SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Angelique Ashby, Chair
2025 - 2026 Regular

Bill No:	AB 408	**Hearing Date:**	July 7, 2025
Author:	Berman		
Version:	April 21, 2025		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Sarah Mason		

Subject: Physician Health and Wellness Program

SUMMARY: Replaces the existing statutory framework authorizing the Medical Board of California (MBC) to establish a Physician and Surgeon Health and Wellness Program (PSHWP) that includes various requirements for the PSHWP to support a physician and surgeon in their rehabilitation from substance abuse, in compliance with the Department of Consumer Affairs' (DCA) Uniform Standards Regarding Substance-Abusing Healing Arts Licensees (Uniform Standards), with an entirely new framework authorizing MBC to establish a Physician Health and Wellness Program (PHWP) by contracting with a third-party entity to administer a program to support, treat, monitor, and rehabilitate physicians and surgeons and allied health care professionals licensed by MBC, as well as applicants, prospective applicants, trainees, and students with impairing or potentially impairing physical or mental health conditions, including substance use disorders, that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner. Specifies that the PHWP established under this bill only complies with the Uniform Standards for non-voluntary participants referred as a condition of probation. Authorizes MBC, in lieu of disciplinary action, if MBC determines that unprofessional conduct may be the result of an impairing or potentially impairing condition, to refer a licensee to the PHWP, as specified.

NOTE: This bill is double-referred to the Senate Committee on Judiciary, second.

Existing law:

1) Provides for the licensure and regulation of physicians and surgeons by MBC pursuant to the Medical Practice Act (Act). (Business and Professions Code (BPC) § 2000 *et. seq.*)

2) Requires MBC to prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Requires cases involving drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient to be handled as a high priority. (BPC §2220.05)

3) Provides MBC with the authority to issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited to practice limited to a supervised, structured environment, continuing medical or psychiatric treatment, ongoing participation in a specified rehabilitation program, or abstention from the use of alcohol or drugs. (BPC §2221)

4) Provides that the MBC shall take action against a physician who is charged with unprofessional conduct, as specified. (BPC § 2234)

5) Provides that a violation of any federal or state statute or regulation regulating dangerous drugs or controlled substances constitutes unprofessional conduct. (BPC § 2238)

6) Provides that the use of, or self prescribing or self administering, of any controlled substance or dangerous drugs or alcoholic beverages in such a manner as to be dangerous or injurious to the licensee or any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely, or more than one misdemeanor or any felony involving the use, consumption or self-administration of any of these substances, constitutes unprofessional conduct. (BPC § 2239)

7) Establishes the DCA which oversees boards and bureaus that license and regulate businesses and professions, including but not limited to physicians, nurses, dentists, engineers, architects, contractors, cosmetologists, automotive repair facilities and private postsecondary education institutions. (Business and Professions Code (BPC § 101)

8) Requires individuals or entities contracting with the DCA or any board within the DCA to provide services relating to the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs to retain all records and documents pertaining to those services until such time as these records and documents have been reviewed for audit by DCA for a maximum of three years, as specified. (BPC § 156.1)

9) Requires all records and documents pertaining to services for the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs provided by any contract vendor to the DCA, or to any board to be kept confidential, and not subject to discovery or subpoena. (*Id.*)

10) Establishes the Substance Abuse Coordination Committee (SACC) in the DCA, comprised of executive officers of the DCA's health care professional licensing boards and a designee of the State Department of Health Care Services. (BPC § 315 (a))

11) Requires the SACC to formulate uniform and specific standards in specified areas that each health care professional licensing board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program. (BPC § 315 (c))

12) Requires a health care professional licensing board, except the Board of Registered Nursing (BRN), to order a licensee of the board to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program. (BPC § 315.2)

13) Permits a health care professional licensing board to adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice due to a major violation or if the licensee has been ordered to undergo a clinical diagnostic evaluation pursuant to uniform and specific standards, as specified, but that this requirement shall not apply to the BRN for purposes of their intervention program. (BPC §§ 315.4 (a) and (d))

14) Prohibits an order to cease practice from being governed by the Administrative Procedures Act (APA), and states that the order shall not constitute a disciplinary action. (BPC §§ 315.4 (b) and (c))

15) Requires the following boards to establish a diversion program for board licensees in order to seek ways and means to identify and rehabilitate licensees whose competency may be impaired due to abuse of dangerous drugs and alcohol, so that licensees may be treated and returned to practice in a manner which will not endanger the public health and safety. Most also specify Legislative intent that a diversion program (or intervention program) is a voluntary alternative approach to traditional disciplinary actions:

    a) The Dental Board of California for dentists. (BPC §§ 1695-1699)

    b) The Dental Hygiene Board for dental hygienists. (BPC §§ 1966-1966.6))

    c) The Osteopathic Medical Board of California for osteopathic physicians and surgeons. (BPC §§ 2360-2370)

    d) The Physical Therapy Board of California for physical therapists. (BPC §§ 2662-2669)

    e) The Board of Registered Nursing for registered nurses. (BPC §§ 2770-2770.14)

    f) The Physician Assistant Board for physician assistants. (BPC §§ 3534- 3534.10)

    g) The Board of Pharmacy to operate a recovery program for pharmacists or intern pharmacists. (BPC §§ 4360-4373)

    h) The Veterinary Medical Board for veterinarians and registered veterinary technicians. (BPC §§ 4860-4873)

16) Establishes the Attorney Diversion and Assistance Act within the State Bar of California to address the substance abuse and mental health problems of attorneys who voluntarily participate in the program. (BPC §§ 6230-6238)

17) Provides for the professional review of specified health care professional licensees by a peer review body, as defined, including a medical or professional staff of any licensed health care facility or clinic, health care service plan, specified health professional societies, or a committee organized by any entity that functions as a body to review the quality of

professional care provided by specified health care practitioners. (BPC § 805)

18) Requires a report to be filed by a peer review body to an agency having regulatory jurisdiction over health care professional licensees if a licensee's application for staff privileges is denied or rejected, has had their membership, staff privileges, or employment terminated or revoked for medical disciplinary reasons; or if restrictions are imposed, or voluntarily accepted, on staff privileges, membership or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason (Commonly referred to as an "805 report" pursuant to § 805 of the BPC.)

19) Requires a peer review body to file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action to be taken against a licensee if it is determined, based on the investigation of the licensee, that the licensee was involved in the use of, or prescribing for or administering to themselves, any controlled substance; or the use of any dangerous drug or alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, any other person, or to the public, or to the extent that such use impairs the ability of the licentiate to practice safely. (BPC § 805.01)

20) Requires MBC to investigate complaints from the public, other licensees, health care facilities or from others as specified. Requires MBC to investigate the circumstances underlying a report received pursuant to BPC §805 or §805.01 above within 30 days to determine if an interim suspension order or temporary restraining order should be issued. (BPC § 2220)

21) Authorizes MBC to establish a PSHWP for the early identification of, and appropriate interventions to support a physician and surgeon in their rehabilitation from, their substance use to ensure that the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession; if established, the program shall aid a physician and surgeon with substance abuse issues impacting their ability to practice medicine. (BPC § 2340)

22) Requires the PSHWP to:

    a) Provide for the education of all licensed physicians and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.

    b) Offer assistance to a physician and surgeon in identifying substance abuse problems.

    c) Evaluate the extent of substance abuse problems and refer the physician and surgeon to the appropriate treatment by executing a written agreement with a physician and surgeon participant.

d) Provide for the confidential participation by a physician and surgeon with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues; if an investigation of a physician and surgeon occurs after the physician and surgeon has enrolled in the program, the board may inquire of the program whether the physician and surgeon is enrolled in the program and the program shall respond accordingly.

e) Comply with the Uniform Standards. (BPC § 2340.2)

23) Requires MBC, if it establishes a PSHWP, to contract for the program's administration with a private third-party independent administering entity that meets specified qualifications, pursuant to a request for proposals. (BPC § 2340.4)

24) Requires a physician and surgeon to enter into an individual agreement with the PSHWP and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the participant's written agreement as a condition of participation in the program. (BPC § 2340.6)

25) Establishes the PSHWP Account within the Contingent Fund of the MBC and provides that any fees collected by the MBC through the PSHWP must be deposited in that account. (BPC § 2340.8)

26) Authorizes MBC to prepare and provide electronically or by mail to every licensed physician at the time of license renewal a questionnaire containing any questions necessary to establish that the physician currently does not have a disorder that would impair the physician's ability to practice medicine safely. (BPC § 2425)

27) Prohibits MBC from requiring an applicant for physician and surgeon license or a postgraduate license to disclose a condition or disorder that does not impair the applicant's ability to practice medicine safely or a condition or disorder for which the applicant is receiving appropriate treatment and which, as a result of the treatment, does not impair the applicant's ability to practice medicine safely. Authorizes MBC to require an applicant to disclose participation in a mental health or substance use disorder treatment program, including an impaired practitioner program, resulting from an accusation or disciplinary action brought by a licensing board in or outside of California. Specifies that if an applicant discloses that they currently have a condition or disorder that impairs their ability to practice medicine safely, MBC must provide the applicant with information on the availability of a probationary or limited practice license. (BPC § 2090)

This bill:

1) Authorizes MBC to establish a PHWP to for the early identification of, and appropriate interventions to support, treat, monitor, and rehabilitate physicians and surgeons and allied health care professionals licensed by MBC, as well as applicants, prospective applicants, trainees, and students with impairing or potentially impairing physical or mental health conditions, including substance use disorders, that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner. Defines "impaired," "impairing," or "impairment" as the inability to practice medicine or other health care profession

regulated by MBC in a reasonably safe, competent, and professional manner due to mental illness, physical illness, disruptive behavior, or substance use disorder.

2) Defines "participant" as a licensee, applicant, prospective applicant, trainee, or student who was or is enrolled in the PHWP for evaluation, treatment, or monitoring pursuant to an agreement between that person and the PHWP, including voluntary participants and those referred by MBC pursuant to an order of probation. Defines "voluntary participant" as a participant who voluntarily enrolled in the PHWP for evaluation, monitoring, or treatment services, including an individual referred by MBC in lieu of MBC pursuing disciplinary action, and is not required by MBC to participate in the PHWP pursuant to an order of probation.

3) Authorizes MBC, in lieu of disciplinary action, if MBC determines that the unprofessional conduct may be the result of an impairing or potentially impairing condition, to refer a licensee to the PHWP, other than for allegations of patient or client harm or sexual misconduct with a patient, client, or any other person which do not render the licensee eligible for referral to the PHWP. Authorizes MBC to take disciplinary action if the licensee does not consent to the referral to the PHWP or if the referred licensee does not successfully complete the PHWP.

4) Requires a PHWP to:

   a) Educate the public, licensees, applicants, prospective applicants, trainees, students, health facilities, medical groups, health care service plans, health insurers, and other relevant organizations on specified topics.

   b) Enter into relationships supportive of the program with professionals experienced in working with health care providers to provide education, evaluation, monitoring, or treatment services.

   c) Receive and assess reports of suspected impairment from any source.

   d) Intervene in cases of verified impairment or suspected impairment, as well as in cases where the individual has a condition that could lead to impairment if left untreated.

   e) Upon reasonable cause, refer participants for evaluation, treatment, monitoring, or other appropriate services.

   f) Provide consistent and regular monitoring, care management support, or other appropriate services for PHWP participants.

   g) Advocate on behalf of participants, with their consent, to MBC to allow them to participate in the PHWP as an alternative to disciplinary action, when appropriate.

   h) Offer guidance on participants' fitness for duty with current or potential workplaces, when appropriate.

5) Exempts MBC and the PHWP from imposing or following the requirements of the Uniform Standards for voluntary participants. Only applies the Uniform Standards to a participant subject to an order imposing the Uniform Standards. Requires a participant subject to an order of probation to comply with the terms of probation and requires the PHWP to provide the required evaluations, treatment, monitoring, and reports to MBC consistent with the participant's order of probation.

6) Specifies that if MBC chooses to establish a program, it shall contract with a third-party independent administering entity that is a nonprofit with expertise and experience in the areas of impairment and rehabilitation in health care providers. The leadership of the administering entity shall have at least one medical director, who is specially trained or board certified in addiction medicine or addiction psychiatry and has expertise in health programs for health care providers. Authorizes MBC to enter into a multiyear contract with the administering entity without having to obtain the approval of the Department of General Services, the Office of Legal Services, or any other state entity to justify a multiyear term.

7) Requires the administering entity to have a MBC-approved system to immediately report a participant to MBC when required, including but not limited to when a participant withdraws or is terminated from the program prior to completion.Requires the administering entity to provide deidentified program statistics to MBC, annual reports, and upon request of MBC, submit to periodic quality and compliance evaluations conducted by an independent third party approved by MBC.

8) Requires the contract with the administering entity to cover procedures on various topics, including report information about a participant to MBC when the participant is probably an imminent danger to the public. Requires the contract with the administering entity to report deidentified voluntary participants who commit a PHWP violation but only authorizes information to be provided to MBC about the actual participant upon MBC request. Authorizes MBC to, even for these voluntary participants, encourage continued PHWP participation with additional conditions, in lieu of disciplinary action, when MBC determines that the licensee is able to continue to practice in a reasonably safe, competent, and professional manner.

9) Requires the administering entity to report to MBC if a licensee is unable to practice their profession in a reasonably safe, competent, and professional manner. Requires the administering entity to report to MBC if a licensee who fails to comply with the PHWP agreement, pursuant to a waiver the participant is required to sign allowing the administering entity to report information to MBC. Specifies that MBC is not restricted from its authority to take disciplinary action against a licensee who withdraws or is terminated from the PHWP or for any other unprofessional conduct.

10) Specifies actions, authorities, and responsibilities related to program records and their confidentiality and admissibility as evidence only under specified circumstances.

11) Entitles specified individuals and entities to immunity from civil liability for reporting information or taking action in connection with the PHWP

12) Authorizes MBC to establish one or more advisory committees of at least three members unaffiliated with the PHWP to assist MBC in carrying out its duties related to the PHWP. Specifies that one member must not be a MBC licensee but must be knowledgeable in a MBC-recognized field relating to substance use disorders, mental illness, or physical illness. Specifies that at least one MBC licensee appointed to the advisory committee shall specialize in the diagnosis and treatment of substance use disorders in health care professionals. Specifies advisory committee responsibilities.

13) Establishes a PHWP Account within the Contingent Fund of MBC available, upon appropriation by the Legislature, for the support of the PHWP. Authorizes MBC to seek and use grant funds and gifts of financial support from public or private sources to pay any cost associated with the PHWP and requires annual reporting to the Legislature and public the amount and source of funds received for the PHWP.

14) Requires a MBC licensee, if MBC establishes a PHWP, to report to the administering entity or the board, the name and current contact information of another licensee if they, in their good faith judgment, believe that the other licensee may be impaired.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by Legislative Counsel.

COMMENTS:

1. **Purpose.** The Medical Board of California is the sponsor of this bill. According to the Author, "When our physicians struggle with substance use disorders, it is in the best interest of both patients and physicians to support them in seeking out help. AB 408 builds off California's longstanding efforts to destigmatize seeking treatment for substance use disorders. This bill is fundamentally about patient safety. Today, physicians struggling with substance use disorders can feel pressure to hide their condition and often never get the help they need. The creation of this program will help healthcare providers get the care they need, which will better protect patients in the end."

2. **Background.**

   MBC Enforcement. MBC's enforcement activities are the core of its program, with the majority of its staff and resources dedicated to enforcement functions. The enforcement process begins with a complaint. Complaints are received from various sources, including the public, generated internally by MBC, or based on information MBC receives from various entities that are required to report information to MBC, including:

   - Reports of malpractice settlements, judgements, or arbitration awards from professional liability insurers, self-insured governmental agencies, physicians and/or their attorneys, and employers.

   - Reports of indictments charging a felony and/or any convictions of any felony or misdemeanor, including a guilty verdict or plea of no contest from licensees and notifications of arrests and convictions from DOJ.

- Reports from a coroner if a death may have been the result of a physician's gross negligence.

- Reports from a licensed health care facility when the physician's application for staff privileges or membership is denied, the physician's staff privileges, or employment is terminated or revoked for a medical disciplinary cause.

- Reports from a licensed health care facility when restrictions are imposed or voluntarily accepted on the physician's staff privileges.

- Reports from a health care facility of any allegation of sexual abuse or sexual misconduct, if the patient or the patient's representative makes the allegation in writing.

MBC's complaint priorities are outlined in BPC section 2220.05 in order to ensure that physicians representing the greatest threat of harm are identified and disciplined expeditiously. MBC must ensure that it is following this section of law when investigating complaints, including complaints alleging the following as being the highest priority:

- Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public

- Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient

- Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor

- Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation

- Sexual misconduct with one or more patients during a course of treatment or an examination,

- Practicing medicine while under the influence of drugs or alcohol; and

- Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

For complaints that are subsequently investigated and meet the necessary legal prerequisites, a Deputy Attorney General (DAG) in the OAG drafts formal charges, known as an "Accusation". An accusation is filed upon signature of the MBC Executive Director. A hearing before an Administrative Law Judge (ALJ) is subsequently scheduled, at which point settlement negotiations take place between the DAG, the physician and their attorney and MBC staff.

Licensing boards often resolve a disciplinary matter through negotiated settlement, typically referred to as a "stipulated settlement." This may be done, rather than going to the expense of lengthy administrative hearing on a disciplinary matter. According to information from the Citizen Advocacy Center, (a national organization focusing on licensing regulatory issues nationwide) "It is not uncommon for licensing boards to negotiate consent orders [stipulated settlements] 80% of the time or more." Similar to a plea bargain in criminal court, a licensee admits to have violated charges set forth in the accusation and accepts penalties for those violations. A stipulated settlement is not necessarily good or bad from a public protection standpoint. However, it is important for a licensing board to look critically at its practices to make sure that it is acting in the public's interest when it enters into a stipulated settlement and that it is acting in the best way to protect the public in each of these stipulated decisions.

The DAG assigned to a case reviews it, along with any mitigation provided, the strengths and weaknesses of the case, MBC's Disciplinary Guidelines, and, when applicable, any prior disciplinary action against the respondent physician to assist in drafting a settlement recommendation that frames the recommended penalty. MBC uses its Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines, 16 CCR section 1361) and the Uniform Standards for Substance-Abusing Licensees (Uniform Standards, 16 CCR section 1361.5) as the framework for determining the appropriate penalty for charges filed against a physician. Boards rely on disciplinary guidelines adopted through the regulatory process to guide disciplinary actions. Disciplinary guidelines are established with the expectation that ALJs hearing a disciplinary case, or proposed settlements submitted to a program for adoption, will conform to the guidelines. If there are mitigating factors, such as a clear admission of responsibility by the licensee early on in the process, or clear willingness to conform to board-ordered discipline, or other legal factors, a decision or settlement might vary from the guidelines. At other times in a disciplinary case, there can be problems with the evidence, but the licensee admits to wrongdoing in a matter and may be willing to settle a case without going to a formal hearing.

MBC states that this settlement recommendation takes into account consumer protection but also BPC Section 2229(b) requirements for MBC to "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of CME or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." The DAG's recommendation is reviewed and either approved or edited by the supervising DAG. Once that approval is received, the DAG submits the settlement recommendation to MBC staff for review and consideration. The Chief of Enforcement holds regular meetings with the MBC's Executive Director, Deputy Director and Chief Medical Consultant to review the settlement recommendations using the same criteria as the DAG – the

recommendation at this level can either be approved or it can be changed. Both the prehearing settlement conference and the mandatory settlement conference are assisted by an ALJ who reviews the case and hears information from the DAG and the respondent physician and/or their counsel while helping to negotiate the settlement. During the settlement conference, the appropriate MBC representative must be available to authorize any change to the previously agreed-upon settlement recommendation.

Most formal disciplinary actions result in a stipulated settlement. If a settlement agreement is reached, the stipulated settlement document must be approved by Panel A or Panel B (panels created under MBC's statutory authority in BPC 2008 to appoint panels from its members to evaluate appropriate disciplinary actions. Panel A considers actions related to physicians with a last name starting with A-L and Panel B considers actions related to physicians with a last name starting with M-Z) unless the settlement is for a stipulated surrender. The MBC Panel may adopt the settlement as written, request changes to the settlement, or reject the settlement and request the matter go to hearing.

MBC reports that throughout the process, public protection is the priority and that settling cases by stipulations that are agreed to by both sides facilitates consumer protection by imposing discipline more quickly. Entering into a stipulation places the individual on probation or other restriction sooner without the risk and delay of going to hearing, and it eliminates the ability of the licensee to appeal the decision in Superior Court. It also puts the public on notice of practice limitations and restrictions earlier than if the matter went to hearing. In addition, MBC may ultimately achieve more terms and conditions on a license through the settlement process than would have been achieved if the matter went to hearing. MBC advises that when deciding on a stipulation, Panel A and B members are provided the strengths and weaknesses of the case and notes that settlement recommendations stipulated to by MBC must provide for public protection and, when not inconsistent with public protection, rehabilitation of the licensee.

If a licensee contests charges, the case is heard before an ALJ who subsequently drafts a proposed decision. This decision is reviewed by Panel A or Panel B who either adopt the decision as proposed, adopt the decision with a reduced penalty, or adopt the decision with an increased penalty. If probation is ordered, a copy of the final decision is referred to MBC's Probation Unit for assignment to an inspector who monitors the licensees for compliance with the terms of probation.

MBC's probation unit works to ensure that physicians who are not compliant with probationary orders have swift action taken against their license by either issuing a citation and fine, issuing an order for the individual to cease practicing or referring the matter to OAG for subsequent discipline. MBC's Disciplinary Guidelines were updated to include language allowing MBC to issue a cease practice order for probationers not in compliance with certain terms of their probation.

MBC's Experience with Diversion Away From the Traditional Enforcement Pathway. MBC previously had a Physician Diversion Program (PDP). The PDP was created in 1980 to rehabilitate doctors with mental illness and substance abuse problems without endangering public health and safety. Under this concept, physicians who

abuse drugs and/or alcohol or who are mentally or physically ill may be "diverted" from the disciplinary track into a program that monitors their compliance with terms and conditions of a contract that is aimed at ensuring their recovery.

The PDP was a voluntary program and only those physicians and surgeons who voluntarily requested diversion treatment and supervision could participate in the program. A physician could enter the diversion program in any of the following ways: a) self-referral; b) referral by the MBC's Enforcement Unit in lieu of discipline; or c) directed as part of a disciplinary order. Confidentiality was required for physicians and doctors that self-refer and could be granted to those who were referred by MBC (doctors could avoid public discipline if there was no evidence of patient harm and they successfully completed the program). For those who were directed to the program as part of a disciplinary order, disciplinary actions are public records and the practice violation that triggered the MBC's involvement would be reflected in the doctor's public file. Any physician and surgeon terminated from the PDP for failure to comply with program requirements was subject to a disciplinary action for acts committed before, after or during participation in the PDP, and a physician that successfully completed the PDP was not subject to any disciplinary action for any alleged violation that resulted in referral to the PDP. The PDP monitored participants' attendance at group meetings, facilitated random drug testing, and required reports from work-site monitors and treatment providers. Many of the physicians in the PDP retained full and unrestricted medical licenses during their participation and enjoyed complete confidentiality.

The Bureau of State Audits (BSA) audited the PDP four times between 1982 and 2007. In 2005, a statutorily created enforcement monitor also audited the PDP. The enforcement monitor's audit indicated that "the Board's PDP is significantly flawed; its most important monitoring mechanisms are failing, it is chronically understaffed, and it exposes patients to unacceptable risks posed by physicians who abuse drugs and alcohol." The 2007 BSA audit concluded, "Although the PDP has made many improvements since the release of the November 2005 report of the enforcement monitor, there are still some areas in which the program must improve in order to adequately protect the public." BSA pointed out the following: Although case managers appear to be contacting participants on a regular basis and participants appear to be attending group meetings and completing the required amount of drug tests, the PDP did not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors. In addition, although the PDP reduced the amount of time it takes to admit new participants into the program and begin drug testing, it did not always respond to potential relapses in a timely and adequate manner. Specifically, the PDP did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a non-prescribed or prohibited drug. Further, of the drug tests scheduled in June and October 2006, 26 percent were not performed as randomly scheduled. Additionally, the PDP currently did not have an effective process for reconciling its scheduled drug tests with the actual drug tests performed and does not formally evaluate its collectors, group facilitators, and diversion evaluation committee members to determine whether they are meeting program standards. The BSA indicated that MBC had not provided consistently effective oversight of the PDP.

In recognition that patient safety could not continue to be compromised, the MBC voted unanimously on July 26, 2007 to end the PDP, declaring in its motion that "in light of Board's primary mission of consumer protection and as the regulatory agency charged with the licensing of physicians and surgeons and enforcement of the Medical Practice Act, the Board hereby determines it is inconsistent with Board's public protection mission and policies to operate a diversion program." This declaration prompted the Board to approve a Diversion Transition Plan on November 2, 2007 to accommodate the 203 physicians already in the PDP. The PDP was allowed to sunset on June 30, 2008.

Uniform Standards. SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) required the DCA to develop uniform and specific standards to be used by health care practitioner licensing boards dealing with substance-abusing licensees in 16 specified areas, including requirements and standards for: (1) clinical and diagnostic evaluation of the licensee; (2) temporary removal of the licensee from practice; (3) communication with licensee's employer about licensee status and condition; (4) testing and frequency of testing while participating in a diversion program or while on probation; (5) group meeting attendance and qualifications for facilitators; (6) determining what type of treatment is necessary; (7) worksite monitoring; (8) procedures to be followed if a licensee tests positive for a banned substance; (9) procedures to be followed when a licensee is confirmed to have ingested a banned substance; (10) consequences for major violations and minor violations of the standards and requirements; (11) return to practice on a full-time basis; (12) reinstatement of a health practitioner's license; (13) use and reliance on a private-sector vendor that provides diversion services; (14) the extent to which participation in a diversion program shall be kept confidential; (15) audits of a private-sector vendor's performance and adherence to the uniform standards and requirements; and (16) measurable criteria and standards to determine how effective diversion programs are in protecting patients and in assisting licensees in recovering from substance abuse in the long term. The Uniform Standards were finally adopted in early 2010, with the exception of the frequency of drug testing which was finalized in March 2011. MBC formally implemented the Uniform Standards in July 2015. The Uniform Standards were amended in 2019.

MBC's Current PSHWP. SB 1177 (Galgiani, Chapter 591, Statutes of 2016) authorized MBC to establish the PSHWP for the early identification and appropriate interventions to support a licensee in their rehabilitation from substance abuse. The bill required MBC, if it establishes a PSHWP, to contract for administration with an independent administering entity selected by MBC through a request for proposals process. MBC previously noted that it anticipated having all of the necessary activities completed so a program could start in the fall of 2018.

MBC reported during prior sunset review oversight discussions that draft regulations for the PSHWP were submitted to DCA for review in April 2018. Following the submission of the draft regulations to DCA, the DCA SACC met as required by SB 796 (Hill, Chapter 600, Statutes of 2017) and approved some changes to the Uniform Standards. According to MBC, this development, along with other factors, caused MBC staff to reconsider the format of the draft PHWP regulations. MBC advised that since the SACC would be formally changing the Uniform Standards, MBC would be required to go through the rulemaking process to amend its own

Uniform Standards set forth its regulations. If the requirements were repeated in both MBC's Uniform Standards and the PSHWP regulations, then changes to multiple regulatory sections would likely be necessary every time the SACC changed the Uniform Standards, thereby causing inefficiency.

MBC advised throughout the discussions about the PSHWP that this program is very different than the prior PDP. Physicians will not be able to divert from the disciplinary process by entering and successfully completing this program. In addition, the program will have to comply with regulations that are based upon the law, as well as the Uniform Standards. These regulations are going to follow the Uniform Standards adopted by MBC in 2015, which in most circumstances do not allow for deviations. The program will also be run by a third-party entity, not MBC staff, and will have more expertise and not be subject to civil service requirements. MBC will be able to have an independent auditor review the program at least every three years, which in turn will provide MBC with information about program compliance with the regulations and Uniform Standards. Lastly, the program will provide updates MBC on the status of individuals in the program.

In November 2019, MBC voted to move forward with a modified regulatory proposal, which was submitted to the DCA; two years later, the MBC voted once again to move forward with another revised version of its regulations, which were formally noticed for public comment in September 2023. After receiving public comments through November 2023, the MBC reviewed what it has described as "thoughtful feedback from stakeholders and experts who raised valid concerns about the effectiveness of our proposal and its potential unintended consequences." Specifically, the MBC determined that the PSHWP authorized by SB 1177 would not align with national best practices for encouraging participation and achieving successful outcomes. One specific concern was that the framework for the PSHWP would still require the MBC's program to comply with the Uniform Standards, which would require the board to disclose information to the public on licensees participating in the program "regardless of whether the licensee is a self-referral or a board referral." Concerns were raised that this would only serve to further stigmatize practitioners who seek care for disorders and disincentivize those who would otherwise consider voluntarily entering a program.

In response to these concerns, MBC voted to withdraw its proposed regulations and instead move forward with new legislation to establish a new framework for a new program.

Today, impaired physicians with substance use disorder or other issues find their own treatment facility for assistance. MBC is not made aware that the physician received treatment unless a complaint is received, and the physician may present the treatment as evidence in a disciplinary proceeding only if he or she wishes. When MBC is made aware of substance use issues, licensees follow the enforcement track and may be placed on formal probation, with terms customized to fit the licensee's individual need. Typical terms include participation in support group meetings, random testing for drug and alcohol use, practice restrictions, and/or medical or psychiatric treatment, including psychotherapy. MBC still retains the power to currently order biological fluid testing as a condition of probation. Each physician must find a collector to perform random drug testing as required by MBC's

Probation Unit, and the collector must meet the testing requirements set out in the terms and conditions of probation. If the physician tests positive, MBC issues a cease practice order, if allowed in the condition of probation, until the Board investigates and takes subsequent action. If the condition does not authorize a cease practice order, the Board investigates whether the physician is safe to practice medicine. If not, MBC staff will seek an Interim Suspension Order or ask the physician to agree not to practice via a stipulated agreement.

3. **Arguments in Support.** Supporters representing physicians write that AB 408 creates the framework for an effective, confidential program, tailored to physicians' unique needs, similar to those in other states, that supports physicians' health and wellness and protects patients by allowing physicians to be at their best. According to supporters, all physicians deserve to recover and move forward with renewed resiliency and establishing a program would enable MBC to prevent patient harm by connecting impaired or at-risk physicians with treatment before issues arise. Supporters write that physicians and healthcare professionals are often hesitant to seek help due to stigma, confidentiality concerns, and fear of negative professional repercussions. This reluctance can lead to untreated or inadequately addressed conditions, ultimately jeopardizing provider well-being and leading to high rates of burnout.

   The Medical Board of California writes that the "bill includes reporting requirements so that the program and/or Board is aware of its licensees who are unsafe to practice, authorizes program quality and compliance evaluations, and requires public disclosure of various program statistics. The Board's mission is to protect consumers and, too often, we first learn about a dangerous physician after their patient has been hurt. This legislation takes a proactive approach to prevent patient harm by providing a confidential pathway for physicians and other providers to seek care and treatment early, before they become unsafe to practice medicine."

4. **Arguments in Opposition.** According to the Consumer Protection Policy Center at the Center for Public Interest Law, University of San Diego School of Law (CPCC), MBC's "tenuous budget, staffing concerns, and program costs demonstrate the Board's inability to oversee this program properly. According to the Board's most recent budget update, there are 28 vacant positions within the Board's staff. The Board expects a projected fiscal year-end revenue of $92.2 million, with a total expenditure cost of $80 million. The Board received an $8 million loan from 2022—23, a $6 million loan from 2023—24, and a repayment obligation in 2025—26.3 Further, the current fund conditions demonstrate that the Board would remain solvent with only 1.4 months in reserves without an additional $27 million loan.4 In light of the vacant staff positions and current budget concerns, it is a mystery how the Board will have dedicated staff to oversee this program. Without proper oversight, this program fails to address the previous program failures that led to catastrophic patient harm." CPCC also notes that "California's current regulatory framework clearly achieves outcomes comparable to states with established PHWPs, despite operating without such a program..the Board's best argument 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…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 transparency, accountability, and timely enforcement improvements to ensure meaningful consumer protection."

CPCC suggests that "To avoid the time-consuming nature of a Board-monitored wellness program and encourage physician well-being, the Legislature can enact a new complaint procedure to evaluate when a doctor is suitable for rehabilitation center treatment. When a complaint is filed with the MBC, the Board approves it 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. 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."

According to CPCC, 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.

According to the Consumer Attorneys of California, AB 408 does include two important and commendable provisions: It retains existing disclosure requirements for licensees who enter the program following allegations of patient harm or misconduct; It mandates reporting of licensees believed to have a condition impacting their ability to practice safely. These are steps in the right direction—but they do not outweigh the risks created by the lack of enforcement clarity and the rollback of uniform standards. In 2016, SB 1177 (Galgiani) was the result of thoughtful collaboration and compromise. It empowered the Medical Board of California to support physician recovery, while explicitly requiring adherence to the Department of Consumer Affairs' Uniform Standards. The bill recognized the need for compassion and rehabilitation—but not at the expense of public protection. AB 408 disrupts this equilibrium.

Consumer Watchdog writes in opposition, noting "Proponents have said confidentiality only applies to doctors entering the program voluntarily. This is false. The bill's Orwellian definitions define doctors who choose diversion so they can

escape discipline, after for example they are reported to the Board by a hospital for substance use on the job, as "voluntary participants" in bill Section 2340(b)(16). Choosing diversion only after being caught is clearly not joining the program voluntarily. Proponents have said that the bill does not change any requirements if a patient has been harmed. This is true, but doctors who have already harmed someone are not the only ones who pose a risk to patient safety. For example: A San Francisco doctor suspected of stealing drugs from her hospital was recently arrested after she was found passed out in an operating room shortly after she was scheduled to participate in a toddler's surgery. AB 408 would send that doctor into diversion in lieu of the disciplinary investigation, treatment oversight and consequences that are all mandatory under current law. And because the bill does not require reporting of a positive drug test to the Board, the doctor could continue treating patients while keeping her diversion program violations secret and place patients in harm's way. The only required report of failure is when a doctor quits or is booted from the program completely. The Uniform Standards were created because leaving those decisions to the program allowed doctors to relapse and continue practicing with impunity. The prior diversion program failed doctors and patients and AB 408 will repeat its mistakes. Even for those who support the creation of a diversion program at the Board in concept, this bill does not do it right. At minimum, AB 408 should be amended to ensure the Uniform Standards – including a report to board enforcement staff when a doctor fails a drug test – are maintained for any doctor referred to the program by the board."

According to Disability Rights California, "Section 2351 of AB 408 mandates that all licensees report suspected impairments of their colleagues, fostering a chilling cultural shift that further deters physicians with disabilities or mental health histories from seeking appropriate care. AB 408 erodes core ethical foundations and legal protections of disability rights by conflating diagnosis with incompetence, subjecting those with protected medical conditions to greater scrutiny relative to their peers. Evidence shows that fear of reprisal is a primary deterrent to physicians accessing mental health services8. Mandating that all licensees report "suspected impairment" creates a culture of surveillance and erodes trust. The bill's broad and ambiguous definitions of "impairment," "disruptive behavior," and "mental illness" risk institutionalizing discriminatory referral patterns and surveillance of individuals with neurodivergent, psychiatric, or chronic medical conditions without evidentiary basis or public health benefit. AB 408 also violates ADA protections against compelled disclosure of diagnosis and lowers the burden of evidence for referral, particularly for those with disabilities. AB 408 allows the Medical Board to contract with a third-party administrator to operate the PHWP while exempting key oversight mechanisms… In addition, AB 408 effectively consolidates market control and fosters a coercive, monopolistic structure that raises serious ethical and legal concerns. By mandating engagement with specific contracted vendors with unilateral authority to 'recommend' treatment, this bill deprives licensees of patient choice or clear cost disclosure for medical care. Furthermore, the legislation states that all costs associated with the program are the participant's responsibility, permitting gross misuse of disciplinary authority to issue treatment decisions influenced by financial rather than clinical needs."

5. **Proposed Author's Amendments**. The Author has proposed amendments to do the following:

    - Strike disruptive behavior from the definition of impaired or impairing condition.

    - Replace a requirement that the administering entity make the PHWP and related services available to trainees and students and instead authorize this if MBC and the administering entity determine that sufficient resources are available.

    - Update the makeup of the advisory committee.

    - Clarify that MBC may introduce PHWP records in a licensing or enforcement action.

    - Make various technical and conforming changes.

6. **Comments and Concerns.**

    Implementation by MBC. While MBC states that this bill is permissive and does not mandate MBC to establish a PHWP, it is clear, based on MBC's multi-years efforts and sponsorship of this bill, that PHWP establishment is inevitable. What remains unclear is what resources MBC has, will have, or worse, will redirect from existing priorities, to fund a contract with an administering entity to have a MBC PHWP. MBC has implied that outside private funding could become available if a PHWP has standards that are more favorable to potential participants, however, creating a massive statutory framework, which will result in significant workload for MBC once a PHWP is actually established, without a stable funding source, is irresponsible, particularly given MBC years' long struggles to even have sufficient revenue to do its current job. This leaves implementation questionable at best and will likely result in additional steps or necessitate additional Legislative involvement to even bring a PHWP of this magnitude to fruition.

    Patient and public protection is lacking. Existing law already authorizes MBC to establish a PHWP, one that allows for self-referral by a MBC licensee, but that still complies with the Uniform Standards to ensure accountability for participants who do not comply with program expectations and agreements. MBC and supporters have denounced the Uniform Standards as outdated and stated that the current standards include provisions which all but guarantee a MBC licensee with substance use disorder would never choose to seek out the PHWP. They state that, for example, Standard #14, which ensures that the public is made aware of a licensee's practice restrictions, without disclosing anything about program participation, has a chilling effect on licensees seeking support. But the existing law has never even been implemented so MBC's evaluation of something that does not exist, in favor of starting over and establishing a whole new statutory framework, adds to the confusion about this effort.

This bill instead only mandates compliance with Uniform Standards for participants who are already required to comply with the Uniform Standards as part of a disciplinary order. Yet MBC licensees typically only come onto MBC's radar when they have done something in violation of their practice act and the bill clearly presumes that MBC is aware that a licensee may have violated the law since it allows "voluntary" PHWP participation in lieu of discipline. The bill further establishes a cumbersome process by which MBC may even become aware when a licensee, one that MBC itself referred to a PHWP in lieu of discipline, faces challenges complying with PHWP terms. MBC would be provided deidentified information from the PHWP about licensees who violate program terms and instead of automatic reporting to MBC as current law ensures, MBC retains the choice whether to even request further information about the licensee and whether to potentially pursue action. This creates diversion from enforcement without clear action for failure to comply. If participation is in lieu of discipline, it is troubling that the new PHWP envisioned by this bill would deviate so markedly from providing MBC timely, direct information about licensees who do not comply with program terms and requirements. The structure under current law already provides an opportunity for any licensee facing substance use disorder issues to self-refer to a PHWP and nothing prevents MBC from, rather than entirely repealing authority to establish a PHWP that includes clear accountability for participants to their licensing board, evaluating whether certain of the Uniform Standards need to be updated in order to effectively meet PHWP goals and requirements.

SUPPORT AND OPPOSITION:

Support:

American College of Obstetricians & Gynecologists - District IX
California Academy of Child and Adolescent Psychiatry
California Dental Association
California Medical Association
California Orthopaedic Association
California Public Protection & Physician Health
California Society of Addiction Medicine
California Society of Anesthesiologists
California Society of Dermatology & Dermatologic Surgery
California Society of Pathologists
California State Council of Service Employees International Union (SEIU California)
Center for Professional Recovery
Dr. Lorna Breen Heroes' Foundation
Drug Policy Alliance
Federation of State Physician Health Programs
Medical Board of California
Physician Association of California
Psychiatric Physicians Alliance of California
San Francisco Marin Medical Society
Union of American Physicians and Dentists

Opposition:

Consumer Attorneys of California
Consumer Protection Policy Center at the University of San Diego School of Law
Consumer Watchdog
Disability in Medicine Mutual Mentorship Program
Disability Rights California

-- END --