University of San Diego SCHOOL OF LAW
CONSUMER PROTECTION POLICY CENTER
at the
CENTERS FOR PUBLIC INTEREST LAW
5998 Alcalá Park
San Diego, CA 92110-2492
P: (619) 260-4806 | F: (619) 260-4753
www.sandiego.edu/cppc | info@cpil.org

April 11, 2025

Chairman, Marc Berman
Vice Chair, Heath Flora & Members of the Committee
Assembly Committee on Business and Professions
The Legislative Office Building
1020 N Street, Room 379
Sacramento, CA 95814

Re: Testimony of the Consumer Protection Policy Center – AB 408 (Berman): Physician and Surgeon Health and Wellness Program – OPPOSE

Dear Assembly Committee on Business & Professions:

On behalf of the Consumer Protection Policy Center (CPPC) at the University of San Diego School of Law, I am pleased to submit the following testimony to the Legislature regarding AB 408 (Berman) – Physician Health and Wellness Program. CPPC believes this program is inconsistent with the Medical Board of California's statutory priority of public protection over other interests sought to be promoted. CPPC is opposed to AB 408 at this time.

CPPC Expertise Regarding the Medical Board of California

CPPC is a nonprofit, nonpartisan academic and advocacy center based at the University of San Diego School of Law. For 44 years, CPPC has examined and critiqued California's regulatory agencies that regulate business, professions, and trades, including the Medical Board of California (MBC) and other Department of Consumer Affairs (DCA) health care boards. CPPC's expertise has long been relied upon by the Legislature, the executive branch, and the courts where the regulation of licensed professions is concerned. For example, after numerous reports of problems at MBC's enforcement program were published in 2002, the DCA Director appointed CPPC's then-Administrative Director, Julianne D'Angelo Fellmeth, to the position of MBC Enforcement Monitor pursuant to Business and Professions Code section 2220.1 (now repealed). Over a two-year period, she directed an in-depth investigation and review of MBC's enforcement program and its so-called "diversion program" which purported

to monitor substance-abusing licensees. In two exhaustive reports,[1] CPPC's Administrative Director made 65 concrete recommendations to strengthen the Board's programs.

Lack of Necessity for a PHWP

MBC has framed its proposed Physician Health and Wellness Program (PHWP) as a consumer protection measure, asserting that this method of rehabilitating impaired physicians will allow safer continuation of medical practice, thereby protecting consumers. However, this rationale requires persuasive evidence. If the Board intends to focus on physicians already under formal scrutiny, such as those placed on probation for substance abuse, the available data from peer state programs exposes fundamental flaws in this approach. This analysis focuses on New York and Washington, jurisdictions selected for their comparable regulatory frameworks, physician population demographics, and transparent enforcement data. Other states with PHWPs were excluded due to insufficient program transparency or markedly different regulatory structures, leaving New York and Washington as the most relevant comparisons.

The enrollment numbers from New York and Washington strongly suggest relatively low enrollment should be expected in California. This consideration then raises the question as to whether the development, implementation, and management of a PHWP is necessary for such a small proportion of licensees. For example, New York maintains the nation's second-largest physician population at over 134,000 licensees, yet its state-run PHWP enrolled only 302 physicians in 2023, a negligible 0.23% of its total licensee pool.[2] Washington's program demonstrates similar limited reach, with just 81 enrolled participants out of 37,425 licensees[3] (0.22% participation) in the fiscal year 2024, which also may include participants in other states and reasons other than substance-abuse disorders.[4] When contrasted with California's 153,462 licensees, these figures suggest that implementing a PHWP would likely yield a statistically insignificant impact given the minimal participation rates observed in comparable jurisdictions.[5]

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[1] Initial Report: https://www.sandiego.edu/cppc/publications/mbc-initial.php; Final Report: https://www.sandiego.edu/cppc/publications/mbc-final.php

[2] New York State Department of Health. (2023). *Annual report on physician conduct*. https://www.health.ny.gov/professionals/doctors/conduct/annual_reports/docs/2023_report.pdf

[3] Washington Medical Commission (2025). *2024 Fact Sheet*. https://wmc.wa.gov/sites/default/files/public/Fact%20Sheet%20%28FY24%29.pdf

[4] Washington Physicians Health Program. (2025). *2024 Annual Report*. https://wphp.org/wp-content/uploads/2025/04/WPHP_AnnRep2024.pdf

[5] California Medical Board. (2024). *Annual report 2023–2024*. https://www.mbc.ca.gov/Download/Reports/Annual-Report-2023-2024.pdf

Available complaint data also underscores the lack of compelling evidence for the necessity of a PHWP. In 2023–2024, California reported only 358 personal conduct complaints that are not related to patient harm (3.7% of 9,715 total complaints), a category that includes, but is not limited to, substance abuse violations.[6] By comparison, Washington—with its operational PHWP and substantially smaller physician population—recorded seven substance-specific complaints (0.4% of 1,671 total complaints) within fiscal year 2023–2024.[7] However, if we include the 55 of the 158 referrals to the Washington program that were related to substance-abuse disorders, then the potential 62 substance-abuse related complaints out of 1,726 would be roughly 3.6% of total complaints in Washington without their wellness program.[8] Both Washington and California have potentially similar numbers of substance-abuse related complaints if you remove Washington's PHWP, even after many years of Washington's PHWP implementation. Thus, once California can send potential substance-abuse related complaints to a PHWP program, MBC can report lower numbers of substance-abuse related complaints almost immediately, even though the potential harm to patients remains the same. Further, Washington only enrolls about half of the referred physicians (81 out of 158 referrals), which equates to less than .2% of total licensees that are enrolled annually. Therefore, using Washington as a model example, California's goal would only reach a fraction of one percent of total licensees; a miniscule impact as to the current substance-abuse physician trend in California.

When compared to other states, California's probation data also strongly suggests the lack of a need for a PHWP. During the 2023–2024 reporting period, California had only 141 physicians (0.09% of licensees) on probation for substance abuse related violations,[9] while New York's longstanding PHWP monitored 472 physicians (0.35% of licensees) for impairment.[10] This disparity becomes more significant when considering that California's physician population exceeds New York's by roughly 13%, yet New York's PHWP serves a proportionally similar cohort to California's probation population without demonstrating superior consumer-protection outcomes. As noted above, methodological differences account for at least some of the gaps between these figures.

Disciplinary data further undermines the case for California's proposed PHWP. The state imposed 55 administrative actions and probation violations related to substance

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[6] *Id.*

[7] Washington State Department of Health. Complaints and disciplinary actions against physicians, 2008–February 2025 [Excel spreadsheet; analyzed subset: July 1, 2023–June 30, 2024]. Provided in response to public records request.

[8] Washington Physicians Health Program. (2025). *2024 Annual Report*. https://wphp.org/wp-content/uploads/2025/04/WPHP_AnnRep2024.pdf

[9] California Medical Board. (2024). *Annual report 2023-2024*. https://www.mbc.ca.gov/Download/Reports/Annual-Report-2023-2024.pdf

[10] New York State Department of Health. (2023). *Annual report on physician conduct*. https://www.health.ny.gov/professionals/doctors/conduct/annual_reports/docs/2023_report.pdf

abuse in 2023–2024 (14.7% of 374 total disciplinary cases),[11] while New York, with its established PHWP, took only 30 final board actions for impairment (10.6% of 284 cases).[12] This near parity in disciplinary rates demonstrates that California's existing enforcement mechanisms address substance abuse as effectively as states with dedicated monitoring programs. The marginal difference in disciplinary outcomes, despite New York's additional PHWP infrastructure, provides no compelling evidence that such a program would meaningfully enhance patient protection in California. Again, as noted above, methodological differences account for some of the gaps between these figures.

With these comparisons in mind, California's current regulatory framework clearly achieves outcomes comparable to states with established PHWPs, despite operating without such a program. Moreover, even if a PHWP was a promising venture, MBC's proposed PHWP does not differ from New York's or Washington's programs in material ways that would significantly improve outcomes for patient-consumers. The Board's best augment in favor of the proposed PHWP is that 141 out of 577 probationers (518 active monitoring cases plus 59 inactive cases due to the probationer being out of state) have substance abuse issues and the proposed PHWP would assist in rehabilitating those physicians, thereby further protecting consumers. However, as shown above, there is little to no persuasive evidence that MBC's proposed PHWP would significantly impact probationary monitoring or disciplinary enforcement. Therefore, the proposed PHWP would not increase protection for consumers (even minimally), and subsequently there is a failure to show a need for a PHWP in California.

Instead, the Board's attention and resources would be better focused on improvements related to transparency, accountability, and timely enforcement to ensure meaningful protection for consumers.

Alternative Proposal to Avoid Antitrust Concerns

To avoid the time-consuming nature of a Board-run wellness program and still encourage physician well-being, the Legislature can enact a new complaint procedure to evaluate when a doctor is suitable for rehabilitation center treatment. Currently, when a complaint is filed with the MBC, the Board approves the complaint and sends it to the investigation unit with DCA. MBC has the power to enforce an interim suspension order to restrain the doctor's license, but otherwise the investigation would continue before it would eventually be referred to the Attorney General's Office (AG) and then later assigned to an Administrative Law Judge (ALJ). This process can take years before an ALJ sees the complaint. Meanwhile, the doctor continues to practice as a fully licensed physician.

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[11] California Medical Board. (2024). *Annual report 2023-2024*. https://www.mbc.ca.gov/Download/Reports/Annual-Report-2023-2024.pdf

[12] New York State Department of Health. (2023). *Annual report on physician conduct*. https://www.health.ny.gov/professionals/doctors/conduct/annual_reports/docs/2023_report.pdf

A new process can instead refer complaints to the AG first, at which point an ALJ can determine whether rehabilitation treatment is appropriate for the physician in question. Further, Courts already have approved treatment programs in California for substance abuse related crimes. An ALJ can refer a physician to one of these Court approved treatment facilities and the physician would be liable for providing updates on the rehabilitation process to the ALJ. If an ALJ determines that treatment is appropriate in lieu of discipline, then that would be an independent decision that is not influenced by licensed members of the medical profession. This independence is particularly beneficial as disciplinary decisions by a board controlled by a majority of licensees can lead to antitrust issues.[13]

In 2015, the U.S. Supreme Court held that a state agency controlled by a majority of active-market participants (active licensees) is not exempt from antitrust regulations under the Sherman Act by the state-action doctrine, unless "the action is clearly articulated and affirmatively expressed as state policy," and the state actively supervises the policy.[14] To show why this case is applicable, and why MBC should take note of its holding in this context, the key elements are elaborated below.

Just as MBC was created by the passage of the Medical Practice Act, North Carolina's Dental Board was created through passage of its Dental Practice Act. The principal duty of both boards is essentially to "create, administer, and enforce a licensing system" for their respective licensees, as "matter[s] of public concern."[15] MBC's Board is composed of a majority of licensed medical professionals (eight out of fifteen members), and the N.C. Dental Board was also made up of a majority of licensed dentists. Both boards promulgate rules and are subject to their respective state's Administrative Procedures Acts, public records acts, and open-meetings laws.[16]

As both boards are similarly situated, the next step in an antitrust analysis is whether the state-action doctrine applies. This doctrine, also referred to as *Parker* immunity,[17] was tempered by SCOTUS in the *N.C. Dental* case. In *N.C. Dental*, the Board argued that such immunity applied because the Board's "members were invested by North Carolina with the power of the State."[18] The Court ruled that such immunity would apply "only if [the Board] satisfies two requirements," also known as the Midcal Test.[19] The first requirement is that the challenged action is "clearly articulated and affirmatively expressed as state policy."[20] This essentially means that the Board's rule must be

[13] *N.C. State Bd. of Dental Exam'rs v. FTC*, 574 U.S. 494, 504 (2015)
[14] *Id*. (citations omitted, quoting *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc*., 445 U.S. 97, 105 (1980)).
[15] *Id*. at 499.
[16] *Id*. at 500.
[17] *Parker v. Brown* 317 U.S. 341 (1943).
[18] *N.C. Dental*, 574 U.S. at 503.
[19] *Id*. at 504.
[20] *Id*.

aligned with state policy, such as mirroring the legislature's interpretation of the agency's governing statute. The second requirement is that the policy or regulation is "actively supervised by the State."[21] This element was directly at issue in the *N.C. Dental* case, which also noted that generally, "'state-action immunity is disfavored'."[22]

The Court in *N.C. Dental* recognized that state agencies may claim to act under state authority despite divergence from the State's definition of "the public good," and subsequently "[t]he active supervision requirement demands . . . that state officials have exercised power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.'"[23] To clarify, statutory authorization is not enough, hence the term "active supervision" for boards that comprise of majority licensees. With this legal background in mind, MBC's proposed PHWP will likely pose antitrust issues given the majority-licensee makeup of the Board and lack of active state supervision in deciding which doctors should be enrolled in a PHWP to avoid discipline. Moreover, the alternative complaint procedure described above would avoid such concerns.

In short, actions by MBC are similarly not exempt from challenges under the antitrust laws of the Sherman Act. Therefore, MBC should also not proceed with its proposed PHWP due to lack of state-action immunity when it comes to potential antitrust violations. Further, declining to adopt the proposed PHWP would allow MBC to spend its time and resources on areas that are of greater concern for the Board.

CPPC Suggests MBC Step Away from a PHWP to Focus on More Important Issues

At MBC's March 1, 2024, meeting, MBC's second enforcement monitor, Les Lombardo, gave his presentation on the Final Report of the Enforcement Monitor. Mr. Lombardo summarized key issues and recommendations MBC should address. The issues included [1] Central Complaint Unit (CCU) serious injury or death complaints closed without Health Quality Investigation Unit (HQIU) investigation and problems with the complaint tracking system project; [2] lack of collaboration between Health Quality Enforcement (HQE) prosecutors and HQIU investigators that significantly impacted efficient, effective, and timely adjudication, as well as problematic medical expert analysis and the imposition of sanctions/discipline in accordance with disciplinary orders/guidelines; [3] physician and surgeon demographic data analysis; and [4] additional enforcement program issues such as critical issues of program funding shortages and complaint outreach interviews.

[21] *Id*.
[22] *Id*. at 504 (citations omitted).
[23] *Id*. (citations omitted).

Mr. Lombardo gave recommendations as well at the March 1, 2024, meeting. These recommendations included [1] MBC's need to collaborate with Complaint Tracking System (CTS) stakeholders to ensure legally allowable public visibility to CTS information; [2] establish structured collaboration between HQIU investigation and HQE prosecution to ensure necessary, appropriate and timely communication throughout a complaint investigation (and restructuring the MBC enforcement program if the communication cannot be achieved); [3] recruiting, training, compensation, and feedback of medical experts in adjudication proceedings; [4] review the disciplinary guidelines and procedures for departing from identified disciplines relative to associated violations; and [5] MBC to establish a formal process for self-identified race/ethnicity information to be periodically extracted, analyzed, and reviewed by the Board to provide insight on demographic trends. A wellness program for physicians and surgeons was ***not*** identified by the enforcement monitor as an appropriate MBC focus.

None of these issues highlighted by an independent enforcement monitor has been the subject of a major discussion by the Board. None of these issues led to special meetings to be discussed outside of regular MBC quarterly meetings. Yet the Board has dedicated time and resources to have presenters on a PHWP, and even a special meeting for interested parties on October 24, 2024, to discuss the new proposed PHWP legislation. MBC staff has put time and resources into two separate PHWP proposed implementations, and yet none of the above recommendations by the enforcement monitor have been given the same amount of time and resources. CPPC believes MBC should focus on the issues highlighted by the enforcement monitor instead of dedicating time and resources to a PHWP that is designed to benefit doctors more than it is designed to protect patients and the public interest.

If physicians want a rehabilitation program (outside of the various rehabilitation programs already in existence throughout California), then interest groups should advocate without the aid of MBC resources. The creation of a governing agency to directly oversee said rehabilitation program could provide sufficient oversight, like the programs in Washington and Georgia. Of course, the program would need to be in contact with MBC to ensure the enlisted physicians are not in violation of their treatment program. A mandatory reporting requirement by the new governing agency would be necessary for MBC to uphold its enforcement obligations.

Issues With the Previous MBC Diversion Program

MBC voted to terminate its previous substance-abuse diversion program in 2008 due to multiple failed audits. The Enforcement Monitor found that all of the monitoring mechanisms by which the program purported to monitor substance-abusing physicians—including required biological fluid testing, required group therapy meeting attendance, worksite monitor requirements and reporting, and treating psychotherapist reporting—were failing; that the program lacked sufficient internal

controls to alert program staff to these failures; and that the program had been so under resourced and understaffed that staff could not have corrected these failures even if they detected them. Of critical importance, the Monitor also found that the program suffered from an absence of enforceable rules or standards to which participants and personnel were consistently held because MBC itself—contrary to applicable provisions in the Business and Professions Code—had failed to exercise any meaningful oversight over the program. These findings echoed the results of three earlier audits of the program by the Auditor General.

Following the publication of the Enforcement Monitor's reports in 2004 and 2005, the Legislature directed the State Auditor to re-audit MBC's diversion program. In June 2007, the Auditor released Report 2006-116R, which concluded that while the program had improved since the 2005 Enforcement Monitor report, many of the problems identified by the Enforcement Monitor had not been corrected. Specifically, the program failed to ensure that all participants were randomly drug tested; failed to adequately monitor and/or require reporting from its various contractors (including urine specimen collectors, group meeting facilitators, and worksite monitors); did not respond to potential relapses in a timely and adequate manner; and did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug. Lastly, the Auditor found that MBC—which was charged with overseeing the diversion program—"has not provided consistently effective oversight."

Following receipt of the Auditor's Report, MBC—at its July 2007 meeting—unanimously voted to abolish the diversion program and to seek a repeal of the statutes creating the program. The program was abolished effective July 1, 2008. Thus, MBC has not had a program to monitor substance-abusing licensees for 16 years.

Conclusion

CPPC urges the Legislature to reject the proposed PHWP legislation and instead encourage MBC to focus on matters that truly and appropriately concern the legitimate regulatory functions of MBC. When MBC seeks to create a rehabilitation program, it is the Board's burden to ensure that patients are protected above all else. This Board previously rejected similar PHWP proposal in the form of rulemaking and there are identical similarities to this new proposed PHWP legislation. There is no need for MBC to be concerned in physician and doctor rehabilitation in light of the Board's enforcement obligations. If California is in need of a rehabilitation program for substance abusing physicians and surgeons, the California Medical Association (CMA) should look elsewhere outside of MBC to establish a PHWP. MBC needs to dedicate its time and resources to matters that truly risk public safety, such as the adjudication issues highlighted by the previous enforcement monitor.

CPPC cannot stress enough that MBC's obligations are to the protection of patients and the public. Time and resources dedicated to a physician rehabilitation program would be designed to benefit physicians first, with the protection of the public only being an auxiliary side-effect if the program is more successful than other states' programs.

Sincerely,

Marcus Friedman
Administrative Director
Consumer Protection Policy Center