COUNTY OF SAN DIEGO

OFFICE OF THE CORONER

5555 Overland Avenue
Building 14
San Diego, California 92123
(619) 565-5645

DAVID J. STARK
CORONER

CORONER'S REPORT

____ Natural Death
_X_ Traumatic Death
____ Undeterminable

File # 96687

CC # 543-84

INVESTIGATOR: P. F. Hammerstead

DATE: March 23, 1984

PERSONAL DATA

Name of Deceased: HEIDI ANN MUIR (First-Middle-Last) — Found, 3-23-84 0645 (Date & Time of Death)

Sex	Race	Birthplace	Date of Birth	Age	Citizen of What Country
Female	Caucasian	California	5-28-58	25	U.S.A.

Marital Status	Social Security #	Current Occupation	Name of Employing Company
Single	569-27-9925	Executive Secretary	The Waterbed Emporium

Place of Death: Apartment	Person Notified: Carol Muir — Relationship: Mother
Street Address: 141 Grandview Street, Apt. 4	Street Address: 141 Grandview Street, Apt. 4
City or Town: Encinitas — State: California — Zip: 92024	City or Town: Encinitas — State: California — Zip: 92024
Usual Residence: 5930 Rancho Mission Road, Apt. 104	Telephone #: 753-1918 — Notified: Yes
City or Town: San Diego — 92108	Mailing Address or Temporary Address: P. O. Box 330, Solana Beach, Ca. 92075

INJURY INFORMATION

Place of Injury: Physician's Office, 9834 Genesee Avenue, Ste. 100, La Jolla, California

Date & Time of: Accident: 3-22-84; between 1215-1445
Specify: Accident - Suicide - Homicide - MVA, etc.

How Occurred: Administered overdose of medications during surgical procedure

At Work? No — Employer Notified? N/A — Name of Law Enforcement Agency: Sheriff's Dept.

Report # N/A — Officer/Team # M. Babbev, ID# 0825

NAME: HEIDI (NMN) MUIR CC# 543-84

Property: None Taken X Cor to Fam ___ Cor to PC ___ Cor to PA ___ Info to PA ___ PD/Sheriff ___

PROPERTY

Vehicle: NA
Make Model Year State & License #

Location of Vehicle: NA
Name of Towing Company Address Phone

Other Property: NA

Military: NA
Serial # Rate Branch Duty Station Notified?

Name of Physician(s): Robert Singer, M.D. Phone: 455-0290 Notified? Yes

Date Last Seen by Physician: 3-22-84

MEDICAL HISTORY

Medical History: Clavicle fracture
Asthma

Medications: Morphine, SoluMedrol, Phenergan, Cefadyl, Dilaudid, Valium, Demerol, Antilirium, Narcan, Polysporin, Xylocaine, Dextrose 5% in Ringers Lactate

Hospitals: NA

Operations & Dates: Rhinoplasty, septoplasty, chin reduction 3-22-84

Cause of Death: Cardiopulmonary arrest, due to combined effects of lidocaine, morphine, meperidine, cocaine and diazepam Pathologist: M. A. Clark, M.D.

Disposition: Humphrey Mortuary. Chula Vista, California
Name of Mortuary

Informant: Sheriff's Department Date: 3-23-84 0735 Arr: 0845 Comp: 1108

Identification: Family members, present at the residence

P: N (C) PD SO D.R.: (Y) N E: Y (N) S.N.: Y (N) (1) (2) (4) 5 6

INVESTIGATIVE SUMMARY:

Heidi Muir

CC# 543-84

INVESTIGATIVE SUMMARY:

The decedent was viewed in a supine semi-recumbent position in a twin bed in a bedroom of her mother's apartment residence. Her back rested against the wall, with the head slumped to the left against two pillows. She was dressed in a men's style pajama top and sweatpants. The body was cold, fully enveloped in rigor mortis, and postmortem dependent lividity was fixed. A 2x2 gauze surgical dressing covered the nares, and was held in place by a strip of tape which was affixed to both cheeks. On the chin was a surgical dressing of stretchy adhesive tape which extended across the jawline. No drainage was noted on either dressing. In a small plastic bag on the dresser were nine gauze pads with a small amount of sanguinous dressing on each. On the bedside table were two capsules which were identified as Nalfon. A large full glass of fruit juice which was at room temperature was also on the table. There was no evidence of trauma.

A personal interview with Carol Muir, the decedent's mother, revealed the following information. The decedent had undergone cosmetic surgery on 3-22-84, and had been taken to her mother's residence afterward to recover from the anesthetic. At 6:15 a.m., on this date, Carol Muir noted the decedent's right hand was cold and rigid. She telephoned her mother, a retired registered nurse, who suggested to Carol that she play some loud music and shake the decedent in an attempt to awaken her. When the decedent did not respond, Carol went to the apartment of Nancy Badheim, a radiology technician at Sharp Memorial Hospital, and requested that she check the decedent. Ms. Badheim went to the residence, and at 6:45 a.m., determined the decedent to be without vital life signs and felt certain she was expired. She instructed Mrs. Muir to call the emergency number "911", which she did. The San Dieguito Fire Department responded, and determined expiration had occurred a significant period of time prior to discovery, preventing resuscitative efforts from being initiated.

A review of the decedent's medical record in the office of Robert Singer, M.D., revealed the following information. The decedent had consulted Dr. Singer on 2-10-84 regarding information for a possible rhinoplasty. She had experienced ongoing sinus problems and was concerned about her appearance. She complained of difficulty breathing, more pronounced on the left side and in the morning, and wished to have her nose thinner and smaller. After examination, it was Dr. Singer's opinion the decedent was an excellent candidate for a subtle improvement in the nose by narrowing it, decreasing the irregularities, thinning the septum, and partially resecting the turbinates. It was also advised she undergo a chin reduction which could be done at the same time under intravenous sedation and local anesthesia. A preoperative blood count, urinalysis, and clotting times were within normal limits. On 3-22-84, she underwent the above procedure in the physicians office, beginning at 12:15 p.m. During the procedure, she received Morphine Sulfate 22 mg. intravenous, Phenergan 87.5 mg intravenous, Dilaudid 3 mg intravenous, Valium 10 mg intravenous and Demerol, 62.5 mg intravenous, as sedation. In addition to these drugs, she also had taken Valium 10 mg orally at the physician's instruction prior to leaving her residence for the surgery. Local anesthesia consisted of 2% Xylocaine (with epinephrine) 24 cc., to the nose, mouth, and neck, and a 5% Cocaine nasal

Heidi Muir

CC# 543-84

packing (unspecified amount). During the procedure, no problems were recorded with the exception of a statement written at the bottom of the anesthesia record "Pt (sic) has high tolerance for pain. States she uses cocaine." Postoperatively, she was taken to the recovery room where she reportedly was drowsy, but responding to verbal commands and taking ice chips. At 4:10 p.m., she was given Narcan 0.2 mg intravenous, having been noted to be slow to respond to verbal stimuli, and a large amount of red drainage was suctioned. At 4:20 p.m. she was reportedly awake and alert, and at 4:25 p.m., was reportedly discharged via wheel chair. However, an entry at 4:30 p.m., stated the decedent was up to the bathroom, voided sufficient quantity, ambulated to the bathroom, and called her mother and the nurse by name. Verbal and written instruction were given to "mother/friend" and the return appointment was scheduled for 3-23-84. The operative report indicated the decedent tolerated the procedure well and was discharged from the operating area in satisfactory condition. The decedent's mother stated the decedent was discharged from the doctor's office at approximately 5:30 p.m., however, there are no entries in the record regarding the decedent's condition or care during that time and it shows the decedent to have been released at 4:25 p.m.

A personal interview with Dr. Singer on 3-23-84, was held in his office. His initial statement to the undersigned was that he was "mad---very mad" at Mrs. Muir, and she had been told numerous times when she had picked up the decedent to awaken her regularly and check the level of her consciousness. He also related the decedent had no problems or complications during the surgery or in the immediate postoperative period, however, he did relate the decedent required a large amount of medication for sedation and control of pain during the procedure, which was performed with a local anesthetic.

The postoperative instruction sheet given to the decedent's mother was reviewed. There were typed instructions for dressing care, elevation of the head on pillows, cold packs to the eyes and nasal bridge, taking pain medication, using a soft or liquid diet, possible oozing, swelling, or bruised appearance of the area, calling the physician for unrelieved pain or excessive bleeding, and a handwritten instruction beneath the typed instructions advised keeping ice to the chin area. However, there was no instruction given on the sheet regarding periodic waking of the decedent, checking level of consciousness, or possible side affects or problems with these after surgery.

At the request of the undersigned, on 3-23-84, the decedent's mother and Lisa Lopez recorded in writing to the best of their memory the specific events which had occurred following the decedent's surgery. A meeting was held on 4-24-84, at which time, Carol Muir related the following events. At 2:45 p.m., on 3-22-84, she received a telephone call from Dr. Singer's office informing her the surgery on Heidi had been completed and that she could pick up the decedent from the office in one hour. She and her neighbor, Lisa Lopez, left their residences together at 3:30 p.m., and when they arrived at the physician's office, they were shown to a back sitting room where the nurse, Cheryl, came in and sat down next to Mrs. Muir. Cheryl said that Heidi was fine, and that Mrs. Muir would be able to see the decedent shortly. Cheryl went over the page of postoperative instructions and hurriedly left the room and closed the door, after another nurse "with a mask over her face" came in and handed Cheryl a piece of paper. Ms. Lopez left the room, as she was not feeling well, and Mrs. Muir waited in the room.

Heidi Muir

CC# 543-84

The nurse later told Mrs. Muir to get the car as Heidi was ready to go. Heidi was pushed to the car in a wheelchair, and was very groggy, drifting in and out of sleep, and mumbled a few statements. On the way home, they stopped at a local convenience store and purchased some juice, arriving at their residence at 6:10 p.m. They got her into the house with the assistance of two neighbors, as the decedent was too wobbly to maneuver without the assistance of two persons. Mrs. Muir assisted Heidi to the bathroom, after which, Heidi wanted to wash her hands and, after doing so, was assisted to bed. Mrs. Muir put three pillows behind her in bed, and attempted to give her a glass of juice with a straw, however, Heidi was unable to drink and only blew bubbles through the straw, and then fell asleep. She checked the decedent every fifteen to thirty minutes and changed her dressing periodically. The night light was left on all night. At 6:30 p.m., Heidi had slipped down in the bed and Mrs. Muir had Ms. Lopez assist her in pulling her to a sitting position. At 8:30 p.m., the decedent had again slipped down in the bed and Mrs. Muir obtained the assistance of three male neighbors to pull her back up in bed. Mrs. Muir related the decedent never changed position during the entire night, and she felt it was advisable to let her sleep since she had not been instructed otherwise. She stated she had never seen a deceased person before, and did not notice any changes in Heidi of an unusual nature which would indicate reason for concern until noticing her hand to be cold and stiff the following morning. She also related that at the physician's office, she was within sight of the recovery room, and the decedent did not walk to the bathroom during the recovery period and did not speak to either her or call the nurse or anyone by name in her presence.

Lisa Lopez related the following series of events. She went with Carol Muir on 3-22-84 to the office of Dr. Singer to assist her in bringing Heidi home following surgery. They waited in the office lounge until a nurse came into the room and gave them some instructions on a printed page, which she briefly explained, however, she made no mention of awakening the decedent periodically or checking the level of consciousness. The nurse, Cheryl, asked the other nurse to get Heidi ready to go home. Lisa was nearest the door, and could see and hear the recovery room from her seat. The nurse attempted to waken Heidi several times by saying, "Heidi wake up, it's time to wake up," in a loud, clear voice, however, Heidi did not respond. The nurse came back to the lounge and signaled for Cheryl to come and assist her. The two nurses went into the recovery room and closed the door behind them. Lisa began to feel ill and queasy, and went outside the office and sat down. The office receptionist had left for the day by that time. Lisa sat in the hall for a few minutes, and was then joined by Carol. They sat there for 15 to 30 minutes and then were told to bring the car around for Heidi to go home. Lisa had seen Heidi from her chair in the lounge, and felt "something wasn't right" when the decedent did not respond when awakened.

Heidi Muir

CC# 543-84

When they got the decedent to Mrs. Muir's residence, she assisted her in getting Heidi upstairs, as Heidi was unable to walk on her own. She prepared Heidi some juice while Mrs. Muir assisted Heidi to the bathroom, however, Heidi was not able to drink any of the liquid and blew bubbles with the straw. At 6:30 p.m., Mrs. Muir went to Lisa's apartment and asked for her assistance in pulling Heidi up in bed. When Lisa went into the room, she noticed the decedent was having a "snoring type of heavy respirations with a gurgling sound." She did not see the decedent again.

Carol Muir had also related to the undersigned that Heidi seemed to be very sensitive to any drugs or medication, since "she never took anything, not even an aspirin." She emphatically denied any drug use of abuse by the decedent at any time.

A telephone interview with Jim Kindalen, the decedent's boyfriend of two years with whom she shared a residence, revealed that the evening before the surgery, Heidi had been very hesitant to take the Valium tablet prescribed by Dr. Singer, as she was unfamiliar with the medication, and was worried as to what effect it might have on her. He also related the decedent was taking only oral contraceptives, and had not taken any over the counter drugs, medications, and had not at any time used any street drugs, and he specifically denied the use of marijuana or cocaine by the decedent.

P. F. Hammerstead

P. F. HAMMERSTEAD, Deputy Coroner

PFH:gh
7-10-84

COUNTY OF SAN DIEGO

OFFICE OF THE CORONER

5555 Overland Avenue
Building 14
San Diego, California 92123
(619) 565-5645

DAVID J. STARK
CORONER

AUTOPSY REPORT

Name of Deceased	HEIDI MUIR	File #	96687
Place of Death	141 Grandview Street, Apt. 4, Encinitas	CC #	543-84
Date of Death	FOUND, March 23, 1984	Age	25
Place of Autopsy	San Diego County Examining Room		
Date of Autopsy	March 24, 1984		

EXTERNAL EXAMINATION

The body is that of an unembalmed, well-developed, well-nourished Caucasian female whose general physical condition is consistent with a chronologic age of 25 years. The body weighs 140 pounds and the body length is 70 inches. The irides are blue. The hair is blond.

The eyes, ears, nose and mouth are not remarkable. The neck, upper extremities, thorax, mammae, abdomen, external genitalia, lower extremities and dorsum of the body exhibit no significant abnormalities.

EVIDENCE OF MEDICAL THERAPY

Multiple nasal packs are noted in the nares bilaterally. In addition, a metal splint is noted over the bridge of the nose which is held in place by pads and adhesive tape. Underlying the dressing, a purple contusion is noted on the bridge of the nose and extending inferiorly under the medial halves of the borders of the eyes bilaterally. On the inferior surface of the chin just posterior to the symphysis menti there is a recent, sutured surgical incision measuring 2 1/2 inches in length which is covered by a gauze dressing and by adhesive tape.

INTERNAL EXAMINATION

The abdominal and thoracic organs occupy their normal positions.

The peritoneal, pleural and pericardial surfaces show no unusual features.

CARDIOVASCULAR SYSTEM

The heart weighs 300 grams. Multiple sections of the coronary arteries reveal no evidence of recent or old occlusion. Multiple sections of the myocardium reveal no evidence of recent or old infarct. No abnormality of the tricuspid, pulmonic, mitral or aortic valves is noted. The aorta shows no significant atherosclerosis.

RESPIRATORY SYSTEM

The larynx, tracheobronchial tree and pulmonary artery are unremarkable. The right and left lungs weigh 850 grams and 700 grams, respectively. Multiple sections show intense acute congestion.

GASTROINTESTINAL SYSTEM

No abnormality of the esophagus is noted. Examination of the stomach, duodenum, jejunum, ileum and colon reveals no abnormality.

LIVER AND BILIARY SYSTEM

The liver weighs 1500 grams. Multiple sections reveal no abnormality. The gallbladder and extrahepatic biliary tract are unremarkable.

PANCREAS

The pancreas is not remarkable.

ENDOCRINE SYSTEM

The thyroid gland is not palpably enlarged.

The adrenal glands are of usual size, shape and consistency.

HEMATOPOIETIC SYSTEM

The spleen weighs 200 grams and multiple sections reveal an intact gross architecture.

The lymph nodes of the mesentery and mediastinum are not enlarged. Inspection of the bone marrow reveals no grossly remarkable findings.

GENITOURINARY SYSTEM

The right kidney weighs 200 grams; the left kidney, 175 grams. Multiple sections reveal no remarkable findings.

The urinary bladder is not remarkable.

The cervix, uterus, tubes and ovaries reveal no significant abnormality.

MUSCULOSKELETAL SYSTEM

The musculature is well developed and consistent with that of an adult female.

The skeleton is consistent with that of an adult female.

CENTRAL NERVOUS SYSTEM

The scalp is reflected, and there is no evidence of subcutaneous or muscular hemorrhage. The calvarium is intact and without evidence of fracture.

There is no evidence of epidural, subdural or subarachnoid hemorrhage. The cerebral vessels have a normal anatomical distribution.

Examination of the skull and cervical vertebrae reveals no abnormality.

The brain weighs 1400 grams and is symmetrical.

Multiple coronal sections of the cerebrum, mesencephalon, pons, medulla and cerebellum reveal an intact gross architecture. The pituitary gland is unremarkable. The upper cervical spinal cord and cerebral sinuses are unremarkable.

MICROSCOPIC EXAMINATION

Liver, lung, spleen: mild acute passive congestion.

Heart, adrenal, thyroid, brain, kidney, pancreas: no diagnostic change.

CAUSE OF DEATH:

Gross autopsy, microscopic and toxicologic studies were conducted. The cause of death is determined to be cardiopulmonary arrest due to combined effects of lidocaine, morphine, meperidine, cocaine and diazepam.

M. A. CLARK, M.D.
Pathologist for the Coroner

MAC:ksc
T: 6-13-84

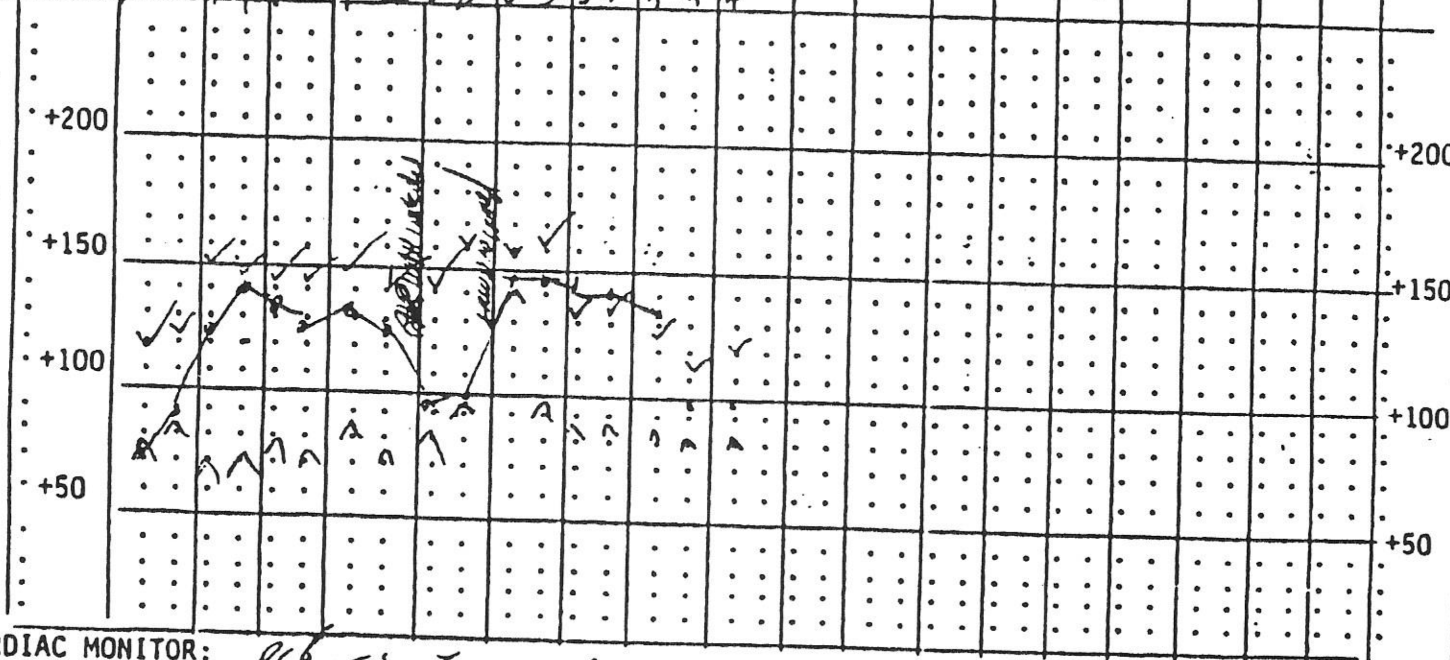
OPERATION: Chin Reduction, Rhinoplasty, Septoplasty

SURGERY Begin: 12[30] End: 3[40] pm	Surgeon: Robert Singer	Preop Med: Valium 10mg
	Scrub: C. Malone	Circ: C. Mueller
TIME:		

AGENTS/DRUGS																			
O2 N2O		12[6]	12[20]	12[22]	12[25]	12[27]	12[29]	12[30]	12[32]	12[33]	12[40]	12[50]	1[03]	1[15]	2[30]	2[40]	2[45]		
Mg		4	4	2			4	4	2										
[illegible]		40													2				
[illegible]		25																	
Cefadyl			500							25		25				12.5			
[illegible]																			
Valium					1mg	1mg 5							1mg						
Demerol									5										
[illegible]										25		25				25	12.5		

TIME: 12[15] 12[30] 12[45] 1[00] 1[15] 1[30] 1[45] 2[00] 2[15] 2[30] 2[45] 3[00] 3[15] 3[30] 3[45] 4[00] 4[20]

VITAL SIGNS



CARDIAC MONITOR: RSR - Sinus Tachycardia

I.V. Cannula (L) R Gauge [illegible] (Antecubital) Forearm Hand D5RL 1000 infused 250	Local Anesthesia: 2 % Xylo c 1: 1 00,000 Epi x 24 cc to: nose, mouth, neck ___% Xylo c 1: ___00,000 Epi x___cc to: ___% Xylo Plain x___cc to: 5% Cocaine Nasal Packing at: 1235 pm	Skin Prep: Polysporin ophth oint to eyes pre-op Phisohex scrub to face, neck
Ground Pad: to Back	Drains: / Sponge Count:	Status entering R.R. Drowsy - responds to verbal command

REMARKS: 4[10] pm 110/82 - pulse 94 Reg. Narcan 0.2mg I.V. Pt slow to respond to verbal stimuli - suctioned - large amt of red drainage. Breathing[?] - [illegible] - 4.5[?] [illegible]

DTC: Pt [illegible] [illegible] [illegible]

ROBERT SINGER, M.D., F.A.C.S.

DISCHARGE SUMMARY: 4[25] [illegible] pulse 88
Discharge Time: 4[?] pm VIA: ambulance[?] c DR. R. R. - [illegible] mother's name -
Dressing: [illegible]
Verbal/Written Instructions given to: Mother friend
Scheduled to return: 3-23-84 3[30] pm

TIME	PULSE	BLOOD PRESSURE	MORPHINE SUL.	PHENERGAN	DILAUDID	VALIUM	DEMEROL	ANTILIRIUM	SUBLIMAZE	NARCAN	NOTES
12:15	52	128/78	4	25							
12:20			4								
12:22			2								
12:25					1						
12:27					1	5					
12:29			4								
12:30	88	122/82	4								
12:32			2			5					
12:33				25			25				
12:40								1			
12:45	125	150/70									
12:50				25			25				surgery commences
1:00	140	148/72									
1:05					1						
1:15	132	142/78									
1:30	122	142/72									
1:45	132	150/85									
2:00	122	140/73									.5 SHOULD HAVE BEEN .05
2:05								.5* or .05			.5% cocaine nasal pack, airway inserted
2:15	98	140/80								0.4	
2:30	99	160/92	2								
2:38											airway removed
2:40				12.5							
2:45	148	148/140				12.5					
3:00	148	152/98									
3:10											surgery ends
3:15	140	132/86									
3:30	140	132/86									
3:45	132	128/85									
4:00	98	112/82									
4:10		110/82					0.1			0.2	"pt. slow to respond to v.stim.
4:20	98	120/82									"awake and alert"
4:25											
4:30											"pt. up to bathroom etc."
4 HR 15 MIN			22	87.5	3	10	62.5	1.1	*	0.6	total mg.

*(The chart refers to the administration of Sublimaze at 2:05. The medication was drawn and administere by nurse Cheryl Minkler. She originally testified that the dosage was ".5". She was deposed a second time and testified that she could not decipher the entry. During her second deposition she referred to a narcotics log that was subsequently examined. It is reported that the corresponding entry for this case indicates that a dosage of ".05 mg" of Sublimaze was drawn.)

BOARD OF MEDICAL QUALITY ASSURANCE

GUIDEBOOK
TO
LAWS GOVERNING THE PRACTICE
OF MEDICINE
BY PHYSICIANS AND SURGEONS

1987
Fourth Edition

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San Diego, CA 92101

REDDING DISTRICT
Post Office Box 468
Cottonwood, CA 96022

II. LAWS ADMINISTERED BY THE DIVISION OF MEDICAL QUALITY

2.1 General Responsibilities

The responsibilities of the Division of Medical Quality include:

1. Review the quality of medical practice carried out by physicians and surgeons under the jurisdiction of the Board.
2. Administer and hear disciplinary actions.
3. Carry out disciplinary action appropriate to the findings of the Division, a Medical Quality Review Committee, or an Administrative Law Judge.

2.2 Medical Quality Review Committees

There are fourteen Medical Quality Review Committees (MQRC) established on a geographical basis (the same area designations as Health System Agencies) to insure that there is local participation in the disciplinary process and to extend the reach and the effectiveness of the Board of Medical Quality Assurance in the local community. These committees are composed of physicians (60 percent of membership), allied health professionals (20 percent of membership), and public members (20 percent of membership). The total number of members on a given committee ranges from ten to forty persons depending on the number of physician licensees in the district. Physician members are selected from nominees submitted by the Division of Medical Quality, county medical societies and deans of California medical schools. Committee members are chosen by the Governor and are appointed for terms of four years.

The activities of the Medical Quality Review Committees can be grouped into five major areas:

A. *Hearing Activities*—MQRC members sit on panels which hear disciplinary charges against medical doctors, as well as petitions for restoration of revoked licenses, or for the modification or termination of a probation order. The role of the Medical Quality Review Committees in hearing cases is an important responsibility. The use of local panels composed of physicians, allied health professionals, and consumers to hear disciplinary charges against physicians is intended to insure responsive and responsible decision making.

The hearings are open to the public and are held only after a thorough investigation of the incident(s) which constituted the basis for the filing of disciplinary charges against the physician. These investigations are conducted by the staff of the Board of Medical Quality Assurance and are usually initiated by the filing of a complaint against the physician with the Board.

The Medical Quality Review Committees are also involved in "nondisciplinary review" meetings. These meetings are held when a physician has been investigated but there is insufficient evidence to file formal disciplinary charges. It is felt that in certain cases the physician will benefit from a discussion of his or her delivery of medical care and that the quality and level of his or her services will improve as a result of such a discussion. This process often eliminates the need for formal discipline.

B. *Peer Physician Counseling Panels*—The MQRCs also may convene Peer Physician Counseling Panels comprised of two physician MQRC members and a medical expert to provide practice review, education and assistance to individ-

ual physicians referred by the Division of Medical Quality. These panels focus on strengthening various aspects of practice, particularly the appropriate management of prescription drugs, and information on common approaches used by addicts to manipulate physicians into giving them unwarranted prescriptions.

C. *Physician Liaison and Education*—MQRCs function as a link between the local professional community and the BMQA. Committee members often are asked to speak to local medical groups. In this way they are able to extend the visibility and effectiveness of the Board. Some MQRCs also have been active in presenting the joint BMQA/CMA Physician Responsibility videotape and program to hospital medical staffs in their districts.

D. *Consumer Liaison and Education*—MQRCs provide information to local consumers on the role and functions of the Board. They also undertake projects to strengthen physician-patient relations. Examples include preparing brochures on patient rights and responsibilities, and on choosing a physician.

E. *Investigation of Local Health Care Problems*—Many of the Medical Quality Review Committees are working to identify those problems in the health care system in their areas which have the greatest impact on consumers, to develop resources and coordinate activities with other groups to address those problems and to inform the appropriate people of possible solutions. The Medical Quality Review Committees can have substantial impact in improving the quality of health services delivered in their areas.

.3 Reporting Requirements for Health Facilities

Section 805 of the Business and Professions Code requires health facilities to report medical staff actions to the Board, and specifies information that can be released to health care facilities by the Board.

The law requires the Chief Executive Officers and the Chief of the Medical staff of a hospital or similar institution to report to the Board all actions taken against physicians, podiatrists or clinical psychologists which denied, restricted for 45 days or more per calendar year, or removed staff privileges for medical disciplinary cause or reason. If the removal or restriction was accomplished by resignation or other voluntary action that was requested or bargained for in lieu of medical disciplinary action, that is to be reported also. (Dentists and osteopathic physicians are reported to their respective boards.) Failure to make the required report is a misdemeanor, punishable by a fine of at least $200.00 and not more than $2,000.00.

Reports are required to be made to BMQA within 20 working days. The report must contain "a detailed description of the cause(s) for the action, including all the reasons for and the circumstances surrounding the action."

Providing this information does not constitute a waiver of confidentiality of medical records and committee reports. Persons making a report under this section are exempted from civil or criminal liability as a result of making the report.

Prior to granting or renewing staff privileges of physicians, podiatrists and clinical psychologists, hospitals and other health facilities must ask BMQA if a Health Facilities Report has been filed against any of the licensees under consideration. If such a report exists, BMQA is required to provide a copy of the report the health facility within 30 working days. If the Board does not respond within

30 working days, the hospital may assume there is no report. All decisions regarding staff privileges remain entirely at the discretion of the hospital. The law requires only that information from BMQA regarding reports from other facilities be obtained before a final decision is made. Failure by the health facility to request such information also is a misdemeanor.

The foregoing laws are aimed at improving communication between health facilities within California through the Board of Medical Quality Assurance. The goal is that such improved communication will have a positive impact on the quality of care rendered to the public.

2.4 INCOMPLETE MEDICAL RECORDS (Business and Professions Code, Section 805)

The Division of Medical Quality has adopted a policy regarding incomplete medical records. Hospitals, under this policy, need only report physicians suspended for a cumulative total of 45 days or more in any calendar year for failure or refusal to complete or maintain hospital medical records where the deficiencies in the medical record are serious and have the potential of affecting or interfering with patient care. The determination to report, or not to report, physicians suspended for failure or refusal to complete hospital medical records must be assumed by the medical staff. When a physician's medical staff suspension is reported to the Medical Board, a memorandum attached to the reporting form is required. It must be signed by the chief of the medical staff stating the reasons why the medical record deficiencies involved are regarded as serious and why the deficiencies described have the potential of affecting or interfering with patient care.

2.5 The Complaint and Investigation Process

Complaints may be submitted by any consumer, individual, or group, preferably in writing, to Consumer Service Representatives (CSR) of the Board in the appropriate regional offices. The addresses of the four regional offices which have CSRs are as follows:

1430 Howe Avenue, Suite 85A
Sacramento, CA 95825
(916) 920-6013

155 Bovet Road, Suite 660
San Mateo, CA 94402
(415) 573-3888

8939 So. Sepulveda, Suite 520
Los Angeles, CA 90045
(213) 412-6363

606 E. Mill Street, Room 1022-B
San Bernardino, CA 92408
(714) 383-4755

A. Consumer Complaints—Before a formal complaint is registered, the Consumer Service Representative encourages the complainant to contact his or her physician in an attempt to resolve the problem. If such an attempt is unsuccessful, a formal complaint is made. The Board provides forms on which members of the public may file written complaints (Business and Professions Code, Section 800). The complaint and any accompanying documentation are reviewed by the CSR and a medical consultant to determine if possible violations of the Medical Practice Act exist. If so, an investigation of the complaint is initiated.

B. Reports of Liability Insurers—Medical malpractice reports against Board licensees come from three district sources, each mandated to report to the Board by separate sections of the Business and Professions Code. The sources and code

sections are:

1. Professional liability insurers (Section 801).
2. Professional liability insurers [Section 801(b)]

Are required to report to BMQA every settlement, arbitration award or judgement of more than $30,000 in a claim or action for damages for death or personal injury caused by a physician's negligence, error or omission in practice, or rendering of unauthorized professional services.

Such reports must be sent within 30 days of the settlement, award or judgment. Forms for making reports under these sections are available from the Board.

3. Uninsured licensees or their counsel [Section 802(b)]

This is similar to 801(b), but requires an uninsured physician or his or her attorney to report such settlement or award.

4. Clerks of the court [Section 803]

Are required to report a licensee who has committed a crime or is liable for judgment in excess of $30,000.

C. *Complaints outside the Board's jurisdiction*—Not all complaints against physicians are within the jurisdiction of the Board. Complaints not accepted by Consumer Service Representatives include the following:

1. Ethical matters, referred to county medical societies.
2. Fee disputes, referred to county medical societies.
3. Medi-Cal fraud or other misuse of the Medi-Cal program, referred to the State Department of Health Services, Surveillance and Utilization Review.
4. Medi-Care fraud or other misuses of the Medi-Care program, referred to the local Federal Social Security Office.

D. *The Investigation Process*—The Board of Medical Quality Assurance must investigate any complaint or report which may involve a violation of the Medical Practice Act. Investigations are conducted by medical consultants and lay medical investigators employed by the Board. The initiation of an investigation is not evidence of guilt.

The following priorities assigned to investigations are guidelines which are utilized by the Division of Medical Quality's Enforcement Program. The priorities are divided into two categories. Each violation listed in each category is considered as equivalent in that category.

Category I investigational priorities are classified into four headings which signify the greatest potential harm to medical care consumers.

	B&P Code Section
I. QUALITY OF MEDICAL CARE	
Gross negligence	*2234 (b)*
Repeated similar negligent acts	*2234 (c)*
Incompetence	*2234 (d)*
II. IMPAIRMENT	
Mental illness	*822*
Abuse of dangerous drugs, narcotics, or alcohol	*2239*
Intoxication while attending a patient	*2240*
III. DRUG LAW VIOLATIONS	
Repeated acts of clearly excessive prescribing or administering of drugs or treatment	*725*

Prescribing dangerous drugs without a prior medical exam	*2242*
Furnishing drugs to an addict	*2241*
Conviction under narcotics or drug statutes	*2237*
IV. SEXUAL ABUSE	
Sexual Misconduct with a patient	*726*

Category II investigational priorities are categorized as miscellaneous violat which usually signify lesser potential harm to the medical care consumer.

Conviction of a crime, in general	*2236*
Aiding & abetting the unlicensed practice of medicine	*2264*
Practice, attempting to practice, or advertising without a license	*2052*
Use of terms or letters falsely indicating the right to practice	*2054*
Holding one's self out as a physician	*2054*
Employing an uncertified physician's assistant	*2265*
Betraying of professional secrets	*2225 & 2263*
Employing unlicensed or suspended persons	*2264*
Use of terms or letters falsely indicating authority to practice	*2274*
Unlawful referral or refund fee	*650*
False or misleading advertising	*651, 2271 & 17500*
Anonymous advertising	*2272*
Capping and steering	*2273*
Making false statements	*2261*
Alteration of medical records	*2262*
Practice under false or fictitious name	*2285*

Investigation typically begins with an informal contact with the physiciar the investigator. Although a physician is not required by law to respond at stage, cooperation by the physician may avoid formal proceedings whe minor or technical violation has occurred.

When interviews are warranted, the investigator will try within reasona limits to schedule appointments at times convenient to the physician. The inv tigator will not disclose any information to the physician's office staff. Investi tors will furnish little information to the physician by telephone due to sensitivity of the investigative situation.

When first contacted by an investigator, the physician should carefully con er the seriousness of the matter and the degree to which the underlying fa may be susceptible to an interpretation which could support disciplinary acti The physician may seek consultation with legal counsel at any time. Once physician has been advised of the seriousness of the allegations, he or she n wish to defer further discussion until legal advice has been obtained.

E. *Review of records by the investigator*—Patients are entitled to confident ity of records and communications. There are statutory exceptions, includ requirements of physician reports regarding child and elder abuse, childr communicable diseases, pesticide poisonings, and so forth (see Section 8.4 this guidebook). Similarly, there is a statutory exception to confidentiality apl cable to investigation by the Board of Medical Quality Assurance.

The Board's authority to examine patient records in the office of a physic is limited to the records of those patients who have complained about t particular practitioner. It is not a breach of confidentiality to voluntarily provi this information to the Board's investigators (Business and Professions Co

Division 2, Chapter 5, Sections 2225 & 2263). The Board and its employees, agents, and representatives must keep in confidence the names of any patients whose records are reviewed unless, and until, a formal accusation is filed.

F. *Subpoena process*—Investigators have "peace officer" authority (Penal Code, Section 830.3); however, they may not seize or compel the production of records without a search warrant or subpoena. At the informal inquiry stage the investigator may inform the physician that consequences of noncooperation may be the issuance of a subpoena requiring the production of records. If the physician refuses to honor the subpoena, the State will obtain a court order for compliance. Any objections to this process may be raised by the physician in the court proceeding.

The subpoena process is burdensome to both the investigator and the physician. It is time-consuming, entails additional work for both parties, and may involve greater legal expenses for the physician. In addition, enforced participation in a formal investigation is likely to be less convenient for the physician than an informal inquiry.

G. *Maintenance of information by the Board*—The Board is required to maintain a central file of complaints and reports of judgments, settlements, and medical staff disciplinary actions. This file is confidential. However, a physician or the physician's legal counsel or representative, may examine any complaints or reports in the central file regarding that physician. If desired, additional exculpatory or explanatory statements or other information may be submitted by the physician, and these must be included in the file.

H. *Formal accusation*—At the conclusion of an investigation, the case is reviewed by a medical consultant. If it appears that the physician has violated the Medical Practice Act, the results of the investigation are submitted to the Office of the Attorney General for review and, at his or her discretion, the filing of a formal accusation. The information contained in a formal accusation is public record.

Under law, a physician has a right to a hearing when formal charges are filed. Formal charges should be taken seriously by the physician because they place the physician's license in jeopardy. There are legal protections available to the physician that can best be pursued with the assistance of an attorney experienced in medical matters.

An administrative hearing may be conducted by a panel of a Medical Quality Review Committee or by an Administrative Law Judge sitting alone, or, in rare instances, by the Division of Medical Quality, itself. The hearing may result in either a final or proposed decision. A final decision is one reached by a Medical Quality Review Committee or one of its panels that calls for suspending a license for 30 days or less, or limiting the extent, scope, or type of practice of a physician for one year or less. All other decisions—those which involve suspension for periods greater than 30 days, place limitations on a practice for more than one year, or any decision made by an Administrative Law Judge—are proposed decisions. Such decisions are submitted to the Division of Medical Quality for final decision and must be acted upon by the Division within 100 days. Final decisions are public record.

2.6 Disciplinary Action

A. *Discipline of a physician by the Division*—Disciplinary action agains physician may take any of the following forms:

1. Revoking a license.
2. Suspending a license for a period not to exceed one year.
3. Placing a physician on probation and restricting or limiting the scope type of practice (including prohibiting the personal use of dangerous dr or alcohol, practicing with a restricted Drug Enforcement Administrati certificate, providing free community service, being in psychiatric tre ment, attending Alcoholics Anonymous, obtaining additional training expertise).
4. Taking such other disciplinary actions as the Division of Medical Quali in its discretion, may deem proper.

B. *Disciplinary Guidelines*—The Medical Practice Act mandates, amo other things, that the Division of Medical Quality "shall promulgate recommen ed uniform disciplinary measures for particular situations." In addition, the Di sion has become aware that most physicians licensed in California have nev read the Medical Practice Act, are not fully aware of activities for which discip nary action may be taken against their licenses, nor appreciate the extent of t discipline which might be rendered. The guidelines are for the use of Medic Quality Review Committees and Administrative Law Judges, as well as to infor the medical community. The Division recognizes that these penalties and conc tions of probation are merely guidelines and individual cases often will neces tate variations in taking into account particular circumstances. Complete copi of the disciplinary guidelines will be sent on request from the Board's Sacr mento headquarters office. Board of Medical Quality Assurance, 1430 How Avenue, Sacramento, CA 95825.

C. *Medi-Cal violations*—The Board does not generally have jurisdiction i Medi-Cal disputes except insofar as a physician may be involved in a violatio of the Medical Practice Act. Investigation of Medi-Cal fraud or other misuse c the Medi-Cal program is the domain of the Department of Health Service Medi-Cal providers are required to furnish patient records to the Department c Health Services' investigators on demand (Welfare and Institutions Code, Sec tion 14124.5). Failure to comply may result in the physician's suspension fror the Medi-Cal program. Furthermore, such failure or refusal may constitute un professional conduct as defined in the Medical Practice Act and, therefore, ma involve investigative and disciplinary action by the Board. Likewise, a finding c Medi-Cal fraud is a violation of the Medical Practice Act.

D. *General advice on the disciplinary process*—The following quotation fron a journal article summarizes well the advice to physicians regarding the discipli nary process:

> "The right of a physician to practice his or her chosen profession must b balanced against the right of the public to be protected from unprofessiona conduct by physicians. By providing notice and a hearing before imposin discipline, if any, on a physician for unprofessional conduct, the Californi Board of Medical Quality Assurance meets the basic requirements of proce dural due process. However, although the constitutional rights of the physi cian may be protected in this way, the administrative disciplinary process itsel