California College of Midwives  / ACDM

3889 Middlefield Road, Palo Alto, Ca 94303

650 / 328-8491   info@CollegeofMidwives.org

[www.collegeofmidwives.org](http://www.collegeofmidwives.org/)

May 1, 2002

### Written Testimony

Joint Legislative Sunset Review Committee

Mr. Jay DeFuria

Consultant B&P ~  Joint Legislative Sunset Review Committee

State Capital, Room 2139

Sacramento, CA \*\* 95814

916/445-3435

Topic: Spirit of Renewal ~Reformulation of the MBC Disciplinary Process

Within my lifetime I have seen the practice of medicine at its very best and on occasion, its worst. I am intimately familiar with medical "miracles" and have personally & professionally experienced the practice of medicine as a noble pursuit. After working in acute-care hospitals as a nurse for 15 years and as an out-of-hospital midwife for an additional 20 years, I have a deep and abiding loyalty to the humanitarian mission that medical care represents. It is not my intention to casually denigrate something with such a beneficent quality � only to point to a glaring incongruity in its regulation that begs for legislative reform.

**Background:** I am a former hospital L&D nurse and mother of three, currently a licensed community midwife and grandmother of two. In 1991-92 I did an extensive legal study on medical and midwifery practice legislation in California from 1876 to 1980. Metaphorically speaking, I am an *idiot savant* of the California Medical Practice Act. I have regularly attended quarterly medical board meeting since 1993 and participated in the seven meetings of the Midwifery Implementation Committee to develop MBC policies and regulations for the licensed midwifery program. I also worked with Senator Figueroa�s office in the development of additional midwifery legislation (SB 1479).

**Statement of Problem:** In the various roles of nurse, midwife and mother, I�ve have been repeatedly exposed to the problems that beset the regulatory process as it impacts on the agency, its licentiates, the appointed Board and public safety. In many instances, the process fails all four groups. This includes discrimination against non-physician practitioners (such as Licensed Midwives) and MDs that provide non-allopathic care. This occurs simultaneously with a widespread failure by the MBC to appropriately discipline the many physicians who regularly misuse and abuse their professional power over employees, hospital staff, other healthcare professionals, patients and their families.

My experience has given rise to a series of recommendations to improve the public oversight function of the agency and the agency�s oversight of its licentiates. These requests were originally communicated as oral testimony at various MBC meetings, the Center for Public Interest Law, the Joint Legislative Sunset Review Committee hearings in 1997 and 2001, the Little Hoover Commission and in individual letters to members of the Board and agency staff. Occasionally some aspect of these suggestions has been implemented but in the main, there has been little dialogue or serious attention paid to their potential for elevating the functional of the MBC while improving its relationship with its licentiates, the public and the media.

**Success by the post-Presley Medical Board** **gets mixed reviews:** There was a 1,300% increase in licensure revocations between 1991 and 1997. The activities of the Board went from an �old boys club� of  �see no evil� *lassie-fair* discipline that was characteristic of the agency before 1991 (revoking only 4 physician licenses in the previous 3 years) to the current the high-profile numbers game, in which more than 2,039 cases were investigated and 567 cases referred for prosecutions in FY 96-97. This was an incredible change in the medical board culture in the short time of 6 years and the Board is to be commended for its considerable success. However, egregious cases are still being overlooked (such as Dr Rutland�s story as reported in by OCR). While the outrageous behavior of orthodox doctors goes unnoticed and uncorrected, many generally competent doctors are sacrificed on the public relations alter of looking �tough� on medical crimes, adding numbers to the record of revoked licenses but adding nothing in the way of meaningful protection of the public. The cause of consumer safety is not advanced by extremes or selective enforcement of any kind. Specific examples of what many of us find so disturbing about the combination of excessive and/or ineffective methodologies that represent the current MBC culture are provided in a separate document.

**Whatever the problems of public safety are --- quotas are NOT the answer.** The notion of California being numerically �first� in medical board disciplinary actions leads to counter-productive activities. It was the negative publicity surrounding the CBS expose that brought about this popular (but false) notion that consumer protection can only be guaranteed by a quota of "culprits", as if some Supreme Being had communicated the correct ratio of licensed physicians to disciplinary actions. Disciplinary quotas of any kind are morally reprehensible and intellectually dishonest. When an important piece of machinery becomes bent and dysfunctional, it needs to be straightened out, not simply turned upside down or backwards. The scandal following in the wake of the CPIL �Code Blue� report unfortunately triggered a reactionary inversion that replaced the original problem with another of equal magnitude.

**Physician oversight as a force for positive change and systems correction**: A fatal flaw in the current disciplinary process is that it does not help practitioners identify behaviors that are likely to trigger serious disciplinary action or assist the agency to improve its methodologies. Early warning systems require a uniform method to help identify patterns of substandard or sub-optimal care, negligent, dishonest, rude, cruel, sadistic or devious behavior and other early symptoms of practitioners who need someone to intervene before a personal, professional or medical tragedy occurs. �Preventive discipline� could be likened to �preventive medicine�, which we all agree is more successful and less traumatic than drastic, painful and expensive cures. After identifying problem practitioners, this model of early intervention can offer remedial education and rehabilitation (when appropriate) and only if the physician fails to take common-sense "corrective measures" would punitive ones be employed. Priorities for action by the Board should be the least punitive (and most remedial) most of the time, with fewer and fewer serious sanctions applied as one ascends in severity of discipline until you get to permanent "revocation" which, (if the system is working properly) should be rare. I would rather see the state of California have the LOWEST number of revoked licenses as *a tribute to* *what a good job the MBC* was doing in monitoring and mentoring its physicians. This should be the legislative mandate for this regulatory agency, instead of the current idea of a medical police force.

**Learning from Mistakes � the Federal Transportation Board Model:** Neither individuals nor organizations can learn from its mistakes when it is necessary to cover them up quickly and pretend they don�t exist in order to prevent permanent damage to professional reputations. Other agencies of government charged with aspects of public safety, such as the federal transportation board, and public services industries such as the airlines, have a model that responds to errors and accidents by trying to learn as much as possible to better prevent future reoccurrences. In this self-education model, sub-optimal behavior or �near misses� and small accidents by individuals are seen as valuable opportunities for the improvement of both the individual and the system. This requires the use of �incident reports� which identify and track these weak links so they can be studied and determinations can be made as to whether they represent individual failures to be addressed (when appropriate) by remedial education or reflect systemic failures in which not fault lies *not* with the individual but instead requires a dysfunctional system to be corrected. Many of the current studies of so-called �iatragenic� deaths identify that in far too many instances, the individual is blamed for what are actually system failures or �nosocomial� (hospital-originating) problems. By focusing all our actions on the punishment of one �caregiver-as-culprit� (nurse or doctor), it further institutionalizes a defective system, making it even more resistant to corrective forces. We are wasting our best opportunities for improvement.

**Legislative Remedies and Systemic Corrections:** From my point of view, the Medical Practices Act needs to be legislatively rehabilitated so as to eliminate allopathic monopolist practices by the MBC. A 21st century scientific or evidence-based standard of care needs to supplant the 19th century �authority� based model that is now used to determine such legally important concepts as negligence and incompetency. Methods are needed to expand public knowledge and participation in the mission of the MBC, including attendance at public meetings and the cable broadcasting of important MBC meetings. The governor-appointed Board needs to be more democratic with a larger percentage of public members and representation of non-physician licentiates such as licensed midwives.

The Board needs to be an �honest broker�, disciplining efficiently and effectively those whose behavior represents a clearly and present danger and by refraining from ill-advised investigation and prosecution of practitioners with trivial �deviations� from standard of care or because the licentiate was providing �alternative� care that did not fit into the allopathically-defined, politically influenced �standard� routinely used by the Board. The administrative law code needs to be revised to better protect the fundamental rights of licentiates. There is a great need to improve the training of �special investigators� and to institute effective oversight that would bring about an equal measure of personal and professional accountability by MBC investigators as is routinely applied to MBC licentiates.

Most of all, the Board has an obligation to make itself truly "user-friendly" by sharing power and reconciling itself to the 21st century.  It is my opinion that opening itself up to meaningful public scrutiny *and* meaningful public participation would be the best method to achieve all these goals.

Speaking for the citizens of California, I urge the Board and the Legislature to think in terms of keeping California on the leading edge of changes in healthcare for the 21st century, a leader in how to incorporate the benefits and better protect us from the excesses. As it stands now, we are on the *trailing* edge, with talented healthcare providers leaving the state rather than deal with what is, at times, the Draconian methods of the Medical Board. Consumers also going to other states in order to receive non-allopathic or �unconventional� treatments that they cannot get in California due to the unnecessary regulatory roadblocks. Our valuable resources should not be squandered this way. **Instead,** **we should work to keep California business in California.**

Included with this brief synopsis are two additional documents that provide specific examples of problems and expanded suggestions for their remedy.

Faith Gibson, LM, CPM

Executive Director, California College of Midwives, chapter of ACDM

Encl:                 Expanded Overview and list of Recommendations

                    Specific Examples of the Failures of the Current System

cc:

        Senators Figueroa & Boatwright

        Jay DeFuria, B&P / JLSRC

    Bob McElderry ~ CMA

    Frank Cuny, CCfHF

    Orange County Register