MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

January 5, 2022

The Honorable Toni G. Atkins
Senate President pro Tempore
1021 O Street, Suite 8518
Sacramento, CA 95814

The Honorable Anthony Rendon
Speaker of the Assembly
1021 O Street, Suite 8330
Sacramento, CA 95814

Dear President Atkins and Speaker Rendon,

On behalf of the Medical Board of California (Board), we are pleased to share with you and all the Members of the California State Legislature the Board's duly approved 2022 legislative requests (attachment). Because the Board and its programs are authorized by the Legislature through the Medical Practice Act, the Legislature has a very important role to play in ensuring the Board can fulfill its mission to protect California health care consumers and promote access to quality medical care. It is a critical time for the Board, and we look forward to your partnership and support as we work to make improvements to the Board for the benefit of all Californians.

In order to protect California consumers, the Board must have adequate financial resources, robust enforcement tools, and appropriate standards. As detailed in the attached memo, the Board's legislative proposals reflect our best judgment as to the resources and enforcement tools that are necessary to meet our statutory consumer protection mission. These requests touch on all key areas of the Board's operations, including enforcement, administration, and licensing. We highlight two of the key proposals below, but stress that all of the proposals included in the attached memo are important to our work to protect consumers.

The Board is currently severely underfunded. Although the Board received a modest increase to its fees in SB 806 (Roth) of 2021 (the first increase in 15 years), that increase is not sufficient to sustainably fund the Board's programs and rebuild its reserve. With approximately 81 percent[1] of the Board's budget supporting our enforcement program, we need adequate financial resources to ensure Californians are protected. We look forward to working with the Legislature in 2022, pursuant to Business and Professions Code section 2435(i), to implement additional fee increases to support the Board's critical functions.

The Board's processes are needlessly more time consuming and costly because our burden of proof is too high. In order to successfully prosecute a physician for unprofessional conduct, California case law currently requires the Board to meet a higher burden of proof than most other jurisdictions throughout the nation. As a result, investigations in this state are needlessly more time consuming and costly. We look forward to working with the Legislature to ensure our processes are fair and in line with the standards common to allopathic Medical Boards across the country.

[1] See the Board's Fiscal Year 2020-2021 Annual Report, p.5

Several of the Board's proposals were also included within the Board's 2020 Sunset Review Report and specifically requested to be included in SB 806. Following enactment of SB 806 into law (which included only a few of the Board's specific requests), the Board re-confirmed its support of the 2020/2021 proposals and approved additional requests during its November 17-18, 2021 meeting.

We hope to partner with the Legislature in 2022 to enact the Board's proposals into law so that the Board will have the resources and enforcement tools necessary to protect consumers from physicians who fail to meet their obligation to act professionally and to appropriately care for their patients. We look forward to your support and collaboration on this matter of statewide importance.

Sincerely,

Kristina Lawson, JD
Board President

Randy Hawkins, MD
Board Vice-President

Cc: Members, California State Senate
Members, California State Assembly
Sarah Mason, Senate Committee on Business, Professions, and Economic Development
Robert Sumner, Assembly Committee on Business and Professions
Stuart Thompson, Governor's Office
Amy Wilson, Business, Consumer Services, and Housing Agency
Jennifer Simoes, Department of Consumer Affairs

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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

TO: Members, California State Legislature
FROM: Bill Prasifka, Executive Director, Medical Board of California
DATE: January 5, 2022
RE: Medical Board of California 2022 Legislative Requests

In furtherance of the consumer protection mission the Medical Board of California (Board), the Members of the Board approved the following proposals, and request that they be enacted into law in 2022. These proposals are organized into four sections: budgetary, enforcement, administrative, and licensing.

Budgetary

Adequate Increase to Physician and Surgeon Fees[1]

SB 806 of 2021 included multiple increases to the Board's fees. However, the requested increase to physician's and surgeon's (P&S) initial licensure and renewal fees (which accounts for more than 90 percent of the Board's revenue) was not provided. Instead, a smaller increase was provided and, as a result, the Board still faces an annual budget deficit and a rapidly depleting reserve fund.

SB 806 requires the Legislature in 2022 to review P&S fees and Board revenue and expenditures to determine the necessity of additional fee increases or changes to Board processes to ensure the solvency of the Board's fund.

Requested change in statute: The Board is not on a sustainable financial pathway and requests that P&S initial licensure and renewal fees be increased from $863 to $1,150, as recommended by an independent organization that reviewed the Board's revenues and expenses. The Board stands ready to provide additional information to support the Legislature's review of the Board's finances in 2022.

Removal of the Board's Two-to-Four-Month Reserve Requirement[2]

The Board is prevented by statute from maintaining a sizeable reserve and must limit its reserve to between two- and four-months' operating expenditures[3]. This is a far lower reserve amount than other boards and bureaus within the Department of Consumer Affairs. The Board's low reserve amount inhibits its ability to address rising costs, forcing it to turn to fee increases to balance its budget.

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[1] Additional information surrounding this topic is discussed in the Board's 2020 Sunset Report – see p. 206
[2] Ibid. see – p. 209
[3] See BPC section 2435(g)

Requested change in statute: Delete subdivision (g) of BPC section 2435, thereby allowing the Board to establish a reserve fund of up to 24 months' operating expenses, as allowed by BPC section 128.5 (b).

Enforcement

The following proposals support the effectiveness of the Board's enforcement program, including the timely and thorough investigation and prosecution of licensees who fail to meet the standard of care or otherwise act unprofessionally (e.g. sexual misconduct and criminal violations).

Change the Evidentiary Standard to Preponderance of Evidence

Under California law, the Board is at a significant disadvantage, in comparison to most other medical boards, when attempting to investigate and prosecute a licensee suspected of failing to properly care for their patients or otherwise act in an unprofessional manner.

Prior to taking disciplinary action, the Board must first investigate to gather evidence sufficient to prove that discipline is appropriate and necessary. Discipline is tailored to the facts and circumstances of each case and, generally, may include public reprimands, probation, suspension, or revocation.

The Board is required, under current case law[4], to obtain "clear and convincing proof to a reasonable certainty." This is a higher burden of proof than in 41 other jurisdictions throughout the U.S. states and territories, which generally apply a "preponderance of evidence" standard. As a result, California is out of step with most other jurisdictions, making it more difficult, time consuming, and expensive to prosecute instances of unprofessional conduct in this state.

The "clear and convincing" standard requires less evidence than the "beyond a reasonable doubt" standard which is used in criminal prosecutions, but is higher than "preponderance of evidence," which is also used in civil litigation and is defined typically as "evidence that shows it is more likely than not that a fact is true."

Requested change in statute: Add a section to the Medical Practice Act stating preponderance of evidence is the standard of proof for the Board's disciplinary proceedings.

Mandate Additional Reports to the Board Regarding Physician Misconduct

Current law[5] generally requires a report to be filed with the Board when a peer review body takes, or recommends, certain actions (e.g. change in staff privileges or termination of employment) against a physician and surgeon (P&S) due to a "medical disciplinary cause or

[4] *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856
[5] See BPC sections 805 and 805.01.

reason[6]" or other unprofessional conduct. In addition, BPC section 805.8, mandates that health care facilities and postsecondary educational institutions report certain complaints of sexual misconduct about a healing arts professional to the appropriate licensing entity. Failure to meet these reporting requirements may result in substantial penalties.

While helpful, these reporting requirements are not sufficient to ensure that the Board is aware of possible P&S unprofessional conduct. Therefore, the Board seeks to require additional appropriate organizations with knowledge of possible P&S unprofessional conduct to provide a report to the Board.

Requested changes in statute:

- First, amend BPC section 805.8 to clarify that "wellness committees," medical groups, health insurance providers, health care service plan providers, and locum tenens agencies[7] are required to report complaints of alleged sexual misconduct to the appropriate licensing entity. This proposal would include additional health care organizations involved in the coordination and delivery of health care and that are likely to become aware of alleged P&S sexual misconduct.

- Second, add or amend statute to require any organization that employs a P&S to report to the Board any employment-related discipline imposed (up to and including termination) due to a medical disciplinary cause or reason.

    - Similarly, require any organization that contracts with a P&S, or other organization (e.g. a medical group or locum tenens provider) for P&S services, to report to the Board when a P&S is dismissed from service, or the contract is terminated, due to a medical disciplinary cause or reason.

New Requirements for Disciplined Licensees Seeking to Modify or Terminate Probation or to Reinstate Their License

Pursuant to Business and Professions Code (BPC) section 2307, a disciplined licensee may petition the Board to seek reinstatement of a revoked or surrendered license or to have their probation modified or terminated early.

The process to evaluate and consider each petition involves substantial legal costs that are born by the Board, not licensees. For example, in Fiscal Year 2020-21, the Board spent nearly $1,000,000 on fees paid to the AGO and the Office of Administrative Hearings for litigation and hearing expenses for the petitions formally considered by a Board panel. The Board is not able to recover these costs through its existing authority.

[6] Definition: that aspect of a licensee's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
[7] Organizations that arrange for physicians to work in a setting on a temporary basis.

Since July 2013, the Board has granted approximately 46 percent of the petitions requesting reinstatement of a physician's license. In Fiscal Year 2018-19 (the most recent year with no pending petitions), the Board granted approximately 52 percent of the petitions for termination of probation and none of the petitions for modification for probation.

Requested changes in statute**:** Considering the low petition approval rate and associated costs, the Board proposes the following changes in statute:

Option 1: Amend BPC section 2307, as follows:

- Licensees revoked or surrendered: After ~~three~~ *five* years, may seek reinstatement of their license. In the revocation order, the Board may specify that a petition for reinstatement may be filed after ~~two~~ *three* years.
    - Eliminate the option to petition after one year if the license was revoked or surrendered due to mental or physical illness.
- Licensees on probation: After two years, *or after more than half their probation term has elapsed, whichever is greater,* a licensee may seek early termination of probation.
    - Provide for the automatic rejection of a petition for early termination of probation if the Board files a petition to revoke probation while the petition is pending.
- Repetitive Petitions: The Board may deny without hearing or argument any petition filed pursuant to BPC section 2307 within ~~two~~ *three* years of the effective date of a decision related to a prior petition.

Option 2: Add a section to the Medical Practice Act that authorizes the Board to establish an application fee for petitioners, not to exceed the Board's reasonable costs to process and adjudicate petitions for reinstatement, early termination of probation, or modification of probation.

Pausing the Statute of Limitations for Subpoena Enforcement[8]

With certain exemptions, the Board generally must file an accusation against a licensee either within three years after it discovers the alleged act or omission or within seven years (10 years for sexual misconduct) following the date the alleged act or omission occurred. If the Board is unable to meet the statute of limitations (SOL), then the complaint must be closed, in accordance with BPC section 2230.5.

If a licensee fails to produce medical records pursuant to a lawful subpoena of the Board, the investigative process is needlessly drawn out, potentially putting the Board's case at risk by failing to meet the SOL. Under current law, the SOL is paused (known as tolling) if the licensee is out of compliance with a court order to produce records. Awaiting action from the

[8] Additional information surrounding this topic is discussed in the Board's 2020 Sunset Report – see p. 211

Superior Court further delays the process and can cost the Board critical time as the SOL continues to run.

Requested change in statute**:** Amend the Medical Practice Act so that the SOL is tolled upon the failure of a licensee to comply with a lawfully served Board subpoena.

Enhanced Medical Record Inspection Authority[9]

The Board is subject to significant limitations in its authority to inspect and review medical records in the possession of a licensee. Generally, the Board must obtain patient consent prior to requesting records from a licensee. However, obtaining patient consent (for example, in cases involving inappropriate prescribing of opioids) may be difficult. If the patient refuses to give consent, then the Board must establish good cause to issue a subpoena and may have to file a motion to compel in superior court to enforce the subpoena. Without quick access to records, investigations take longer to complete. In some cases, the Board is required to close complaints because its investigation cannot proceed without relevant medical records.

To support the timely completion of investigations, the Board seeks enhanced authority to inspect patient records held by licensees without the need for patient consent or a subpoena. Like authority provided to certain Medi-Cal fraud investigators[10], this statutory change would help the Board to determine at an earlier stage if further investigation is warranted and, if necessary, to prepare more effective subpoenas to further investigations.

Requested change in statute**:** Add language to the Medical Practice Act that (1) generally authorizes a Board investigator, and medical consultant, at the Board's discretion, to inspect the business location and records, including patient and client records; and (2) in situations where patient consent to inspect records is not provided, a Board investigator, and medical consultant, at the Board's discretion, may inspect records in the office of a licensee for the limited purpose of determining whether good cause exists to seek an investigative subpoena for those records.

Timely access to pharmacy records[11]

For certain investigations, the Board may require records in the possession of a pharmacy. Unfortunately, the Board may face delays obtaining those records, as it generally must allow a pharmacy to provide the requested records "within a reasonable time[12]." This timeframe is unclear; therefore, Board may be required to wait an unacceptably long period of time, leading to avoidable delays in an investigation.

[9] Ibid. – see p. 212-215 for additional background information, including proposed statutory language.
[10] See Government Code section 12528.1
[11] Additional information surrounding this topic is discussed in the Board's 2020 Sunset Report – see p. 217
[12] See BPC section 4332

The Board of Pharmacy[13], by contrast, may require pharmacies provide requested records within as little as three business days.

Requested change in statute**:** Add a section to the Medical Practice Act to require pharmacies comply with Board requests for records in the same timeframe as requests from the Board of Pharmacy.

Require Earlier Exchange of Expert Testimony Information

The use of expert testimony is foundational in disciplinary proceedings. Experts retained by the Board and licensees under investigation may conflict with one another, which may lead to a hearing before an administrative law judge. BPC section 2334 requires the Board and counsel for the licensee to exchange expert opinions, and related information, no later than 30 calendar days prior to the originally scheduled hearing date.

Requested change in statute: Amend BPC section 2334 to require the exchange of this information no later than 90 calendar days prior to the original hearing date. This change is expected to support the timely resolution of cases by requiring an earlier exchange of expert opinions which can result in productive settlement negotiations or provide grounds for an accusation being withdrawn. An earlier exchange of expert reports is also expected to reduce the number of delayed hearings.

Add Deadline to Participate in an Investigatory Interview

Under current law[14], licensees of the Board are required to attend and participate in an interview requested by the Board when that licensee is under investigation. Failure to participate "in the absence of good cause" is considered unprofessional conduct and could result in discipline of their license. Unfortunately, allowing interviews to be postponed for "good cause" is subject to abuse, which leads, in some instances, to unacceptably long delays in a Board investigation.

Requested change in statute: Amend BPC section 2234(g) to require a licensee to participate in an interview no later than 30 calendar days after being notified by the Board.

Require Patient Records be Retained a Minimum of Seven Years

Current law[15] requires a P&S to maintain adequate and accurate records relating to the provision of services to their patients. In essence, this requires a P&S to maintain records for a length of time that corresponds to the standard of care (which may vary depending upon the services rendered), rather than for a specific time.

[13] See BPC section 4105
[14] See BPC section 2234 (g)
[15] See BPC section 2266

As discussed above, the SOL generally requires the Board to file an accusation against a licensee within three years after the Board becomes aware of the alleged act or omission or seven years of when the alleged act or omission occurred, whichever is sooner.

Aligning the minimum time frame to maintain records to the general SOL will help ensure records are available, if necessary, to support an investigation.

Requested change in statute: Amend BPC section 2266 to require adequate and accurate records be maintained for at least seven years after the last date of service to a patient.

Limiting Letters of Advice to Minor Violations "Unrelated to Fitness to Practice"

SB 806 granted the Board authority to issue a confidential letter of advice to a physician alleged to have committed a minor violation of the law unrelated to patient care. These letters may include a requirement to take educational courses that further the knowledge of a P&S in certain areas of their practice. These letters are intended to encourage quick, non-adversarial resolution of issues of minor concern, while providing a meaningful opportunity to correct issues in the practice of a P&S before they become significant. Prior to using these letters, the Board must publish regulations that govern their use.

Unfortunately, the language approved in SB 806 of 2021 restricted the use of these letters to minor violations that are "not related to patient care." This language significantly limits their use as most types of concerning physician conduct are related to patient care in some manner.

Requested change in statute: Instead of the current restriction, the Board requests that BPC section 2227.3 be amended to state that the letters may be used in minor violations of the law that are not related to a licensee's "fitness to practice." This language will preserve the Board's flexibility to use these letters in situations where only minor remediation is necessary to address concerns the Board may have with a licensee.

Administrative Proposals

The following proposals support the administration of the Board's operations include proposals to change the composition of the Board's membership, provide medical records to patients, and increase the Board's focus on P&S regulation.

Establish a Public Board Member Majority

Current law[16] states the composition of the Board is eight P&S members and seven public (non-P&S) members. The Board believes that changing the composition to a public member majority would help to restore the public's trust in the Board's operations and priorities.

[16] See BPC section 2001

Requested change in statute: Update BPC section 2001 to provide that public members constitute a majority of the Board's members.

Provide Access to Personal Records Contained within MBC Enforcement Files
The law generally provides that the Board's enforcement files (including records and data gathered during an investigation) are confidential and may not be released to the public. Despite this, the Board is required to publish accusations, disciplinary orders, and other information[17] about its licensees on the Board's website.

From time-to-time, the Board receives requests from consumers seeking a copy of their medical records, and related personal information, obtained by the Board during an investigation. The Board produces copies of documents exchanged between the consumer and the Board, but under current law does not share with consumers documents that the Board obtained from other sources as part of an investigation. Without this change in law, consumers may have difficulty determining whether the records they received from their provider are different than what their provider shared with the Board or in a civil action.

Requested change in statute: Amend BPC section 800(c) to authorize the Board to provide to a consumer a certified copy of their personal consumer records obtained during a board investigation, and maintained in the Board's central, investigative, or disciplinary files, within 30 days upon request after paying an appropriate fee, if any, for duplication of the records. The amended statute would refer to the definitions of "consumer" and "personal records" as set forth in Code of Civil Procedure section 1985.3, subdivision (a).

Establishing a Licensed Midwife (LM) Board[18]

Licensed midwives are independent practitioners and not supervised by physicians. Consequently, the Board believes that LMs should be regulated by a separate entity under the Department of Consumer Affairs but has not endorsed a particular approach to establishing this separate board.

Requested change in statute: Create a separate board charged with the regulation of licensed midwives.

Transfer Research Psychoanalyst (RP) Program to the Board of Psychology[19]

According to the American Psychological Association, psychoanalysis is a specialty in psychology that is distinguished from other specialties by its body of knowledge and its intensive treatment approaches. It aims at structural changes and modifications of a person's personality. Psychoanalysis promotes awareness of unconscious, maladaptive and habitual recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing, and creative

[17] See BPC section 2027
[18] Additional information surrounding this topic is discussed in the Board's 2020 Sunset Report – see p. 217
[19] Ibid. – see p. 218

expression. Except for RPs, the Board of Psychology (BOP) regulates the practice of psychology in California.

In 1977, when the RPs were established in law, the Board regulated additional allied health professions, including psychologists. In 1990, when the BOP came into existence, the RPs remained under the Board's oversight while all other psychology professions moved under the BOP. Psychoanalysis is a specialty of psychology; therefore, it is appropriate for RPs to be regulated by BOP.

Requested change in statute: Transfer the RP program from the Board to BOP.

Licensing Proposals

The Board proposes the following technical changes to the Medical Practice Act that would clarify certain aspects of SB 806 of 2021:

- Clarify that P&S license applicants are not limited to attending postgraduate training (PGT) in California[20].
- Clarify that P&S license applicants who obtained some PGT training in another state or Canada and are accepted into a PGT program in California must obtain their license within 90 days of beginning their program, regardless of where they attended medical school[21].
- Clarify that the Board may grant a one-time, 60-day extension of the initial expiration date for a P&S licensee. This would facilitate the initial license renewal process when the licensee must show satisfactory evidence of the completion of 36 months of PGT.
- Clarify the following requirements for P&S license applicants who participated in an oral and maxillofacial surgery training program[22]:
    - Must obtain 12- or 24-months credit in a Board-approved PGT program to receive their initial license.
    - Must obtain 24-months credit in a combined dental and medical degree program accredited by the Commission on Dental Accreditation (or approved by the Board) prior to their initial license renewal.

For further information on these proposals, please contact Aaron Bone, Chief of Legislation and Public Affairs at aaron.bone@mbc.ca.gov or 916-274-6251.

[20] See BPC section 2096(a) and (c), as amended by SB 806
[21] See BPC section 2065(g), as amended by SB 806
[22] See BPC section 2096(c), as amended by SB 806