

**PHYSICIAN DISCIPLINE IN CALIFORNIA:
A CODE BLUE EMERGENCY**

**AN INITIAL REPORT ON THE
PHYSICIAN DISCIPLINE SYSTEM
OF THE BOARD OF MEDICAL QUALITY ASSURANCE**

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I. EXECUTIVE SUMMARY

Physician discipline in California is a code blue emergency. The system cannot and does not protect Californians from incompetent medical practice. It is effectively moribund.

In this report, the Center for Public Interest Law proposes a wide-ranging series of administrative and statutory reforms to provide the necessary information, independence, professionalism, authority, and resources needed to protect the health of California's citizens.

Each year, 50,000–80,000 phone calls come to the Board of Medical Quality Assurance (BMQA), which regulates physicians. Uncoordinated complaint handlers lacking medical or legal experience cull from these calls a current level of 6,000 annual complaints about physician competence, sobriety, or honesty within BMQA's discipline jurisdiction. One-half of these are then eliminated as without merit, or by informal warning phone calls or conferences with the accused physicians. Of the current level of 2,500–3,000 per year considered serious enough for formal investigation, 109 resulted in formal accusation or hearing in fiscal year 1987–88. All but those 109 were closed, routed, or "resolved" in secrecy. Thirty of those 109 were later dismissed or withdrawn.

The 79 formal accusations pursued resulted in the revocation of 27 licenses during 1987–88, down from 40 in 1986–87. License suspensions were at 15 in 1987–88, down from 18 in 1986–87. Levels of both revocations and suspensions for 1988–89 appear to be even lower yet. A grand total of 12 physicians were subject to any discipline (revocation, suspension, or probation) in 1987–88 for incompetence, and 5 for self-abuse of drugs or alcohol. These levels are typical, not aberrational statistics.

These performance levels cover 70,000 licensed physicians currently practicing in California. Many more than the 27 physicians whose licenses were revoked in 1987–88 are annually convicted of multiple felonies. Seven hundred fifteen (715) physicians and health maintenance organizations (HMOs) were either adjudged liable for malpractice or agreed to settlements in excess of \$30,000 in 1987–88, up 50% from 457 in 1984–85. Two hundred forty-nine (249) physicians had their privileges suspended or revoked by hospitals for reasons of drug impairment or medical incompetence in 1987–88, a record number. The American Medical Association (AMA) estimates that 7,000–10,000 currently practicing physicians in California are so severely impaired that they cannot safely practice medicine. Malpractice premiums allegedly paid due to claims and judgments caused by incompetent practice have increased to the \$50,000–\$80,000 per year range for many physicians and most surgeons. Over the past five years, while the number of physicians has increased from 60,000 to 70,000, complaints have increased from just over 4,000 per year to 6,000. But public discipline has declined to trivial levels.

This system of "public protection" is now in its final death from a choking backlog. At this moment, 721 facially meritorious cases that are serious enough for formal investigation sit in files unassigned. Most of these cases are "Priority 1" cases; that is, they involve an immediate threat to patient health. Six hundred fifty-nine (659) more are assigned and remain in additional investigator backlogs (now under investigation for more than six months without resolution). None of these physicians are subject to interim suspension. Another 1,000 are in intake backlog. Since 1985–86, only three temporary restraining orders have been issued to prevent physician practice during the three to four years of a typical proceeding, which stretches to six to ten years where the accused physician contests the discipline in court.

The discipline system is operated by people who are not properly trained to make the decisions demanded, and is controlled at every critical step by currently practicing physicians who eliminate almost every case. To be precise, more than 97% of facially valid complaints never see the light of day. The attitude of those making these decisions is openly solicitous of the physician. While physician rehabilitation is one statutory goal, it is the preoccupation of the current system. The profession and current administration, to some extent over Board and staff objection, have resisted raising physician licensing fees above the current levels of \$145 per year. Current fees assessed for discipline are less than the amount spent on malpractice premiums for six hours of typical practice. The discipline budget for physicians and allied health professionals is less than one-third the level for attorneys, with a comparable number of licensees and complaints received. The discipline budget proposed no additional positions for 1989. Only two-and-one-half positions have been added in the last five years.

The Report documents the following major deficiencies:

1. Lack of Public Outreach. Consumers cannot find BMQA's telephone listing — it is missing from many directories, and directory assistance has "no listing."

2. Lack of Information. Reporting of criminal activity comes only upon conviction — too late; reporting of malpractice cases comes only after settlement or judgment—too late; required hospital reports of denial, suspension, and withdrawal of privileges are evaded and depend upon the "turning in of colleagues" in a setting of antitrust or litigation exposure.

3. Lack of Competent, Independent, Coordinated Evaluation. Complaint intake is handled by persons unschooled in law or medicine operating in seven different regional offices. The process is subject to review by senior investigators and medical consultants in each area. The emphasis is on accommodation—"helping" the physician; almost all cases are closed without serious discipline. Patterns of misbehavior are not effectively detected or tracked.

4. Administrative Review is Cumbersome, Fragmented, and Secret. Evaluation by currently practicing physician consultants and required multi-level review allow numerous opportunities for closure; no part of the process for over 97% of raw intake is open for public review or is disclosed upon consumer inquiry.

5. Investigators are Overburdened and Dysfunctional. Current backlogs make detailed investigations into even serious allegations difficult. Discipline of "allied health professionals" caught in the system are given low priority.

6. The Hearing Process is a Labyrinth. From three to four years elapse between intake and final discipline; six to ten years elapse where the discipline is contested in the courts—even without the backlog. Physicians are free to practice during the entire discipline process; there were no interim suspensions or restraining orders this fiscal year, and only three such orders during the past three years. Cases are often heard by a panel controlled by local practicing doctors. Cases are then reviewed by the Division of Medical Quality—a majority of whose members are also practicing doctors. A closure by staff or a dismissal by any of these entities is not appealable as a practical matter. Where a matter results in a final order of discipline, it then begins a laborious process of judicial review, which starts with a writ of mandate to superior court (where an "independent judgment" test reconsiders all of the evidence anew), followed by court of appeal review, and petition to the Supreme Court.

We here propose a restructuring similar in some respects to the reforms accepted by the State Bar in its 1988 disciplinary reform. Major proposed changes include:

- a statewide toll-free intake number;
- immunity for reports received from physicians and all health professionals;
- automatic reports to BMQA of all actions regarding privileges;
- notification of criminal acts at point of arrest;
- notification of malpractice claims at point of filing;
- centralization of intake at the statewide toll-free number under the control of a specially-assigned Deputy Attorney General;
- computer detection of patterns of errant behavior;
- control of the system by a special unit of the Attorney General's Office from point of intake;
- adequate authority for interim suspension and required drug testing;
- hearing and appeal in a two-step process, cutting the current adjudication time in half: first to a Medical Quality Court of hearing judges with independent judicial standing, and then appeal to a special panel of the Court of Appeal; and
- resources by adding \$140 to the current annual renewal fees (from \$145 to \$285 every year).

II. INTRODUCTION

The Center for Public Interest Law (CPIL) is a nonprofit academic center of the University of San Diego School of Law. CPIL trains law students in public interest law, focusing on California's regulatory agencies. It is intended to serve as a resource and stimulus to open up the processes of state regulatory agencies to public scrutiny and accountability. CPIL publishes the *California Regulatory Law Reporter*, a quarterly journal summarizing the actions of the sixty major agencies regulating business, trades, professions, and the environment. CPIL employs six professional and four clerical staff members, and is assisted by a group of forty law student interns. CPIL maintains offices in three California cities: San Diego, Sacramento, and San Francisco.

Over the past nine years, CPIL has engaged in approximately thirty advocacy projects, ranging from AB 214 (Connelly) (providing a civil remedy for California's Bagley-Keene Open Meeting Act) to the creation of the Utility Consumers' Action Network (UCAN), now a 70,000-member utility ratepayer organization.

In 1986, driven by the disclosure of a 3,000-case backlog in the discipline system of the State Bar, the legislature enacted Senate Bill 1543 (Presley), which mandated system reforms and created the position of State Bar Discipline Monitor. That position was delegated the powers of the Attorney General and authorized to investigate the Bar's discipline system and make recommendations to the legislature and California Supreme Court regarding measures required to create an effective, fair, and expeditious system.

In January 1987, the Attorney General appointed CPIL Director Professor Robert C. Fellmeth to the position of State Bar Discipline Monitor. Professor Fellmeth is a graduate of Stanford University and the Harvard Law School, and is a tenured professor of administrative and consumer law at the University of San Diego School of Law, the co-author of *California Regulatory Law and Practice* (Butterworths 1983), the former Chair of the state Athletic Commission, and for nine years served as a state and federal white collar crime prosecutor.

Under the direction of Professor Fellmeth, CPIL issued its initial critique of the Bar's discipline system in June 1987, followed by four subsequent progress reports and by the adoption of numerous administrative reforms. In 1988, at the urging of CPIL and the State Bar, the legislature enacted two statutes to comprehensively overhaul the Bar's discipline system. SB 1498 (Presley) created an independent State Bar Court for discipline and gave the Bar enhanced detection ability and authority to discipline errant attorneys. AB 4391 (Brown) increased by \$140 annual attorney licensing fees, to \$417 per year.

The Center for Public Interest Law began its inquiry of discipline performance of the Board of Medical Quality Assurance (BMQA) during 1987, assisted by a grant from the Weingart Foundation. That inquiry has included interviews; review of BMQA's Division of Medical Quality (DMQ); a substantial document request under the California Public Records Act on November 7, 1987; review of the documents received thereunder; substantial further research and document searches from other sources; and research into the legal and empirical record of DMQ.

The Report which follows relies largely on information provided by the agency and its staff. The Report was submitted in draft form to agency staff for comment prior to its public release. BMQA's response was detailed, gracious, and constructive. It was carefully considered in the formulation of this Report. That review implies no responsibility for the content of the report or agreement with its conclusions.

This Report focuses on the information-gathering and administrative processes of the BMQA discipline system as supervised by DMQ. Additional studies will later consider the performance of BMQA's Diversion Program for the treatment of alcohol/drug-dependent licensees; the performance of BMQA's Medical Quality Review Committees (MQRCs); preventive measures to ensure competence; the post-discipline monitoring of probationers; and consideration of petitions for reinstatement.

The Report includes its major recommendations in bold print and separates out those recommendations appropriate for legislation in Section VI.

III. CURRENT OPERATIONAL MODEL FOR THE DISCIPLINE OF PHYSICIANS AND ALLIED HEALTH PROFESSIONALS

A. Structure

The Board of Medical Quality Assurance operates under the Department of Consumer Affairs within the executive branch of California state government. It is a quasi-independent regulatory agency exercising broad powers under the Medical Practice Act (Business and Professions Code section 2000 *et seq.*) and other statutes designed to assure competent and honest delivery of medical care to consumers in California.

The Board of Medical Quality Assurance includes nineteen members appointed to four-year terms. By provision of law, twelve of those members must be currently practicing physicians. Hence, members of the profession directly control the state agency and exercise police powers under broad authority on behalf of the general public and for its protection.

The Board is separated into three divisions: the Division of Allied Health Professions (DAHP), the Division of Licensing (DOL), and the Division of Medical Quality (DMQ). This report focuses on DMQ, although the other two divisions have significant roles in ensuring the honesty and competence of health care professionals and will be discussed in later reports.

The Division of Medical Quality consists of seven BMQA members and meets approximately every three months. The Board members constituting DMQ oversee an enforcement program and exercise authority comparable to that exercised by other boards or commissions in California state government. That is, the critical rulemaking and adjudicative decisions made by DMQ members operate effectively as final state determinations.

The Division of Allied Health Professions includes eight separate examining committees which license non-physician health care providers. These eight committees regulate acupuncturists, physical therapists, physician's assistants, hearing aid dispensers, podiatrists, psychologists, speech pathologists, audiologists, and respiratory care therapists. In addition, medical assistants, registered dispensing opticians, research psychoanalysts, and contact lens dispensers are also directly regulated by DAHP. The enforcement of the Medical Practice Act as to these allied health professionals is assumed by their respective "committees" under BMQA. DMQ provides investigative services and findings within its disciplinary operation to these allied health committees for action in the administrative adjudicative process.

B. Statutory Duty

The Medical Practice Act provides general statutory authority under which DMQ (with BMQA's approval) exercises considerable rulemaking powers and directs the discipline/ enforcement function. Under the statute, DMQ is directly responsible for the investigation of allied health professionals, and for the investigation and final adjudicative outcome of the following kinds of abuse in medical practice: (1) gross negligence; (2) incompetence; (3) excessive prescribing or administering of drugs or treatment; (4) the conviction of a crime; (5) a conviction under, or compromise of, a narcotics or drug statute; (6) misuse of dangerous drugs, narcotics, or alcohol; (7) furnishing drugs to addicts contrary to law; (8) prescribing dangerous drugs without a prior medical examination; (9) medical illness; and (10) intoxication while attending a patient.

The statutory command to DMQ is protection of the public from physician incompetence, dishonesty, or alcohol/drug abuse (whether by the physician or improper facilitation of private use). No other profession or trade regulated by the state is more justifiably restrained for assured quality of care than the medical profession. Consumers entrust their lives, personal health, and welfare to physicians to a degree unknown in other professional relationships. A lack of competence may result in irreparable harm to consumers. To preclude that harm, the state has interposed significant barriers to entry into the profession. The accreditation of medical schools, a difficult series of examinations, and residency requirements in which actual performance is reviewed, all predate final licensure by the Board of Medical Quality Assurance.

Despite the initial difficulty in securing licensure, the medical license when issued is a general license unrelated to the actual area of medicine likely to be practiced. Although medical practice is highly specialized in nature, a general medical license is granted, allowing—for purposes of state control—practice in any or a large number of medical fields. Hence, as far as DMQ is concerned, a medical license authorizes practice in child psychiatry, colon surgery, dermatology, forensic pathology, gastroenterology, gynecology, internal medicine, nephrology, nuclear medicine, obstetrics, orthopedic surgery, pediatrics, plastic surgery, proctology, thoracic surgery, and urology, among others. There is no required post-licensure retesting. Continuing education requirements are minimal.¹ There is no required medical malpractice coverage guaranteeing recovery to patients harmed by incompetent physicians.

A supplemental series of private sector admission and certification standards exists, which may serve some theoretical competence-enhancing purpose. “Board certification” standards have been established for specialties. These do not preclude practice in those areas by others, but may give some warning to informed patients about competence. Most important, hospital privileges must be obtained and retained by a physician in order to gain the access to hospital or related facilities most specialties require. This last control operates beyond the scope of the state and is subject to the limitations discussed below.

The burden on the regulatory agency to ensure honest and competent physician services, relied upon by consumers, is rightfully heavy. This responsibility is enhanced by the irreparable nature of the failure to ensure that competence, by the lack of post-licensure quality control, and by the intrusion of private decisionmakers in the disallowance of practice by their peers.

C. Present Procedure (Theoretical)

1. Outreach: Consumer Complaints

Consumers or patients account for over 50% of the complaints received by DMQ about physicians and allied health professionals. Complaints are received at one of the seven regional offices of DMQ. Six of these offices (Torrance, Woodland Hills, San Bernardino, Santa Ana, Sacramento, and San Mateo) have one consumer services representative (CSR) who serves an initial intake function. Operating under the general supervision of the Regional Office Supervisor and a Medical Consultant appointed for each region, the CSR evaluates the case upon intake. The CSR may close the complaint immediately as “mediated, negotiated, settled or dismissed.” Complaints closed by the CSR are presumptively “without merit” and are automatically purged, without review, from DMQ’s records after thirty days. Complaints relevant to allied health professionals may be referred to their respective committee or enforcement personnel as appropriate. Allegations which,

¹ Licensed physicians are required to take 25 units of continuing education per year.

if true, constitute violations of the Medical Practice Act, may be referred for investigation.

2. Other Reporting

In addition to receiving consumer complaints, DMQ receives reports on criminal convictions of licensees and malpractice judgments over \$30,000 against a licensee. DMQ may also receive so-called "section 805" (of the Business and Professions Code) reports regarding the denial, restriction, or revocation of hospital privileges. These reports are filed with DMQ by professional liability insurers (section 801), uninsured licensees or their counsel (section 802), clerks of the court (section 803), and peer review entities (section 805). Medical malpractice reports (sections 801–03) notify the Board when a malpractice case judgment, settlement, or arbitration award against a physician exceeds \$30,000. Regional Medical Consultants review each report to determine whether DMQ investigation is warranted. Note that although malpractice awards may be based on simple negligence, disciplinary action by BMQA requires gross negligence or repeated negligent acts.

Section 805 reports require the chief of the medical staff of any organized system where physicians, clinical psychologists, or podiatrists work to notify BMQA when any licensed physician is denied staff privileges, has had privileges limited, or is removed from the staff. (The types of facilities required to report under section 805 were expanded by SB 1620 and AB 2249 in 1987.) Section 805 also requires that the covered facilities request relevant information from the Board regarding any licensed physician prior to granting or renewing staff privileges.

DMQ also receives complaints from other government agencies including the federal Drug Enforcement Administration (DEA), the state Department of Health Services, the state Board of Pharmacy, and district attorneys (usually related to Medi-Cal fraud or drug violations).

3. Consumer Services Representatives (CSRs)

Within ten days of the receipt of a complaint from a consumer, the CSR is to acknowledge receipt of that complaint. The flow chart for complaint receipt in the usual case is presented in Exhibit 1. The case will be assigned a priority from 1 to 4. Up until February 1989,² the highest priority is given to those complaints which, if proven, demonstrate a high potential for public harm. Complaints in this category include gross negligence, sexual abuse, incompetence, substance abuse, mental illness, and those which allege criminal behavior. These high-priority cases are to be assigned to an investigator within thirty days and the investigation is to be completed within 180 days.

The next priority classification encompasses complaints which require additional information before a decision can be made regarding the disposition of the case. Until a decision is made, these cases are handled by the CSR, the Regional Supervisor, and the Medical Consultant.

Complaints which, even if proven, would probably not result in discipline are within the third priority. In such cases, merely bringing the complaint to the attention of the physician may prevent more serious problems in the future. These cases are not referred for investigation, but are addressed through information and warning letters.

²In March 1989, DMQ adopted a new priority system, which is discussed *infra* in Section V(H) (see also Exhibit 3).

The lowest priority is given to complaints which do not involve patient care issues and appear to be the least serious in nature. Most of these complaints can be resolved through appropriate referrals and warning letters.

4. Regional Medical Consultant/Supervising Investigator

Where the CSR evaluation indicates appropriate jurisdiction for DMQ enforcement, the case will be reviewed by a Regional Medical Consultant and/or a Supervising Investigator. The Supervising Investigator may refer the matter to another agency or close it as without merit. A Case Investigation Tracking System (CITS) will be checked to determine whether any existing investigations are under way or whether prior discipline may be relevant, before assigning it for formal investigation.

5. Regional Supervisor/Opening of Investigation

If the Regional Supervising Investigator finds that the complaint, considering the CITS, warrants formal investigation, he/she may order the opening of a formal investigative file. A file is opened and one of approximately 39 investigators is assigned to the case. Investigators work from regional offices in Fresno, Los Angeles, Sacramento, San Bernardino, San Diego, San Mateo, Santa Ana, and Redding. Investigators are largely concentrated in Los Angeles and San Mateo; the other offices have from one to five investigators. The investigator communicates with the accused physician, obtains medical records, commences an investigation, and files regularly required progress reports at one- or two-month intervals.

6. Review by Regional Medical Consultant

DMQ includes a Chief Medical Consultant and Regional Medical Consultants operating from each of the DMQ regions noted above. These medical consultants are generally current or recent practicing physicians and operate out of six of the eight regions. A Regional Medical Consultant is relied upon by DMQ for critical decisions and may, with the agreement of the Supervising Investigator, close a case, refer it to an expert panel for recommendation, or may engage in what is termed a "physician performance conference." This latter represents an opportunity for the consultant to informally review the problem with the physician and to receive assurances of behavior modification in the future. The case may also be referred to a Medical Quality Review Committee (MQRC) for non-disciplinary review. Finally, the consultant may recommend formal discipline.

7. Medical Quality Review Committees (MQRCs)

Pursuant to sections 2320 and 2332 of the Business and Professions Code, DMQ has created fourteen Medical Quality Review Committees in various regions throughout the state. These MQRCs consist largely of practicing physicians appointed on a voluntary basis to assist DMQ in its enforcement and adjudicative functions. The MQRCs serve as a liaison with medical and community groups, perform non-disciplinary reviews, and function as hearing panels for formal disciplinary cases. They range in size from ten to forty members and consist of physicians, allied health professionals, and public members. A majority of the Committee members are practicing physicians, nominated by DMQ, medical societies, and medical school deans. Public members and allied health members are directly appointed by the Governor. Each term of office is four years.

8. Referral to Office of Attorney General for Accusation

The Office of the Attorney General receives the investigative reports of the BMQA investigators and decides whether to prepare formal disciplinary charges (“accusations”) for signature by BMQA’s Executive Director and filing. For allegations involving single acts of incompetence or gross negligence, or any case involving quality of care, such an accusation requires the Attorney General to obtain the concurrence of two outside medical experts that the investigation indicates incompetence. Incompetence may not be simple negligence, but must be a pattern of negligent acts or gross incompetence and must be proved by “clear and convincing” evidence. Hence, the standard for prosecution under the Medical Practice Act is substantially more than is required to justify tort damages for negligence in a civil case against a physician or other health professional.

9. Administrative Hearing

The Attorney General and BMQA determine whether an accusation should be filed, which seeks the formal discipline of a physician or other health professional pursuant to the adjudicative sections of the Administrative Procedure Act (APA) (Government Code sections 11500 to 11528). The Attorney General must show with clear and convincing evidence to a reasonable certainty that the physician or allied health professional has violated a statutory duty warranting license revocation, suspension, or other discipline. Pursuant to the APA, the physician may answer the accusation by formal pleading and commence discovery.

Following discovery and preliminary motions, a hearing occurs. A number of alternative formats are available under the APA and DMQ practice for that hearing. The first alternative is to assign the matter to an administrative law judge (ALJ) from the Office of Administrative Hearings for hearing and tentative decision. The second is to use the ALJ for evidentiary rulings at the hearing and to appoint five members of the local MQRC to sit as a panel and make the formal tentative decision. The third alternative is to use the ALJ for evidentiary rulings at the hearing but to have DMQ sit as an adjudicative panel and make the decision directly. Where one of the first two alternatives is chosen (which is the normal course), the accused physician and the Attorney General both have available to them right of review by DMQ.

Under Business and Professions Code section 2335(c), DMQ review is required where the proposed decision of the ALJ or MQRC would restrict or limit the extent, scope, or type of practice for a period exceeding one year; suspend the license for more than thirty days; or revoke the license.

10. DMQ Review Hearing

DMQ receives the hearing transcript and recommended decision. Where DMQ declines to adopt the decision upon review of the proceedings below, it may hold its own hearing. Written and oral argument at that hearing is permissive at the option of the respondent and the Attorney General.

In the case of allied health professionals, the adjudicative process does not occur through DMQ but, after the filing of an accusation, is then subject to ALJ proceedings either alone or in conjunction with panels of the respective allied health examining committees, subject to review by the appropriate allied health committee within DAHP. Like the physicians who control the majority of votes in DMQ, the respective allied health professionals subject to discipline control those committees engaging in the review. Where DMQ (or the allied health committee) makes a decision recommending no discipline, that decision is effectively final. Although a substantial procedural error by DMQ may theoretically give rise to a basis for court review initiated by the Office of the Attorney

General, such a review is rarely sought and would be subject to overwhelming difficulties in reversing a substantive decision of no discipline.

11. Superior Court Review by Writ of Mandate

Where the final decision of DMQ is to impose discipline—even where that discipline is a suspension conditioned on retesting or other probationary requirements, the accused physician has an absolute right to review by writ of mandate in superior court. The accused physician or allied health professional has a substantial number of permissible venues in which to petition for judicial review of the administrative procedure which led to a final decision of discipline. Filing a writ of mandate delays the imposition of any actual penalty, including probationary conditions imposed on a suspended revocation or suspension, until the conclusion of court review. The superior court is required by law to exercise its “independent judgment,” rather than applying the “substantial evidence” test. Under the latter test, the court determines whether the findings are supported by substantial evidence in light of the entire record. In recognition of the potential taking from the physician of a “vested right” (the right of continued use of the license to practice), the superior court reviews the evidence *de novo*. The court does not review the decision of the ALJ or Division for error, but reviews the entire factual record and exercises his/her own independent judgment as to the appropriateness of the finding that the Medical Practice Act was violated (thus warranting discipline), and that the discipline imposed was appropriate to that offense.

12. Court of Appeal Review

Where the accused physician or health professional is denied the requested writ of mandate, he/she has a right of appeal to the court of appeal in which that superior court sits. Appellate review involves the transmittal and certification of the administrative record from the superior court to the court of appeal, the filing of written briefs, the scheduling of oral argument, and submission for final decision. Where a writ of mandate is granted reversing a discipline decision, the Attorney General may have the opportunity to appeal that decision to the court of appeal where legal error may have occurred. Court of appeal review normally takes several years to complete.

13. Petition to the Supreme Court

Whatever the decision of the superior court or the court of appeal, both the Attorney General (on behalf of DMQ) and the accused physician or allied health professional have a right to petition the Supreme Court for review. This review by the Supreme Court is discretionary and may or may not be granted. Where it is granted, a two- to three-year period can be expected between the granting of the petition and the final published decision of the Supreme Court. In some cases, an accused physician may also seek further review to the U.S. Supreme Court where he/she alleges a federal constitutional question exists under the statute or terms of discipline imposed.

IV. STRUCTURAL PROBLEMS: AN INTRODUCTION TO THE SYSTEM'S FLAWS

The basic administrative structure described above, taken from DMQ documents illustrative and representative of the current model for discipline, outlines serious structural infirmities. We describe *infra* the problems we have encountered in the respective stages of the operation of that system. However, while the basic structure is still in mind, several general observations are appropriate.

First, any one of nine separate individuals in the complaint flow process is able to recommend the closure or diversion of a case from the discipline track. Thus it is not surprising that in fiscal year 1987–88, of 4,685 complaints received against physicians, only 109 reached accusation filing for formal discipline. (See Exhibit 3.) Thirty of these 109 were dismissed or withdrawn. Until the accusation is filed, the entire procedure described in steps 1–8 above is not subject to public disclosure. During fiscal year 1987–88, final discipline output included revocation of 27 physician licenses, the voluntary surrender of 11, suspension of 15, and probation without any actual suspension or revocation for 37. (See Exhibit 3.) Out of 70,000 practicing licensees in California, only 42 were sanctioned by revocation or suspension of their license.³

This output is lower than the 58 revocations and suspensions during the 1986–87 fiscal year, notwithstanding the increase in complaints received from 4,361 in 1986–87 to 4,685 in 1987–88. More recent data shows a further increase in complaints to a projected 6,000 per annum level and a further retraction in the number of revocations and suspensions. (See Exhibit 2; see also Exhibit 3 at Table 5.) This discipline output represents but a small fraction of the physicians who are convicted of serious felonies every year. During 1987–88, 715 suffered malpractice judgments or settlements of over \$30,000; 249 had their hospital privileges denied or suspended by private action based on medical incompetence or impairment; and 7,000–10,000 are estimated to be currently impaired by alcohol, drugs, or other infirmity. All of these numbers have increased markedly over the last five years, particularly over the past three years. (See Exhibit 3 at Table 5.)⁴

The final discipline result of 42 cases trivializes any concept of deterrence. Only 12 physicians received *any* discipline (including straight probation) for incompetence in 1987–88, and 5 for self-abuse of drugs or alcohol. (See Exhibit 3 at Table 8.) Almost 100 have flunked or abandoned drug/alcohol control treatment. (See Exhibit 3 at Table 14.)⁵

³These numbers exclude those physicians subjected to conferences or advice from Regional Medical Consultants or others. These discipline outcomes are “confidential,” involve no enforceable limitations on practice, are not subject to probation monitoring, and are unknown to consumers and colleagues.

⁴Note that Table 5 of Exhibit 3 indicates 1,359 hospital privilege denials for medical reasons. This BMQA document is incorrect; the actual number is 249, up from 169 during the previous year. Note also that the 715 malpractice judgments include 150 against HMOs.

⁵Note that Exhibit 3, Table 14 excludes withdrawals from diversion, understating the number who have not successfully completed diversion.

The length of time that transpires during the administrative and judicial process ranges from six to eight years.⁶ During this interim, in virtually every case, the physician maintains his/her license in good standing and is free to practice medicine within the state of California. The number of temporary restraining orders or interim suspensions during 1987–88 was zero; there have been a total of three since 1985–86 (see Exhibit 3 at Table 5).

DMQ spent in excess of \$8 million dollars in enforcement and related overhead allocations to achieve this statistical discipline result. As described below, the issues of trivial output, expense, and delay are not surprising, given the multi-layered structure of the discipline system with decisions being made by the wrong people with inadequate information and in a fragmented fashion. The entire system is then further infected with a blatant solicitude for the profession both in its excessive orientation toward “rehabilitation,” and by the active participation of interested competitors, peers, and colleagues in the administrative process. The entire structure does not function as a device to excise the incompetent physician, but rather as a means to “help” physicians with problems which might impact patients seriously. Hence, when Dr. Ellis, President of DMQ, reminded us in a March 3, 1989 public hearing that “society has a great investment in the education and training of physicians and the emphasis of the DMQ program must be therefore on rehabilitation,” his attitude is not aberrational, but permeates the structure of the system from CSRs to the medical consultants to MQRCs and investigators. Because no prosecutor charged with protection of the public in the enforcement of these statutes enters the system until after a multiplicity of peer entities has determined that the investigative report should be presented for formal prosecution, the system operates only *in extremis* to discipline physicians.

The *in extremis* nature of the “scoping” of complaints to its trivial result in terms of output is apparent when one considers that the American Medical Association (AMA) itself recognizes that drug abuse, alcoholism, and other infirmities both mental and physical render 10–15% of practicing physicians “unfit to practice medicine.” Hence, California has between 7,000–10,000 licensed physicians who are unfit to practice under AMA standards. Approximately 200 are now participating in BMQA’s drug diversion program.⁷ The Diversion Program grants total immunity from discipline while the physician is in compliance with the terms of the program. The incidence of malpractice and physician negligence is serious and is reflected in malpractice judgments upheld on appeal, which have contributed to insurance premiums now in the \$20,000–\$80,000 per year range, depending on area and specialty.

⁶ See, e.g., *Miller v. BMQA*, 193 Cal. App. 3d 1371 (1987), which involved acts showing serious mental incompetence in the late 1970s, a BMQA disciplinary order on December 1, 1981, and a final affirmation on July 31, 1987; *Kearl v. BMQA*, 189 Cal. App. 3d 1040 (1986), in which an anesthesiologist exhibiting gross incompetence in 1975 was investigated for five years; an accusation was filed on October 15, 1980; a DMQ decision was made on April 30, 1984 and upheld by the court on November 5, 1986—eleven years after the complained-of acts. These two examples are typical of current timelines, during which medical practice continues.

Note that the actual time between receipt of information and final discipline averages just under four years. However, these outcomes include stipulated discipline. Where discipline is resisted, the average time between the acts giving rise to discipline and final discipline exceeds seven years.

⁷The drug abuse problem, given occupational pressures and the ready access of physicians to restricted drugs, is serious and impairs almost three-quarters of those entering the existing BMQA alcohol/drug diversion program.

An output of 42 license revocations or suspensions out of 70,000 practicing physicians, with 7,000–10,000 alcohol- or drug-impaired and 200 in the diversion program (approximately one-third of whom will not successfully complete that program), and malpractice premiums and judgments at current levels suggest a system in serious crisis. It is particularly telling that although the number of licensees has grown, drug abuse has increased over the decade, and malpractice premiums and negligence judgments have proliferated, the output of the system has actually declined. The current rate of license revocations is at 27 per annum.

V. THE ACTUAL DISCIPLINE OF CALIFORNIA'S PHYSICIANS

A. Outreach/Detection

The first step in a discipline system is the detection of behavior which violates statutory standards. As noted above, approximately 55% of DMQ's open investigations originate from consumer complaints. Although this source of information is inadequate for total reliance, it is a major source of information about likely incompetence, drug abuse, and dishonesty. It is therefore appropriate for consumers to be within easy reach of DMQ to convey relevant information about the performance of BMQA licensees.

During 1988, the Assembly Office of Research performed an investigation and issued a report about the outreach (and related) performance of DMQ at the request of Assemblymember Jackie Speier. The report was released in July 1988 under the blunt title "No Such Listing—Consumer Access to the Board of Medical Quality Assurance." The report noted that as of June 1988, BMQA's number appeared in only 33 of 172 surveyed California telephone directories. The cost of being listed in the state agency section of the Pacific Bell directory is \$1.00. BMQA does not advertise in any telephone book's yellow pages. The survey also concluded: "[telephone 411] information operators are often unable to help confused callers." Operators are trained only to check phone numbers covered by that area's phone directory; hence, if BMQA is not listed, a call to 411 directory assistance will not produce a means for consumer access to this agency. The response is simply "no such listing exists."⁸ The report listed three measures BMQA had taken to facilitate outreach, but described outreach by this critical agency as generally minimal. As discussed below, in examining DMQ's current backlog of investigations, such a lack of priority concerning outreach is perhaps understandable. Nevertheless, it is not indicative of a minimally acceptable operating system.

Even when consumers are able to obtain a BMQA regional office number, the number of CSRs to answer complaint calls is generally insufficient. Note that this situation is particularly marked in San Diego.⁹

As described above, DMQ intake is decentralized in its regional offices in Sacramento, San Mateo, Fresno, Woodland Hills, Torrance, Santa Ana, and San Bernardino (as well as storefront district offices in San Diego and Redding). Hence, CSRs located in one office may have sufficient time to handle calls while CSRs in others may not. It is unclear why there is not a centralized complaint receipt number and facility. CSRs do not conduct on-the-scene detailed investigations, nor are they qualified to do so. They need not be in the field. Further, even for consumers in the counties where telephone numbers are available through directories, these are often toll calls. DMQ should replicate the complaint receipt reforms of the State Bar and immediately create a statewide 800 toll-free number listed in every telephone directory in the state (under the white pages "State Government" section), with 800 and 411 directory assistance, and included in major yellow page phone directories under "Physicians – Complaints." As described below, CSRs should be trained and supervised by experts in the prosecution of medical incompetence and dishonesty; that is, by a professional prosecutor familiar with the legal standards and with the methodology required to put together a case for administrative and judicial review. The CSRs are currently subject to no supervision by any person specifically trained in law in what is essentially a legal process.

⁸See "No Such Listing," Assembly Office of Research (July 1988) at 8.

⁹*Id.* at 12.

Medical experts in a wide variety of subject areas should be available to CSR supervisors in order to gauge the facial merit of incoming calls by quick reference. This reference expert panel should not consist of a single “medical consultant” because any such consultant may well be trained in a particular area of medicine and have very little knowledge about minimally acceptable standards of professional care in the many different specialties in which DMQ licensees practice.

At present, CSRs in seven different offices operate under separate supervising investigators, and make necessarily inconsistent decisions in fragmented fashion. These decisions are significant because the total number of phone calls coming in to BMQA has been estimated at between 30,000–50,000 per year, notwithstanding the lack of outreach by BMQA. Although most of these calls do not involve disciplinable complaints about doctors, many of them do.¹⁰ Precisely which calls involve alleged violations of statutory and rule requirements enacted to safeguard the health of Californians is a matter best evaluated consistently throughout the state. These standards of performance are not substantially different in Sacramento *vis-a-vis* San Diego. The centralization of all intake in one office allows for economies of scale,¹¹ the publicity of a single 800 toll-free number, the consistent training of CSRs, the supervision of CSRs by a trained professional prosecutor, and the easy referral of technical questions to experts available to a single source. Such receipt also allows for the immediate computer entry of all phone calls which might involve complaints against physicians or indications of physician drug/alcohol abuse problems at point of entry, where patterns may be detected. The current tracking system registers such information only after a substantial filtering process. Such a centralized toll-free number would also allow the easy provision of bilingual services for any caller in the state. A substantial number of Californians speak English only as a second language at best, yet certainly have useful information about the performance of California physicians.

As important as outreach and consumer information are, a system designed to protect consumers cannot rely on them alone. Patients are not in the best position to judge the competence of physicians. They do not know the standards of medical performance required by law, and they are not in a position to compare decisions and outcomes across a wide population. In the other two areas of discipline—drug abuse and dishonesty, consumers may be equally unable to detect serious violations. Excessive prescribing of drugs is not best detected by the consumer victim (or instigator) who is not likely to report the violation. Physician dishonesty is equally undetectable by consumers, particularly the kickback/conflict of interest problems which are endemic to the medical profession. A patient is not in a position to compare the bill received for a procedure referred by a doctor to

¹⁰These calls result in the designation of approximately one in ten as a facially valid and jurisdictional complaint. Approximately 5,000–6,000 per year are so designated. About one-half of these are then closed as without merit or are subject to informal mediation, warning, or “conference” with the regional medical consultant, with the remaining one-half (2,400–3,000 per year) assigned to an investigator for formal investigation.

¹¹Note that the Assembly Office of Research reports that the Fresno office “was unfairly overburdened by complaint calls” (Report at 14), while others have adequate resources. A comparison with New York as revealed by the Assembly Office of Research report indicates the utility of standard outreach. Expanded outreach in New York in 1986 and 1987 raised the number of complaints received by the state’s physician discipline system from 2,352 to 3,429 as to a similar number of practicing physicians. In New York, the increase resulted in 3,380 closed cases, including 284 cases referred for hearing—three times the number in California on a similar licensee population base (Report at 31).

determine whether it is at market level, or reflective of unlawful rebates to the referring physician.¹²

As one alternative to total reliance on consumer complaints, DMQ must monitor the various section 800 reports described above. At present, it monitors criminal convictions; malpractice actions which are settled or adjudicated in amounts above \$30,000; reports of excessive prescribing (725 reports); reports from other physicians; and, to a limited extent, self-reporting through its diversion program. Finally, as noted above, BMQA receives certain information—usually in the area of drug abuse—from other agencies such as federal DEA and the state Board of Pharmacy. Each of these areas of information-gathering has serious impediments to its utility.

The tracking of criminal cases post-conviction and referral for possible discipline is not timely. Final conviction following appeal often occurs three to four years after the criminal acts occurred. Under the current scheme, physicians are able to continue practicing during this long interim and often face disciplinary charges not only after they have been convicted, but after they have served their sentences. DMQ is then in the difficult position of attempting to punish someone for a transgression that occurred many years ago and for which that person may have “paid his/her debt to society” through incarceration or stringent terms of probation imposed by a court.

In fact, many criminal cases warrant immediate action by DMQ to suspend the license of those who are accused prior to conviction. The standard for conviction of a criminal offense is proof beyond a reasonable doubt; the standard for the revocation of a license is clear and convincing evidence to reasonable certainty. The two standards are substantially different. Further, the societal interest in deterrence and retribution in punishing a criminal may be less urgent than the need to remove that person from a position of trust as a physician in the community. Information about the potential criminal conduct of physician licensees should be available at point of arrest by automatic tie-in of DMQ to the Arrest Notification System (ANS) of the Attorney General’s Office. Where licensees are fingerprinted, this system allows the automatic notification of a regulatory agency whenever its licensees are arrested at the time of the arrest. The Bar has agreed to submit fingerprints of new licensees to the ANS so this automatic notification may take place at the most appropriate point in time—at the initial discovery of the possible criminal act. DMQ should do likewise with new medical licensees.

Shortly after a criminal arrest occurs for a felony offense (within three weeks for a defendant held in custody), a preliminary hearing is held in municipal court. At this hearing, witnesses testify under oath and are examined by prosecutors and cross-examined by counsel for the defendant. The defendant is present and may testify should he/she so desire. The proceedings are under oath and a transcript is prepared. If and only if enough evidence is presented at that hearing to indicate probable cause that a crime was committed and reasonable suspicion that the defendant committed it, the matter is “bound over” to superior court for a felony trial. The transcript of the preliminary hearing, constituting testimony under oath, is a critical albeit underutilized source for DMQ to evaluate the charges and case (in addition to consulting with the district attorney involved).

¹²Major cases over the past two decades have documented substantial unlawful rebating for referral of patients to medical laboratories and ancillary health providers. For example, in *People v. TFI*, prosecuted by the Director of CPIL while a deputy district attorney, over 200 physicians readily agreed to a salesperson’s pitch to bill patients three times market levels for laboratory tests in return for “limited partnership shares,” subject to increase based upon the volume of business referred. This direct kickback system was participated in by over 200 physicians before a single physician complained to the district attorney. BMQA failed to discipline any of those involved, although the evidence was made available to the agency. These violations were not detected, nor were they detectable, by consumer victims.

Although the burden of proof is somewhat different in a preliminary hearing than a license revocation case, the preliminary hearing transcript may be used for the latter and can be an important tool for interim relief remedies (discussed below). It has been traditional in DMQ discipline to wait until the conclusion of a criminal (or of a civil) case, and then to apply the result for discipline purposes. There is no reason why discipline cannot occur contemporaneously. It does not necessarily cover the same ground, it has a different burden of proof, and it is a more urgent proceeding. It should not trail gratuitously.

B. Section 801–03 Reports (Malpractice Actions)

Section 801, 802, and 803 reports concerning malpractice actions are made to DMQ only if there is a settlement or judgment in excess of \$30,000. There are two problems with this reporting mechanism. First, a \$30,000 stipulation or judgment figure may or may not relate to the appropriateness of reporting the matter to DMQ for its separate purposes. Damages in a malpractice action may be limited for a variety of reasons.¹³ A physician defendant will be aware of the BMQA notice threshold of \$30,000 and may take \$25,000 from the insurance company and make a side arrangement for additional funds personally. Alternatively, medical malpractice cases often involve multiple defendants; the physician can avoid reporting by keeping his/her own settlement below \$30,000, while the plaintiff recovers from other defendants.

Even in a litigated case, the degree of negligence of the physician and its likelihood of recurrence are not factors which directly relate to passing the \$30,000 threshold amount for reporting. A physician may commit a series of egregious wrongs, but the patient involved may not suffer severe damages beyond additional medical treatment costs. However, the competence level revealed may bode ill for future patients, which should be the focus of DMQ concern.

On the other hand, the fact of a malpractice filing is important information for DMQ. The law provides substantial protections to doctors from malpractice cases. Under the new MICRA statute,¹⁴ medical malpractice actions are severely limited. Attorneys are limited on their contingency fees, lessening the likelihood of spurious claims. Before each case is filed in court, it must be evaluated and certified by a qualified medical expert indicating negligence below acceptable standards for medical practice in that area. Damages are strictly limited. Hence, where cases *are* filed, they are worth looking at.¹⁵

BMQA only learns about these cases at their conclusion, replicating the problem with criminal convictions discussed above. These allegations, given the MICRA statute, are appropriate for immediate DMQ evaluation and tracking. As with the preliminary hearing in a criminal context, civil filings are made under oath and often include early discovery “on the record.” On-the-record documents include pleadings and transcripts of depositions of witnesses under oath. At the very least,

¹³There may be a statute of limitations problem or technical defense barring civil recovery, leaving defense counsel to bargain the case away at a lower figure.

¹⁴The Medical Injury Comprehensive Reform Act was added by AB 1XX in 1975.

¹⁵Note the marked and steady increase in reported settlements with 457 in fiscal year 1984–85 increasing to 715 in fiscal 1987–88 (see Exhibit 3, Table 11).

a review of this evidence as available will enable BMQA to evaluate the case for its own purposes.¹⁶

DMQ should evaluate all malpractice actions from the filing of a claim or suit and track them in all official documents filed as to any licensee under its jurisdiction thence forward. Where evidence adduced indicates the likelihood of an incompetent practitioner, DMQ should proactively intervene contemporaneously with the civil action (not after its conclusion) to protect the public through interim relief or independent license revocation action.

It is important for DMQ to be aware of the fact that in both criminal and civil cases filed against physicians, its licensure revocation power may be used by prosecutors or plaintiffs in an inappropriate way. It must not defer to the decisions of prosecutors or plaintiffs to plead to lesser charges or agree to settlements or even dismissals. To allow a case outcome to influence DMQ's determination results in prosecutors and plaintiffs using the threat of license revocation as additional leverage for their own narrow purposes. DMQ must make its own separate evaluation free from the process of criminal plea bargaining or civil case settlement. It must be prepared to pursue a case even where the plaintiff has been "bought off" by the physician in a civil settlement. Its function is to protect the public and prevent future incidents from occurring, and if that requires the compelled subpoena of plaintiffs who have been satisfied, then that is what must happen.

C. Coroner Reports

Coroners are another major source of information about serious physician incompetence. Coroners evaluate causes of death as a professional specialty. They are in a position to perform autopsies, detect medical failure, and assess physician performance. At present, coroners are theoretically able to report possible negligence by physicians—but rarely do so. Coroners are part of the medical profession and work with practicing physicians. This regular working relationship creates an occupational interface which makes the reporting of physician incompetence extremely difficult. Coroners who report errors or incompetence may face pressure or accusations of bias. They are also subject to charges of "turning in a colleague" with the possible consequence of depriving that colleague of his/her livelihood.

The California Coroners' Association has candidly admitted that its members do not routinely report physician error or incompetence because of the current voluntary nature of the system. The Association has requested a mandatory requirement to report in order to, in effect, "take its members off the hook." By removing the discretion, the outside pressures not to report are eliminated. Further, the Coroners' Association believes that reports indicating negligence should be filed without requiring

¹⁶At present, the manual used by CSRs effectively instructs them to disregard malpractice cases. See CSR Desk Manual (March 1987) at 3–4. In a letter to Assemblymember Jackie Speier dated November 8, 1988, BMQA Executive Director Ken Wagstaff wrote: "The average time between filing of a malpractice claim with the court and judgment or settlement is approximately 4.5 years. This aging factor, coupled with the fact the majority of claims do not involve 'gross negligence, repeated negligence, or incompetence,' further limit the value of malpractice reports...."

In fact, most cases do indeed involve alleged gross negligence and often involve repeated acts or are second or third cases against a licensee. BMQA here confuses the proper course of plaintiff's counsel to allege what is needed to sustain a judgment (simple negligence) with what the facts may show. The solution to the infirmities in this important source of information is to review it in a timely fashion and look at the evidence gathered by others, not abandon it. Nor is Mr. Wagstaff's citation that "less than 1%" of DMQ's investigations originate from malpractice reports appropriate. This self-fulfilling justification for nonfeasance is not persuasive and is instantly deflated upon any review of the facts of a large number of these cases. A pattern of past failure and self-created impotence does not justify its perpetuation.

the coroner to make any findings regarding “gross negligence” appropriate for discipline. Just as the coroners do not want discretion on *whether* to report, they also do not want discretion on *what* to report.

These changes in the reporting requirement were endorsed in principle by the MQRCs and DMQ in December 1988. Draft legislation has been formulated. That legislation provides:

when a coroner or deputy coroner receives information indicating that a death may be the result of physician negligence or incompetence, a report shall be filed with the Board of Medical Quality Assurance....The initial report shall be followed, within 90 days, by copies of the coroner’s report, autopsy protocol and any/all additional relevant information.

The report required by this section shall be confidential.

No county coroner or medical examiner, nor any authorized agent thereof, shall be liable for damages in any civil action as a result of his or her filing of a report pursuant to this section.

This legislation is important in stimulating one of the most important sources of information available to DMQ about physician incompetence and deserves enactment.

D. Section 805 Reports

Until 1988, whenever a licensed physician was “denied staff privileges, removed from medical staff of the institution, or if his or her staff or membership privileges [were] restricted for a cumulative total of 45 days in any calendar year for any medical disciplinary cause or reason,” a “section 805” report must be filed with BMQA. A report includes a statement detailing the nature of the action and the reasons for it. The law also required that a report be made if the removal or restriction was “by resignation or other voluntary action that was requested or bargained for in lieu of medical disciplinary action.”

This mechanism for reporting physician incompetence, drug abuse, or dishonesty is theoretically among the most important sources of information about physician performance extant. Those with whom a physician works know more about his/her economic arrangements, sobriety, and medical competence than do patients. They are in a position to survey his/her work in relation to that of others in the community.

Unfortunately, most of the protection from physician incompetence derives not from the state agency assigned this basic purpose, but from the private decisionmaking of medical clinics, hospitals, and other institutions. Physicians must have access to these facilities in order to practice, and to the extent that these facilities deny that access, they affect who the practitioners are.¹⁷ For the same reasons that coroners are hesitant to report occasions of negligence, so are colleagues of impaired or incompetent physicians. A detection mechanism that depends upon such “turning in” may receive as many reports based on personal animosity and “hospital politics” as on medical performance.

¹⁷The number of physicians subject to hospital privilege denial or withdrawal in 1987–88 was 249, nine times the number whose license were revoked by DMQ over the same period (see Exhibit 3 at Table 5).

While reviewing the basis for denial or suspension of staff privileges, DMQ seeks to compel information about a physician's performance which would otherwise be unavailable. In so requiring, DMQ must recognize the inappropriateness of total reliance on these private decisionmaking structures. Many do not afford the physicians involved traditional due process and most have historically raised serious antitrust questions. The extent to which a group of competitors controlling a medical facility is able to effectively boycott a competitor by excluding him/her from an institution may indicate incentives other than the objective evaluation of medical performance. In an industry as lucrative as medical practice, such ancillary incentives are not insignificant.

While there are examples of the inappropriate boycotting of physicians because of personality or economic factors, there is also physician inactivity in the removal or denial of staff privileges for clearly incompetent practitioners. This latter phenomenon is the result of an inherent conflict of interest in a medical institution turning away someone who provides economically rewarding business. That "underactivity" is exacerbated by confusion over the required due process procedures to properly deny staff privileges in the private setting, the possibility of antitrust exposure should its decision not be upheld on appeal, and the possibility of personal liability for the persons making the decisions. Whatever the justification for these fears, they are perceived as real.

The problem of unjustified denial of staff privileges is not directly critical to DMQ's discipline detection needs because DMQ must conduct its own independent evaluation. A greater concern is the fact that the entire process of denying or suspending staff privileges as a basis for incompetence review is flawed because of the extreme disincentives to deny or suspend those privileges notwithstanding incompetent practice, and further disincentives to file section 805 reports where such privileges are suspended or revoked. The problem for DMQ is not obtaining too many 805 reports, but obtaining too few.

The section 805 law described above was altered effective January 1, 1988, making a number of changes. These changes were to some extent spawned by the Federal Health Care Quality Improvement Act of 1986, an attempt to improve the amount of data concerning peer review actions and to encourage those activities by extending immunity to those making reports through state and federal law. Two years ago, legislation (SB 1620 and AB 2249) was enacted by the California legislature, effective January 1, 1988. These bills require more peer review entities to report; expand somewhat the definition of "staff privileges"; and require reporting of staff privileges suspension for 30 days rather than 45 days, the furnishing of a copy of the 805 report to the person who is its subject (with notice of his/her right to submit exculpatory information to the agency), and supplemental reports where the licensee is deemed to have satisfied any terms or conditions imposed as a precondition to renewed staff privileges. As with the previous law, section 805 reports about a physician are submitted to other hospitals to whom that physician may apply for privileges.

Procedurally, BMQA takes section 805 reports and sorts out those which concern only failure to properly "complete" medical records. These are by law not distributed under section 805.5 to other medical institutions. If the report is for medical disciplinary action, the reports are logged into a "master log book", and sent to Enforcement. The information cover sheet is completed by Enforcement and returned to be logged again in the master log book. They are sent to the specific regional office where the physician is practicing. Reports that are to be investigated are given a CITS number (see below). The reports are then xeroxed and five copies are made: one copy to the regional office, and four copies to the file to be mailed upon written request to the different health facilities and organizations which, in turn, mail in the 805 reports.

There are numerous problems with this statute, even as amended. First of all, the statute defines the term “denial or termination of privileges” to mean “failure or refusal to renew a contract or renew, extend, or re-establish any staff privileges, when the action is based on medical disciplinary cause or reason.” A primary problem in receiving adequate information, even where an institution decides to deny, suspend, or revoke hospital privileges for a licensee, is the tendency to let the licensee know there is a problem and to allow him/her to voluntarily resign prior to proceeding. The other institutions where that physician may have privileges never learn of the problem and BMQA never investigates his/her performance. This “withdraw your application or resign now” (or take a “vacation”) option is understandably tempting for any medical institution. The alternative is going to be, under the law as it is evolving, a full-blown due process hearing.¹⁸ Further, there is the danger of countersuit.

On the other hand, the institution may be concerned, in good faith, about its reputation and its other practitioners should this marginal or incompetent practitioner be allowed to continue. The easy way out is the withdrawal or resignation option, which does not trigger an 805 report. In order to meet this problem, the amendments of section 805 purport to require the reporting of resignations as well. Section 805(d) states: “in addition to the duty to report set forth [above] the peer review body also has the duty to report under this section a licentiate’s resignation from membership, staff, or employment following notice of an impending investigation based on information indicating medical disciplinary cause or reason.”

This resignation reporting has a number of problems. First, it does not apply in cases where an initial application for privileges is made but has not yet been reviewed, and is then withdrawn (perhaps upon informal indication that it would not be accepted). More important, what does “notice of an impending investigation” mean? In fact, those with existing hospital privileges, to whom the resignation reporting requirement may apply, are well aware in the normal course of the prospect of an “impending investigation.” It is unclear when the “impending investigation” is initiated, and when a withdrawal occurs before it is initiated, thereby excusing a section 805 report. Second, it is also unclear what is a “medical disciplinary cause or reason” in practice. If the reason is otherwise, no report is required.

Although well-intentioned, the alterations in the law effective January 1, 1988 do not solve the underlying problem. That problem is two-fold. First, it is reliance on the evaluation of the performance of physicians as they practice in their specialties by existing competitors and institutions as the basis for competence judgment. The second and subsidiary problem is a reliance on the reporting of such incompetence by institutions with strong disincentives to provide those reports except in extreme circumstances.

The most important legislative change which might address at least the subsidiary problem is the granting of clear immunity to those who do report the incompetence of other physicians.

Section 805(d) provides that “no person shall incur any civil liabilities as a result of making the report required by this section.” However, the information provided leading to the report, and information directly from physicians to DMQ about other physicians, is subject to a limited immunity

¹⁸Although cases allow more leeway than in administrative license revocation proceedings (see *Young Rhee v. El Camino Hospital District*, 201 Cal. App. 3d 477 (1988)), the procedural burden is nevertheless significant.

provision allowing suit where the matter is not “reasonably believed to be true.”¹⁹ While it may appear appropriate to allow a cause of action against someone who “unreasonably believes” reports of drug abuse, dishonesty, or incompetence, such a limited immunity operates as virtually no immunity at all. In fact, the plaintiff need simply allege a lack of reasonable basis to file suit. The potential exposure of having to defend such a case seriously impedes reports of drug abuse and incompetence.

Reports made directly to DMQ should be absolutely privileged without limitation or condition. These reports are kept confidential by the agency and are the basis for “leads” for its own independent investigation. Where a licensee continuously provides false leads, the agency may begin to disregard that information. However, the information is not provided to the general public to slander the reputation of the physician involved, but is provided to a state agency with the responsibility to evaluate the sobriety, competence, and honesty of physicians. That report should be made with full confidence that there will be no retribution, including the filing of a lawsuit.

Exhibit 3, Table 11 presents the historical and recent data of information disclosures through section 800 reports to DMQ. In relation to the number of physicians known to be drug-impaired, the number of reports is minimal. The reports coming from physicians about the incompetence of their colleagues is an extremely minor source of information given the current constraints on such reporting as noted above.

Failure to submit a section 805 report gives rise to a misdemeanor criminal offense. However, as noted above, staff privilege withdrawal before the impending investigation “begins” and the ambiguity about the cause being a “medically disciplinable basis” stimulates evasion. There has yet to be a misdemeanor criminal prosecution for failure to file a section 805 report in the history of the statute. It is critical for DMQ to gather egregious examples of failure to so report, and to prosecute those cases as criminal misdemeanors in order to send a signal to the medical institutions about their clear obligations under law. In addition, a more useful and mechanical approach would be to amend the statute itself to require the reporting of all withdrawals, denials, suspensions, or restrictions of medical privileges from any institution for any reason as a routine matter. Submitted with that report should be any documentary or explanatory information available to the institution concerning the standard of care, performance, honesty, or sobriety under current standards which may apply to that licensee. Hence, complaints received by the hospital from the staff, other physicians, and patients *must* be transmitted to DMQ where there is any action regarding privileges, however that action is characterized by the institution. It is not appropriate to delegate to a private entity, or to an economic competitor in the medical marketplace, the decision regarding what constitutes a disciplinable offense. Information should be supplied to DMQ which would make that evaluation, and that information should be completely and automatically submitted as a matter of normal course.²⁰

¹⁹See Civil Code sections 47, 43.7, 43.8.

²⁰The primary incentive for an institution to suspend or revoke the privileges of a practitioner has to do with its own perception of its liability, and its competitive and professional injury should that practitioner continue association with the institution. However, even where the difficult decision to revoke privileges is made, there is no mechanism by which a decision of one hospital to revoke its physicians’ privileges becomes generalizable for public protection. No matter how exhaustive and appropriate a decision by a hospital to revoke the privilege of an obviously incompetent or impaired practitioner, every other hospital or institution with which that physician may hold privileges may make its own decision. Unless DMQ acts to protect the public, the only way an incompetent or impaired practitioner is barred from the practice is if every single private clinic and hospital makes, *seriatim*, a similar judgment. Such a private system of limitations is fragmented and generally ineffective.

Even where a hospital revokes staff privileges for a good reason, as noted above, that physician may

E. Self-Reporting/Diversion

In addition to the sources of information described above, physicians are in a position to “self-report” under DMQ’s Diversion Program. This program allows physicians who are chemically dependent or suffering from psychological ailments to enter a rehabilitation program and, in turn, receive immunity from discipline. This program, as presently constituted, is one of the most generous and solicitous programs of its kind in the nation. Rather than proceed with discipline and allow an agreement to seek medical treatment to mitigate the discipline to be imposed, BMQA opts for a maximum carrot and minimal stick by granting absolute immunity so long as the program is entered and completed. Further, if the referral into the Diversion Program does not originate with the discipline system (from DMQ), failure to complete the program will not result in discipline or discipline review. Hence, a self-surrender where discipline is likely to be imminent will achieve immunity for a licensee which, as a practical matter, precludes discipline even if the treatment program is rejected and abandoned contrary to the written agreement entered into by the licensee with the program.

We are reserving an analysis of the Diversion Program for a future report. However, there are approximately 200 persons in the Diversion Program. Approximately one-third of those entering the program have failed to successfully complete it.²¹ These statistics do not compare favorably with the magnitude of the problem. The AMA estimates that 10–15% of physicians are currently seriously impaired by drugs, alcohol, or other mental impairment. This means there are 7,000–10,000 impaired California physicians. Although such self-reporting has advantages and should certainly be attempted, it is unreliable as a source of information about physician performance and rehabilitative needs.²²

have privileges in five other institutions. Will they receive an 805 report about that physician? If they do receive it, what will they do with it? Our research indicates that a decision to revoke privileges of a physician does not necessarily mean the revocation of those privileges in other facilities. It does not even mean a vigorous review of the 805 documents or records leading to the withdrawal of those privileges by other institutions. An institution is more likely to affirmatively inquire about 805 reports of a *new* applicant seeking hospital privileges who may have been denied those privileges or had them revoked by another institution previously. But even here, there will be an explanation or evidence proffered by the practitioner *vis-a-vis* paper records presenting very limited information through the 805 process. As noted above, when a withdrawal occurs early in the process, there may be no information easily available to the other private institutions from which to evaluate the competence or status of an applicant for staff privileges.

The new statute somewhat exacerbates these problems by acknowledging this inappropriate privatization of discipline by including in the reports the “conditions” demanded by the institution for reinstatement and their fulfillment, as if these determinations are properly delegated to economically interested hospitals.

²¹In its response, BMQA argues that diversion failures are reported to DMQ, enabling it to continue investigations abated by entry into the diversion program. But this is true only for physicians diverted from DMQ discipline proceedings, not pure “turn-ins”. A diversion program is perhaps not enormously useful if it includes follow-up only in those cases where the physician has been caught. Here, mitigation of punishment should be sufficient incentive, without the abatement/immunity grant offered.

²² BMQA staff argue that it is a “quantum leap to imply that most of this population presents a known danger that must result in formal state discipline. Also, to be fair, one should consider the significant number of physicians with such problems who are currently receiving private treatment under peer review auspices.” We would respond that the numbers addressed by BMQA discipline, in relation to impairment incidence—whether as defined by the AMA or by stricter definition, rebut convincingly BMQA’s caveat.

F. Detecting Patterns

In addition to telephone calls at point of intake, all of the information described above should be included in a case investigation tracking system (CITS). DMQ has such a system, but it does not include the information described above. It does not include the 50,000–80,000 initial contacts from consumers, many of which may involve information relevant to physician performance—not that each alone constitutes evidence of a disciplinable offense, but insofar as these reports contain information which may, in combination with other reports and information, reveal a pattern appropriate for further investigation or other intervention.

As noted above, CITS does not include information about criminal matters in a timely fashion (at point of arrest), or about malpractice actions at point of filing or in all relevant cases. As to the latter, even those matters which are reported are usually “closed without merit” where the settlement or judgment is for damages below \$100,000.²³ As does the statute, DMQ incorrectly assumes that there is a direct relationship among the monetary award to a patient, the severity of the conduct, and the appropriateness of a disciplinary investigation. The concepts are, in fact, distinct. As a result, cases appropriate for computer entry for detection of marginal but repeated acts, and which in cumulative impact warrant intervention, are lost.

In addition, as the 1986 Arthur Young report documents, there are problems with the accuracy of the current CITS information.²⁴ The DMQ CITS system nevertheless represents a mechanism through which pattern detection may occur, and it does have more information in it than is the case with many detection systems. However, in an area as important as medical practice, and given the incidence of drug and alcohol abuse as well as clear incompetency problems, it is perhaps uniquely appropriate for this disciplinary entity to detect incompetence and drug/alcohol abuse accurately and early. To do so requires the accumulation of all the information available, its filtering for relevance, and its use for pattern detection.²⁵ Where the entry into an information system requires each separate piece of information to be a potential disciplinable offense in and of itself, the detection of patterns based on pieces of information unable to meet that threshold test is impeded.

G. Proactive Investigations

DMQ conducts proactive investigations primarily involving violations of section 725 of the Business and Professions Code (excessive prescribing). Where there are “repeated acts of clearly excessive prescribing,”²⁶ they may be investigated by undercover operations, pharmacy audits, obtaining patient complaint records, or other means. For purposes of enforcing the Medical Practice Act, DMQ investigators are considered “peace officers” and may engage in undercover activities.

²³ BMQA contends that the dollar amount is not determinative, but that each case is weighed on its merits.

²⁴ The Arthur Young Report notes that CITS reported 1,150 cases backlogged at a time when the actual backlog was about 700. “Separate case assignment/closure data are not provided for district offices.” “Allied Health cases are not reported by DMQ office.” “Case disposition data must be manipulated to determine the number that fall within the various closure classifications used by management.” (Young Report at III-20 to 21.)

²⁵ Separate reports of a physician who has suffered a DUI arrest, a letter from a patient complaining about sobriety, a phone call from another patient about missed appointments, and a malpractice complaint which may involve a lack of sobriety are currently not in the CITS system. They should be.

²⁶ See BMQA Investigator’s Manual, Chapter 9 at 9-11.

One impediment to this enforcement is the fact that section 632(a) of the Penal Code prohibits one-party consensual taping of communications without the permission of the district attorney or attorney general. Sheriff's deputies, city police departments, and the AG's office are exempt from this requirement. **BMQA is now seeking statutory authority to engage in one-party consensual taping exempt from the Penal Code section 632. That request should be granted.**

This authority is not the same as a wire-tap. It is simply the right to put a "wire", or place a recording device, on an undercover operator who consents to that recording. A physician or other health professional who then deals with that operator speaks not only to him/her, but to the tape recording or wire as well. Privacy rights are not breached, since they are waived in the conversation to the operator. However, the existence of the tape, whether by direct recording or wire, is often critical to the successful prosecution of the case. It establishes clearly exactly what was said and intended. DMQ is to be applauded for its proactive approach to investigating excessive prescribing. However, the same proactive approach, where the patterns detected above so warrant,²⁷ should be employed in investigating physician dishonesty and incompetence.

BMQA investigators, operating as peace officers, may serve not only subpoenas but search warrants. **The statute should be amended concerning medical privacy to allow unlimited access to medical records by DMQ investigators, subject to confidentiality within DMQ and appropriate protective orders in public discipline proceedings, to allow unlimited search of patient records for discipline purposes.** Such an intrusion into a patient's privacy occurs for the benefit of all patients and does not excessively compromise privacy rights where the information is held confidential within the agency and subject to protective order confidentiality in later proceedings and court review.

In prior years, the Bureau of Automotive Repair (BAR) has gone so far as to take vehicles with a specific and known defect to licensees in order to determine whether their diagnoses were accurate. Where incompetent, discipline was a possible outcome. We see no reason why a properly resourced DMQ could not do the same kind of proactive investigation of the sobriety, honesty, and quality of physicians as BAR has in the past successfully undertaken for automotive repairs. There is no reason why physicians in specific specialties are not tested proactively by DMQ to gauge their competence or sobriety, particularly where a pattern of behavior provides probable cause for such an inquiry.²⁸ Such proactive testing, even beyond investigation where patterns elicit probable cause, may take the form of competency tests similar to those historically used by BAR. One way to

²⁷As a follow-up to the 1986 federal statute discussed above, the Department of Health and Human Services is creating a nationwide data bank of disciplinary actions taken against physicians and other health professionals. The "National Practitioner Data Bank" will be used to provide hospitals, licensing agencies, and others with information concerning the discipline of licensees. The Data Bank will have some utility insofar as a physician may suffer the withdrawal of hospital privileges in one state, then have that information unavailable in another state where he/she may also practice. Information in the Data Bank will not be public and will be used only by medical facilities and DMQ and its counterparts in other states. The Data Bank will collect and disseminate information concerning disciplinary measures, malpractice payments made by hospitals, medical groups and insurance companies, and restrictions on hospital privileges of doctors.

²⁸Even where such probable cause is lacking, proactive testing of licensees is not precluded by law and, at least for this particular profession, is appropriate.

DMQ is in no position currently to initiate proactive inquiries even in areas of identified abuse; see, e.g., recommendations of the Commission on California State Government Organization and Economy, *The Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight*, (February 1989) at 13-14.

determine whether or not unnecessary procedures are being ordered or false diagnoses are being made is to establish a clear set of facts testing that thesis, and see what practicing licensees do when confronted with a situation which clearly and properly warrants a given diagnosis or procedure.

This proactive investigation posture is particularly appropriate in cases of suspected drug abuse where dysfunction can be fatal to patients. Hence, procedures should be established for the affirmative and required drug testing of specified medical professionals whose mental alertness and sobriety are essential to patient survival. This would include anesthesiologists, surgeons, and others whose physical fine motor skills cannot be impaired at the risk of irreparable harm. That system should allow proactive drug/alcohol testing upon a showing of “reasonable suspicion” that there is a drug/alcohol impairment problem as to that person.²⁹

H. Backlog

A condition precedent to an effective discipline system is an office of investigations able to follow up on the reporting and detection of possible abuse as described above. DMQ now has a backlog of cases which preclude immediate attention to incoming cases. DMQ staff has counted a current backlog of 721 cases. However, this figure is not fully reflective of the problem because of the limited definition of “backlog” used by DMQ. DMQ includes in its backlog only those cases which warrant investigation but have not yet been assigned to investigators.³⁰

The State Bar properly defines “backlog” as any case which has been in its Office of Investigations longer than six months (with the exception of cases designated as “complex” by the Bar’s Chief Trial Counsel). Interestingly, DMQ imposes a similar time limit for the investigation of Priority 1 cases. Although DMQ’s count of 721 unassigned cases reveals part of the backlog, cases should be defined as “backlogged” if they are in process longer than maximally acceptable time spans

²⁹Where there is probable cause to believe a motor vehicle may be driven by someone under the influence of drugs or alcohol (minimal weaving within the lane), a police officer is justified in stopping the vehicle and in demanding a chemical test (breath, blood, or urine). Refusal to comply with the test results in a six-month loss of a driver’s license by operation of law. It is unclear why a physician should not have to submit to a similar condition for licensure. And it is equally unclear why that condition should not be imposed without warning if in the context of the delivery of medical services.

Hence, the statute should provide that where there is reasonable suspicion that a physician may be drug- or alcohol-impaired, and that physician is continuing to perform services in specialties where impairment to fine motor skills will cause irreparable harm to patients, DMQ investigators should be trained and have the authority to perform spot drug or alcohol testing on the scene (at a moment that does not interfere with necessary delivery of medical services). Further, refusal to comply should be grounds for immediate suspension of a medical license in the same way that the refusal to submit to a chemical test on the highway results in the automatic suspension of a driver’s license for six months. Both are harsh remedies and both are a substantial intrusion into the privacy rights of citizens. However, in both cases they are justified—that justification is *a fortiori* as to physicians where sobriety is relied upon for the very survival of the patients who entrust to them their health and safety.

³⁰ The creation of this backlog as defined was precipitated by a decision of staff to not assign cases to investigators where investigators were already at maximum case load levels. But staff is, in fact, also beyond workable caseload levels as to *assigned* cases not among the 721 (see Exhibit 8 and discussion *infra*). The extreme time in investigations for many serious cases means that the actual backlog is substantially greater than those which have not been assigned.

for investigation or processing.³¹ Otherwise, simply assigning a case to someone eliminates a backlog. Defined in the generally accepted manner, the BMQA backlog exceeds 1,500 cases. Moreover, this backlog may be further increased if one counts cases delayed or improperly diverted at the CSR stage (now described by Chief of Enforcement Vern Leeper at 1,043 cases), and cases backlogged in the adjudication process. This latter backlog includes those cases delayed post-investigation and would properly include a substantial percentage of the 462 cases awaiting accusation drafting, hearing, or otherwise delayed.³² In total, it appears that the backlog condition of DMQ's discipline system is more serious than the backlog of the State Bar's discipline system at its worst levels.

The actual backlog of DMQ is much more serious than the reported 721 figure suggests because of its qualitative nature. Five hundred of them are Priority 1 cases involving potential patient harm. The Legislative Analyst, in analyzing the BMQA budget for 1988–89, noted that the vast majority of cases in DMQ's backlog are those involving "potential harm" to patients.³³ Almost 200 of these cases involving Priority 1 potential harm to patients have been unassigned for more than six months.

In order to deal with this emergency, the staff informed the members of Division of Medical Quality on February 28, 1989 that it was altering its investigation priorities and procedures as described in Section III above. The staff noted that in addition to the current 721 backlogged assigned cases and additional cases that have been in process well over six months, and other cases backlogged in other parts of the system, the number of cases coming through intake has increased substantially during 1988–89. The staff noted "during the first half of fiscal year 1988–89 we received 3,065 complaints. Of the complaints received, 1,507 were put into the formal investigation process. At this rate we will experience an increase of 17.2% in complaints and 18.5% in investigations over fiscal year 1987–88. Using these figures, we can assume a similar increase in the investigative backlog and the CSR complaint processing backlog. It is clear that absent additional staff we must make some hard decisions regarding what we investigate formally, informally and what we just can't

³¹ On March 22, 1989, in response to our request, DMQ calculated the age of cases currently assigned to investigators (beyond the 721 cases backlogged awaiting assignment) as follows:

Aging of Cases Currently Under Investigation:

	Physician & Surgeon	Allied Health Professionals	Total
0 – 30 days	122	47	169
31 – 90 days	191	75	266
91 – 180 days	246	64	310
181 – 365 days	202	84	286
366+ days	<u>217</u>	<u>156</u>	<u>373</u>
	978	426	1,404

Note: 419 of the 978 physician cases and 240 of the 426 allied health professional cases have been in investigation more than six months without resolution.

³² See Exhibit 4 (Memorandum from Vernon A. Leeper to Kenneth Wagstaff, March 2, 1989).

³³ See Exhibit 5 (Legislative Analyst's 1989 bar chart re: length of time BMQA complaints have gone unassigned).

investigate.”³⁴

The four priorities unveiled at DMQ’s March 3, 1989 meeting categorize as Priority I those cases which demonstrate actual or high potential for patient harm. The February 28 memo then revealingly confesses: “Due to the severity of these complaints a target date of 30 days for an assignment to an investigator and 180 days for completion is reasonable. However, unless caseloads assigned to individual investigators are decreased, the completion dates will be difficult to accomplish.”³⁵

Priorities 2 and 3 are simply other cases which do not involve immediate potential irreparable harm to patients. “These cases would be handled, at least initially, by the Consumer Services Representative, Medical Consultant and Supervisor.”³⁶ In other words, these cases will be effectively removed from the discipline system and subject to a phone call remonstrations or letter of warning. Fourth priority is given to complaints that do not involve patient care issues. These include “insurance fraud, absent indication that it is willful or repetitive.” (It is unclear how “insurance fraud” is ever not “willful”.) Complaints which are multi-jurisdictional and where another agency may have jurisdiction will also be classified as Priority 4 cases.

It will be nine months or more before most of the unassigned backlog will be reviewed. The current DMQ case carryover from year to year now equals in size (2,000) the total number of new investigations opened or closed during a full year. Put another way, BMQA started this year with a caseload that was 100% filled. If not a single new case appeared, more than a year would transpire before the decks were cleared for the investigators. Additional time would be required for CSR and AG backlogs.

The situation with regard to the DMQ discipline system covering doctors is not a matter of administrative concern—it is an emergency. In the face of this emergency, as we discuss below, BMQA’s 1989–90 budget—as approved by the Department of Consumer Affairs and the Department of Finance—includes no additional resources or positions for enforcement. The Legislative Analyst writes: “BMQA has 44 investigators and 3 limited term assistant investigative positions to investigate complaints. For 1989–90, the budget proposes to maintain the same staffing level as in the current year.”³⁷ When asked in December the direct question, “Will BMQA ever catch up on the unassigned case backlog?” Mr. Leeper simply answered, “No.”

³⁴ See Exhibit 2.

³⁵ *Id.*

³⁶ *Id.*

³⁷ Legislative Analyst, Budget Report for 1989–90, at 97. BMQA correctly notes that it requested additional positions for enforcement each fiscal year from 1986 to the present. It received over those four years 2.5 additional permanent positions. It has requested a total of seventeen positions over this period, ten of which were requested in 1986–87. All were denied by the Department of Finance before reaching the legislature.

However, DMQ requests have never approached the numbers necessary to create a functioning discipline system, particularly during the past two years. Although the Department of Finance and the current administration rightfully bear substantial responsibility for DMQ’s lack of resources, BMQA is not a “department” or “bureau” of the Executive. As a creature of the legislature with quasi-independent regulatory agency status, it has the responsibility to take its case to the Department of Consumer Affairs and the legislature directly and vigorously where it is impeded from carrying out its statutory task.

I. Authority

In order to properly respond to an overflow situation, address high-priority items effectively, or properly maximize limited resources, the DMQ discipline system needs adequate authority with which to function. This authority includes investigative authority as described above, and the power to act effectively in the interests of the public. Such authority would provide for summary proceedings. It would allow for the automatic revocation of licenses upon certain preconditions. It would provide for interim license suspension where necessary for public health and safety. It would also allow the use of flexible remedies to protect the public upon a showing lesser than the clear and convincing requirement for total license revocation.

At present, as described above, the DMQ discipline process operates along a single track. Where contested, it is a six- to eight-year resource-exhausting odyssey, during which the licensee continues to practice.

We discuss below basic structural changes for all cases. However, in addition to that generalized improvement, it is also possible to create accelerated procedural tracks with enhanced authority for DMQ. We describe in Section VI below all of the legislative changes we believe are appropriate in order to streamline and render effective the discipline system for physicians.

Critical among these proposed amendments are provisions to allow interim suspension of physicians. At present, interim suspension is accomplished through a temporary restraining order (TRO) process in superior court which is extremely difficult to accomplish and rarely attempted.³⁸ Even in cases of egregious incompetence, BMQA is effectively powerless to act to protect the public. The same kind of interim relief now used by the Bar to suspend accused attorneys should be adopted for DMQ use.

In addition, conviction of certain felonies should result in automatic license revocation, and other changes should be made to give DMQ the authority necessary to carry out its task effectively. (See Section VI.)

J. Administrative Process

Exhibit 6 outlines the actual steps of the administrative process for discipline. That chart depicts the various levels and numerous exit points and accommodation opportunities extant. Actual discipline must run this gauntlet. The system is fragmented at the outset with intake at seven regional or two district offices by one of numerous separately operating CSRs or consumer service technicians. BMQA receives from 50,000–80,000 phone calls per year from consumers. Approximately 6,000 are designated “complaints.” That culling is a critical function. One-half of these 6,000 complaints are then in turn filtered, mediated, or closed.

The specifications for the consumer services representative are included in Exhibit 7. CSR qualifications require two years of experience in state service including contact with the general public or three years in a professional trade or consumer organization handling consumer complaints. CSRs are not required to have any expertise or experience in law or medicine. They are supervised, again in fragmented fashion, by separate supervising investigators. The primary motivation of supervising investigators is the management of the backlog of caseloads described above. In the manual BMQA

³⁸No such orders were obtained in fiscal year 1987–88, and only three have been secured since fiscal year 1985–86 (see Exhibit 3 at Table 5).

supplies to its CSRs, the front-line intake personnel who actually receive the information directly from the complaining public, BMQA tells the CSRs: “Patients are the chief source of complaints to the Board.” The next sentence tells the CSRs, however, that “only a small proportion of patient complaints result in disciplinary actions against physicians.” The manual nonetheless assures the CSRs that “the handling of patient complaints is one of the most important functions of the CSR [because] the proper handling of such complaints is critical to the public’s confidence in the Board and the medical profession.” The message is barely hidden: patients who complain rarely have anything of value, but listen so that they don’t magnify their complaint or extend it to us.

The primary orientation of medical consultants has been to “solve problems” as a mediator. In addition to evaluating complaints for their merit, the regional consultants generally view themselves as “dutch uncles” to physicians who have problems. They take pride in meeting privately with physicians and in straightening out their problems. They have no expertise in the law and are not oriented toward or trained in law enforcement. Nor are they necessarily medical experts in the area of medicine addressed in the complaint.

As Exhibit 6 makes clear, there are numerous exit points or opportunities for “private conferences” with physicians which result in the closure of matters prior to formal investigation. Less than 50% of the matters designated as facial complaints by a CSR are transmitted for formal investigation. Less than 50% of the matters formally investigated result in the filing of formal accusations, and less than 2% result in recommended license revocation or suspension. “Scoping” of discipline from intake to final disposition is to be expected, but not to this extreme degree. Whatever the failures of outreach or proactive detection, surely more than 1% of the complaints determined by CSRs to be valid must warrant actual discipline.³⁹

We discussed above the justification for a centralized intake system. **That unit should be directed onsite by a special deputy attorney general appointed for that purpose in consultation with DMQ. The CSRs should be trained in the legal requirements for proving a discipline case by someone trained in that subject.**

The existing MQRCs should serve as expert advisory panels to be used in the evaluation of cases, as expert witnesses at hearings, and as probation monitors to those who have been adjudicated appropriate for discipline. These functions are extremely important and are appropriately performed by practitioners in the field. They involve expert advice and on-the-scene monitoring. But there is no reason for current practitioners in the field to involve themselves as adjudicators of the discipline of their colleagues. They are neither experts in the law nor necessarily experts in the relevant area of medicine. Such individuals are important resources and should be used to provide information, but not to make a decision on behalf of a public agency.

The assigned intake deputy attorney general should be supervised by a specially

³⁹ Note the statistical indications of enforcement need in comparison to output: California practicing physicians have increased to 70,000; complaint receipts are up dramatically to 6,000 per year; major malpractice judgments are up to 715; hospital privilege denials for medical incompetence are up to 249; medical malpractice premiums are topping \$80,000 per year for many specialties; voluntary surrender for drug/alcohol abuse is up to 220; and the AMA estimates 7,000–10,000 drug/alcohol-impaired California physicians. All of these numbers have been increasing over the past three years. Discipline output has actually declined over the same period to a total of 109 accusations, 79 of which are pursued—leading to 27 revocations and 15 suspensions. See Exhibit 3, Tables 2, 5, 11, 14. The largest single category of discipline of any type is that which follows “discipline by another state board” (Exhibit 3, Table 8).

assigned BMQA discipline deputy attorney general. The latter should supervise a defined group of deputies who prosecute these cases on behalf of the People of the state of California.

The special deputy attorney general assigned to intake would train the CSRs in the law and review every CSR-closed case to guarantee that it is properly closed under consistent legal standards, and that it is registered in the enhanced CITS system for pattern detection, as described above. The intake deputy attorney general would then refer cases out, as appropriate, to the regional medical consultant for “warning conferences” where the violations are marginal or are not likely to result in final discipline. The cases that the deputy attorney general believes are appropriate for further investigation, based on a consistent set of proper legal criteria and an evaluation of the evidence which may be available and capable of achieving a discipline result, will be turned over to the appropriate regional investigating supervisor for further investigation, as is presently the case. However, at the same time, a prosecuting deputy attorney general would be assigned to the case. That attorney general will supervise the investigative work, assist the investigator in identifying evidence which must be obtained in order to sustain any discipline sought, approve closure, and seek interim suspension where appropriate.

The present system of CSR categorization, medical consultant consultation, followed by DMQ investigation would not occur in the current fragmented and unsupervised fashion. Competence, honesty, and even drug abuse cases are often complex and involve difficult questions of proof. The discipline system is a legal process. Those who are trained in relevant legal procedures, with the guidance of expert advice on the medical practice aspects, must properly control the process. Where cases are complex, as is often the case, it is necessary to have the person who must conduct the hearing and the person who must gather the evidence working together from the start.⁴⁰

The regional medical consultant should review the progress of the investigation and comment on its technical features and medical aspects. The deputy attorney general supervising the case can direct the gathering of evidence and, together with the regional medical consultant, refer matters involving expertise to specific MQRC members or DMQ volunteers expert in that field of medicine. There is a lack of even facial justification for the use in a discipline process as adjudicators or final decisionmakers persons because they have some medical expertise where: (a) the judgments they are rendering are legal judgments, not medical judgments; and (b) their expertise is not in the area of medicine relevant to the case. Both serious defects are remedied where a person with specific legal expertise, responsibility, and knowledge of statewide standards of prosecution and appropriate remedies, can obtain precise medical advice from the experts who know about that particular field or a particular case. This revised structure would also facilitate the undercover operation of investigators since they will be working under the direct supervision of the deputy attorney general. It makes more possible the proactive undercover investigation in other areas, ranging from drug testing to the testing of competence described above.

In addition to structural problems, DMQ’s administrative process is suffering a serious work overload. Exhibit 8 indicates the problem. Caseloads have increased from 35.6 in 1982 to 43.4 in

⁴⁰ Very few major white collar crime entities in the state operate on a “hand-off basis” as does the DMQ system. Under the DMQ procedure, an investigator in the field works up an investigation and at some point, following the approval of staff and regional medical consultant, submits the matter to the AG (performs a “hand-off”). At this point, the AG may be dissatisfied with the investigation and require additional work. This kind of case is prosecuted effectively only where the prosecutor and the investigator work together from the beginning.

1987. At present, if the isolated unassigned backlog were assigned, case levels would exceed 60 per investigator, double the prior staff estimates of optimum levels. Perhaps even more important has been an increase in cases monitoring those on probation. These cases have increased in number from 65 in 1982, to 75 in 1987. We believe current levels approximate 80 per investigator. These cases concern those impaired or incompetent practitioners extreme enough to survive the vigorous culling described above and indicated by Exhibit 6. These physicians are a demonstrable danger and cannot realistically be monitored at current caseloads.

K. Legal Process: Hearing and Review

Under the current system, following the multi-staged administrative review, the matter goes to hearing before a five-member panel of the Medical Quality Review Committee and/or an ALJ from the Office of Administrative Hearings. The matter is then subject to review by and oral argument before DMQ itself.

This administrative process has some severe drawbacks. First, because the factual determinations, findings, and recommended discipline are not being decided by a court, and because a physician has a constitutional right to "court review," the end result will usually be judicial review of the entire proceeding under the "independent judgment test." This phenomenon tends to lessen the value and utility of what went on before. That is, the "trier of fact" in an administrative proceeding (either the ALJ or an MQRC panel with an ALJ making evidentiary rulings) is the judge who sees and hears the witnesses, and who makes the very important factual findings. It is a sensible presumption of American law that it is important to see the witnesses and evidence directly. Evaluating credibility of witness testimony requires physical presence. Courts accord a great deal of deference to the factual findings of the person who directly sees the witnesses and their cross-examination, considering not only what they say, but how they say it. In any discipline case, these judgments are of great import. However, the hearing where this decision is initially made is not held before a "court". Hence, a reviewing court, who does not see the evidence, must exercise its own independent judgment as to what the facts show, but has only the transcript from which to work. The more removed one is from actual testimony, the more one may be swayed by the vagaries of the adversarial process and by skilled counsel.

To the extent possible, decisions should be made by people with the most information and who have maximum knowledge and independence. Such is not the case in the current context. Rather, panels from one of fourteen different MQRCs are likely to make the factual findings. Although the involvement of these persons is justified by the need to provide "expertise," in fact, more often than not they lack expertise in the particular area of medical practice at issue. Likewise, the review by DMQ, although it consists of a majority of practicing physicians, is likely not to involve a review by those with medical expertise in the particular area of practice involved. Although the decisionmaker should understand the expert testimony, he/she does not have to be the medical expert.⁴¹

The judicial review process at present involves writ of mandate consideration by any one of almost 1,000 superior court judges whose decisions are not reported and who do not normally

⁴¹ In our judicial system, judges who are not themselves experts listen and evaluate expert testimony in a variety of subjects, ranging from complicated antitrust cases to the licensing of nuclear power plants without being economists or nuclear engineers themselves. Ideally, according to some commentators such as Professor Kenneth Culp Davis, judges should have available to them their own staffs of experts to enable them to properly understand those issues. Such expert resources are available to decisionmakers under the system we propose herein.

communicate one with the other. The understandable and inevitable inconsistencies in their judgments are then resolved by a series of four different district courts of appeal. Where there are conflicts at that level, final resolution occurs by petition review of the Supreme Court.⁴² However, this means of achieving consistency and judicial review is inefficient in the extreme.

Instead of a series of decisions which are, in effect, going to have to be repeated in a six- to eight-year process where contested by respondents, and at enormous cost, we propose the following alteration: a Medical Quality Court. **The Medical Quality Court's judges would perform the same functions as the ALJs. They would adjudicate cases. Since this Court would be a part of the judiciary, its process would satisfy the constitutional right of judicial review, eliminating the current duplication, delay, and expense.**

The MQRC members would assist in detecting violations, preventive educational projects, provision of expert testimony, and probation monitoring, as noted above. But they would not involve themselves in adjudication of their peers. The Division of Medical Quality, an important body, would not become involved in oral argument consideration during its meetings once every three months as an adjudicative body. It is there to perform the more important quasi-legislative function of adopting rules and setting standards for the profession. Those rules guide the discipline system in its general parameters. It makes judgments about allocation of resources. It performs a function most appropriate for a body with its expertise and workload.

The creation of a Medical Quality Court with hearing judges would provide a status for those judicial officers equivalent to state superior court judicial positions. These judges would be experts in administrative law and in medical terminology. They would communicate with each other and know their respective decisions in order to achieve consistency. They would be legally trained, and specialists in this area of law both procedurally and substantively. They would be more knowledgeable than the ALJs who are currently assigned from a large pool, and more knowledgeable than MQRC panel members in areas of law. Most important, they would be recognized as judicial officers—as part of the judicial branch. This means that their decisions would constitute judicial decisions sufficient to satisfy the constitutional requirements of due process. An administrative process that now takes four-and-one-half steps can be accomplished in two-and-one-half.⁴³ Following the decision by this panel, the matter could then be assigned to a specific court of appeal now existing, a group of court of appeal judges so assigned, or a separate court of appeal panel specifically established for review purposes (should the volume of cases so justify). Following the review at the court of appeal level, there would be the current discretionary petition for review to the Supreme Court. It would be a one- to two-year system instead of the six- to eight-year system now in place.

The system we have described above is not just a theoretical model; it is the system which has been accepted by the State Bar for the discipline of lawyers and which is now being put into effect. In adopting this system, the State Bar Board of Governors surrendered its role in reviewing the discipline of attorneys. It still engages in the very important rulemaking process, as described

⁴² One of the bases for the Supreme Court's granting of such a petition is the existence of inconsistencies among the various district courts of appeal.

⁴³ The current steps — MQRC/ALJ hearing, DMQ hearing and review, superior court writ of mandate "independent judgment" review, court of appeal review, and petition to the Supreme Court — would become hearing before the Medical Quality Court; appeal to the court of appeal; and discretionary petition to the Supreme Court.

above, but has properly deferred to an independent, professional, and expert entity the determination of these questions in the public interest. The Bar did so at the price of a dues increase of \$110 per member for discipline enhancement, including the creation of this court system.⁴⁴

L. Access to Information—Disclosure

At present, no information is made public about a physician until or unless a formal accusation is filed by the Attorney General. Even if a physician is the subject of nine complaints and seven malpractice actions, DMQ will not release that information, even where a consumer calls and asks for the current record of that particular physician. In fact, the consumer would be firmly and misleadingly told that the physician has “no record of discipline.” Nor are the section 801, 802, and 805 reports made public. The proposed national Data Bank will be likewise for agency and medical facility use only.

With a single toll-free 800 number and a computerized CITS system that operates from the intake level, DMQ could and should provide useful information to consumers who inquire. If a hospital or colleague makes an inquiry about a physician’s record, they also deserve to know the truth. We acknowledge that most complaints are without merit. This is true because consumers are often confused about the jurisdiction of the agency they are talking to, or about the legal standards that are currently effective. However, if there are one or more ongoing investigations designated as Priority 1, it is unclear why that information should be concealed from consumers who inquire. Certainly, no information should be disclosed until the complaint has been reviewed, and it is determined that the matter is at least facially appropriate for discipline and that it falls into a Priority 1 category relevant to public safety. It is also true that any such disclosure should be made with the appropriate disclaimer, including the following elements: the matter is under investigation; no decision has been made to file charges; there has been no finding of wrongdoing by the physician; the matter is still pending inquiry.

Patients deserve to know the whole truth about a physician to whom they entrust their lives, health, and future. The information has been compiled by public officials paid through tax dollars and is subject to appropriate qualification. Where complaints have been filtered from 50,000–80,000 initial calls made to BMQA,⁴⁵ to approximately 6,000 designated as complaints, to 3,000 serious enough to be submitted for investigation and to be prioritized as Priority 1, consumers should be informed upon request that the physician they inquire about is the subject of such an investigation. Further, if there is a malpractice filing or a criminal arrest, both are matters of public record, and the DMQ (which should be gathering that information as described above) should reveal that as well to any consumer upon request, again with the appropriate disclaimer.

M. Resources

The Board of Medical Quality Assurance has authority under Business and Professions Code section 2435(e)(3) to assess its members dues sufficient to accomplish its statutory tasks. The

⁴⁴ Note that in addition, the Bar did not benefit, as will BMQA, from the reduction of steps. The Bar system does not allow a writ of mandate in superior court review or a court of appeal review; appeals are taken directly to the Supreme Court from administrative process because of the Court’s unusual concern over the legal practices of attorneys operating under the imprimatur of that court.

⁴⁵ This range is a count of all calls. DMQ has not broken down the calls by source or type. Many are not initial complaints about physician competence. However, a significant number may be reasonably assumed to concern matters within DMQ’s jurisdiction—which is focused on the assurance of medical quality through the monitoring of physician and allied health professional performance.

renewal fee it currently requires of most licensees is set at \$290 every two years (as of 1989). The previous level was \$255 every two years. The amount was raised from \$255 to \$290 not in order to add new enforcement personnel positions, but simply to keep the current reserve balance surplus at a level equivalent to four months of agency spending. That is, the minimal increase that occurred in 1988 was accomplished for technical budgetary reasons and not to create any new positions in licensing or discipline. Exhibit 3 includes statistics concerning the increase in the number of licensees and complaints entering the discipline system. The former is increasing but the latter is not. Exhibit 9 includes past, current, and projected budgets for BMQA enforcement. As noted above, there is a current backlog of cases involving physicians actually and potentially harming patients of unprecedented proportions.

The minutes of the DMQ meeting on December 2, 1988 in San Diego illustrate the candor with which the staff has been attempting to apprise the Division, the Board, and the current state administration of DMQ's problem. To quote Enforcement Chief Vern Leeper: "However, even though these [enforcement] vacancies have been filled, it does not mean that enforcement program is out of the red. As far as cases in the backlog, the program has been in the red for a couple of years and it doesn't look like things are going to get any better." Mr. Leeper described a backlog in excess of 700 cases statewide, primarily in Orange County, Los Angeles County, and in the Bay area. Leeper continued: "The enforcement program has attempted over the years to acquire more staff. They have had studies done by the Little Hoover Commission, the Department of Finance, and a study contracted with Arthur Young and Company. Unfortunately, for the last eleven years, these studies have not helped get additional staff, with the exception of two investigative positions to work surveillance cases in 1979. At one time additional staff was obtained to work licensing fraud cases when the influx of licensing fraud cases hit California. The positions were limited terms and the enforcement unit has been able to retain one permanent position."

BMQA did request ten additional positions in fiscal year 1986–87. All ten were refused. Subsequent smaller requests have been similarly cut from the budget by the Governor's Department of Finance. It appears that DMQ has essentially thrown up its hands following the 1986–87 denials. At its meetings, its staff and members bemoan these irresponsible decisions of the Department of Finance, and then resign themselves to the outcome. Requests since 1986–87 have been generally sequentially smaller up to the present budget. DMQ's self-surrender creates a Catch-22 which is as much an abdication as the ill-advised denials of the Governor's budget officials. DMQ is mandated to carry out a legislative directive and has been straitjacketed into paralysis. Its response should not be a quiet whimper but a steadily rising cry of alarm, buttressed by candid confessions of resource impotence and increasing demands for the necessary positions.

It is particularly ironic that physicians pay but \$145 per year in renewal fees. This is approximately the same amount of money that lawyers *added* to their dues to achieve the current \$417 per year figure they are now paying, primarily for discipline. BMQA identifies 57% of its budget as allocated for discipline (in addition to a properly allocated portion of its overhead). The Bar, with a licensee base and complaint level approximately 50% higher, is now spending over three times more than are physicians on their discipline system. This includes comparable costs for intake, investigations, prosecutions, adjudications, and discipline follow-up.

We recommend that renewal fees for physicians should be approximately doubled as soon as possible. An additional \$8–9 million is required to implement the Medical Quality Court system, to retain the services of the assigned supervising deputy AG and full-time staff AGs, and to provide sufficient investigative resources to enable this agency to accomplish its assigned tasks. The additional resources—in conjunction with the efficiency-enhancing changes of centralizing intake, placing the system under the control of those with expertise, diminishing the number of adjudicative

steps from four to two, and the other changes discussed herein—would make a marked difference in the quality of DMQ's output and of medical care delivery in California.

What is most puzzling about the failure of the current discipline system is that it costs the doctors who support it money. Attached as Exhibit 10 are the medical malpractice rates of the largest carrier of medical malpractice insurance in southern California, effective 1989. For most medical practitioners, current premiums range from \$20,000–\$80,000 per year. Using a fairly typical figure of \$50,000, the current annual renewal fees devoted to funding the physician discipline system amounts to the malpractice premiums paid *every six hours* of a typical 2,000-hour working year.

Studies in the area of attorney malpractice, where premiums are in the \$4,000–\$6,000 per year range, indicated convincingly that expenditure of an additional \$110 per year per attorney would more than pay for itself in reduced insurance premiums. For physicians, the argument is far more telling. First, the premiums are much higher. Second, the relationship between malpractice premiums and discipline is much clearer. Unlike the case of attorney discipline, which focuses on dishonesty, BMQA discipline focuses on drug impairment and gross incompetence, directly related to claims payouts which form the purported basis for insurance premiums. Particularly in the context of Proposition 103's requirement of effective competition among insurance companies (the removal of the antitrust exemption), it is reasonable to assume that at least a portion of any reduction in claims payouts will result in a reduction in insurance premiums.

It is also obvious that notwithstanding the perception of many in the medical community, many malpractice cases have merit. Further, those physicians who attract meritorious claims are likely to attract more than one. Our interviews with insurance executives affirm that there is a definite relationship between physicians who are subject potentially to the discipline system of DMQ and those who are often defendants in major malpractice actions. Further, those conversations affirm a clear relation between more aggressive discipline of incompetent physicians (whether it be rehabilitative or excision from the profession) and the reduction of cases and claims paid. Insurance executives know that many cases filed have merit and that many are against repeat offenders. At present, those costs are effectively socialized among all physicians. Those physicians who practice with care are subsidizing those who repeatedly suffer malpractice judgments.

In recent years, the legislature has properly shown more interest in reviewing the special funding levels of the boards and commissions regulating professions and trades in California. Hence, it carefully scrutinized the State Bar's 1988 dues request submitted in AB 4391 (Brown). These renewal fees are not direct taxes, but they operate indirectly as taxes since any fee imposed across an industry will be passed through to the users of those services. But in this case, the fee increase will result in a net reduction in medical costs. Investing a certain amount of money in a fee enhancement (although it is passed onto consumers) in order to reduce a greater cost which is also passed onto consumers (malpractice premiums) will achieve a net savings for consumers. It is clear to us that the effective expenditure of resources as we have described, and at levels that we are proposing, will yield a substantial return—to the benefit of physicians who are currently paying outrageous levels of malpractice premiums, and to the benefit of consumers who pay those costs indirectly through increasing medical care costs.

For far too long, competent physicians who carry malpractice insurance have been cross-subsidizing their less competent, drug- or alcohol-impaired, and dishonest colleagues. Such is usually the case in a system where they themselves control the means for reducing those harms. In this case, it is in the interest of the public and in the self-interest of those physicians who are paying so much to eliminate the cause of that expense.

VI. YOUNG REPORT RECOMMENDATIONS/STATUTORY REFORMS

In addition to enhanced resources and enhanced authority (particularly with regard to interim suspension), DMQ needs statutory changes to accomplish the reforms outlined in this Report. These suggestions differ in significant respects from the proposals of the 1986 Arthur Young Report. Although that Report included a number of cogent observations, it also suffered from *non sequitur* recommendations deriving from a lack of understanding about these kinds of legal proceedings.

For example, that Report notes that investigators sometimes attend hearings with deputy attorneys general when not testifying and appear to be wasting time. In a conclusion typical of a time/motion approach, the Report recommends that investigators stay out of proceedings unless specifically requested on forms by deputy attorneys general. In fact, more often than not it is very important for investigators to be present in these proceedings to help with documents, witnesses, a possible rebuttal case, *et al.*; to set up a red-tape procedure to compel their daily presence is a serious and waste-producing error.

Likewise, another major proposal of the Young Report—that is, to have investigators specialize in probation monitoring so that no investigator has a mix of original and probation cases—has disadvantages. The original investigator knows the facts, patterns, and credibility of the disciplined physician better than a newcomer. Although there may be instances where an investigator should be shifted away from the physician he/she investigated in some depth (*e.g.*, should personal antagonism inhibit professionalism), the presumption should be to take advantage of the knowledge of the investigator in tracking compliance.

Nevertheless, the Young Report includes a number of recommendations of merit, primarily (1) absolute caseload limits are not appropriate where mixes of very different kinds of cases make workload highly variable; (2) caseloads should be customized in terms of quantity, depending upon the nature of the case(s) handled; (3) paraprofessionals should be used more efficiently; and (4) the CITS system should be supplemented with additional information.

In addition to the administrative changes discussed above, a number of statutory changes are compelled to give DMQ adequate authority. These statutory changes or additions include the following:

1. BMQA licensees should be fingerprinted at point of initial written examination and those prints retained for the limited purpose of entry in the Arrest Notification System of the Attorney General. (See Business and Professions Code section 6054 for analogous section pertaining to the State Bar.) This change allows computer entry, review, and tracking at point of criminal arrest rather than post-conviction years after the criminal acts.

2. Plaintiffs filing malpractice cases against physicians should be required by the clerk of the court to show proof of service on BMQA. (See SB 1434 (Presley), which would amend Business and Professions Code section 803.) Section 2220(c) should be amended to delete the word “unusually”, to require the investigation of a “high” number of malpractice awards, and not an “unusually high” number.

3. Physicians reporting disciplinable offenses of licensees to DMQ should have absolute immunity. (Requires amendments to Civil Code sections 43.7 and 43.8, or the addition of section 2318 to the Business and Professions Code.)

4. BMQA investigators should have authority, with approval from either the deputy attorney general assigned to oversee DMQ discipline, or by the DMQ Chief of Enforcement, to utilize one-party consensual wiring or taping as defined in Penal Code section 633 within the scope of enforcing the disciplinary statutes within DMQ jurisdiction. (Requires amendment of Penal Code section 633.)

5. DMQ should have authority to require competency examinations upon reasonable suspicion of incompetence liberally defined, including a single act of negligence. Current law requires a pattern of acts, death, or serious injury from a single act before competency can be tested. (Requires amendment to Business and Professions Code section 2292.)

6. DMQ should have authority to flunk a physician in an oral competency exam where two of three examiners fail to pass the examinee. At present, two examiners hear the test and both must vote to fail, followed by a second examination where both must again vote to fail the physician, or he/she is deemed to have passed. (Requires amendment to Business and Professions Code section 2293.)

7. All licensees should be required to inform BMQA whenever:

(a) they are charged with a felony offense, or with a misdemeanor involving the unlawful possession, sale, or use of alcohol or dangerous and restricted drugs; or

(b) they are subject to disciplinary charges by any other California agency or by physician discipline jurisdictions outside of California (see the State Bar version at Business and Professions Code section 6068(n)).

8. Business and Professions Code section 805 should require automatic reporting of the circumstances of all denials, suspensions, restrictions, or revocations of hospital privileges, broadly defined, including all resignations. Failure to report should not be a criminal offense, but should give rise to civil penalties in actions brought by the Attorney General of up to \$5,000 per violation, to be collected by BMQA for inclusion in its special fund. Intentional evasion of the statute should be a misdemeanor/felony “wobbler.” (Requires amendment to Business and Professions Code section 805.) The current low fine/misdemeanor structure mean that the prosecutor must prove specific intent for criminal conviction, but is confined to a low fine as a remedy.

9. Coroners should be required by law to report any indication of physician error, incompetence, or negligence to DMQ, and should be given absolute civil immunity for such reporting (see suggested provisions quoted in text *supra*).

10. Probation reports in criminal matters concerning licensees should be sent automatically to BMQA. At present, they are sealed after thirty days and DMQ often does not see them.

11. All felony preliminary hearing transcripts concerning defendant licensees should be sent automatically to BMQA.

12. The Attorney General should have the authority to obtain the immediate involuntary suspension of a licensee from practice who is an imminent threat to patient health by noticed motion before the proposed Medical Quality Court (see *infra*). The burden should shift to the licensee to show cause why such interim suspension should not be ordered where:

(a) a pattern of negligent behavior involving two or more separate acts threatening the health or safety of two or more members of the public is established; or

(b) The licensee is convicted of a felony or misdemeanor involving alcohol, drugs, or sexual misconduct; or

(c) The Medical Quality Court has issued a decision recommending license revocation. (See current Business and Professions Code section 6007(c) provisions as model; see also current sections 2313, 2236 and 2237 of the Medical Practice Act.)

13. The authority of the Medical Quality Court should include broad powers to grant remedies short of license revocation and suspension in interim proceedings for the protection of the public, *e.g.*, provisions requiring immediate supervision of certain procedures by another licensee, immediate continuing education and retesting, *et al.* (See Business and Professions Code section 6007(h) as model.)

14. Although the current “clear and convincing” test for license suspension or revocation should remain, DMQ should have authority to obtain direct orders by interim or final proceedings short of such sanctions by a “preponderance of the evidence” test. Hence, if an interim order or final order is directly imposed (not as a probationary term under a revocation or suspension order) which requires drug testing, continuing education, re-examination, or supervision of certain procedures, such an order could be entered upon meeting the “preponderance of the evidence” test.

15. BMQA should be authorized to assess disciplined licensees the “reasonable costs of investigation, hearing and review,” and the costs of probation supervision as well. (See Business and Professions Code section 6086.10.)

16. BMQA should be subjected to a statutory goal to eliminate the present backlog, to preclude future backlogs, and to conduct all investigations within six months, except for complex economic cases which should be investigated within one year. (See Business and Professions Code section 6140.2.)

17. A Complainants’ Grievance Panel should be established to audit classifications of intake as not complaints, decisions not to proceed to accusation of designated complaints, and the appropriateness of penalties imposed prior to accusation and before the process is subject to public scrutiny. (See Business and Professions Code section 6086.8.)

18. Section 2228 of the Medical Practice Act should be amended to add subsection (e), requiring a licensee on probation or subject to a direct order limiting practice to notify patients of that status and those conditions.

19. Sections 2229 and 2344 should be amended to clarify that priority is given to protection of the public and not rehabilitation, and that revocation or protective license restrictions are the presumed remedy for any licensee who has been previously disciplined, is on probation, or who has been or is in a substance abuse diversion program.

20. Section 2227 should be amended to make it clear that all discipline—whether imposed pursuant to public proceeding, agreed to, or imposed in the secret proceedings prior to filing of an accusation—be made public, including warning letters and conferences.

21. Section 2234(c) should be amended to delete the word “repeated.” Even one negligent act may appropriately result in some discipline under the lenient terms of subsections (c), (d), and (e).

22. Section 2313 should be amended to require more complete reporting of DMQ performance to the legislature, including the following: number of consumer calls received; number

of consumer calls or letters designated as discipline-related complaints; number of calls resulting in complaint forms sent to complainants and number returned; number of section 800 reports by type; coroner reports received; referrals from other agencies, respectively; number of complaints and referrals closed, referred out, or resolved without discipline, respectively, prior to accusation; number of accusations filed and final disposition of accusations through DMQ and court review, respectively; number of cases in process more than six months from receipt of information concerning the relevant acts by DMQ to filing of accusation; average and median time in process from original receipt of a complaint by DMQ for all cases at each stage of discipline and court review, respectively; number of persons in diversion, and number successfully completing diversion programs and failing to do so, respectively; number of licensees interim suspended or subjected to interim practice limitations pending final discipline, respectively; probation violation reports and probation revocation filings and dispositions; number of petitions for reinstatement and their dispositions; caseloads of investigators for original cases and for probation cases, respectively.

23. Section 2307 should be amended to require at least a three-year period before a physician may petition for reinstatement. At present the waiting period is only one year from the DMQ decision.

24. Section 2344 should be amended to require that a quorum of the diversion evaluation committees established under section 2342 must include at least one public member.

25. Section 2354 should be amended to provide that any failure to comply with a diversion program shall result in license revocation unless “the likelihood of successful rehabilitation clearly outweighs the threat of harm to patients which might occur as a result of the impairment.”

26. A section should be added to the Medical Practice Act allowing sworn testimony in other proceedings to be used in discipline matters where the licensee was represented by counsel and had reasonable opportunity to cross-examine. (See AB 2948 (Floyd) from 1988.)

27. A section should be added to the Medical Practice Act providing that a civil negligence judgment is conclusive proof of negligence for purposes of discipline.

28. A Medical Quality Court should be created, consisting of three judges appointed by the Governor, paid at superior court levels, and subject to all of the status and protections of judicial officers in every respect. These judges would handle all hearings, motions, probation revocations, petitions for reinstatement, and other proceedings of the DMQ discipline system. The judges would individually try cases arising only from DMQ and DAHP, with possible later expansion to discipline cases of the Board of Osteopathic Examiners, the Board of Chiropractic Examiners, the Board of Pharmacy, and the Board of Dental Examiners.

The Court would serve as a one-step APA and judicial proceeding, following the format of the APA, but with the Court substituting for the ALJ and agency. The statute would cross-reference APA adjudicatory procedures.

29. Appeals of decisions by the Medical Quality Court should be to a designated court of appeal, such as the Third District Court of Appeal in Sacramento, or to a special panel of judges selected by the Supreme Court for review purposes.

30. In order to finance the resources necessary to diminish the backlog and to otherwise improve the system, renewal fees should be increased from \$145 per annum to \$285 per year. The additional \$140 per licensee should yield approximately \$12 million per annum and should be spent

on payment of full salaries and overhead contribution for no fewer than 30 deputy attorneys general to be specifically assigned for BMQA investigation, supervision, and prosecution as described *supra*; an increase in the number of BMQA investigators from 40 to 70; the creation of a centralized intake system; enhanced computerization and information receipt as described *supra*; enhanced investigative resources and support staff; the establishment of a Medical Quality Court with three initial judges and attendant clerks and facilities (two judges in Los Angeles and one in San Francisco). Our experience with discipline systems leads us to estimate the following costs:

1. AG unit:	\$4.8 million
2. Investigators:	\$3.5 million
3. Centralized intake:	\$1.2 million
4. Enhanced computerization information receipt:	\$1.1 million
5. Enhanced investigative resources:	\$900,000
6. Medical Quality Court:	\$650,000
7. Additional administrative overhead:	\$1.9 million

Although the numbers total \$14 million, most of the changes will save substantial money, including the Medical Quality Court and other measures, sufficient to reduce current expenses by \$2.3 million, while accomplishing effectively a doubling of current enforcement.

It is recommended that five of the deputy attorneys general and ten of the added investigators be assigned to a special vertical prosecutions unit handling complex and difficult cases, and that deputy attorneys general be paired with investigators along specialized teams (incompetence in major substantive areas, misprescribing, *et al.*).

It is also recommended that BMQA's budget process be altered from a biennial renewal process to an annual process. Annual review by the policy and fiscal committees is appropriate to ensure effective expenditure of special fund monies which are passed onto consumers as an indirect tax.

31. Budget control language should be included which prohibits caseloads of more than fifty probationers or more than twenty-five diversion program participants per investigator.

32. Budget control language should be included which requires BMQA to spend no less than 5% of its annual budget on affirmative public outreach programs informing consumers "how to complain about a doctor" or otherwise proactively detecting violation of statutes or standards.

VII. CONCLUSION

We have omitted discussion of numerous bits of evidence in this initial Report: the analyses of hospital discharges by California Medical Review Incorporated; the MQRC Council Report (the Weisman Report), attempting to analyze why 11 of 21 cases of recommended discipline by MQRC hearing were not adopted by DMQ; and the warning sounded by the Legislative Analyst of lack of resources and backlog. There are numerous procedural infirmities we have not addressed in detail—for example, the “Physician Peer Counseling Panels” (PPCPs) now proposed not only for “misprescribing” physicians, but for “substandard practice” of medicine as well. There is also the fact that if DMQ determines that a local panel hearing a discipline case is too lenient, the result is a DMQ review—which takes almost one year, during which there is no penalty imposition whatever. There is the fact that even the rare revocations last only one year, when reinstatements may be pursued. Most petitions for reinstatement are granted within three years.

Finally, there are the specific criticisms contained in the 1986 Arthur Young Report, many of which—inevitable assurances of corrective action notwithstanding—are still quite valid: DMQ’s ignorance of discipline investigations of allied health professionals (at III-6); elapsed time for investigations is “substantially excessive” (“there is no sense of urgency...even serious allegations are pursued at a slow pace” (at III-16)); “DMQ policies are not enforced consistently...the reference here is *not* to minor mundane policies” (at III-3); “the reviewers note unsatisfactory performance in more than 15 percent of the 400 or so closed cases...reviewed” (at III-3). Although mistakenly prescribing time/motion bureaucratic band-aids (more meetings, standardized forms, *et al.*), the Young observations further indicate the underlying diagnosis presented here: fragmentation, delay, lack of competent case management, elimination of the attorneys who must prove the case from investigative management of that case, and solicitude for the profession.

One could also examine individual cases; take the case of Zaguirre, who committed and admitted to multiple acts of oral copulation on an 11-year-old girl. The respondent physician served time in state prison. DMQ was content with straight probation, until the Attorney General sought a rare motion for reconsideration. Although BMQA states that Zaguirre is “effectively out of business,” he is free to practice should he so desire.

Or take the case of Palmieri. He was involved in “cytotoxic testing,” a well-known scam. Here is a doctor of psychiatry using his name to lure thousands of patients into testing blood for “cytotoxins” in a totally bogus procedure which tests nothing for anything and which consumers are likely to rely upon to delay legitimate diagnosis. The defendant claimed he was “used” although he signed a cover letter promoting it, gave the promoters his signature stamp, and took over \$30,000 in profits. The sentence? No suspension, sixteen hours per month in community service work; a required oral clinical exam in nutrition; and a medical ethics course.

Pages of such examples are available in the public record or to anyone who attends DMQ hearings. But cumulative and repetitious recitation is unnecessary where the breakdown is as *in extremis* as it is here. The focus of this Report is on the large questions where reform would render moot specific defects. Nor, given the obvious numbers and reality of the present system, is a more exhaustive cataloguing required. In fact, further detail only serves to distract from the basic reforms which are here compelled and for which support should be forthcoming not only from public officials but from the profession itself. It is costing the profession money—and lots of it. And it will cost more and more. The failure to purge the incompetent, the drug/alcohol-impaired, and the dishonest from the profession will result in further dramatic increases in malpractice premiums already at onerous levels. Nobody gains from the current malaise: the victims of malpractice would rather have their health, the physicians would rather not pay these premiums, and the public would rather not pay for

unpredictable care at prices inflated by the malpractice premium pass-through.

The current system is mired in an “old boys club” mentality. It is fragmented, clogged, slow, embarrassingly solicitous of the profession, and produces virtually nothing. Quite literally, its final output in revocations makes it less of an effective remedy for public protection than does the current rate of death from natural causes of those who should be disciplined.

The answer lies in an effective system of detection, quick action where there is imminent harm, professional and thorough investigation, fair hearing, and the excision or limitation of those causing professional costs and public harm. Part of the current cartel system will have to give up its impeding territory in discipline. DMQ would focus on the critical area of policy- and rulemaking: the setting of standards, allocation of resources, and review of performance, for which it is appropriately constituted. Volunteer physicians would have important roles, especially as expert witnesses and probation monitors.

The system proposed involves a professional, informed, independent structure in which the public can have confidence—professional supervision of intake, enhanced detection of misbehavior, early intervention where needed, adequate resources, and a two-step administrative process of quality that combines independence and judicial review with expertise. We suggest a one- to two-year system instead of the six- to eight-year system currently extant. We suggest production. We suggest consistency. We suggest deterrence. Combined with a workable diversion program, preventive measures in the competence area, and effective probation monitoring, we would expect malpractice premiums to drop many, many times more than the relatively trivial \$140 per year estimated as its cost. Indeed, an impact of less than one-fourth of 1% on average malpractice premiums would pay for the entire increase proposed.

The structure proposed has a precedent: the California State Bar has already reduced its backlog to below the total levels of DMQ, and is on track to a model system of discipline by 1990. We have reason to be at least as demanding of physicians as of attorneys. Those who argue that the reforms are inappropriate for physicians because attorney discipline is somehow “different” are in error. There are differences to be sure, but they do not relate to the process for judging incompetence, impairment, or honesty. Both systems deserve fairness, authority, and resources to accomplish similar ends. The basic mechanisms to achieve these results are the same: comprehensive intake, detection of patterns, interim suspension powers, adequate and timely investigations, expeditious hearing and review. How should physicians differ from this model? Why?

It is difficult to appreciate the impact of the current disgraceful system on real people. We present numbers in this Report, but they represent people who have been hurt. Here is one such account:

I consulted a gynecologist for an operation in 1984 [a routine hysterectomy]...I ended with three operations instead of one. This incompetent doctor ... severed my ureter, a urologist was summoned to re-open me for another operation. Subsequently, I developed severe and annoying urinary problems; I had the third operation a year later. We paid three doctors, two hospitals, a cardiologist, three anesthesiologists, a host of radiologists and pathologists for the battery of x-rays and lab work. Most damaging ... is the blow to the spirit: not only [did it leave] me physically a wreck, it bereft me [of] the will to live, transformed my dreams into nightmares, my future a phantasmagoria.

Checking on [the doctor's] reputation, I was aghast to uncover these facts: In August

1983, he was sued for malpractice but succeeded in keeping the lid off by settling [for] \$50,000.... From 1983 to 1984 he was involved in ... litigation with Pomerado Hospital, San Diego, which Board voted to terminate his medical staff membership for failing to meet 'professional competence, professional ethics or worthiness of character.' Staff from Sharp Hospital, San Diego, where he was earlier terminated supported Pomerado presenting their own case files confirming [the doctor's] negligent and substandard patient care. The total of 9 cases cited included failure to diagnose [resulting in a patient's death]; falsification of medical data; performing unwarranted surgery; failure to administer proper clinical tests; failure/or backdating discharge dictations; failure to disclose surgical procedures performed; and unethical collusion with a patient on insurance coverage. Staff at Sharp Hospital has reported [the doctor] to the Board of Medical Quality Assurance (BMQA). Unimpressed with the palpable gross medical misconduct [and] the statistics, BMQA still considered him competent to practice — thus mak[ing] me a marked victim when I was operated on at Mercy Hospital. Thanks to BMQA!

...Gambling on worst odds, I spent a week at UCSD Medical Library preparing an 8 page credible complaint. But if the head of a medical staff could not get a dent on [this doctor], what are my odds as a health consumer? As good as Michael J. Fox against Mike Tyson! Again, BMQA found [this doctor] competent to keep on practicing. Doesn't it make you wonder if BMQA is clear where their accountability lies? Do they check supplementary superior court cases? ... Sure, doctors cover for each other...but why were the doctors at Pomerado and Sharp Hospitals involved [in their successful case to revoke hospital privileges] not called [in my BMQA case] for balanced testimony? Moreover, why was I never invited to my complaint hearing?

There may well be legitimate answers to some of this consumer's questions. And she may be incorrect about any number of technical matters. But she identifies the solicitude and fragmentation which plague the current system. Two major hospitals revoke privileges while a third makes its own judgment. So long as one hospital anywhere is willing to take the moneys generated, the physician operates. Only BMQA can say no as to all.

Two hundred forty-nine (249) section 805 reports were generated in 1987–88, representing hospitals denying or suspending hospital privileges for physicians for medical incompetence reasons. Given the strong incentives not to deny privileges or to deny them in a way which does not generate an 805 report, which we have discussed, these 249 represent a very small proportion of current incompetently practicing physicians. Separate from these reports, over 700 physicians suffered malpractice awards or judgments against them of over \$30,000. During the same period, BMQA revoked 27 licenses. Only 12 physicians were disciplined—revocation, suspension, or even straight probation—for incompetence. These are not our numbers. These are BMQA's numbers. The agency is not doing its job. It is so moribund it is unclear why it should continue at all in its current form. For its malaise, good physicians pay a heavy price, and consumers pay a heavier one.

EXHIBITS⁴⁶

1. BMQA's Complaint Process Flow Chart
2. Memorandum from Vern Leeper to DMQ (February 28, 1989)

⁴⁶Available upon request from the Center for Public Interest Law.

3. Recent BMQA Disciplinary Statistics (15 tables)
4. Memorandum from Vern Leeper to DMQ (March 2, 1989)
5. Legislative Analyst's 1989 Bar Chart re: Length of Time Complaints Have Been Unassigned for Investigation
6. Actual Complaint Process Flow Chart
7. Consumer Services Representative Specifications
8. Chart: Average Number of Cases Carried by BMQA Investigators
9. BMQA Budget Overview by Board Component
10. 1989 Medical Malpractice Rates