2020 California Society of Physical Medicine and Rehabilitation

Southern California
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Medical Board Reflex Unsympathetic License Dystrophy

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I. The Medical Board of California.

A. Organization.

1. The MBC is one of 40 regulatory state agencies, within the Department of Consumer Affairs, responsible for regulating physicians and surgeons and a number of allied Professionals. *See* Cal. Bus. & Prof. Code § 2004.

2. The Board consists of 15 members (8 physicians and 7 public members), headed by a president appointed by the Governor (currently Denise Pines), and functioning in two Panels.

3. The MBC's Executive Director is William Prasifka (formerly Kimberly Kirchmeyer, who has now been appointed director of the Dept. of Consumer Affairs), to whom the Board delegates authority to investigate, inspect and institute proceedings (Cal. Bus. & Prof. Code § 2227), but not final disciplinary action (which is a non-delegable function of the Board) other than to adopt decisions entered by default and stipulations for license surrender. *See* Cal. Bus. & Prof. Code § 2224.

4. Board's dedicated Deputy Attorney General staffing.

5. Investigation by the DCA's Division of Investigation.

6. Administrative disciplinary proceedings by the Attorney General's Office, Health Quality Enforcement Section.

7. Administrative Procedure Act (Cal. Gov't Code § 11370 *et seq.*) administrative proceedings before the Office of Administrative Hearings (1 Cal. Reg. Code § 1000 *et seq.*).

B. Mission: "The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professionals and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions."

II. **MBC Responsibilities and Authority.**

A. Licensing Program: verification and renewal, and related functions (license status, fictitious name permits, medical corporations, continuing medical education).

B. Enforcement Program: receive, review and evaluate complaints, mandatory reports and other information relating to the practice of licensees; investigate circumstances related to complaints; review proposed stipulated decisions and decisions following administrative hearings; carry out disciplinary action pursuant to final decisions; administer program to oversee physicians on probation.

1. The Board "has been charged with the duty to protect the public against incompetent, impaired or negligent physicians." *Arnett v. Dal Cielo,* 14 Cal. 4th 4, 7 (1996).

2. It is responsible, *inter alia,* for enforcing disciplinary and criminal provisions of the Medical Practice Act (Cal. Bus. & Prof. Code § 2000 *et seq.*). *See* Cal. Bus. & Prof. Code § 2004.

3. It may investigate "complaints from the public, from other licensees, from health care facilities, or from the board that a physician or surgeon may be guilty of unprofessional conduct." Cal. Bus. & Prof. Code § 2220(a).[1]

   a. Complaints may be anonymous.
   b. Non-required, erroneous reports will still be considered. No un-ringing the bell.
   c. On he-said, she-said complaints, *e.g.*, sexual misconduct allegations, the Board investigators, and its experts, are instructed to make determinations on the assumption what the consumer reported is factually true.
   d. Reports of settlement or judgments (Cal. Bus. & Prof. Code § 801).
   e. Reports of peer review disciplinary action (Cal. Bus. & Prof. Code § 805).
   f. Mandatory reports by hospitals, coroner, law enforcement and criminal courts. See also Death Certificate Project.

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[1] For years the Board's website allows anyone to look-up any physician concerning the licensee's profile and learn the licensee's status, whether he or she has had malpractice judgments or settlements, negative action taken by hospitals or peer review organizations or governmental agencies, disciplinary actions and related orders, as well as pending accusations, criminal convictions or adverse orders affecting license, etc., and the pertinent documents, including the actual accusation even though the decision or stipulated settlement did not validate the charges. See https://www.mbc.ca.gov/Breeze/License_Verification.aspx.

The Board has developed an app for consumers—so far only for Apple users. Surely one will be out for those using Android devices. See https://www.mbc.ca.gov/About_Us/iOS/. The iOS app allows consumers with iPhones and iPads to have:

> Access to information on your doctor at your fingertips, 24/7. Developed by the Medical Board of California as part of its ongoing commitment to protecting California's health care consumers. Making informed health care decisions has never been easier.
>
> Receive notifications when a doctor's name, address, practice status, license expiration, or survey data changes, and when administrative actions and enforcement documents are added to a doctor's profile. The information includes notification when a doctor is suspended, revoked, or placed on probation.
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> It's import for the traditional physician-patient relationship and therapeutic alliance and rapport remains to be seen.

g. MBC is politically sensitive to supporting consumers and consumer expectations.

h. In Jan. 2019, the MBC ended vertical enforcement, that is, where an assigned deputy attorney general oversaw the investigation of physicians. Now investigations are spearheaded by investigators from the DCA.

4. The Board's investigators are sworn peace officers. *See* Cal. Bus. & Prof. Code §§ 159.5(b)(1), 160(a); Cal. Pen. Code § 830.3(a).

5. Board investigators may interview and take statements from witnesses, issue subpoenas "for the attendance of witnesses and production of papers, books, accounts, documents...and testimony pertinent or material to any inquiry [or] investigation." Cal. Gov't Code §§ 11181(e), 11182[2]; Cal. Bus. & Prof. Code § 101; *Arnett, supra,* 14 Cal. 4th at 8.

6. The MBC/DCA are authorized to access the Department of Justice's maintained CURES[3] databank, without patient or physician's knowledge or consent, the patient's constitutional privacy rights notwithstanding. Information gleaned from this warrantless search of the CURES database may in turn be used by the agency or investigators as part of a good cause basis to issue a subpoena for further records in the course of investigating the patients' physicians. *See Lewis v. Superior Court,* 3 Cal. 5th 561 (2017).

7. If after an investigation the Board determines there is sufficient evidence to warrant a formal disciplinary action against the licensee, it refers the matter to the Attorney General's Office, and the matter is prosecuted by its Health Quality Enforcement Section in proceedings conducted pursuant to the Administrative Practice Act. *See* Cal. Gov't Code § 12529; *Arnett, supra,* 14 Cal. 4th at 9.

C. The MBC's Central Complaint Unit. Cal. Bus. & Prof. Code § 800(c) requests for "comprehensive" summary of the substance of the complaint/investigative files open.

1. Information is gathered (records and/or summaries requested of physician
2. Material forwarded for expert review.
3. Matter may be forwarded to district office for further information if deemed indicated for obtaining records by patient authorization or investigative subpoena, witness interviews, "subject" interviews (by DCA/MBC investigator and district medical consultant), and/or further investigation, followed by a second expert review.
4. Assessments regarding investigation disposition are based on the expert opinion, but the investigator can encourage further assessments by the expert.
5. Notification to physician whether 1) investigation closed, 2) cite and fine program, 3) referral to Attorney General's Health Quality Enforcement Section for determination whether to file an accusation or criminal prosecution), etc.

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[2] Investigatory subpoenaing power to investigate wrongdoing of physicians (Cal. Bus. & Prof. Code §§ 108, 220, 2234; Cal. Gov't Code § 11181) are enforced in the superior court under the procedure outlined under sections 11187 and 11188 of the Government Code.

[3] The Controlled Substance Utilization Review and Evaluation System (CURES), California's prescription drug monitoring program, require all prescriptions for schedule II, III or IV controlled substances (Cal. Health & Saf. Code §§ 11054-11058) be logged in CURES, along with the patient's name, address, telephone number, gender, date of birth, drug name, quantity, number of refills, and information about the prescribing physician and pharmacy. *See* Cal. Health & Saf. Code § 1165(d).

III. **The numbers (2018-2019 reporting by the MBC).**

A. "The Board continued to fight the opioid epidemic by reviewing California death records when the death involved a prescription drug. As of the date of this publication, 23% of the cases that were opened based upon this project have resulted in the filing of an accusation, disciplinary action, or action had already been taken against the physician for inappropriate prescribing issues."[4]

B. There are 142,873 California-licensed physicians and surgeons, 25,303 of whom practice out of state. Nationwide, there are 1,356,995 physicians.

C. The Board received 11,407 complaints (about 8%–8 out of 100) of all California licensed physicians)—up from 10,888 in fiscal year 2017-2018.[5] Of the 11,407 complaints received:

1. 10,019 were closed.
   a. 7768 complaints were closed; 109 were referred to the cite and fine program; and 2142 were referred to investigation.
2. 1544 investigative cases were opened, and 1749 investigative cases were closed.
3. 638 cases were referred to the Attorney General (for filing a disciplinary accusation).
4. 39 cases were referred for criminal prosecution.
5. 39 probation violation reports were referred to the Attorney General (for petition to revoke probation).

IV. **The Pain of Pain—Patients (and Their Families) Who Represent the Failures of Medicine and Medical Practitioners.**

V. **MBC Neurotic, Frenetic Yo-Yo Reactivity Regarding Treating Patients Who Suffer From Severe Chronic Pain.**

A. Fundamentals.

1. The Medical Board is authorized to supervise physicians to assure compliance with existing standards of care.[6]

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[4] The "Death Certificate Project" has been criticized as a draconian "witch hunt" of physicians who had been "abiding by the now outdated mantra that patients' pain complaints should be aggressively treated with whatever it takes." The Board has been accused by some as creating a chilling effect on the practice of medicine regarding treatment for pain, causing practitioners to be fearful to prescribe ethical opiates and other controlled substances because they fear their license will be at risk if they do. Some observe that the Board's aggressive agenda of scrutinizing physicians has resulted in patients with intractable pain becoming desperate over obtaining adequate relief for chronic pain and related sequelae. *See, e.g.*, https://californiahealthline.org/news/death-certificate-project-california-investigation-opioid-deaths-called-witch-hunt-by-prescribing-doctors/ and https://www.medpagetoday.com/special-reports/exclusives/81954.

[5] There has been an inexorable upward tick on complaints against physicians. In fiscal year 2014-2015, it was 8267, then in 2015-2016 the Board received 8679 complaints, 9619 in 2016-2017, then 10,888 in 2017-2018, and now 11,407 in FY 2018-2019.

[6] There is often more than one way to diagnose and treat. A difference of opinion concerning the desirability of one approach over another does not establish that the one selected was negligent. *See Clemens v. Regents of the Univ. of Cal.*, 8 Cal. App. 3d 1, 13 (1970); *Meier v. Ross Gen. Hosp.*, 69 Cal. 2d 420, 434 (1968); *see also* Judicial Council of California Civil Jury Instructions (CACI) instr. no. 506 (2020). "A charge of negligence in a choice of treatment is refuted, as a matter of law, by showing that a respectable minority of expert physicians approved the method selected." *Sim v. Weeks*, 7 Cal. App. 2d 28, 37 (1935). *See also Rainer v. Community Mem'l. Hosp.*, 18 Cal. App. 3d 240, 260 & n.22 (1971). In other words, to act below the standard of care, the physician must do something

(footnote continued)

2. The Medical Board is not licensed to practice medicine, nor is it a medical specialty society which is in a position to provide science-based, peer vetted standards and guidelines for the profession. The Medical Board should be enforcing existing acceptable standards, not imposing its normative standard on licensees in the form of discipline.

3. Change in acceptable standards of practice are properly effected through education, guidance and time. It is not appropriate for the Medical Board to effect its desired changes in currently practiced behaviors through punishment and fear of punishment—which interferes in a licensed physician's exercise of professional judgment.

B. In the mid-1990s, the Medical Board admonished physicians of the duty to adequately treat pain and consider the patient's subjective report of pain and collaborative input in treating chronic pain.

1. Physician were mandated to take courses concerning the appreciation and adequate treatment of pain; not doing so would be considered unprofessional conduct. A patient's subjective report of pain became a fifth vital sign to be charted and respected. *See* Cal. Health & Saf. Code § 1254.7. The use of opiates to treat pain was considered efficacious if not encouraged. *See* Cal. Bus. & Prof. Code § 2241.5(c); Cal. Health & Saf. Code § 124960.[7]

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no other reputable practitioner would have done under same of similar circumstances, or the doctor failed to do something all reputable practitioners would have exclusively and uniformly done when confronting a same or similar situation.

The standard of care is a descriptive concept. It is about what other reputable practitioners do or do not do under same or similar circumstances. It is not a normative one—what an expert personally believes should or should not have been done, nor what an expert says he or she would have personally done under the circumstance, or even what might have been a better or more optimal approach. That is neither proper nor germane to the penultimate inquiry. *See Jensen v. Findley*, 17 Cal. App. 2d 536, 544-45 (1936); *see also Clemens*, 8 Cal. App. 3d at 13.

Likewise, it is neither indicative of a breach of acceptable standards, nor an automatic reason for discipline when a physician makes a mistake or is proven wrong in his or her assessment or efforts. Medical perfection is not required. Long ago our Supreme Court explained: "The law has never held a physician or surgeon liable for every untoward result which may occur in medical practice." *Huffman v. Lindquist*, 37 Cal. 2d 465, 473 (1951). A physician can make a mistake in diagnosis, err in judgment or experience an untoward result, without being negligent. *See* CACI instr. no. 505. To that end, "[i]t was not only necessary for plaintiff to prove a mistake in diagnosis, but also that the mistake was due to failure to exercise ordinary care in making the diagnosis . . . , and mere proof that the treatment was unsuccessful is not sufficient to establish negligence." *Huffman*, 37 Cal. 2d at 474, *quoting from Lawless v. Calaway*, 24 Cal. 2d 81, 89 (1944) (citations omitted). "Mere error of judgment, in the absence of a want of reasonable care and skill in the application of his medical learning to the case presented, will not render a doctor responsible for untoward consequences in the treatment of his patient . . ., for a doctor is not a 'warrantor of cure,' . . . or 'required to guarantee results . . ." *Id.* at 475 (citation omitted). *See also Rainer*, 18 Cal. App. 3d at 260 & n.22; *Black v. Caruso*, 187 Cal. App. 2d 195, 201 & n.2 (1960).

[7] In course material from 2000, physicians were shamed over "the discouraging information" that healthcare practitioners fail to relieve pain effectively in 80% of patients. They were instructed on the "consequences of ineffective pain management," including the prospect of being sued by patients and their families. They were reminded that under federal regulations (21 C.F.R. § 1306/07) and California's Intractable Pain Treatment Act (Cal. Bus. & Prof. Code § 2241.5) "[i]t is lawful to prescribe opioid analgesics in the course of professional practice for the treatment of intractable pain." Physicians were further counseled regarding the California Pain Patient Bill of Rights (Cal. Health & Sa. Code § 124960 *et seq.*), which became law on Jan. 1, 1998. It gave patients suffering from severe, chronic, intractable pain the option to 1) request or reject the use of opiates and 2) request or reject the use of any and all modalities in order to relieve his or her pain.

2. The MBC's Action Report from Jul. 1994 assured physicians of the protection accorded by the legislature. Section 2241.5(c) of the Business and Professions Code stated: "No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment for a person for intractable pain."[8] The assurance to physicians was iterated in the Board's Oct. 2003 Action Report.

3. The legislature promulgated the Pain Patient's Bill of Rights. It provided that "a patient who suffers from severe chronic intractable pain has the *option to request or reject the use of any or all modalities* in order to relieve his or her pain." Cal. Health & Saf. Code § 124961 (emphasis added). A patient had the right to choose opiates to treat his or her severe chronic intractable pain. The legislature found that "inadequate treatment of acute and chronic pain...is a significant health problem" and "for some patients, pain management is the single most important treatment a physician can provide"—with opiates recognized as an efficacious treatment modality. Cal. Health & Saf. Code § 124960.

4. The Board published general guidelines for treatment of pain in 1994, and again in 2003.

C. New Ballgame: The Board's November 2014 Guidelines.[9]

1. These guidelines provide richer educational and practical material and analysis for the complex management of pain, but they ostensibly are directed at offering guidance to primary care physicians, not pain management specialists.

2. The guidelines continue to recognize the valuable role of opiates.

3. The guidelines the Board published acknowledge the changes since the original guidelines were published in 1994, and the need for this monograph "to provide additional direction to physicians who prescribe controlled substances for pain" and to "help physicians improve outcomes of patient care and prevent overdose deaths due to opioid use."

4. The guidelines by the Board reflect the caveat: "These guidelines are not intended to mandate the standard of care," the Board recognizes appropriate deviations from these guidelines will occur, physicians are encouraged to document their rationale for each prescribing decision, and "[t]he Board does not endorse one treatment option over another" in this "extraordinary" complex, evolving area of medicine.

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[8] There was a significant pivot when this statute was quietly modified in 2006, with subdivision (b) subtly altering the guaranty with different language. Now it read: "No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances *in accordance with this section*" (emphasis added)), with subdivision (c) specifically authorizing the board to go after doctors when it disagrees with regarding their prescribing or treatment of pain patients.

[9] These guidelines can be found at: https://www.ombc.ca.gov/forms_pubs/pain_guide.pdf.

The California Department of Public Health offered its take, comparing the MBC's guideline with that promulgated by the Center for Disease Control and Prevention. That comparison can be found at: https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/PrescribingGuidelines4.26.17Compliant.pdf.

5. Criteria:

a. Adequate Patient Evaluation and Risk Stratification.

1. Completing a medical history and physical examination.
2. Performing psychological evaluation.
3. Establishing a diagnosis and medical necessity from review of past medical records, laboratory results, imaging studies and screening tools
4. Exploring non-opioid therapeutic options, and discussing risks, benefits and alternative therapy with the patient
5. Being cognizant of aberrant or drug-seeking behavior
6. Undertake urine drug testing.
7. Reviewing CURES report on patient, to see if patient is receiving controlled substances from other California providers.

b. Treating physician should seek consultation with or refer the patient to a pain, psychiatry or addiction or mental health specialist as needed.

c. Develop treatment plan when considering long-term use of opioids for chronic, non-cancer pain, with treatment goals identified for different symptomatic parameters (sleep disturbance, depression, anxiety, other medication, functionality, etc.).

d. Patient informed consent regarding risks, benefits and alternative therapy options.

e. Entering into a Pain Management Agreement covering expectations, policies regarding prescriptions and "issues", patient responsibility, periodic drug testing, etc.

f. Counseling patient on overdose risk and response.

g. Initiating opioid trial before initiating opioid therapy for chronic pain, with monitoring.

h. Ongoing patient assessment for response, medication side effects, etc.

i. Ongoing compliance monitoring, e.g., via CURES, drug testing, periodic pill counting, etc.

j. Discontinuing/weaning from opioid therapy.

k. Maintaining adequate and accurate medical records concerning H&P, IC, pain management agreement, risk assessment results, treatment provided, instructions to patient, results of patient monitoring, patient progress or lack of progress, functionality, notes re consultations with specialists, authorizations, CURES, etc.

l. Supervising allied health professionals.

m. Complying with controlled substances laws.[10]

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[10] On Mar. 17, 2017, the California Department of Public Health admonished physicians that despite the problem with overuse of prescription opioids and patient deaths from overdose, "don't 'fire' your patients who may be over-using opioids."

(footnote continued)

6. Board applying the Nov. 2014 Guidelines when investigating or prosecuting physicians for care before and around Nov. 2014.

7. Death Certificate Project.[11]

8. CURES sign-up by all physicians and use regarding prescribing controlled substances mandated, beginning Oct. 2, 2018. *See* Cal. Health & Saf. Code §§ 11165, 11165.1, 11165.4 (2016).[12]

D. *Quo Vadis*?

1. Current chilling effect on practitioners, and patient going to primary care physicians, or emergency rooms, for pain medication, as pain management experts cleave to doing only interventional medicine.

2. With some patients being the proverbial baby thrown out with the bathwater, patients may be seeking unapproved alternative care (including turning to the streets), leaving the protection of being in the system, as they seek adequate pain relief.

3. What will be the conventional thinking in 2030 after this latest shift of the pendulum has a chance to sort things out?

VI. MBC/DCA Pre-Accusation Investigation.

A. Report/notice to the Board–from family members, pharmacies, disgruntled employees, law enforcement, peer review organizations, settlements and judgments, anonymous tips, routine CURES checks on targeted physicians (especially pain management physician and those previous on the Board's radar). Statements and information taken; CURES reports automatically run to identifying prescribing not only in patient of concern but other patient prescribing profiles that appear outliers.

1. Notification to Physician.

a. *Sub-silento* investigation, including uncover patient shills.

b. 800(c) requests.[13]

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https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/Guidance%20Letter%203.21.17%20Compliant.pdf

This comes from the Department of Public Health. It may be argued the Medical Board's experts would expect a prescribing doctor to terminate care from a non-complying or abusing patient. Of course, in this population of patients desperate for relief, along with some who may be diverting, compliance issues are not uncommon.

[11] See note 4 *supra.*

[12] A physician must sign-up for CURES 2.0 and use it 1) first time a patient is prescribed or furnished a controlled substance; 2) within 24 hours or the previous business day before prescribing or furnishing controlled substances, absent exceptions (e.g., emergency care, surgery); 3) before subsequently prescribing a controlled substance; and 4) at least every four months if controlled substance remains part of patient's treatment plan.

[13] See Sect. II-C *supra.*

c. Letter to physician for patient records and/or summary of care, usually with a brief statement of the reported complaint/allegation, and a signed patient authorization.

d. Request for Board interview.

1. Absent good cause, failure to appear and cooperate if under investigation, is considered unprofessional conduct, and grounds for discipline. *See* Cal. Bus. & Prof. Code § 2234(h).

e. Request or order the physician submit to a physical or mental examination by an evaluator selected by the Board should good cause appear to the Board. *See* Cal. Bus. & Prof. Code §§ 820-824 (Board's right to evaluate licensee and take "disciplinary" [term employed by the MBC, but not statutory language] for public protection).

1. Failure to comply with an order issued under § 820 is grounds for suspension or revocation of the licentiate's certificate or license. *See* Cal. Bus. & Prof. Code § 821.

B. Internal review, indices of suspicion (from investigator and Board's medical consultants).

1. A physician's profile showing large patient population receiving controlled substances, or in heavy dosing, or in combination with other controlled substances.

2. High morphine equivalent dosages of single or multiple pharmacology (> 100 MED).

a. CURES identifying a sampling of some patient of a pain management specialist having high MEDs in excess of 100, may simply represent outliers being properly treated and monitored; without more, such whether a high percentage of all patients being treated, or incidences of drug-related maloccurrences, this is insufficient to demonstrate good cause over a patient privacy objection. *See Grafilo v. Wolfsohn,* 33 Cal. App. 5th 1024 (2019); *Grafilo v. Cohanshohet,* 32 Cal. App. 5th 428 (2019).

3. Polypharmacology, mixing multiple respiratory/central nervous system depressant drugs, e.g., opiates, benzodiazepines, soma, etc.–and potential patient danger.

4. *Nb.* The Board evinces little concern over the prospect that some patients may not be getting adequate opiates or benzodiazepines to relieve pain, muscle spasm and anxiety associated with severe pain–though that too may be a basis to find unprofessional conduct by the treating clinician. The Board's focus is invariably the charge the doctor is providing controlled substances, either too often, too many times, in too high a dose or combination, or choosing to employ them at all.

C. MBC needs patients' records in order to properly evaluate clinical justification for the prescriptions seen on CURES, and to substantiate prima facie concerns. Some patients are opiate-tolerant, requiring but able to handle higher dosing, while others may be opiate-naïve.

D. MBC's efforts to obtain confidential patient information/patient medical records to support a basis for instituting disciplinary proceeding against physician

1. Approach patients identified on a CURES report, by letter or in person, and convince/intimidate them into signing an authorization for release of records from the prescribing physician under inquiry.

a. Physician must produce records to Board in accord with the patient authorization, unless the patient rescinds permission.

2. Issue an investigatory subpoena for records, served on the doctor who holds the records.

a. Must include notice to consumer (the real party-in-interest patient) in order to comply with due process requirements. Although no consumer notice is specified under sections 11180 of the Government Code regarding service of an investigational subpoena for records, the notice to consumer requirements of Code of Civil Procedure section 1985.3(b) are found to nonetheless apply based on constitutional grounds. *See Lantz v. Superior Court,* 28 Cal. App. 4th 1839, 1848-55 (1994); *Sehlmeyer Department of General Services,* 17 Cal. App. 4th 1072, 1079-82 (1993).

b. Subpoena request, in order to comply with constitutional requirements implicated by patient privacy concerns, must not be overbroad, e.g., catch-all request for any and all records. *See Cross v. Superior Court,* 11 Cal. App. 5th 305, 329-30 (2017).

c. So long as the patient has not agreed to disclosure of the information, the physician has standing to object to production and disclosure of confidential information on behalf of the patient, the real party in interest, based on the physician-patient (or psychotherapist-patient) privilege, and patient's constitutional right of privacy—even where the patient has not specifically interposed an objection. *See People v. Barksdale,* 8 Cal. 3d 320, 332-33 (1972); *see also Eisenstadt v. Baird,* 405 U.S. 438, 444-46 (1971); *In re Lifschutz,* 2 Cal. 3d 415, 429-31 (1970) (objection good even in face of statutory waiver); *Wood v. Superior Court,* 166 Cal. App. 3d 1138, 1145 (1985); Cal. Evid. Code §§ 994, 995, 1014, 1015.

3. In order to compel compliance with the subpoena in face of an objection, the MBC/DCA must petition the superior court judge for an order to show cause and compel compliance with the subpoena. *See* Cal. Gov't Code § 11180 *et seq.* The petition is substantiated by a declaration of the Board's expert establishing good cause and a legitimate state interest to access the requested records, overriding the countervailing privacy interest of the patient. *See Williams v. Superior Court,* 3 Cal. 5th 531, 552 (2017); *Hill v. National Collegiate Athletic Ass'n.,* 7 Cal. 4th 1, 35, 37 (1994); *Kirchmeyer v. Phillips,* 245 Cal. App. 4th 1394, 1402 (2016); *Fett v. Medical Bd. Of Cal.,* 245 Cal. App. 4th 211, 221 & n.2 (2016); *Wood, supra.*

a. The agency should serve and join the patients, the real parties in interest, with the petition, so they have an opportunity to be heard, and to protect their rights. The Board does not do this and resists notifying the patients or joining them in the matter; it goes after the doctor alone. *See Valley Bank v. Superior Court,* 15 Cal. 3d 652, 658 (1975); *Wood, supra* at 1149.

b. While the proceedings have priority status for hearing, discovery should be allowed (*see* Cal. Civ. Proc. Code §§ 22, 2016.020(a), 2017.010; *City of Fairfield v. Superior Court,* 14 Cal. 3d 768, 774-75 (1975)), *e.g.*, taking the deposition of the Board's expert.

1. But the Board may be allowed to suppress from discovery a requested production of the CURES report it relied

upon—and recounted by hearsay statement—to support its expert's opinions. *See Grafilo v. Soorani,* 41 Cal. App. 5th 497, 510-12 (2019).

c. Respondent physicians, or patients, may offer counter-declaration of their expert challenging the Board's attempt at showing good cause exists for it to suspect wrongdoing and receive the records.

d. Superior court's decision is subject to appellate review.

E. Board may insist that physician appear in the Board's district office for a subject interview, which will be recorded, and may be taken under oath.

F. Authority to request or order a physical or mental evaluation of physician by doctor of Board's selection to assess fitness to practice (Cal. Bus. & Prof. §§ 820 *et seq.*)

G. Notification to physician whether the investigation is closed without further action, or if the matter is being referred to the Attorney General's Office for bringing an accusation against the physician.

VII. Board experts.

A. Board keeps experts, compensated at $150 an hour ($200/hour to testify), usually with a 10-hour review time limit, who tell the Board investigators what they want to hear. *See* https://www.mbc.ca.gov/Enforcement/Expert_Reviewer/.

B. Board experts follow Board written guidelines, including the admonishment to accept the patient's account, especially in cases of sexual claims, and render opinions based on that presupposition. *See* https://www.mbc.ca.gov/Download/Documents/expert-reviewer-guidelines.pdf, at p.12.

C. Board experts tend to offer formulistic reports, tracking and polemically arguing the Board's guidelines ("as consistent with the standard of care")[14] regardless of when the care occurred.

D. Board investigators will approach the expert concerning an opinion for more egregious allegations (*e.g.*, extreme departure from the standard of care (gross negligence) over merely repeated negligent acts (simple departure).

E. Not uncommon for the Board to have more than one expert, where the they disagree concerning the characterization of the conduct under review. This can cause problems for the Board's case where its burden is proving wrongdoing by "clear and convincing evidence to a reasonable certainty." *See Ettinger v. Board of Med. Qual. Assurance,* 135 Cal. App. 3d 853 (1982).[15]

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[14] Being consistent with the standard of care does not do it. True, the guidelines undoubtedly are consistent with one acceptable standard or approach to care for a patient. It's just not the only way. It is not the way all doctors uniformly and exclusively treat patients at this time, and under all circumstances. To find substandard care, it must be established that the posited standard to be met is required of all doctors under all circumstances at the time in question, and the physician could not have done it in another way, the way he or she approached the patient, and still be comporting with acceptable practices of even a minority of respected physcians. *See* note 6 *supra.*

[15] What constitutes "clear and convincing evidence to a reasonable certainty"—the Medical Board's burden of proof? It is that evidence which "commands the unhesitating assent of *every* reasonable mind." *In re David,* 152 Cal. App. 3d 1189, 1208 (1984) (emphasis added); *accord, In re Marriage of Weaver,* 224 Cal. App. 3d 478, 487 & n.8 (1990) (evidence which is "clear, explicit, and unequivocal," "so clear as to leave no substantial doubt" and "sufficiently

(footnote continued)

VIII. Experts for the Defense.

A. It is difficult to find a pain management expert willing to testify in defense of a physician in Medical Board matters. Many have soon learned that they too come under Board scrutiny regarding their own practice, and accusations have been brought by the Board against some hitherto high profile experts for the defense. Even those who have not, remain fearful of the Board. Even the Board's expert realize the chilling effect this has on experts being willing to come forward, not to mention those who practice pain management or are called upon to treat for pain with ethical medication.

IX. The Accusation

A. Medical Board jurisdiction.

1. Fundamental grounds for proceeding against a licensee based on unprofessional conduct.

a. Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of the Medical Practice Act (Cal. Bus. & Prof. Code §§ 2000 *et seq.*). Cal. Bus. & Prof. Code § 2234(a).

b. Gross negligence. Cal. Bus. & Prof. Code § 2234(b). Defined as "want of even scant care or an extreme departure from the standard of conduct." *See Franz v. Board of Med. Qual. Assur.*, 31 Cal. 3d 124, 138 (1982).

c. Repeated negligent acts. Cal. Bus. & Prof. Code § 2234(c). The Board merely needs to prove two or more distinct acts of neglect; it need not prove a pattern of neglect. *See Zabetian v. Medical Board,* 80 Cal. App. 4th 462, 467-70 (2000).

d. Incompetence. Cal. Bus. & Prof. Code § 2234(d).

e. Commission of any act of dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon. Cal. Bus. & Prof. Code § 2234(e).

f. Action or conduct that would warrant a denial of a certificate. Cal. Bus. & Prof. Code § 2234(f).

g. Practicing medicine from this state in another state or country without meeting the legal requirements of that state or country for the practice of medicine. Cal. Bus. & Prof. Code § 2234(g).

h. Failure of a certificate holder, in the absence of good cause, to attend and participate in an interview by the board when under investigation by the board. Cal. Bus. & Prof. Code § 2234(h).

i. General unprofessional conduct. Discipline is not limited to certain enumerated conduct, so long as the charged conduct relates to the fitness of the physician. Unprofessional conduct is that conduct which breaches the

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strong to demand the unhesitating assent of every reasonable mind"). *See generally In re Angelia P.*, 28 Cal. 3d 908, 919 (1981).

rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. Cal. Bus. & Prof. Code § 2234. *See Shea v. Board of Med. Exm'rs,* 81 Cal. App. 3d564, 575 (1978).

2. Specific prescribing grounds.

a. Violation of any federal statute or regulation, or statutes or regulations of California, regulating dangerous drugs or controlled substances. Cal. Bus. & Prof. Code § 2238. Includes self-prescribing.

b.. Repeated acts of clearly excessive prescribing, furnishing, dispensing or administering drugs or treatment. Unprofessional conduct warranting discipline, and punishable as a misdemeanor offense. Cal. Bus. & Prof. Code § 725.

c. Prescribing, dispensing or furnishing dangerous drugs, as defined in section 4022, without an appropriate prior examination and a medical indication. Cal. Bus. & Prof. Code § 2242.

3. Failure to maintain adequate and accurate records. Cal. Bus. & Prof. Code § 2266.

B. A causal connection between the alleged wrongdoing and an injury is not required, or relevant. The absence of harm does not negate whether a violation of the Medical Practice Act has occurred, and the Board may proceed and discipline violations. *See Shea v. Board of Med. Exm'rs,* 81 Cal. App. 3d564, 578-79 (1978), *citing Cooper v. Board of Med. Exm'rs,* 49 Cal. App. 3d 931, 949-50 (1975). "Protection of the public shall be the highest priority for the Division of Medical Quality...and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority." Cal. Bus. & Prof. Code § 2229. The Board need not have to wait to act until harm to a patient occurs. "To prohibit license discipline until the physician-licensee harms a patient disregards these purposes; it is far more desirable to discipline before a licensee harms any patient than after harm has occurred." *Griffiths v. Superior Court,* 96 Cal. App. 4th 757, 770, 772 (2002).

C. Discipline.

1. A licensee who has been found guilty following hearing or a default, may be disciplined by 1) having his or her license revoked; 2) having his or her practice suspended for period not to exceed one year; 3) being placed on probation and being required to pay the cost of probation monitoring; 4) being publicly reprimanded, which may include the licensee having to complete relevant educational courses approved by the board; or 5) having any other action taken in relation to discipline as part of an order of probation. Cal. Bus. & Prof. Code § 2227.

2. Non-discipline: Cite & Fine Program. Cal. Bus. & Prof. Code § 125.9.

X. Accusation Hearing and Disposition.

A. The Board's burden of proof is clear and convincing evidence to a reasonable certainty. *See Ettinger v. Board of Med. Qual. Assurance,* 135 Cal. App. 3d 853 (1982).[16]

[16] See note 15 *supra.*

B. Heard before an administrative law judge with the Office of Administrative Hearings.

C. After submission of the matter, the ALJ issues a proposed decision (PD) within 30 days.

D. The Medical Board has 100 days from receipt of the ALJ's PD in which to adopt or nonadopt the the PD for the final decision in the case. *See* Cal. Gov't Code § 11517. The decision of the MBC becomes a final decision within 30 days of its issuance.

E. Final decisions of the Board may be reviewed by:

1. Request for reconsideration by the Board. *See* Cal. Gov't Code § 11521.

2. Petition for writ of administrative mandamus to the superior court. The judge independently reviews the record for whether the agency proceeded without or in excess of its jurisdiction; whether there was a fair trial; and whether there was a prejudicial abuse of discretion (the agency did not proceed in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence). *See* Cal. Civ. Proc. Code § 1094.5.

F. Appellate review of the judgment of the superior court in Medical Board matters is solely by discretionary writ of mandate. *See* Cal. Bus. & Prof. Code § 2337.

G. Adverse decision appears under the doctor's profile on the Medical Board's website, and is filed with the National Practitioner Data Bank. *See* https://www.npdb.hrsa.gov/.

XI. **Consequences of Board discipline.** Far-reaching consequences (and shame) which transcend the discipline itself.

A. Posting of doctor's name, discipline and reason on the Board's public website forever.

B. Report to National Practitioner Data Bank informing other boards and the medical community.

C. Requirement of probationed physician to make disclosure of status to patients. *See* Cal. Bus. & Prof. Code §§ 1007, 2228.1, 2228.5, 2459.4, 3663.5, 4967.

D. Possible curtailment or termination of Medicaid/Medicare privileges.

E. Possible termination from preferred or network provider panels for insurance copies or IPAs.

F. Possible impact on hospital staff privileges.

G. Possible loss of American Specialty Board Certification status.

H. Possible loss of, or action by the Drug Enforcement Agency, of physician's DEA license.

I. One's reputation and livelihood.

The End