feature to its Web site. The Board has posted almost 500 enforcement-related documents — including accusations, disciplinary decisions (including stipulations), public letters of reprimand, and citations — from September 2004 forward. These documents are now available in their entirety on MBC’s Web site. As additional resources and staffing become available, MBC will attempt to backload all public enforcement-related documents on its Web site; in the meantime, they are available upon request.

B. Recommendations for the Future

- ***Disclosable misdemeanor criminal convictions.*** MBC and HQE should establish a task force to develop the list of disclosable misdemeanor criminal convictions required by section 2027(d).

Chapter XIV

PUBLIC EDUCATION AND OUTREACH

A. Overview of Function and Updated Data

As described in the *Initial Report*, MBC uses a number of methods to communicate with and educate consumers, licensees, and other stakeholders regarding the Board's enforcement program. Under the general direction of the Board's Public Education Committee, MBC's public information officer (PIO) and her staff are responsible for outreach to the public generally; while the enforcement program is charged with communicating with complainants, subject physicians, and others who become involved with MBC's discipline system.

■ ***Outreach to consumers and patients.*** The Board conducts public outreach and education to the general public in an effort to ensure that consumers know of the existence of the Board and how they can access the Board's services. MBC maintains a toll-free phone line for complaints,²⁶⁶ but not for general Board information or questions.²⁶⁷ Through its Web site, MBC provides consumers with easy access to information on the Board, its enforcement program,²⁶⁸ the disciplinary histories of California-licensed physicians,²⁶⁹ and numerous health care issues.²⁷⁰ The Board has

²⁶⁶ MBC's toll-free complaint line is (800) 633-2322.

²⁶⁷ To ask about a physician's record or obtain general information about the Medical Board, the public must call (916) 263-2382. MBC staff and the Public Education Committee have advocated a toll-free information line for consumers and licensees; due to budget constraints, that proposal has never been adopted or implemented.

²⁶⁸ MBC's Web site — www.medbd.ca.gov or www.caldocinfo.ca.gov — provides information on (1) how to file a complaint; (2) the types of complaints over which the Board has jurisdiction; (3) phone numbers for contacting the Board regarding a complaint; (4) links to MBC brochures on complaint handling, investigations, and medical consultants; and (5) a downloadable complaint form that a consumer may print, complete, and mail to the Board.

²⁶⁹ See *supra* Ch. XIII.A. See especially Ch. XIII.B.4., which documents MBC's major 2004 initiative to provide public access to the full text of enforcement-related public documents on its Web site.

²⁷⁰ By clicking on "Services for Consumers" on MBC's Web site, one can access fact sheets related to California physicians and medical marijuana, guidelines for prescribing controlled substances for pain, patient privacy protection, tips on choosing a doctor, Internet prescribing, how to order public documents from the Board, patient access to medical records, resources available for reduced-cost mammograms, specialty board advertising, and links to other MBC forms

created and distributed public service announcement (PSAs) in English and Spanish for both radio and television.²⁷¹ Subject to budget and staffing limitations, the Board engages in public outreach at consumer or healthcare events, and provides presentations about the Board to physician groups and other healthcare entities. Finally, the Board engages in outreach to consumers via the media; MBC routinely issues press releases to notify media of disciplinary actions taken by the Board, and these disciplinary actions are often reprinted in newspapers in the locality of the disciplined physician.

During 2005, MBC's public information officer and enforcement chief have taken advantage of every opportunity to participate in on-camera television interviews to educate the public on the dangers of seeking medical care from unlicensed practitioners. These segments have aired in English and Spanish in Los Angeles and Orange counties and in the Bay Area.

■ ***Outreach to Board licensees.*** The Board's primary vehicle for communicating with California physicians is the *Action Report*, a quarterly licensee newsletter that includes articles on medical issues of interest to physicians, updates on recent legislation, enforcement-related articles (including information on the Board's Diversion Program for substance-abusing physicians and its Expert Reviewer Program), and a summary of MBC disciplinary actions.²⁷² MBC's Web site also provides information directed towards its physician licensees. Under "Services for Licensees," a physician may find information related to the enforcement process in general,²⁷³ California physicians and medical marijuana, the Expert Reviewer Program, fictitious name permits, guidelines for prescribing controlled substances for pain, patient privacy, patient activity reports from the California Department of Justice, the Diversion Program, and links to various forms, fact sheets, and other MBC publications (including a list of publications that physicians are required by law to provide to patients under certain circumstances).

■ ***Outreach to mandated reporters.*** Business and Professions Code section 800 *et seq.* requires many entities — including malpractice insurers, employers of physicians, court clerks, coroners, hospitals, and physicians — to report certain information about physicians to the Board. As described in Chapter VI above, these mandated reporters are particularly valuable sources of

and publications.

²⁷¹ The PSAs, which advise consumers to choose only licensed physicians and to contact MBC if they have questions about the healthcare they have received, are available on the Board's Web site.

²⁷² The *Action Report* is posted on MBC's Web site.

²⁷³ During 2005, the Central Complaint Unit updated the Web site's description of the enforcement process for physicians; this explanation and an enforcement program flowchart may be accessed at www.medbd.ca.gov/Complaint_Process.htm.

information that assists MBC in detecting physician misconduct warranting discipline — including section 2220.05 priority cases.²⁷⁴ Although MBC has posted easily-downloadable reporting forms for all mandated reporters on its Web site, some mandated reporters do not always file required reports with the Board, and/or do not fully comply with their reporting responsibilities.²⁷⁵

In the *Initial Report*, the importance of these mandated reporters and the Board's outreach to them were the subject of several Monitor recommendations, some of which have been implemented. As described in Chapter VI,²⁷⁶ SB 231 (Figueroa) has amended Business and Professions Code section 802 to require physicians to self-report medical malpractice judgments in excess of \$30,000; amended section 802.1 to require physicians to self-report certain misdemeanor criminal convictions; and amended section 805.2 to require expedited completion of the peer review study that is intended to improve hospital and HMO reporting of adverse peer review actions. The Department of Consumer Affairs is in the process of implementing an educational program with the Judicial Council aimed at improving court clerk compliance with state laws requiring them to report criminal convictions and civil malpractice judgments against physicians. MBC's enforcement program has made a concerted effort to educate California's coroners regarding their reporting responsibilities under section 802.5. All of those efforts should be continued, and much work — both legislative and administrative — remains to be done to improve insurer/employer reporting of medical malpractice settlements under sections 801, 801.1, and 803.2.

■ ***Outreach to prospective expert reviewers.*** As noted above in Chapter VIII, outreach to physicians who may be willing to serve as expert reviewers is handled primarily through notices in the *Action Report* newsletter and information regarding these positions is posted on the MBC Web site. Additionally, Board members and enforcement program representatives occasionally make presentations to hospital staffs, local and specialty medical societies, and other physician organizations to recruit prospective experts.

■ ***The enforcement program's outreach to complainants and subject physicians.*** In the *Initial Report*, the Monitor noted that MBC — in response to poor results in past consumer satisfaction surveys — took steps to improve its effectiveness in communicating with complainants to its enforcement program. MBC now sends an acknowledgment letter when a complaint is received, and includes a brochure entitled *How Complaints Are Handled*, an overview of the steps taken in processing complaints. MBC next notifies the complainant when medical records are being reviewed by a medical consultant, and includes its brochure entitled *Most Asked Questions About*

²⁷⁴ See *supra* Ex. VI-A, Ex. VI-B.

²⁷⁵ See *supra* Ch. VI.B.5.

²⁷⁶ *Id.*

Medical Consultants to explain that part of the process. When that consultant makes findings, MBC mails a letter to the complainant explaining those findings. If the complaint is referred for investigation, the complainant is again notified and mailed another brochure entitled *Questions and Answers About Investigations*. Thereafter, the complainant is notified if an accusation is filed. If the case is closed, the consumer is informed of the reasons for closure and the manner in which that decision may be appealed.

Although MBC has improved its communications with complainants throughout the enforcement process, it was less successful in consistently communicating with subject physicians. This issue was the subject of two Monitor recommendations whose implementation is discussed below.

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's public education and outreach program, and documents the responses to those findings implemented by the Medical Board during 2005. More detail on each of the findings is available in Chapter XIV of the *Initial Report*.²⁷⁷

1. Physicians are not required to provide patients with information about the existence of the Board and its disciplinary jurisdiction.

In the *Initial Report*, the Monitor noted that many other regulatory agencies — including health care-related agencies — require their licensees to provide customers or clients with information about their licensing board, its regulatory authority, and its contact information. Depending on the agency, this notice may be provided in a variety of nonintrusive ways — through brochures, posted notices, or statements on invoices and/or other documents that are given to the customer or client. However, the Medical Board has never imposed a similar requirement on physicians. During prior discussions of this issue, some Board members have noted that MBC's depleted staff can barely keep up with its current caseload, and have expressed concern about the capability of MBC's enforcement program to handle the surge of patient complaints which may result if MBC imposes a similar requirement on physicians.

To a certain extent, these Board members have a point. Although Exhibit VI-A indicates that patients are the source of the vast majority of MBC complaints, it also demonstrates that few patient complaints are referred for investigation and/or result in disciplinary action. On the other hand, Exhibit VI-B indicates that — in raw numbers — patients were the top source of section 2220.05

²⁷⁷ *Initial Report*, *supra* note 13, at 230–32.

priority complaints resulting in disciplinary action taken between January 1, 2003 and June 30, 2005. Exhibit VI-B and its explanatory notes also indicate that MBC itself is the “source” of a large number of priority complaints resulting in disciplinary action; in many of those complaints, a Board investigator looking into a particular matter checked the Civil Index and found civil malpractice lawsuits filed against the subject physician by patients who had not filed a complaint with MBC. It seems clear that many California citizens do not know of the existence of the Medical Board, and that MBC is not educating patients sufficiently on the kinds of matters they should bring to MBC’s attention. In Recommendation #53, the Monitor suggested that MBC sponsor legislation requiring physicians to inform patients about the Medical Board’s existence, disciplinary jurisdiction, address, and toll-free complaint number.

Neither MBC nor the Legislature took action on this recommendation during 2005. Although this is understandable due to the press of other higher-priority issues (including the needed fee increase and the fundamental structural change to a vertical prosecution model), this issue should find its way onto the agendas of MBC and its Public Education Committee during 2006. Many California agencies manage their caseloads while still meeting their obligation to help the public seek redress of legitimate grievances. As reflected in Chapter V,²⁷⁸ the number of complaints and reports to MBC has decreased over the past three or four years — which may be a product of inadequate public outreach. The Monitor believes that, as a matter of sound public policy, the Medical Board should make better efforts to meet its obligation to assist victims of medical wrongdoing in understanding how to be involved with its enforcement program.

2. The Board does not communicate consistently with physicians during the complaint review and investigative process.

As noted above, the Medical Board has made a concerted effort to improve its communications with complainants throughout the complaint handling process, but has been somewhat inconsistent in ensuring that physicians are notified of the status of complaints against them — partly because its various procedure manuals were inconsistent on this point. In Recommendations #20 and #54, the Monitor urged MBC to clarify its procedure manuals and ensure that subject physicians are notified when complaints against them are closed.

As described in Chapters VI²⁷⁹ and VII²⁸⁰ above, MBC has revised its *CCU Procedure Manual* and its *Enforcement Operations Manual* to require CCU and its district offices to notify a

²⁷⁸ See *supra* Ch. V.A; see also Ex. V-B, Ex. V-C.

²⁷⁹ See *supra* Ch. VI.B.8.

²⁸⁰ See *supra* Ch. VII.B.10.

subject physician who has been contacted by CCU or field staff during complaint processing of the closure of that complaint.

3. MBC should communicate with local county medical societies about their obligations under Civil Code section 43.96.

Civil Code section 43.96 requires medical societies, hospitals, and local government agencies that receive a written complaint against a physician to affirmatively notify the complainant that they have no jurisdiction over the physician's license, and that only MBC may discipline a physician's license. Further, the local entity must "provide to the complainant the address and toll-free telephone number" of the Board. In researching the *Initial Report*, the Monitor checked a number of Web sites of county medical societies. A few of them that offer "complaint processes" state in bold print that the medical society has no authority to require a physician to follow its recommendation or to take action against a physician's license; those sites provide MBC's address and toll-free number. Others make no such statement. Because some of these organizations with the word "county" in their name offer "complaint processes," consumers sometimes confuse them with the Medical Board and fail to file a complaint with the only entity that can protect the public from a dangerous physician. In Recommendation #55, the Monitor suggested that MBC periodically communicate with local county medical societies and remind them of their obligations under section 43.96.

During March 2005, MBC's public information officer (PIO) responded to this recommendation by checking the Web sites and/or otherwise contacting all 58 local county medical societies. According to MBC, all but two societies are in compliance with section 43.96. The PIO sent letters to those two societies setting forth the requirements of section 43.96.

C. Recommendations for the Future

■ ***Required notice to consumers regarding the Board's existence and disciplinary jurisdiction.*** Consistent with the practice at many other California regulatory agencies, the Medical Board should require its licensees to provide their patients with some form of affirmative notice concerning the Board's existence, jurisdiction, toll-free complaint number, and Web site address. MBC's complaint intake has decreased over the past several years, and this may be due to inadequate public outreach.

■ ***Continued outreach efforts directed at mandated reporters.*** MBC should continue its outreach efforts to individuals and institutions who are mandated reporters under Business and Professions Code section 800 *et seq.*, as these reporters are valuable sources of complaints and reports that lead to detection, investigation, and disciplinary action in priority complaints under Business and Professions Code section 2220.05.

Chapter XV

MBC'S DIVERSION PROGRAM

A. Overview of Function and Updated Data

This chapter addresses the Medical Board's Diversion Program, which "diverts" substance-abusing physicians out of the enforcement program described in the preceding fourteen chapters and into a program that is intended to monitor them while they attempt to recover from the disease of addiction.²⁸¹ The Diversion Program designs a contract with required terms and conditions of participation for a five-year monitoring period, including random bodily fluids testing, required group meeting attendance, required worksite monitoring, and often substance abuse treatment and/or psychotherapy. During participation in the Program, physicians generally retain their full and unrestricted license to practice medicine, and many of them are in fact permitted to practice medicine subject to the terms and conditions of their contracts. Many of them participate in absolute confidentiality — their participation in the Diversion Program is concealed from the Board's enforcement program, their patients, and the public. Those who comply with the terms and conditions of their Diversion Program contract may be "successfully terminated" from the Program after three years of continuous sobriety. Those who violate the terms and conditions of their Diversion Program contract may be "unsuccessfully terminated" from the Program and referred to the enforcement program for the commencement of disciplinary action.

It is important to understand that the Diversion Program is a *monitoring* program, not a treatment program. It does not provide substance abuse treatment; its staff is not authorized or trained to do so. Instead, it evaluates the needs of its participants; provides a rehabilitative plan that directs them to treatment — including inpatient detoxification, medical and psychiatric evaluation, and psychotherapy, as appropriate; monitors their compliance with the terms and conditions of their contract with the Program through a variety of mechanisms (including random drug testing, required

²⁸¹ The enabling act of the Diversion Program also refers to physicians with "impairment due to . . . mental illness or physical illness." Bus. & Prof. Code § 2340. However, the Diversion Program has historically and primarily been structured to monitor substance-abusing physicians (or physicians who are "dually diagnosed" with both chemical dependency and mental illness). Despite the inclusion of the terms "mental illness and physical illness" in its enabling act, the Diversion Program was not authorized to "divert" singly-diagnosed mentally ill physicians until January 1, 2003, when an amendment included in SB 1950 (Figueroa) became effective. Thus, for most of its history, the Diversion Program has been structured primarily to monitor chemically dependent physicians, and this chapter focuses on that function.

attendance at group meetings facilitated by Program contractors, and required quarterly reporting by worksite monitors and treating psychotherapists); and is authorized to terminate them from the Program (and refer them to the enforcement program) if they do not comply.

In researching the *Initial Report*, the Monitor studied the Diversion Program’s statutes, regulations, and procedure manuals; reviewed prior audits, evaluations, and annual reports of the Program; and extensively interviewed the staff of the Program. The Monitor also examined the files (both paper and electronic) of 60 Diversion Program participants — almost one-quarter of the Program’s population — to determine whether the Program is functioning in compliance with its statutes, regulations, and the policies and procedures set forth in its internal manuals.²⁸² The *Initial Report* provided an in-depth discussion of the Diversion Program’s purpose, structure, personnel, participants, and problems.²⁸³ For the convenience of the first-time reader, some of that information is repeated here.

■ **Statutory purpose.** Business and Professions Code section 2340 *et seq.* — enacted in 1980 — created MBC’s Diversion Program and expressly charged MBC’s Division of Medical Quality with its oversight and administration.²⁸⁴ In the enabling legislation, the Legislature stated its intent “that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.”²⁸⁵ This language thus requires the Board to “identify and rehabilitate” impaired physicians and “return” them to the practice of medicine, but only if this can be done “in a manner which will not endanger the public health and safety.” As one of MBC’s regulatory programs, the Diversion Program is subject to Business and Professions Code sections 2229 and 2001.1, both of which declare that protection of the public is the highest priority for the Medical Board of California. Both statutes specify that whenever public protection is inconsistent with other interests sought to be promoted, public protection is paramount.

■ **Program structure, staffing, funding, and participation.** MBC’s Diversion Program is one of the few state-sanctioned impaired physician programs to be run from within a state medical

²⁸² See *Initial Report*, *supra* note 13, at 236–38 for a complete description of the Monitor’s methodology in evaluating the Diversion Program. Prior to releasing the *Initial Report*, the Monitor team reviewed its findings and conclusions on each of the 60 case files with the outgoing Diversion Program administrator (who resigned in August 2004); the program administrator concurred each of the Monitor’s findings concerning individual participants.

²⁸³ *Id.* at 238–54.

²⁸⁴ Bus. & Prof. Code § 2346.

²⁸⁵ *Id.* § 2340.

licensing board by employees of that board. As noted in the *Initial Report*, most other state medical boards and California occupational licensing agencies with diversion programs contract out all functions of their impairment programs to the private sector. MBC's Diversion Program contracts out some components of its program, including its drug testing, laboratory, and group meeting components. But the critical case management component and all aspects of the Diversion Program's management and administration are performed by employees of the Medical Board — and have been since the Program's inception in 1981.

At the time of the *Initial Report*, the Program was staffed by a program administrator based in Sacramento; five “case managers” (CMs) scattered throughout the state and working out of home offices, each responsible for overseeing a caseload of participants in their region and ensuring that they comply with the terms and conditions of their contracts; and four support staff based in Sacramento, including a Collection System Manager (CSM) with responsibility for overseeing the Program's urine collection and testing system — the Program's major objective measure of compliance with Diversion contracts. These Board employees are supplemented by thirteen “group facilitators” (GFs) based throughout the state; GFs facilitate biweekly group meetings of Diversion Program participants in their localities. The Program is also assisted by approximately 30 local businesses throughout the state that serve as urine specimen collectors for the Diversion Program.

As described briefly in Chapter V, the Diversion Program maintains the Diversion Tracking System (DTS), its own separate database of information on its participants that is unavailable to Board management or the enforcement program. DTS contains a file on each participant that is supposed to include all personal and professional information on the participant, the terms and conditions of his/her Diversion Program contract (including restrictions on medical practice), and the details of his/her participation in the Diversion Program, including results of all bodily fluids testing (which are downloaded directly into DTS from the laboratory that tests participants' urine samples), absences from required group meetings, and dates of worksite monitor and treating therapist reports.

As of June 30, 2005, 232 physicians were admitted to and participating in the Diversion Program.²⁸⁶ In fiscal year 2004–05, the Diversion Program cost almost \$1.2 million.²⁸⁷ That cost was subsidized entirely through license fees paid by all California physicians. Participants in MBC's Diversion Program pay nothing toward the overhead costs of the Program. They are required to pay

²⁸⁶ Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at iv. In addition to its 232 active participants, the Program was also monitoring 28 prospective participants who had signed an “interim agreement” (see below) but had not yet seen a DEC or signed a formal Diversion Program Agreement, and 17 California physicians participating in other-state diversion programs.

²⁸⁷ *Id.* at ii.

the costs of their own drug testing (approximately \$220 per month during the first two years²⁸⁸) and group meetings (as of July 2005, \$331 per month for two meetings per week²⁸⁹), for a total of \$551 per month. Additionally, if they are required to undergo substance abuse treatment as a condition of Diversion Program participation, they must pay for that treatment.²⁹⁰

■ **Overview of participation in the Diversion Program.** A physician makes contact with the Diversion Program in one of three ways: (1) he may telephone the Diversion Program at its Sacramento headquarters office seeking information and/or admission into the Program (a so-called “self-referral”); (2) impaired physicians are sometimes detected through complaints or reports made to the enforcement program, and enforcement permits the physician to enter Diversion under a “statement of understanding” (SOU)²⁹¹ (these physicians are called “diverted” or “Board-referred” participants); or (3) the Board may order a physician to participate in Diversion as a term of probation in a public disciplinary order (“Board-ordered participants”).

Regardless of why the physician is entering the Program, a Program analyst conducts a telephone interview to record basic information about the physician’s situation. The analyst checks the enforcement program’s CAS computer system to determine whether any complaints are pending against the physician; if not,²⁹² the analyst relays the information on the prospective participant to the CM with responsibility for covering the geographical area of the state in which the physician lives. Within the next four days, the CM telephones the physician, assesses the situation, and schedules an in-person “intake interview” which should occur within seven days of the physician’s

²⁸⁸ Participants currently pay \$20 to the collector for each observed collection, and \$35 for laboratory testing of the sample, for a total of \$55 per test. During the first two years of participation, participants are tested at least four times per month; thus, participants pay approximately \$220 per month for drug testing during the first two years.

²⁸⁹ At its July 2005 meeting, the Diversion Committee and DMQ approved an increase in group facilitator fees, from \$322 per month for two meetings per week (or \$225 per month for one meeting per week) to \$331 per month for two meetings per week (or \$231 per month for one meeting per week).

²⁹⁰ According to Program staff, inpatient substance abuse treatment ranges from \$8,000–\$20,000, and is not always covered by insurance.

²⁹¹ See Bus. & Prof. Code § 2350(b).

²⁹² If there is a complaint pending against a physician who seeks admission into the Diversion Program, the Program asks the deputy chief of enforcement to “divert” the physician into Diversion. If the complaint is based primarily on “the self-administration of drugs or alcohol under Section 2239, or the illegal possession, prescription, or nonviolent procurement of drugs for self-administration, and does not involve actual harm to the public or [the physician’s] patients,” the deputy chief “shall refer” the physician to Diversion for an evaluation of eligibility. However, before making the referral, enforcement may require the physician to sign a “statement of understanding” (SOU) in which the physician agrees that “violations of this chapter or other statutes that would otherwise be the basis for discipline may nevertheless be prosecuted should the physician . . . be terminated from the program for failure to comply with program requirements.” Bus. & Prof. Code § 2350(b).

initial contact with the Program.²⁹³ At the intake interview, the physician must sign an “interim agreement” with the Program.²⁹⁴ At this point, the CM is required to do three things: (1) arrange for a comprehensive multidisciplinary physical and mental evaluation of the prospective participant by a physician who specializes in addiction medicine and is competent to recommend the type of treatment and monitoring needed by the prospective participant²⁹⁵; (2) refer the physician to a local GF who conducts weekly group therapy meetings attended by other impaired physicians who are participating in the Diversion Program, so that the physician may begin to attend meetings immediately pending his formal admission into the Program; and (3) arrange for random urine testing of the physician commencing immediately.

Once the physician’s comprehensive evaluation has been completed, the results and recommendations are forwarded to the CM, who then refers the physician’s file to a local Diversion Evaluation Committee (DEC) and schedules the physician for an in-person appointment with the DEC. The Diversion Program maintains five DEC’s throughout the state; by statute,²⁹⁶ each DEC consists of five individuals (three physicians and two non-physicians) who have expertise in substance abuse detection and treatment. DEC members are private parties appointed by DMQ.²⁹⁷ DEC’s meet quarterly and in private.²⁹⁸ The DEC reviews the file, meets with the physician, and makes a recommendation to the program administrator whether the physician should be accepted into the Program, whether the physician should be permitted to continue practicing medicine, and the terms and conditions of the physician’s Diversion Program contract (including proposed

²⁹³ These timeframe goals are not stated in any statute, regulation, or procedure manual. They are set forth in the Diversion Program’s “Quarterly Quality Review” reports that are reviewed by the Diversion Committee at its quarterly meetings.

²⁹⁴ In the interim agreement, the physician acknowledges that he is applying for admission into the Diversion Program, recognizes that he may have a substance abuse disorder, and agrees to restrict or cease practice if so instructed by the Diversion Program; enter a treatment program if so instructed by the Diversion Program; undergo a minimum of four observed urine tests per month; attend facilitated group meetings with other Diversion Program participants; attend additional group meetings of Alcoholics Anonymous or Narcotics Anonymous, as instructed by the Diversion Program; abstain from the use of alcohol and drugs except those that have been prescribed by another physician and approved by the Diversion Program; refrain from self-prescribing any medications that require a prescription; and immediately report to the Program any relapse or use of alcohol or unauthorized drugs.

²⁹⁵ Business and Profession Code section 2350(h) requires DMQ to “establish criteria for the selection of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion” In 1981, DMQ adopted the following regulation: “A physician selected by the program manager or his/her designee to conduct medical and psychiatric evaluations of an applicant shall be a licensed physician who is competent in his/her field of specialty.” 16 CAL. CODE REGS. § 1357.3.

²⁹⁶ Bus. & Prof. Code § 2342.

²⁹⁷ *Id.*

²⁹⁸ *Id.* § 2353.

treatment requirements). The DEC acts in an advisory role to the program administrator.²⁹⁹ The program administrator prepares a formal Diversion Program contract, and — if the physician signs it — he is formally accepted into the Program.

The time period from the initial contact by the physician with the Program to the DEC meeting and signature on the formal contract generally exceeds three months. In the meantime, the participant is expected to attend two group meetings per week and is subject to at least four random urine tests per month during the first 24 months of participation.³⁰⁰ If the participant is permitted to practice medicine while participating in the Diversion Program, he must secure a “worksite monitor” who must file quarterly written reports on the participant.³⁰¹ In addition, if the participant has hospital privileges, the participant must also secure a “hospital monitor” and notify the well-being committee at each hospital where the participant has privileges. The hospital monitor must also file quarterly written reports on the participant.³⁰² If the Program requires a participant to undergo psychotherapy, the treating therapist is also required to file quarterly written reports on the participant’s progress.³⁰³ The CM is responsible for ensuring that all of these quarterly reports are received, recorded, and forwarded to headquarters for placement in the participant’s file.³⁰⁴

Assuming no relapses or other noncompliance, the Program’s monitoring continues for at least five years.³⁰⁵ Participants are expected to file semi-annual reports assessing their own progress

²⁹⁹ *Id.* § 2344.

³⁰⁰ The rules governing the frequency of random urine testing and group meeting attendance do not appear in any statute, regulation, or even the *Diversion Program Manual*. The Program’s policy regarding the frequency of random urine testing is contained in a June 30, 2000 memo from the program administrator, which was then clarified in a March 26, 2001 memo from the program administrator. These memos are contained in an undated supplemental compilation of Diversion Program policies prepared for the Monitor entitled *Diversion Program Policy, Guidelines, and Procedures*. The rule concerning frequency of required group meeting attendance appears nowhere — not in any statute, regulation, or procedure manual. The closest the Program comes to defining its expectations regarding required group meeting attendance is Appendix D to its *Diversion Program Manual*, which contains a compilation of materials given to new participants. Appendix D states: “During the first eighteen months of participation in the Diversion Program, most participants are expected to attend two Diversion Group meetings a week. At the end of this period, the participant may request a reduction in meeting attendance from two to one a week. Your request should also be discussed with your facilitator and case manager.”

³⁰¹ Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at 7.

³⁰² *Id.* at 7–8.

³⁰³ *Id.* at 8.

³⁰⁴ *Id.*, Ch. 2 at 8.

³⁰⁵ Due to relapses, however, it takes most participants five to seven years to “successfully terminate” from the Program.

toward recovery;³⁰⁶ these reports are reviewed by the DEC on an annual basis, along with all of the other documentation that is required to be gathered by the case manager, including quarterly worksite and hospital monitor reports, treating therapist reports, and the participant's drug testing history.³⁰⁷ After two years of continuous sobriety, urine testing may be decreased to three times per month; after three years, it may be decreased to twice per month. At that point, required group meeting attendance may be reduced to once per week.³⁰⁸ After three years of sobriety, compliance with the terms of the contract, and adoption of a "lifestyle to maintain a state of sobriety," a participant may be "successfully terminated" from the Diversion Program.³⁰⁹ At that point, a physician who entered the Program under an SOU is immune from discipline for the alleged violation that resulted in his referral to Diversion.³¹⁰ Most Diversion Program records of "successfully terminated" participants — including treatment records — are destroyed.³¹¹ Thereafter, the Program does not inquire into or track the sobriety or performance of its graduates in any way.

Under Diversion Program policy, the consequences for a relapse depend on the facts of the situation, the level of breach, and the way in which it is detected. If the physician is practicing medicine at the time of the relapse, he is usually directed to cease practice until he can meet with the DEC, and is placed on the DEC's calendar for the next available meeting. Depending on the circumstances, the Program may also direct the physician to enter treatment, increase the frequency of required urine testing or group meeting attendance, or require the participant to undergo psychiatric evaluation and/or psychotherapy. According to the *Diversion Program Manual*, "a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program."³¹²

In an average of 13 cases per year for the past five years, the Program has "unsuccessfully terminated" a participant. The consequences of "unsuccessful termination" depend on the type of participant who has unsuccessfully terminated. Participants who are in the Diversion Program under

³⁰⁶ Medical Board of California, *Diversion Program Manual* (undated) at Appendix D ("semi-annual reports").

³⁰⁷ *Id.*, Ch. 4 at 1, 3.

³⁰⁸ *See supra* note 300.

³⁰⁹ Bus. & Prof. Code § 2350(g)(1).

³¹⁰ *Id.* § 2350(g).

³¹¹ *Id.* § 2355(a). A DMQ regulation specifies a few types of Diversion Program records that must be retained in confidence by the Diversion Program. 16 CAL. CODE REGS. § 1357.9.

³¹² Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at 4; *see also* Medical Board of California, *Diversion Program Policy, Guidelines, and Procedures* (undated) ("Guidelines for Maximum Relapses While in the Diversion Program") ("a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program").

an SOU or as a condition of Board-ordered probation are referred to enforcement, which can then file an accusation for the alleged violation that resulted in the referral to Diversion,³¹³ or a petition to revoke probation based on the unsuccessful termination. “Self-referred” participants who are “unsuccessfully terminated” will not be referred to enforcement unless the DEC “determines that he or she presents a threat to the public health or safety.”³¹⁴ According to the Program Administrator, DEC does not generally make such a finding unless the participant is actively using drugs or alcohol. Thereafter, the Program does not inquire into or track the sobriety or performance of participants it has unsuccessfully terminated in any way.

■ **Prior audits of the Diversion Program.** Prior to the Monitor’s examination of the Diversion Program in 2004, the Program had not been subject to an external audit since 1986. Beginning in the early 1980s, the Auditor General’s Office (now called the Bureau of State Audits) conducted a series of audits of MBC’s Diversion Program. In its three audits,³¹⁵ the Auditor General found that participants in the Program were not drug-tested as often as they should be and were not terminated from the Program even after repeated violations; additionally, no standards existed to guide the functioning of “worksites monitors” who purportedly oversee Program participants when they practice medicine. Overall, the Auditor General found that the Program — due in part to severe understaffing — generally failed to adequately monitor substance-abusing physicians while permitting them to practice medicine, and that the Medical Board had inadequately supervised the Program. Despite repeated findings by the Auditor General and repeated promises by the Board to address the problems identified, the *Initial Report* documented that all of these problems continued to exist over twenty years later.

B. The Monitor’s Findings and MBC/Legislative Responses

In the *Initial Report*, the Monitor — as did the Auditor General twenty years ago — identified and documented numerous significant deficiencies in the functioning of the Diversion Program.³¹⁶ These weaknesses — which range from the philosophical to the structural to the operational — are summarized below. The Monitor then made ten recommendations to MBC regarding the Diversion Program — not all of which could possibly have been implemented in the

³¹³ Bus. & Prof. Code § 2350(e).

³¹⁴ *Id.* § 2350(j)(3).

³¹⁵ Auditor General of California, *Review of the Board of Medical Quality Assurance* (No. P-035) (August 1982); Auditor General of California, *The State’s Diversion Programs Do Not Adequately Protect the Public from Health Professionals Who Suffer from Alcoholism or Drug Abuse* (No. P-425) (January 1985); Auditor General of California, *The Board of Medical Quality Assurance Has Made Progress in Improving Its Diversion Program; Some Problems Remain* (No. P-576) (June 1986).

³¹⁶ *Initial Report*, *supra* note 13, at 254–85.

year since the *Initial Report* was issued. As described below, the Medical Board and the Diversion Program have begun to implement those Monitor recommendations that can be achieved with limited staff and resources. Further, MBC has created a new Diversion Committee and charged it with considering and resolving significant policy issues that have long plagued the Program and that could not realistically be addressed in the year since November 1, 2004; those issues — originally identified in the *Initial Report* — are recapped in Chapter XV.C. below. And finally, in SB 231 (Figueroa), the Legislature has given the Committee and the Board a last chance to fully address and resolve the problems that have been repeatedly identified by the Auditor General and now the Monitor. As described in Chapter IV above, the bill requests the Bureau of State Audits to thoroughly audit the Program by June 30, 2007, and places a July 1, 2008 sunset date on the existence of the Program.

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are: (1) random urine screening requirements; (2) case manager attendance at required group meetings; (3) required worksite monitoring; and (4) regular reporting to the Program by psychotherapists who are treating participants.

In the *Initial Report*, the Monitor found — as did the Auditor General in its three reports during the 1980s — that all of these monitoring mechanisms were failing the Program and the public, and that the Program lacked internal quality controls that would otherwise enable staff to detect these failures. As a result, Program staff and oversight authorities were unaware of the deficiencies that existed in the Program and falsely assumed that the Program was effectively monitoring participants when it was not. Following is a brief summary of the Monitor's *Initial Report* findings about each of the Diversion Program's monitoring mechanisms.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means of monitoring participants' sobriety and detecting relapses. Available data suggest that more than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major

objective measure of participant compliance with the terms of the contract and with the Program’s requirements.

As described above, the Sacramento-based Collection System Manager (CSM) is supposed to maintain a “master collection schedule,” generate random dates on which Program participants must be tested by local collectors, forward the testing schedule to local collectors and to regional case managers (CMs), and generally provide “oversight and coordination for the collection system process” and “the integrity of the collection system.”³¹⁷ The CMs are required to monitor a caseload of participants in their region and ensure that all participants comply with all terms and conditions of their Diversion Program contracts — including required urine testing. Both of these “gatekeepers” are in a position to monitor participant compliance with the Program’s urine collection requirements.

However, the Monitor found that, because of other Program responsibilities and a shortage of staff, the CSM was only able to devote two hours per month to her CSM duties; all she was able to do within that timeframe was generate the random schedule and send it to collectors. The CMs were burdened by excessive caseloads and could barely respond to positive tests much less track whether each participant was being tested as often as required and on the random dates generated by the CSM. The local collectors were essentially unsupervised and were free to adjust the random schedule to suit their convenience. They often unilaterally shifted collections to dates that could be anticipated by the participants,³¹⁸ or skipped scheduled tests altogether and failed to make them up. These failures went undetected by Program staff. The “gatekeepers” simply assumed that collections were completed as required and scheduled, that test results were negative unless they received a positive finding from the laboratory, and that all test results were being correctly downloaded and appended to each participant’s record in the DTS. All of these assumptions were frequently erroneous. The Monitor found that there were insufficient positive controls on the collection system to provide assurance of six major components of the Program’s urine collection system:

- a. All active participants are included in the master collection schedule maintained by the CSM.
- b. Each participant is scheduled for the required number of tests, per the Diversion Program’s “frequency of testing” policy described above.
- c. Collections are actually completed on the random dates assigned by the CSM.

³¹⁷ Medical Board of California, *Diversion Program Manual* (undated), Ch. 5 at 3.

³¹⁸ In this regard, the Monitor found that collectors disproportionately shifted collections from weekend days (Friday, Saturday, and Sunday) to weekdays, particularly Tuesday and Thursday. The reduced frequency of testing on weekends and increased frequency of testing on Tuesdays and Thursdays potentially enables participants to “game” the system by anticipating when they are least likely to be tested. *Initial Report, supra* note 13, at 260.

- d. The same number of collections is completed as is scheduled for each participant.
- e. Collected specimens are received at and processed by the laboratory.
- f. Test results are correctly downloaded and appended to each participant's record in the DTS.

Due to the absence of sufficient positive controls over the scheduling and collection process, the Monitor — like the Auditor General in the 1980s³¹⁹ — found that many Diversion Program participants were tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there was a problem. In 60% of the case files reviewed by the Monitor, testing did not occur on the random dates generated by the CSM; when it occurred, it occurred with frequency on dates that could be anticipated by the participant. In many cases, test results (including positive test results that indicate relapse) were not promptly communicated from the lab to the Program. When test results were received, they were sometimes appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there was a problem. The Monitor found numerous errors, gaps, and inconsistencies in the Program's recordkeeping on its participants — recordkeeping that must be available, correct, and reliable in the event of a relapse.³²⁰

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The Program's case managers represent another “monitoring” mechanism of the Diversion Program.³²¹ The *Diversion Program Manual* requires case managers to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants.³²² Case managers are required to report their group meeting attendance in monthly reports to the program administrator.³²³ However, the Monitor — like the

³¹⁹ The Auditor General's 1985 and 1986 reports found that the Diversion Program does not test its participants as frequently as Program policy requires. See *Initial Report*, *supra* note 13, at notes 444–45.

³²⁰ See *Initial Report*, *supra* note 13, at 258–65 for a detailed description of the defects in the Diversion Program's urine collection system.

³²¹ Medical Board of California, *Physician Diversion Program* (March 2000) at 2 (“[t]he role of the case managers is to ensure that the participants who are assigned to them comply with the provisions of their Diversion Agreements and are solidly in the recovery process. The Case Manager has direct contact with each participant every 4–8 weeks”).

³²² Medical Board of California, *Diversion Program Manual* (undated) at Ch. 2, p. 5 (“CMs attend the facilitators' group meetings once a month to observe the facilitators and participants”).

³²³ Medical Board of California, *Diversion Program Manual* (undated) at Ch. 1, p. 12.

Auditor General in the 1980s³²⁴ — found that few case managers filed monthly reports as required, so there was no documentation as to whether they had attended group meetings as required by Program policy.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are “monitored” by non-impaired physicians.³²⁵ However, since its inception, the Program has set forth no workable definition of the duties, qualifications, or expectations of a “worksite monitor.”³²⁶ Although some Diversion Program materials convey the idea that participants are “supervised” while practicing medicine, that is not the case. No statute, regulation, or procedure manual contains a definition of or standards for a “worksite monitor.” The *Diversion Program Manual* contains no requirements that the worksite monitor actually be onsite at the same time as the participant, supervise the participant in any way, or even meet with or talk to the participant. The *Manual* sets forth no qualifications or criteria for someone functioning as a “worksite monitor,” nor does it even require the monitor to be a physician.

Further, the Monitor found that people functioning as worksite monitors were not consistently filing quarterly reports as required by the Program. Yet in many cases reviewed by the Monitor, DEC’s recommended that participants be allowed to increase their practice hours or — in one case — resume practice on a full-time basis notwithstanding continuing deficiencies related to the submission of quarterly worksite monitoring reports.

(4) Treating psychotherapist reporting is deficient. The Diversion Program assures the public that impaired physicians are monitored by treating psychotherapists who are required to file quarterly written reports with the Program.³²⁷ However, the Monitor found that this monitoring

³²⁴ The Auditor General’s 1982, 1985, and 1986 reports identified the problem of inconsistent or inadequate contact by case managers with participants. See *Initial Report, supra* note 13, at notes 449–51. The Auditor General’s 1985 and 1986 reports documented the problem of inadequate reporting by case managers and inadequate supervision of case managers by the program administrator. See *Initial Report, supra* note 13, at notes 452–53.

³²⁵ Medical Board of California, *Physician Diversion Program* (March 2000) at 2 (“[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including “worksite monitor(s)” and “hospital monitor(s)"] is used in order to ensure patient safety and provide strong support for the physician’s recovery”).

³²⁶ The Diversion Program’s failure to adequately define the duties, qualifications, and functions of worksite monitors and the failure of worksite monitors to submit quarterly reports were identified by the Auditor General in 1982, 1985, and 1986. See *Initial Report, supra* note 13, at notes 455–57.

³²⁷ Medical Board of California, *Physician Diversion Program* (March 2000) at 2 (“[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including “ongoing psychotherapy” and “progress reports: therapists, monitors, treating physicians”] is used in order to ensure patient safety and provide strong support for the physician’s recovery”). See also Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at p. 8 (treating psychotherapist quarterly report requirement).

requirement was not being satisfied. Neither the case managers, the program administrator, nor the DEC's (which annually review all Program participants) were ensuring that quarterly treating psychotherapist reports were filed.

b. The Program is so understaffed that staff could not correct the failures in its monitoring mechanisms even if they knew about them.

In the *Initial Report*, the Monitor found significant understaffing of the Diversion Program at all levels: program management, case management, and analytical/clerical support staff. The program administrator was charged with (1) supervising the case managers and support staff; (2) making Program policy decisions; and (3) engaging in overall program oversight, including fact-based decisionmaking concerning participants — a burdensome combination of duties that one person cannot competently handle alone. In 2002, case manager caseloads soared to over 80 cases for three of the five CMs, leading to inadequate monitoring of participants and failure to ensure compliance with all Program requirements. Even the Program recognized its staffing limitations and began to turn away prospective participants.³²⁸ The employee in the critical CSM position — implied to be a full-time position devoted to ensuring the integrity of the collection system in the *Diversion Program Manual* — was so overloaded with unrelated responsibilities that she was incapable of devoting more than two hours per month to urine collection system oversight. The four Sacramento-based support staff could not possibly keep up with their Program-related work responsibilities (including the calendaring and staffing of all DEC meetings all over the state) plus the work necessary to accommodate the needs of the Diversion Committee, the Liaison Committee, and the Division of Medical Quality.

In Recommendation #58 of the *Initial Report*, the Monitor found that — if the Medical Board chooses to continue administering the Diversion Program — DMQ must spearhead a comprehensive overhaul of the Program to correct longstanding deficiencies that limit the Program's effectiveness. This overhaul must include an influx of additional staff if the Program is to adequately monitor its participants. However, the Monitor emphasized that the mere addition of staff alone will not solve the Diversion Program's problems. In addition, the Program must install and staff sufficient and significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. According to the Monitor, "[i]t is abundantly clear that the Program has functioned without adequate internal controls for 24 years. These controls

³²⁸ Beginning in March 2002, case manager caseloads in certain parts of the state were deemed so excessive that Program management curtailed entry into the Program by participants who would have been served by those case managers, and simultaneously lessened the participant monitoring expected of those case managers. Today, in 2005, at least one CM still has an excessive caseload.

must be designed, installed, and adequately staffed.”³²⁹ Finally, any restructuring of the Diversion Program must include the resolution of significant and longstanding policy issues by the Diversion Committee and DMQ; those policy issues are detailed in Chapter XV.C. below.

To address fundamental flaws in the Program’s monitoring mechanisms, MBC Executive Director Dave Thornton — who personally stepped in and served as Acting Diversion Program Administrator from August 2004 through February 2005 — announced in January 2005 his intent to “deconstruct and reconstruct” the Diversion Program, and has taken several initial steps toward this goal. Since February 2005, there has been almost complete turnover in the staff of the Diversion Program — almost all Program staff are new, have no commitment to or stake in the Program’s prior policies and procedures, and appear to be committed to the purpose of the Program (protection of the public while assisting impaired physicians to recover from addiction). The following improvements have occurred since the release of the *Initial Report*:

■ ***Diversion Program staffing.*** Effective February 17, 2005, MBC hired a new Diversion Program Administrator who has significant experience in both enforcement and in impairment programs. The new administrator has been instrumental in addressing several of the operational deficiencies identified by the Monitor. On February 8, 2005, MBC added a new management position to the Diversion Program — a supervisor for the case managers. Although this individual was required to carry a CM caseload until June 1, 2005, since then she has been active in providing critically needed supervision of the CMs. She ensures that CMs are filing required monthly reports on their activities, and that those reports contain documentation of their attendance at group meetings — as required by Program policy. She ensures that CMs acquire, and forward to Sacramento headquarters, required quarterly worksite monitor and treating psychotherapist reports. Under the direction of the new program administrator and CM supervisor, the case managers have been moved out of their former home offices and now work from Medical Board district offices. They access the DTS from MBC computers and have office space (including locking cabinets for confidential Diversion Program files) in Medical Board facilities. This change has led some of the prior CMs to resign or retire — paving the way for the new Program management to hire new case managers who have no familiarity with the way the Program previously functioned.

Significantly, on March 1, 2005, the Program formally expanded its existing Collection System Manager position to a full-time position devoted almost entirely to overseeing the operations and integrity of the Program’s urine collection system; additionally, another Program analyst has been cross-trained to handle CSM duties when the CSM is on vacation or otherwise out of the office. The new CSM is in the process of completely rebuilding the Program’s urine collection system from the ground up (see below for details).

³²⁹ *Initial Report*, *supra* note 13, at 273.

Finally, MBC has submitted a budget change proposal (BCP) for additional Diversion Program case managers and the conversion of a seasonal clerical position to a permanent position. The additional CM positions are of particular importance; if approved, average CM caseloads will decrease from over 50 cases to approximately 40 cases each — and should enable CMs to adequately monitor participants and greatly improve the public protection afforded by the Diversion Program. Funding for these positions was included in the Board's calculation of the fee increase which was included in SB 231 (Figueroa) — now passed by the Legislature and signed by the Governor. The Monitor urges all applicable control agencies to approve the creation of these new positions for the Diversion Program.

■ ***Improvements to the Program's urine testing system.*** As noted above, the Medical Board has finally devoted a full-time analyst position to the Diversion Program's critical CSM function. The new CSM has contacted all Program CMs, GFs, and urine collectors and reinforced the Program's expectations of each regarding performance and regular and complete reporting of that performance. She has created a monthly reporting form for local urine collectors which requires them to document that they have administered tests on the random date scheduled, and instituted a policy requiring advance notification of and written justification for the adjustment of any of those test dates. She has established regular contacts with the Program's CMs to ensure that they provide her with updated information regarding the identities of new participants who should be added to the master collection schedule, participants who have gone into treatment, and participants who are on vacation or are otherwise unavailable for Program urine testing — so the master collection schedule can be adjusted and the dates for testing can be randomly established by the CSM (and not by CMs and collectors). Upon her recommendation, the Program has terminated several collectors who would not adhere to the random schedule and other Program requirements, and brought in others who are willing to do the job expected of them.

Unhappy with the error-riddled and obsolete Diversion Tracking System, MBC management in late 2004 commissioned the Board's Information Systems Branch (ISB) to create a new DTS to electronically track data (including all results of urine tests) on all Diversion Program participants. As described in Chapter V, ISB was able to create a new system that was up and running as of July 1, 2005. The DTS is now a Web-based real-time system that is accessible to Program case managers at MBC district offices. Although the new DTS is operational, it is still a work in progress as new features are being added or enhanced. ISB has created a program whereby urine test results forwarded by the lab are automatically downloaded to the DTS and appended to the tested participant's DTS file (which is being spot-checked for accuracy by the CSM). As of September 1, 2005, ISB installed a new "random date generator" (RDG) that produces monthly schedules for random drug testing of Program participants. Staff plans to adhere strictly to the random dates generated by the RDG, and not to manually tinker with dates selected (except to add additional tests or "elite" tests so that the Program's frequency of testing policy becomes a floor and not a ceiling).

Finally, ISB is in the process of creating a new “exception report” that will compare the randomly scheduled dates to the dates of actual testing, and identify tests conducted on dates other than randomly-scheduled dates.

Collectively, MBC’s recent changes to the Diversion Program’s urine collection system have addressed the six missing assurances identified by the Monitor as follows:

- a. *All active participants are included in the master collection schedule:* Because of previously inaccurate recordkeeping and the errors in the DTS, the new CSM was required to manually compile an accurate list of active Program participants who are subject to urine testing. She then reconciled that list with the master collection schedule to ensure that the name of every active participant in the Diversion Program is on the schedule and is programmed for the correct number of tests per month pursuant to Program policy. To keep the schedule updated, the CSM has frequent communications with the Program’s CMs and GFs to ensure that all active participants are listed on the master schedule — that is, new participants are added and participants in treatment are temporarily deleted (but are added back immediately upon their release from treatment). The goal is to ensure that the CSM establishes random testing dates — not the CMs or the local collectors.
- b. *Each participant is scheduled for the required number of tests, per the Diversion Program “frequency of testing” policy described above:* The new CSM has manually recalculated applicable testing requirements for each active participant, and is manually verifying that all participants are being given the minimum number of tests per month as required by Program policy. Program staff is also studying and reevaluating the Program’s “frequency of testing policy” (a minimum of four tests per month during the first two years of participation; then — assuming no relapse — three tests per month during the third year and two times per month during subsequent years). According to Program staff, this test rate “drop-off” at these intervals is no longer automatic, but is within the discretion of the Program. Staff is also examining “frequency of testing policies” in other states.
- c. *Collections are actually completed on the random dates assigned by the CSM:* The CSM is requiring monthly reports from collectors that document and verify that tests have been administered on the random dates selected by the computer. Collectors must submit advance notice of any change in those dates to the CSM, and must provide written justification for the change in their monthly reports.

- d. *The same number of collections is completed as is scheduled for each participant:* Currently, this factor is being manually checked by the full-time CSM; however, she will soon be assisted by the new “exception report” function being developed by ISB.
- e. *Collected specimens are received at and processed by the laboratory:* This factor is being checked by the full-time CSM.
- f. *Test results are correctly downloaded and appended to each participant's record in the DTS:* Currently, the CSM performs spot checks to ensure accuracy in the DTS receipt and recording of test results. At the end of every month, the CSM has been manually verifying the accuracy of lab test reporting displayed on DTS (ensuring that the number of required tests has been administered, and that all tests have been administered on the random dates selected by the computer). In the near future, manual checking will be unnecessary because of the new “exception report” function being developed by ISB.

■ ***Case manager attendance at group meetings.*** The new case manager supervisor now requires and reviews monthly reports filed by case managers that document their compliance with the Program's policy of CM attendance at each group meeting in their region at least once monthly. Most CMs are able to comply with that requirement now. If a CM is burdened by an excessive caseload and is unable to attend group meetings as required, the program administrator and/or case manager supervisor attempt to fill in for them at group meetings. As noted above, MBC has submitted a BCP for additional CMs, which will assist in lowering all CM caseloads and enable CMs to fulfill this monitoring duty.

■ ***Worksite monitoring standards and reporting.*** Under the supervision of the new case manager supervisor, CMs are now beginning to address issues related to the timely filing of quarterly worksite monitor reports. Program staff is working with ISB to develop a program whereby a list of participants who are not in compliance with the worksite monitor requirement is generated.

Although worksite monitor reporting has improved, the Diversion Committee has not yet established meaningful standards for actual worksite monitoring — that is, the duties, responsibilities, and qualifications for worksite monitors. This issue is listed in Chapter XV.C. below. The Program's CMs are currently responsible for ensuring that each participant has secured one or more worksite monitors (as required by Diversion Program policy) who are willing to perform the job and file quarterly reports, and for communicating with worksite monitors. However, the parameters of worksite monitoring must be fleshed out by the Diversion Committee and DMQ. Among those job duties should be a responsibility for monitoring the availability of drugs and narcotics at the workplace, especially small or sole practitioner physicians' offices. Importantly, the

Program's new management has instituted a policy change and will no longer approve a DEC recommendation to increase a participant's work hours (or lower his testing frequency) if the participant is not in compliance with the Program's worksite monitor reporting requirements.

■ ***Treating psychotherapist reporting.*** Under the supervision of the new case manager supervisor, CMs are now beginning to address issues related to the timely filing of quarterly treating psychotherapist reports. As noted above, the Program will no longer approve the recommendation of a DEC for increased working hours (or a "drop-off" to lesser testing frequency) for participants who are not in compliance with the Program's treating psychotherapist reporting requirements.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held.

In the *Initial Report*, the Monitor found that the Diversion Program is plagued by an almost complete lack of enforceable rules, standards, or expectations to which participants or staff are consistently held. The Diversion Program's statutes and regulations are skeletal at best. None of the monitoring mechanism described above are even mentioned in, much less governed by, statute or regulation. All of the monitoring mechanisms and other Program "rules" and "policies" are contained in an unenforceable "procedure manual" that has not been updated since 1998 and is effectively obsolete.

Despite statutory requirements to the contrary, the Program has no meaningful criteria for admission to the Program or termination from the Program. It has no clear standards regarding consequences for or response to relapse. Although the *Diversion Program Manual* contains documents entitled "Response to Relapse" and "Relapse Response Matrix," neither document was ever reviewed and approved by the Diversion Committee or DMQ, both are unenforceable, and neither provide much guidance to DEC's or Program staff. The Program's policies have been applied in ways that allow chronic repeat offenders — physicians who have had multiple "bites of the apple" and are simply wasting the time and limited resources of the Diversion Program — to remain in the Program and to remain licensed as physicians.

As far back as 1985, the Auditor General concluded that the Medical Board must "[s]pecify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination," and "develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly."³³⁰ Over 20 years later, DMQ has still failed to establish meaningful and enforceable standards for the handling

³³⁰ See 1985 Auditor General Report, *supra* note 315, at 22–32.

of relapse by Diversion Program participants and for termination from the Program — apparently preferring to delegate to DEC's and the program administrator a “case-by-case” approach. The Monitor appreciates the difficulty of fashioning a “one-size-fits-all” rule regarding relapse, but it seems patently unfair to both physicians and consumers that chronic relapsers who repeatedly and egregiously violate the terms of their Diversion contracts remain in the Program while other physicians genuinely seeking help are denied admission because of resource constraints and the Program's unwillingness to terminate the chronic relapsers.

In Recommendation #58, the Monitor stated that DMQ must adopt meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse. In Recommendation #62, the Monitor suggested that DMQ establish enforceable standards and consistent expectations of Diversion Program participants and staff through legislation or the rulemaking process, and oversee a complete revision of the *Diversion Program Manual*.

On its own, staff was not able to address these recommendations unilaterally other than to commence an overhaul of the *Diversion Program Manual* — that project is under way. The redrafted manual must be reviewed by MBC's legal counsel, the Diversion Committee, and DMQ. During 2006, the Diversion Committee and DMQ must address the fundamental policy issues listed in Chapter XV.C. below.

As noted above, SB 231 did not amend substantive law governing the Diversion Program. However, the bill sunsets the whole program effective July 1, 2008, thus requiring the Legislature to pass and the Governor to sign extension legislation in 2007. For inclusion in that extension legislation, the Diversion Committee and DMQ should submit any substantive policies they have developed — for example, meaningful criteria for termination from the Program; and/or a Penal Code section 1000-type mechanism applicable to Board-ordered and Board-referred participants, which may excise repeat offenders from the Program and result in the revocation of their license without further procedure.³³¹

3. Contrary to statute, the Division of Medical Quality has never taken “ownership” of or responsibility for the Diversion Program.

State law requires DMQ to administer the Diversion Program and oversee its functioning.³³² However, the Auditor General reports during the 1980s universally found that the Division has failed

³³¹ See *Initial Report*, *supra* note 13, at 288; see *supra* Chapter XV.C. below.

³³² Bus. & Prof. Code § 2346.

to adequately supervise and oversee the Diversion Program.³³³ The 1985 report could not be more clear: “The diversion program of the Board of Medical Quality Assurance does not protect the public while it rehabilitates physicians who suffer from alcoholism or drug abuse. . . . The medical board has allowed these problems to develop because it has not adequately supervised the diversion program.”³³⁴

One of the reasons for DMQ’s failure to adequately oversee the Diversion Program lies in MBC’s 1982 creation of the “Liaison Committee to the Diversion Program” (LCD) — a committee which has no statutory existence or authority but was formed and funded by the California Medical Association (CMA), the California Society of Addiction Medicine (CSAM), and (recently) the California Psychiatric Association (CPA). As described in the *Initial Report*,³³⁵ the LCD consists of the chairperson of each DEC and representatives from CMA, CSAM, CPA, and MBC. Although the LCD was intended to be an advisory body that could offer clinical expertise on addiction issues to DMQ and MBC staff who administer the Diversion Program, over the years it has been delegated responsibility for or has inserted itself into operational, legal, and other issues that do not require clinical expertise. In the past, staff of the Diversion Program has interpreted Liaison Committee directives and recommendations as orders, and has implemented them without DMQ or Diversion Committee review.³³⁶ More recently, MBC has created a standing Diversion Committee which has attempted to oversee the Program and its functioning, but that Committee has inherited the existence of the Liaison Committee and has not always been willing or able to carve out its own role.

³³³ See 1982 Auditor General Report, *supra* note 315, at 36 (“the board has not established policies governing frequency of contact with participants”), 40 (“the board has not established policies for approving and monitoring supervised, structured environments for Diversion Program participants”), 43 (the board has failed to establish “standards and guidelines for terminating participants”). See also 1986 Auditor General Report, *supra* note 315, at 21 (“[t]he Board of Medical Quality Assurance has improved some elements of its diversion program for physicians; however, further improvement is needed. . . . [T]he board still does not routinely monitor physicians in the diversion program adequately”).

³³⁴ See 1985 Auditor General Report, *supra* note 315, at 29.

³³⁵ *Initial Report*, *supra* note 13, at 247.

³³⁶ In 1999 documents, the Liaison Committee noted that it had engaged in numerous activities and made many recommendations regarding the functioning of the Diversion Program over the prior five years. Those activities include a report and recommendation on the Program’s urine testing program (Oct. 16, 1998); a recommendation on elements which should be included in the clinical evaluations of physicians applying for or participating in the Program (Feb. 25, 1998); a report specifying the role and responsibilities of the DEC member who is serving as a case consultant, plus two measures for identifying whether a case consultant is carrying out the intended function (Aug. 21, 1996); and the adoption of a policy in 1994 requiring group facilitators to maintain a current file on each participant. Liaison Committee to the Medical Board’s Diversion Program, *Testimony before the Medical Board’s Diversion Task Force* (Jan. 20, 1999) (on file at CPIL); see also Liaison Committee to the Medical Board’s Diversion Program, *Agenda Packet for May 27, 1998 Meeting* (Agenda Item V.F. regarding Facilitator Records) (on file at CPIL). None of these recommendations were ever discussed, reviewed, or ratified by DMQ at any public meeting.

In Recommendation #59, the Monitor urged DMQ to reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it currently exists. The Monitor noted that the Liaison Committee has evolved into an unwieldy 19-member committee whose members have not been chosen by DMQ, whose purpose is unclear, and whose output is modest and excessively delayed. In the view of the Monitor, DMQ and the Diversion Committee should determine whether there is a need for external clinical expertise and — if so — convert the Liaison Committee into a workable advisory panel that both serves the needs of DMQ (as determined by DMQ) and makes the very best use of the skills, expertise, and time of Liaison Committee members.

In response, MBC President Ronald Wender, M.D., has appointed a new Diversion Committee headed by DMQ member Martin Greenberg, Ph.D. Dr. Greenberg and the Committee are actively reconsidering the purpose and role of the Liaison Committee, and ways in which volunteer addiction professionals can best provide input to the Program on issues that require clinical expertise. This issue will be discussed at the Committee's November 2005 meeting and at a special meeting of the Diversion Committee to be scheduled in late 2005 or early 2006.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC management.

As described in the *Initial Report* and briefly in Chapter V above, the management of the Diversion Program is not well-integrated into overall MBC management. For many years, the Medical Board — both the Board and its staff — has permitted Diversion to effectively function in a vacuum. Considering the current confidentiality under which the Diversion Program operates, it is not unreasonable that the identities of self-referred Diversion Program participants be concealed from the enforcement program and from MBC management. However, the entire operation of the Diversion Program has been walled off from the rest of MBC management. In the Monitor's view, this separation resulted in the breakdowns in overall Diversion Program functioning and in the key monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which were not communicated to MBC management so they might be addressed. In Recommendation #62, the Monitor suggested that MBC more effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management — especially concerning Board-ordered and Board-referred participants who are participating in Diversion in lieu of being disciplined.

MBC has responded to this recommendation positively. As noted above, it has hired a new program administrator who has extensive experience in both enforcement and impairment programs; he has presented training programs to MBC investigators regarding the Diversion Program, and has met with all of MBC's supervising investigators to advise them of changes to the Diversion Program.

Both the new program administrator and the new case manager supervisor have been actively interacting with MBC's enforcement program and its probation monitors with respect to Board-ordered and Board-referred participants. Board-ordered participants are required to sign a release authorizing Diversion to communicate with Probation (and vice versa) concerning their progress or lack thereof. Diversion Program case managers now contact probation monitors any time a Board-ordered participant is ordered to cease practice. According to Diversion Program officials, there is increased dialogue among MBC's diversion, enforcement, and probation programs concerning these participants. Further, and as described above, the new program administrator has moved the Diversion Program's case managers from their home offices into Medical Board district offices. The CMs now function from MBC offices, where they can access the DTS and interact with MBC investigators. Finally, the Diversion Program is actively working to revamp the obsolete *Diversion Program Manual* — a key management function that was ignored for many years.

5. The Program's claim of a "74% success rate" is misleading.

In the *Initial Report*, the Monitor noted that the Diversion Program periodically calculates the total number of admissions into the Program, the total number of "successful completions," and the total number of "unsuccessful terminations." Based on this calculation, the Program advertises a "success rate."³³⁷ This is misleading. The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Program has no idea whether it is successful in rehabilitating physicians over the long term. At the very least, such a "success rate" claim should not be made without fully explaining its meaning.

The Monitor also noted another oft-repeated statement made by former Program staff, former Diversion Committee members, and Liaison Committee members to the effect that "no patient has ever been injured by a physician in the Diversion Program."³³⁸ This is similarly misleading and probably untrue. Injury to patients is not the type of information that participants would ever volunteer or that the Program generally captures or publicizes. The *Initial Report* identifies at least

³³⁷ For example, in its March 2000 brochure, the Program announced that "[f]rom the inception of the Diversion Program in 1980 to March 1, 2000, there have been 981 participants. Six hundred sixty-three (663) of these have completed the program successfully. After factoring out physicians who did not complete for reasons unrelated to their disorders, this results in a 74 percent success rate."

³³⁸ In fact, the Liaison Committee has included this very statement in a September 2005 report accompanying the minutes of its October 6, 2005 meeting. Liaison Committee members have no access to Diversion Program participant files and have no idea what is in them or not in them. While the Diversion Program itself cannot be expected to publicize information on patient harm caused by a participant, the news media has. See, e.g., David Washburn and David Hasemyer, *Substance Abuse Program Criticized as Full of Loopholes*, S.D. UNION-TRIB., Mar. 11, 2002.

one case in which a Program participant injured a patient.³³⁹ And, as the Monitor testified to the Joint Legislative Sunset Review Committee in January 2005, the Monitor team's research of participant files revealed at least five additional cases where Diversion Program participants who were permitted to practice medicine were caught using drugs while on duty by their employers. In most of these cases, the participants had stolen or diverted narcotics at their workplace, used while on duty, and tested positive while on duty in a test administered by their employers. Most disturbingly, the statements of these participants to their employers after the detection — which were reported to the Diversion Program not by the participants but by their employers — revealed that they had been using while practicing medicine for a period of months. Yet none of the Diversion Program's monitoring mechanisms detected their relapse. These cases illustrate the severe degree of risk and endangerment to which patients are exposed when the monitoring mechanisms of the Diversion Program fail.

The current management and staff of the Diversion Program have ceased making either claim. Although no concrete plans have been developed, staff is discussing the possibility of arranging for an external long-term study of both “successfully terminated” and “unsuccessfully terminated” Diversion Program participants in an attempt to determine whether the Program is effective in assisting physicians to recover from addiction. Obviously, the Program would need the consent of its participants to pursue such a study. However, such an assessment would provide invaluable information and enable informed decisionmaking to guide future Diversion program structure and operations.

C. Recommendations for the Future

Within a short time period and under severe budget constraints, MBC management has added staff and made other enhancements to the Diversion Program that have significantly improved its operations. Part of the fee increase in SB 231 (Figueroa) is earmarked for additional Program staffing, which is necessary in order to lower caseloads and further improve the Program's monitoring of its participants.

In the *Initial Report*, the Monitor presented some fundamental threshold issues for consideration by MBC. The Monitor suggested in Recommendation #56 that MBC reevaluate whether the “diversion” concept is feasible, possible, and consistent with the Medical Board's “paramount” public protection priority. If the Board concludes that the concept is feasible, the Monitor suggested in Recommendation #57 that MBC then determine whether to house the diversion program within the Medical Board or contract it out to a private entity, as do the vast majority of

³³⁹ See *Initial Report*, *supra* note 13, at 277 (self-referred participant relapsed several times during August and September of 2003 and “overmedicated a patient [and] was observed carrying unnecessary medications on his cart”).

other state medical boards and California boards with licensee impairment programs. Neither of these threshold issues were directly addressed by MBC during 2005. However, the Board has created a mechanism — a new Diversion Committee — to consider the other policy issues raised by the Monitor and listed below. SB 231’s July 1, 2008 sunset date on the Diversion Program should serve as an incentive for the Committee and DMQ to fully and finally resolve these significant and longstanding policy issues:

1. Whether Diversion Program participation should be an “entitlement” for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Program (Monitor’s *Initial Report Recommendation #60*).
2. Whether the Diversion Program should charge participants who are practicing medicine participation fees to cover part of the overhead of the Program — as several other agencies do (Monitor’s *Initial Report Recommendation #60* and discussion at page 241, note 390).
3. Development of meaningful “worksite monitor” and “hospital monitor” standards, criteria, and requirements (*Initial Report* discussion at pages 267–69).
4. Development of meaningful consequences for relapse, including a review of the Relapse Referral Matrix contained in the *Diversion Program Manual*. The matrix should be restated and adopted as policy or regulations to provide consistent guidance to the DEC’s and Program staff (*Initial Report Recommendation #58* and discussion at pages 245, 275–77).
5. Consideration of the establishment of consistent criteria for termination from the Diversion Program (for example, “three strikes and you’re out”) (*Initial Report Recommendation #62* and discussion at pages 274–80).
6. Consideration of the establishment of a mechanism that not only terminates Diversion Program participation but also revokes the license of Board-ordered and Board-referred “repeated-bite-of-the-apple” participants who have been admitted to the Program, terminated for noncompliance, readmitted to the Program, terminated for noncompliance, etc. (*Initial Report Recommendation #62* and discussion at pages 277–80).
 - a. For example, use of a Penal Code section 1000-type mechanism where a repeat offender is required, upon his second or third admission to the Diversion Program, to sign a stipulated surrender of his license which is then filed while he is participating in Diversion. If he violates his contract, that stipulation is resurrected and not only is he terminated from the Program but his license is revoked without further proceedings.

- b. As an alternative, MBC should develop standards for the filing of a petition to revoke probation and revoke the license of a Board-ordered participant after X number of relapses while in the Program. This would take more time and require additional procedures that are avoided in 6(a) above.
7. Review and evaluation of the appropriate role, purpose, and structure of the Liaison Committee to the Diversion Program (*Initial Report* Recommendation #59 and discussion at pages 280–81).
8. Protocols for the Diversion Program's communication with MBC's enforcement and probation programs on participants who are Board-ordered and/or Board-referred. There should be a greater level of communication between Diversion and enforcement on these participants, who are participating in Diversion in lieu of enforcement.
9. The categories of information that should be included in "quarterly quality review" (QQR) reports from Program staff to Diversion Committee members that would enable the Committee to responsibly oversee the functioning of the Program as required by law.
10. A review of the role and duty statements of the Program's group facilitators. Most GFs are licensed therapists of some sort, and they are functioning as therapists. The program must ensure that GF duty statements require appropriate licensure or certification, and that GFs comply with all laws regulating their practice.
11. Regulations establishing qualifications and criteria for "evaluating physicians" who perform initial multidisciplinary physical and mental examinations on participants as they enter the Program. Since 1981, DMQ has been required to adopt regulations codifying these criteria, but the current regulation (section 1357.3, Title 16 of the California Code of Regulations) is meaningless. This issue was delegated to the Liaison Committee in 2000, but that Committee has never presented alternative standards (*Initial Report* discussion at pages 279–80 and notes 398 and 473).
12. Regulations governing competency examinations for Diversion Program participants. This option was added in SB 1950 (Figueroa) in 2002, and the statute requires rulemaking by the Division of Medical Quality. The Diversion Committee delegated this issue to the Liaison Committee in 2003, which produced draft standards for the conduct of a competency exam allowing Diversion Program participants three chances to pass a basic clinical competency exam in May 2004. The Diversion Committee chair returned those draft standards to the Liaison Committee for more work, but no revised standards have ever been produced (*Initial Report* discussion at note 460).

13. Consideration whether there should be a mandatory “practice cessation” period for participants upon entry into the Diversion Program (as the Board of Registered Nursing requires). In practice, this happens in many cases because the physician immediately enters treatment upon entry into the Program. However, should it be a requirement? At least a presumption? (*Initial Report Recommendation #62*).

14. Whether MBC's Diversion Program is equipped — either now or in the future — to handle singly-diagnosed mentally ill physicians, as required by SB 1950 in 2002 (*Initial Report discussion on page 253*).

Chapter XVI

OTHER AREAS OF MONITOR INQUIRY

During the first year of the MBC Enforcement Monitor project, the Monitor was unable to examine several components of MBC's enforcement program that deserve mention. These "back end" components of the enforcement program include the Board's citation and fine program, its Probation Unit, and the Physician Assessment and Clinical Education (PACE) program at the University of California San Diego School of Medicine.

A. MBC's Citation and Fine Program

Business and Professions Code section 125.9 authorizes MBC to implement, by regulation, a system for the issuance of citations, fines, and orders of abatement for minor or technical violations of the Medical Practice Act or the Board's regulations.

The citation and fine remedy generally. Enacted in 1986, the purpose of the citation and fine remedy was to "bridge the gap" between the two sanctions then available to most occupational licensing boards to address violations of statute or regulation by their licensees: (1) institution of the full-blown and costly (to both board and licensee) adjudicative proceeding under the Administrative Procedure Act (APA) described in the first twelve chapters of this report—complete with filed accusation, representation of the board by the Attorney General's Office, evidentiary hearing by an administrative law judge (ALJ) from the Office of Administrative Hearings, board review of the resulting ALJ proposed decision, board adoption of a final disciplinary decision, and judicial review of the board's decision; and (2) nothing. At that time, most boards had no "intermediate remedies" enabling them to deal with violations of statute or regulation which are not serious enough to merit a full-blown adjudicatory proceeding, but should not be ignored and/or addressed via a private "slap on the hand" which is never thereafter tracked by the licensing board. The citation and fine remedy was the first of those "intermediate remedies" to be enacted and authorized, and was intended to be a relatively quick and decisive alternative to the lengthy disciplinary process in situations where the violation is technical or minor in nature.

As enacted in 1986, section 125.9(a) authorizes most DCA boards to issue a “citation which may contain an order of abatement or an order to pay an administrative fine . . . where the licensee is in violation of the applicable licensing act or any regulation adopted pursuant thereto.” Section 125.9(b) requires agencies to adopt regulations setting forth the precise procedure they will utilize in issuing citations and fines. The procedure must afford any cited licensee a written citation which describes “with particularity” the nature of the violation. Further, the procedure must include an opportunity for the cited licensee to request a full hearing pursuant to the APA. Any licensee who avails him/herself of this right is entitled not only to a hearing before an ALJ, but also to board review of the ALJ’s proposed decision and court review of the board’s decision. As amended in 2003, section 125.9(b)(3) permits agencies to accompany a citation with a fine not to exceed \$5,000 per violation; in assessing the amount of any fine, consideration must be given to specifically-identified criteria (including the gravity of the violation, the good faith of the licensee, and the history of previous violations).

MBC’s implementation of the citation and fine remedy. As noted in the *Initial Report*, MBC did not implement its citation and fine authority until 1994.³⁴⁰ At that time, MBC adopted section 1364.10 *et seq.*, Title 16 of the California Code of Regulations. Of import, section 1364.10 permits a “board official”³⁴¹ to determine when and against whom a citation should be issued, and to issue citations including orders of abatement and fines. Section 1364.11 identifies statutory and regulatory provisions whose violation may justify the issuance of a citation, fine, and/or order of abatement.³⁴²

Section 1364.14 sets forth the procedure for challenging a citation. In addition to the “process” required by the statute, the regulation allows a cited licensee to request, within ten days after service of the citation, an informal conference with the board official who issued the citation. If the physician requests an informal conference, the board official must schedule one within 30 days of the request. At the conclusion of the informal conference, the board official may affirm, modify, or dismiss the citation, including any fine levied or order of abatement issued. Within ten days after the informal conference, the board official must “state in writing the reasons for his or her action and serve or mail a copy of his or her findings to the person cited. . . . This decision shall be deemed to

³⁴⁰ *Initial Report*, *supra* note 13, at 37.

³⁴¹ The term “board official” is defined to include the chief, deputy chief, or supervising investigator II of the Board’s enforcement program, and the Board’s chief of licensing. 16 CAL. CODE REGS. § 1364.10(a).

³⁴² At this time, MBC is in the process of amending section 1364.11 to include several additional provisions whose violation will justify the imposition of a citation and fine. The Board also intends to implement SB 362 (Figueroa) (Chapter 788, Statutes of 2003), which increased the statutory ceiling on fines from \$2,500 to \$5,000 per violation. MBC’s proposed amendments to section 1364.11 would permit it to impose a \$5,000 fine where the cited person has received two or more prior citations for the same or similar violations, or where the citation involves multiple violations that demonstrate a willful disregard for the law.

be a final order with regard to the citation issued, including the fine levied and the order of abatement.”³⁴³ Thus, the Board’s implementation of section 125.9 affords the licensee four levels of procedural due process protection — informal conference, ALJ hearing, DMQ review of ALJ decision, and court review of DMQ’s decision — both as to sanction generally and as to the degree of sanction.

2004 changes to MBC’s processing of citation and fine cases. In May 2004, the California Medical Association complained to MBC that two physicians had recently been issued citations without ever having been contacted prior to their issuance. At about the same time, MBC’s handling of citation and fine cases changed significantly — largely as a result of the assignment of a deputy attorney general and a supervising investigator to the Central Complaint Unit. As described briefly in the *Initial Report*,³⁴⁴ these individuals examined MBC’s citation and fine program and prompted several important policy changes that have since been codified in MBC’s various procedure manuals.³⁴⁵

Cases in which the citation and fine remedy is appropriate may be identified by the Central Complaint Unit or by MBC district offices during investigation. MBC’s procedure manuals now clarify that, in either case, a citation will not be issued unless staff has first contacted the subject physician for information, an explanation, and an attempted resolution.³⁴⁶ In practice, MBC’s goal is to encourage compliance with the law. Complaints warranting a citation and fine — such as a complaint about misleading advertising, a physician’s failure to distribute a statutorily-required brochure to a patient, or inadequate medical recordkeeping — can be and often are resolved before a citation is issued. If a contacted physician responds to MBC and agrees to change his/her behavior, compliance has been achieved and the citation will likely not be issued.

³⁴³ 16 CAL. CODE REGS. § 1364.14(b). If the board official sustains the issuance of the citation, the cited physician has 30 days within which to file a written request for a hearing before an ALJ. Bus. & Prof. Code § 125.9(b)(4).

³⁴⁴ *Initial Report*, *supra* note 13, at 82.

³⁴⁵ The 2004 changes to the way in which citation and fine cases are reviewed are reflected in the Board’s *Citation and Fine Manual*, which was completely rewritten effective September 15, 2005. MBC’s handling of citation and fine cases identified in the Central Complaint Unit is additionally governed by section 8.5 of the *CCU Procedure Manual* (newly added as of January 30, 2005); citation and fine cases identified in MBC’s field offices are governed by section 9.3 of its *Enforcement Operations Manual*, which was revised in October 2004.

³⁴⁶ *CCU Procedure Manual* § 8.5. The only exception to this notice requirement is in cases where MBC cannot locate the physician because he/she has not notified MBC of a change to his/her address of record; in those cases, the physician will be issued a citation (not a fine) for failure to notify the Board of the address change as required by law (a so-called “change of address citation”).

If the physician disputes the matter or has been the subject of similar complaints and cited/fined for similar conduct in the past, MBC will proceed with the citation and fine remedy. A citation and fine case identified in the Central Complaint Unit is first reviewed by the appropriate CCU manager (depending on whether the underlying case is a quality of care case or a physician conduct case). If the manager agrees that the citation and fine remedy is appropriate, the file is referred to the supervising investigator and the deputy attorney general assigned to CCU; they review the file to determine whether it includes sufficient evidence of the violation (including documentation of MBC’s written contact with the physician and the physician’s response, if any). If so, the matter is transferred to the Board’s citation and fine analyst, who prepares the citation for signature by the Board’s enforcement chief — who again reviews the file for sufficiency of the evidence and actually “issues” the citation by signing it. Citation and fine cases identified in MBC’s field offices undergo similar review: The district office investigator prepares an investigative report recommending a citation, which must be reviewed and approved by the office’s supervising investigator and the DIDO DAG assigned to the office — at which point the matter is referred to the citation and fine program analyst and then the enforcement chief.

Exhibit XVI-A below reflects MBC’s recent citation and fine activity, and indicates a significant decline in the number of citations and fines issued in recent years. MBC insists that it is utilizing the citation and fine remedy judiciously, and mostly in an attempt to educate physicians about their legal responsibilities and encourage compliance with the law. The numbers appear consistent with this claim. The vast majority of citations issued over past three years are citations (with no fines) for failure to notify the Board of a change of address. Many (if not most) citations are withdrawn when compliance is achieved — including change of address citations (which are withdrawn without the necessity of an informal conference once the physician submits updated address of record information). During 2004–05, CCU issued 59 advisory and educational letters (40 of which were in quality of care cases) to physicians in lieu of citations and fines — which accounts (in part) for the dramatic decrease in the number of citations issued in 2004–05.

Ex. XVI-A. Citation and Fine Activity

	FY 2002–03	FY 2003–04	FY 2004–05
Total citations/fines issued	532	423	307
Change of address citations	340	327	248
Other citations without fines	1	0	1
Citations with fines	191	96	58
Total fines ordered	\$49.7 million	\$3.4 million	\$152,100
Total fines collected	\$83,120	\$76,770	\$36,900
Informal conferences requested	91	56	30
Citations/fines withdrawn	174	144	75
ALJ hearings requested	6	3	0

Source: Medical Board of California

Thus, MBC has addressed CMA's complaint. Under current Board policy, MBC must contact any physician against whom a citation/fine is being contemplated and seek information. Further, in many cases where MBC chooses to proceed with a citation/fine, it notifies the physician in writing that a citation will be issued within ten days³⁴⁷ — thus affording the licensee another chance to make contact with the agency and resolve the matter. As noted above, any citation that is issued to a physician includes a notice that the physician may, within ten days of the issuance, request an informal conference with the board official who issued the citation. These informal conferences provide another opportunity for MBC and the physician to communicate about the violation, and for MBC to suggest remedial continuing education courses which would provide information regarding the violation to the physician. If the physician agrees to take the course or otherwise change his/her behavior as a result of the informal conference, the board official may withdraw the citation.

Public disclosure of citations and fines. Citations are not considered “disciplinary actions” because they have not been issued by the Division of Medical Quality.³⁴⁸ However, citations are public information, and are required to be posted on MBC's Web site.³⁴⁹ Pursuant to Board regulation,³⁵⁰ citations and fines are posted for a period of five years from the date of resolution, and then are purged; a citation that has been withdrawn or dismissed is purged immediately upon being withdrawn or dismissed.

In its May 2004 complaint, CMA also questioned the fairness of MBC's posting of citations on its Web site upon issuance, before the physician has had an opportunity to request and participate in the informal conference and the “full due process hearing” before the ALJ. This issue presents a closer question. MBC is authorized to “issue” citations,³⁵¹ and it is required to post them when they are “imposed.”³⁵² Although CMA argues that there is a clear difference between “issued” and “imposed,” the Monitor is not convinced.

The bottom line is that citations/fines are not disciplinary actions and physicians are given several opportunities to resolve them before they are issued. The Board's longtime practice has been

³⁴⁷ *CCU Procedure Manual* § 8.5 at 2–3.

³⁴⁸ However, failure to comply with an order of abatement or to pay a fine may result in formal disciplinary action.

³⁴⁹ Business and Professions Code section 2027(a)(8) requires MBC to post “[a]ny information required to be disclosed pursuant to Section 803.1,” and section 803.1(a)(5) requires MBC to post “[i]nfractions, citations, or fines imposed.”

³⁵⁰ 16 CAL. CODE REGS. § 1364.15.

³⁵¹ Bus. & Prof. Code § 125.9.

³⁵² *Id.* § 803.1(a)(5).

to warn first and cite later (for ignorance of the warning and repetition of the violation). During 2004–05, the Board has established a clear record of utilizing educational letters in lieu of citations/fines, such that most citations now being issued are either for repeated violations or for uncontested failure to notify the Board of a change of address (which would be of no concern to reasonable consumers). MBC’s 2004 policy changes assure that physicians received notice at least once (if not twice) before any citation is either “issued” or “imposed,” such that physicians have an opportunity to talk or meet with board officials and resolve the matter. The Board’s new investigator/attorney review procedures ensure that MBC staff has gathered sufficient evidence (including the Board’s written contact with the physician and the physician’s response) to support issuance of a citation. According to the Board’s enforcement chief, the Web posting upon “issuance” is the only event that attracts the attention of some physicians and enables MBC and its medical consultants to insist on coursework as a condition of withdrawing the citation. The Monitor is informed that MBC representatives met with CMA in March 2005 and offered to institute a procedure whereby MBC will formally notify all physicians ten days in advance of “issuance” and posting that they are about to be cited — in a last attempt to elicit information and cooperation from the physician; according to MBC, CMA has not responded to that offer. In light of all the above, the Monitor finds that offer reasonable and is not prepared to recommend other changes in MBC’s practice regarding the posting of citations upon their “issuance.”

B. MBC’s Probation Unit

Business and Professions Code sections 2227(a)(3) and 2228 authorize DMQ to place the license of a physician on probation subject to specified terms and conditions. In its 2003 disciplinary guidelines, DMQ has identified approximately 35 standard and optional terms and conditions of probation that it may include in a disciplinary order depending on the circumstances of the case. Through probation, DMQ may restrict a license (for example, it may prohibit a physician from prescribing certain types of controlled substances, practicing without a third-party chaperone, or engaging in solo practice) or condition continued practice on participation in the Board’s Diversion Program for substance-abusing licensees; require a physician to take and pass a professional competency exam, psychiatric examination, ethics and/or other continuing education courses, or to undergo psychotherapy or other medical evaluation and treatment; and/or require participation in the Physician Assessment and Clinical Education (PACE) program (see below).

Since 1992, MBC has maintained a centralized Probation Unit whose purpose is to protect the public by ensuring that any physician whose license has been placed on probation complies with the terms and conditions imposed in the probationary order. Under the direction of a deputy chief of enforcement and headed by a supervising investigator II, MBC’s Probation Unit includes offices in Sacramento, Rancho Cucamonga, and Cerritos. Each regional office is headed by a supervising investigator I. Overall, the unit currently includes 14 sworn peace officer probation investigators,

two investigative assistants, and three retired annuitants.³⁵³ The Unit’s investigators monitor an assigned caseload of probationers to ensure that imposed probationary terms and conditions are met; additionally, they investigate new complaints filed against one of their assigned probationers.³⁵⁴

When a physician’s license is put on probation, the assigned probation investigator conducts an intake interview with the physician to secure his signature on various acknowledgment forms and to explain each term and condition of probation to ensure that the physician understands DMQ’s expectations. Thereafter, the probation investigator is expected to meet with the probationer at least quarterly; these visits may be scheduled or unannounced. Probation investigators may also meet with any required practice monitor of the probationer, and must generally ensure that the probationer is fulfilling all required terms and conditions of the probationary order. On a quarterly basis, each probation investigator submits a report on each probationer in his/her caseload to the supervising investigator, and that supervisor records completed probation reports and other events (such as the completion of required educational courses or the passage of competency exams) in MBC’s CAS computer system.

Effective January 1, 1996, SB 609 (Rosenthal) (Chapter 708, Statutes of 1995) amended Business and Professions Code section 2227(a)(3) to permit the Board to recoup the costs of its probation monitoring from probationers. Since then, MBC has imposed an annual probation monitoring fee on probationers (which is currently \$3,173 per year); in 2004–05, MBC ordered the payment of \$922,540 and actually collected \$838,626 in cost reimbursements from its probationers.

Ex. XVI-B. Probation Unit Activity

	FY 2001–02	FY 2002–03	FY 2003–04	FY 2004–05
Number of in-state probationers	498	516	547	545
Probation violations referred to AG	27	12	34	32
Petition to revoke probation filed	21	18	26	26

Source: Medical Board of California

Exhibit XVI-B above reflects recent Probation Unit activity. At any given time during the past four fiscal years, the Probation Unit has monitored approximately 526 probationers. Probation investigators carry an average caseload of 40 probationers, plus an additional five investigations of

³⁵³ Prior to 2001, the Probation Unit included 17 sworn investigators; three investigator positions were lost in the hiring freeze. Additionally, the supervising investigator II position and two of the supervising investigator I positions were lost for several years, but have now been reinstated.

³⁵⁴ In addition to monitoring disciplined physicians, Probation Unit investigators may monitor physicians who have been granted a probationary license by MBC’s Division of Licensing; occasionally, they also investigate new “overflow” complaints and reports of physician misconduct.

new complaints against existing probationers; these high caseloads sometimes preclude quarterly in-person meetings between probationer and probation investigator. Collectively, the Probation Unit refers an average of 26 probation violations to HQE, and HQE files an average of 23 petitions to revoke probation every year. According to MBC, HQE DAGs have traditionally been hesitant to file petitions to revoke probation for relatively minor noncompliance with probationary terms; however, MBC has had no other remedy to address that noncompliance. To fill that loophole, MBC is in the process of amending its citation and fine regulations to authorize it to utilize that sanction to address probation violations that do not warrant a petition to revoke probation.³⁵⁵

C. The Physician Assessment and Clinical Education Program

When inserted into a formal disciplinary order, optional condition #19 of DMQ’s disciplinary guidelines requires a respondent physician to “enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education (PACE) Program at the University of California San Diego School of Medicine.”

Founded in 1996 by UCSD Professor of Clinical Family Medicine William A. Norcross, M.D., the PACE program offers a relatively unique service — it provides clinical competency assessment for physicians and delivers remedial education for detected deficiencies in the core clinical competency areas identified by the American Council on Graduate Medical Education (ACGME).³⁵⁶ Although the staff of the PACE program is relatively small, it is able to call upon the full resources of the UCSD School of Medicine — including 40–50 physicians who are board-certified and experienced in all medical specialties and subspecialties — to assist in the assessment, evaluation, and remedial education of program participants. PACE is the oldest and most experienced program of its kind — and one of very few — in the nation. Having observed Dr. Norcross make numerous presentations to DMQ about PACE since its inception, the Monitor knows that PACE has continuously evolved and enhanced its services to meet the needs of the Medical Board of California and other medical boards whose licensees it assesses.

Currently, the basic PACE program consists of two phases. Phase I involves a comprehensive assessment of the physician participant and his/her clinical skills which is tailored to the specialty in which the participant practices. Phase I includes a complete history and physical

³⁵⁵ Specifically, MBC is in the process of amending section 1364.11, Title 16 of the California Code of Regulations, to add new subsection (b), which will state: “In his or her discretion, a board official may issue a citation under Section 1364.10 to a licensee for a violation of a term or condition contained in the decision placing that licensee on probation.”

³⁵⁶ The six core clinical competencies identified by the ACGME are (1) patient care, (2) medical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism, and (6) systems-based practice.

examination of the participant, and completion of several questionnaires and “self-report” forms by the participant which are designed to elicit information regarding personal health behaviors, educational and training experiences, habits of continuing professional development, and medical practice history. The participant must undergo a computerized neurocognitive examination (which is normed for physicians by age so as to be able to detect early dementia); a one-hour clinical examination in the participant’s specialty that is administered by a PACE faculty member in the same specialty; a number of computerized patient simulation/patient management scenarios, with a subsequent review of the participant’s thought processes by a PACE faculty member; and several standardized post-licensure examinations created by the National Board of Medical Examiners (which has authorized PACE to administer them). Additionally, during Phase I, a PACE faculty member in the participant’s specialty performs a chart review of a random sample of the redacted medical records of patients personally treated by the participant; and the participant is required to perform a complete history and physical on a patient (one of the PACE staff), which is videotaped and later evaluated by a PACE faculty member.³⁵⁷

At the completion of Phase I, PACE holds a multidisciplinary staff meeting to discuss the results of all aspects of the assessment.³⁵⁸ The results of Phase I, along with recommendations by PACE staff, are communicated to a PACE faculty member for incorporation into Phase II — a five-day clinical education program onsite at the UCSD Medical Center. While PACE participants do not have direct responsibility for patient care, they are integrated into the full spectrum of specialty-specific educational opportunities offered at a busy academic health center teaching service. Under the guidance of a PACE faculty mentor, these opportunities typically include outpatient clinics, inpatient ward rounds, grand rounds and other conferences, and observation of procedures. To the greatest extent possible, PACE customizes Phase II to the results of the Phase I assessment, the

³⁵⁷ In October 2004, PACE added a so-called “360-degree assessment” tool to Phase I. This tool, whose use is required in Canada, requires the physician participant to identify eight physician colleagues and eight non-physician staff colleagues, all of whom are surveyed about the participant and his/her clinical skills; additionally 25 randomly-selected patients of the physician complete questionnaires about the participant. The surveys are completed anonymously and returned to a third-party entity which compiles the data and creates an initial report flagging perceived deficiencies and identifying strengths. Six months after completion of Phase II remedial education and training, the eight physician colleagues, eight non-physician staff colleagues, and 25 other patients of the physician are surveyed — so that PACE can evaluate whether Phase II has been effective in addressing deficiencies in the physician’s clinical competencies, and whether the physician has learned and applied that learning to his practice. As noted above, PACE just added this component in October 2004, so it is only now starting to receive summary reports. According to PACE staff, the “360-degree assessment” is not helpful with those who may need it most — physicians who are sole practitioners and who, in the words of Dr. Norcross, are “intellectually and geographically isolated” — because they do not have eight colleagues and eight support staff who have observed their practice and are capable of evaluating them.

³⁵⁸ In August 2005, the Monitor attended one of these staff meetings and witnessed staff’s impressive presentation and discussion of eight cases. Although one staff member took primary responsibility for the oral presentation of each case, all other staff members actively reviewed the results of all Phase I examinations and questionnaires in that case (they were physically distributed around the table for inspection) and quizzed the presenter about the details of the case until all had a complete understanding of the facts and could contribute to the recommendation in the case.

perceived deficiency which has resulted in the physician's referral to PACE, and the instructions of DMQ. Also during Phase II, the participant is required to complete several evidence-based medicine research projects requiring Internet and other research and writing.

At the conclusion of Phase II, the PACE faculty member prepares a report on the participant's performance, which is reviewed by a multidisciplinary group and from which a detailed report is drafted for submission to DMQ. In the report, PACE determines whether the physician has successfully completed the program, as required by the DMQ probation order. Most physicians who have enrolled in PACE have successfully passed the program.

In July 2004, PACE introduced a new Physician Enhancement Program (PEP) which can occur subsequent to completion of Phases I and II. PEP involves an individualized practice review by a PACE faculty member, and can provide a practice monitor where DMQ requires one. The enhanced PEP program involves an initial and annual practice review by a PACE faculty member; monthly chart reviews by PACE physicians who practice in the same specialty as the participant; a "360-degree assessment" if possible; creation of an individualized personal and practice development plan (including suggested coursework); and monthly telephone conversations between the participant and the PACE faculty member. Additionally, PACE has developed and offers courses that are often required by DMQ as a condition of probation, including courses in prescribing, medical recordkeeping, clinician-patient communication, professional boundaries, researching medical literature, and anger management for health care professionals.

Currently, PACE is working with MBC and HQE to tackle a difficult issue — the creation of a program to assess and remediate surgical skills. Still in the development stage, this program may involve computerized simulated surgeries, proctoring/supervision during surgery, audio- and videotaping of surgical procedures, and both a pre- and post-program chart review of the physician's surgical patients. In cooperation with MBC and HQE, PACE is examining complex issues surrounding the creation of a surgical skills assessment program — including patient consent, confidentiality, and liability issues; the cost of such a program; and the criteria that should be considered and applied by DMQ when requiring a physician to complete such a program.

In the Monitor's view, MBC, its licensees, and California patients are fortunate that MBC has ready access to the professionals at PACE and the comprehensive assessment and education programs that PACE has developed in its nine-year existence. Our interviews of PACE, MBC, and HQE staff indicate that PACE management has established an excellent working relationship with HQE and MBC enforcement staff. PACE communicates frequently with MBC enforcement and probation staff about the progress of referred physicians in enrolling and completing PACE requirements, and has worked cooperatively with HQE prosecutors to develop a "template" expert declaration in the event that it determines a physician is incompetent to practice medicine. PACE

has responded constructively to every request and requirement of DMQ, including concerns regarding the length of time it takes physicians to enroll in and complete the program.

It appears that PACE can be counted on to conduct a thorough, respectful, and unbiased assessment of physician clinical competency, and that it is willing — when circumstances require — to testify that a physician is not competent to practice based on its evaluation of that physician. Although optional condition #19 of MBC’s disciplinary guidelines allows a physician to complete PACE or an “equivalent” clinical assessment and education program, not all such programs are created equal. Over the years, several alternative programs have ceased to exist because they were not affiliated with a large institution and lacked the volume of participants needed to make them economically stable. DMQ would be well-advised to ensure that any alternative program claiming to be “equivalent” administers the same comprehensive multilevel assessment techniques and examinations, demands the same depth and breadth of remedial education, and is as responsive to DMQ as PACE has been throughout its existence.

Chapter XVII

CONCLUSION AND RECOMMENDATIONS FOR THE FUTURE

This report concludes the Medical Board of California Enforcement Program Monitor project mandated by SB 1950 (Figueroa) and Business and Professions Code section 2220.1.

This report and the Monitor's November 2004 *Initial Report* have documented the Monitor's analysis of the MBC enforcement program and her efforts to fulfill the statutory mandate to "reform and reengineer . . . the board's enforcement program and operations and . . . improve . . . the overall efficiency of the board's disciplinary system."³⁵⁹

The Monitor finds that major reform of MBC's enforcement program has successfully begun and significant improvements in the efficiency of the Board's disciplinary system have been and are being achieved — all as the result of the collaborative efforts of a broad coalition of stakeholders. Further, the Monitor believes that the long-term prospects for reform and further improvement are excellent.

Faced with daunting challenges in resources, structure, and process, the Medical Board and its enforcement partner, the Health Quality Enforcement Section of the Attorney General's Office, have enthusiastically embraced almost all of the Monitor's 65 recommendations for the reform of this disciplinary program, and the initial fruits of this effort are praiseworthy. Through the combined efforts of the Medical Board, its staff, HQE management and staff, the Legislature, and numerous public and private participants, the following reforms and improvements have been realized:

- MBC will soon benefit from a 30% increase in operating revenues to dramatically boost enforcement program resources.
- The vertical prosecution system, which is the modern paradigm for complex regulatory casework of this kind, will be employed by MBC and HQE staff working together in case teams, starting January 1, 2006.

³⁵⁹ Bus. & Prof. Code § 2220.1(c)(1).

■ MBC’s processes for gathering medical records and obtaining physician interviews — important contributors to overall case processing delays — have been streamlined and strengthened, and these delays are already on the decline.

■ Timely exchange of expert opinions in MBC administrative actions will soon be the rule, increasing informed case evaluation and earlier case disposition.

■ Enforcement operations manuals and training efforts have been extensively updated and enhanced.

■ The Central Complaint Unit’s structure and process have been improved, and overall complaint processing cycles have dropped by 16% already.

■ The Board’s Diversion Program has undergone a dramatic change in management and direction with the stated intent of “reconstructing” the program to better protect the public, and significant operational improvements have been implemented despite continuing resource shortages.

■ The long-overdue study of the peer review process will soon commence, and will hopefully identify ways in which Business and Professions Code section 805 should be amended to guarantee that MBC receives important information about physician incompetence and misconduct.

■ MBC’s program of public disclosure of physician information to improve informed consumer choice has been upgraded and will now be reevaluated by a respected oversight agency.

The matrix below, which summarizes the status of the Monitor’s 65 recommendations, demonstrates that MBC, HQE, and the Legislature have implemented (in whole or in part) or will soon implement 50 of the Monitor’s 65 recommendations, and others are under active consideration.

Monitor Recommendation	Status
1. Reinstate lost enforcement positions	To be implemented: To follow the budget augmentation in SB 231 (§17).
2. Increase license fees	Implemented: SB 231 amends BPC §2435 to increase initial and biennial renewal fees to \$790 (§17); authorize MBC to increase fees to compensate for the loss of cost recovery revenue (§17); and authorize MBC to further increase fees if its investigators are transferred to HQE (§19).

Monitor Recommendation	Status
3. Upgrade management information systems	Partially implemented: MBC is studying MIS improvements with DCA; ProLaw is now in use at HQE; the Diversion Tracking System was overhauled as of July 1, 2005.
4. Update and/or rewrite MBC enforcement manuals; HQE must draft a policy/procedure manual	Partially implemented: Most MBC manuals have been rewritten or updated; an overhaul of the <i>Diversion Manual</i> is under way; HQE and MBC staff are planning a joint operations manual implementing vertical prosecution.
5. Revise CCU statistics; discontinue counting NOI/NPDB/change of address citations as complaints	Implemented: New statistics are reflected in MBC's <i>2004-05 Annual Report</i> .
6. Repeal "notice of intent" filing requirement (Code of Civ. Proc. §364.1)	Implemented: SB 231 (§20).
7. Revise and enforce firm policy on medical records procurement	Implemented: CCU revised its procedure manual to emphasize deadlines on records requests; the average timeframe to receive medical records has been reduced from 66 days to 48 days. SB 231 amends BPC §2225 to permit use of cite/fine authority for medical records violations (§13).
8. Expand role of HQE attorneys in CCU to assist with medical records procurement and mandatory reporting issues	To be implemented: The half-time DAG assigned to CCU has been unavailable since May 2005; DOJ plans to assign a full-time DAG to CCU following the budget augmentation in SB 231 (§17).
9. Revisit implementation of "specialty review" requirement of BPC §2220.08	Implemented: MBC staff developed a protocol for the use of qualified alternative expert reviewers.
10. Amend BPC §2220.08 to exempt from specialty review cases of pending investigation, accusation, probation	Implemented: SB 231 amends §2220.08 to exempt from the specialty review requirement complaints against physicians who are under investigation, the subject of an accusation, or on probation (§12).
11. Stakeholder reconsideration of BPC §2220.05 mandatory case processing priorities	Staff is studying the impact of the priorities statute on process. No consensus yet on the impact or need for change.
12. Seek legislation imposing penalties on insurers/employers for failure to comply with BPC §801/801.1 reporting requirement	No consensus yet; would require legislation.
13. Require physician self-reporting of misdemeanor criminal convictions	Partially Implemented: SB 231 requires self-reporting of substantially-related misdemeanor convictions, once MBC presents and the Legislature enacts a list of such crimes (§5).
14. Educate coroners about reporting requirements of BPC §802.5	Implemented: Information letters were sent to coroners and a presentation was made at the coroners' September 2005 annual conference.

Monitor Recommendation	Status
15. DCA educational program for court clerks regarding importance of compliance with BPC §800 reporting requirements of criminal convictions and civil judgments	To be implemented: DCA drafted an article for publication in Judicial Council newsletter and a “universal reporting form” enabling court clerks to report any DCA licensee. To supplement court clerk reporting, SB 231 amends BPC §802 to require physicians to self-report civil judgments in any amount (§4).
16. Fund peer review study authorized in SB 16 (Figueroa) (2001)	Implemented: SB 231 amends BPC 805.2 to mandate completion of the study by July 1, 2007 (§6).
17. Ban gag clauses in civil settlements involving regulatory agency licensees	AB 446 (Negrete McLeod) would have prohibited regulatory gag clauses in civil settlements. Vetoed.
18. Revisit staffing of CCU sections; cross-train Physician Conduct analysts to handle urgent PC complaints	Implemented: One analyst was transferred from the QC section to the PC section and assigned to handle urgent PC complaints.
19. Institute review of “simple departures” in Physician Conduct cases	Implemented: CCU now audits PC cases closed due to “simple departure” for possible repeated negligent acts.
20. Ensure notification of subject physicians when complaints are closed	Implemented: CCU drafted new closure letters and updated the Web explanation of the enforcement process; MBC revised EOM provisions to require notice of case resolution.
21. CCU should ensure policy/procedure manuals are updated	Implemented: CCU manuals have been and will continue to be revised as changes occur.
22. Implement the vertical prosecution model at MBC and HQE	To be implemented: SB 231 requires a vertical prosecution model featuring joint assignment of a DAG and an investigator at the commencement of the investigation. MBC and HQE are implementing this system in two-staged process. A report is due July 1, 2007; the sunset date is July 1, 2008 (§§8, 24–29).
23. Revise and enforce a firm policy on medical records procurement	Implemented: MBC revised EOM §6.14 to set new deadlines and require personal service of requests for medical records. The average timeframe to receive medical records was reduced from 74 days to 44 days. SB 231 amends BPC §2225 to permit the use of cite/fine authority for medical records violations (§13).
24. Develop and enforce a new policy on physician interviews	Implemented: MBC revised EOM §6.2 to set new deadlines for interviews and require tape-recording.
25. Improve cooperation, relationships, and case referrals to state and local prosecutors	Implementation ongoing: MBC staff participate in CDAA meetings and annual conferences, and engage in outreach to variety of law enforcement agencies.
26. Restore lost investigative resources to provide for special projects and teams	To be implemented: To follow budget augmentation in SB 231 (§17).

Monitor Recommendation	Status
27. Improve and regularize investigator training	Partially implemented: Multiple training programs were provided in 2005; reinstatement of the training supervisor position is anticipated after the SB 231 fee increase.
28. Expand and improve the medical consultant program	To be implemented: Increased medical consultant hours and training are planned after SB 231 fee increase.
29. Improve investigator access to law enforcement information systems	MBC staff is studying available systems and costs; may be implemented after SB 231 fee increase.
30. Require mutual expert witness information exchange well in advance of the hearing	Implemented: SB 231 adds new BPC §2334, which requires parties to exchange written expert information 30 days in advance of the hearing, and provides for OAH rulemaking to implement the procedure (§14).
31. Improve medical expert recruitment and utilization	Implemented: In-person training sessions for expert reviewers were reinstated; additional outreach was targeted to reviewers in needed specialties.
32. Increase expert witness compensation	Under consideration; increased compensation possible with SB 231 fee increase.
33. Implement the vertical prosecution model at MBC and HQE	To be implemented: SB 231 requires a vertical prosecution model featuring joint assignment of a DAG and an investigator at the commencement of the investigation. MBC and HQE are implementing this system in two-staged process. A report is due July 1, 2007; the sunset date is July 1, 2008 (§§8, 24–29).
34. Revise and enforce a firm policy on medical records procurement	Implemented: MBC revised EOM §6.14 to set new deadlines and require personal service of requests for medical records. HQE publicized policy changes and increased enforcement actions. SB 231 amends BPC §2225 to permit the use of cite/fine authority for medical records violations (§13).
35. Restore lost HQE attorney positions	To be implemented: To follow budget augmentation of SB 231 (§17).
36. Increase coordination with state and local prosecutors and use of PC §23 mechanism	Partially implemented: MBC staff meet regularly with local prosecutors via CDAA; PC §23 filings have decreased due to <i>Gray</i> decision.
37. Increased use of ISO and TRO filings	Implemented: MBC/HQE motions for ISO/TRO increased by 50% in 2004–05. The vertical prosecution system required by SB 231 may identify more ISO/TRO matters.
38. Develop an HQE policy and procedure manual	To be implemented: AG staff is reviewing MBC EOM and has begun work on an HQE operations manual for vertical prosecution required by SB 231.

Monitor Recommendation	Status
39. Amend Gov't Code §11508 to limit hearing venue to four major OAH locations in most cases	Implemented: SB 231 amends §11508 to regulate venue and the process for selecting or changing venue (§22).
40. DMQ should engage in public dialogue on the value of DMQ review of proposed decisions and stipulations	Considered by Enforcement Committee in April 2005; deferred.
41. Make use of precedential decision authority under Gov't Code §11425.60	Implementation ongoing: DMQ staff is continuously assessing decisions for potential designation as "precedential."
42. DMQ should address procedural issues relating to requests for stay of effective date of disciplinary actions	MBC staff is clarifying criteria to guide its decisions on motions for stay.
43. Repeal Gov't Code § 11371(c) publication requirement	Implemented: SB 231 repeals §11371(c) (§21).
44. Revise policy to ensure notification of defense counsel when DMQ rejects stipulated settlements	Implemented: §32 of DCU manual was revised to require notice to both counsel when DMQ rejects a stipulation.
45. Amend BPC §2230(b) to reflect the addition of two new members to DMQ	Implemented: SB 1111 revises the statute to reflect correct DMQ panel membership (§27).
46. Amend BPC §2019 to require challenges to MBC disciplinary decisions to be instituted in the forum closest to the location of the administrative hearing	Earlier versions of SB 231 included an amendment to §2019; the final version does not address this issue.
47. Amend Gov't Code §11523 to require petitioner to pay the full cost of a hearing transcript.	Implemented: SB 231 requires petitioner to pay the full cost, but preserves the right of reimbursement and <i>in forma pauperis</i> rights (§23).
48. Revise BPC §§2027 and 803.1 to eliminate redundancies, inconsistencies, and errors in MBC's public disclosure statutes	Partially implemented: SB 231 clarifies MBC authority to post prior disciplinary actions (§11); it also requires the Little Hoover Commission to study public disclosure issues by July 2008 (§10).
49. Disclose medical malpractice settlements exceeding \$30,000	Partially implemented: SB 231 requires the Little Hoover Commission to study public disclosure issues by July 2008 (§10).
50. Disclose all misdemeanor criminal convictions substantially related to MD qualifications, functions, and duties	Partially Implemented: SB 231 requires MBC disclosure of substantially-related misdemeanor convictions, once MBC presents and the Legislature enacts a list of such crimes (§5).
51. Disclose all significant terms and conditions of public probation orders on MBC's Web site	Implemented: A new "enforcement public document search" feature was added to MBC Web site in November 2004; public documents are being added continuously.
52. Amend §2027 to permit MBC to disclose resignation or surrender of privileges following notice of impending peer review investigation	Partially implemented: SB 231 requires the Little Hoover Commission to study public disclosure issues by July 2008 (§10).
53. Require physicians to inform patients about MBC, its jurisdiction, and contact information	No consensus on the need for action.

Monitor Recommendation	Status
54. MBC should notify subject physicians of complaint dispositions	Implemented: MBC revised EOM and CCU manuals to require notice of complaint closure.
55. Educate county medical societies about their obligations under Civil Code §43.96	Implemented: MBC staff contacted county medical societies and reviewed Web sites, and found substantial compliance with the requirement.
56. Reevaluate basic concept of diversion as means of public protection	Implementation deferred until the operational deficiencies of the Diversion Program are addressed; then the Diversion Committee will study longstanding policy issues. SB 231 requests a full performance audit of the Program by July 1, 2007 (§15), and sunsets the Program on July 1, 2008 (§16).
57. Reevaluate whether diversion should be an MBC in-house function or contracted to a private entity	Implementation deferred until the operational deficiencies of the Diversion Program are addressed; then the Diversion Committee will study longstanding policy issues. SB 231 requests a full performance audit of the Program by July 1, 2007 (§15), and sunsets the Program on July 1, 2008 (§16).
58. If the Diversion Program remains with MBC, implement comprehensive overhaul of the program to correct deficiencies	Partially implemented: New Program staff was added and some operational deficiencies have been addressed; the Diversion Committee will study longstanding policy issues. SB 231 requests a full performance audit of the Program by July 1, 2007 (§15), and sunsets the Program on July 1, 2008 (§16).
59. Abolish the Liaison Committee to the Diversion Program as it currently exists and restructure it to meet the needs of the Program and DMQ	Implementation to be considered by Diversion Committee in late 2005/early 2006.
60. Determine if the Diversion Program should be capped at a maximum number of participants that staff can adequately monitor	Implementation deferred until the operational deficiencies of the Diversion Program are addressed; then the Diversion Committee will study longstanding policy issues.
61. Separate the Diversion Program budget and implement means to supplement the budget	Partially implemented: SB 231 requires the Diversion Program Manager to separately account for expenses/revenues of the Program on a quarterly basis (§15).
62. Establish consistent and enforceable standards for participation in and termination from the Program	Implementation deferred until the operational deficiencies of the Diversion Program are addressed; then the Diversion Committee will study longstanding policy issues.
63. Explore methods of assessing long-term Program effectiveness	Implementation deferred until the operational deficiencies of the Diversion Program are addressed; then the Diversion Committee will address longstanding policy issues.
64. Improve or replace the Diversion Tracking System	Implemented: MBC's Information Systems Branch replaced DTS with a new system on July 1, 2005.

Monitor Recommendation	Status
65. Required performance audit of Diversion Program	Partially implemented: SB 231 (§1 intent language) requests the Joint Legislative Audit Committee to assign the Bureau of State Audits to complete a performance audit of the Diversion Program by June 30, 2007.

The Monitor applauds the commitment to improvement and the gratifying efforts to bring about that change by the Medical Board, HQE, the Legislature, and many other stakeholders, as reflected in the matrix above. However, as documented elsewhere in this *Final Report*, a great deal of work remains before the Medical Board's enforcement program fulfills its potential as a model of public protection. At the conclusion of each substantive chapter, this *Final Report* contains recommendations for future consideration and action by MBC, HQE, and the Legislature. Some of the most important recommendations include the following:

- ***Full and immediate access to new enforcement program resources*** should be the Board's highest priority. The 30% fee increase will generate vital new funding for replacement of lost staff, improvements to services and equipment used, and resources otherwise needed to shorten case processing times. Every effort should be made to secure the earliest possible control agency approvals for authorization to use these new resources as they were intended by the Legislature.

- ***Full and effective implementation of the vertical prosecution system***, ultimately resulting in the transfer of MBC's investigators to HQE after 2007 — including the following:

- prompt development of operating protocols and implementation of the case team process mandated by SB 231;
- rapid retraining of MBC and HQE staff in new vertical prosecution procedures;
- drafting and distribution of a jointly-developed operations manual guiding the MBC and HQE staff in the new vertical prosecution process. Development of a single operations manual guiding the joint investigation and prosecution of MBC disciplinary matters is an essential step toward successful implementation of the vertical prosecution system to be used starting January 1, 2006; and
- expanded use of ProLaw by HQE to maximize its ability to effectively manage MBC's caseload, and the earliest feasible shift-over to the ProLaw system by MBC investigators and supervisors to permit the development of a jointly-operated

management information system unifying the data capabilities of the two agencies. An integrated MIS is essential to effective case tracking for the new vertical prosecution system.

■ ***Continued enforcement of the vigorous new “zero tolerance” policies on records procurement and investigative interviews.*** MBC and HQE have begun to establish a new industry norm of prompt cooperation with the lawful demands of the disciplinary program. Using the citation and fine sanction and other tools, this progress can be increased to yield proportional decreases in excessive case cycle times.

■ ***Greater use of expedited disciplinary tools in appropriate cases.*** MBC and HQE should expand their use of ISO/TRO powers, Penal Code section 23 authority, and subpoena enforcement.

■ ***Adequate staffing for HQE, and increased HQE assistance for CCU.*** MBC and HQE must come into compliance with Government Code sections 12529(c) (“[t]he Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions”). MBC and HQE must also comply with Government Code section 12529.5(b) by ensuring that CCU is properly staffed with attorneys “to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.” Both MBC and HQE agree that the assistance of a DAG in CCU is essential to assist not only with complaint disposition review but also with medical records procurement and mandatory reporting issues.

■ ***Improved insurer/employer reporting of malpractice payouts.*** Insurer/employer compliance with the reporting requirements in Business and Professions Code sections 801, 801.1, and 803.2 has dramatically declined, and the absence of a penalty for failure to report surely encourages abuse and neglect. MBC and HQE should form a working group to review examples of noncompliance; draft statutory amendments to close loopholes; identify and educate mandated reporters at insurance companies and physician employers; and seek legislative action to add substantial penalties for noncompliance with Business and Professions Code sections 801, 801.1, 803.2, and 804.

■ ***Increased hourly rates for records review and report preparation by expert reviewers.*** If funds are available, MBC should consider an increase in the hourly rate paid to MBC’s experts for records review and report preparation. Increased compensation may aid in the recruitment of qualified experts — who are essential to the Board’s ability to prove a quality of care case — and may prompt experts to review cases in a more timely fashion.

■ ***Evaluation of the costs and benefits of DMQ review.*** The Medical Board should engage in an informed public discussion of the costs and value of DMQ review of ALJ decisions, together with the advantages and disadvantages of alternative models.

■ ***New procedure on requests for stay.*** DMQ should adopt a regulation governing rulings on requests for a stay — which regulation ensures that a DMQ member or members rule on those requests, not MBC enforcement staff.

■ ***Disclosable misdemeanors list.*** MBC and HQE should establish a task force to develop the list of disclosable misdemeanor criminal convictions required by Business and Professions Code section 2027(d).

■ ***Required notice to consumers regarding the Board's existence and disciplinary jurisdiction.*** Consistent with the practice at many other California regulatory agencies, the Medical Board should require its licensees to provide their patients with some form of affirmative notice concerning the Board's existence, jurisdiction, toll-free complaint number, and Web site address. MBC's complaint intake has decreased over the past several years, and this may be due to inadequate public outreach.

■ ***Improved outreach and compliance efforts directed at mandated reporters.*** MBC should continue its outreach efforts to individuals and institutions who are mandated reporters under Business and Professions Code section 800 *et seq.*, as these reporters are valuable sources of complaints and reports that lead to detection, investigation, and disciplinary action in priority complaints under Business and Professions Code section 2220.05.

■ ***Resolution of longstanding policy issues affecting the Diversion Program.*** These issues — listed in full at the end of Chapter XV — include the development of meaningful criteria for admission to and termination from the Program; identification and enforcement of consistent consequences for relapse; consideration of options for funding the Program to ensure that Program participation does not outstrip staff's ability to adequately monitor all participants; the development of standards, qualifications, and duties of "worksite monitors" and "hospital monitors"; reevaluation of the role, purpose, and functions of the Liaison Committee; the adoption of regulations defining standards for "evaluating physicians" and competency examinations for Program participants (as required by law); the ability of the Program — as currently staffed and structured — to monitor singly-diagnosed mentally ill physicians; and — importantly — the identification of the categories of information that should be included in quarterly "quality review reports" from staff to members of the Diversion Committee, to enable that Committee and DMQ to responsibly oversee the functioning of the Program as required by law.

The many process improvements now under way, and the important reforms coming soon as the result of SB 231 (Figueroa), point to a much brighter future for MBC and its disciplinary process. MBC's enforcement program has demonstrated strong new momentum and clear improvement, but further progress is needed for this agency to fully meet its vital public safety obligations.

The Monitor calls upon every stakeholder in the healthcare system — MBC, HQE, OAH, the Department of Consumer Affairs, the Legislature, organized medicine and the healthcare industry, physicians, and patients — to embrace the cause of a better Medical Board enforcement program. An ongoing collaborative effort to continue MBC's recent progress will result in greater protection for every Californian who relies on the healthcare system.

The Monitor team extends its thanks for the opportunity to serve, and its gratitude to all those who have joined with the Monitor in this good cause.

