



TESTIMONY OF JULIANNE D'ANGELO FELLMETH
SB 1441 SUBSTANCE ABUSE COORDINATION COMMITTEE
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Thank you, Director Lopez, for inviting me to speak to you and this committee today.

For those who don't know me, let me introduce myself. I am not a physician, and I have no formal clinical training or expertise in substance abuse detection, rehabilitation, or prevention. I am not here to tell you whether addiction is a disease, or that it can be treated, or that X treatment has a Y percent success rate.

I have a different background and I want to provide you with my perspective on the patient protection side of this very important coin you are considering.

I am an attorney and a law professor, and the Center for Public Interest Law — my organization at the University of San Diego School of Law — has been monitoring occupational licensing agencies in California for 29 years. I myself have been doing this for 23 years. I have attended almost every Medical Board meeting over the last 23 years — and I've attended meetings of many of the other healing arts boards over that timeframe as well.

As many of you know, CPIL specializes in enforcement. We have served as independent enforcement monitors — external auditors of the enforcement process — at the State Bar, the Contractors State License Board, and — most recently — the Medical Board.

In 2003, I was appointed by the Director of Consumer Affairs — after a competitive bidding process — as the Medical Board Enforcement Monitor. In that role, I was charged by statute with auditing both the Medical Board's enforcement program and its diversion program — which, despite three failed audits in the 1980s, had inexplicably gone 18 years with no external audit.

I published two reports – an Initial Report in November 2004 and a final report in 2005. Both of those reports are available on CPIL's Web site and on MBC's Web Site. Obviously, MBC's Diversion Program is the one I know most about.

I think it is fair to say that the Initial Report was not kind to the Diversion Program, because it was not a good program in any respect.

I am not saying it never helped any participant. It did. But our analysis of the Program files of 60 Diversion Program participants (fully one-quarter of the Program's population) revealed that it only helped that slim sliver of a minority who truly wanted to recover. It did NOT help people who did not want to be helped, and it did NOT monitor them adequately. All it did for those participants was shield their participation from their patients and enable them to maintain both their licenses and their addictions, because it did NOT consistently or adequately monitor those doctors while they were in the program.

As a result of the Initial Report, the legislature — in 2005 — imposed a June 30, 2008 sunset date on the program, and it required the Bureau of State Audits to go back in and re-audit the Program during 2007. It gave the Board one last chance and two more years to address the problems that we and prior auditors had found. During that two-year period, the Board pumped a half a million dollars in additional resources into the program to improve it. Despite that, the Program then flunked BSA's 2007 audit. BSA confirmed what we found, and BSA confirmed that much of what we had found was still occurring 2.5 years later. After five failed audits, the Board unanimously decided in July 2007 not to seek an extension of the sunset date on the program.

If you have not read the Initial Report, you should. And if you have not read BSA's June 2007 audit, you should. You should read these whether your board has a formal diversion program or not.

I want to step back and focus on a few fundamental threshold facts:

FIRST: The statute creating each DCA board and bureau says that public protection is the highest priority for each board. And when public protection is inconsistent with any other interest sought to be promoted (including rehabilitation of an impaired licensee), public protection is paramount. You are supposed to err on the side of public protection.

SECOND: Let's focus on the consumers of the services provided by the licensees of your boards. They are patients. Health care patients. They are sick and vulnerable. They are weak and upset and anxious. They are not sharp or observant or assertive. They may be unconscious or paralyzed. They may not be sophisticated people — and that's why your boards exist: because consumers are generally not able to judge the competence of health care practitioners for themselves. They may not speak the same language as their provider, and they may not be able or willing to articulate a complaint or a concern to you — either because they can't, or they don't want to, or because they don't know where to go. They don't even know you exist. Those patients are depending on you to protect them from licensees who abuse drugs or alcohol. And you are supposed to err on the side of public protection.

THIRD: You all have enforcement programs, and you all know those programs are not supposed to be punitive in nature. They are supposed to be preventive. They are supposed to prevent future harm to a patient by a practitioner whom you have detected as being negligent, reckless, dishonest, or impaired. Again, you are supposed to err on the side of public protection — and prevent harm.

FOURTH: All healing arts boards have licensees with substance abuse problems. Health care practitioners suffer from substance abuse in at least the same ratio as the general population — which means that 10-15% of all of your licensees will become impaired due to excessive alcohol and/or drug use at some point in their career, and some studies project an even higher percentage among some types of practitioners. Health care practitioners often have ready access to narcotics at their workplaces; some of them pull in hefty salaries so they can buy them on the street; and the stress and burnout that are part of their everyday lives all contribute to this problem. These are potentially very dangerous people. These people pose a serious risk of harm to patients who depend on them — patients who know nothing of this problem, and who can learn nothing of this problem due to the confidentiality and secrecy that surrounds most impairment programs.

FIFTH: Some of you have formal diversion programs. Others do not. Those that do share two things: (1) you all contract out their operation to a private vendor; and (2) none of your programs have ever been audited by an external independent auditor. You and your staff may think you know how your program works; and some of you may have a better idea than others. But you don't really know how your program works. You know what the vendor tells you. You know its answers to your questions (if you ask any), but you don't know whether the information they tell you is true. I'm not casting any aspersions, but the Medical Board's experience proves that external audits are required in order to ferret out the truth about actual program functioning.

SIXTH: You also don't know IF your program works, because none of you track in any meaningful way whether your program has effectively helped a licensee to recover from substance abuse in the long term. Our analysis is kind of grim on that issue. 10% of the participants we analyzed had previously "successfully completed" MBC's Diversion Program, and another 15-20% had "unsuccessfully completed" it.

Does that sound like patient protection to you?

I'm supposed to be addressing "potential for public harm," and — in my view — maintaining and touting programs like these present a real potential for public harm, not only to patients but to the participants in the program.

SB 1441 has created this committee and has directed the committee to look at and agree upon standards to govern the way in which health care boards deal with impaired licensees.

This bill was drafted — and drafted in a fairly detailed manner — because the Senator knew from my report and from BSA's report that neither the Medical Board's statutes nor regulations contained any standards in any of the sixteen areas set forth in the bill.

This lack of standards is addressed in some detail on pages 273-280 of the Initial Report — those statutes and regulations contain NOTHING in the way of standards for any of the monitoring mechanisms that the Board and its program touted for 27 years.

And this is not just my opinion, or Senator Ridley-Thomas's conclusion. This was a major criticism leveled in all five audits of the Medical Board's Diversion Program — the Board's failure (despite legislative directive) to establish any standards governing any aspect of the program.

NOTHING in the way of standards or expectations for program staff or DEC's or participants.

NOTHING in the way of consequences for relapse or other noncompliance.

NOTHING in the statutes or regulations could prevent manipulative addicted doctors with highly-paid lawyers from abusing the system — getting repeatedly referred into the program despite numerous prior failures, wasting its resources, enabling the participant to maintain his or her license and his or her addiction because the program was frankly such a fraud as to the vast majority of the doctors who ever participated in it.

There was a huge disconnect between the Medical Board's disciplinary orders and expectations on the one hand, and the reality that was its Diversion Program on the other. For example, the Board would order — in a case of clear and obvious and long-standing substance abuse — abstinence from all use of alcohol and unapproved drugs, and it would refer that respondent into the diversion program so it could monitor the respondent's compliance with that term of probation.

I'm sure you all do the same. But the Medical Board's program did not test for abstinence, and neither does the private vendor that you contract with — I've seen your contract. If you are really going to test for abstinence, you'd test once every 24 hours, or maybe more frequently depending on the participant's drug of choice.

The Medical Board's program did not test for abstinence. It tested for "relapse" through allegedly random drug testing four times per month. In the early years, it required only two tests per month — and one of those was scheduled for a group meeting — so the participant knew when he would be tested. Later on, the program increased testing to four times per month, but it still did not test for abstinence and its drug testing was incredibly easy to game. We found that, and BSA found the same thing after we did. We found that all of its monitoring mechanisms were easy to game — and that nobody at the program knew just how easy they were to game, or cared.

You simply cannot run a secret program that purports to protect patients from substance-abusing health care providers with no enforceable standards or expectations for program staff or program participants who — according to your Web sites — retain a full and unrestricted license to practice.

No standards means inconsistent treatment of participants. It means fast and loose, case-by-case decisionmaking in an area of extraordinary sensitivity and grave patient risk.

No standards means unfairness — to both participants and patients.

No standards means nothing against which to judge program performance.

No standards means no accountability. No accountability by the Program, and no accountability by the participants. Think about this: You have identified a licensee with a serious problem. You know it, and the licensee knows it. Yet the licensee is greeted with a loopy-goopy program that he quickly learns he can easily game. What kind of incentive does that give him to want to recover?

And the Senator knew from a hearing that he held in March 2008 that the statutes and regulations of other health care boards creating diversion programs were based directly (and regrettably) on the Medical Board's statutes and regulations.

And he also knew that, other than the Medical Board, no board's diversion program had ever been audited.

And that brings us to today, and to this meeting.

This committee is charged with doing something that all of your predecessors neglected — and that is to meaningfully deal with this issue — the forgotten stepchild of occupational licensing agencies.

Some of you may be thinking that “doctors can cause a great deal more harm than, say, nurses or occupational therapists or physical therapists. I can see a crackdown for doctors, but not for everybody else. You should not try to create a ‘one-size-fits-all’ way of approaching this issue for all health care providers.”

I disagree with that notion. All health care providers can cause a great deal of harm to patients and to society if they abuse alcohol or narcotics. I see no reason why a substance-abusing doctor should be treated differently from a substance-abusing podiatrist or a substance-abusing respiratory care practitioner just because they are licensed by different boards — that makes no sense to me.

After many years of looking at this issue, I came across a court decision called *Griffiths v. Superior Court* — and it has to do with a doctor who had three DUI convictions.

There is a provision in the Medical Practice Act — section 2239 (and this is another example of inconsistency in treatment; this provision applies only to doctors and probably podiatrists and maybe osteopaths — and probably not to many of the rest of you) says that if a physician sustains more than one misdemeanor conviction involving the consumption of alcoholic beverages, those convictions constitute unprofessional conduct and are a basis for discipline. Well, the Medical Board filed an accusation against Dr. Griffiths because he had three such convictions within a five-year period.

Dr. Griffiths put up a good fight. He made the “big three” arguments that all doctors make: (1) none of the convictions have anything to do with medical practice generally or his practice specifically; (2) no patient had been injured; and (3) this was “purely personal misconduct” that had nothing to do with the practice of medicine. The ALJ agreed with him and dismissed the accusation.

The Medical Board nonadopted the ALJ's decision and revoked Griffiths' license. But then it stayed the revocation and — ironically enough — threw him into the Diversion Program as one term of probation (this was back in about 1998).

Dr. Griffiths fought this up to the superior court and the court of appeal. Both courts agreed with the Medical Board.

Granted: This case has to do with criminal convictions and whether the crimes are substantially related to the duties, qualifications, and functions of a physician.

But in this decision, the court articulates some language that is equally applicable to substance abuse by all health care professionals. It tells us why we should care about this issue and why we should do something about it. I want to read some excerpts from this decision to you:

Convictions involving alcohol consumption reflect a **lack of sound professional and personal judgment** that is relevant to a physician's fitness and competence to practice medicine. Alcohol consumption quickly affects normal driving ability, and driving under the influence of alcohol threatens personal safety and places the safety of the public in jeopardy. It further shows a **disregard of medical knowledge** concerning the effects of alcohol on vision, reaction time, motor skills, judgment, coordination and memory, and the ability to judge speed, dimensions, and distance.

Driving while under the influence of alcohol also shows an **inability or unwillingness to obey the legal prohibition** against drinking and driving and constitutes a **serious breach of a duty owed to society**.

[Noting that two of Griffiths' three convictions occurred while he was on probation for the prior convictions, the court continued.] Knowledge of such repeated conduct by a physician, and particularly of its propensity to endanger members of the public, tends to **undermine public confidence in and respect for the medical profession**. Repeated convictions involving alcohol use, two of which violated Griffiths's probation, reflect poorly on Griffiths's common sense and professional judgment, which are essential to the practice of medicine, and tend to undermine public confidence in and respect for the medical profession.

Griffiths argues that the discipline based on section 2239, subdivision (a) was invalid because no evidence showed his alcohol use impaired his medical practice. Griffiths contends that private conduct having no effect on a physician's treatment of patients cannot be a basis for imposing discipline on a medical license.....**[W]e reject the argument that a physician can seal off or compartmentalize personal conduct so it does not affect the physician's professional practice.**

For a nexus to exist between the misconduct and the fitness or competence to practice

medicine, **it is not necessary for the misconduct forming the basis for discipline to have occurred in the actual practice of medicine.**

Substantial legal authority provides that conduct occurring outside the practice of medicine may form the basis for imposing discipline on a license because such conduct reflects on a licensee's fitness and qualifications to practice medicine.....A physician who commits income tax fraud, solicits the subornation of perjury, or files false, fraudulent insurance claims has not practiced medicine incompetently. Nonetheless that physician has shown **dishonesty, poor character, a lack of integrity, and an inability or unwillingness to follow the law,** and thereby has demonstrated professional unfitness meriting license discipline.

Griffiths argues that he cannot be disciplined because no evidence showed his drinking and driving convictions resulted in any harm to patients. If accepted, this argument would have a serious implication for license discipline proceedings. In essence, it would prohibit the imposition of discipline on a licensee until harm to patients had already occurred. **We reject this argument because it overlooks the preventative functions of license discipline, whose main purpose is protection of the public ... but whose purposes also include prevention of future harm and the improvement and rehabilitation of the physician. 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.**

In other words, you are supposed to err on the side of patient protection and prevent future harm.

In sum, I don't think SB 1441 changes the discretion you have in determining that a licensee is abusing drugs and/or alcohol. What it may change is what you do after you have made that finding. The bill seeks known, published, consistent, enforceable, deterrent-producing standards so that both providers and patients are ensured consistency and accountability.

I am happy to answer questions.