No. S205568

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

MARK FAHLEN, M.D.,

Plaintiff and Respondent,

v.

SUTTER CENTRAL VALLEY HOSPITALS, STEVE MITCHELL, et al.,

Defendants and Appellants.

After Published Decision by the Court of Appeal
Fifth Appellate District
Case No. F063023

REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF ANSWERING BRIEF OF PLAINTIFF AND RESPONDENT; SUPPORTING MEMORANDUM; DECLARATION OF STEPHEN D. SCHEAR

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Attorneys for Plaintiff and Respondent Mark Fahlen, M.D.

REQUEST FOR JUDICIAL NOTICE

Pursuant to Evidence Code sections 452 and 459, Plaintiff and Respondent Mark Fahlen, M.D. hereby requests that this Court take judicial notice of the following documents:

Exhibit A: Relevant portions of the transcripts from the administrative hearing held by Sutter Central Valley Hospitals concerning Mark Fahlen, M.D.: portions of the May 3, 2010 hearing testimony of Thong Nguyen, M.D.; Dikram Bairamian, M.D.; and Mark Fahlen, M.D.; the May 24, 2010 jury instructions of the hearing officer and the closing arguments of both Memorial Medical Center and Dr. Fahlen.

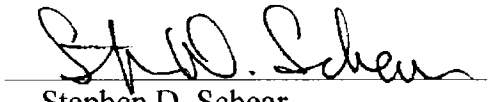
Exhibit B: Senate Health and Human Services Committee Analysis of SB 97, March 10, 1999; (legislative history of California Health and Safety Code section 1278.5.)

Exhibit C: Opinion of the Legislative Counsel on the constitutionality of S.B. 1472, September 20, 1978; Enrolled Bill Report of Department of Consumer Affairs on S.B. 1472, September 6, 1978; Enrolled Bill Report of Governor's Office of Legal Affairs on S.B. 1472; (legislative History of S.B. 1472, 1978 amendment to California Code of Civil Procedure 1094.5.)

Exhibit D: The "*Comprehensive Study of Peer Review in California*", July 31, 2008, by Lumetra, under contract with the Medical Board of California, conducted pursuant to the statutory mandate of California Business & Professions Code section 805.2.

The accompanying Memorandum sets forth the grounds for the request and the accompanying Declaration of Stephen D. Schear authenticates the documents and includes the documents at issue in this request.

Dated: April 3, 2013

By: 

Stephen D. Schear
Jenny Huang
Justice First, LLP
Attorneys for Plaintiff and
Respondent Mark Fahlen, M.D.

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

I. THE COURT SHOULD TAKE JUDICIAL NOTICE OF RELEVANT RECORDS OF THE ADMINISTRATIVE HEARING AT ISSUE IN THIS APPEAL.

Exhibit A consists of hearing transcripts from the administrative hearing provided to Dr. Fahlen by Sutter Central Valley Hospital. All of the hearing testimony submitted as a part of Exhibit A was taken under oath and recorded by certified court reporter. (Decl. of Stephen D. Schear.) The jury instructions and the closing arguments presented to the Memorial Medical Center Judicial Review Committee ("JRC") were also all transcribed by a certified court reporter and are part of the administrative record in this action.

Appellants Sutter Central Valley Hospital and Steve Mitchell (hereafter collectively referred to as "Sutter) argue in their opening brief that when Sutter terminated Dr. Fahlen's privileges, its Board of Directors "effectively restor[ed] the MEC's recommendation that the Hospital not renew Fahlen's privileges". (Appellants' Opening Brief ("AOB") at p.7.) Sutter's argument thus attempts to legitimize the action of its Board by citing the initial recommendation of the Memorial Medical Center Medical Executive Committee (MEC) to terminate Dr. Fahlen's privileges. The testimony of Drs. Nguyen, Bairamian and Fahlen is relevant to show how the medical staff was influenced by the hospital administration to issue its recommendation, and that there was evidence of discriminatory treatment of Dr. Fahlen which is not included in Sutter's written decision to terminate Dr. Fahlen's privileges. Dr. Nguyen was a member of the Ad Hoc Investigating Committee that investigated Dr. Fahlen on behalf of the medical staff and Dr. Bairamian was a member of the MEC. (Exhibit A, pp. 1223-1224, p. 1245.)

The jury instructions and closing arguments presented to the JRC are relevant to show that the issue of discriminatory treatment and retaliation of Dr. Fahlen by Sutter was not litigated or decided in the Memorial Medical Center administrative hearing at issue here. This issue is relevant to the central question presented in this appeal, whether a writ of mandate is required before filing an action pursuant to Health and Safety Code Section 1278.5 (Section 1278.5).

The transcripts contained in Exhibit A were prepared before the trial court's order on the Anti-SLAPP motion at issue here. Judicial notice of these transcripts was not requested in the trial court, because the documents were not necessary for Dr. Fahlen to present a prima facie case of retaliation in opposition to Defendants' motion, his evidentiary burden after Defendants brought the anti-SLAPP motion at issue here. (Decl. of Stephen D. Schear.) However, those documents are relevant to refute Sutter's argument in this Court and they are also relevant to address the legal and policy issues presented in this appeal.

This Court may take judicial notice of documents even though judicial notice of those documents was not requested in the courts below. (Evidence Code section 459; *Friends of Aviara v. City of Carlsbad* (2012) 210 Cal.App.4th 1103, 1109, n. 3; California Rule of Court 8.252.(a).) Official acts subject to judicial notice include records of administrative agencies. (Evidence Code section 452, subdivision (c); *Taiheiyo Cement U.S.A., Inc. v. Franchise Tax Bd.,* (2012) 204 Cal.App.4th 254, 268.)

This Court should therefore take judicial notice of the records of the Judicial Review Committee hearing contained in Exhibit A.

II. THE COURT SHOULD TAKE JUDICIAL NOTICE OF THE LEGISLATIVE HISTORY IN EXHIBITS B AND C.

Exhibit B contains 1999 legislative history of Senate Bill No. 97, the original bill that became Section 1278.5, specifically the Senate Health and Human Services Committee Analysis of SB 97, March 10, 1999. In the trial court, Dr. Fahlen requested judicial notice of the legislative history of the 2007 amendment to Section 1278.5 which is most pertinent to the question presented here. He did not request judicial notice of the legislative history of the 1999 enactment of the bill in the trial court.

On or about February 4, 2013, Sutter requested that this Court take judicial notice of additional legislative history concerning both the 1999 passage of SB 97 and the 2007 passage of Assembly 632, the amendment to Section 1278.5. Dr. Fahlen did not oppose that request. However, Sutter did not include the Senate Health and Human Services analysis of SB 97 in its request. The committee's analysis is relevant to the purpose of the Section 1278.5 and is therefore relevant to the question presented here. Legislative committee reports are subject to judicial notice under Evidence Code section 452. (*Kaufman v. Broad Communities, Inc.* (2005) 133 Cal.App.4th 26, 32.)

Exhibit C is legislative history of Code of Civil Procedure section 1094.5, subdivision (d). Because the issue presented here is whether the procedures provided by that law must be exhausted before filing the instant ligitation, the legislative history of that law is also relevant to the issues presented here. Exhibit C contains the opinion of Legislative Counsel, which is subject to judicial notice as legislative history. (*Kaufman v. Broad Communities, Inc., supra,* 133 Cal.App.4th at 35; *Trinkle v. California State Lottery* (2003) 105 Cal.App.4th 1401, 1410, fn. 7.) It also contains two enrolled bill reports, which are also subject to judicial notice. (*Kaufman v. Broad Communities, Inc., supra,* 133 Cal.App.4th at 37; *Elsner v. Uveges*

(2004) 34 Cal.4th 915, 934, fn. 19.)

This Court should take judicial notice of Exhibits B and C as legislative history relevant to the issues presented here.

III. THE COURT SHOULD TAKE JUDICIAL NOTICE OF THE REPORT ON PEER REVIEW MANDATED BY BUSINESS AND PROFESSIONS CODE SECTION 805.2.

Business & Professions Code section 805.2 required the Medical Board of California to contract with an independent entity that was "fair, objective, and free from bias" to conduct a comprehensive study of peer review by entities subject to Business and Professions Code section 805 et seq. Pursuant to that law, the Medical Board of California commissioned such a study. The results of that study were reported in a document entitled "*Comprehensive Study of Peer Review in California*", July 31, 2008, by Lumetra, attached hereto as Exhibit D. The document is published on the website of the Medical Board of California as an official government study.

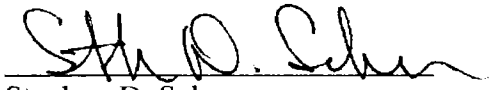
Official acts subject to judicial notice include reports and orders of administrative agencies. (Evidence Code section 452; *Taiheiyo Cement U.S.A., Inc. v. Franchise Tax Bd.,* (2012) 204 Cal.App.4th 254, 268; see also, *Los Angeles Gay and Lesbian Center v. Superior Court* (2011) 194 Cal.App.4th 288, 301, n. 6.) Since the study was a product of a legislative mandate and an executive body commission, and it is an official publication of the Medical Board of California, judicial notice is appropriate pursuant to Evidence Code sections 452, subd. (c) and 459.

The study is relevant to Sutter's argument that whistleblower claims under Health & Safety Code section 1278.5 are subject to the exhaustion requirement. In particular, Exhibit D is related to a legal and policy question presented here, specifically whether a ruling in Dr. Fahlen's favor will lead to large number of non-meritorious retaliation cases being filed by

will lead to large number of non-meritorious retaliation cases being filed by California physicians.

Dated: April 3, 2013

Respectfully submitted,



Stephen D. Schear
Jenny Huang
Attorneys for Plaintiff and
Respondent Mark Fahlen, M.D.

DECLARATION OF STEPHEN SCHEAR

I, Stephen D. Schear, declare:

1. I am an attorney at law duly licensed to practice before the courts of the State of California. I am one of the attorneys who represents Plaintiff/Respondent Mark Fahlen, M.D., in this proceeding and I served as counsel in all of the proceedings below, including the peer review hearing, the civil case in Stanislaus County Superior Court, and the appeal before the Fifth District Court of Appeal. I have personal knowledge of the following facts, and if called upon as a witness, I could and would testify competently to the contents of this declaration.

2. I attended all of the evidentiary sessions of the Judicial Review Committee's ("JRC") medical staff hearing to address whether Memorial Medical Center ("Memorial") should renew Dr. Fahlen's privileges. All of the testimony given at the medical staff hearing was taken under oath and transcribed by a certified court reporter. The jury instructions and closing arguments of counsel were also transcribed by a certified court reporter. Attached as Exhibit A are true and accurate copies of relevant excerpts from the hearing transcript including (1) the testimony of Thong Nguyen, M.D.; Dikram Bairamian, M.D.; and Dr. Fahlen on May 3, 2010, (2) the jury instructions by the hearing officer given on May 24, 2010, and (3) the closing arguments by Memorial and Dr. Fahlen on May 24, 2010.

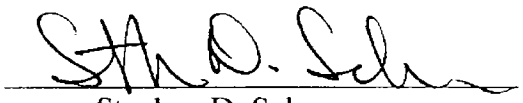
3. Attached as Exhibit B is a true and accurate copy of the Senate Health and Human Services Committee Analysis of SB 97, March 10, 1999; (legislative history of California Health and Safety Code section 1278.5.)

4. Attached as Exhibit C is a true and accurate copy of the Opinion of the Legislative Counsel on the constitutionality of S.B. 1472, September 20, 1978; Enrolled Bill Report of Department of Consumer Affairs on S.B. 1472, September 6, 1978; Enrolled Bill Report of Governor's Office of

Legal Affairs on S.B. 1472; (legislative History of S.B. 1472, 1978 amendment to California Code of Civil Procedure 1094.5.)

5. Attached as Exhibit D is a true and correct copy of the "*Comprehensive Study of Peer Review in California*", July 31, 2008, by Lumetra, under contract with the Medical Board of California, conducted pursuant to the Legislative mandate of California Business & Professions Code section 805.2, obtained from the website of the Medical Board of California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on April 3, 2013, at Oakland, California.



Stephen D. Schear

MEMORIAL MEDICAL CENTER, MODESTO

---oOo---

MEMORIAL MEDICAL CENTER, MODESTO,

vs.

MARK FAHLEN, M.D.,

EXAMINATION OF: THONG NGUYEN, M.D., DIKRAN BAIRAMIAN, M.D. AND MARK FAHLEN, M.D.

Monday, May 3, 2010 at 6:09 p.m.

VOLUME XII

BEFORE: HEARING OFFICER DOUGLAS A. HAYDEL
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INDEX OF EXAMINATION

INDEX OF EXHIBITS

No exhibits marked.

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MR. HAYDEL: Dr. Nguyen, could you raise your right hand. Do you swear or affirm that the testimony you will give in this proceeding is the truth, the whole truth and nothing put the truth?

THE WITNESS: I do.

MR. HAYDEL: Thank you. Could you please state your name for the record and spell your name.

THE WITNESS: Dr. Thong Nguyen. Last name is N-g-u-y-e-n. First name is T-h-o-n-g.

MR. HAYDEL: Thank you.

You may proceed.

DIRECT EXAMINATION

BY MR. SCHEAR: Q Good evening. I'm Steve Schear. I'm Dr. Fahlen's attorney.

A Hi, Steve.

Q Could you describe your educational background beginning with undergraduate.

A I graduate from UC Davis with a Bachelor degree in Biochemistry. After that I spent two years in a Master Program at UC Santa Cruz in Chemistry followed by four years of medical school at SUNY State University of New York in Brooklyn. Once I complete my four years of medical degree I went back to my local hometown in Stockton and do my residence training there in internal medicines. And after I finish my

residency trainings there, I came to Modesto and joined the Sutter Gould Medical Group.

Q Okay. And what your current position?

A Currently I work as a hospitalist for Memorial, but mainly employed by Sutter Gould.

Q Okay. And you have privileges at Memorial, correct?

A That is correct.

Q And since when have you had privileges at Memorial?

A Since when I have the privilege at Memorial?

Q (Nods head.)

A When I joined Sutter Gould back in 1998, if I'm not correct.

Q And have you held any administrative positions either for Gould or Memorial?

A Yes. I was a primary care provider when I first joined Sutter Gould. After five years in the clinic I decide to become a hospitalist. I was among the first hospital -- first physicians who pioneer the program here and also as a department chairs of the hospitalist at that time.

Q Okay. And as chair of the hospitalist program, did you have any responsibilities over physician complaints or complaints about physicians?

A That's part of my role, correct.

Q And did you have any experience dealing with physicians who demonstrated behavioral problems?

A There is a few occasions when I have encountered with physicians with difficulties.
Q And how did you typically respond to physicians who had behavioral issues?
A Well, we normally perform an investigation to verify the events or the complaints. And then after we verify that, we also interview or talk to the physicians directly to confirm with that. And depending on the severities of the issue, if the issue, if the severity is low, we may make a record and have the hospitalist to make a corrections for it. But if it's a repeated behaviors or if it's a more severe behaviors then we normally discuss with the medical directors and together we come up with a recommendation.
Q And did you refer any physicians for professional counseling?
A Yes, we have referral a couple hospitalists for professional counseling.
Q And were you responsible for selecting a psychologist or did the physician select his own?
A We make the recommendations to the physicians. So we give them the option, the recommendations and we let them decide as far as the time-wise and the particular professional person that they want to talk to.
Q And based on your experience, did the professional counseling help those physicians address their behavioral

issues?
A I have seen some difference. Although I did not follow through and didn't know exactly how many visits that the hospitalists have go through, but yes, we do see some improvements in the physicians' behaviors.
Q And then before the investigation of Dr. Fahlen, have you ever participated in a formal medical staff investigation?
A Regarding Dr. Fahlen?
Q Had you ever been part of a formal medical staff investigation of a physician like the one that you participated in with Dr. Fahlen?
A No.
Q Okay. And had you ever been involved in a medical staff disciplinary action or hearing like the one we're having today?
A No.
Q And how long have you known Dr. Fahlen?
A Since he joined Sutter Gould which is about five years ago, I believe.
Q And at some point did you learn that Dr. Fahlen had some problems in terms of his relationships with nurses at Memorial?
A I heard some of the rumors although, you know, I wasn't really interested in it until I was asked by the hospital to join an Ad Hoc Committee.

MR. GEARY: I have nothing else.

MR. HAYDEL: Wait a second. The panel may have questions of this Witness.

Thank you, Dr. Nguyen, for being here tonight.

THE WITNESS: Thanks.

(Recess taken.)

MR. HAYDEL: Back on the record.

MR. SCHEAR: So for Dr. Fahlen's next witness, we'll call Dr. Bairamian.

THE WITNESS: Yes.

MR. SCHEAR: Is that pronounced correctly?

THE WITNESS: Correct.

MR. SCHEAR: This is the hearing officer.

MR. HAYDEL: Dr. Bairamian, could you raise your right hand. Do you swear or affirm that the testimony you will give at this proceeding will be the truth, the whole truth and nothing but the truth?

THE WITNESS: I do.

MR. HAYDEL: All right. Could you please state your name for the record and spell both your first and last name.

THE WITNESS: D-i-k-r-a-n, B-a-i-r-a-m-i-a-n.

DIRECT EXAMINATION

BY MR. SCHEAR: Q I'm Stephen Schear, I'm one of Dr. Fahlen's attorneys. Could you please describe your educational background starting with your undergraduate studies.

A What does "graduated" mean, before medical school?

Q Yeah.

A Going way back. Finished high school in '69 -- no, '70. Then I graduated from medical school in Syria in 1976. Then I served two-and-a-half years in the military because we have mandatory service there. And then I came to America in 1980. Did my internship in general surgery either '81 or '82. Then I did some research at the NIH and I don't remember the details, actually the years. And I did six months of neurology in Philadelphia. Again, I don't remember the exact years. And eventually I found a position in neurosurgery in Rhode Island and I finished my residency in 1993.

Q And then your employment history after getting your residency?

A I did two years, I worked two years in Rhode Island after finishing my residency and I moved to Modesto and I have been here since 1995.

Q Okay. And you have privileges at Memorial?

A Yes, I have privileges at Memorial.

Q How long have you had privileges at Memorial?

A Since 1995.
Q Okay. And do you presently hold any administrative positions at Memorial?
A I'm Chief of Neurosurgery.
Q And as Chief of Neurosurgery do you also serve on the Medical Executive Committee?
A Correct.
Q How long have you been on the Medical Executive Committee?
A Maybe two years.
Q Okay. And are you familiar with Dr. Fahlen's work as a nephrologist?
A Can you be more specific.
Q Well, what's your impression in terms of his clinical competence?
A I have not personally worked with him that much. I think I have asked him to consult on a couple of patients, but I was very happy with what he did.
Q And correct, you were on the MEC in 2008 when the decision was made to deny Dr. Fahlen's reappointment? You were on the MEC in 2008 when the vote was taken?
A What's "MEC"?
Q Medical Executive Committee.
A Oh. That's correct.
Q In 2008 when the decision -- when there was a vote to

recommend termination of Dr. Fahlen?
A Yes.
Q Dr. Fahlen's privileges?
A Yes.
Q And how many Medical Executive Committee meetings did you attend where Dr. Fahlen's reappointment was discussed?
A Two.
Q Okay. And what was discussed at the first meeting about Dr. Fahlen?
A I don't remember the details.
Q And do you have any recollection how long that first discussion was?
A Maybe 30 minutes or less.
Q And did you say anything at that meeting regarding Dr. Fahlen?
A I'm not sure if I said something at that meeting or the other meeting, but I do remember asking, "Are we going to talk to him? Is he going to come here and say something because I want to hear from the accused?"
Q And did you get any response to your question about whether Dr. Fahlen was going to be allowed an opportunity to talk to the MEC?
A That's not what they said. They didn't say he was going to be allowed or not. They said, "He doesn't want to talk and he doesn't want to come."

Q Okay. And do you recall the second MEC meeting?
A Yes.
Q And what happened in that meeting in regards to the discussion about Dr. Fahlen?
A I don't remember details, but I remember Dr. Cadra presented the case. Again, I don't remember the details, but then there was a vote.
Q Approximately how long did Dr. Cadra's presentation last?
A Maybe 15 minutes.
Q And were there any questions that you can recall by members of the MEC about Dr. Fahlen?
A I believe Dr. Montelongo asked a question because he was sitting next to me, but I don't remember what the question was and what -- or who answered him.
Q And to your recollection was there any discussion about referring Dr. Fahlen to get professional counseling or anger management rather than --
A I don't remember hearing that, no.
Q Okay. And then is it correct that there was the vote after the discussion, correct?
A Correct.
Q And how did you vote?
A I didn't vote. I abstained.
MR. SCHEAR: And I think that's all the questions I can ask of Dr. Bairamian.

MR. HAYDEL: Any Cross-Examination?

MR. GEARY: I have no questions.

MR. HAYDEL: Does the panel have any questions for this Witness?

DR. EVE: Why did you abstain?

MR. HAYDEL: Well, I had a made a ruling that none of these members of the Medical Executive Committee will be asked questions about their reasons for their vote, but the attorneys are allowed to and you are allowed to find out what happened at the meeting, who said what leading up to the vote, what information was provided, who provided it.

DR. KIRAN: Did others abstain?

THE WITNESS: I'm sorry?

DR. KIRAN: Did anyone else abstain?

THE WITNESS: No.

DR. KIRAN: Everyone else voted?

THE WITNESS: Do I have to answer her question?

MR. HAYDEL: No.

THE WITNESS: They're ignoring you.

MR. HAYDEL: Any other questions?

Thank you, Dr. Bairamian.

THE WITNESS: You're welcome.

MR. SCHEAR: So at this point we can continue with the Cross-Examination of Dr. Fahlen.

MR. HAYDEL: Why don't we get started on that and we'll break about 7:30.

Dr. Fahlen, you are still under oath. You understand that?

THE WITNESS: Yes.

MR. HAYDEL: All right. Mr. Geary, you can proceed.

CROSS-EXAMINATION

BY MR. GEARY: Q Doctor, I'd like to address for a moment the Memorandum of Understanding that was given to you during your meeting with Dr. Davis and Mr. Mitchell. I'm going to have you turn to Exhibit 20.

A 20.

Q Page 102 on the right-hand side. This is the actual physical copy of the actual document you were presented with during your meeting with Dr. Davis and Mr. Mitchell, correct?

A Correct.

Q During the meeting, were you given this document to look at?

A Yes.

Q And did you take a moment to actually read it?

A I read it thoroughly.

Q At what point during the meeting was this Memorandum of Understanding given to you, do you recall?

Supervisors to be a Board member of a Federally qualified health care clinic, that being the Health Services Agency Clinic on Paradise Road.

Q Is that called the Community Health Center?

A Correct.

Q And who appointed you?

A Well, the suggestion was made by Del Morris who is the medical director of the Health Services Agency and I also think that I had an advocate in Peter Broderick who is the residency director of the family practice program.

Q And then that's an appointment by the County Board of Supervisors?

A Correct.

Q When did that occur?

A A couple months ago.

Q Okay. And what is the Community Health Center?

A It's a federally funded primary care clinic that's for low income patients. They see a lot of mostly Medi-Cal is the No. 1 payer. And because Medi-Cal reimbursement is insufficient to keep these clinics going, the Federal Government will overpay them so they can keep in business and serve the Medi-Cal population.

Q And is that a volunteer or paid position?

A It's volunteer.

Q And going back to 2008 when the MEC was considering your

privileges, did anyone ever ask you if you would be willing to talk with the Medical Executive Committee?

A No.

Q Did you ever refuse to talk to the Medical Executive Committee?

A No.

Q Would you have liked to have talked to Medical Executive Committee?

A I really wanted to talk to somebody.

Q And then if we go to Exhibit 69. Now, is Milton Cruz a DTC nurse who was involved in the May 24th, 2006 incident included in the Notice of Charges?

A He's a DTC dialysis nurse.

Q Is the charge related to the May 24th, 2006 incident essentially that you spoke inappropriately to Mr. Cruz?

A That event -- yeah, his description describes that event.

Q Right. But the charges against you is that you spoke inappropriately to Mr. Cruz, correct?

A Correct.

Q And correct, that Mr. Cruz was identified as a potential witness by Memorial?

A I believe so.

Q And then I would ask the panel members to please read Mr. Cruz's declaration. Okay. Does Mr. Cruz's statement accurately describe the interaction you had with him on

MEMORIAL MEDICAL CENTER, MODESTO

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MEMORIAL MEDICAL CENTER, MODESTO,)
)
vs.)
)
MARK FAHLEN, M.D.,)
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)
)

CLOSING ARGUMENTS BY STEPHEN D. SCHEAR AND JAMES F. GEARY
Monday, May 24, 2010 at 6:10 p.m.
VOLUME XIII
BEFORE: HEARING OFFICER DOUGLAS A. HAYDEL
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REPORTER: Gilbert E. Martinez, CSR 7460

INDEX OF CLOSING STATEMENTS

INDEX OF EXHIBITS

No exhibits marked.

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MR. HAYDEL: Let's go on the record.

The record will show that all the attorneys are present as is Dr. Fahlen and all the members of the Judicial Review Committee. At our last session, we completed all the evidence in the case and so tonight we're going to have closing arguments and that consists of Mr. Geary going first, then either Mr. Schear or Ms. Huang for Dr. Fahlen and then Mr. Geary will give a final closing argument because, as I will explain, Mr. Geary has the burden of proof in this hearing.

Now, before the attorneys begin their arguments, I'm going to give instructions to the Judicial Review Committee as to what law pertains to this hearing and I think it's appropriate for me to give these instructions first because the arguments may well refer to the instructions given. And then finally after the closing arguments are given, the Judicial Review Committee will be given the duty of coming to a decision and we'll talk about the scheduling of when you meet. You could actually start your discussions tonight, although I've been told by the attorneys that their estimates as to how long the arguments will go is that it should take about as much time as we have been devoting to the hearing, so we may not get started tonight. But I will want to talk to the members of the committee after the attorneys have argued so we can figure out when to get together again. All right.

As far as the instructions. In this proceeding you have been called upon to decide the following issue, whether the MEC's recommendation not to reappoint Dr. Fahlen for medical disciplinary cause or reason is reasonable and warranted. Medical disciplinary cause or reason means that aspect of a physician's competence or professional conduct that is reasonably likely to be detrimental to patient's safety or to the delivery of patient care. Within 30 days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached.

With respect to the issue before you, the MEC has the burden of proving by a preponderance of the evidence that its recommendation to not reappoint Dr. Fahlen based upon medical disciplinary cause or reason is reasonable and warranted.

Preponderance of the evidence means evidence that is more convincing than that opposed to it. Stated another way, a party who has the burden to persuade you by a preponderance of the evidence must persuade you by the evidence presented in the hearing that what he or she is required to prove is more likely to be true than not true. If the evidence is so

evenly balanced that you are unable to say that the evidence on either side of the issue preponderates, then your finding on that issue must be for Dr. Fahlen and against the MEC. You should consider all of the evidence bearing upon every issue regardless of who produced it. Your decision is to be based solely on the evidence produced at the hearing before the Judicial Review Committee including all logical and reasonable inferences from the evidence and the testimony.

Evidence means sworn testimony, writings, material objects or other things offered to prove the existence or nonexistence of a fact. Evidence is either direct or circumstantial. Direct evidence proves a fact without an inference and if true, conclusively establishes that fact. Circumstantial evidence proves a fact from which an inference of the existence of another fact may be drawn. There is no distinction between direct and circumstantial evidence as to the degree of proof required. Each is a reasonable method of proof. Each should be considered for whatever convincing force it may carry.

The unsworn opening and closing statements of the attorneys are not evidence. However, if the attorneys have stipulated to a fact, you are to accept that fact as having been established. Do not speculate as to the answers to questions to which objections were sustained or the reasons for the objections. You are not required to decide any issue

according to the number of witnesses. The testimony of one witness worthy of belief is enough to prove any facts. This does not mean that you are free to disregard the testimony of any witness merely from caprice or a desire to favor either side. It does mean that you must not decide anything by simply counting the number of witnesses who have testified on the opposing sides. The test is not the number of witnesses, but the convincing force of the testimony. You may consider the ability of each party to provide evidence. If a party provided weaker evidence when it could have provided stronger evidence, you may distrust the weaker evidence. You may consider whether a party failed to explain or deny some unfavorable evidence. Failure to explain or deny unfavorable evidence may suggest that the evidence is true.

A party may offer into evidence any oral or written statement made by an opposing party outside the hearing. When you evaluate evidence of such a statement you must consider these questions. One, do you believe that the party actually made the statement? If you do not believe that the party made the statement, you may not consider the statement at all. Two, if you believe that the statement was made, do you believe it was reported accurately? You should review -- you should view testimony about an oral statement made by a party outside the hearing with caution. Your decision must be based only on the evidence you have seen and heard. Do not let

bias, sympathy, prejudice or passion influence your decision. You are the sole and exclusive judges of the believability of the witnesses and the weight to be given to the testimony of each witness.

In determining the believability of a witness, you may consider any matter that would logically or reasonably prove or disprove the truthfulness of the testimony of the witness, including but not limited to the following: The demeanor and manner of the witness while testifying, the character and quality of the testimony, the extent of the capacity of the witness to perceive and recall. The existence or nonexistence of bias, interest or other motive, a statement previously made by the witness that is consistent or inconsistent with the testimony of the witness and admission by the witness of untruthfulness.

Discrepancies in a witness' testimony or between such witness' testimony and that of other witnesses does not necessarily mean that any such witness should be discredited. Failure of recollection and innocent misrecollection are not uncommon. Two persons witnessing an incident may see or hear it differently. When a discrepancy pertains to an important matter or only to something trivial, is for you to determine. In deferring what weight to give any opinion expressed by a witness at this hearing, you should consider the qualifications and believability of the witness. The facts of

materials upon which each opinion is based and the reasons for each opinion. An opinion is only as good as the facts and reasons upon which it is based. Likewise, you must consider the strengths and weaknesses of the reasons on which any opinion is based. You are not bound by any opinion, give each opinion the weight you believe it deserves.

I have not intended by anything I have said or done or by any questions that I have asked to suggest how you should decide any questions of fact or that I believe or disbelieve any witness. If anything that I have done or said has seemed to so indicate, you must disregard it and form your own opinion. The purpose of my instructions is to assist you in your deliberation so that you may arrive at an appropriate decision. Whether some instructions apply will depend upon what you find to be the facts. Even though I have instructed you on various subjects, you must not treat the instructions as indicating my opinion on how you should decide any issue in this case.

When you convene to deliberate, it is your duty to discuss the case in order to reach agreement. Each of you must decide the case for yourself but you should do so only after considering the views of the other committee members. You should not hesitate to change an opinion if you are convinced it is wrong. However, you must -- you should not be influenced and decide any question in a particular way simply

because a member or members of this committee favor such a decision. That concludes my instructions.

After argument of Counsel, you will convene to -- conduct your deliberations. I will join you in that session. If requested by you, I may participate in your deliberations and be a legal advisor to you, but I shall not be entitled to vote. All right.

And so now we will have the closing arguments. As I mentioned, Mr. Geary will go first.

MR. GEARY: Thank you, Mr. Haydel.

MR. HAYDEL: You're welcome.

CLOSING STATEMENT

BY MR. GEARY: First of all, let me thank you on behalf of the MEC for your attention and attendance at all of the hearings that we have had. This process cannot work without the cooperation of other physicians in reaching these sort of decisions. And I know this took quite a bit longer than we anticipated when the panel was first chosen, but I think it is a tribute to your dedication, we have all the same panel members that we started with. And considering this has gone on over a year since the panel was accepted, I think that's a real tribute to your dedication.

Now, as Mr. Haydel pointed out to you, you have a single decision to make and that is to determine whether or not the

MEC's recommendation not to reappoint Dr. Fahlen is reasonable and warranted. And we'll go into what that means in a few moments. But I can tell you that it is not for you to determine that you, as a panel, would have come to the same conclusion. You don't have to make that decision. You don't have to come to the conclusion that you would have made the same recommendation either personally or as a group. What you do have to decide is whether or not that recommendation is reasonable and warranted. To put it another way, to rule against the MEC, you'd have to find that the MEC's decision was unreasonable and unwarranted.

MR. SCHEAR: I'll object. He's misstating the law.

MR. HAYDEL: Go ahead. Continue.

MR. GEARY: So as Mr. Haydel pointed out to you, there is a specific level of proof necessary to make this finding and that is by a preponderance of the evidence. And simply as Mr. Haydel pointed out, it is that which is more convincing than that opposed to it. And by that, ultimately the decision you're going to make is the MEC recommendation more likely reasonable than unreasonable? It's that simple. The decision is simple, the process of getting to it is rather complicated.

You are not here to decide whether or not nurses should have been disciplined by the administration, whether or not

the coaching that was done of Dr. Fahlen was qualified or unqualified. Whether or not Gould Medical Group fired him with or without cause. Whether or not Lisa Buehler was an appropriate choice to conduct the interviews for the Ad Hoc Committee. Whether or not Dr. Fahlen had the right to an attorney at the Ad Hoc Committee meeting or even whether or not he suffered from anger management problems or any other disorder. Simply put, what you have to reach an understanding on is whether it's more likely than not that Dr. Fahlen engaged in numerous incidents of misconduct over a four-year time period. Were those incidents violations of the medical staff bylaws and medical staff rules and regulations and was the MEC reasonable in concluding that these violations were likely to be detrimental to the delivery of patient care?

MR. SCHEAR: I'll object as misstating the facts.

MR. GEARY: Now, Dr. Fahlen has argued --

MR. HAYDEL: You may proceed.

You can argue it in your session.

MR. GEARY: And I'm sure they'll make this argument tonight. There's no particular behavior of Dr. Fahlen that has been shown to adversely impact a particular patient. In other words, that a patient didn't suffer an injury or a death as a result of Dr. Fahlen's conduct. You heard no instruction that that is the burden of

proof for the Medical Executive Committee and it certainly is not your burden of proof. The burden of proof is that his violations were likely to be detrimental to the delivery of patient care. I have heard no testimony during this entire hearing process as to why any disruptive and intimidating behaviors which were clearly, clearly engaged in by Dr. Fahlen must be tolerated in any workplace let alone in a hospital. No one, to my knowledge, has defended Dr. Fahlen's conduct. Even Dr. Fahlen hasn't defended his own conduct. As we'll get into in a few moments though, his perception of the impact of his conduct may very well be a reason that you should consider the speechlessness of the argument that somehow or other Dr. Fahlen has done something in the last 8, 10, 12 months, that he's fundamentally changed and therefore, you should take into account the lack of incidents in the past few months.

The simple fact is that the creation of an unhealthy and hostile work environment is inexcusable by a professional, any professional, let alone a physician. No organization and staff should have to endure that type of conduct. It just simply is not permitted. I cannot imagine a professional setting with a conduct of Dr. Fahlen that would be acceptable, at least in the United States. And when we go over some of the conduct that, as I say even Dr. Fahlen has not denied, it is simply inexcusable.

As you already know, there are a number of steps that a

physician can take advantage of before his or her day of reckoning unlike any other profession that I know of. There are investigations, there are graduated disciplines, there are notices of inappropriate conduct, the Memorandum of Understanding which really should take a moment and look at that. That Memorandum of Understanding did nothing other than say, "Dr. Fahlen, act like a decent human being. Follow the rules." And Dr. Fahlen refused and continues to refuse to accept those standards as something that a medical doctor should have to follow. And I'll review some of his comments he made at the very last hearing to give you some insight as to what I mean by that.

If you have a problem with behavior, your own behavior, the first thing you have to do to correct it is recognize that it's wrong. And whatever education, counseling or whatnot that Dr. Fahlen has reportedly received, it evidently has not taught him that simple lesson. You first have to accept the conduct as wrong before you can fix it.

Now, let's look at the actual substance of the case. As noted in the Notice of Charges which is the complaint, so to speak, of why the Medical Executive Committee took the action it did. It stated, "The type and nature of your unacceptable behavior towards others are longstanding and a description of that conduct is set forth below." And you have the Notice of Charges in your binder. And by the way, any of the exhibits

that are in your binder and admitted into evidence, which are all of them, can now be reviewed and read by you and measured against the standards that Dr. -- that Mr. Haydel pointed out to you in regards to oral or written testimony, both are entitled to the same weight. And the fact there are writings in that binder that were not specifically reviewed orally in this hearing should not be discounted by you unless someone actually provided evidence contrary to what's in those writings. It's pretty simple to determine how to measure Dr. Fahlen's conduct because unlike many standards of conduct that we're held to just as ordinary human beings, in this case it's actually in writing. Section 2.5 of the bylaws states, "It is a basic responsibility of the physicians to 'work cooperatively with members, nurses, hospital administration and others so as to not adversely affect patient care.'"

And then the medical staff rules specifically state, "The Board of Directors and the medical staff have adopted a policy promoting civil and respectful relationships between all employees, physicians and other independent and allied health practitioners regardless of their status or position. The Board of Directors and the medical staff recognize that disruptive behavior compromises the quality of patient care either directly or because it disrupts the ability of other professionals to provide quality care. This policy states that disruptive conduct of any kind, rude or abusive

conduct towards medical staff, hospital staff, independent and allied health practitioners, patients or visitors, negative comments to patients about other medical or hospital staff or their treatment in the hospital, threats of physical assaults, refusal to accept assignments, disruption of committee or departmental affairs, uncontrolled rage, intimidation, verbal tirades, vulgar language are inappropriate remarks in medical records or other official documents will not be tolerated." That almost sounds like a road map to the behavior that we've heard over the past months in regards to Dr. Fahlen. At least 80 or 90 percent of those directives, which once again are repeated at least in their general nature and Memorandum of Understanding, told Dr. Fahlen his behavior is not acceptable.

But Dr. Fahlen tells us and his Counsel tells us he's changed his behavior. Because he's recognized, evidently, the error of his ways. Here is his response, Dr. Fahlen's response under oath to questions regarding the bylaws and the medical staff rules and his behavior. This is the last night of testimony, May 3, 2010 in this room.

"Mr. Geary: Do you believe that any of your conduct between December of 2006 and May of 2008 was disruptive in the operation of the hospital?"

Answer: "No."

"None of the conduct?"

"I think at times my conduct could have been better, it

may have been classified as inappropriate, but I wouldn't go so far as to label it as disruptive."

Question: "You are aware that there were rules and regulations both for the medical staff, medical staff bylaws and medical rules and regulations issued by the hospital?"

"Yes."

"And they defined disruptive behavior?"

"Yes."

And part of that definition is this policy states as disruptive conduct of any kind rude or abusive conduct toward the medical staff, hospital staff and then I read the rest of the rule that I read to you a few moments ago.

"Do you believe you engaged in any of that behavior?"

"No."

"Do you believe you violated the medical staff bylaws in any way in regards to your conduct?"

"I think my behavior could have been better, but I don't think I violated the bylaws."

This is from a physician that his attorney says has now taken some sort of courses that we've never heard about, some sort of counseling we never heard about and he now recognizes that his behavior was inappropriate. The fact of the matter is as we sit here tonight, Dr. Fahlen does not believe his behavior was disruptive in any way, shape or form.

If we look at the testimony at the hearing.

Jackie Davis: "Did Dr. Fahlen actually use the terms killers and murders in describing nurses?"

"Yes. Many times in that incident. Dr. Fahlen hammered and harassed me after that event for a very long time. It was so bad after it happened. Dr. Fahlen was out of control."

Myna Gandy: "Generally they were to the point of badgering, constantly going up to the nurse, walking away for a few moments, coming back to the nurse, bringing it up again, discussing the situation with physicians and whoever happened to be in the doctor's area, discussing with whoever he happened to come in contact with."

"Were you there when that telephone call was going on?"

"Yes, yes. Because she gave the phone to me. Because he started talking to her about still having privileges at Memorial and she didn't know how to react so she handed the phone to me and he went on and on. And he said, 'I have privileges here.' And I said, 'Yes, you do. I'm aware of that.' And he said, "I'm going to sue you. The DTC staff was the reason I'm being fired. And then he started talking about his issues with Dr. Skokan."

"Nurses have told me they tend to avoid him, they'll go down another hallway and go into a patient room so that when they see him coming down the hall they don't have to interact with him, well, you know, it's not my way, I would want to work with him. The nurses have to be able to talk to them,

feel comfortable to speak with the physicians, they feel belittled. Some, you know, is self-esteem, it really hurts some of the self-esteem."

Myna Gandy: "She describes one of the nurses in which the doctor kept yelling at her, calling her incompetent at bedside in front of the patient which made her feel very demeaning. He was loud. He kept on going saying she wasn't doing her job. She was going to cause issues with this patient."

When we really looked at a number of incidents and I'm going to direct you in a few moments where you can actually read the words of the nurses that interacted with Dr. Fahlen over the past four years, there is a general theme. And it really has nothing to do with anger. What it has to do with is an attempt to humiliate. You will see time and time again comments made by Dr. Fahlen that really have only one justification and that is when you want to humiliate someone.

When you say to a nurse in front patients, "You're murdering my patients. You're incompetent. You don't know what you're talking about," that's not a point in time where you're trying to help out the situation. It's not even a point in time when you're trying to instruct the nurse on what would be a better procedure. What you're really doing is humiliating the nurse and there's a certain streak of meanness in there that when I go over some of his comments during the

hearing, it's still there. This idea that people are attempting to do Dr. Fahlen wrong and I'm going to get back at them by suing them, by humiliating them in public or even in private. It's a very, very disturbing theme throughout many of his engagements and it really has nothing to do with anger, it really doesn't. But it does have to do with a very flawed perception, I think, that Dr. Fahlen has about the impact of his words and his conduct towards the hospital staff that, as far as I can tell, has not been dealt with at all.

So how did the nurses react to this? Carla Zayek testified, "I had several nurses say they won't even take care of his patients."

"Does this create a problem from your standpoint?"

"Yes, it does. It causes a problem because the assignments are made to get a report. Then they have to have a change in their assignment and a report has to be given again so there's a time delay before they can see the patients."

"Have nurses told you why they don't want to take care of his patients?"

"Because they're never sure how he's going to react."

Now, this is a doctor that just a few weeks ago testified to you that in his opinion none of his conduct has ever been disruptive. And yet he heard that testimony under oath at this hearing.

Lisa Buehler, this is her testimony. "I think another theme was that everybody described him in a similar way which was his behavior sort of relentlessly pursuing an issue coming back over and over and over to reopen or rediscuss an event again about an issue that most people had felt had been resolved." I recall several, many witnesses reported that. Another theme was the difficulty often in dealing with him, with the trepidation in calling him or interacting with him. The fear of how he would react certainly by the nurses who were having to call him when he was on call, for example, or just encountering him in the hospital. So that was another theme. Some people described it as fear. Others described it as reluctance to have to interact with him at all because of not understanding how he was necessarily going to react to their questions.

Julie Meyers testified, "They really got to a point where they would avoid him. They didn't want to have any interactions with him. They were concerned that they would have the same experience that they had had historically so they would do anything they could to avoid having any direct interactions with him. Or even trying to avoid making telephone calls."

Now, what I direct you to is in Exhibit 10, beginning at Page 25, and I'm not going to ask you to read that right now, but what that is, is that begins the summary of the interviews

both of the nurses and then the interviews with Dr. Fahlen and his responses. And I think you'll find something interesting in that. If you recall, Dr. Fahlen testified that he thought that report was all one sided and they left out his side of the story. If you read the manner in which Dr. Fahlen interacted and answered questions during the Ad Hoc Committee and you think of the way Dr. Fahlen interacted with my questions at this hearing, you're going to see a startling similarity. And in fact, that similarity, if you go back and you read the discussions about the interview with Dr. Fahlen about the MOU and his inability to focus and wandering off into the wilderness on his answers and blaming everybody else for his problems, it's all the same. It's all the same right up until the hearing where Dr. Fahlen testified here. You asked him simple questions and we'll go over some and you'll see the answers either have nothing to do with the question or an attempt to shift the responsibility. And that's not testimony back in front of the Ad Hoc Committee, that's not talks that he had with the MOU at the MOU meeting, it's what he did at this hearing right here. He refused to answer questions and then when he did answer questions, he laid the responsibility off on other people. So I think what you'll have is basically, after you review particularly the in-depth report done by Lisa Buehler, and we also have if you want to go deeper, you can see the original complaints filed against

Dr. Fahlen. And even these individuals were interviewed sometimes two, three, four years after the incident, their stories are remarkably consistent and strangely enough, so are Dr. Fahlen's. His refusal to answer what really happened or his acknowledgment, "Maybe I said that, but I didn't say it in that way" is also remarkably consistent. The other thing that's remarkably consistent is his utter failure to do anything other than, "Well, I wish it didn't happen. I'm sorry it happened, but it wasn't my fault. It was Myna Gandy" or "it was Jackie Davis, it was Steve Mitchell, it was Dr. Cadra, it was all the chiefs of staff, everybody is ganging up on me. Why?" Because of his behavior. I don't know how much more simple it can be put, it's because of his behavior. If they were just ganging up on him for the sake of ganging up of him, why wouldn't we have heard of a whole bunch of incidents in the past eight months? We haven't. We haven't because we'll go into later, Dr. Fahlen has a game plan and he's laid it out as to what his game plan is and that's why we haven't had any incidents in the past eight months. This is nothing to do with some psychiatric or psychological condition, it has to do with Dr. Fahlen. That's what it has to do with. I think it would be fair to say that what you've heard over the last six or seven months and what you've read and what you would be able to read in the exhibits is that Dr. Fahlen's attitude essentially demonstrates the

contempt for the medical staff rules. He does not believe the rules regarding professional behavior and the hospital's attempts to assist him in improving his behavior is anything but to use his words, "A joke." Because that's really what he believes is what he said in numerous occasions and that's what he believes. He believes the attempts of the MEC, of the coaches, of Steve Mitchell, of the MOU, of the Ad Hoc Committee, it was all a joke and it was all intended for some bizarre reason to destroy Dr. Fahlen. I have yet to hear a reason why all of these people would be dedicated to that goal other than Dr. Fahlen's behavior.

Of course, in Mr. Schear's opening he tells us that, "Well, actually all this is in the past. Dr. Fahlen is cured." To quote his opening, "On his own with no help from hospital management Dr. Fahlen has successfully addressed his behavior issues on his own without being required to do so. Dr. Fahlen has attended anger management courses and learned how to handle his emotions in an appropriate way. On his own, without being required to do so, Dr. Fahlen obtained psychological counseling to help him gain some better self-awareness about his own behavior, his origins and its impact on others.

Well, unless I missed that part of the hearing, I did not hear any counselor speak, I did not hear any psychologist speak, any psychiatrist speak, anyone that participated in a

course with Dr. Fahlen. I have no idea what he did because we don't know. No health care professional came in and said, "Well, he had an anger management problem. He had 'this' or he had 'that' and this is what I did and now he's all better." I don't know even know what he did, let alone who he did it with. There's absolutely no evidence whatsoever.

However, we did hear from Dr. Fahlen's wife that the reason he went to some sort of counseling was his attorney told him to, which I have no doubt is the truth. And he may very well have taken some course but you didn't see any evidence of it in here. And in fact, Dr. Fahlen himself has denied he engaged in any conduct that violated any of the bylaws or any of the rules and he certainly has denied he had any psychological problem.

He was asked during the hearing, "Between the time that you received the Memorandum of Understanding that you rejected in May of 2008, during that time frame, roughly December 2006 through May of 2008, do you believe you required counseling?"

Answer: "No. I didn't think I needed counseling then."

Mr. Schear protested in his opening statement that there's not been a single incident of Dr. Fahlen treating any staff member in any inappropriate way for the past 18 months. Well, as you know the record does not bear that out, but I think it would be fair to say that his inappropriate conduct towards the staff has certainly been severely limited, but I

think there's some clearly logical reasons for that. One, is he's working at a different hospital now and there's very few patients here. The other is Dr. Fahlen intends to sue the hospital, intends to sue the medical staff and evidently a whole bunch of other people at the end of this process. That's why he's acting the way he's been acting or not acting in the way he did before.

As Dr. Fahlen stated at the last hearing, "In order to restore my reputation I've made it known that I felt they," meaning the MEC, the chiefs of staff and the hospital, "acted in an unlawful, immoral and unethical behavior."

And I asked, "Have you made that known to other physicians?"

Answer: "When they ask."

"And you've made that known to other staff in the hospital?"

"I try not to talk about this. Sometimes staff come up to me and ask, 'What's going on?' I really try not to discuss it, but people are curious." That, by the way, is a "Yes" in Dr. Fahlen speaking.

"And you told patients?"

"Well, when my patients were all involuntarily transferred to a new physician, I had to tell them what was going on. I mean I had to tell them what happened. 'What's going on?'" This is also an answer of "Yes" in Dr. Fahlen

speaking.

The fact of the matter is when he was asked questions by me during the hearing, he was argumentative, he blamed other persons for his conduct, he certainly refused to answer simple and direct questions and he clearly stated that the MEC, administration and chiefs of staff "Acted in an unlawful, immoral and unethical conduct in attempting to resolve his behavior." That is his opinion now, not in 2004, 2006, 2008, that is his opinion now. He honestly believes that the attempts to redirect his behavior was unlawful, immoral and unethical.

So where does this leave us right now in deciding whether or not the MEC made a reasonable recommendation not to allow him to be reappointed to the staff. I actually think it's a pretty easy answer. There really does come a time when enough is enough. Years of refusal to abide by the rules, ultimately contemptuous of the rules, crude and derogatory remarks, immature, almost childish actions. It's resulted in hundreds, if not thousands of hours in trying to redirect Dr. Fahlen right up until tonight and it's clear that it is all the result of Dr. Fahlen's behavior. No one else caused Dr. Fahlen to act in the way he did. No one else caused Dr. Fahlen to testify the way he did. The fact of the matter is that we're here because of his behavior, the MEC made a recommendation to deny reappointment because it decided that

there could be no more chances. I submit to you it is a reasonable recommendation and therefore, should be upheld. I will have a few moments to address you at the close of Mr. Schear's argument, but I promise you it will be brief and I will only direct my attention to comments made by Mr. Mr. Schear. Thank you.

MR. HAYDEL: Okay. Do you want to start?

MR. SCHEAR: I'm ready to start.

MR. HAYDEL: Or would you like to take a break?

CLOSING STATEMENT

BY MR. SCHEAR: Some of our power points will be difficult to read unless you brought your binoculars. So for those, you can look at the handouts.

So good evening, ladies and gentlemen, physicians. On behalf of Dr. Fahlen, I too want to thank you and express our appreciation for all the time you've taken to participate in this hearing. I know you're all volunteers and this hearing has taken away a lot of time from your family and friends and perhaps work as well.

Now, the closing argument is my opportunity to discuss both the evidence and the law relevant to your decision and I'll be referring at times to transcript pages that I've referred and you may want to write them down in case you want

to verify the accuracy that I'm quoting.

And the first thing I'm going to do is talk about the legal standards that you must apply in this hearing, including burden of proof, the evidence you must consider and the standard that governs the decision whether or not to review or terminate a physician's privileges. And then I'm going to talk about Dr. Fahlen's conduct and then thirdly, I will talk about problems with how the issues were handled by the hospital and why the MEC came to the wrong conclusion. And finally I'll talk about the factual determinations that are warranted by the evidence in this hearing.

So on to the legal standards. So the question as Mr. Haydel instructed you is whether nonrenewal of privileges is reasonable and warranted, not whether it was reasonable and warranted at the time the MEC met. Memorial, it bears the proof, the burden of proving that his privileges should be removed. The bylaws and the California law that governs these hearings is the present tense and not the past tense. So the question for you to decide is whether Dr. Fahlen's behavior presently warrants nonrenewal of his privileges based on all the evidence you have heard including his conduct since the Notice of Charges.

Your decision, and this is according to the Memorial bylaws, must be based on all the evidence that you've heard in this hearing. In legal terms this is called a trial denovo, a

new trial based on all of the evidence. You're not acting like a court of appeals as Mr. Geary is suggesting determining whether the MEC's decision made sense at the time based on the evidence it had. If that was the only question, then the only evidence you would have heard would have been the evidence that the MEC had. But as the law permits, both parties have introduced evidence that was not considered by the MEC, including evidence of Dr. Fahlen's behavior since August of 2008 in support of their respective cases. According to Memorial's own bylaws, you must consider that evidence. And that's obviously very important in this case for several reasons.

The first reason is that the hospital administration provided incomplete and inaccurate information about Dr. Fahlen's behavior and attitude to the Ad Hoc investigating committee and to the MEC so their decisions were based on flawed data. It's the old saying, "Garbage in, garbage out." I'm not saying all the information they got was garbage, but it was incomplete and one sided and intended to lead to a particular conclusion and I'll provide examples of that later.

Secondly, as the evidence will show, as has shown, the hospital administration gave the Ad Hoc Committee and the MEC inaccurate and misleading information about what procedures it should follow during the investigation and decision-making process and as a result Dr. Fahlen did not receive a fair

opportunity to provide his side of the story before the MEC's recommendation was made and I'll provide examples of that as well.

And third, the most important evidence in this case is the evidence of Dr. Fahlen's behavior in the past two years. Since April of 2008, there have been no significant incidents of the kind of angry outbursts which upset nurses in the past. It's undisputed even by Mr. Geary as conceded that Dr. Fahlen has stopped the kinds of behavior that has been described in the Notice of Charges. There's no evidence that Dr. Fahlen currently has any behavior problems which threaten the delivery of patient care.

The fact that Dr. Fahlen has successfully addressed his anger management issues, amended relations with the nurses and the DTC proves that terminating his privileges is unnecessary and unwarranted. Another very important legal standard in this case is the standard which applies to removing a physician's privileges. Interpersonal friction, difficult physicians, conflicts over peer review or economic or political issues aren't unusual in hospital settings. A charge that a physician has had interpersonal conflicts in the past is insufficient justification to take away a physician's privileges. In order to restrict a physician's privileges based on the behavioral issues, Memorial was required to prove that the physician's problems had an adverse impact on the

quality of medical care provided to patients. And this is also in the instructions that you were given and it's a statement of the law. You're being asked to decide a medical disciplinary cause or reason and that means that aspect of the physician's competent or professional conduct, that is again the present tense, is reasonably likely to be detrimental to patient safety or to the delivery of patient care. This is the most important instruction in this case. Because what that means is you must decide in order to advocate his nonrenewal is that Dr. Fahlen presently, his behavior is reasonably likely to be detrimental to patient safety or to the delivery of patient care. Memorial has not provided any evidence to support a conclusion that Dr. Fahlen presently poses a current risk to patient care safety.

Under California law, a physician cannot be denied staff privileges merely because he's argumentative or is difficult in getting along with physicians or other hospital staff when the conduct does not relate to the quality of medical care the physician is able to provide. So under the law, Memorial had the burden of proving that Dr. Fahlen's current behavior is reasonably likely to be detrimental to the medical care received by Memorial patients and it has failed to do that.

In fact, one fact that is undisputed in this hearing is Dr. Fahlen's clinical excellence. His excellence as a nephrologist has not been disputed by anyone, it's also

undisputed that his he's a strong advocate for patients. That's important because it means that Dr. Fahlen will not be the only loser if his privileges to practice at Memorial are taken away. The Memorial patients who are denied access to his care and to his patient advocacy will lose out too. Members of the medical staff, such as yourself, who now rely on Dr. Fahlen's clinical expertise will lose a valued resource. In removing an excellent clinician from the hospital staff will also damage Memorial's reputation within the physician community. So it's not even in the hospital's own best interest really to terminate Dr. Fahlen's privileges.

I'm going to address Dr. Fahlen's alleged misconduct. The Notice of Charges contains 18 specific incidents of alleged and inappropriate conduct. If you read the Notice of Charges, a lot of them are vague charges like, "Dr. Fahlen was condescending with a nurse" or "adopted a tone." Most of these incidents were relatively minor cases of workplace friction which were put into the Notice of Charges to increase the number of incidents charged. In any event, at this point, these alleged incidents, all of which occurred from 2004 to 2008, were essentially irrelevant to your decision because of Dr. Fahlen's success in learning to control his anger and frustration. I don't have time to go into each incident separately in this closing and I'm not going to since the accuracy of those charges doesn't really matter anymore.

Furthermore, the hospital failed to prove that Dr. Fahlen acted inappropriately in most of those incidents. As everyone agrees, the hospital had the burden of proof and as Dr. Fahlen testified when we started this hearing, we were given a witness list from the hospital. It contained 44 witnesses including most or all of the nurses involved in the charged incidents.

June Barton, who was the nurse involved in the Denise Gonsalves incident, Connie Khan, Stephen Nelson, Mark Carlin, Helen Willhide, Tarin Martin, Jennifer Givens and many other nurses were identified as witnesses by Memorial, but Memorial did not call any of those nurses to testify.

As this jury instruction states, "You should consider the ability of each party to provide evidence." If Memorial provided weaker evidence when it could have provided stronger evidence, you may distrust the weaker evidence. Here Memorial is claiming, basing its claim of inappropriate behavior by Dr. Fahlen, almost entirely on hearsay evidence rather than on live witnesses. Hearsay evidence is admissible in this hearing, but it is weak evidence that can be distrusted. And the reason that hearsay evidence is suspect and generally is not admitted in courts is the witness isn't there. So you don't get to look at her and assess her credibility about what happened. The witness isn't subject to Cross-Examination. So you don't know if there are holes in the testimony or there's

things that haven't been said. The witness is not under oath. So you don't know, it hasn't been tested when the person is sworn and is obligated to tell the truth. And here Memorial's evidence is not only hearsay, but almost all of it is double hearsay. Most of the documents aren't the nurses' statements written by themselves, but rather descriptions of what they said taken down by Lisa Buehler or someone else. So it's not just a statement that's secondhand, but the statement of thirdhand because it goes from the nurse to Lisa Buehler to a written document and then to you.

And under the jury instructions that Mr. Haydel gave you, you're not required to credit that hearsay evidence, you know. As the trier of fact, you're entitled to give evidence whatever weight you feel is appropriate for it to have. And given that they failed to call most of the nurses that were involved in those incidents, you don't need to give a lot of weight to that hearsay evidence.

The unreliability of their hearsay evidence is demonstrated by Milton Cruz' declaration, Exhibit 69, which you read on May 3rd. The Notice of Charges states that, "Dr. Fahlen was yelling and screaming at Mr. Cruz on the phone on May 24th and was verbally abusive to him. This conduct was supposedly overheard by another staff member and as established by the declaration of Mr. Cruz, that charge was false." This is an example of the unreliability of the

hearsay evidence Memorial has tried to use against Dr. Fahlen. Memorial only called three nurses as witnesses. One of them, Myna Gandy, did not herself observe Dr. Fahlen acting inappropriately in any of the cases. Jackie Davis testified but she actually observed or was involved in only two of the incidents in the Notice of Charges, the aftermath of the Denise Gonsalves incident and the orange juice incident. And I'll talk about Carla Zayek's testimony more towards the end.

So why did Memorial not call more live witnesses? You can conclude Memorial did not call more live witnesses because either the nurses could not confirm the accuracy of the charges or they would have testified that they now have no problems working with Dr. Fahlen or both. Memorial's failure to produce live witnesses to support most of the Notice of Charges and the unreliability of its hearsay evidence demonstrates that Memorial has failed to meet its burden of proof with regard to whether these incidents occurred as described in the charges.

Another factor you should consider is the reason Dr. Fahlen became frustrated with nurses at Memorial. Now, he's admitted that he did conduct himself inappropriately on several of these occasions, that he lost his cool, he blew up, he was upset, raised his voice, you know, he doesn't deny that for several of the incidents. But he also explained how in many of these incidences nurses refused or failed to follow

his orders or were disrespectful to him and that testimony was undisputed by Memorial.

Myna Gandy, in fact, testified that most of the incidents occurred after nursing errors and that's at Page 154 of the transcript.

As Dr. Fahlen testified, the improper conduct of the nurses did not excuse or justify his losing his cool or raising his voice, but it does provide a context that's important. And it's also a factor that should be considered when evaluating his actions. We can all agree that Dr. Fahlen was sometimes not at all tactful when he addressed insubordinate or disrespectful nurses. Oftentimes our strengths are our weaknesses and I'm sure that's true of Dr. Fahlen. One of Dr. Fahlen's strengths is that he is very direct, very honest and he tells you what is on his mind. And Mr. Geary talked about his conduct during Cross-Examination and I think it is true that when Dr. Fahlen is challenged, he tends to respond to the challenge, but he responds honestly and he tells you what's on his mind. And when the nurses challenged him and refused to do his orders, he did get sometimes upset and he did tell them what was on his mind. And that helps in many ways, you know, in terms of his life and his career as a nephrologist to be so direct and honest, it helps make him a good nephrologist because he's direct and honest with his patients. You heard testimony about how

nurses really appreciated how honestly he could deal with patients in these very difficult situations where people are terminally ill and he is, I'm sure, direct and honest with his colleagues. But it also made him less than diplomatic when he was confronted with nurses overstepping their bounds. And so he does not claim or he does not deny and we do not contend that he was wholly innocent or blameless. He made a contribution to the contention and discord which used to pervade the DTC especially. However, based on the evidence you've heard, it's also obvious that Dr. Fahlen was not the sole or primary cause of the tension with the Memorial nurses. You heard testimony from Shawn Smith who has worked with Dr. Fahlen on a daily basis at Doctors Hospital four years on the Critical Care Unit and three more years as a nursing supervisor at Doctors. Mr. Smith testified that Dr. Fahlen had no problems working with any of the nurses or other staff at Doctors, that he had never received a complaint about Dr. Fahlen. And he was one that testified about Dr. Fahlen's ability to be honest and caring with his patients and their families. You also heard from Sheila Kelly, Kim Baker and Jerry Grace who worked with Dr. Fahlen at the Outpatient Dialysis Center. All three of them testified, in essence, how great it was to work with Dr. Fahlen. You also heard Netta Berry, a Memorial dialysis nurse and Vishnu Prakash, a Memorial ICU nurse. Ms. Berry has worked with Dr. Fahlen

approximately for five or six years and Mr. Prakash has worked with Dr. Fahlen for seven years in the ICU and both of them testified that Dr. Fahlen was easy to work with and that they had not observed him have problems with any of the other nurses.

If Dr. Fahlen had an uncontrollable behavioral problem or was just a bad person as essentially Memorial makes him out to be, then you would expect that those traits would manifest themselves wherever he works, but Dr. Fahlen has been able to work just fine everywhere but at Memorial including during his residency and his fellowship in Texas, his work at Doctors where he was elected chief of medicine and the Outpatient Dialysis Center.

The evidence you heard shows that Dr. Fahlen's problems here were pretty much isolated to Mark Carlin, some of the nurses in the DTC, especially Jackie Davis and the hospital administration. So the most reasonable conclusion is that Dr. Fahlen was not the primary cause of the problem. There was a real problem here with nurses that were out of control in playing doctor like Mark Carlin or nurses that were not following orders or providing good care because of a lack of training or experience. But it would also be a gross oversimplification to blame the nurses. The situation was much more complicated than that.

It did start with the nurse acting extremely

inappropriately, refusing Dr. Fahlen's orders to use paddles in a life-threatening situation on January 11th of 2004.

Then Mark Carlin again refused his orders on February 20th of 2004, again threatening the life of a critically ill patient. Dr. Fahlen's anger and frustration boiled over and an unhealthy dynamic began to fester with a few of the nurses at Memorial. The incidents of Dr. Fahlen losing his composure were actually relatively few and far between, scattered over more than four years. But each incident must have spurred or damaged Dr. Fahlen's reputation among some of the nursing staff, especially with the DTC unit.

The real problem which led to this hearing was neither the nurses nor Dr. Fahlen, but the hospital administration's failure to effectively deal with the tension between the nursing staff and Dr. Fahlen. Now, Mr. Mitchell and Dr. Smith seemed to be very nice people and what I'm going to say about their conduct and what hospital administration is doing should not be taken as a personal attack on anyone, but it also seems the hospital administration had on blinders that impaired their ability to see what was going on and what would be an appropriate, constructive and ethical response.

Memorial has not produced any evidence of any efforts by the hospital to address the problems of nurses refusing to follow a physician's order which clearly jeopardizes patient care. Memorial has not produced any evidence of any action by

hospital administration to require the nurses to treat Dr. Fahlen with respect and courtesy. The hospital administration never attempted to use recognized methods of conflict resolution like an organizational development consultant or professional mediator. Instead it just let the situation fester like a small but irritating open wound. And it got so bad that Jackie Davis, a charge nurse, avoided Dr. Fahlen when he tried to talk about clinical concerns and went into hiding when he came on the unit. That's at Page 112 and 133 of the transcript. Now, what kind of message did that send to the nursing staff when you have a charge nurse who's hiding when the doctor comes in the unit. But Memorial did nothing to rein in Jackie Davis, not when she yelled at Dr. Fahlen in the Denise Gonsalves incident, not when she ignored Dr. Fahlen and walked away when he was trying to talk to her and the orange juice incident.

Jackie Davis testified that the hospital administration did not do one thing to try to resolve the tension between her and Dr. Fahlen and that's at Pages 115 and 114. Instead of addressing the group dynamic that had developed, the hospital administration developed a posture as it still has, as you heard from Mr. Geary, that Dr. Fahlen was the exclusive cause of the problem, it was all on him, he's just a bad person, can't control himself, breaks the rules and it's all his fault. And that was also Jackie Davis' testimony, she never

did anything inappropriate. Myna Gandy testified that she never acknowledged to Dr. Fahlen that there might be a problem with any of the nurses. That's at Page 199. And that was the essence of Mr. Mitchell's testimony too, that it was all Dr. Fahlen's fault.

Dr. Fahlen testified that he believes that the entire problem could have been solved if the hospital had simply sat him down with the nurses and requested that they gave each other mutual respect and based on subsequent events, he's probably right. On his own with no help from the hospital administration, Dr. Fahlen has been able to work out his problems with the nurses by being friendly to them. If the administration had helped in that process, the problems could have been resolved much sooner and we wouldn't have had to go through this hearing, but the hospital administration didn't do anything to break that negative stuff that was going on. And you can see in this hearing, you know, today that negative energy is still coming. Now, "Dr. Fahlen's bad, Dr. Fahlen is evil, look at these bad things that he did," you know. The Memorial administration is living in the past and rather than trying to recognize or rather than recognizing that he has improved his behavior and that he really does deserve to stay on the staff and really recognize the reality of what has happened here, it's entrenched in the past. It's entrenched in its prior position that Dr. Fahlen was the sole and

exclusive problem and that he's just secretly hiding it and as soon as he gets his renewal of his privileges, he's going to break out and become evil guy again, so scary. You've seen Dr. Fahlen and you know Dr. Fahlen, he's not evil, he's not perfect, he's made mistakes, he's admitted he was inappropriate. I mean he's taken on some responsibilities for his actions. The hospital administration has taken no responsibility for its incompetent way that it dealt with the situation. Under their interpretation of the bylaws, the bylaws were, you know, if you raise your voice, if you step out of line, there's 20 different things, you use a cuss word, any of those things, that's a violation of the medical staff rules and regulations and we can throw you off the staff because you committed disruptive behavior. So I hope none of you ever curse where anyone can hear you because that would be a violation of the bylaws and you could lose your privileges under the interpretation that Mr. Geary has thrown out there.

But when Dr. Fahlen said he wasn't guilty of disruptive behavior, he meant it in the true sense that his behavior, while inappropriate and certainly upsetting to some of the nurses, did not disrupt the hospital operations. And that's what the law is. You can't just throw somebody off the staff because they raised their voice or because they act inappropriately on certain occasions. It has to be a sufficient severity that it's actually disrupting the

operation of the hospital and jeopardizing patient care and they cannot prove that if he did that in the past, but even if they did prove that he had done that in the past which they haven't, Dr. Smith testified he wasn't aware of a single patient whose care was compromised by anything Dr. Fahlen did so they didn't prove it about the past. There's certainly no evidence of anything in the past two years that meets that statement.

Another obvious failure of the hospital's administration was its failure to suggest that Dr. Fahlen seek anger management training, psychological counseling, assistance from the hospital's medical staff aid committee or a fitness review for duty examination. If the administration truly believed that Dr. Fahlen was the sole or the primary cause of the problems that were popping up from time to time, it should have addressed those issues in a systematic, intelligent and competent manner. As Mr. Mitchell himself pointed out, the phenomenon of physicians with anger and behavior problems is nothing new and has recently been emphasized by the joint commission which accredits hospitals.

Mr. Mitchell admitted he was aware that counseling and anger management classes are recognized tools for addressing behavioral issues of doctors. Dr. Nguyen testified on May 3rd that two Memorial doctors had been referred for psychological counseling and that the counseling had helped

alleviate their behavioral problems. Yet no one in the hospital administration ever once suggested to Dr. Fahlen that he take an anger management class, go to counseling or consult with the hospital's medical staff aid committee or have a fitness for duty evaluation. This was not a competent response by a hospital administration.

Mr. Mitchell had several excuses for the hospital's failure to suggest that Dr. Fahlen get some help. One excuse was the hospital had provided Myna Gandy and Julie Meyers as behavioral coaches and that had worked. Mr. Geary and Ms. Buehler have emphasized an alleged comment by Dr. Fahlen during his interview by Ms. Buehler that he "plays the game of going to coaching." Well, having now heard the evidence, you can understand that comment and the context of what Dr. Fahlen actually experienced. The counseling really was a bad joke. According to Julie Meyers' E-mail, Exhibit 50, there was supposed to be regular meetings of Dr. Fahlen with Myna Gandy, monthly meetings with Julie Meyers and written reports by Myna Gandy at least once or twice a month on Dr. Fahlen's progress. None of that happened. There were no regular meetings. Myna Gandy who was reluctant to be Dr. Fahlen's coach in the first place refused to talk to Dr. Fahlen about his issues with Gould or the reasons for his behavior. That's at Page 218 and 219. How can you coach somebody if you can't talk about what's bothering him and what he feels is going on.

And as Dr. Fahlen testified, there was no proactive coaching on how to prevent problems or improve relations with the nursing staff or how to address his anger management issues or stress. And it's not surprising and it's not their fault that Ms. Gandy and Ms. Meyers were not effective coaches. It's not an easy task to coach a physician with behavior issues. Physicians usually are -- you know, you're people who have all gone through medical school, you're all smart people, most of you think, you know, you got things pretty well figured out so coaches aren't the easiest people to train often. There are professional coaches with experience and training including coaches who specialized in helping physicians with interpersonal problems. Ms. Gandy and Ms. Meyers were never qualified to serve as coaches in the first place since neither of them had the training or experience as personal coaches. Based on the testimony of Ms. Gandy, Ms. Meyers and Dr. Fahlen, it's quite apparent that no real behavioral coaching ever took place. If the hospital administration thought that Dr. Fahlen had a serious problem, then it should have provided him with serious help rather than a pretense of amateur coaching.

It's now 7:30 so I mean I think out of courtesy to Gilbert --

MR. HAYDEL: This is a convenient breaking place in the argument. Let's take a 15-minute break and then

we'll resume. 15 minutes.

(Recess taken.)

MR. HAYDEL: Let's go back on the record.

We're all back.

Mr. Schear can continue.

MR. SCHEAR: Thank you.

Another excuse of the hospital administration for not asking Dr. Fahlen to take anger management classes or get counseling was Mr. Mitchell's assertion that other physicians had responded positively to a Memorandum of Understanding. That excuse has no merit for several reasons. This is Exhibit 60. You can't really read it I'm sure from where you are. But in this E-mail Dr. Alex Davis expresses a desire to talk to Dr. Fahlen face to face before handing him an MOU and I'm sure Dr. Davis' intention was to make the situation more collegial and less adversarial, but that didn't happen which created the setup for the adversarial confrontation that occurred on January 4th of 2007. The MOU is also an inappropriate method to address Dr. Fahlen's behavioral issues, at least the way it was used in this case.

As Dr. Kardos testified, the MOU should reflect an agreement after an agreement is reached. This MOU was drafted in advance by hospital administration with no input or

discussion with Dr. Fahlen, then they called Dr. Fahlen into the meeting and attempted to force it down his throat with no input, discussion or agreement. And it's little wonder that in that context Dr. Fahlen resisted signing it and he was certainly right that if he had signed it, it would have been used against him. The MOU has been used against him in this hearing even though he did not sign. If he had signed it, Mr. Geary would certainly have been arguing tonight that Dr. Fahlen made an agreement, he signed the agreement and then he breached it and therefore, his privileges must be terminated.

In any event, the fact that the MOU had worked or supposedly worked with other doctors is no reason not to use other options. That is like saying, "I've used ampicillin successfully in three of my patients' infections. If it didn't work with you, that's your fault, too bad. You go ahead and have your infection. I'm not going to try anything else because this worked with other patients."

If the MOU didn't work with Dr. Fahlen then, you know, if you're competent and intelligent and thinking constructively, then you try something else like anger management or counseling.

Another excuse Mr. Mitchell used to explain why he never recommended counseling or anger management was his determination that Dr. Fahlen was unable and unwilling to

improve. And that excuse has proven to be false in the light of the evidence you've heard and read.

Let's see. This was Dr. Fahlen's response to the MOU. Now, Dr. Fahlen did respond positively to the meeting, you know, related to the MOU even though he didn't sign it. Myna Gandy testified that she thought that Dr. Fahlen was trying to improve his relationships with nurses after the Denise Gonsalves incident in 2006 and that's at Page 188 of the transcript. And despite the aggressive stance of the hospital administration at the MOU meeting, Dr. Fahlen did in this E-mail agree to try to improve his behavior. He also agreed to accept Ms. Gandy and Ms. Meyers as his coaches even though they had no training or experience in coaching and were part of hospital management.

And he did improve his behavior after the MOU. There were actually no incidents from November 3rd of 2006 until August 15th of 2007 when Dr. Fahlen was allegedly condescending to a nurse. That's a period of over nine months without a problem. Mr. Mitchell recognized his improvement and touted him as a success story to others which is in Exhibit 55. He also, Dr. Fahlen also volunteered to get anger management training in a meeting with Dr. Mitnick, he never refused psychological counseling, anger management or referral to the medical staff aid committee, no one from the hospital administration or the medical staff ever suggested any of

those options to him. And then in September of 2008, Dr. Fahlen went on to, on his own, to attend anger management classes and psychological counseling.

Now, Mr. Geary was saying there's no evidence that that ever happened, but Dr. Fahlen's testimony is evidence, it's sworn testimony, there's no reason to believe he's lying. He's an honest person, he's not making that up and Diane Fahlen, who came in, verified that there's no reason for you to believe that he didn't do that. And there's also not a shred of evidence that Dr. Fahlen would have refused anger management or counseling or medical staff assistance if any of those had been suggested or required of him.

Mr. Mitchell has no training in psychology or psychiatry or counseling and had rarely even talked to Dr. Fahlen. He was professionally unqualified and lacked sufficient information to make a determination that Dr. Fahlen was unwilling and unable to improve.

And finally, Mr. Mitchell's conclusion that Dr. Fahlen was unwilling and unable to improve his behavior has been proven wrong by the facts that after Dr. Fahlen attended anger management classes and got professional counseling, his behavioral problems at Memorial went away.

Now, I want to address the role of the medical staff and the events leading up to this hearing. The Notice of Charges claim that Dr. Fahlen had serious behavioral problems from

2004 through July of 2008. But the only action the leadership of the medical staff took to address those problems during those four-and-one-half years was to have Alex Davis attend a five- or 10-minute meeting with Dr. Fahlen to present the MOU for his signature. Dr. Golden also had a brief conversation with Dr. Fahlen and that was it. The medical staff leadership gave no help to Dr. Fahlen, no guidance, no assistance. However, despite that, I would not and will not encourage Dr. Fahlen to sue the MEC or its leadership if he prevails in this hearing. Although the conduct of Dr. Davis and Dr. Smith as chiefs of staff was not exemplary or even competent in terms of their position as chiefs of staff, the reality is that physicians who have little training or experience in hospital management are often thrust into leadership positions sometimes for the wrong reasons. It can be expected to look at hospital administration with its experience for guidance on what to do. That certainly happened in this case and the medical staff leadership was led astray by the hospital administration. The events leading up to this hearing were a process that was biased to achieve the results desired by administration.

Going back to the MOU in December of 2006, Dr. Davis decided not to meet with Dr. Fahlen one-on-one after meeting with Mr. Mitchell on December 22nd of 2006. That's in Exhibit 60 and 61. Again, we can't read it. But not only

that, not only did he not have the meeting, but Mr. Mitchell also rebuffed Dr. Davis' suggestion that a psychologist from outside Sutter would be a better coach for Dr. Fahlen than Myna Gandy. Mr. Mitchell also rejected Dr. Davis' suggestion that the medical staff aid be involved in helping Dr. Fahlen. So Dr. Davis was actually on the right track and Mr. Mitchell was saying, "No. We don't want to handle it that way. Let's use our people as coaches. Don't send them to the medical staff aid committee, don't get them outside psychological counseling."

And then in the spring and summer of 2008, the hospital administration again manipulated events, this time to drive Dr. Fahlen out of town using the medical staff as its tool.

If we go to Exhibit 62, this is an E-mail between Mr. Mitchell and Mr. Benn dated April 7th of 2008. And after being shown this E-mail during this hearing, Mr. Mitchell admitted initiating a meeting of Dr. Mitnick and Dr. Fahlen in order to get Dr. Fahlen fired so that he would be forced to leave Memorial and the hospital would not have to go through this hearing and that's at Pages 740 to 743. And here's an excerpt of Mr. Mitchell's testimony and it basically what it says is, "The idea was that Fahlen would meet with Mitnick and then Fahlen would be upset and angry and Mitnick would fire him and then he would be gone and then he wouldn't have to go through this hearing." So Mr. Mitchell was trying to take a

shortcut that would avoid Dr. Fahlen being able to use his legal rights. Then on May 5th of 2008, you know, and he was interfering with Dr. Fahlen's employment and you can judge the appropriateness of that on your own. On May 5th of 2008, Mr. Mitchell arranged a meeting of Dr. Smith with Dr. Mitnick, James Conforti, Dave Benn and himself to get Dr. Smith on board the idea of having the medical staff investigate Dr. Fahlen. And that's documented by Exhibit 55 and Mr. Mitchell's testimony at Page 753.

The hospital administration accomplished its goal of having Gould fire Dr. Fahlen without cause but that did not accomplish the goal of forcing him off the medical staff of the hospital. As you heard Dr. Fahlen testify, after Gould terminated Dr. Fahlen, Dr. Mitnick told Dr. Fahlen that he would be suspended if he set foot in Memorial. That threat, too, must have been intended to persuade Dr. Fahlen to leave town rather than having his reputation damaged by a summary suspension which means, you know, that's always on your record, a summary suspension, that you've been considered an imminent danger to patients.

Dr. Fahlen didn't just leave town though, he contacted Mr. Mitchell's office to set up a meeting to see if the threat was genuine and if that would really happen. And Mr. Mitchell then sent this E-Mail to Mr. Benn and at this hearing before seeing this E-mail, Mr. Mitchell denied under oath that the

hospital administration had decided to use the MedQual reports to try to get rid of Dr. Fahlen after he refused to resign and that's at Page 781. Before seeing the E-mail, Mr. Mitchell also testified that he didn't think he knew why Dr. Fahlen wanted to meet with him in late May. After seeing this E-mail, however, Mr. Mitchell admitted that he must have known why Dr. Fahlen wanted to met with him and that's at Page 783. And that's because, of course, it says, "Dr. Fahlen called to schedule a meeting with me on Friday to discuss his privileges in private practice. He does not get it."

Mr. Mitchell also admitted that he meant that Dr. Fahlen did not get that he was going to lose his privileges at Memorial. And that's at Page 784 of the transcript.

And then Dave Benn's response was, "Looks like we need to have the medical staff take some action on his MedQuals soon."

Now, Mr. Geary talked about Dr. Fahlen treating things as a joke, but it really seems like Mr. Benn was treating, as a joke, the idea that we're going to take action against this guy's privileges and we're going to cripple or damage his career and we're going to force him out of town and isn't that fun. Let's take some action on his MedQuals. This E-mail reminds me of an old movie set in Africa where a British colonial governor tells his assistant to put a native rebel in front of the firing squad made up of African soldiers. We'll have the medical staff MedQuals soon.

The very same day, May 27th, Steve Mitnick called Dr. Todd Smith and told him that he was concerned that the Fahlen issue was not completely resolved. Dr. Smith then wrote Dave Benn, "He does still have privileges at the hospital and apparently has a small dialysis clinic. What are your thoughts?"

Now, giving the timing of these events, Mr. Mitchell must have called Steve Mitnick to tell him that Dr. Fahlen intended to set up a private practice in Modesto. Dr. Mitnick then called Todd Smith to put pressure on him to have the medical staff take action against Dr. Fahlen and then Todd Smith sent this E-mail to Dave Benn to ask his advice. Three days later on May 30th, Mr. Mitchell met with Dr. Fahlen and you'll have to read the one in front of you. But this memo demonstrates that Mr. Mitchell threatened Dr. Fahlen with the new occurrence reports from late April and with the termination of his Memorial privileges. He went on to say that the MEC was going to investigate him, but if he resigned, there would be no report to the Medical Board. But if he quit after the investigation started, there would be a report to the Medical Board. And Mr. Mitchell admitted both in this memo and in his testimony that he suggested that Dr. Fahlen leave Modesto and start over someplace else.

This was another improper effort by hospital administration to induce Dr. Fahlen to forego his legal right

to a hearing and to leave town by using a threat of a report to the Medical Board that would stain his reputation forever. But Dr. Fahlen did not take the easy way out. He decided he would not be run out of town, he decided he didn't want to move his family to some unknown destination where he could find another job as a nephrologist. When Dr. Fahlen refused to give in to Mr. Mitchell, the hospital administration followed through with a threat that the MEC would take action against Dr. Fahlen. On June 5th of 2008, Todd Smith was brought into another meeting with Mr. Mitchell, Dave Benn, Julie Meyers and Larry Dempsey, the hospital's attorney. The meeting took place before any investigation of the April 2008 event had been completed.

After Todd Smith's meeting with the hospital administrators and their attorney without first talking to Dr. Fahlen, Dr. Smith went to the MEC and asked for a formal investigation of Dr. Fahlen. Mr. Mitchell admitted at Pages 786 to 787 that he was the first one to suggest the MEC investigation of Dr. Fahlen. Mr. Mitchell also admitted that the MEC requested a formal investigation of Dr. Fahlen before the hospital investigation of the April 2008 events had even been completed and that's at Page 790.

After doing virtually nothing for four years about Dr. Fahlen's problems with Memorial nurses, now there was a rush by hospital administration to get the investigation

going. Ms. Buehler was hired and her investigation was nearly completed before the Ad Hoc Committee even met for the first time on July 22nd of 2008. What was the rush? As Dr. Smith testified at Page 605, Dr. Fahlen, now that he was no longer a member of Gould, had become a competitor to Gould for nephrology patients which is a lucrative source of revenue. Most likely the Sutter Gould leadership was anxious to damage Dr. Fahlen's ability to get a private nephrology practice established in Modesto.

MR. GEARY: This is really well beyond any appropriate argument. The notice of Gould is just --

MR. HAYDEL: I've been giving wide latitude on the argument and you can respond to it in your rebuttal.

MR. SCHEAR: Well, as they say, if you're looking for answers to people's motivations, it's often wise to follow the money. After successfully initiating the MEC's formal investigation, hospital administration also manipulated the investigation to ensure that it obtain the results it wanted. Mr. Mitchell admitted at Page 793 that he arranged for himself and Lisa Buehler to be put on the medical staff's Ad Hoc investigating committee even though they were not members of the medical staff. He also admitted on Page 794 that he suggested physician members of the committee. Mr. Mitchell arranged for the contract with Ms. Buehler and the hospital administration paid for her services. It's

obvious that Ms. Buehler and the hospital administration, not the Ad Hoc committee, controlled and conducted the investigation.

Before the Ad Hoc Committee had even met, Ms. Buehler had already interviewed 23 hospital employees whose names were provided to her by the hospital administration. Dr. Fahlen was refused permission to tape record his own interview or to have an attorney present based on the advice of Attorney Flo Di Benedetto. That decision was made without the participation of the physician Ad Hoc Committee members, other than Dr. Cadra. Dr. Fahlen testified that the hearing was essentially an interrogation by Lisa Buehler.

Now, Dr. Cadra's testimony was different. He testified that the questioning was divided up pretty evenly, everybody was asking Dr. Fahlen questions. Dr. Cadra's testimony was proven to be false by the subsequent testimony of Ms. Buehler who said she did 99 percent of the questioning. That's at Pages 341 and 342 by Mr. Mitchell at Page 812, 813 and also by the testimony of Dr. Nguyen, Dr. Fahlen and Diane Fahlen who all testified that Ms. Buehler did all or virtually all of the questions.

Dr. Cadra also repeatedly testified that the Ad Hoc Committee was limited to answering four questions posed by the MEC. That's at Pages 239, 252, 53, 255, 258 and 259 of his testimony. And that was in response to my questioning about,

"Well, why didn't you look at other alternatives like psychological counseling, anger management?"

"Oh, we could only answer these four questions. The MEC told us we could only answer these four questions." That testimony was also contradicted by Lisa Buehler who testified that she was the one who had created the four questions contained in the report without any input from the MEC, that there was no discussion in the Ad Hoc Committee about the committee being limited to deciding those four questions and that she was not aware of the MEC making a decision about limiting the scope of the investigation to the four questions that Ms. Buehler had presented. That's at Page 376 to 383. Mr. Mitchell also testified at Page 796 that the MEC never limited the Ad Hoc Committee authority to make recommendations.

Dr. Cadra was not the only one who testified falsely under oath in this hearing to disguise the extent that the medical staff was manipulated by the administration. Mr. Mitchell testified that the Ad Hoc Committee decided how the investigation would be conducted. That's at Page 800. That was an obvious falsehood since 23 of the 24 witnesses selected unilaterally by the hospital administration had already been interviewed before the Ad Hoc Committee even met.

Mr. Mitchell also admitted that he was the one who decided what documents Ms. Buehler would review and that other

members of the committee were not invited to participate in the interviews of witnesses except for Dr. Fahlen's. That's at Page 804. Despite that Mr. Mitchell refused to admit that the administration and Ms. Buehler had decided how to do the investigation, claiming that the committee had concurred with the administration's methods, that's like getting a patient's consent to surgery, at the end of the operation when you're sewing them back up, there's no real choice involved. By the time the Ad Hoc Committee concurred, most of the investigation had already been done. The physician members of the committee had nothing to do with how the investigation took place. Mr. Mitchell's statement that the Ad Hoc Committee decided how to do the investigation was false testimony under oath.

Mr. Mitchell also manipulated the committee's investigation by feeding the physicians on the committee slanted or false information before they had ever met. Again, you have to look at the document that's Exhibit 51, the E-mail of Mr. Mitchell to the Ad Hoc Committee dated July 3rd of 2008. In this E-mail Mr. Mitchell claimed that, "Dr. Fahlen had committed abusive and very bad behavior which continues today with little or no improvement." He wrote that, "Dr. Fahlen had made only small improvements in his behavior even though he had previously touted him as a success story and characterized Dr. Fahlen's improvement as 'wonderful'." This E-mail was obviously an effort to give the committee a

negative first impression about Dr. Fahlen to influence how they thought about him before they interviewed him. In this E-mail which is an E-mail to Dr. Masson dated July 28 of 2008, Mr. Mitchell strenuously fought Dr. Masson's more compassionate approach of trying to help Dr. Fahlen by getting him a psychiatric evaluation and sending him to PACE courses.

Mr. Mitchell falsely wrote that Dr. Fahlen had ignored all notices, assistance and warnings even though Dr. Fahlen had responded to all or virtually all of the hospital's attempts to address his issues with nursing staff.

Mr. Mitchell again falsely wrote that Dr. Fahlen had not improved at all. He warned that a terrible medical mistake was bound to occur if he were allowed to continue to work at Memorial. He had no evidence to support that prediction, a prediction that has been proved to be completely wrong in the nearly two years since this E-mail. He wrote that Dr. Fahlen had no insight into his problems. Mr. Mitchell admitted that this statement was false at Page 819 of the transcript. Why was Mr. Mitchell giving Dr. Masson false information? It was obviously intended to prevent the Ad Hoc Committee from recommending psychological counseling rather than the termination of Dr. Fahlen's privileges. Mr. Mitchell has admitted that he wanted to get rid of Dr. Fahlen and he did not feel constrained by the truth when trying to achieve that agenda.

The hospital administration acted in the same way in the second meeting of the Ad Hoc Committee. If we go to Exhibit 8, this is the minutes from the meeting. When Dr. Nguyen and Dr. Wani supported psychological counseling rather than termination of Dr. Fahlen's privileges, Mr. Mitchell claimed that Dr. Fahlen neither wanted to improve nor could improve his behavior. Susan Donker then raised the prospect of employee lawsuits against the hospital even though no employee had filed a lawsuit or threatened one, at least there's been no evidence of that. She also questioned whether the medical staff could require Dr. Fahlen to seek medical care when it clearly did have that power under the bylaws which authorized the committee to take any action it deemed appropriate.

Ms. Buehler said that the Memorial attorney believed that there was sufficient facts under the law to justify Dr. Fahlen's termination and then Dr. Cadra again raised the threat of lawsuits if Dr. Fahlen was allowed to remain in the hospital.

Dr. Cadra falsely testified that no one told the committee members that the decision had to be unanimous. That's at Page 273.

Dr. Nguyen testified that the committee was told that its decision had to be unanimous. The information given to the committee, that its decision had to be unanimous was

untrue, there's nothing in the bylaws that requires a unanimous decision by the investigating committee. The fabricated unanimity requirement was made up to help conceal Dr. Nguyen's and Dr. Wani's recommendation for counseling rather than termination. They were trying to create an allusion of consensus to help make sure that the MEC would not be diverted in a more compassionate direction.

Dr. Cadra also testified in answer to a question by Dr. Cash that only the physicians voted in the Ad Hoc Committee and that's at Page 287. That was another false statement. Dr. Nguyen testified that the entire committee participated in the decision, including the administrators.

Lisa Buehler also testified in a response to a question by Dr. Kiran that everyone on the committee, including her, voted on the recommendation. And that's at Pages 429 to 430. So you can see the administration did everything it could very scientifically in a way, very rigorously, very intently to make sure that the recommendation for psychological counseling never got to the MEC.

And if you look in the report of Ms. Buehler, it was written and provided to the MEC, she emphasized the decision of the Ad Hoc Committee had been unanimous, she prominently repeated Mr. Mitchell's false statement that Dr. Fahlen had no insight into his behavior and had not expressed in any way a desire to modify his behavior, which was just untrue. And

Ms. Buehler's report to the MEC was essentially, take a look at and read it, it's a nasty, negative and completely one-sided hit piece. It was written by a lawyer who was doing what she was hired to do and was doing it very well which was to help the hospital administration to get rid of Dr. Fahlen. It contains not one word of empathy, concern or compassion for Dr. Fahlen. There's also not one word in Ms. Buehler's report about the possibility of having Dr. Fahlen get psychological counseling despite the discussion that had taken place in the Ad Hoc committee about that option. The minutes of the Ad Hoc Committee which would have shown the positions of Dr. Nguyen and Dr. Wani were not shown to the MEC.

Dr. Smith testified that the alternatives of anger management counseling and so on were all discussed with the MEC, but when Dr. Bairamian came here to testify, he testified he did not remember any discussion of those issues. Dr. Bairamian also testified that he asked at the MEC meeting if Dr. Fahlen was going to talk to the MEC because he wanted to hear from Dr. Fahlen. He wanted to hear Dr. Fahlen's side of events, a reasonable request. Dr. Fahlen testified that the MEC was told that Dr. Fahlen had refused to speak to the MEC. That was another lie. And that lie served two purposes. First, it prevented the MEC from asking Dr. Fahlen to come and talk which might have revealed that Dr. Fahlen was not the unrepenting, irrational, angry, abusive person who was being

portrayed in Ms. Buehler's report. And also that he was ready and willing to go to anger management, psychological counseling or to do whatever to save his privileges.

And then secondly, it reinforced the idea that Dr. Fahlen was not interested in addressing his problems or cooperating with the MEC, he was just this crazy guy that wouldn't even talk to them. So the unethical manipulation of the MEC was successful based on the one-sided, slanted and inaccurate information it was given that voted for nonrenewal of Dr. Fahlen's privileges and this hearing was the result.

So you know, Mr. Geary wants you to give a lot of deference to that decision, but you're not required to give any deference to it, that's the reason for the hearing, that's why we present all this evidence so you can make an independent judgement. And you can see that based on the process and the information that was given to the MEC, that decision really deserves no deference, they were manipulated and fooled by hospital administration. And I think the other thing that's important to consider in terms of the role of medical staff is it's how you see the medical staff. Is it an enforcer that if you break a rule, that you're out, you know, is that the role of medical staff or are you supposed to be given mutual aid and assistance to each other so that you can all provide the best possible care and help each other and help each other with your problems as well as with the medical

care. And I think historically and traditionally --

DR. EVE: Just a second. Excuse me.

MR. HAYDEL: Let's go off the record for a minute.

(Recess taken.)

MR. HAYDEL: Okay. We're back on the record.

Mr. Schear, you may continue.

MR. SCHEAR: Thank you.

Historically and traditionally medical staffs were there to help each other, not just providing medical care, but to help each other with problems, that's why there's a medical staff aid committee, that's why there's the opportunities to aid physicians that run into problems because Dr. Fahlen's certainly not the only physician that's run into problems during the course of his career. And what's happened is the economics of health care has changed over the years and now you have more of this corporatization of medicine and there's this, as we see very well in this case, the effort of the corporate side to basically try to control the medical staffs and make them into tools of the corporations and the corporation's objectives, whatever they may be rather than independent medical staffs. And we're fortunate that the law

provides this mechanism where you have the opportunity to be an independent voice for the medical staff and to identify what is going on and to be able to protect the interests not of just Dr. Fahlen, but to protect the interests of all physicians to make sure that they all have a fair process.

There's no question that this entire hearing could have been avoided if the hospital administration or the medical staff had simply asked Dr. Fahlen to take anger management or psychological counseling. Since he started, since he did that, there have been no significant problems with nurses. Memorial has talked about the four incidents since the MEC decision, but those incidents were qualitatively different than the earlier incidents. The first one was the one where Dr. Fahlen requested to change from the face mask oxygen to a nasal cannula for palliative care, the nurse didn't do it. When that happened Dr. Fahlen did not yell at the nurse, he went and talked with her, according to both Dr. Fahlen and according to Myna Gandy. And after she changed the mask to a cannula, he thanked her. And the nurse did not complain about Dr. Fahlen's conduct, he complained about her failure to follow his orders which is how that incident came to light.

In the second one in April of 2009, Dr. Fahlen needed immediate dialysis for a critically ill patient, but found the dialysis nurse was doing an inappropriate dialysis on a patient who didn't need dialysis. And when Dr. Fahlen asked

the nurse to discontinue the unnecessary dialysis and help with his patient, she appropriately asked Dr. Fahlen to call the other doctor which he did. And he didn't get upset with the nurse, he was upset with the situation, but he didn't yell at her or the other doctor and again, he handled a somewhat difficult situation much better than in the past.

In the third one or the third incident was an incident between Dr. Fahlen and Dr. Anago where they both raised their voices about a patient being admitted to the Gould hospitalist rather than to the patient's own physician. And again, it was Dr. Fahlen who raised a complaint about this incident. Dr. Fahlen worked out his issues with Dr. Anago, they get along fine. And again, Dr. Fahlen showed a capacity to actually deal with problems and address them without getting into big issues or longstanding problems.

And in the forth and final one in September of 2009, there was a Carla Zayek one where Dr. Fahlen was upset about one of his patients being admitted to the Gould hospitalist. Carla Zayek testified that Dr. Fahlen spoke in a very loud voice to her, but she did not complain about his conduct either and she admitted that in response to Dr. Heck's question that other doctors also sometimes raised their voices and Dr. Fahlen was again the one to file a complaint about this incident, not the nurse.

So you know, there were these incidents but they actually

showed growth by Dr. Fahlen that in cases where he was frustrated, he was able to deal with it better, without losing it, without badgering anyone, you know, he's not perfect and he's got, you know, as he says, you know, he's got tendencies to be aggressive if he's challenged or if he feels something is wrong, you know, that's his personality. But he's really done a tremendous amount of growth, two years without any real significant incidents and there's been no incidents in the past eight months of any kind. So the fact -- and also there's the fact the MEC did not add these four incidents to the Notice of Charges. So that demonstrates that the MEC and its own attorneys didn't think those four incidents constituted credible evidence of disruptive behavior by Dr. Fahlen.

So Mr. Mitchell's claim that Dr. Fahlen was unwilling and unable to improve his behavior has been empirically proven to be false. So you know, the theory now, I guess, of Memorial is, "Well, he's controlling his behavior, but that's because he wants to sue us." Well, I mean the real issue for you guys is he's controlling his behavior, he's being nice to everybody. You know, I don't think, again, that's attributing evil motives as opposed to him realizing he had problems and that if you treat people nicely, even people that aren't necessarily treating you nicely in the long run you get better results, you know. And these found that to be true, he's

operating in that way and he's always operated that way when things are going smoothly in other hospitals, never been any problems and now there's no problems at Memorial.

He testified that all the nurses on the DTC now get along with him. No current problems with any of the Memorial nurses and Memorial did not contest that evidence with a single witness or any other evidence. In fact, even Jackie Davis testified that in the past 18 months Dr. Fahlen had been courteous to her and she had not received a single complaint about his behavior in her position as assistant nursing manager. That's at Pages 144 and 189.

And there's another jury instruction about how you can and should consider Memorial's failure to produce any evidence contrary to Dr. Fahlen's statements that all is well with the nurses now. They haven't disputed that, you can take that as a fact. You know, they can't produce a single nurse that says, "No, I don't get along with him anymore."

Dr. Fahlen, on the other hand, has produced along with other commendations, a recent unsolicited E-mail from the Memorial nurse, Tina Tong who said that Dr. Fahlen is one of the kindest persons that she's ever met and that she loves working with him. His behavior at Memorial is now exemplary like his past and current behavior at Doctors Hospital and at the Outpatient Dialysis Center.

On his own with no help from administration, Dr. Fahlen

has healed the wounds that had developed in his relations with some of the Memorial nurses. At this point in time he deserves to be commended rather than punished for his behavior. So really undisputed evidence requires that you issue a recommendation that Memorial should renew Dr. Fahlen's privileges. The only reason for terminating his privileges would be if his continued practice at this time would harm patient care. There's no evidence, none at all, to support any conclusion that any current behavior problems jeopardize patient care. So the law and the evidence mandate a recommendation in Dr. Fahlen's favor.

Now, under the law, the final decision on what to do or the next decision on what to do rests with the MEC. And your findings in terms of a recommendation that his privileges should be renewed is only a recommendation and the MEC will make its own decision. But your factual findings must be respected unless there is no substantial evidence to support that. So why is that important? It's important because it means that the language of your report should be strong and unequivocal. If you equivocate, then any kind of waffling language may be used as an excuse not to follow your recommendation. You should strongly and unequivocally recommend that Dr. Fahlen be permitted to retain his privileges, given his proven ability to practice medicine with appropriate behavior toward staff.

Secondly, you should make clear and unequivocal factual findings that support your recommendation and here's what we suggest as appropriate factual determinations. First, that none of the incidents charged in the Notice of Charges involve behavior that impair the quality of care provided to patients at Memorial and that was essentially admitted by Dr. Smith. Most of the charges involve minor incidents which were the product of workplace friction rather than disruptive behavior by Dr. Fahlen.

The second one, Dr. Fahlen has taken adequate remedial measures to address his behavioral issues including anger management and psychological counseling.

And three, it's been over two years since Dr. Fahlen has had a significant negative interaction with Memorial nursing staff. For the past eight months there have been no incidents of any kind.

Four, Dr. Fahlen currently gets along well with the nursing staff and other staff at Memorial Hospital. That's undisputed.

And five, Dr. Fahlen's behavior does not currently pose a risk of affecting the quality of care provided to Memorial patients. It's not reasonably likely that Dr. Fahlen's behavior will be detrimental to patient safety or to the delivery of patient care. Those are the essential findings. You can amplify on those findings or make other factual

findings, you can address the conduct of hospital administration providing an accurate or one-sided information to the medical staff, but that's up to you. That's not required in terms of assessing the issue of whether Dr. Fahlen's privileges should be removed, removed or not.

If you want to address -- I don't think you need to address each of the incidents. They are in the past, it would take a lot of time and your factual findings according to the bylaws are supposed to be concise and we really haven't had that much evidence that you've heard on most of the incidents. And if you do want to make a factual finding on each of the incidents, I would suggest that you make a finding that it didn't meet its burden of proof showing that any of those incidents or their cumulative affect significantly interfered with the delivery of patient care, because that's the real fundamental question.

As you can see, we're not asking for a specific finding of bad faith or improper motive by the hospital administration. The hospital administration's conduct explains how we got here, but it's not something you need to decide in terms of your issue of the removal of Dr. Fahlen's privileges. So I ask you to please make clear and unequivocal findings that will support your recommendation so that further time and resources will not be wasted in efforts to discipline Dr. Fahlen for conduct that was somewhat overblown to start

with and is now no longer an issue.

By recommending that Dr. Fahlen be allowed to keep his privileges, you enable Memorial to keep an excellent nephrologist on its staff to the benefit of both the patients and the other physicians who practice here. You will also prevent unfair damage to Dr. Fahlen's career and reputation which would otherwise follow him for the rest of his life and you will protect all Memorial physicians by hopefully preventing this kind of unfair and wasteful conduct by the hospital's administration in the future. So I thank you very much for your attention to this closing and for your attention throughout this hearing.

MR. HAYDEL: Thank you.

Mr. Geary.

REBUTTAL

BY MR. GEARY: I do have a very simple comment on the remark just made that you should find in favor of Dr. Fahlen in order to protect the other physicians at this hospital. Well, if that's the case, what you're voting for is for physicians to act in the way Dr. Fahlen acted in his last four or five years in this hospital. If that is your opinion that doctors should be allowed to act that way, then I would agree with that comment. If on the other hand your duty is to protect the patient care, protect the staff and protect the

operation of the hospital so that patient care is of a topnotch and high quality, then you should not buy into that comment that your decision in the favor of Dr. Fahlen somehow or other protects other physicians at this hospital. In fact, I think we can make exactly the opposite argument. And that is if you find that the MEC's recommendation is unreasonable, then you must find that the conduct outlined in this record is appropriate and does not raise any issues in your mind about the appropriate conduct that a physician should engage in when he's dealing with the staff, with the physicians, with the administration and with the Medical Executive Committee.

Mr. Schear at the beginning of his statement said, "His conduct between 2006 and 2008 is irrelevant to the decision you should make." And then he spent 75 or 80 minutes telling you why the Medical Executive Committee, the administration, the nursing staff and a host of other people are responsible for us being here tonight. That's utterly irrelevant. There is no instruction you are going to receive that says that you are to adjudicate whether or not the Medical Executive Committee of the hospital administration should have or may have given Dr. Fahlen another chance. That's not the decision for you to make. And as Mr. Schear pointed out in his closing, you need make no findings in regards to whether or not the hospital administration acted in good faith in their investigation. Well, it goes a little beyond that. That

isn't even in your instructions. Your instructions are very, very simple in that regard. You are to determine if the MEC's recommendation based upon the oral testimony and the exhibits in front of you, whether their recommendation not to reappoint Dr. Fahlen is reasonable and warranted. It is not to decide whether or not the process was fair or unfair. It's not to decide whether or not one doctor or another doctor or administrator or the nursing staff didn't like Dr. Fahlen. That's not what your decision is. It is whether or not based upon this record, his conduct warranted a reasonable recommendation by the Medical Executive Committee that Dr. Fahlen should no longer be on the staff. That's the decision to make.

So I recommend you go to Exhibit 10 beginning at Page 25 in your deliberations, look at the number of witnesses, where they came from, what they said and equally important, look at what Dr. Fahlen said in response and you will find it amazingly similar to his responses or nonresponses during this trial. The fact of the matter is the misbehavior that Dr. Fahlen engaged in is a given. We just heard 75 minutes on why the administration should have done other things and virtually nothing about what Dr. Fahlen's conduct was and there's a simple reason for that. What is in this report is what he did and what he said and how he treated the staff, the physicians, patients and family members. Read that.

Now, of course the reason that Mr. Schear wants you on one hand to forget everything that Dr. Fahlen did during 2006, 2007 and 2008, but remember all the evil motives and all the evil actions of the administration and the Ad Hoc Committee and Lisa Buehler is that he wants to gain your sympathy. It has nothing to do with what his conduct is or what his conduct was. It has absolutely no relevancy whatsoever to the instruction you were given as to what your decision is. But by appealing to your sympathy, he's hoping that you will avoid the issue at hand and that is, was his direct recommendation reasonable and warranted. Read that report. It's meaningless how they got to the information, it's whether or not the information is true. Read it. Read Dr. Fahlen's responses. Dr. Fahlen testified in Cross-Examination that Lisa Buehler's report was all one sided and everything she said about him was true. I took two incidents and went through them in detail as far as what his response was at that Ad Hoc Committee and he admitted in every single page he reported as accurate.

Now, it is interesting that Mr. Schear put up on the overhead that you may consider the ability of each party to produce evidence. If a party provided weaker evidence when it could have provided stronger evidence, you may distrust the weaker evidence. The entire defense of Dr. Fahlen, other than the evil motives and that sort of stuff of his, "I'm fixed. I got counseling, I went to anger management, I got it all

fixed." Now, who should have come in and testified to that, the person that was fixed or the person that did the fixing? We have not a shred of evidence other than from Dr. Fahlen that he's "fixed." And in fact, as I read to you in his testimony, he never believed anything needed to be fixed. He didn't believe it then and he doesn't believe it now. And if a physician says under oath -- Dr. Fahlen testified here on March 22nd, 2010 and he's talking about his conduct at the Ad Hoc Committee meeting, read the review of that and you know what the testimony was by the individuals that attended that meeting. He called them, "liars." He told them that he was going to sue them. He told them that they were all out to get him. Read the comments that he made at that meeting. Here's what Dr. Fahlen testified. "My responses were vigorous but I don't consider myself to be verbally abusive." He just said that a few months ago. He said to the Ad Hoc Committee, he said to Lisa Buehler, "You people are all liars." And he doesn't believe that's abusive. If you recall the testimony of his meeting when the MOU was brought up, exactly the same sort of behavior in which he blamed everything on everyone else. So what did we hear tonight? It's everybody else's fault. It's not Dr. Fahlen's. I don't know of a more clear case where a person has self inflicted their behavior to the point that we're all sitting here tonight. It's not even a close call. I have reviewed this report on more times that I

want to relate to you. If you review it once and you find a rational excuse for his abusive and humiliating behavior, I'm going to be quite surprised, let alone with all of the incidents. This was not an incident with a couple of nurses. There are 25 or 26 different witnesses and Mr. Schear says, "Well, those witnesses were all provided to the Ad Hoc Committee. That's unfair." These are the witnesses that complained about him. That's what they were doing. They were investigating whether or not his behavior was abusive and whether or not it was detrimental to the operation of the hospital. This is not a close call. When the nursing supervisors say, "We have to change staff. We have people that won't work with him. We have people that hide from him. We have people that won't call him." This isn't a close call.

And yet as I say, there is not a shred of evidence that, number one, he had a problem, some sort of psychiatric or psychological condition, let alone that he's been cured of it. As I mentioned in my opening, this is not a question of a physician with an anger problem, this is a physician who does not understand the gravity of his actions and his words. And right up until the last day of his testimony I asked him. "I remember your question," this is Dr. Fahlen. "Do I have a psychological or psychiatric condition that needed counseling in 2007?"

"And what is your answer?"

"That Myna Gandy and Jackie Davis were well on their way to driving me to one."

"So your answer is 'Yes'?"

"My answer is 'No,' but I was at risk of developing a condition."

"Did you develop such a condition the next year in 2007?"

"I think I was temporarily cured according to Steve Mitchell's assessment."

"Doctor, I'm talking about you. Do you believe in 2007 you required any psychiatric or psychological counseling as a result of your interaction with the nursing staff?"

"No. Because Steve Mitchell quit bullying me."

And yet Mr. Schear suggests the whole answer to this misconduct was further counseling or sending him to anger management. That is a person that in March of this year is telling you that none of his behavior warranted any intervention and then he, in fact, is suffering from no condition. Why would you even suggest anger management counseling to someone who takes that position? Not only back then, but right now. You can sugarcoat it any way you want, that in the last eight months he hasn't acted out. I'll tell you why he hasn't acted out, because he's in complete control. He knows what he's doing. And he knows that if he had acted out in the past few months, it would have come to your attention. He had some missteps a few months before that, but

he also had an attorney and he had an attorney that had been recommending, "Go to counseling, get psychiatric intervention."

And according to both Dr. Fahlen and his wife, he got it. Where's the evidence? Where is the evidence that complies with that instruction you received that if someone produces weak evidence when they have the potential for producing strong evidence they should produce it. There was none. The fact of the matter is that Dr. Fahlen has not evidenced his change one bit. Had is a physician who recently testified that all these people --

MR. HAYDEL: Hold on.

DR. EVE: I need to turn this off.

MR. HAYDEL: Let's go off the record.

(Recess taken.)

MR. HAYDEL: Okay. Let's go back on the record.

MR. GEARY: This is a physician that testified at the last hearing that these people acted in an unlawful, immoral and unethical manner in attempting to resolve his apparently not bad conduct, according to him. But to put this another way, is this a physician who has accepted the requirement of the bylaws and accepted the requirement

of the medical staff rules that it is a basic responsibility of the physician to work cooperatively with members, nurses, hospital administration and others so as to not adversely affect patient care?

I think it's quite obvious he has not and that the recommendation of the Medical Executive Committee is clearly appropriate and is clearly reasonable. And that's the only task that you're faced with when you're in deliberations.

Thank you.

MR. HAYDEL: Thank you. It's too late to start anything so we're adjourned for tonight. I would like to meet with the committee just briefly.

MR. SCHEAR: We made a couple of suggestions. One was that panel might be given written copies of the jury instructions because they probably didn't memorize them.

MR. HAYDEL: I have copies.

MR. SCHEAR: Yes. We can make a DVD available that would go to you or that would have all the transcripts on one disc and then you can load it in the computer.

MR. HAYDEL: Do we have -- I assume we've got a machine to do whatever a computer --

MR. GEARY: Well, we actually have all the transcripts typed up.

MR. SCHEAR: Well, the advantage to the electronic transcripts and I mean the written ones are good too, but the advantage of the electronic ones is that you can do the word searches like that. If you want to see what Myna Gandy said about --

MR. GEARY: This is something we can talk about. We're not going to have the deliberations for a while. But I've got a complete set of the actual --

MR. HAYDEL: Perhaps you can make it available.

MR. SCHEAR: Why don't they do the written one and we'll provide the electronic one.

MR. GEARY: Steve, you said we can use a different room when the panel gets together?

MR. MITCHELL: Yes.

MR. HAYDEL: Okay. We're done.

Thank you.

---oOo---

(Whereupon the hearing of
MARK FAHLEN, M.D.
concluded at 9:04 p.m.)

---oOo---

STATE OF CALIFORNIA)
) ss
COUNTY OF STANISLAUS)

I, GILBERT E. MARTINEZ, do hereby certify that I am a licensed Certified Shorthand Reporter, duly qualified and certified as such by the State of California;

That the said hearing was by me recorded stenographically at the time and place herein mentioned; and the foregoing pages constitute a full, true, complete and correct record of the closing arguments given by the said attorneys;

That I am a disinterested person, not being in any way interested in the outcome of said action, or connected with, nor related to any of the parties in said action, or to their respective counsel, in any manner whatsoever.

DATED: June 5, 2010

_____

Certified Shorthand Reporter

SENATE HEALTH AND HUMAN SERVICES
COMMITTEE ANALYSIS
Senator Martha M. Escutia, Chair

BILL NO:	SB 97	S
AUTHOR:	Burton	B
AMENDED:	As introduced	
HEARING DATE:	March 10, 1999	9
FISCAL:	Appropriations	7
CONSULTANT:		
Umino		

SUBJECT

Health Facilities: Retaliation Against Employee or Patient with Grievance

SUMMARY

This bill prohibits a health facility from discriminating against a patient or employee who presents a grievance or cooperates in any investigation against that facility.

ABSTRACT

Existing law prohibits :

1.An employer from retaliating against an employee who provides information to a government or law enforcement agency about the employer's violation of law or regulation. A violation is considered a misdemeanor and is punishable by (a) imprisonment in the county jail not to exceed one year, (b) a fine not to exceed $1,000, or (c) both. A corporation may be fined up to $5,000.

Continued---

2.A long-term health care facility from retaliating or

discriminating against an employee or patient, who has filed a grievance, or provided information to a governmental entity relating to care, services, or conditions at that facility. A violation is subject to a civil penalty of not more than $10,000.

This bill:

1. Makes findings and declarations to encourage patients, nurses, and other health care workers to notify government entities of suspected unsafe patient care and conditions.

2. Prohibits any health facility from retaliating or discriminating against an employee or patient, who has filed a grievance or provided information to a governmental entity relating to the care, services, or conditions at that facility.

3. Requires a health facility that violates this provision to be subject to a civil penalty of not more than $25,000.

4. Establishes a "rebuttable presumption" that any discriminatory treatment taken by a health facility is retaliatory if it occurs against (a) a patient within 180 days of his/her filing a grievance or complaint or (b) an employee within 120 days of his/her filing a grievance or complaint.

5. Defines "discriminatory treatment of an employee" to include discharge, demotion, suspension, any other unfavorable changes in employment, or the threat of these actions.

6. Establishes a misdemeanor penalty of up to $20,000 for any person who willfully violates the provisions in this bill.

7. Requires that an employee who has been discriminated against, pursuant to this bill, is entitled to reinstatement, reimbursement for lost wages and benefits, and legal costs associated with pursuing the case.

8. Exempts from the above provisions (a) an inmate of either

a Department of Youth Authority or Department of Corrections' correctional facility and (b) a long-term health care facility that is subject to existing law.

FISCAL IMPACT

Potential costs at state facilities from the General Fund. Both state hospitals and University of California hospitals, which are licensed health facilities owned and operated by the state, would be responsible for paying for fines and civil action incurred from violating provisions in this bill.

BACKGROUND AND DISCUSSION

Previous legislation includes: (1) AB 3309 (Burton, 1996) which failed passage in the Assembly Health Committee and (2) SB 253 (Burton, 1997) which was vetoed by Governor Wilson because "[t]here is no empirical data to indicate that health facilities workers require a higher level of protection than other employees."

Supporters argue:

1. The purpose of this bill is to extend to hospital patients and health care workers the same whistleblower protections that currently apply to long-term care facilities.

2. This bill would help protect nurses and patients who complain about possible unsafe patient care in hospitals.

3. Retaliatory actions against patients, nurses and other health care workers are on the increase. Nurses working in hospitals and other health care facilities who report unsafe patient care or conditions put their own jobs at risk and, therefore, are afraid to speak out.

4. Existing laws are so vague and general that they do not protect patients and employees in hospitals.

Opponents argue:

1. Retaliation against a whistleblower is already a crime that is subject to penalties.
   Employees who are subjects of retaliation can go to the Department of Industrial Relations, Division of Labor Standards Enforcement or to the courts for relief.

STAFF ANALYSIS OF SENATE BILL 97 (Burton) Page 4

2. "Rebuttable presumption" is bad public policy. By creating the legal presumption that a hospital is guilty of retaliation unless it can prove itself innocent, this bill tilts the process in favor of one of the parties in a dispute. Furthermore, rebuttable presumption in this bill will have an adverse impact on patient care, if swift action cannot be taken against an incompetent employee.

3. This bill encourages an incompetent employee to file a frivolous complaint against a hospital due to the protections provided in this bill.

4. This bill creates no corresponding penalties for employees who willfully or negligently misuse the process for their own purposes.

The California Department of Health Services (DHS) reports:

1. An annual average of 11,000 complaints against all types of health facilities, including long-term care facilities and hospitals. An estimated 7,000 complaints per year are against long-term care facilities.

2. In fiscal year 1997-98, DHS issued 1,258 citations against long-term care facilities. One of these citations was against a long-term care facility for retaliation and discrimination against an employee.

3. DHS staff indicates that they receive a number of retaliation complaints against health care facilities, other than long-term care facilities, but without statutory authority they cannot follow-up on them.

POSITIONS

Support: California Nurses Association (sponsor)
California School Employees Association
Congress of California Seniors

Oppose: California Healthcare Association
Kaiser Permanente Medical Care Program

-- END

SENATE BILL NO. 472 **1978 REGULAR SESSION** **CHAPTER** 1348

AUTHOR Behr

DATE RECEIVED 8/31 1978

LAST DAY TO ACT 9/30 1978

✓ LC	✓	— I.R.	—	— PUC	—		
✓ A&S	✓	— F&A	—	— LCC	—		
— B&T	✓	— FIN.	—	— CSAC	—		
✓ H&W	✓	— OPR	—	— D/ED.	—		
— E. O.	—	— LEGAL	—	—	—		
— RES.	—	— OER	—	—	—		

ACTION OF GOVERNOR 9/29 1978

Ch. 1348

ENROLLED BILL MEMORANDUM TO GOVERNOR	DATE September 27, 1978
BILL NO. SB 1472	AUTHOR Behr

Vote—Senate ____Unanimous

Ayes— 23
Noes— 5 - Campbell, P. Carpenter, Dills, Garamendi, Petris

Vote—Assembly ____Unanimous

Ayes— 75
Noes— 1 - Miller

SB 1472 - Behr Under existing law where a writ of mandate is issued for the purpose of inquiring into an administrative order or decision, the court is generally required to exercise its "independent judgment" with respect to decisions affecting a vested right.

This bill would provide that in cases where the court is reviewing the decision of a private hospital board, it shall use the "substantial evidence" test. An exception is made for cases of alleged discrimination against podiatrists or osteopaths, in which case the court would exercise its independent judgment on the evidence if the plaintiff made a preliminary showing of substantial evidence to support the allegation.

SPONSOR

California Hospital Association

SUPPORT

Legal Affairs
Consumer Affairs

OPPOSITION

No expressed opposition

FISCAL IMPACT

None

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DEPUTIES

Sacramento, California

September 20, 1978

Honorable Edmund G. Brown Jr.
Governor of California
Sacramento, CA

REPORT ON ENROLLED BILL

S.B. 1472 BEHR. Amends Sec. 1094.5, C.C.P., re private boards.

SUMMARY: See Legislative Counsel's Digest on the attached copy of the bill as adopted.

FORM: Approved.

CONSTITUTIONALITY: See Comments.

TITLE: Approved.

COMMENTS: This bill would provide that in an administrative mandamus review of an order or decision of a private hospital board, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record, except in certain cases of discrimination where the court would exercise its independent judgment.

This bill would reverse the decision of Anton v. San Antonio Community Hospital, 19 Cal. 3d 802, if its provisions are constitutional.

Anton v. San Antonio Community Hospital, supra, involved judicial review of the decision of a hospital not to renew a physician's staff privileges. Prior to Anton, supra, it had been held that in reviewing the decisions of public administrative agencies, other than constitutional agencies, if the decision substantially affected a fundamental vested right, the court was required to exercise its independent judgment (Id., 821). It had been widely assumed that this sort of review was not required in reviewing the decision of a private agency (Id., 821). However, in Anton, supra, the court held that in reviewing the decision of a private hospital not to renew a physician's staff privileges, the court was required to exercise its independent judgment, as the hospital's decision was an administrative decision of an adjudicatory nature which affected a fundamental vested right (Id., 830).

The basis for the decision in Anton, supra, was that a physician is entitled by constitutional guarantees of due process to a hearing prior to the termination of staff privileges (see Ascherman v. Saint Francis Memorial Hosp., 45 Cal. App. 3d 507; Silver v. Castle Memorial Hospital, 497 P. 2d 564). In reviewing the decision reached at the hearing, the court should apply the independent judgment test if the decision affects a fundamental vested right (Anton, supra, 821). This is because such a decision is an exercise of judicial power and administrative agencies do not possess such power (Anton, supra, 822; Bixby v. Pierno, 4 Cal. 3d 130; Strumsky v. San Diego County Employees Retirement Assn., 11 Cal. 3d 28).

Thus, the court is required to exercise its independent judgment because a hearing is required in cases involving the termination of staff privileges because of constitutional guarantees of due process (Anton, supra, 824), and because nonjudicial bodies do not possess adjudicatory power under the Constitution (Id., 822). Since Anton, supra, held that independent judgment review is required by the Constitution in reviewing

a decision of a private hospital board which affects a fundamental right, such as the right to retain staff privileges, it is our opinion that Senate Bill No. 1472 could not be constitutionally applied in such cases.

Bion M. Gregory
Legislative Counsel

By
William K. Stark
Deputy Legislative Counsel

WKS:mcj

Two copies to Honorable Peter H. Behr, pursuant to Joint Rule 34.

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Senate

CALIFORNIA LEGISLATURE

PETER H. BEHR
SENATOR
MARIN, SONOMA, MENDOCINO, LAKE, HUMBOLDT
AND DEL NORTE COUNTIES

STANDING COMMITTEES:
CHAIRMAN, INSURANCE AND FINANCIAL INSTITUTIONS
EDUCATION
FINANCE
NATURAL RESOURCES AND WILDLIFE

JOINT COMMITTEE:
FAIRS ALLOCATION AND CLASSIFICATION

September 27, 1978

The Honorable Edmund G. Brown, Jr.
Governor of California
State Capitol
Sacramento, CA 95814

Dear Governor Brown:

This is a follow-up to my previous letter on SB 1472, legislation which is enrolled and before you for your signature.

Legislative Counsel has submitted to you a report which states their belief that SB 1472 would not be constitutional as applied to private hospital board decisions affecting staff privileges. Without questioning the integrity of Legislative Counsel, for which I have a high regard, I would like to suggest that the question of SB 1472's constitutionality deserves the opportunity to be resolved in court.

The policy issues of peer review in this legislation are straightforward, however, the case law is not. It was with full knowledge of both the legal questions involved and the eventual need to resolve them in court that I proceeded with this bill. I believe that the questions of public policy regarding peer review and the authority of private hospital boards to discipline staff members warrants final resolution in court. Such resolution is possible only if SB 1472 is approved by you.

Sincerely,

Peter H. Behr

PETER H. BEHR

PHB:kfr

Lumetra

Brighter insights. Better healthcare.

Comprehensive Study of Peer Review in California: Final Report

July 31, 2008

Prepared By:
Jean Ann Seago, PhD, RN
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Barbara McDougall, RN, BA
Michelle Fernandez, MPH
Alan Giberson, MD, MPA
Pat Daniel, RN

This report was prepared by Lumetra under contract with the Medical Board of California (MBC).

Acknowledgments

Medical Board of California: Executive Director Barbara Johnston, Deputy Director Kim Kirchmeyer, Susan Cady, Laura Sweet, and Marg Bromagem

Lumetra: Lewis Anderson; Marcus Gonzalez; Sue Jackson, RN, BSN; Susan Merrill, PhD, MPH; Daisy Okamura; Cynthia Purchase; Aaron Rabideau; Fabio Sabogal, PhD; Linda Sawyer, PhD, RN; and Annie Wing

All study participants and entities

Funding: Medical Board of California

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Executive Summary

In October 2005, Governor Arnold Schwarzenegger signed into law California Senate Bill 231 (Figueroa), which, among other things, amended the California Business and Professions Code 800, including Section 805.2.

Section 805.2 provided for a comprehensive study of the physician peer review process, as conducted by peer review bodies. Another equally important component of this study was to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusively, and their relevance to the conduct of peer review in California, since they play such a critical role in ensuring quality medical care.

Lumetra, a non-profit healthcare consulting organization with 24 years of experience in California, was selected as the independent entity to conduct this peer review study, which was to be completed by July 31, 2008. The study, designed around the requirements of the 805.2 legislation, focused on four entities involved in peer review activities: 1) Licensed healthcare facilities/clinics, 2) Healthcare service plans, 3) Professional societies, and 4) Medical groups. The research was quantitative and qualitative, cross-sectional, retrospective, and descriptive. Multiple data collection methods were employed, including document review, surveys, focus groups, key informant interviews, and onsite visits.

The study generated controversy and anxiety among the four entities, particularly hospitals. Their concerns ranged from the time and expense to provide documents for review to reluctance in releasing legally protected information for "fear" of discovery. Lumetra was able to respond to and overcome these barriers and produce statistically valid findings from the data that were collected from study participants.

This report presents these findings, which enabled us to draw several conclusions about the state of peer review in California and make sound recommendations to improve the current system.

Findings

The complete findings are presented in Chapter IV: Results. One finding that was apparent is that the present peer review system is broken for various reasons and is in need of a major fix, if the process is to truly serve the citizens of California. This report cites the inconsistencies in the way entities conduct peer review, select and apply criteria (e.g., implicit vs. explicit review), and interpret the law regarding 805 reporting and 809 hearings.

These variations can result in physicians continuing to provide substandard care (at times for years) impacting the protection of the public. We also found that, although entities make a sincere effort to conduct peer review, it rarely leads to actual 805 or 809 actions, perhaps due to the confusion over when to file a report. And there is evidence that entities do not understand what should trigger a peer review, 805, or 821.5 reporting. Additionally, the costs in time and money associated with 805 reporting are high and may influence an entity's desire to actively pursue a case against a physician and choose a less expensive alternative (e.g., resignation, remediation, etc.).

This study also examined the role of the Medical Board of California (MBC) and assessed its effectiveness in the regulation of the practice of medicine in California. We found the MBC procedures for the complaint and enforcement process and the rules for public disclosure to be complex and multi-layered. The MBC is sometimes viewed as only intermittently responding to 805

reports (particularly focusing on those events that result in patient harm), unacceptably delaying the response, and failing to report public information. While the MBC obviously has earnest intentions about protecting the public's health, its bureaucracy and current mode of operation may create barriers. And in all fairness to the MBC, it is somewhat hampered by current laws and legislation.

Recommendations

The study findings led to recommendations that are logical, practical and, most importantly, achievable. They also address the relevant study requirements specified in the 805.2 legislation. The complete list of recommendations appears in Chapter V.

One major recommendation is to re-design the peer review process, including establishing a separate, independent peer review organization that has no vested interest in the review outcome, except the protection of the public. Each of the four entities would still provide the first level quality/safety screening of the physician practice, but the independent agency would assume the responsibility for making decisions about any actions toward the physician, including 805 or 821.5 reporting. The establishment of an unbiased third party would eliminate the inconsistencies, variations, and conflicts of interest that confront and baffle entities that perform peer review. The MBC would continue to investigate all 805 reports and make determinations about any license actions.

Less dramatic but equally important recommendations involve correcting the transparency issue (e.g., through improved public disclosure), emphasizing credentialing and re-credentialing as a means to identify and further investigate potential physician practice problems, and promoting education to better inform physician and entities about peer review and 805 and 809 reporting criteria. We recommend that the codes be clarified, especially as they relate to the timing of when to report an 805. We also offer suggestions on ways to fund these recommendations that would not involve increasing taxes or diverting State funds.

Finally, we emphasize the importance of pilot studies and program evaluation in implementing any system change and recommend that any change be phased in over time to allow adjustments by the affected systems and entities.

Lumetra appreciates the opportunity to have a major role in trying to measure, evaluate, and improve peer review in California.

Chapter I: Introduction

In October 2005, Governor Arnold Schwarzenegger signed into law California Senate Bill 231 (Figueroa), which, among other statutory changes, amended the California Business & Professions Code 800, including Section 805.2.

Briefly, it is the intent of 805.2 "to provide for a comprehensive study of the peer review process, as it is conducted by peer review bodies," by an independent firm selected by the Medical Board of California (MBC). A primary goal of the study is to "evaluate the continuing validity of Section 805 and Sections 809 and 809.8, inclusive, and their relevance to the conduct of peer review in California." The due date for the written report of this study was extended to July 31, 2008 (from the original due date of July 31, 2007).

This Report details the findings of the Peer Review Study for the Medical Board of California and the California State Legislature. It encompasses the 10 required components of the Study, as dictated by Section 805.2.

Table 1.1 lists the ten required components for the Comprehensive Study of Peer Review (Peer Review Study) and the mechanisms used by Lumetra to satisfy each component.

Table 1.1: Comprehensive Study of Peer Review Report Components

Comprehensive Study of Peer Review Components[1]	Mechanism Used by Lumetra
1) A comprehensive description of the various steps of and decision makers in the peer review process as it is conducted by peer review bodies throughout the State, including the role of other related committees of acute care health facilities and clinics involved in the peer review process.	Entity documents, surveys, site visits
(2) A survey of peer review cases to determine the incidence of peer review by peer review bodies, and whether they are complying with the reporting requirement in Section 805.	Entity documents and site visits
(3) A description and evaluation of the roles and performance of various State agencies, including the State Department of Health Services and occupational licensing agencies that regulate healing arts professionals, in receiving, reviewing, investigating, and disclosing peer review actions, and in sanctioning peer review bodies for failure to comply with Section 805.	MBC site visit and data analysis
(4) An assessment of the cost of peer review to licentiates and the facilities which employ them.	Survey and focus groups
(5) An assessment of the time consumed by the average peer review proceeding, including the hearing provided pursuant to Section 809.2, and a description of any difficulties encountered by either licentiates or facilities in assembling peer review bodies or panels to participate in peer review decision-making.	Survey and focus groups
(6) An assessment of the need to amend Section 805 and Sections 809 to 809.8, inclusive, to ensure that they continue to be relevant to the actual conduct of peer review as described in paragraph (1), and to evaluate whether the current reporting requirement is yielding timely and accurate information to aid	Survey, focus groups, and key informant interviews

Comprehensive Study of Peer Review Components[1]	Mechanism Used by Lumetra
licensing boards in their responsibility to regulate and discipline healing arts practitioners when necessary, and to assure that peer review bodies function in the best interest of patient care.	
(7) Recommendations of additional mechanisms to stimulate the appropriate reporting of peer review actions under Section 805.	Survey, focus groups, and key informant interview
(8) Recommendations regarding the Section 809 hearing process to improve its overall effectiveness and efficiency.	Survey, focus groups, and key informant interview
(9) An assessment of the role of medical professionals, using professionals who are experts and are actively practicing medicine in this State, to review and investigate for the protection of consumers, allegations of substandard practice or professional misconduct.	Surveys, key informant interviews, and MBC visit and data analysis
(10) An assessment of the process to identify and retain a medical professional with sufficient expertise to review allegations of substandard practice or professional misconduct by a physician and surgeon, if the peer review process is discontinued.	Surveys, key informant interviews, and MBC visit and data analysis

Following a competitive review process, the MBC selected Lumetra as the independent firm to conduct the Peer Review Study.

As an independent healthcare consulting firm with nearly 24 years of experience in healthcare program evaluation and peer review analysis in California, Lumetra understands well the nuances and political landscape of California's variety of healthcare entities, including hospitals, clinics, health plans, medical groups, and professional entities and societies - the key targets of this study.

Section 2220.1 provided for the appointment of an independent enforcement monitor, charged with evaluating "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system."

In November 2005, the MBC and the legislature received the final report from the Enforcement Monitor[2, 3]. Two of the findings, listed below, are related to the work of this study, because they describe limitations of the MBC.

> "...5. **Many of MBC's most important detection mechanisms are failing it.** Despite the extensive "mandatory reporting scheme" set forth in Business and Professions Code section 800 et seq., the Medical Board is not receiving information to which it is statutorily entitled (underlining added for emphasis) about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law - information that enables MBC to detect possible physician wrongdoing, investigate, and take disciplinary action as appropriate.
>
> Further, physicians themselves routinely conceal information about their own misconduct from the Board through the insertion of **"regulatory gag clauses"** (underlining added for emphasis) — provisions that prohibit an injured plaintiff from complaining to or cooperating with the Medical Board — into civil malpractice settlement agreements....

6. **The Medical Board's public disclosure policy is insufficient.** The Board's complex public disclosure statutes and regulations – which have evolved in patchwork-quilt style over the past decade – do not allow the Board to disclose sufficient information about physician conduct and history (underlining added for emphasis) to enable patients to make informed decisions about their physicians (p. ES-5)..."[3].

The Legislature took steps to address the recommendations in the final Fellmeth and Papageorge report, including closing the gag clause loophole[3]. However, it is not clear that the MBC is even now receiving information "to which it is statutorily entitled," nor is it clear that the MBC is able to "disclose sufficient information about physician conduct and history" to protect the public.

In preparing this report, we note the following exclusion and limitation to this study. The Peer Review Study excludes Allied Health Licensing Programs (AHLP). The MBC serves not only physicians and surgeons, but also several "allied health licensing programs" that regulate non-physician healthcare practitioners.

In recent years, most AHLPs have successfully sought legislation creating discipline-specific boards. However, some of them still contract for the use of components of MBC's enforcement program to varying degrees. Because the intent of SB 231 (Figueroa) was to assess the physician and surgeon peer review programs, we have generally excluded peer review of AHLP. Additionally, the AHLP reviews constitute only a small proportion of overall MBC workload.

A limitation of this report was the reluctance of many of the entities, particularly hospitals, to provide access to documents (specifically peer review committee minutes) needed to estimate the efficacy and efficiency of peer review.

Although the legislation (and subsequently the law) states that any documents provided to the independent entity are not "discoverable," several entity staff members reported that hospital attorneys had advised clients to not provide peer review committee minutes because of California Evidence Code 1157. Therefore, verification of hospital compliance with policies and bylaws was difficult.

In some cases, the entities **only** communicated with Lumetra through attorneys. In spite of these obstacles, Lumetra reviewed documents from 68 entities (excluding site visits) from the four entity types and was able to estimate the overall efficacy of medical peer review process in the State.

This report is organized as follows:

- Chapter I is an introduction.
- Chapter II provides the background and significance of the study.
- Chapter III discusses the study methodology and details each study component and mechanism used to collect data for each component.
- Chapter IV presents the study results.
- Chapter V provides conclusions and recommendations based on the findings.

Chapter II: Background and Significance

Introduction

In order to understand the complexity and challenge of Sections 805, 821, and 809, and their requirements, Chapter II provides a background of the MBC, an overview of medical peer review, a historical perspective which has significantly influenced the peer review process, and the relevant codes and regulations that govern the practice of medicine in California today.

Medical Board of California

The Medical Board of California (MBC) is a State government agency, which licenses and disciplines medical doctors. In 2007, the MBC regulated 124,056 physicians, 96,299 of whom resided in California. The MBC receives no funding or support from the State's general fund, rather it is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a "special-fund agency." The California Business and Professions Code, Section 2001.1, defines the highest priority of the Medical Board as:

> "Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount"[4].

The Board provides two principal types of services to consumers: 1) public-record information about California-licensed physicians and 2) investigation of complaints against physicians[4].

The Board does not regulate health plans or insurance companies. The Department of Managed Healthcare (http://www.dmhc.ca.gov/default.aspx), in the Business, Transportation and Housing Agency, regulates California health plans, and the Department of Insurance (http://www.insurance.ca.gov/) regulates insurance companies in the Executive Branch of State government[5].

Although physicians are closely associated with hospitals and clinics, those facilities are regulated by other agencies. The California Department of Public Health (CDPH) (http://www.cdph.ca.gov/Pages/default.aspx), within the California Health and Human Services Agency (CHHS) (http://www.chhs.ca.gov/Pages/default.aspx), regulates hospitals and clinics. However, the California Department of Healthcare Services (DHCS) (http://www.dhcs.ca.gov/Pages/default.aspx) contracts for Medi-Cal and other services and, therefore, has some regulatory relationship with primary and rural health (which includes come clinics and hospitals), and long term care.

The MBC is semi-autonomous in that its members make final licensing and enforcement decisions (subject to judicial review). MBC was composed of two autonomous divisions - the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). These two divisions were abolished, effective January 1, 2008, by AB 253.

Now, the Board as a whole manages the business that was formerly managed by the two divisions. The Board focuses on the licensure of physicians and the regulation of several non-physician healthcare professions, oversees a large enforcement staff, and adopts final decisions in disciplinary matters against licensees[3, 6].

Overview of Medical Peer Review

In academia, scholars use peer review as a way to subject their work to criticism by discipline-specific experts. It serves to help normalize high standards and expectations and prevents unwarranted conclusions or interpretation in research. The notion of medical peer review is similar, that is to review and critique the work of a colleague in order to maintain high standards of medical care. It has been defined as:

> "a process where selected members of the medical or other professional staff review the basic qualifications (credentials), medical outcomes and professional conduct of other physicians or licensed professional members and staff applicants, to determine whether the professional may practice or continue to practice in the hospital or other clinical setting and, if so, to determine the parameters of their practice" (p. 1)[7].

There is a long history of the relationship between hospitals and physicians related to patient quality and safety. Prior to 1846, hospitals were essentially almshouses for the poor that gradually became a place to care for the sick. With the advent of anesthesia in 1846 by Morton, the emphasis on sanitation by Nightingale in the Crimea in 1854, and Lister's work in antiseptics in 1867, hospitals began to become safer for surgical patients[8]. During the late 19th century, the hospital medical staff members could generally be categorized as:

1. Consulting physicians who had no regular duties
2. Resident or house physicians who supervised treatment
3. Residents or house physicians in training who carried out treatments
4. Dispensary physicians who saw outpatients

Hospitals paid none of these doctors for their work. The physicians provided their services without pay in order to train, have access to surgical suites, gain prestige, and add patients to their private practices. A small elite group of physicians held hospital appointments (privileges), and physicians outside that elite group resented the "unjust" control exerted by a "ring of monopolists" (p. 166)[8].

Generally, the American College of Surgeons is credited with beginning medical peer review in 1918[9] or 1919[8] as part of its Hospital Standardization Program. The medical staff members of hospitals were required to be "competent reputable physicians abide by formal bylaws, and hold monthly meetings and reviews of clinical experiences" (p. 107)[8].

However, Glaser wrote in 1963, "...Granting or withdrawing hospitalization privileges [in other countries] cannot be used to regulate professional and personal behavior; in fact, this use of hospitalization privileges makes America one of the few countries with any controls over the quality of private practice" (p. 54)[10].

In contrast, Starr opined that it was never clear that withdrawing hospital privileges was effective at raising quality of private practice, but there was no doubt that it was used to exclude undesirables[8]. He maintained that it was used to exclude black doctors and "anyone else who threatened to rock the boat" (p. 168)[8]. So, from the beginning of modern medical care in the US, physicians, surgeons, and hospitals were mutually dependent, physicians were generally not paid for their work in the hospital, and granting or withholding hospital privileges was used to try to ensure quality care, but was also thought to be used for "political" reasons, such as excluding "undesirables."

It is not surprising that the question of whether peer review and restriction of hospital privileges are used to exclude "undesirables" remains. The phrases "sham peer review" or "peer review injustice" refer to the use of the peer review process to eliminate "mavericks, whistleblowers, rivals, and nonconformists" (p. 1)[11].

These issues are often raised by physicians who have had negative experiences with peer review. Others in the medical-legal community claim that this is just "sour grapes" from people who deserved disciplinary action. However, there are such a growing number of concerns raised about peer review injustice, that it has become more difficult to ignore the complaints.

The Association of American Physicians and Surgeons has a Web page listing numerous opinion pieces, presentations, news reports, and court causes related to sham peer review[12]. A physician from that organization opines that the sham process "begins in the minds of those who set out to destroy a targeted physician" (p. 3)[13].

Others use stronger language to describe sham peer review in medicine calling it "workplace mobbing" and allege that it is used to rid an entity of a troublemaker or to rid an "insider" physician of a competitor[14]. This is reiterated in a publication describing the peer review process as "misused, ineffective, and corrupt"[11].

The literature mentions two general types of peer review: implicit and explicit. Implicit peer review relies on expert judgment and is typically performed by a physician. Explicit peer review, frequently used by nurses, involves applying a specific set of criteria[15].

Evidence of reliability of the methods is mixed. A report comparing the two methods found many discrepancies in findings. In the discordant cases, physicians tended to find quality problems unavoidable, there was no adverse outcome, or they were present on admission[16]. Another report found unstructured implicit review was not a reliable method for determining error and measuring compliance with standards[17]. However structured implicit review tended to be moderately reliable and certainly more reliable than unstructured implicit review[15, 18, 19].

Peer review in the U.S. is closely related to the credentialing and re-credentialing of providers, the method used to restrict or allow hospital privileges, and it continues to be linked with disciplinary action in the form of allowing or withdrawal of hospital privileges[7]. Although there was a movement by hospitals in the 1980s and 1990s to focus on systems analyses rather than individual blame to control error, the difficulty of changing systems provided a barrier to this notion. Therefore, individual blame continues to be a large part of error management in hospitals.

In medical-care-providing entities, quality, risk, or error management customarily begins in one of several ways:

1. A complaint
2. As the result of a routine quality screening study
3. A sentinel or egregious event
4. An unexpected adverse outcome or other triggers

The issue/case then goes before one or more peer review bodies. There may be one of several results of the peer review investigation within the entity that affects the physician:

1. Nothing
2. Mandatory education or training
3. Monitoring or proctoring procedures and practices
4. Mandatory behavior counseling or some variant
5. Change/restriction in privileges
6. Summary suspension or termination.

Some of these results require reporting to state or national agencies and may have an impact on the physician's livelihood and ability to work. But whether the result is positive or negative for the physician, the peer review process is a significant part of the investigation and any discipline that occurs. Because of the link between peer review and disciplinary action, physician generally are apprehensive about the process of peer review, whether as a recipient or as a reviewer.

If the event that triggered the peer review investigation meets the criteria for reporting to a state medical board, disciplinary action by the medical board may occur. A number of studies have reported characteristics of physicians who have been disciplined by medical boards, including being male[20-23], not being board certified[20-22, 24], not being white[21], being a foreign medical graduate[21, 22], and increasing age[22, 25].

Specialties that tend to be disciplined more frequently include anesthesia, psychiatry, internal medicine/family practice, obstetrics and gynecology, and emergency medicine[21-24, 26]. Interestingly, lower patient-provider communication scores were associated with higher numbers of retained complaints made to regulatory authorities[27].

The complaints were both communication-related complaints and quality-of-care complaints. Also, lower scores on traditional written examinations that tested clinical decision-making at the end of medical school were also associated with higher numbers of communication and quality of care complaints[27]. Among other findings, these studies provide support for the notion that foreign medical graduates and non-whites are disciplined more frequently than U.S.-trained graduates and whites.

One of the most difficult issues facing entities is working with a physician who is incompetent, disabled, disruptive, or impaired[28, 29]. Leape has suggested categorizing "problem doctors" as psychopathic, impaired, demonstrating declining competency, or demonstrating behavioral problems[28]. These categories are not mutually exclusive, and one type of issue frequently is related to another.

The most common reasons for disciplinary actions taken by medical boards against physicians are impairment related to drugs or alcohol, negligence or incompetence, and drug-related charges/inappropriate prescribing practices[20, 24]. The issue of incompetence, dyscompetence[30], or underperformance are often addressed first by recommending or requiring continuing medical education (CME) or skill training and monitoring or proctoring[31, 32]. However, it has not been demonstrated that CME or skill training is effective in changing practice behavior of physicians[25]. There is evidence that some physicians who are incompetent have some type of cognitive impairment that accounts for the poor performance. This cognitive or neuropsychological impairment has been found more frequently in the elderly physician[33, 34].

An even more difficult issue facing entities is managing the physician with cognitive difficulty, alcohol or drug impairment, or disruptive behavior. The latter is typically defined as the use of profane or

disrespectful language, demeaning behavior, throwing instruments, and anger outbursts, among others[28]. Entities typically ignore these behavior problems for extended periods of time and may not manage them at all[28].

Some state medical boards have developed diversion programs that seek to monitor physicians with drug or alcohol problems rather than discipline them. The programs became popular in the 1980s with California creating the first such program in 1980[35]. Initially, evidence indicated that this program was successful in encouraging the treatment of physicians[36]. However, the California Medical Board recently voted to terminate the program effective 2008 after multiple audits determined that the program did not protect patients[37].

Malpractice litigation increased between 1840 and 1850[38]. If a medical error led to patient injury, the patient had the option of suing the physician for malpractice. Previous to that time period, medical doctors had advertised flamboyant successes and made exaggerated claims of cures. Additionally, there were few regulatory statutes or professional standards of medical practice and education[38]. The public became unwilling to tolerate unfavorable medical outcomes. Other issues were involved, but also during this time, the relationship between doctors and lawyers deteriorated and remains tenuous today.

Malpractice litigation also encouraged and continues to encourage holding individual providers accountable for poor outcomes and perpetuates the blaming of an individual rather than considering systematic problems as the cause. Risks of malpractice litigation include being a surgeon and having a higher number of patient complaints and increased patient volume[39]. Interestingly, the majority of technical errors in surgery were associated with experienced surgeons. These errors occurred in routine operations and involved patient-related complexity[40].

Errors and the threat of malpractice take a toll on physicians as well as on patients. There is evidence that some specialty physicians reduce the number of high-risk procedures they perform in order to control their risk of malpractice litigation. Some neurosurgeons in Florida are reported to have reduced the volume of brain surgeries they perform, and patients have had to travel longer distances to obtain care[41].

Physicians report increased anxiety, sleep loss, job dissatisfaction, and harm to their reputation following serious errors[42, 43, 44]. In 1975, California legislators passed the Medical Injury Compensation Reform Act of 1975 (MICRA)[45], codified in the California Civil Code Section 3333.2. Medicine and hospital trade entities hailed this legislation as the action that kept doctors' offices opened and increased patient access to healthcare. Others note that malpractice litigation has declined in California since the legislation was passed and that the $250,000 limit on "pain and suffering" has not been altered since 1975.

Disclosure of errors to patients and reporting of errors are topics that often leave physicians conflicted. Generally, physicians want to be transparent but are fearful of litigation, embarrassed, or unsure of the best way to disclose[42, 46, 47]. Some reports provide evidence that disclosure of errors to patients is associated with a reduced likelihood in the patient changing physicians, increased patient satisfaction, trust, and a positive emotional response. However, there was mixed evidence about whether the patient was likely to seek legal advice[48, 49]. Another report found that disclosure was not associated with reduced litigation volume or cost[50].

Today, hospitals typically do not "employ" most physicians, although there are exceptions (i.e., contracted anesthesiologists, ED physicians, and hospitalists). Rather, the relationship of mutual

benefit between physician and hospital persists as it has in the past. There is no "employer-physician" relationship, and physicians perform work at the hospital, such as participating in peer review, usually without compensation in exchange for the privilege of admitting patients. Additionally, there are few recognized employee-employer safeguards in the hospital-physician relationship, other than those provided in the medical staff bylaws or those that can be won in litigation[51].

Because the physician needs a place for acutely ill patients and the hospital needs patients, the relationship is generally smooth. However, when there are potential quality issues, there are several liability "landmines": 1) anti-trust issues; 2) due process issues; and 3) ethical dilemma issues[51]. Although legal protection exists, there is the potential that a reviewed physician, whose privileges have been terminated, might litigate alleging that the peer review (or reviewer) was used to eliminate competition[52]. This type of litigation generally fails, as long as the decision was made in good faith[51].

Another potential litigation issue is the allegation of the denial of the protection of due process. Because of a number of successful lawsuits related to due process, such as Potvin v. Metropolitan Life Insurance Company[53], hospitals feel compelled to err on the side of caution and increase the number of protections for the physician[51]. In that case the California Supreme Court held that a managed care entity cannot terminate one of its panel physicians unless it accords that physician a fair hearing with basic due process protections[53].

Another issue of concern is that of the ethical dilemma. When reporting an error or reporting a colleague, the individual will weigh the consequences of the actions that might be taken:

- Potential improvement of patient care quality and safety and knowledge that you are doing the right thing, versus,
- Potential for anti-trust or due process violation litigation and potentially creating a rift among the medical staff group that may lead to tension, a loss of referrals, and/or a decrease in peer cooperation (such as emergency coverage for your patients)[51].

As discussed previously in regard to disclosure, physicians are generally moral individuals who try to do the right thing, but the negative consequences of reporting are significant and will undoubtedly be weighed by thoughtful, intelligent people.

805 Reporting – A Historical Perspective

In 2001, the California legislature added Section 805.2 to the Business and Professions Code requiring the MBC to contract with the Institute of Medical Quality, a subsidiary of the California Medical Association, to engage in a comprehensive study of the way in which peer review was actually conducted in California at that time, and to compare the process with the reporting language in section 805. The study report was to be completed by November 1, 2002, which was later extended to November 1, 2003[54].

When the study was not performed due to budget shortfalls, SB231 (2005) amended 805.2 to require MBC to contract with an independent entity to conduct the 2001-mandated study by July 31, 2007. The 2007 deadline was later extended to July 31, 2008[3].

The specific language and requirements of the study of peer review is documented in Table 1.1. The peer review process, as defined in the legislation, is essential to maintaining safe, quality medical care for California citizens. However, the peer review process is obscure[55], and it is not clear that the MBC receives reports as required by law.

Based on absolute numbers, 805 reporting has varied over time and, based on number of reports adjusted for population of citizens or population of physicians, the number has declined (see Figures 2.1, 2.2, 2.3, and 2.4). This decline is not an isolated event to California. The January 1995 Newsletter of the California Medical Board stated, "Over the past year, we have noted deterioration in the cooperation required between hospitals and the Board in protecting consumer/patient safety. We have experienced incomplete reports, and on some occasions, excuses for not reporting at all[56].

The Federation of State Medical Boards reported a decline in reports of disciplinary actions against physicians by medical boards in the U.S. beginning in 2005 and continuing through 2006 and 2007[57, 58]. Baldwin et al reported a low and declining level of hospital privileges action reporting to the National Practitioner Data Bank between 1991 and 1995[59]. The Office of the Inspector General reported that as of September 30, 1998, only about 67 percent of U.S. hospitals had made a report[60], and issued another report in 2001 warning that the database was underused[61].

Historical events in the State and nation likely influenced the number of 805 reports submitted to the MBC (see Figure 2.1). In the mid-1990s, managed care penetration increased substantially in California with the objective of controlling costs[62, 63]. Hospitals instituted dramatic staffing reductions.

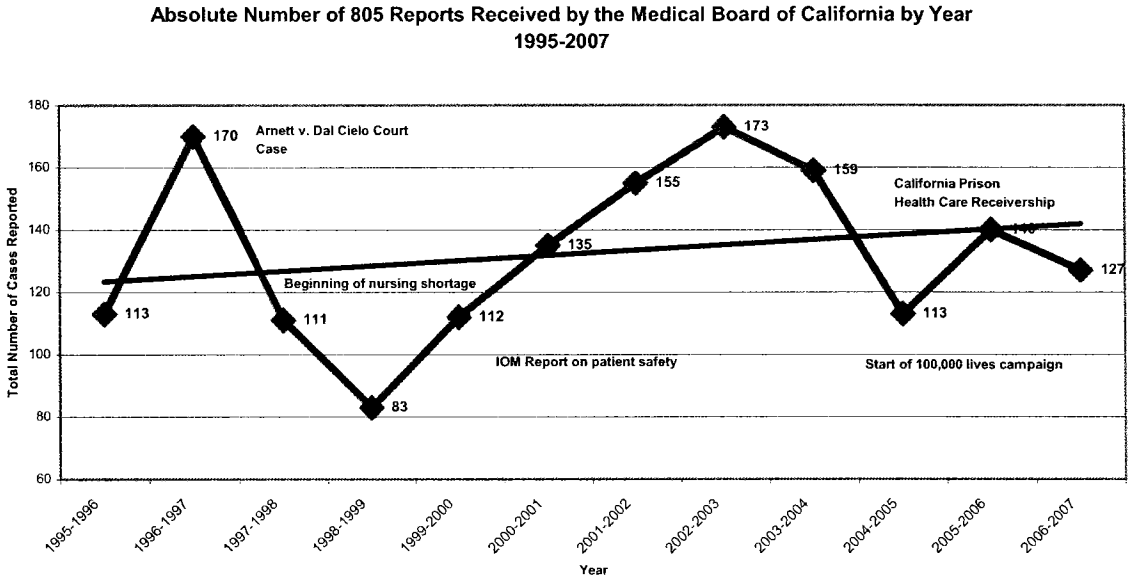
In 1996, the California Supreme Court clarified that a subpoena of peer review records by the Medical Board did not constitute "discovery" in the legal sense[64] and the Board had the right to enforce its subpoena for such records. This may have affected responses to 805 reporting and likely made entities more cautious and more reluctant to provide any information, other than what was specifically subpoenaed.

In 1997, the federal government passed the Balanced Budget Act[65], which put more financial pressure on hospitals and health plans to curb costs. The latest and very substantial nursing shortage started in hospitals in California in 1998[66, 67], and in 1999 California passed the first mandated hospital nurse to patient ratios legislation in the United States[68, 69]. This added more financial pressure on hospitals.

In 2000, the Institute of Medicine published To Err is Human[43], which generated publicity and interest in medical errors, particularly in hospitals. Even though the wording is "medical errors," it should be remembered that physicians are not responsible for all "medical" errors in hospitals. Many medical errors are related to the complex and chaotic systems in U.S. hospitals. (Note: This report will address complaints, errors, and events directly related to physician medical practice, not to system errors in the study entities.)

Figure 2.1 graphs the absolute number of 805 reports and includes major historical events that occurred over the 12-year period between 1995 and 2007. The added trend line indicates that the number of 805 reports increased during those years.

Figure 2.1: Absolute Number of 805 Reports Received by the Medical Board of California by Year, 1995-2007



However, if you adjust the number of 805 reports received by the MBC for the number of MDs licensed by the State (see Figure 2.2), the number of MDs licensed and living in California (see Figure 2.3), or the number people living in California (see Figure 2.4), the trend lines show a downward direction.

Figure 2.2: Number of 805 Reports per 1000 MDs Living Both In and Out of California by Year, 1995-2007

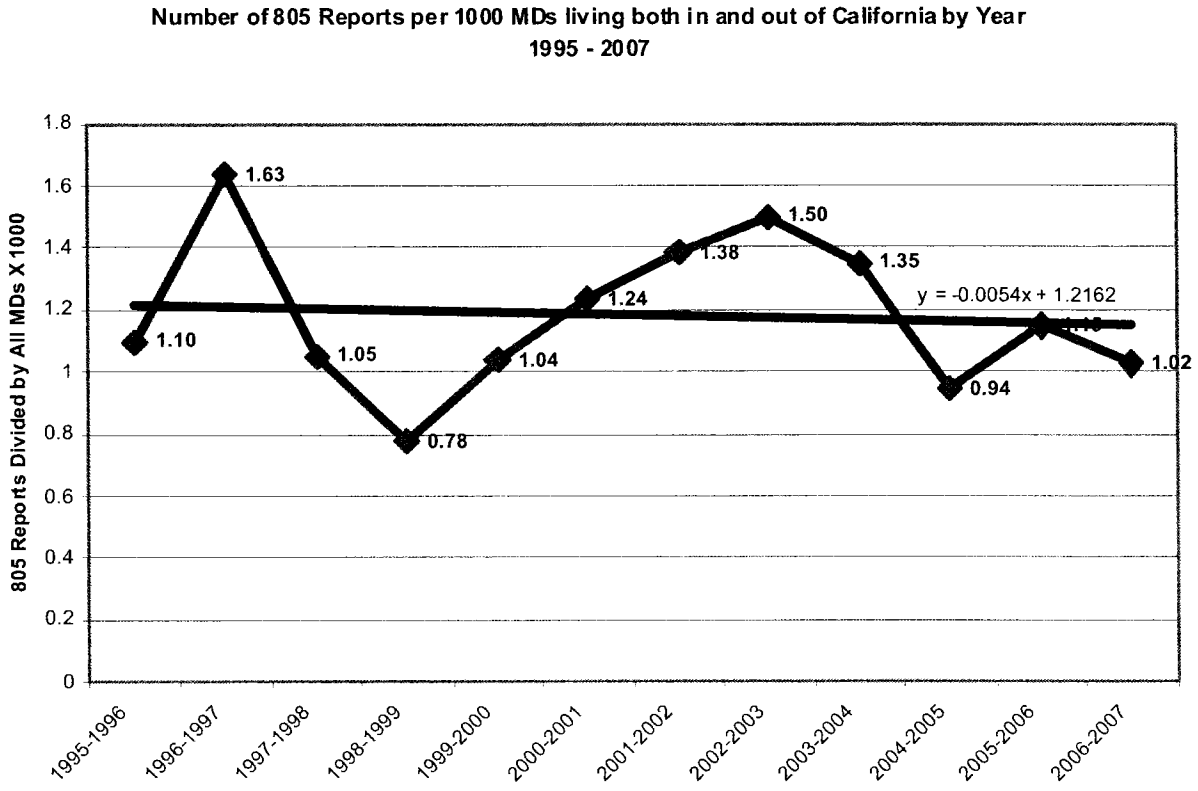


Figure 2.3: Number of 805 Reports per 1000 MDs Living in California by Year, 1995-2007

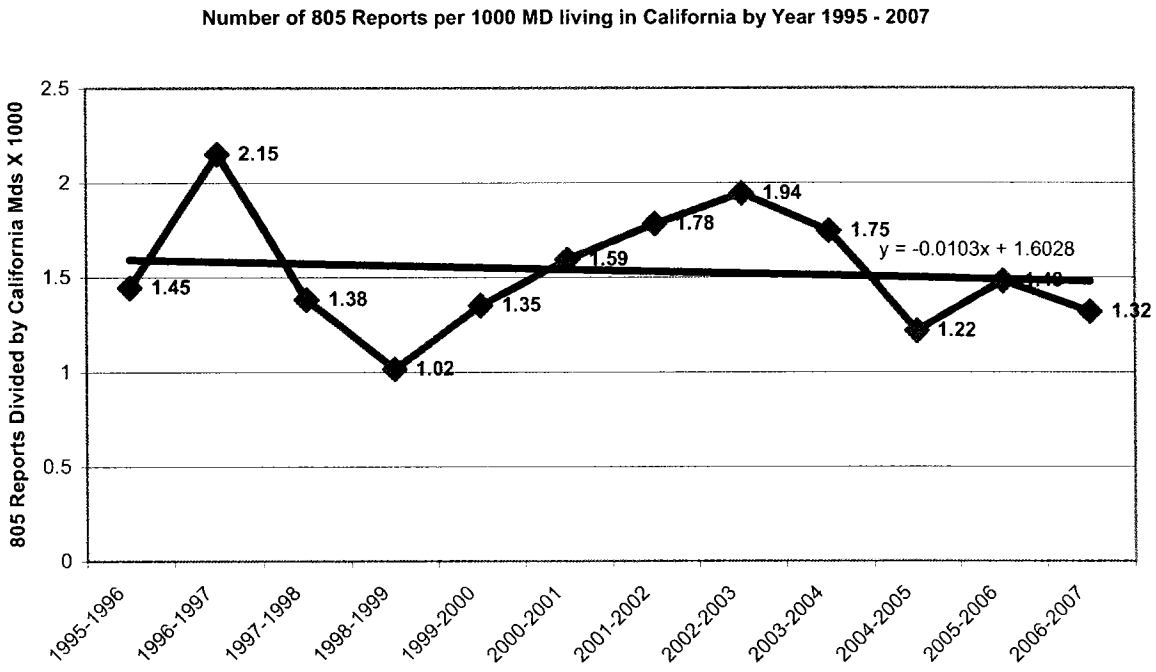
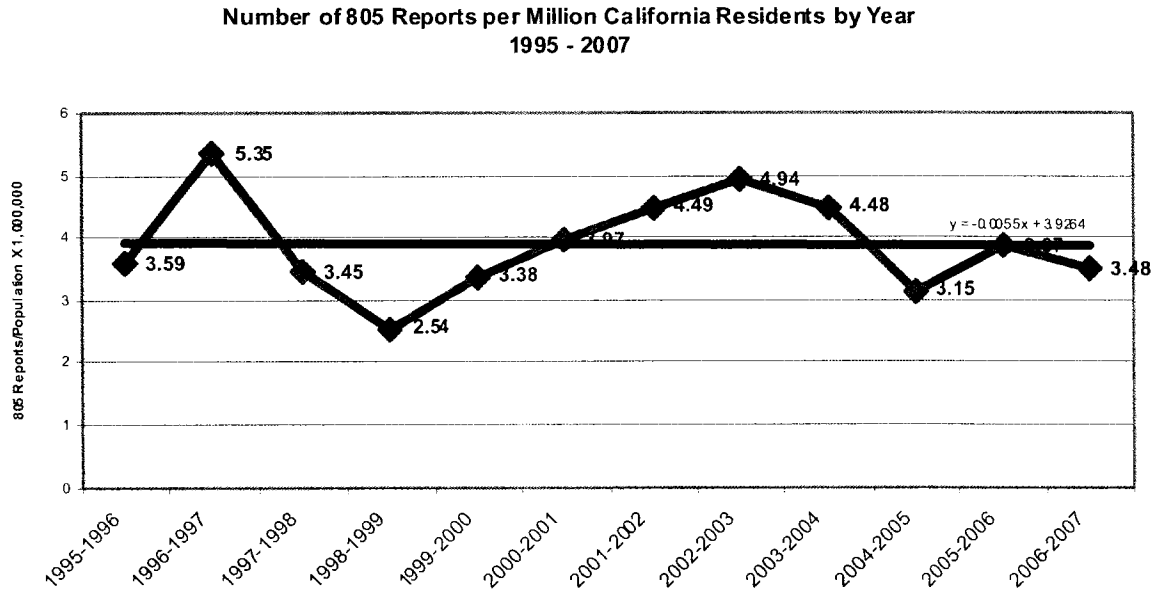


Figure 2.4: Number of 805 Reports per Million California Residents by Year, 1995-2007



These historical events likely influenced the California legislators to become interested in evaluating the mechanisms, such as peer review, used to assess medical care in the State. In this matter, the California Legislature was prescient. In 2005, the Federation of State Medical Boards announced

that reports of disciplinary actions against physicians by U.S. state and territory medical boards had declined in 2005 for the first time in eight years and declined again by 4.6% between 2006 and 2007[57, 58]. The time for this evaluation of peer review is entirely appropriate.

The Challenge and Future of Peer Review

In the years since 1918, the provision of medical care has evolved into a multi-national industry that includes numerous ancillary providers, mid-level providers, administrators, insurers, federal and state laws, attorneys, and others. Some of the questions raised during the early 19th century are still being raised today:

1. Should physicians be paid for work such as peer review in the hospital?
2. Are peer review and discipline using the withdrawal of hospital privileges effective in ensuring quality care?
3. Are peer review and exclusion from hospital privileges done for "political" reasons?

Some entities and states have proposed or tried new ways to determine quality and safety in medical care. Since 1987, the Massachusetts Medical Board has required all hospitals, physicians, and clinics to report adverse events through the Patient Care Assessment (PCA) program. All unexpected deaths and major complications must be reported quarterly through this confidential program, which is protected from legal discovery. A somewhat unique advantage of the Massachusetts Medical Board is that it has extensive authority over physician practice and healthcare facilities in the areas of quality, safety, and error prevention[70].

The Texas State Board of Medical Examiners uses an investigations process that includes the informal show compliance (ISC). The ISC is a mechanism that allows the physician to show that he or she has not violated the medical practice act. The physician can provide written documents and/or make a personal appearance and is encouraged to engage the assistance of an attorney. This process is not recorded and the rules of evidence do not apply, but it allows the board to provide recommendations to the physician and attempt to reach an agreement informally[71].

Other entities have suggested using independent review entities and adjusting for patient risk[72], providing confidential ongoing feedback[73], establishing or designating independent federal oversight through Patient Safety Organizations (PSO) in the U.S. Department of Health and Human Services[74], and using centralized supervision or regulation, practice guidelines, information technologies, and continuous quality improvement activities[75].

The literature seems to indicate that professionals are questioning whether peer review should continue to be the primary way that medical quality and safety are estimated. Some have even questioned whether there is still any place for medical peer review in determining quality and safety of medical care[11, 15]. There is evidence that with structured implicit review, physician-reviewers are less likely to record poor quality in surgical patients presenting with an acute illness[19], and discussion between physician reviewers does not improve the reliability of peer review hospital quality[76]. Other evidence indicates that developing an enhanced peer assessment using trained peer assessors in one-on-one interactions is a promising method of changing physician behavior[77]. Other suggested strategies include using:

1. Performance assessment rather than peer review[78].
2. Multi-source feedback to assess physician competencies[79].

3. Specialty certification status to measure quality[80].
4. Administrative data for some types of complications[81].
5. Standardized patients (actors trained to present certain symptoms to train and evaluate practitioners) to evaluate decision making[82].
6. Clinical vignettes to measure quality of physician practice[83].

However, California codes require the use of peer review in healthcare entities as one of the processes for determining safe and effective medical care, and they are used in defining who is required to report medical events to the licensing board (see Table 2.6).

Codes and Regulations

The codes that govern the practice of medicine in California are extensive and complex, but it is necessary to have a basic comprehension of these statutes in order to understand the process of medical peer review and event reporting and the challenges they present in conducting this study. In order to explicate the complexity of the laws, we provide a partial list of codes and regulations in the following tables.

Many of the laws (codes) related to medical practice in California are contained in various sections of the **Business and Professions Code** (B&P) (see Table 2.1)[84, 85].

Table 2.1: Select California Business and Professions Code

Topic	Section
General Provisions	Section 500
Physician Advertising	Section 651
Medical Malpractice Reporting	Section 801
Medical Practice Act Internet Information on Doctors License Required and Exemptions	Section 2000 Section 2027 Section 2050
Medical Assistants	Section 2069
Physician and Surgeon Licensing Information Requirements for Licensure Foreign Medical Graduates	Section 2080 Section 2080 Section 2100
Continuing Medical Education Outpatient Surgery Settings Enforcement Unprofessional Conduct Prescribing/Dispensing Reinstatement of License/Modification of Probation Diversion Evaluation Committee Medical Corporations Renewal of Licenses	Section 2190 Section 2215 Section 2220 Section 2234 Section 2241 Section 2307 Section 2340 Section 2400 Section 2420
Alternative Practices and Treatments	Section 2500
Licensed Midwives	Section 2505
Research Psychoanalysts	Section 2529

There are other State regulations, codes, sections of codes, and case law that dictate the highly complex business and practice of the science and art of medicine (see Table 2.2 and Table 2.3). We reference these laws in this report because they are relevant to the study. For example, letters from study respondents (see Appendix III: Hospital Related Documents) highlight the fact that entity attorneys made numerous references to Evidence Code 1157 and the Lanterman-Petris-Short Act as reasons for not providing peer review minutes for the study.

Two more examples of relevant law to this study are the Dal Cielo case, which was described by participants as a turning point in the relationship between the MBC and hospitals, and the Patrick case which relates to the issue of peer review and the issue of antitrust liability. The other laws listed are related to the issue of quality of care.

Table 2.2: Other California Laws and Cases Relevant to Peer Review

Regulations, Codes, Case Law	Relevance to Medical Practice
Arnett v. Dal Cielo; CA Supreme Court 1996[64]	The Court ruled that an investigative subpoena issued by the Medical Board of California as part of its inquiry into the conduct of a physician with an apparent drug problem is not "discovery" within the meaning of Evidence Code 1157
CA B&P Code 2027[86], 805.5 and 803.1[1]	Definition of what is publicly disclosed by the MBC
CA B&P Code 2056[86]	Protects against retaliation for physicians who advocate for medically appropriate healthcare for their patients
CA B&P Code 2222.07[87]	Elimination of the "Gag Clause" in malpractice suits
CA Code of Regulations Title 22[88]	Governs many aspects of hospitals and hospital care
CA Code of Regulations Title 28, Division 1, Chapter 1 (Sections 1300.41-1300.826)[89]	Detailed regulations under which healthcare plans must operate
CA Evidence Code Section 1157[55]	Provides that the records of a hospital peer review committee are not subject to discovery
CA Health & Safety Code Section 1278.5 (aka Whistleblower Protection for Healthcare Workers)	Protects patients, nurses, members of the medical staff, and other healthcare workers if they report suspected unsafe patient care and conditions
CA Health & Safety Code Section 1340-1345 (aka. Knox-Keene Healthcare Service Plan Act of 1975)[45]	The set of laws that regulate health maintenance entities (HMOs) in CA
CA Welfare & Institutions Code Section 5000 (aka Lanterman-Petris-Short Act of 1972)[90]	To guarantee and protect public safety; to safeguard individual rights through judicial review, specifically mentally disordered persons and persons impaired by chronic alcoholism
Patrick v Burget and the Healthcare Quality Improvement Act of 1986; U.S. Supreme Court, 1988[91]	The Court ruled that the state action doctrine (Parker v Brown)[92] does not protect Oregon physicians from federal antitrust liability for their activities on hospital peer review committees

*partial list

There are other laws governing the medical profession and entities that provide medical and health care, which try to ensure quality and safety of patients. Multiple persons and entities are required to report events to the MBC using different mechanisms. Additionally, consumers can file complaints directly to the Medical Board.

Table 2.3: Select California Codes Defining Who Must Report and What Gets Reported Related to Medical Practice*

B&P Code Sections	Who Reports and What is Reportable
801.1[1]	Physician self-reporting of settlements, judgments, or arbitration awards
802.1[1]	Physician self-reporting of indictment for felony or conviction of misdemeanor or felony
802.5[1]	Coroner report evidence of negligence or incompetence related to death
803[1]	Court clerks reporting of physician criminal actions
805[1]	**Peer Review body reporting of issues related to changes in entity privileges for medical cause or reason**
805 (j)[1]	No person shall incur any civil or criminal liability as the result of making any report required by this section
809.2[1]	Physician is entitled to fair hearing
820-828[93]	Peer Review Body reporting of physical or mental illness or substance abuse
2021[86]	Physician self-reporting of change of address within 30 days after each change
2220-2319[87]	MBC Enforcement; Definitions of reasons for discipline and unprofessional conduct; gross negligence and incompetence
2240[87]	Physician self-reporting of deaths while performing procedures outside hospital; ED transfers

*partial list

Two closely related federal laws also are related to medical event reporting and the goals of patient care quality and safety:

1. The Sherman Anti-Trust Act[52, 94]
2. Healthcare Quality Improvement Act (HCQIA) of 1986[95]
    a. National Practitioner Data Bank (NPDB)
    b. Healthcare Integrity and Protection Data Bank (HIPDB)

The Sherman Anti-Trust Act is important because physician practices are typically for-profit business entities and are subject to laws relevant to tax-paying entities, specifically laws about anti-competitive practices. Confusion can occur because hospitals and some health plans are nonprofit entities (non tax-paying). Thus the anti-trust act becomes particularly important when physician competitors are required to participate in peer review of each other.

The HCQIA created two databanks: 1) the National Practitioner Data Bank (NPDB) to which certain entities are required to report events related to medical practice; and 2) the Healthcare Integrity and Protection Data Bank to be used as part of credentialing and peer review. The HCQIA also provided immunity, given restrictions, from damages by peer review participants[7]. However, a case taken to the U.S. Supreme Court in 1988, Patrick v Burget[91] (see Table 2.2), provided further legal guidance.

The Court held that Oregon physicians are not protected by the federal antitrust exemption known as the state action doctrine[92] for their activities on hospital peer review committees[96]. If the peer review process conforms to the standards of the HCQIA and is done in good faith, there are state and federal protections[96, 97], and some authorities maintain that it is difficult to win an antitrust case that challenges peer review of individual competence[98]. Other authorities view the immunity from liability provided by the laws as a way to hide from consequences of bad faith peer review[99]. This controversy continues today.

An essential part of the process of measuring patient quality and safety is medical peer review and event ("805") reporting. Although the terms "peer review" or "peer review body" have been misused by various entity committees (Quality, Risk, Utilization, small "p" peer review versus large "P" peer review), the California code language seems clear about what is a reportable event (see Table 2.4) and what the law defines as a peer review body (see Table 2.6).

Rather than inserting the statute language, the following tables highlight various events in the 805 process. The Business and Professions Code specifies what is to be reported and which entities are to report under Section 805 (see Tables 2.4 to 2.6 and 2.7). Definitions of terms and reporting times are also specified in the code (see Tables 2.4, 2.5, and 2.6).

Table 2.4: What is "805" Reportable (California Business & Professions Code 805)[1]

805 (b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed healthcare facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date of any of the following that occur as a result of an action of a peer review body:

What is "805" Reportable (California Business & Professions Code 805) [1]
(1) A licentiate's application for staff privileges or membership is denied or rejected for **a medical disciplinary cause or reason;**
(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for **a medical disciplinary cause or reason;**
(3) 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;**
805 (c)...Any of the following occur after notice of either an impending investigation or the denial or rejection of the application for **a medical disciplinary cause or reason:**
(1) Resignation or leave of absence from membership, staff, or employment. (2) The withdrawal or abandonment of a licentiate's application for staff privileges or membership. (3) The request for renewal of those privileges or membership is withdrawn or abandoned.
805 (e) An 805 report shall also be filed within 15 days following **the imposition of summary suspension** of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

Table 2.5: Relevant Definitions (California Business & Professions Code 805)[1]

Relevant Definitions (California Business & Professions Code 805)[1]
805 (a) (2)"Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, or dentist. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 (see Table 2.1).
(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.
(5) "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.
(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Table 2.6: Peer Review Bodies Defined - Who Reports (CA Business & Professions Code 805) [1]

"Peer review body" includes:

Peer Review Bodies Defined - Who Reports (CA Business & Professions Code 805) [1]
805 (a) (1) (A) A medical or professional staff of any healthcare facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare Program as an ambulatory surgical center.
(B) A healthcare service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.
(C) Any medical, psychological, marriage and family therapy, social work, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.
(D) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class, that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

Table 2.7: Entities that Report through California 805 Mechanism*

B&P Code 805 & Codes Referenced in B&P Code 805	B&P Code Excerpts
Business & Professions Code 805[1]	Any facility **certified** to participate in the federal Medicare Program as an ambulatory surgical center
Business & Professions Code 805[1]	A committee organized by any entity consisting of or employing **more than 25 licentiates** of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity
Health and Safety Code 1200[100]; 1250-1264[101]	Licensed healthcare facilities or clinics; definition of licensed healthcare facilities or clinics; 1204 defines clinics eligible for licensure; 1250 defines as "health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, ...
Health and Safety Code 1340[45]	**Certified** healthcare service plan; Definition of certified healthcare service plan; KKA 1345(f)(1), (f) "Healthcare service plan" or "specialized healthcare service plan" means either of the following: (1) Any person who undertakes to arrange for the provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees (but there are several exemptions).
Health and Safety Code 1370; 1370.1[1]	Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.
Insurance Code 10133 (aka. Knox-Keene Healthcare Service Plan Act of 1975)[45]	A disability insurer that contracts with licentiates (providers) to provide services at **alternative rates of payment**
Revenue and Taxation Code 23701 tax exempt[102]	Any medical, psychological, marriage and family therapy, social work, dental, or podiatric professional society having as members **at least 25 percent** of the eligible licentiates in the area
Welfare and Institutions Code 14087.95[103]	**Exempts** counties in this category from Health and Safety Code 1340

*partial list

The Business and Professions code specifies the procedure for a "fair hearing" (see Table 2.8) related to 805 reporting. The sections that follow 809.2 in the code further detail the procedures to be followed.

Table 2.8: The 809 Hearing (California Business & Profession Section 809.2[104])

If a licentiate timely requests a hearing concerning a final proposed action for which a report is required to be filed under Section 805, the following shall apply:

B & P Section 809.2
(a) The hearing shall be held, as determined by the peer review body, before a trier of fact, which shall be an arbitrator or arbitrators selected by a process mutually acceptable to the licentiate and the peer review body, or before a panel of unbiased individuals who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, fact finder, or initial decision maker in the same matter, and which shall include, where feasible, an individual practicing the same specialty as the licentiate.
(b) If a hearing officer is selected to preside at a hearing held before a panel, the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.
(c) The licentiate shall have the right to a reasonable opportunity to voir dire the panel members and any hearing officer, and the right to challenge the impartiality of any member or hearing officer. Challenges to the impartiality of any member or hearing officer shall be ruled on by the presiding officer, who shall be the hearing officer if one has been selected.
(d) The licentiate shall have the right to inspect and copy at the licentiate's expense any documentary information relevant to the charges which the peer review body has in its possession or under its control, as soon as practicable after the receipt of the licentiate's request for a hearing. The peer review body shall have the right to inspect and copy at the peer review body's expense any documentary information relevant to the charges which the licentiate has in his or her possession or control as soon as practicable after receipt of the peer review body's request. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable licentiates, other than the licentiate under review. The arbitrator or presiding officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires.
(e) When ruling upon requests for access to information and determining the relevancy thereof, the arbitrator or presiding officer shall, among other factors, consider the following: (1) Whether the information sought may be introduced to support or defend the charges. (2) The exculpatory or inculpatory nature of the information sought, if any. (3) The burden imposed on the party in possession of the information sought, if access is granted. (4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.
(f) At the request of either side, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.
(g) Continuances shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause.
(h) A hearing under this section shall be commenced within 60 days after receipt of the request for hearing, and the peer review process shall be completed within a reasonable time, after a licentiate receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the arbitrator or presiding officer issues a written decision finding that the licentiate failed to comply with subdivisions (d) and (e) in a timely manner, or consented to the delay.

The Business and Professions code also defines what is meant by an 821.5 report and how impaired physicians are to be reported (see Table 2.9).

Table 2.9: The Impaired Physician (California Business & Profession Section 821.5[105])

B & P Section 821.5
821.5. (a) A peer review body, as defined in Section 805, that reviews physicians and surgeons, shall, within 15 days of initiating a formal investigation of a physician and surgeon's ability to practice medicine safely based upon information indicating that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care, report to the diversion program of the Medical Board the name of the physician and surgeon under investigation and the general nature of the investigation. A peer review body that has made a report to the diversion program under this section shall also notify the diversion program when it has completed or closed an investigation.
(b) The diversion program administrator, upon receipt of a report pursuant to subdivision (a), shall contact the peer review body that made the report within 60 days in order to determine the status of the peer review body's investigation. The diversion program administrator shall contact the peer review body periodically thereafter to monitor the progress of the investigation. At any time, if the diversion program administrator determines that the progress of the investigation is not adequate to protect the public, the diversion program administrator shall notify the chief of enforcement of the Division of Medical Quality of the Medical Board of California, who shall promptly conduct an investigation of the matter. Concurrently with notifying the chief of enforcement, the diversion program administrator shall notify the reporting peer review body and the chief executive officer or an equivalent officer of the hospital of its decision to refer the case for investigation by the chief of enforcement.
(c) For purposes of this section "formal investigation" means an investigation ordered by the peer review body's medical executive committee or its equivalent, based upon information indicating that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care. "Formal investigation" does not include the usual activities of the well-being or assistance committee or the usual quality assessment and improvement activities undertaken by the medical staff of a health facility in compliance with the licensing and certification requirements for health facilities set forth in Title 22 of the California Code of Regulations, or preliminary deliberations or inquiries of the executive committee to determine whether to order a formal investigation. For purposes of this section, "usual activities" of the well-being or assistance committee are activities to assist medical staff members who may be impaired by chemical dependency or mental illness to obtain necessary evaluation and rehabilitation services that do not result in referral to the medical executive committee.
(d) Information received by the diversion program pursuant to this section shall be governed by, and shall be deemed confidential to the same extent as program records under, Section 2355. The records shall not be further disclosed by the diversion program, except as provided in subdivision (b).

B & P Section 821.5
(e) Upon receipt of notice from a peer review body that an investigation has been closed and that the peer review body has determined that there is no need for further action to protect the public, the diversion program shall purge and destroy all records in its possession pertaining to the investigation unless the diversion program administrator has referred the matter to the chief of enforcement pursuant to subdivision (b).
(f) A peer review body that has made a report under subdivision (a) shall not be deemed to have waived the protections of Section 1157 of the Evidence Code. It is not the intent of the Legislature in enacting this subdivision to affect pending litigation concerning Section 1157 or to create any new confidentiality protection except as specified in subdivision (d). "Pending litigation" shall include Arnett v. Dal Cielo (No. S048308), pending before the California Supreme Court.
(g) The report required by this section shall be submitted on a short form developed by the board. The board shall develop the short form, the contents of which shall reflect the requirements of this section, within 30 days of the effective date of this section. The board shall not require the filing of any report until the short form is made available by the board.
(h) This section shall become operative on January 1, 1997, unless the regulations required to be adopted pursuant to Section 821.6 are adopted prior to that date, in which case this section shall become operative on the effective date of the regulations.

Table 2.10: Public Disclosure - (California Business & Profession Section 2027)

The Business and Professions code defines what the Medical Board can report to the public, what can be reported to entities and agencies, and how long the information is to remain public (see Table 2.10).

B & P Section 2027[106]
2027. (a) On or after July 1, 2001, the board shall post on the Internet the following information in its possession, custody, or control regarding licensed physicians and surgeons: (1) With regard to the status of the license, whether or not the licensee is in good standing, subject to a temporary restraining order (TRO), subject to an interim suspension order (ISO), or subject to any of the enforcement actions set forth in Section 803.1. (2) With regard to prior discipline, whether or not the licensee has been subject to discipline by the board or by the board of another state or jurisdiction, as described in Section 803.1. (3) Any felony convictions reported to the board after January 3, 1991. (4) All current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" shall mean an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the Medical Board of California unless an appeal of that decision is pending. (5) Any malpractice judgment or arbitration award reported to the board after January 1, 1993. (6) Any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. (7) Any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed. (8) Appropriate disclaimers and explanatory statements to accompany the above information, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation. (9) Any information required to be disclosed pursuant to Section 803.1.
(b) (1) From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain posted for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Web site. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003. Settlement information shall be posted as described in paragraph (2) of subdivision (b) of Section 803.1. (2) The information described in paragraphs (3) and (6) of subdivision (a) shall not be removed from being posted on the board's Internet Web site. Notwithstanding the provisions of this paragraph, if a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges, as described in paragraph (6) of subdivision (a), shall remain posted for a period of 10 years from the restoration date of the privileges, and at the end of that period shall be removed from being posted on the board's Internet Web site.
(c) The board shall provide links to other Web sites on the Internet that provide information on board certifications that meet the requirements of subdivision (b) of Section 651. The board may provide links to other Web sites on the Internet that provide information on healthcare service plans, health insurers, hospitals, or other facilities. The board may also provide links to any other sites that would provide information on the affiliations of licensed physicians and surgeons.

Summary

The Medical Board of California is charged with protecting the public in regards to medical practice and is responsible for tracking and enforcing the laws that govern medical practice. As the laws and healthcare have increased in complexity, so has the work of the Medical Board. It has become more difficult to ensure that entities are adhering to all the laws and that the laws do not conflict with each other.

Required by law, medical peer review by entities is one of the key mechanisms to monitor patient quality and safety. But peer review as a quality and safety process is being called into question. Professionals have begun to wonder if the "old" way of peer review is sufficient or even necessary any longer. This chapter has provided an overview of some of the history and positive and negative aspects of peer review. Additionally, it has provided alternate strategies used by other states and other entities to monitor quality and safety.

California laws governing medical practice are numerous and complex. Because of this complexity, most hospitals and many physician groups and health plans employ or contract with an attorney or attorneys. The intent of all of these laws has been to protect the public and improve patient care quality and safety. Unfortunately, they have not always worked as intended.

Previous to this study, there has been little empirical evidence on which to base a decision to change the current peer review system. This Peer Review Study is an effort to analyze empirical data to ascertain whether peer review can continue to be relevant in assessing medical care. Chapter III will detail the methodology used in this study to determine whether medical peer review is still appropriate for ensuring patient safety and quality in California medical care entities.

Chapter III: Methodology

Introduction

In this chapter, we provide a detailed explanation of the study methodology in the following format.

Research design includes:

- Study type
- Population
- Sample selection
- Sample size estimates
- Independence of study personnel
- Measurement instruments
- Data collection
- Data analyses

Additionally, we cover criticisms of the study uncovered during the study and the methods used to mitigate them.

Research Design

Study Type

The design of this study is both quantitative and qualitative; it is cross-sectional, retrospective, and descriptive. Since the topic has not been extensively studied in the past, we used multiple data collection methods, including document review, survey, focus groups, site visits, and key informant interviews. All these methods, described in detail later in this chapter, cover the questions required in the 805.2 legislation (see Table 1.1) but in different ways and in different formats. We examined peer review from as many perspectives as possible.

Population

The legislation specified the population for the study. Specifically, Section 805.2 states, "peer review bodies throughout the State, including the role of other related committees of acute care health facilities and clinics involved in the peer review process."[1] We produced a population frame based on the definitions of the eligible entities, as specified in the legislation (see Tables 2.6 and 3.1). We used multiple sources to identify the population of each entity type (see Table 3.1).

Table 3.1: Population Count and Data Source for Study Entities

Entity Type	Population	Sources
Hospitals	366	Office of Statewide Health Planning and Development (OSHPD) 2005[107]
Healthcare plans	51	The California Department of Managed Care 2007[108, 109], California Association of Health Plans[110], Medicare database of health plans
Professional societies	9	Web sites of the state and national professional entities
Medical groups/clinics	123	OSHPD[107], Cattaneo and Stroud Databases and Reports[111], the California Office of the Patient Advocate[112], Medicare database of medical groups

Professional societies are defined in the legislation (see Table 2.6), but we had difficulty estimating a comprehensive population. The legislation lists a number of professions in addition to medicine, so we included those professional entities in our sample. Since the MBC focuses specifically on monitoring the practice of medical doctors and podiatrists, we also included professional entities related to medicine and podiatry.

We defined healthcare facilities as short-term general/general acute care (GAC) hospitals; we defined healthcare plans as full-service medical plans versus dental plans, behavioral health or other system or disease-specific plans. We included both licensed/certified and unlicensed healthcare plans, and we sampled medical groups and clinics that are both licensed/certified and unlicensed/not certified.

We encountered several barriers in obtaining comprehensive lists of health plans, clinics, and medical groups. A list of licensed health plans is available from the Department of Managed Care, but a list of unlicensed health plans is not. We were able to identify some unlicensed health plans using a proprietary Medicare database but were unable to determine why some health plans are not required to be licensed.

Certain primary care and specialty clinics are licensed or certified and lists are available from OSHPD; some clinics are certified by the federal government (e.g., VA and Indian Health). However, there are many clinics that are neither certified nor licensed. Again, we were unable to determine the reasons for why some clinics are neither licensed nor certified by the State. No separate list of "medical groups" exists. Some medical groups can be found in the list of health plans. Others are found in the list of clinics; and some others are found in a proprietary Medicare database.

Another barrier in identifying the population was that health plans and medical groups frequently have multiple aliases (e.g., also-known-as or aka) and doing-business-as (dba) names. Health plans also have multiple names and use different names for various programs within the company, such as the Medicare-specific program, a psychiatric/behavioral health program, or others. An additional complicating factor was that management service organizations (MSO) frequently manage multiple medical groups or clinics and perform various services for them, including peer review. The MSOs may also have other management business, such as a health plan or hospital, or own a health plan or hospital, in addition to managing clinics or medical groups.

The Cattaneo and Stroud Databases maintained jointly by Cattaneo and Stroud and the Pacific Business Group on Health were extremely helpful, as were the reports they produced that were

funded by the California Healthcare Foundation[111]. Therefore, our population is based on the most accurate information available, as well as on the setting-specific parameters mentioned previously. The next section of this chapter details our sampling selection method.

Sample Selection

After establishing the populations, we used the SAS survey select procedure to generate the sample. Following our initial selection, we discovered that a number of the health plans and medical groups were closed and others were duplicates because of dba and aka names. At this point, we discovered the Cattaneo and Stroud databases[111] and were able to obtain the multiple names of medical groups, along with their correct addresses. We searched health plan Web sites to identify the multiple names and multiple program names that were in use, as well as addresses and other contact information. We corrected the populations and again selected our sample. We searched for California chapters of national professional associations for the professions listed in the legislation. There were nine professional societies that were selected to participate.

The selected sample produces an accurate representation of the population of hospitals, health plans, and medical groups in California because 1) the sample adheres to the assumptions in the proportions from a finite population sampling methodology, and 2) we over-sampled both health plans and medical groups by 25% to ensure an adequate number. In the hospital sample, two had changed designation to long-term care (LTC), so we replaced them with matches from their strata. The hospitals were over-sampled by 10% so the sample size remained robust. After the cleaning and replacements, our total sample was n=245 (see Table 3.2).

Table 3.2: Population and Final Sample for Entities

Entity type	Population	Final Sample	% of Population
Hospitals	366	132	36.1%
Healthcare plans	51	28	54.9%
Professional societies	9	9	100.0%
Medical groups/clinics	123	76	61.8%
Total	**549**	**245**	**46.5%**

This final sample was used for Phase I (Document review) and Phase II (Online survey) of the study. Phases III (Site visits) and V (Validation) participants were a 5% sub-sample drawn randomly from within the initial sample (see Table 3.3). Phase IV (Focus groups and Key informant interviews) used invited participants who met certain criteria listed in the proposal: representatives from the four entities, attorneys involved in peer review, physicians who had been reviewed and were reviewers, malpractice company representatives, and patient advocates.

Table 3.3: Sample Counts for Entities by Study Phase

Entity Type	Phase I Document Review	Phase II Survey	Phase III Site Visit	Phase IV Focus Groups*	Phase V Validation (Parts 1 & 2)
Hospitals	132	132	6	*	5/6
Healthcare plans	28	28	1	*	1/1
Professional societies	9	9	0	*	1/0
Medical groups/clinics	76	76	3	*	1/3
Total	**245**	**245**	**10**	*	**8/10**

*Focus group participants and key informant interviewees were invited based on the proposal criteria. These data will be described in Chapter IV.

Sample Size Estimates

Hospitals

We conducted a stratified random selection based on 366 short-term general hospitals in the 14 Health Services Agencies (HSAs) of California[113]. We additionally ensured that the sample was representative of the hospital population in number of staffed beds, rural/urban mix, teaching/non-teaching mix, type of control/ownership, and major hospital systems in California. These variables have previously been shown to have a relationship with hospital patient outcomes and also describe the variability in California medical care delivery. We over-sampled by 10% and selected 132 hospitals.

The sample size was estimated using proportions from a finite population with a bound of .05 (i.e., the sample size is > 5% of the population), a confidence of 95% (i.e., we can be 95% certain that the population parameters are within the confidence intervals), and a predicted population proportion of .50 (i.e., we assume the maximum allowable variance [50%] in the population and use the most conservative [largest] sample [in the language of the social sciences; this produces adequate statistical power to find an effect if an effect is present]).

Table 3.4 provides comparisons of percentages and absolute numbers of the population frames versus sample estimates for each of the strata. The percentages are similar, so we are confident our selection method provides a representative sample of the hospitals in California.

Table 3.4: Comparisons of Hospital Sample Stratified to Population

		Population (n=366)		Sample (n=132)	
Variable	**Level**	**N**	**% of 366**	**n**	**% of 132**
Region	Northern Cal.	31	8.5%	7	5.3%
	Golden Empire	18	4.9%	7	5.3%
	West Bay	14	3.8%	5	3.8%
	North Bay	20	5.5%	7	5.3%
	East Bay	20	5.5%	7	5.3%
	N. San Joaquin	21	5.7%	8	6.1%
	Santa Clara	12	3.3%	5	3.8%
	Mid Coast	11	3.0%	4	3.0%
	Central	30	8.2%	10	7.6%
	Santa Barbara	12	3.3%	5	3.8%
	LA	91	24.9%	36	27.3%
	Inland Empire	33	9.0%	12	9.1%
	Orange County	31	8.5%	11	8.3%
	San Diego/Imperial	22	6.0%	8	6.1%
Bed No.	<120	143	39.1%	53	40.2%
	120-249	128	35.0%	47	35.6%
	250-499	81	22.1%	24	18.2%
	500+	14	3.8%	8	6.1%
Rural/Non	Rural	66	18.0%	22	16.7%
	Non Rural	300	82.0%	110	83.3%
Teach/Non	Teaching	26	7.1%	9	6.8%
	Non Teach	340	92.9%	123	93.2%
Profit/Non	City/County/State	26	7.1%	9	6.8%
	District	46	12.6%	12	9.1%
	Investor	93	25.4%	37	28.0%
	Non Profit	201	54.9%	74	56.1%
System/ Non	CHW	28	7.7%	11	8.3%
	Kaiser	28	7.7%	8	6.1%
	Tenet	20	5.5%	14	10.6%
	Sutter	21	5.7%	10	7.6%
	HCA	5	1.4%	1	0.8%
	Adventist	14	3.8%	4	3.0%
	Non/Other	250	68.3%	84	63.6%

Notes:
Sample frame 2005 Financial Data from OSHPD – Short term general hospitals only.
Simple random selection stratified by HSA.

Health Plans

The sampling method for health plans was a stratified random selection based on strata for HSA (region) and rural versus non-rural. The sampling size was estimated using proportions from a finite population with a bound of .075 (i.e., the sample size is > 7.5% of the population), a confidence of 95% (i.e., we can be 95% certain that the population parameters are within the confidence interval), and a predicted population proportion of .50 (i.e., we assume the maximum allowable variance [50%] in the population and use the most conservative [largest] sample [in the language of the social sciences, this produces adequate statistical power to find an effect if an effect is present]).

Table 3.5 provides comparisons of percentages and absolute numbers of the population frames versus sample estimates for each of the strata. The percentages are similar, so we are confident our selection method provides a representative sample of the health plans in California. We over-sampled by 25% and selected 28 health plans.

Table 3.5: Comparison of Health Plan Sample Stratified to Population

		Population (N=51)		Sample (n=28)	
Variable	**Level**	**N**	**% of 51**	**n**	**% of 28**
Region	01 – Northern California	0	0.0%	0	0.0%
	02 - Golden Empire	3	5.9%	1	3.6%
	03 - West Bay	1	2.0%	1	3.6%
	04 - North Bay	5	9.8%	4	14.3%
	05 - East Bay	8	15.7%	4	14.3%
	06 - North San Joaquin	1	2.0%	0	0.0%
	07 - Santa Clara	3	5.9%	1	3.6%
	08 – Mid Coast	0	0.0%	0	0.0%
	09 - Central	2	3.9%	1	3.6%
	10 - Santa Barbara/ Ventura	2	3.9%	1	3.6%
	11 - Los Angeles County	16	31.4%	11	39.3%
	12 - Inland Counties	1	2.0%	1	3.6%
	13 - Orange County	6	11.8%	2	7.1%
	14 - San Diego/ Imperial	3	5.9%	1	3.6%
Rural/Non	Rural	0	0.0%	0	0.0%
	Non	51	100.0%	28	100.0%

Notes:
Matched health plan address county location to assigned 14 OSHPD regions.
Matched health plan address county location with assigned Rural vs. Urban location based on the 2005 CMS MSA crosswalk.

Medical Groups/Clinics

The sampling method for medical groups was a stratified random selection based on strata for HSA (region), number of physicians in the medical group/clinic, and rural versus non-rural. The sampling size was estimated using proportions from a finite population with a bound of .075 (i.e., the sample size is > 7.5% of the population), a confidence of 95% (i.e., we can be 95% certain that the population parameters are within the confidence interval), and predicted population proportion of .50 (i.e., we assume the maximum allowable variance [50%] in the population and use the most conservative [largest] sample [in the language of the social sciences; this produces adequate statistical power to find an effect if an effect is present]).

Table 3.6 provides comparisons of percentages and absolute numbers of the population frames versus sample estimates for each of the strata. The percentages are similar, so we are confident our selection method provides a representative sample of the medical groups/clinics in California. We over-sampled by 25% and selected 76 medical groups.

Table 3.6: Comparison Medical Group/Clinics Sample Stratified to Population

		Population (N=123)		Sample (n=76)	
Variable	**Level**	**N**	**% of 123**	**n**	**% of 76**
Region	01 – Northern California	2	1.6%	2	2.6%
	02 - Golden Empire	5	4.1%	3	3.9%
	03 - West Bay	5	4.1%	3	3.9%
	04 - North Bay	5	4.1%	2	2.6%
	05 - East Bay	6	4.9%	4	5.3%
	06 - North San Joaquin	4	3.3%	2	2.6%
	07 - Santa Clara	5	4.1%	3	3.9%
	08 – Mid Coast	3	2.4%	2	2.6%
	09 - Central	4	3.3%	2	2.6%
	10 - Santa Barbara/ Ventura	4	3.3%	2	2.6%
	11 - Los Angeles County	41	33.3%	26	34.2%
	12 - Inland Counties	18	14.6%	12	15.8%
	13 - Orange County	10	8.1%	5	6.6%
	14 - San Diego/ Imperial	11	8.9%	8	10.5%
No. of Physicians	1-100	12	9.8%	9	11.8%
	100-500	48	39.0%	31	40.8%
	501+	16	13.0%	7	9.2%
	Unknown	47	38.2%	29	38.2%
Rural/Non	Rural	3	2.4%	3	3.9%
	Non Rural	120	97.6%	73	96.1%

Notes:
Sample frame 2006 California Office of the Patient Advocate (from www.opa.gov site) – Healthcare Quality Report Card Directory and original file sent from OPA contact.

Matched medical group administrative address county location with assigned Rural vs. Urban location based on the 2005 CMS MSA crosswalk.

Two individual primary care clinics were included in the sample for representation.

Professional Societies

We were unable to locate a comprehensive list of professional societies in California. We selected the California chapters of national professional associations/societies representing all the professions listed in the legislation. Additionally, we contacted the California Association of Neurological Surgeons, because they were listed as having filed an 805 in the past, and the California Association of Physician Groups, because they represent physician groups. We contacted a total of nine professional associations/societies and report on the entire population (N=9) rather than a sample.

Independence of Study Personnel

The Legislature and the MBC required that the healthcare consulting firm and the scientists performing the study remained independent of any of the numerous individuals and entities with a vested interest in the peer review process. We maintained this independence in various ways. When we received unsolicited telephone calls and e-mails from entities and individuals asking us questions about the study or offering to assist us with the study or to redesign the methods, we used the following strategies to handle these inquiries:

1. Answered specific questions about the legislation that authorized the study and method.
2. Referred the person to the legislation.
3. Set up a Web site with details and frequently asked questions about the study and referred people to the Web site.
4. Encouraged the person to send messages to the e-mail box listed on the Web site.
5. Encouraged the person to write letters with comments to us.

We consistently informed everyone that the messages and letters would be reviewed near the end of the study and incorporated them in the report or the appendices. Study personnel referred callers or e-mails to Lumetra personnel not involved in the study to allow callers to express their opinions.

In determining the population frame and sample estimates, making decisions, managing refusals, and answering questions and criticisms, we used accepted scientific standards and rigorous methodology in the study. We kept track of all telephone calls and responses, e-mails and responses, and faxes, confirmations, and responses. We responded promptly to participant questions and requests and were flexible in extending deadlines for study phases when possible, while still maintaining the project timeline. We followed up on all calls, e-mails and faxes to ensure the entity an opportunity to participate in the study and maintained the confidentiality of all participants. However, we were required by contract to disclose those entities that declined, did not return contacts, or failed to participate.

We notified these entities that their lack of participation would be noted in the final report. We solicited facts, opinions, and perceptions and attempted to objectively and fairly represent divergent views in this report.

Measurement Instruments

Data were collected using multiple methods to investigate processes of medical peer review, the fair hearing process, and physician physical or mental impairment within the 805 and 821 processes. Phase I of the study was a mailed letter that requested documents from all the sampled entities, including policies, procedures, bylaws, and committee minutes. Phase II of the study was an online structured short-answer survey to staff in specified roles within each participant entity. The survey was designed to specifically address questions raised by the legislation. The survey questions were designed to be analyzed separately, so no psychometric testing was needed.

The survey was piloted twice with internal Lumetra respondents, including physicians, non-physician administrative staff, registered nurses, and statistical analysts. Based on input from these pilot participants, questions were edited for clarity and to make analyses more quantitative.

We created six versions of the survey. Each version was directed to individuals with different peer review roles related within the entities. The peer review committee chair and the non-physician support staff member received the full survey, while people in other positions received a shorter version with questions relevant to their role in the process.

Phase III consisted of site visits to 10 entities as part of the validation process. We created a sub-sample of 5% of the initial sample for site visits to compare documents, minutes, and interviews during an onsite review. Phase IV included focus groups, key informant interviews, and telephone conversations with people with a vested interest in peer review (representatives from the four entities, attorneys involved in peer review, physicians who had been reviewed and were reviewers, malpractice company representatives, and patient advocates). Phase V was the second part of the validation process using a different 5% sub-sample of the initial sample comparing survey results with documents and structured implicit patient record review by physician reviewers.

Data Collection

We followed up with entities by e-mail, telephone, or fax. If they did not respond within four weeks, we made two more attempts to contact them. After three attempts, the entities were listed as "no response" (see Appendix VI: Organizations that Declined or Made No Comment). A number of entities inquired about a penalty if they did not participate, and we cited the legislation as saying, "The independent entity for the study had no authority over them." However, the MBC directed that we list the names of those entities that did not participate in the final report.

Contacts between Lumetra study staff and each entity were maintained by e-mail, telephone, and/or fax with a primary contact (typically a medical staff support person) designated by the CEO or Chief of Medical Staff. In Phase I of the study, we requested all policies, procedures, bylaws, or other documents that described the entities' peer review process. We asked for five years of minutes from any committee whose function was peer review, particularly the decision-making committee such as the Medical Executive Committee (see Appendix I: Study Results and Appendix IV: Structured Review Forms).

In Phase II of the study, we requested that the primary contact forward our request for survey completion to the appropriate individuals within the entity, including peer review committee chairs, reviewing physicians, reviewed physicians, attorneys who represented the entity, attorneys who represented reviewed physicians, and non-physician support staff. We also solicited survey completion by direct mail to physicians who had been reported through the 805 mechanism in the year 2007. As noted earlier, not everyone received the complete survey because not all the questions were relevant to each role (see Appendix II: Survey and Focus Group Questions).

In Phase III of the study, we selected 10 sites from our site visit sample to compare onsite peer review minutes and policies with the documents submitted. The study reviewer spent a day at each site checking documents, including policies and minutes, as well as discussing the entity's processes with the contact person (see Appendix IV: Structured Review Forms). We also made two site visits to the MBC to ask questions and collect data and information (see Appendices I and IV)

In Phase IV, we conducted two telephone focus groups and several key informant interviews between March 15 and April 14, 2008. There were five to seven invited participants in each focus group, with each group of participants representing different roles, including patient safety advocates, attorneys for entities and physicians, health plan executives, medical group executives, and representatives from malpractice companies.

Key informant interviews included patient safety advocates, malpractice companies, health plan executives, and attorneys. One important concern that was raised in the interviews was the possibility of physicians in solo or small practices without hospital privileges never being peer reviewed.

We invited these types of participants based on our contacts with participant entities and their roles in national, state, and local entities (see Appendix II: Survey and Focus Group Questions). In Phase V (Validation) of the study, we performed several activities to allow us to validate the results of the study, including structured implicit patient record reviews by the study medical director (see Appendix IV: Structured Review Forms), comparison of documents with survey results (see Appendix IV), multiple reviewers of all documents and minutes to check reliability, and a review of all data collected and analyzed.

A Web page linked to the Lumetra Web site was created to give an overview of the study, including the specific legislation. The Web page also included frequently asked questions and an e-mail box for anyone who wished to provide feedback about the study. Lumetra staff in a department separate from the study staff monitored the e-mail box, and the e-mails were only examined in the data analysis phase of the study. Appendices I, II, and V contains all study data collection instruments, including the initial document request letter, document review form, minutes review form, all versions of the online survey, MBC visit questions and document review form, focus group/key informant interview questions, and validation request.

Data Analyses

Because of the numerous ways in which data were collected, the issue of unit of analysis for the study was a concern. Peer review is performed at the entity level, so that is our unit of interest. For analyses of the documents and minutes, we aggregated data results to the level of the entity. The data collected via the online survey were not identifiable by individual and are aggregated to the entity type or the respondents' role in the peer review process.

Because of the way some of the survey questions were phrased, we analyzed them by response rather than by role or entity type. The focus group and key informant interview data are analyzed in the context of the role of the participants in relationship to the type of entity or to their role in relationship to peer review. The site visits and other validation methods are analyzed in terms of entity type.

Data analyses encompassed multiple methods beginning with descriptive information of central tendency of the sample. For Phase I, documents were reviewed using a structured format (see Appendix IV: Structured Review Forms); responses were aggregated and quantified using descriptive statistics. The structured format allowed for analyses of comments related to the policies, procedures, and other documents.

Those data are described using qualitative descriptions. Short answer responses from document reviews, surveys, and site visits, focus group/ key informant responses, and structured implicit

review were qualitatively analyzed using 1) an analysis of words (word repetitions, key terms, and key words in contexts); and 2) a careful reading of blocks of texts to identify themes[114].

For Phase II, survey responses were analyzed using measures of central tendency, including mean, median, and mode, measures of proportion, including frequencies and percentages, and measures of variation, including range and standard deviation. We also investigated correlations and means comparisons. Many of the survey questions allowed respondents to provide comments. These comments are described qualitatively in the results section, and the actual comments appear in Appendix IX: Comments About Study.

For Phase III (Site Visits), data were analyzed using content analysis of the structured reviews (see Appendix IV: Structured Review Forms) and by quantifying data as possible. In Phase IV, focus groups and key informant interviews were also analyzed using content analysis based on the broad questions that were asked (see Appendix II: Survey and Focus Group Questions). Phase V (Validation) data were analyzed descriptively using the comparisons (survey responses and documents) and structured implicit chart review (reviewing actions taken by the entity).

Study Criticisms

Through several sources, we heard about criticism of the study while it was in progress. Below, we describe the types of criticism/concern of which we are aware and list underneath the methods (responses) we used to counter or mitigate any negative effects.

1. Lumetra's ability to maintain independence during the study
   a. Lumetra has no vested interest in the results of the study.
   b. The sampling method was random, blinded to the researchers, and generated by computer.
   c. A Web site was created to explain the study and allowed people to submit comments.
   d. A department separate from the study researchers monitored the site and only provided the comments to the researchers at the end of the study.

2. Funding for Lumetra to conduct this study (i.e., to "do it right")
   Although both money and time were limited, we made use of both by setting deadlines and moving through the study requirements in a consistent manner.

3. Study presumption that there is failure in the 805 reporting method
   a. Although there appears to be a small number of 805 reports per California population, one of the purposes of the study was to investigate the issue of appropriate reporting.
   b. As an independent contractor, Lumetra was in the position of being objective about the data and did not form premature assumptions.

4. Information about cases not reported and reasons why to be used against physician or hospital
   a. In order to understand whether appropriate 805 reporting is being done, it is necessary to understand decisions that are made not to report an event.
   b. The legislation guaranteed that the information would not be used against a hospital or a physician.

5. The burden of and expense of study requests (e.g., five years' worth of cases too many to send to Lumetra).
   a. The entities' policies dictate the number of cases reviewed and the peer review committee minutes format.
   b. Entities with the least electronic record capability were the most significantly impacted.

c. We asked for the minimum data to answer the study questions; we also extended numerous deadlines for entities in all phases of the study.

6. Document requests in violation of Evidence Code 1157
   B&P 805.2 made clear that the documents provided to the study team would not be "discoverable."

7. MBC requirement to provide a list of entities that declined or did not participate
   Lists of entities that declined or did not participate are in Appendix VI: Organizations that Declined or Made No Comment, of this final report, as required by MBC.

8. Superficial and biased survey questions would produce sensational results but no meaningful data (see Appendices II and IV)
   a. The survey was one method of allowing a large number of individuals to have input into the study.
   b. The questions attempted to uncover complex and difficult issues.
   c. Individuals were invited to add comments or write e-mails or letters to Lumetra to provide additional information and for inclusion in the study.
   d. Many did provide additional comments, and they are included in Appendix IX: Comments About Study.

9. Awkward wording of survey questions (see Appendices II and IV)
   a. The questions were reviewed numerous times before the survey went online to try to insure they were clear and concise.
   b. The content of the legislation is complex and questions and absolute answers were difficult to construct.
   c. The wording of some of the questions is a limitation of this part of the study.
   d. We also offered all participants the option of writing comments and letters.

10. Closed hospitals surveyed by Lumetra
    a. Requests were sent to one hospital that had closed between the creation of the database and the beginning of the study; two others had converted from a general acute care hospital to long term care; a third error in our data led to a letter meant for a health plan being sent to one of their older closed hospitals.
    b. We corrected all these errors in our data.

11. People not notified about the survey
    a. Each entity had a primary contact person.
    b. The online survey Web link was forwarded to the contact person.
    c. We contacted physicians who had been the subject of an 805 report and invited them to complete a survey.
    d. All the people who had emailed or called were encouraged to comment through our study Web site or direct mail surveys.

12. The necessity of asking whether MDs are paid or not for peer review
    One of the study requirements is to estimate the cost of peer review.

13. The inclusions of questions suggesting that an elite group controls hospital privileges and uses peer review for political reasons, such as the elimination of competitors, ethnic minorities, persons for whom English is a second language, and females
    a. These questions were required by the legislation.
    b. Some individuals were offended that these questions were asked.
       Other individuals were grateful that these questions were asked.

14. The term "peer review process" not defined by law, and Lumetra staff refusal to elaborate on the law (some entities say "little peer review" and others, "big peer review")
    a. The term peer review is used to mean many things.
    b. This study was designed to study medical peer review performed by medical doctors.

15. Lumetra inability to define peer review body or clarify more specifically what documents would be required
    a. The study team used the definitions in the law to try to clarify terms.
    b. The team attempted to be explicit about what was required (five years of minutes from peer review committees).

16. Study request for information protected by the Lantermann-Petris-Short Act
    a. The team did not ask for protected mental health information, rather we asked for the process of dealing with physicians who are impaired.
    b. We also asked that neither patients nor physicians be identified to us.

17. Lack of a representative sample with only 10 site visits conducted
    a. The primary way the study was designed to answer questions was through a review of policies, procedures, bylaws, and committee minutes.
    b. The initial proposal did not call for site visits; however, we added them because some entities were reluctant to provide peer review committee minutes.
    c. The sampling strategy was presented earlier in the chapter and demonstrates that our sample is representative.

18. Only few events were found that should have, but did not, trigger an 805 report
    a. Generally, we found that entities followed the letter of the law as they understand it.
    b. We contacted organizations that had questionable events and suggested they review the specific issue we found.

19. Creation of peer review policies by entities after requested by Lumetra
    Based on the documents reviewed and telephone and e-mail communication with the entities' staff members, we did not find evidence to support this concern.

Summary

This chapter has provided detail about the research study design, measurement instruments, data collection, and data analyses. The study is retrospective, cross-sectional, and descriptive. The sampling method was stratified random selection. Data collection methods included document review, survey, site visits, focus group/key informant interviews, and study validation. We are confident that our sample is representative of healthcare entities in California based on the rigorous sampling and comparison of respondents and non-respondents.

From the study onset, there was resistance and anxiety from entities that were included in the sample. Although we attempted to alleviate the anxiety by providing explanations and flexible deadlines and listening to concerns, a number of entities and their attorneys have criticized the study methodology during the study. We have endeavored to articulate this criticism and the ways in which we mitigated any negative effects.

Chapter IV: Results

This chapter first presents a description of the sample, including the study respondents and non-respondents. Next, we detail the study findings and list the results from the various data collection methods under the relevant study requirements as specified in the B & P Code Section 805.2 (see Table 1.1). We conclude with the measures taken to validate the study.

Sample Description

The overall study response rate was 75.6%. Even though every entity did not respond to all the study phases, this responses rate is very good, given that survey response rate estimates of 50% are considered good[115] (see Table 4.1). The majority of entities sent some documents and participated in the survey. However, the peer review committee minutes (see Table 4.5) were omitted by many entities.

As required by the MBC, a list of entities that declined or did not respond to our communication, including the e-mail and letters detailing the reasons for non-participation, is in Appendix VI: Organizations that Declined or Made No Comment. The main reason offered was a lack of resources to gather the information. The next most common reason was per the advice of an attorney.

Figures 4.1 and 4.2 are graphic representations of the selected sample and the final participants in relationship to the location of the entities within the State. It is clear from these figures that the sample and the participants represent all geographic regions of California.

Figure 4.1: Map of Study Sample

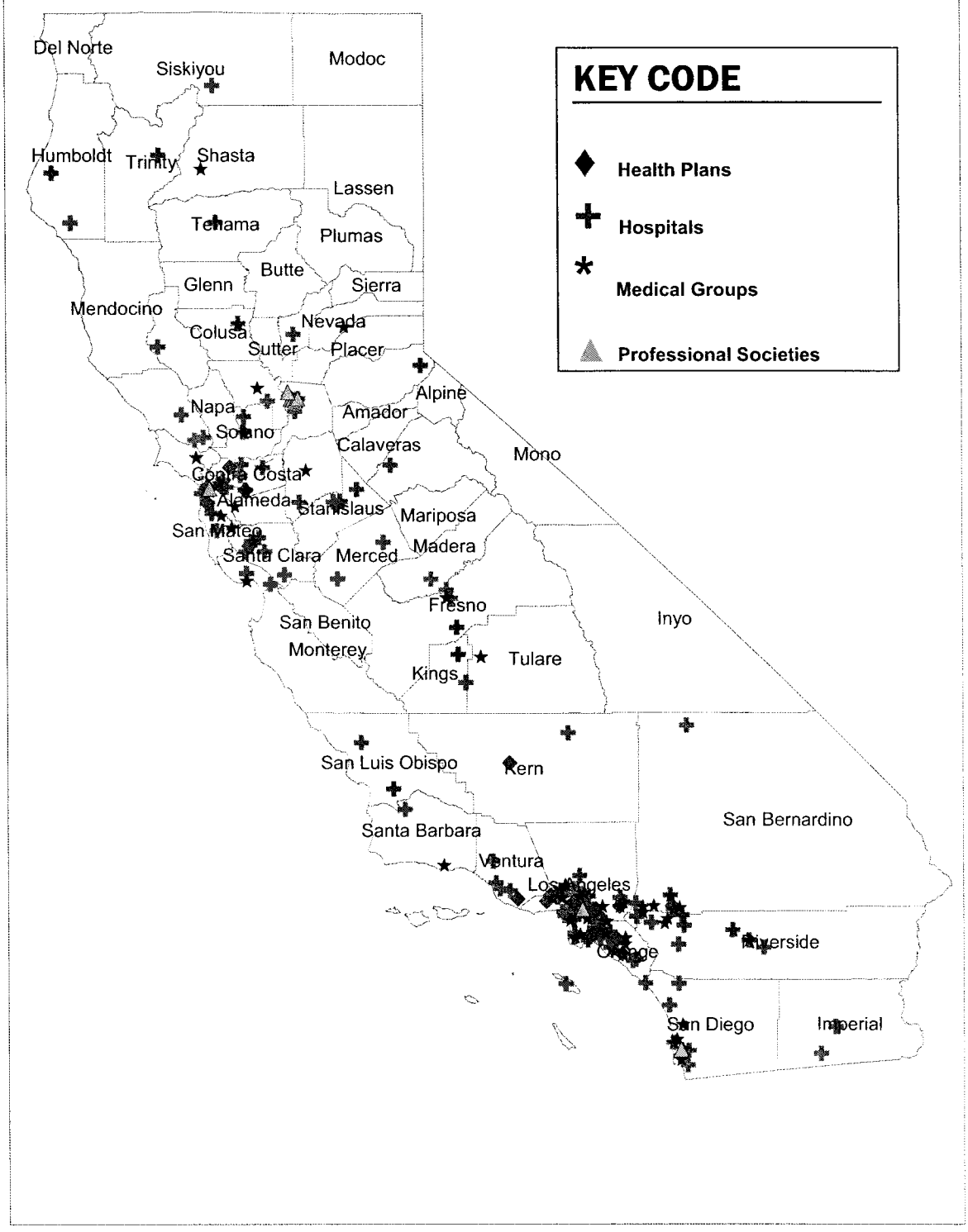


Figure 4.2: Map of Study Participants

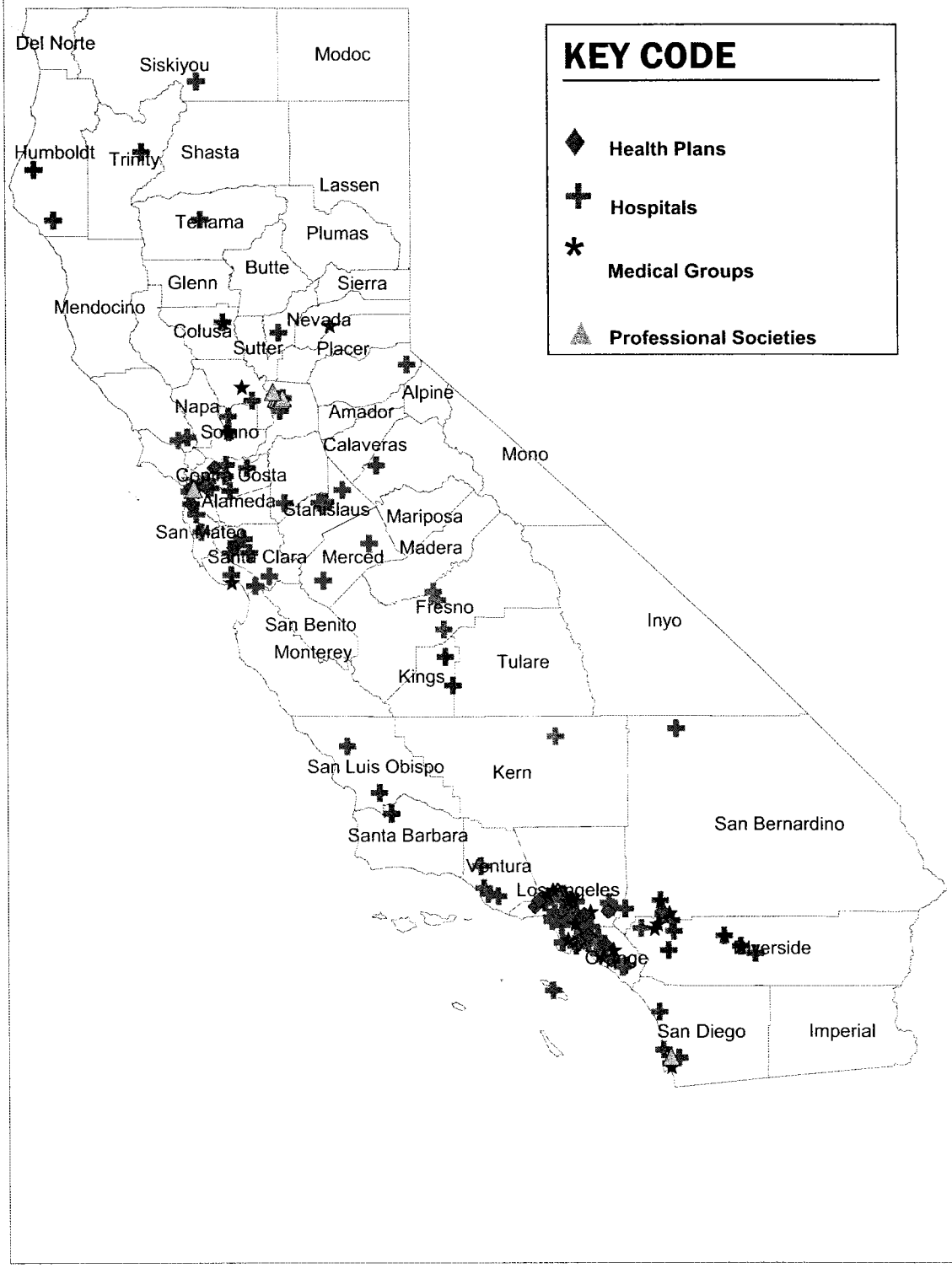


Table 4.1: Entity Participation by Study Phase

Entity type	Final Sample n (% of sample)	Participation in Study n (% of sample)	Declined or Did Not Participate n (% of sample)	Phase I Document Submits n (% of sample)	Phase II Survey n (% of sample)	Phase III* Site Visits	Phase IV** Focus Groups	Phase V Validation Parts 1 & 2
Hospitals	132 (100%)	117 (88.6%)	15 (11.4%)	109 (82.6%)	70 (53.0%)	6	**	5/6
Healthcare plans	28 (100%)	22 (78.6%)	6 (21.4%)	21 (75.0%)	13 (46.4%)	1	**	1/1
Professional Societies	9 (100%)	8 (88.9%)	1 (11.1%)	8 (88.9%)	1 (11.1%)	0	**	1/0
Medical groups/clinics	76 (100%)	38 (50.0%)	38 (50.0%)	34 (44.7%)	23 (30.3%)	3	**	1/3
Total	**245 (100%)**	**185 (75.5%)**	**60 (24.5%)**	**172 (70.2%)**	**107 (43.7%)**	**10**	**	**8/10**

*Two sites included two entities each; one site visit included two hospitals, and one site visit included one medical group and one hospital. This occurred because one department in an entity performed quality/peer review for more than one entity.
**Focus group participants and key informant interviewees were invited based on specific characteristics described in Chapter IV.

As Tables 4.1, 4.2, 4.3, and 4.4 illustrate, the non-respondents were distributed randomly throughout our strata and did not differ from the respondents. Because of the concern expressed about the generalizability of the findings to the population, we took the extra precaution of comparing the population, sample, and participants by strata percentages. Although some of the information is redundant from previous tables, it is important to demonstrate the fact that the participants are sufficiently representative of the sample and the sample is representative of the population (see Tables 4.2, 4.3, and 4.4).

When reviewing these percentages, it becomes apparent that the participating entities are representative of both the overall population of California and of the individual strata from which they were drawn. Therefore, we are confident that the sample is generalizable to the State and to the various regions in the State. In addition to highlighting the generalizability of the sample to the population, the tables display sample characteristics

Table 4.2: Comparison of Hospital Participants Stratified to Sample

		Population (N=366)		Final Sample (n=132)		Study Participants (n=117)	
Variable	**Level**	**N**	**%**	**n**	**%**	**n**	**%**
Region	01 – Northern California	31	**8.5%**	7	**5.3%**	6	**5.1%**
	02 - Golden Empire	18	**4.9%**	7	**5.3%**	7	**6.0%**
	03 - West Bay	14	**3.8%**	5	**3.8%**	4	**3.4%**
	04 - North Bay	20	**5.5%**	7	**5.3%**	6	**5.1%**
	05 - East Bay	20	**5.5%**	7	**5.3%**	7	**6.0%**
	06 - North San Joaquin	21	**5.7%**	8	**6.1%**	8	**6.8%**
	07 - Santa Clara	12	**3.3%**	5	**3.8%**	5	**4.3%**
	08 – Mid Coast	11	**3.0%**	4	**3.0%**	4	**3.4%**
	09 - Central	30	**8.2%**	10	**7.6%**	9	**7.7%**
	10 - Santa Barbara/ Ventura	12	**3.3%**	5	**3.8%**	5	**4.3%**
	11 - Los Angeles County	91	**24.9%**	36	**27.3%**	31	**26.5%**
	12 - Inland Counties	33	**9.0%**	12	**9.1%**	11	**9.4%**
	13 - Orange County	31	**8.5%**	11	**8.3%**	10	**8.5%**
	14 - San Diego/ Imperial	22	**6.0%**	8	**6.1%**	4	**3.4%**
Bed No.	<120	143	**39.1%**	53	**40.2%**	47	**40.2%**
	120-249	128	**35.0%**	47	**35.6%**	41	**35.0%**
	250-499	81	**22.1%**	24	**18.2%**	22	**18.8%**
	500+	14	**3.8%**	8	**6.1%**	7	**6.0%**
Rural/Non	Rural	66	**18.0%**	22	**16.7%**	20	**17.1%**
	Non Rural	300	**82.0%**	110	**83.3%**	97	**82.9%**
Teach/Non	Teaching	26	**7.1%**	9	**6.8%**	7	**6.0%**
	Non Teaching	340	**92.9%**	123	**93.2%**	110	**94.0%**
Profit/Non	City/County/State	26	**7.1%**	9	**6.8%**	6	**5.1%**
	District	46	**12.6%**	12	**9.1%**	10	**8.5%**
	Investor	93	**25.4%**	37	**28.0%**	33	**28.2%**
	Non Profit	201	**54.9%**	74	**56.1%**	68	**58.1%**
System/Non	CHW	28	**7.7%**	11	**8.3%**	11	**9.4%**
	Kaiser	28	**7.7%**	8	**6.1%**	8	**6.8%**
	Tenet	20	**5.5%**	14	**10.6%**	14	**12.0%**
	Sutter	21	**5.7%**	10	**7.6%**	8	**6.8%**
	HCA	5	**1.4%**	1	**0.8%**	1	**0.9%**
	Adventist	14	**3.8%**	4	**3.0%**	4	**3.4%**
	Other	250	**68.3%**	84	**63.6%**	71	**60.7%**

Table 4.3: Comparison of Health Plan Participants Stratified to Sample

		Population (N=51)		Proposed Sample (n=28)		Study Participants (n=22)	
Variable	**Level**	**N**	**%**	**n**	**%**	**n**	**%**
Region	01 – Northern California	0	**0.0%**	0	**0.0%**	0	**0.0%**
	02 - Golden Empire	3	**5.9%**	1	**3.6%**	1	**4.5%**
	03 - West Bay	1	**2.0%**	1	**3.6%**	0	**0.0%**
	04 - North Bay	5	**9.8%**	4	**14.3%**	3	**13.6%**
	05 - East Bay	8	**15.7%**	4	**14.3%**	3	**13.6%**
	06 - North San Joaquin	1	**2.0%**	0	**0.0%**	0	**0.0%**
	07 - Santa Clara	3	**5.9%**	1	**3.6%**	1	**4.5%**
	08 - Midcoast	0	**0.0%**	0	**0.0%**	0	**0.0%**
	09 - Central	2	**3.9%**	1	**3.6%**	0	**0.0%**
	10 - Santa Barbara/ Ventura	2	**3.9%**	1	**3.6%**	0	**0.0%**
	11 - Los Angeles County	16	**31.4%**	11	**39.3%**	11	**50.0%**
	12 - Inland Counties	1	**2.0%**	1	**3.6%**	1	**4.5%**
	13 - Orange County	6	**11.8%**	2	**7.1%**	2	**9.1%**
	14 - San Diego/ Imperial	3	**5.9%**	1	**3.6%**	0	**0.0%**
Rural/Non	Rural medical group	0	**0.0%**	0	**0.0%**	0	**0.0%**
	Non Rural medical group	51	**100.0%**	28	**100.0%**	22	**100.0%**

Table 4.4: Comparison of Medical Group Participants Stratified to Sample

Variable	Level	Population (N=123)		Sample (n=76)		Participants (n=38)	
		N	%	n	%	n	%
Region	01 – Northern California	2	**1.6%**	2	**2.6%**	2	**5.3%**
	02 - Golden Empire	5	**4.1%**	3	**3.9%**	3	**7.9%**
	03 - West Bay	5	**4.1%**	3	**3.9%**	2	**5.3%**
	04 - North Bay	5	**4.1%**	2	**2.6%**	1	**2.6%**
	05 - East Bay	6	**4.9%**	4	**5.3%**	2	**5.3%**
	06 - North San Joaquin	4	**3.3%**	2	**2.6%**	0	**0.0%**
	07 - Santa Clara	5	**4.1%**	3	**3.9%**	0	**0.0%**
	08 - Midcoast	3	**2.4%**	2	**2.6%**	1	**2.6%**
	09 - Central	4	**3.3%**	2	**2.6%**	0	**0.0%**
	10 - Santa Barbara/ Ventura	4	**3.3%**	2	**2.6%**	0	**0.0%**
	11 - Los Angeles County	41	**33.3%**	26	**34.2%**	14	**36.8%**
	12 - Inland Counties	18	**14.6%**	12	**15.8%**	9	**23.7%**
	13 - Orange County	10	**8.1%**	5	**6.6%**	3	**7.9%**
	14 - San Diego/ Imperial	11	**8.9%**	8	**10.5%**	1	**2.6%**
Medical Group Size	1-100	12	**9.8%**	9	**11.8%**	6	**15.8%**
	100-500	48	**39.0%**	31	**40.8%**	14	**36.8%**
	501+	16	**13.0%**	7	**9.2%**	3	**7.9%**
	Unknown	47	**38.2%**	29	**38.2%**	15	**39.5%**
Rural/ Non Rural	Rural medical group	3	**2.4%**	3	**3.9%**	3	**7.9%**
	Non Rural medical group	120	**97.6%**	73	**96.1%**	35	**92.1%**

Findings

The Process of Peer Review

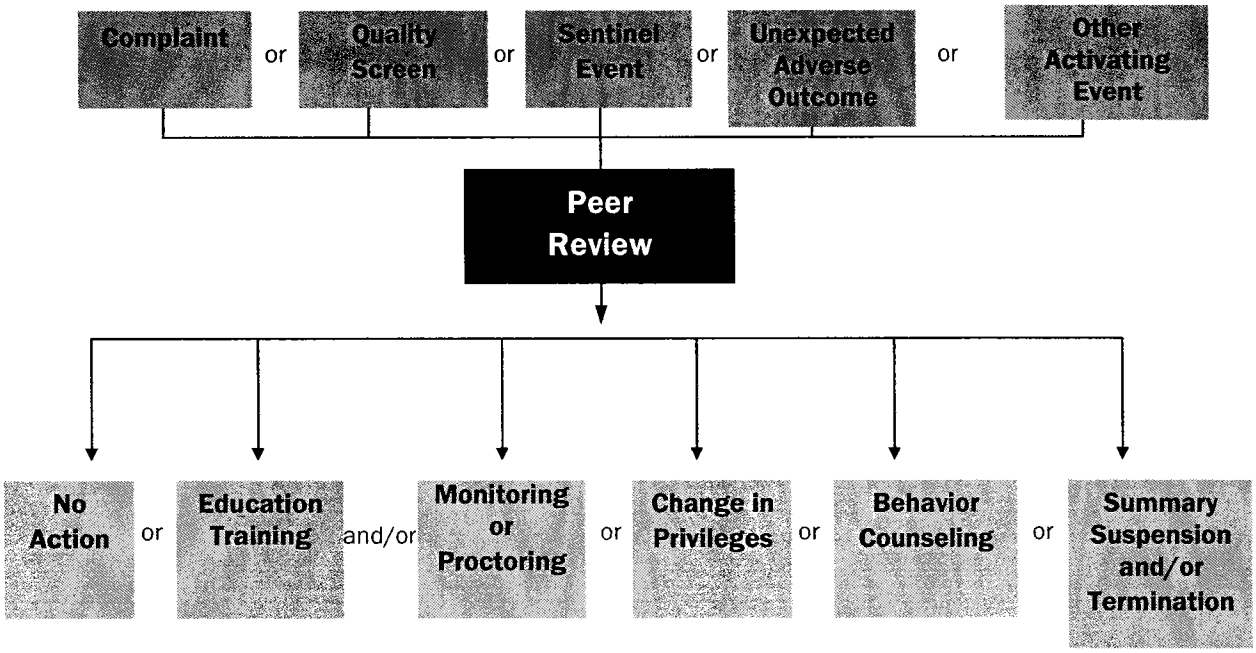
As explained earlier, medical peer review is used to determine whether medical care administered by physicians meets the standards set by an entity to ensure quality and safety in the entity's patient populations. If it does, the physician is allowed to continue to be affiliated with the entity and to treat patients within the context of the entity.

The determination of whether or not physicians' actions meet the standards set by the entity is made by "peer" medical physicians within the entity. Although most medical care entities develop policies and procedures that adhere to standards set by accrediting agencies or professional entities, the entity documents we reviewed indicated that standards within an entity are set by medical staff members who are affiliated with the entity. Oversight by State and federal licensing and credentialing entities provides direction as to standards that should or must be included, but the medical staff members in the entities make the final decisions.

Figure 4.3 displays the peer review process we typically found described in entity documents. Entity peer review policies indicated that there are numerous ways to trigger the peer review process, including routine quality screens done at the medical department level or in various committees in the entity. Peer review also may be triggered by a complaint, an unusual event, a sentinel event, or other methods.

The outcome of peer review likewise is varied. The peer review process may determine that there is no action needed, education may be needed, monitoring is required, or more severe action is needed, including summary suspension or termination. But what actually happens in the "black box" of peer review?

Figure 4.3: The California Peer Review Process



The remainder of this chapter presents evidence to answer this "black box" /"peer review" question. The precipitating events and outcomes of peer review in different entities are highly variable and specific to each entity. The following section details the findings from our document review and comments from participant individuals. The findings are organized by their relevance to the specific requirements of 805.2 legislation.

Requirement I: A comprehensive description of the various steps and decision makers in the peer review process as it is conducted by peer review bodies throughout the State, including the role of other related committees of acute care health facilities and clinics involved in the peer review process.

Document Review

To respond to Requirement I, we used document review and on-line surveys. We requested documents related to peer review activities from all selected entities (see initial request in Appendix I: Study Results), including policies, procedures, bylaws, charters, and minutes from quality, well being, peer review, or department committees for the time period 2002-2007.

We were seeking details of the entities' processes of peer review and event reporting decision-making. We made no fewer than three attempts to contact each entity asking for these documents (see Table 4.3) and responded to over 400 telephone, e-mail, and fax inquiries about the project.

Based on comments from participants and documents from entities, we learned that the term "peer review" is used to mean different activities in different entities. However, in this study, we only studied and reported on medical peer review done by medical peers. Peer review committee minutes and activities are protected from discovery by California Evidence Code 1157[55], and the peer review committee meetings are typically closed to anyone other than recording staff and peers.

Policies and procedures indicate that peers may be physicians in the entity, physicians of a specific specialty or expertise, or physicians external to the entity (external review) depending on the event to be reviewed. The entities make an attempt to create peer review activities that are unbiased and objective, and focus first on remediation rather than disciplinary action whenever possible. However, most medical groups are small enough or the specialty is small enough that it is impossible for reviewers to be unaware of the identity of the physician being reviewed.

Credentialing of a physician by an entity can be thought of as the initial peer review interaction. The physician applies for privileges and presents credentials and other documents testifying to his/her qualifications. It is incumbent upon the physician to convince the entity that he/she is qualified to be a member of the medical staff. Medical executive bylaws that were reviewed indicate that the medical staff members make a determination about the application for privileges in the entity and either grant or deny the right to practice in the entity.

Re-credentialing of each physician who is granted privileges is done on a periodic basis in each entity. In re-credentialing, if the membership is terminated or restricted, it is incumbent upon the entity to demonstrate that the physician is no longer qualified to be a member of the medical staff.

Based on policy, procedure, and minutes review, peer review activities occur between the periodic re-credentialing of physicians. A peer review can be triggered in a number of ways (see Figure 4.3), but most frequently it is part of the quality/safety/risk process of an entity. Policies indicated that it may be started in various committees such as quality assurance/improvement, risk management,

utilization review/management committees, but it is frequently begun in a medical staff department committee.

Most participant entities routinely screen a certain percentage of patient records to check for evidence of substandard care that may be related to system problems, violations of discipline-specific standards, or violation of entity policies and procedures. A complicating factor in understanding the initiation of medical staff peer review issues is that the entity committee minutes indicated that all types of risk management events and actions are combined and discussed in "peer review" committees. Additionally, based on our review of committee minutes, medical staff committees often combine risk management/peer review issues with mundane issues related to running the business of the entity, such as fee increases, other financial issues, and other concerns.

The usual start of the peer review process in many organizations is when a non-physician support staff member (frequently a nurse) performs an explicit review (a review of the record using a structured format and procedure) of a medical record. If the non-physician support staff member using explicit review finds records that "fall outside the screen" (outside the standards of care for the entity), or if there are events that are questionable, the staff member forwards the record for review to the chair of a peer review committee or to the entire committee, depending on the policy and procedure. The record may then be forwarded to a higher-level committee of medical staff for more intensive medical staff review and evaluation.

Depending on the size and structure of the entity and the committees, the more intensive review may be at the departmental level, the medical executive committee, or other responsible medical staff groups, or any variation of these. If there is substantial deviation from the standard of care, the patient record follows the entity procedure and is eventually reviewed by the highest-level medical committee for decision-making and determination if any action should be taken against the physician.

As indicated in Figure 4.3, and based on our review of policies and procedures, events other than routine screening of records also can trigger peer review. Depending on the severity, as determined by the person who learns of the event and those persons who become involved in reviewing the details of the event, the peer review process can move quickly. Generally, however, our review of committee minutes demonstrated that the process is very lengthy involving months or years of re-review, review of more records, interviews with the physician, and/or other investigation methods within the entity.

The medical executive/decision making committee may require a focused review, which is a larger sample of patient records for targeted review of the physician in question. The focused review may require other physicians in the entity to review records and may require discussions about what the standard of care is for the particular event. If there are only a few physicians in the entity with limited expertise in the area of the event, an external review may be initiated. A contracted expert outside the entity conducts an external review, which may further delay any potential action taken as a result of the event.

There are many steps in the peer review process that allow variation. The entity policy defines what is reviewed, but typically a non-physician hospital staff/committee support employee is responsible for the initial review, maintenance of the quality, safety, risk, or credentialing processes and committees minutes, and tracking of events and physician behavior over time. To summarize, there is variation in what is subject to peer review, determined not only by the procedure that initiates peer review, but also by the individual support staff member and committee chairs' knowledge and tenacity in tracking events and physicians over time.

As indicated in Chapter III, we reviewed documents and minutes using a structured format (see Appendix IV: Structured Review Forms) that included assessment of whether:

- A bylaws template was used.
- The process for quality and safety assessment was outlined in bylaws or policies.
- There was a method for a fair hearing.
- There was a process for dealing with impaired physicians.

We also assessed whether the entity had a tracking system that allowed for systematic follow-up for events that potentially would be reported to the MBC, and whether the overall quality/safety/risk management program was organized and easy to understand and follow. Table 4.5 presents some of the findings of our structured review. Rather than submitting minutes, some entities provided a summary of an event to be used as an example of how the entity handled reporting through 805 or deciding not to report.

Table 4.5: Summary of Documents Submitted by Entity Type

Entity Type	Number in Final Sample	Number Submitting Any documents	Number Submitting No Minutes	Number Submitting Any Minutes	Number Submitting Five years Minutes	Number Submitting < Five Years Minutes	Number Providing Event Summary
Hospitals	132	109	104	28	17	11	30
Healthcare plans	28	21	12	16	14	2	11
Professional societies	9	8	9	0	0	0	0
Medical groups/ clinics	76	34	52	24	19	5	6
Total	**245**	**172**	**177**	**68**	**50**	**18**	**47**

Professional societies behave differently than the other three entity types. Of the eight that responded to our document request, four stated that they did not perform peer review and the other four reported that they were rarely involved in peer review. Of the four who were involved in peer review, three have policies and procedures but report any 805s to a professional board rather than the MBC. The remaining entity only accepts complaints about its members and refers other complaints to the MBC, so professional societies/entities have only minor role in the process of peer review.

One hundred-fifty entities (61.2% of 245) described the peer review process used in the entity through policies, procedures, or bylaws. Ninety-seven hospitals (78.5% of 132) used a template for medical staff bylaws, which provided a systematic way to include all the required elements necessary for description of peer review, and the disciplinary process that might occur (see Appendix IV: Structured Review Forms). Fifty-five and a half percent of the entities (136 of 245) described the 805 reporting process, and 55.1% (135 of 245) described the due process/fair hearing procedure. However, only 21.2% (52 of 245) mentioned or described the process for dealing with an impaired physician.

One third (33.1% of 245) of the entities used an event category or rating system based on severity, and a similar percentage (31% of 245) had a rating system for actions taken as a result of an event.

43.3% of the 245 entities had explicit definitions of events that initiated peer review and actions that resulted. Using a scale of 0 to 5 with 0 being no definitions, 1 being the poorest definitions, and 5 being the best definitions, as judged by the research team, entities scored an average of 1.2 (sd=1.7) in having explicit definitions of different categories of events or actions. Hospitals (mean=2.0 [1.8]) and health plans (mean=1.0 [1.7]) had the most explicit definitions, while medical groups (mean=.92 [1.4]) and professional groups (mean=.89 [1.8]) had less specific definitions.

Tracking events over time is an essential part of peer review because of the length and complexity of internal investigations. We scored the entities on whether the tracking systems were comprehensive based on evidence in minutes, policies, and procedures using a 0 (no evidence of tracking) to 5 (most comprehensive) scale based on the judgment of the research team. We determined "comprehensiveness" by reviewing policies and procedures to see if there were specific time frames specified for reviews and evaluating minutes to see if the policies were then followed.

We found that entities scored 0.5 (sd=1.0) overall with health plans averaging .89 (sd=1.6); hospitals averaged .82 (sd=1.5), and medical groups averaged .28 (sd=.9). None of the professional societies provided documents that indicated if they had a tracking system for peer review cases.

Based on the minutes reviewed in submitted documents and site visits, we found that entities generally follow their own policies and procedures related to peer review with the most common policy violation being the length of time it takes to complete an investigation and review. But tracking systems are limited and difficult to follow, and there is a great deal of variation in the specificity of policies and procedures about events that are investigated.

Online Survey

Information gleaned from the surveys is discussed next. One hundred-fifteen entities responded to the online survey from 245 eligible entities (see Table 4.6).

Table 4.6: Online Survey - Entity Response Rate

	Returned Survey	Eligible	Entity Response Rate
Entities	115	245	46.9%

Twenty percent of respondents were chairs of peer review committees, 21.1% were physician reviewers, 8% were physicians who had been reviewed, 41.1% were non physician support staff, 8.6% were attorneys representing entities, and 1.1% were attorneys representing a reviewed physician (see Table 4.7). Each of the four entity types was represented in the survey respondents; 62.9% were hospitals (see Table 4.8).

Table 4.7: Number of Online Survey - Individual Responses by Entity Type and Individual Role in Entity

Role	Entity Type Hospital	Health Plan	Medical Group	Professional Society	Total	%
Peer Review Chair	44	7	15	4	70	20.0%
Physician Reviewer	30	21	21	2	74	21.1%
Physician Reviewed	21	1	5	1	28	8.0%
Non Physician Staff	97	8	32	7	144	41.1%
Attorney Representing Entity	25	0	2	3	30	8.6%
Attorney Representing Physician	3	0	1	0	4	1.1%
Total	**220**	**37**	**76**	**17**	**350**	**100.0%**

Table 4.8: Number of Online Survey - Responses by Entity Type

Entity Type.	n	%
Healthcare Plan	37	10.6%
Hospital	220	62.9%
Medical Group	76	21.7%
Professional Society	17	4.9%
Total	**350**	**100.0%**

Because we used six different versions of the study, we had varying numbers of potential or eligible respondents for each question. We provide the number of persons **eligible** to answer the question. In order to give an accurate representation of missing data, we also provide the number of respondents used as the denominator of the % when we report percentages.

The most common name of the decision-making/final authority committee was the Medical Staff Executive committee, followed by the Peer Review committee and Quality or Quality Improvement committee. The average number of members on the decision-making committee was 16 with an additional four non-physician hospital staff support members. Committees averaged eight different medical specialties represented and three other disciplines (see Table 4.9). Internal medicine, family practice, and surgery were the most frequently mentioned specialties on the committee and the usual length of time a member serves on a committee is for two or more years (see Table 4.10).

Table 4.9: Online Survey - Peer Review Body Composition
(214 eligible respondents)

What is the Composition of the Peer Review Body?	n	Mean	sd*
Total number (#) of members	137	16.4	9.2
Number (#) of committee members who are non-physician staff	140	3.8	3.2
Number (#) of disciplines represented besides medicine (nursing, medicine, pharmacy, etc)	135	2.8	3.7
Number (#) of different medical specialties represented (surgery, pediatrics, etc)	134	7.7	4.6
Number (#) of committee members who are generalists	120	3.4	5.9

*sd - standard deviation

Table 4.10: Online Survey - Peer Review Body Length of Term
(70 eligible respondents; 52 actual respondents; percentages based on a denominator of 52)

What is the usual term for each member who serves on the peer review body?	n	%
1 year	4	7.7%
2 years	14	26.9%
More than 2 years	24	46.2%
Other (please specify term)	10	19.2%
Total	**52**	**100%**

The decision-making committees reported multiple responsibilities, including managing overall quality of care issues, complaint/sentinel event investigation, monitoring physician practice and practice patterns, determining disciplinary action, and filing 805 reports. The respondents said that the committee was also responsible for monitoring utilization, initial screening activities, 809 hearings, and submitting 821.5 reports.

The committees have oversight responsibility for physician practice quality and safety issues, such as gross or flagrant care issues, limitation of practice, practice patterns not consistent with standards of care, egregious events, repeated errors, multiple patient complaints, and multiple physician complaints. They also are frequently responsible for monitoring required proctoring, quality screening issues, employee complaints, health plan complaints, and utilization review and risk management issues (see Table 4.11).

Membership on peer review committees involves a certain time commitment, and we were interested in knowing how difficult it was to replace members on the committee. Based on our survey data, on average, one person declined to be on the peer review committee for every four that were asked (see Table 4.12). We also asked physicians why they agreed to serve on a peer review committee (see Table 4.13). Most indicated a willingness or interest in peer review; others had experience in peer review; or it was required by the entity (see Table 4.13).

Table 4.11: Online Survey - Peer Review Body Tasks
(214 eligible respondents; 123 actual respondents; percentages based on a denominator of 123)

Indicate responsibilities of the peer review body: (check all that apply)	n	%
Quality of care concern (evaluate)	112	91.1%
Series of complaints/events about physician	107	87.0%
Sentinel event	98	79.7%
Secondary or final determination of action, if any, to be taken for a patient care issue related to a physician's practice	97	78.9%
Tracking or monitoring of a physician's practice issue	92	74.8%
Utilization of care (evaluate)	87	70.7%
A physician's practice pattern	87	70.7%
Submit an 805 report	72	58.5%
Submit an 821.5 report	60	48.8%
Initial screening for patient care issue related to a physician's practice	59	48.0%
Convene or oversight of an 809 hearing	57	46.3%
Initial screening for patient care issue related to an entity or systems-problem	50	40.7%
Other	20	16.3%

Table 4.12: Online Survey - Peer Review Body Membership Changes
(214 eligible respondents)

In the last calendar year,	n	Mean	sd
How many new members were added to the peer review body?	128	3	5.7
How many individuals were approached to serve on a peer review body?	101	4.1	6.5
If applicable, of those approached, how many refused?	73	1.1	2.3
How many unanticipated member changes have occurred in the peer review body?	127	0.5	1.1

Table 4.13: Online Survey - Peer Review Body Reasons for Serving
(74 eligible responses; 64 actual respondents; percentages based on a denominator of 64)

Identify the reason(s) you agreed to serve on the Peer Review Body? (check all that apply)	n	%
Willingness to serve	52	81.3%
Interest in peer review	46	71.9%
Experience in peer review	29	45.3%
Requirement for affiliation/employment	9	14.1%
Other	7	10.9%
Payment is offered by entity	4	6.3%
Scheduled/rotating obligation	3	4.7%
Requirement for hospital privileges	2	3.1%

Depending on the entity, various individuals and committees are responsible for determining whether to refer an issue/event to a higher level review, including the committee chair or a majority of members of peer review committees, credentialing committees, department committees, professional affairs committees, and risk management committees.

Fifty-six percent of the respondents indicated that a majority vote of the initial committee was required to refer the issue to a higher-level review body within the entity, and 69.5% of the respondents reported that the committee chair made the decision (see Table 4.14). Fifty-six percent of respondents reported that the decision to forward an 805 report to the MBC was made by a majority of the final decision-making committee (see Table 4.11).

Table 4.14: Online Survey - Peer Review Body Referral Mechanisms
(214 eligible respondents; 118 actual responses; percentage based on denominator of 118)

Indicate the position of the person, committee, or mechanism that determines whether to refer an issue to a secondary or higher review body in the entity:	n	%
Peer review chair	82	69.5%
A majority vote of the initial screening committee	67	56.8%
Credentialing Committee decision	66	55.9%
Medical Department Chair	62	52.5%
Chair of initial screening committee	53	44.9%
Entity policies & procedures	48	40.7%
Risk Management Committee decision	33	28.0%
A majority vote of the Medical Department members	24	20.3%
Professional Affairs Committee decision	14	11.9%

Table 4.15: Online Survey - Peer Review Body Reporting Mechanism
(214 eligible respondents; 124 actual respondents; percentages based on a denominator of 124)

Indicate the person, committee, or mechanism that determines whether an issue (805 or 821.5) is reported to the Medical Board of California (MBC):	n	%
A majority vote of the final review committee	70	56.5%
Other	50	40.3%
Chair of secondary or final determination committee	25	20.2%
Entity policies & procedures	23	18.5%
Peer review chair	18	14.5%
Credentialing Committee decision	15	12.1%
Risk Management Committee decision	5	4.0%
Medical Department Chair	4	3.2%
A majority vote of the Medical Department members	4	3.2%
Professional Affairs Committee decision	3	2.4%

Most respondents (69%) knew that an 805 or 821.5 report must be submitted within 15 days of the event being reported (see Table 4.16), and 67% knew that a supplemental report was to be submitted within 30 days of the physician completing the terms of the discipline.

Fifty-six percent of the respondents knew that an 821.5 report was to be submitted to the MBC within 15 days of the initiation of a formal investigation and knew the timeframe within which the MBC diversion program administrator must contact the reporting peer review body (see Table 4.16).

Table 4.16: Online Survey - Reporting Time Frames
(214 eligible respondents; actual respondents are listed in "Total" row; percentages calculated using the actual respondents as the denominator)

	After a reportable event (805 or 821.5), the entity's designated peer review officer must submit a report to the relevant agency within how many days		After the licentiate has satisfied the terms of a disciplinary action, a supplemental report is made to the relevant agency within how many days:		After initiating a formal investigation of a potential 821.5 event, the entity's designated peer review officer must submit a report within how many days:		Upon receipt of an 821.5 report, the MBC diversion program administrator shall contact the reporting peer review body within how many days:	
	n	%	n	%	n	%	n	%
Correct	78	69.0%	76	67.3%	64	55.7%	70	63.6%
Not correct	35	31.0%	37	32.7%	51	44.3%	40	36.4%
Total	**113**	**100.0%**	**113**	**100.0%**	**115**	**100.0%**	**110**	**100.0%**

Most respondents knew some of the criteria for filing 805 or 821.5 reports (see Tables 4.17 and 4.18). However, the items listed in Tables 4.17 and 4.18 are all criteria for completing 805 or 821.5 reports so each respondent should have checked all of the items except "other." The respondents indicated various resources to use when they needed information with the most frequently cited source for information being the law or code itself (see Table 4.19).

Table 4.17: Online Survey - Peer Review Body Criteria for Filing 805 Reports
(350 eligible respondents; 212 actual respondents; percentages based on a denominator of 212)

Indicate the criteria used for filing an 805 report: (check all that apply)	n	%
When a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment	162	76.4%
When a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason	156	73.6%
When a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason	140	66.0%
The imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days	136	64.2%
After notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason	111	52.4%
Other	42	19.8%
Resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership	39	18.4%

Table 4.18: Online Survey - Peer Review Body Criteria for Filing 821.5 Reports
(214 eligible respondents; 117 actual respondents; percentages based on a denominator of 117)

Indicate the criteria used for filing an 821.5 report for a physician or surgeon POSING A THREAT TO PATIENT CARE: (check all that apply)	n	%
Physician or surgeon suffering from a disabling mental condition	98	83.8%
Physician or surgeon suffering from a disabling physical condition	93	79.5%
Physician or surgeon suffering from a substance abuse condition	90	76.9%
Other	18	15.4%

Table 4.19: Online Survey - Peer Review Body Resources
(70 eligible respondents; 46 actual respondents; percentages based on a denominator of 46)

For either the 805/821.5 report, identify the resources available to assist you in your determination for filing:	n	%
Review of 805/821.5 legal codes	37	80.4%
Web sites	27	58.7%
Entity documents	27	58.7%
Discussions with licensing authorities	24	52.2%
Other	17	37.0%
None	1	2.2%

Summary of Requirement I
Based on the study results, a summary of the findings for Requirement I follows.

1. Variation exists across entities in how they define and conduct "peer review," including:
   - Events that trigger peer review.
   - Procedures that are followed after peer review.
   - Tracking of peer review issues.
   - Expertise of the non-physician support employees and the physician reviewers and chairs.

2. Peer review by entities in California involves common procedures or practices, including:
   - Using remediation for substandard physician care that may last for 12-24 months before taking an action requiring an 805 report.
   - Credentialing of a physician as the initial peer review interaction with peer review activities occurring between the periodic re-credentialing of physicians.
   - Routinely screening a certain percentage of patient records to check for evidence of substandard care.
   - Combining and discussing all types of risk management events and actions (not just activities involving physicians and medical staff) in "peer review" committees, as well as mundane issues related to running the business of the entity.
   - Initiating peer view with a non-physician support staff member performing an explicit review of a medical record.

3. The identification and timeframe for resolving peer review issues depends on a number of factors within each entity, including:
   - The severity of an event, as determined by the person who learns of the event and those persons who become involved in this process. (Our review of committee minutes demonstrated that the process is very lengthy, involving months or years of re-review, review of more records, interviews with the physician, remediation, and/or other investigation methods within the entity.)
   - The entities' own policies and procedures related to peer review.
   - Decision-making committees having multiple responsibilities, including managing overall quality of care issues and complaint/sentinel event investigation, monitoring physician practice and practice patterns, determining disciplinary action, filing 805 reports, conducting utilization, initial screening activities, and 809 hearings, submitting 821.5 reports, proctoring, employee complaints, and working with health plan complaints and risk management issues.

4. Survey respondents knew some, but not all, of the criteria for filing 805 and 821.5 reports and 809 hearings.

Requirement II: A survey of peer review cases to determine the incidence of peer review by peer review bodies and whether they are complying with the reporting requirement in Section 805.

A substantial amount of anxiety about the study was exhibited by the entities, particularly hospitals. Thirty-seven (49 of 132) percent of hospitals communicated with us through attorneys, although only a few health plans or medical groups communicated using attorneys. A number of hospitals or attorneys sent letters (see Appendix III: Hospital Related Documents) detailing reasons for declining to submit certain documents. Most of the letters refer to laws and case law described in Table 2.2. Some hospitals also invited us to visit the facilities for more information.

Most of the letters also refer to a conference call held on October 5, 2007. This call was arranged by the California Hospital Association, ostensibly to allow Lumetra to answer questions posed by various hospitals. However, a few individuals dominated the call and expressed a desire to substantially change the study design.

We answered the questions as best as possible, referred the individuals to the legislation, and terminated the call after one hour. As a result of this meeting and other indications of general anxiety regarding the study, we set up a Web site that described the study purposes and the pertinent legislation, and posted answers to some frequently asked questions.

Since we also had been contacted by various individuals who wanted to influence the study design, we invited people who visited the Web site to e-mail comments to an e-mail box that could be accessed through the site. In order to maintain our independence from outside influence, we agreed to review the comments at the end of the study and include them in the final report (see Appendix IX: Comments About Study).

As indicated in the letters from entities (see Appendix III: Hospital Related Documents), fear of legal "discovery" of protected information was the main reason given for declining to send peer review minutes. The second most common reason given for declining to send minutes was the effort and personnel required to compile the minutes.

We discovered that most entities do not have the documents in electronic form, and many have them stored offsite. Most entities do not appear to have a readily accessible tracking system that allows the staff members to efficiently follow events over time. Additionally, during the study there were two entities that were purchased and the new owner claimed to have no access to minutes or other documents prior to the time when the purchase occurred.

A large share of entities submitted policies, procedures, and bylaws but declined to submit committee minutes (see Table 4.5). Even after lengthy reassurances and identification of the safeguards imposed in the 805 legislation, there were still 177 entities that refused to send minutes. The ability to review committee minutes was critical to determine whether entities were complying with the reporting requirements. Additionally, it was not sufficient to review only 805 reports because it was also necessary to review events and decision-making that did not trigger 805 reports.

Some entities created event summaries that detailed events leading to 805 reports or events that might lead to 805 reports. Because the histories of the events are important, and the histories occur over months or years, the summaries allowed us to track events more efficiently.

Since the study had time and cost constraints, the document review was our primary way to determine whether entities were in compliance with the law. Therefore, we decided to add a number of site visits to the study in order to review documents that the entities refused to submit. The site visits are discussed in the Study Validation Measures section of this chapter.

We reviewed minutes provided by 68 entities and additionally reviewed minutes during the site visits. We also had access to an entity's sample of events and histories for those entities that provided event summaries. Participant entities screened a large number of cases through the routine monitoring process (typically a set percentage of various diagnoses) and selection of cases. These selected cases are peer reviewed in the various committees generally using implicit peer review (i.e., using the reviewers' professional judgment). One large hospital claimed to have screened over 8,000 cases in the five years for which data were requested (see letters in Appendix III: Hospital Related Documents).

Based on the review of committee minutes and cases and discussions with participants, we estimate that a small percentage of routinely screened cases are forwarded to the medical executive/decision making committee for further review, and a still smaller percentage of those cases forwarded results in an action that limits or terminates a physician's privileges for medical cause or reason, thus triggering an 805 report to the Medical Board (see Table 2.4). We were unable to determine an exact percentage for the following reasons:

1. The tracking of cases over time in most entities is poor or lacking.
2. One of the first actions by an initial peer review committee (such as a department committee) is to ask the subject physician to come to the next meeting to discuss the event or for the chair of the committee to speak with the subject physician to understand the subject physician's thinking about the event.
3. Often the subject physician is delayed or the chair is delayed and the matter is held until the following month's agenda or a later agenda.
4. The event or case was not documented in future minutes to which we had access or because the discussion between the physician and the chair happened away from the committee meeting.
5. Following events through minutes of other committees was difficult or impossible because there might not have been any record in the minutes of a follow-up meeting or the follow-up meeting occurred months after the initial event.
6. The committee minutes include issues other than peer review activities, and in some entities, comments about follow-up cases are often missing or limited.

Because there are proportionally few sentinel events, major employee or physician complaints, or events that are particularly egregious or unexpected per number of patients and related to physician practice, these events are almost always forwarded to a higher-level review committee (see Figure 4.2).

Based on our review, we observed that overall the entities are following the letter of the law regarding 805 reporting. Using minutes and event summaries, we discovered that entities try numerous remedial interventions (peer counseling, education, training, mentoring, observation, behavior counseling, UCSD Physician Assessment and Clinical Education (PACE) Program[32]) before informing the physician that a "final proposed action" is being taken. The process to this point is almost never

shorter than one year. Also adding to the process is the disagreement about how to interpret two parts of the California codes: 805 (c) and 809.2 (h).

Business and Professions Code Section 805 (c) states that an 805 report will be filed "within 15 days after any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason" (see Table 2.4)[1]. However, Business and Professions Code Section 809.2 (h) states, "A hearing under this section shall be commenced within 60 days after receipt of the request for hearing, and the peer review process shall be completed within a reasonable time, after a licentiate receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges (underline added), unless the arbitrator or presiding officer issues a written decision finding that the licentiate failed to comply with subdivisions (d) and (e) in a timely manner, or consented to the delay" (see Table 2.3)[1].

Based on focus group and key informant interview data, we learned that some attorneys advise their client entities to behave in the most conservative manner to ensure physician rights. Thus, these entities do not file any 805 reports until after an 809 hearing when the physician (licentiate) receives notice of a "final proposed action." Other attorneys reported that they interpret the code to mean that the 805 is filed after an 809 hearing, unless there is a summary suspension or immediate termination. Therefore, in those entities, 805 reports would not be filed unless there was a summary suspension of more than 14 days or an immediate termination.

Key informants reported that the 809 hearing for due process can add 2-5 years to the process of filing an 805 report. Several affected physicians reported taking various legal actions that further delay the 805 reporting. Some attorneys expressed that they believed they are guilty of legal malpractice if they do not delay the 805 reports as long as possible for their client.

Although there is disagreement about the potential threat to a career, physicians who have been the subject of an 805 report state that it is difficult or impossible to find a new position, their professional lives are ruined, other entities will not grant privileges even if they have fulfilled the terms of the discipline, and they spend years and hundreds of thousands of dollars in court trying to clear their professional names and reputations.

Based on reviews of the minutes from participant entities and key informant interviews, the most common reasons for cases being referred for peer review to a high level (executive medical staff) committee are 1) disruptive physician behavior/impairment (821.5), 2) substandard technical skills, and 3) failure to document/record patient treatment.

Impairment cases have frequently been referred to the diversion program through the MBC. However, this program was terminated effective June 30, 2008. MBC staff members reported that in the diversion program, records of events are required to be destroyed as soon as the case is closed, so there is no means to track recidivism of drug or alcohol use.

Mental or physical illness that impairs a physician's ability to practice medicine safely is also a reason for changes in privileges that require 821.5 or 805 reporting. Bylaws, policies and procedures indicate that physicians may be referred to the entity's "well-being" committee or other behavior modification committees or programs in order to remediate the substance abuse, anger outbursts, and/or mental or physical health issues that affect physician behavior. Because changing physician privileges triggers an 805 report, while the entity is trying to deal with this impaired or disruptive physician, the physician is allowed to continue to practice.

Minutes and event summaries from some entities indicate that physicians are allowed to commit multiple disruptive actions over many years while various strategies are tried or before any remediation is required. In one instance, a physician attended the PACE program but re-offended with the same disruptive behavior in the following year. All of this may occur before an 821.5 report is filed. It is also not possible to discover whether 821.5 reports are filed appropriately because of the codes protecting the rights of the physician.

Physicians having (or who develop) substandard technical skills can be trained, mentored, proctored, and assisted without triggering an 805 report as long as the training is not for medical cause or reason and there is no change in privileges (see Table 2.4). Minutes indicate that entities attempt these interventions to solve the problem before the behavior results in an event that triggers a reporting requirement.

Another common reason for referral to peer review or 805 reporting is for the physician who does not document medical care in a patient record. The lack of documenting eventually becomes so egregious that the entity is at risk for censure by licensing and accreditation agencies, so the entity withdraws or restricts the offenders' privileges and files an 805 report with the MBC.

During the study, key informants from participant entities suggested the elimination of failure to document as a reason for reporting to the Board because it appears to be a squabble between an entity and a physician who will not keep up on charting. However, if professionals agree that documentation of medical care is required to ensure a safe and quality environment in which to treat patients, then the requirement is no different than any other substandard medical practice.

Requirement II Summary

In summary, collecting the data to address Requirement II was a challenge because many of the entities, especially hospitals, expressed anxiety and concern in providing documents for review, particularly peer review minutes for fear of legal "discovery." A second concern was the amount of effort, both in time and personnel, to compile these documents, since most entities do not maintain electronic records or store them offsite.

Our finding revealed the following about peer review and 805 reporting.

1. Event tracking capability of entities is limited due to:
    - Lack of a readily available tracking system that allows the staff members to efficiently follow events over time.
    - Lack of access to prior minutes or other documents by new owners when an entity is purchased.

2. Overall, entities follow the letter of the law regarding 805 reporting and screen a large number of cases through routine monitoring, but few cases lead to actual 805 filings, because of the following:
    - Disagreement/or legal interpretation about whether an 809 hearing is required before every 805 report is submitted.
    - 809 hearings for due process adding years to the process and delaying the filing of an 805 report.

3. Entities use other measures to correct physician behavior before resorting to filing an 805 report (which allows physicians to continue to practice and possibly commit multiple actions over many years before any steps are taken), including:

- Remedial interventions (e.g., peer counseling, education, training, mentoring, observation, behavior counseling, PACE Program).
- Referral to the Diversion Program (which is closing) for impairment cases.
- Bylaws, policies, and procedures that allow physicians to be referred to the entity's "well-being" committee or other behavior medication committee/program to remediate the causes affecting the physician behavior.

4. The most common reasons for cases being referred for peer review to a high level (executive medical staff) committee are 1) disruptive physician behavior/impairment (821.5), 2) substandard technical skills, and 3) failure to document/record patient treatment.

5. Most responses indicated people knew that mental or physical illness that impairs a physician's ability to practice medicine safely is also a reason for changes in privileges that require 821.5 or 805 reporting.

6. It is possible that some physicians would never be subject to peer review because they have practices that do not fit any peer review requirements.

Requirement III: A description and evaluation of the roles and performance of various State agencies, including the State Department of Health Services and occupational licensing agencies that regulate healing arts professionals, in receiving, reviewing, investigating, and disclosing peer review actions, and in sanctioning peer review bodies for failure to comply with Section 805.

In earlier chapters, we listed various State agencies, codes, and regulations that govern the entities in the study (see Table 1.1, 2.2; 2.7). The Department of Managed Care provides governance for HMOs and health plans; Title 22 and OSHPD have some governing responsibility for acute care hospitals. The Office of the Patient Advocate and OSHPD have some control over medical clinics. However, because of the limited timeframe, the focus of this study is on the Medical Board and the regulation of the practice of medicine in California.

In key informant interviews, we found that over the years other professional disciplines have developed State boards of control, so that the MBC only investigates physicians and podiatrists. The discipline-specific boards promulgate regulations governing the practice of individuals who are licensed or certified by the State. We found no systematic communication among these various boards and agencies that would coordinate patient quality and safety issues.

In order to fairly assess the role of the MBC, we reference the standards put forth by the Federation of State Medical Boards (FSMB) of the United States, Inc., which were developed by The Special Committee on Evaluation of Quality of Care and Maintenance of Competence, and approved by the Federation House of Delegates in April 1999[30]. Although some of the standards are beyond the scope of this report, we used quantitative data provided by the MBC and data from structured interviews with MBC staff members to respond to those that are relevant.

FSMB Standard One: State medical boards should develop and implement methods to identify physicians who fail to provide quality care and therefore warrant further evaluation by the State medical board.

This study details the activities that occur within entities prior to and following reporting to the Medical Board of California. The MBC has an extensive procedure to identify physicians who fail to provide quality care. Additionally, the MBC posts numerous public education messages and information on its Web site, which also includes reporting forms for different individuals and entities that are responsible for reporting to the MBC (see Appendix VII: Medical Board of California Documents).

The MBC has 400+ employees in 11 district/field and three probation offices located around the State performing numerous activities in addition to managing the work related to 805 reporting. The efforts to ensure quality are essentially complaint driven, although healthcare entities do provide routine quality screening.

The Board receives over 8,000 complaints (including 805 and all other complaints) annually, which are investigated by physicians and as necessary, MBC staff members with training as law enforcement officers, degrees in criminal justice, or detective-level experience in a police agency. The complaint review process (including 805 reports) is diagramed in Figure 4.4, the enforcement process in Figure 4.5, and the public disclosure process in Figure 4.6.

The diagrams demonstrate the multiple sources of complaints, the multiple ways different complaints are reviewed, and the complex outcomes of the complaints review that would initiate the enforcement process. The Board reviews all complaints to determine whether the complaint falls within the Board's jurisdiction and contacts the physician for a response. After receiving relevant information, the complaint is forwarded to a physician consultant for review of alleged specific standard of care violations. If there is no departure from the standard, the complaint is closed. If the complaint warrants further review, the physician forwards the complaint to one of the field offices for further investigation. In either case, both physician and complainant are notified of the complaint disposition.

The diagrams also illustrate the complexity of the complaint process, the enforcement process and the public disclosure rules. Public disclosure is limited by numerous codes and varies in whether entities or individuals have access to the information, how long a record stays on the Web site and how a request must be made.

An example of a lawsuit that impacted the disclosure laws is the 1993 suit filed by the California Medical Association (CMA) against the MBC to stop public disclosure of an MBC request of the Attorney General's office to file an accusation against a physician [116, 117]. This ruling protected the interest of the physician, but added to the complexity of the laws governing public disclosure. All of the processes are complex and multi-layered.

During the focus group interviews, some participants stated that the MBC did not appear to investigate all 805 reports, or if reports were investigated, the MBC often did not find any wrongdoing. Other participants stated that the MBC follow-up for 805 reports took frequently as long as a year after the report was submitted. Later in the chapter, we report the actual amount of time the MBC takes to investigate complaints. Based on these comments and actual times, it is not clear whether the Board follow-up is timely, and if not, what factors provide barriers to a more effective and efficient process.

Figure 4.4: The Medical Board of California Complaint Review Process

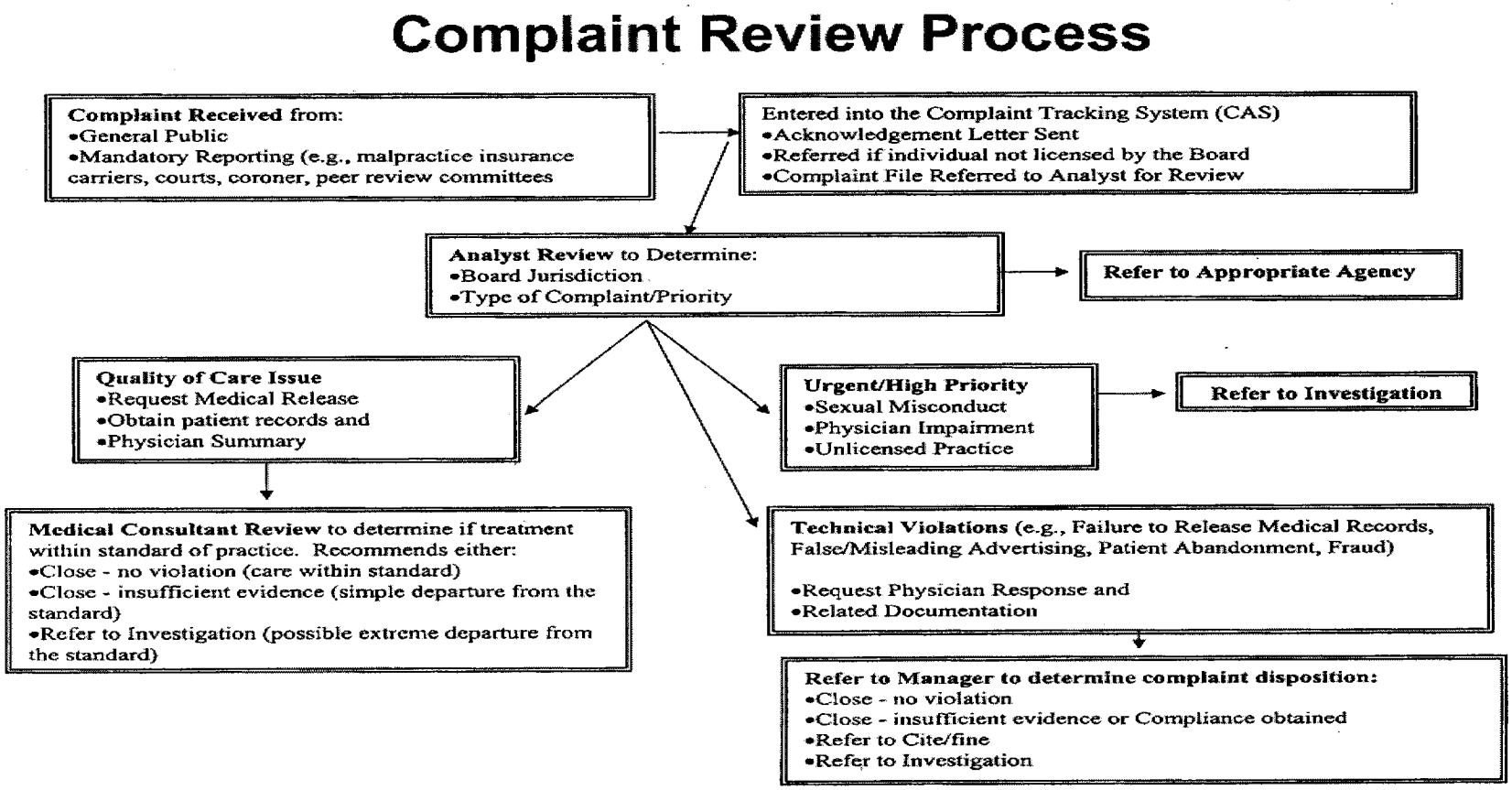


Figure 4.5: The Medical Board of California Enforcement Process

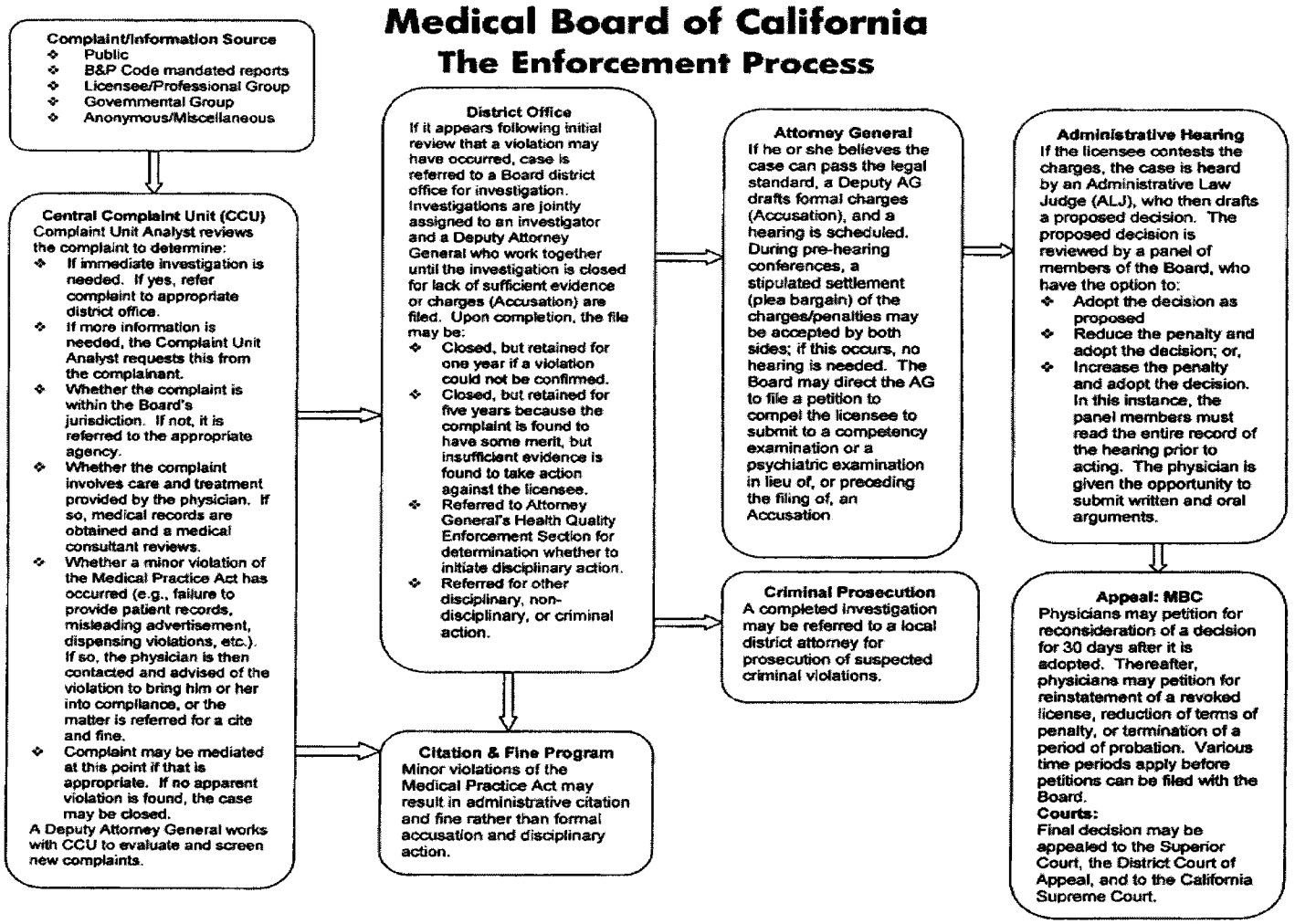


Figure 4.6: The Medical Board of California Public Disclosure Information

MEDICAL BOARD OF CALIFORNIA
PUBLIC DISCLOSURE INFORMATION
Revised January 1, 2007

CAS = Consumer Affairs System; PC = Penal Code; B&P = California Business and Professions Code; CCR = California Code of Regulations; GC = Government Code

		How Long the Document is available to Public	
Document	**When the Document is Made Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
PENAL CODE (PC) 23 SUSPENSION (Partial or full license restrictions per this code; limited or no practice allowed while suspension is in place)	Date issued by a criminal court	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
AUTOMATIC SUSPENSION ORDER (B&P 2236.1) (Licensed suspended per this section; no practice allowed while license is suspended)	Date issued by Medical Board	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
INTERIM SUSPENSION ORDER (ISO) (Licensee's practice has been temporarily restricted or suspended by an Administrative Law Judge, ALJ)	Date issued by an ALJ	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.

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		How Long the Document is available to Public	
Document	**When the Document is Made Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
OUT-OF-STATE AUTOMATIC SUSPENSION ORDER (B&P 2310) (Licensee's practice in California is automatically suspended per notification of suspension or revocation of license in another state)	Date issued by Medical Board	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
TEMPORARY RESTRAINING ORDER (TRO) (B&P 125.7) (Licensee's practice has been temporarily restricted or suspended by a court judge)	Date issued by a court judge	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
ACCUSATION/PETITION TO REVOKE PROBATION/ACCUSATION AND PETITION TO REVOKE PROBATION (includes any amendments or supplementals)	Date filed by the Medical Board	Available indefinitely; or if withdrawn, available for one year from withdrawal date pursuant to Title 16 CCR Section 1354.5(b)	Available only prior to administrative decision becoming effective; once decision becomes effective, the posting of an Accusation is deleted and the outcome of the decision is posted; if the outcome of the decision is that the document is withdrawn or dismissed, the matter is completely deleted from the Web site pursuant to B&P 2027(a)(4)
STATEMENT OF ISSUES (Document, similar to an accusation, that lists reasons for denial of an application for licensure)	Date filed by the Medical Board	Available indefinitely	This information is not posted on a physician profile; the Statement of Issues is available via Enforcement Public Document Search on the Web site. If the outcome is to issue the license and place it on probation, that outcome is posted to the physician profile on the Web site

		How Long the Document is available to Public	
Document	**When the Document is Made Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
DISMISSED ACCUSATION (Accusation dismissed after administrative hearing)	Date filed by the Medical Board	Available indefinitely pursuant to GC 11517	Deleted from Web site/CAS pursuant to B&P 2027(a)(4)
CITATION ORDER (Citation is a written order describing the nature of a violation, including the specific code of law violated; it is not a disciplinary action)	Date issued by the Medical Board	Available for 5 years from decision date; if withdrawn or dismissed, it is purged immediately pursuant to Title 16 CCR Section 1364.15	Available for 5 years from decision date, or if withdrawn or dismissed, deleted immediately from Web site/CAS pursuant to Title 16 CCR Section 1364.15
PROBATIONARY CERTIFICATE (Conditional license issued to an applicant on probationary terms and conditions)	On the ordered date, after adoption by Division of Licensing	Available indefinitely	Available for the duration of probation.
PUBLIC LETTER OF REPRIMAND (B&P 2233) [A lesser form of discipline that can be negotiated for minor violations before the filing of formal charges (accusations)]	Date issued by the Medical Board	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision

Document	When the Document is Made Public	How Long the Document is available to Public: Written Request/Walk-In Request	How Long the Document is available to Public: Web site/Phone Request
STIPULATED DECISION = A form of plea bargaining; the case is negotiated and settled prior to trial DEFAULT DECISION = A Decision which is rendered after the physician refuses or fails to participate in the disciplining process			
• Surrender (While charges are pending, licensee surrenders the license)	On the ordered date, after adoption by Medical Board	Available indefinitely	Available indefinitely
• Revocation, suspension, probation, limitation on practice (e.g. placed in disabled, inactive, or retirement status, etc)	On the ordered date, after adoption by Medical Board	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Public Reprimand/Public Letter of Reprimand (whether or not the Accusation is withdrawn)	On the ordered date, after adoption by Medical Board	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Education course, examination, and/or cost recovery reimbursement (whether or not the Accusation is withdrawn)	On the ordered date, after adoption by Medical Board	Available indefinitely.	Not available pursuant to B&P 2227(b)
• Citation Issued with terms and conditions: an education course, examination and/or cost recovery (whether or not the Accusation is withdrawn)	On the ordered date, after adoption by Medical Board	Available five years from decision date pursuant to Title 16 CCR Section 1364.15. (Only citation document available)	Available five years from decision date pursuant to Title 16 CCR Section 1364.15
• Accusation Withdrawn (Accusation filed by AG's Office was withdrawn before administrative hearing)	Date document filed by Medical Board	Available for one year after withdrawal date pursuant to Title 16 CCR Section 1354.5(b)	Not available pursuant to B&P 2027(a)(4)

Document	When the Document is Made Public	How Long the Document is available to Public	
		Written Request/Walk-In Request	Web site/Phone Request
DECISIONS AFTER AN ADMINISTRATIVE PROCEDURES ACT HEARING			
• Revocation, suspension, probation, limitation on practice (e.g. placed in disabled, inactive, or retirement status, etc)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Public Reprimand/Public Letter of Reprimand (whether or not the Accusation is withdrawn)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Education course, examination, and/or cost recovery reimbursement (whether or not the Accusation is withdrawn)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Not available pursuant to B&P 2227(b)
• Accusation Dismissed (Accusation has been dismissed after administrative hearing)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Not available pursuant to B&P 2027(a)(4)
SURRENDER of LICENSE DURING PROBATION (w/o further administrative action pending)	Date issued by Medical Board	Available indefinitely	Available indefinitely
JUDGMENT/ARBITRATION AWARD (only the information regarding the matter is available, no documents are available from the Medical Board)	Date Medical Board notified or made aware	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information ****	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information
MEDICAL MALPRACTICE SETTLEMENTS (only the information regarding the matter is available, no documents are available from the Medical Board)	When the Medical Board is notified that a licensee has three (low-risk category) or four (high-risk category) settlements within a 10 year period pursuant to 803.1(b)(2)	The information is public during each 10 year period that the licensee has three or four settlements; see B&P 803.1(b)(2)	Pursuant to B&P Code 2027(b)(1), the information is public during each 10 year period that the licensee has three or four settlements; see B&P 803.1(b)(2)

		How Long the Document is available to Public	
Document	**When Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
FELONY CONVICTION (only the information regarding the conviction is available, no documents are available from the Board)	Date Medical Board notified or made aware	Available indefinitely pursuant to B&P 2027(b)(2)	Available indefinitely pursuant to B&P 2027(b)(2)
MISDEMEANOR CONVICTION (only the information regarding the conviction is available, no documents are available from the Board)	Date Medical Board files an accusation related to the misdemeanor conviction.	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information ****	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information
**805 REPORTS to the public - resulting from termination or revocation of hospital privileges for medical disciplinary cause or reason (only the information regarding the termination/revocation is available, no documents are available from the Board unless requestor is another hospital or HMO pursuant to B&P 805.5 - see below)	Date Medical Board notified or made aware	Indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2)****	Indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2)
805 REPORTS given to ***authorized requesters pursuant to B&P 805.5 Authorized requesters may receive a copy of any 805 report (denial, removal, or restriction of staff privileges) except for the following: • reports for failure to complete medical records • reports found to be without merit by the Board	Date Medical Board notified or made aware	The information regarding a termination or revocation of hospital privileges is available indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2)**** The actual report is only available for 3 years from the date the Board received the report pursuant to 805.5(b)(3)	The information regarding a termination or revocation of hospital privileges is available indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2) Information regarding the number of 805 reports for a licensee is posted on the "authorized requestor" Web site for 3 years pursuant to 805.5(b)(3) with the same exceptions as listed under the Document section

* CAS or the Consumer Affairs System, is the database used by the Medical Board to track licensing and enforcement activities.
** 805 Report is a facility initiated discipline report on a physician provided by a hospital, clinic, medical group or clinic, HMO, etc., pursuant to B&P 805.
*** Authorized requestor could be an HMO, hospital, physician requesting for him, or his attorney requesting with written permission from the physician, etc.
**** The law does not require the Board to delete this information from its files, only that the information is no longer displayed on the Board's Web site.

FSMB Standard Two: States should enact mandatory reporting requirements and state medical boards should be provided the authority to impose penalties upon those individuals and institutions failing to comply with reporting requirements. The disciplinary function of all state medical boards is primarily complaint driven. Therefore, a board's effectiveness in handling quality of care cases is enhanced by its ability to receive valid information from reliable sources.

California has multiple codes and laws describing mandatory reporting requirements (see Appendix VII: Medical Board of California Documents) and the Board has the ability to impose penalties ($10,000 fines) on those entities and individuals that fail to comply. During the site visits to the MBC and the review of data and documents that were provided, it was clear that the MBC has internal policies and procedures for initiating "failure to file 805 reports" investigations, as well as how 805 reports are handled within the agency. The MBC staff report that 805 reports are considered urgent complaints and are given top priority within the Central Complaint Unit of the Board.

The MBC staff members reported filing several actions between 2003 and 2008 against entities and individuals for failing to file an 805 report. These actions included five administrative actions against physicians; three active investigations are in process and eight have been closed against physicians or entities; six complaints have been closed; and four civil actions have been filed. Because the Board is dependent on an external source, such as a complaint from the public, to trigger an investigation into an event that should have resulted in an 805, it may be that the Board is not aware of all potential cases of failure to file 805s.

Based on the various interpretations of the 805 and 809 laws by attorneys mentioned earlier in the chapter, it is also not clear that the Board receives valid and complete information from entities or individuals when investigating 805 reports, even with subpoena power. Information provided in the 805 documents is minimal and frequently does not provide the history of events that have occurred prior to the 805 report. It is likewise not evident that the Board receives information in a timely manner, given the interpretation of legislation relating to allowing an 809 hearing prior to filing an 805 report.

Although there is a common perception that all the information about complaints is public information, the Board has multiple restrictions governing the posting of information on the Web site about physician behavior. Although entities can obtain more detailed information, it is often difficult for the general public to obtain the history of a particular physician. The MBC Web site provides frequently asked questions about public information and disclosure and also what is available on the physician license lookup site (see Appendix VII: Medical Board of California Documents). Figure 4.6 summarizes what the MBC can legally disclose, to whom it can be disclosed, and how long the information is allowed to remain on the physician profile Web site.

We were able to investigate in more detail the 805 reports received by the MBC in 2007. In fiscal year 2007, the reports came from 109 different entities involving 144 physicians in 171 events. Twenty-five physicians had multiple 805 reports in 2007. Based on data provided by the MBC about entities, we found that 98% of the entities that filed an 805 did so in less than a year after taking an action against a physician. In slightly more than 1% of the cases, the entities took longer than a year to file an 805 after they had taken an action.

MBC staff members raised the concern that in some instances an entity files an 805 report **after** the MBC takes an action. We investigated this and discovered that in fiscal 2007 there were seven

instances where the MBC hot sheet report specified an action taken by the MBC and the entity filed an 805 report after the hot sheet was circulated.

Table 4.20 displays the reasons for 805 reporting. Note that imposition of summary suspension for longer than 14 days and termination or revocation of privileges for medical cause or reason are the categories that require public reporting on the physicians' Web profile. Therefore, many of the 805s are not available to the public, although some are available to authorized requestors.

Table 4.20: Reasons for 805 Reports in California – 2007

805 Report Description	n	%
Imposition of summary suspension on staff privileges	37	21.6%
Licentiate resigned from staff	18	10.5%
Other - Review Comments	18	10.5%
Restriction(s) imposed on staff privileges	17	9.9%
Restriction(s) voluntarily accepted on staff privileges	12	7.0%
Termination or revocation of membership	11	6.4%
Licentiate resigned from employment	9	5.3%
Licentiate took leave of absence from staff	9	5.3%
Termination or revocation of staff privileges	9	5.3%
Termination or revocation of employment	8	4.7%
Denial/rejection of application for membership	6	3.5%
Licentiate resigned from membership	5	2.9%
Imposition of summary suspension on employment	3	1.8%
Denial/rejection of application for staff privileges	2	1.2%
Imposition of summary suspension on membership	2	1.2%
Restriction(s) imposed on membership	2	1.2%
Licentiate took leave of absence from membership	1	0.6%
Restriction(s) imposed on employment	1	0.6%
Restriction(s) voluntarily accepted on employment	1	0.6%
Total	**171**	**100.0%**

Over 43% of the physicians who were the subject of a report had information on the MBC public web profile; conversely, 56% percent did not. So, if a member of the public looked up one of the 78 physicians who were not on the Web site, they would have no reason to suspect that there had been an event that had triggered an 805 report. Of the 60 physicians found on the MBC public Web site nearly one-half of the events had occurred prior to 2007 (see Table 4.21). This indicates that the 805 reports were not posted on the public site until several months after the event. However, if the public date was prior to 2007, the report may represent a different event than the 805 reported in 2007. In any case, only 33 of 138 physicians with 805 reports could be found in the public Web site stemming from their most recent event.

Table 4.21: Public Reporting of 805 Reports in California – 2007

	n	%
Physicians on Public Web site	60	43.5%
Physicians not on Public Web site	78	56.5%
Total Physicians Reported	138	100.0%
	n	**%**
Public Dates Prior to calendar year 2007	27	45.0%
Public Dates calendar year 2007 or Later	33	55.0%
Total Physicians on Public Web site	**60**	**100.0%**

FSMB Standard Three: State medical boards should develop and implement proactive methods of identifying the individual dyscompetent physician, as well as opportunities for improving physician practice in problematic areas.

The MBC's function is primarily reactive rather than proactive. Although it may be possible to increase the proactive methods, it is not clear whether an agency charged with investigation and disciplinary action is the appropriate agency to proactively identify and remediate dyscompetent/incompetent physicians.

A dyscompetent physician is defined as one who requires retraining or updated training. As mentioned previously, the agency has numerous public information documents on the Web site (in both English and Spanish) to assist the public in understanding the rights and responsibilities of the MBC. There are also many documents that inform physicians about their rights and responsibilities.

The primary concern of the MBC is patient safety and protection. Changing or adding to the perspective of the Board from reactive to proactive would take a specific culture shift, particularly since the current system is deeply grounded in the legal system and uses punitive measures to discipline physicians.

FSMB Standard Four: State medical boards should implement and utilize processes to enhance evaluation and investigation of cases wherein the quality of care rendered is in question.

The MBC has extensive investigation teams throughout the State. Several focus group participants complained that the investigation process was very slow, so we traced through the system a specific event related to a complaint. A hospital submitted two 805s to the MBC, one in December 2006 and the second in March 2007.

The 805 reporting form indicated the reason for the first report was a restriction in privileges and the reason for the second was that the physician resigned from the entity. The supporting documentation submitted with the reports indicated that the physician had first been summarily suspended and then terminated, neither of which was indicated on the reporting form.

When we followed up with questions to the parties about that specific 805, the summary suspension had been for less than 14 days so it was not listed as the reason for the 805 report and the termination/resignation was reported as a resignation. Therefore, the MBC counted the disciplinary actions as restriction and resignation, as reported on the form. The event ultimately raised two issues:

1. Since the 805 was not reported as a summary suspension and termination, the 805 could not be made available to the public, so future patients had no way of knowing the history of this physician. Why did the entity only report the disciplinary action as restriction and resignation? The suspension was for fewer than 14 days and the physician was allowed to "resign."
2. The entity reported that the MBC did not request the patient record for at least six months after the last 805 was filed and has not presently (May 2008) issued a ruling from the investigation.

We investigated whether the forms used by the MBC to report an 805 event were easy to use. The respondents did not find them difficult, so that is not likely a reason for not reporting (see Table 4.22).

Table 4.22: Online Survey - Peer Review Reporting Forms Difficulty
(214 eligible respondents)

	n	Mean	sd
What is the level of difficulty (e.g. user-friendliness, clear documentation) for using the MBC's current 805 reporting forms? (1 = Not Difficult - 5 = Very difficult)	124	2	1

FSMB Standard Five: State medical boards should utilize a list of qualified physicians from which to select peer review panels in the evaluation and investigation of quality of care cases.

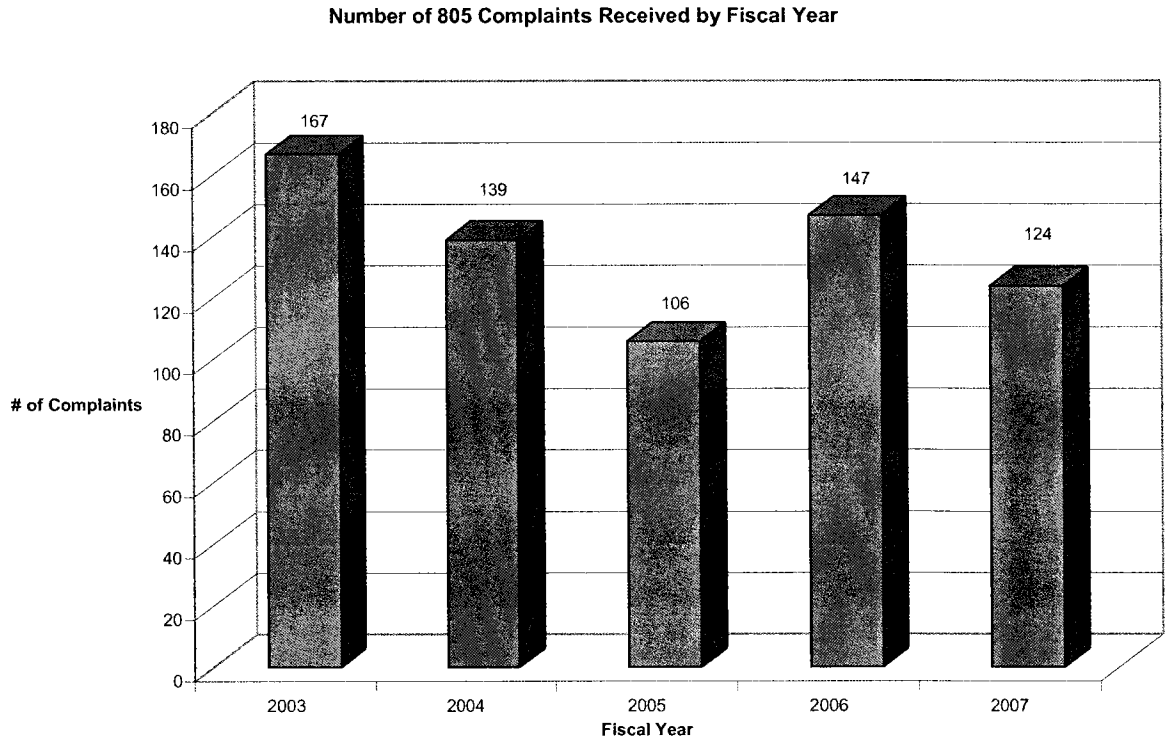
The MBC has policies and procedures in place that provide for the employment of qualified reviewers. The MBC 2006-07 annual report indicates an 11.6% vacancy rate of investigative staff

and that recruitment and retention are a continuing problem. Investigators are able to find employment with higher compensation at agencies where the work is less difficult[118].

FSMB Standard Six: State medical boards should develop and implement systems to efficiently process quality of care complaints processed in a timely and efficient manner.

As mentioned previously, in focus groups and key informant interviews, the MBC has been criticized for failing to investigate all 805 reports and failing to respond to complaints (805s) in a timely manner. Figure 4.7 illustrates the number of 805 reports received by the MBC over a five-year period.

Figure 4.7: Number of 805 Complaints Received by the MBC by Fiscal Year

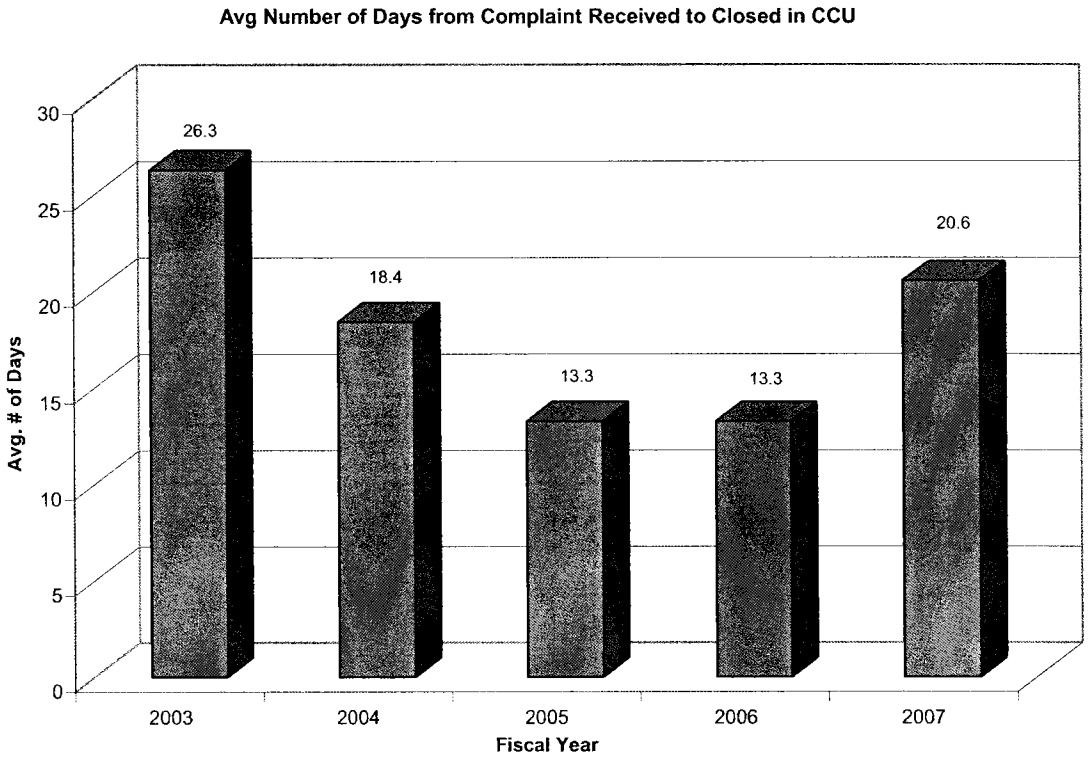


When the Central Complaint Unit (CCU) of the MBC 805 receives a complaint, it is entered into a tracking database and assessed by an analyst. See the Manual of Model Disciplinary Orders and Disciplinary Guidelines in Appendix VII: Medical Board of California Documents. If the complaint is in the correct agency, the analyst determines the next step: 1) medical review related to standard of care; 2) technical violation; or 3) immediate investigation to a field/district office.

Medical review and technical offenses can have various outcomes, including referral to a field office for investigation, but they can also be closed if there is no violation (see Figure 4.4). When the CCU is

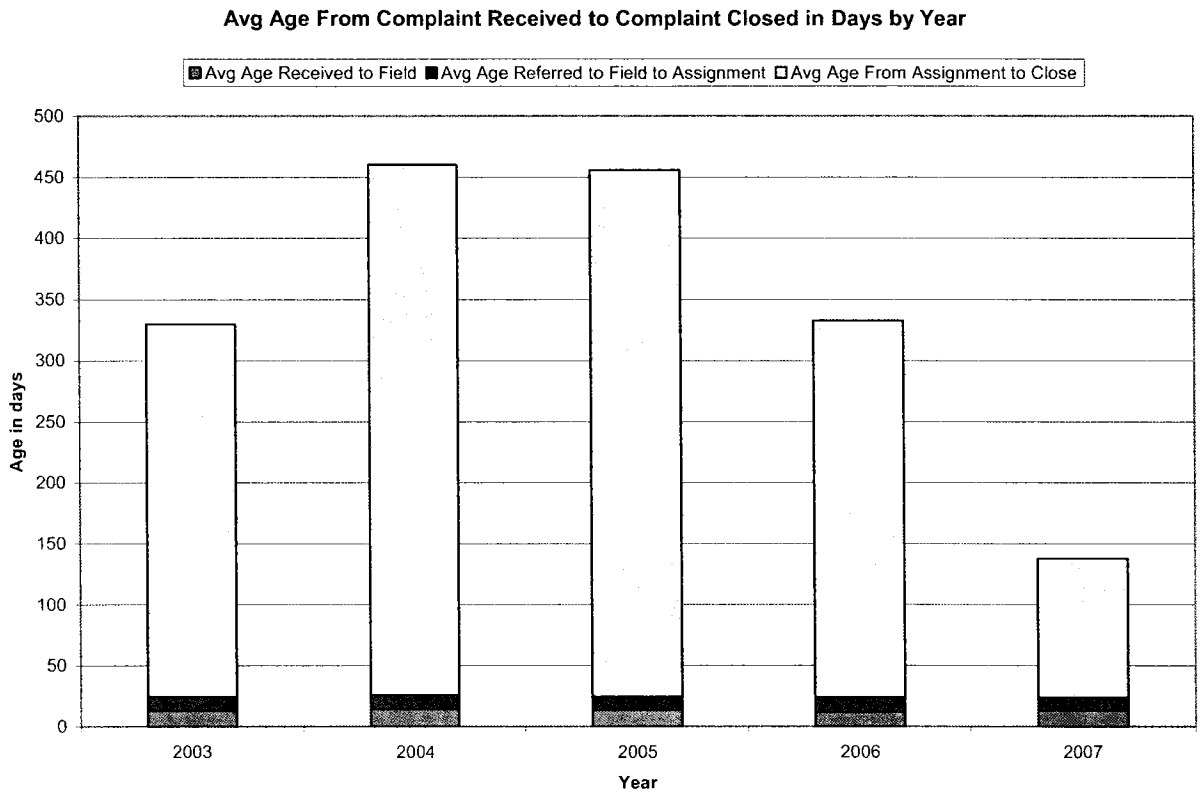
able to close the complaint without referring it to medical review or investigation, Figure 4.8 displays the average number of days to close it.

Figure 4.8: Average Number of Days - 805 Complaint Received at MBC → Closed in Central Complaint Unit



When the 805 is referred to a district/field office for investigation, the time naturally is extended. Figure 4.9 displays the average length of time the district/field office takes to receive the complaint, assign it for investigation, and close it.

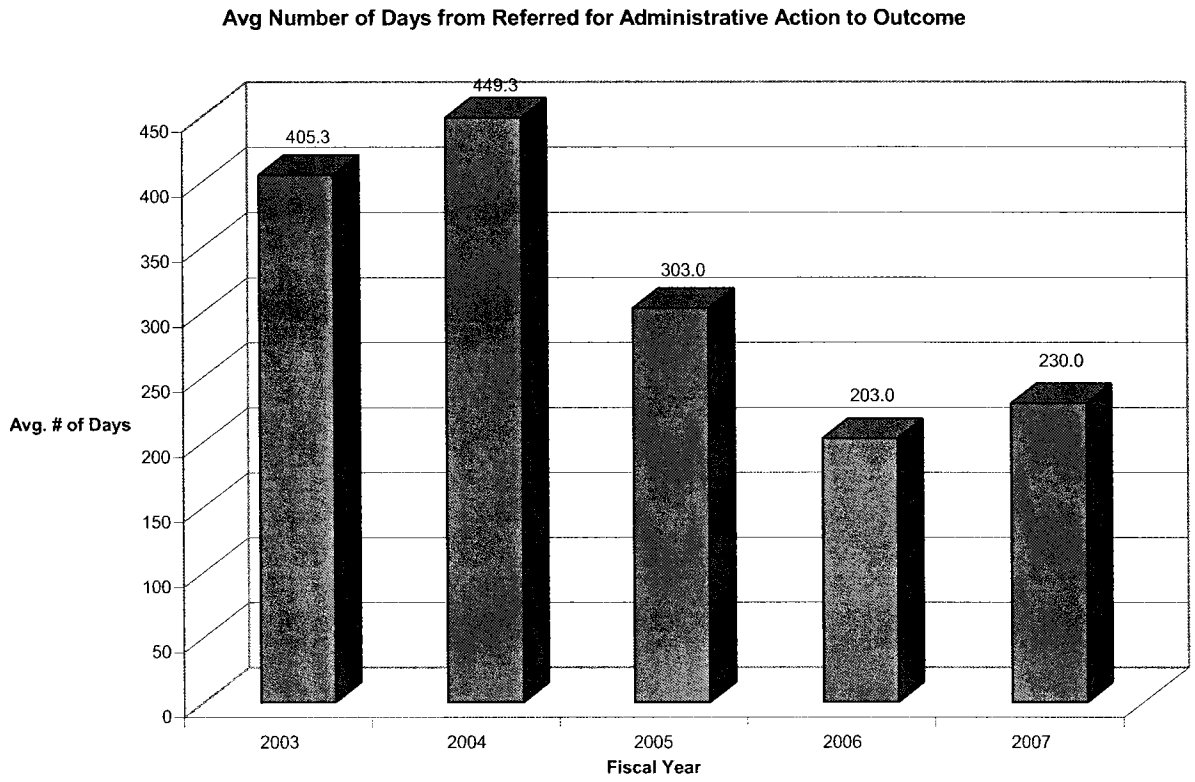
Figure 4.9: Average Number of Days - 805 Complaint Received by MBC → Referred for Field Investigation →Closed Complaint



In 2007, it took two weeks for an 805 to be referred from the CCU to a field/district office; 1½ weeks for an 805 to be assigned to an investigator; and three to four months to close the complaint in the field office. The time for investigation has declined since 2005, but it is still lengthy.

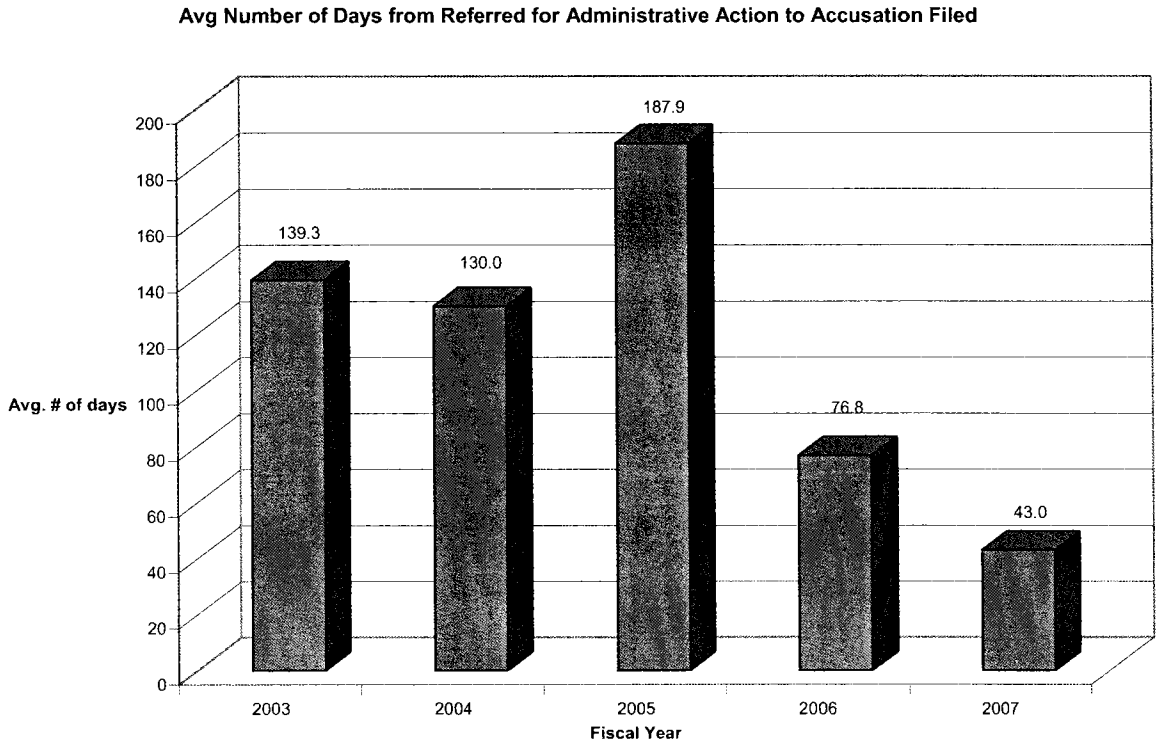
If warranted by the investigation, the 805 complaint is referred for "administrative action." Administrative action can include using sanctions against the physician's license to practice medicine by suspension or revocation, issuing citations for some violations of law, or requiring probation or monitoring. In 2007, the administrative action time averaged an additional seven to eight months (see Figure 4.10).

Figure 4.10: Average Number of Days - MBC Referred for Administrative Action → Outcome



Some issues are referred to the Attorney General's Health Quality Enforcement Section to determine whether to file disciplinary action, such as a formal accusation, which further extends the time. In 2007 the accusation filing took an additional six-plus weeks (see Figure 4.11).

Figure 4.11: Average Number of Days - MBC Referred for Administrative Action → Accusation Filed



Since the accused physician may continue to practice in some capacity throughout this time, it is easy to understand why the focus group participants and key informants reported that the MBC fails to take action or takes too long to take action. There are significant regulations that protect the rights of the physician, but the protections for the physician may conflict with the needs of the public.

Although survey respondents were moderately confident (3.6 on a 1-5 point scale) that the MBC would take action on an 805 that was submitted, focus group members disagreed. A number felt that the medical staff of various entities had become disheartened because MBC action was either absent or very delayed after an 805 was filed (see Figures 4.9 through 4.11, and Table 4.23).

Table 4.23: Online Survey - Confidence in MBC Action
(330 eligible respondents)

	n	Mean	sd
How confident are you that action will be taken by the MBC once an 805 report has been filed? (1 = Not confident - 5 = Very Confident)	225	3.6	1.3

FSMB Standard Seven: State medical boards should broaden the scope of investigation beyond the incident report or complaint...following screening, the investigation of quality of care cases not be limited to the incident...

The MBC is compelled to subpoena documents from entities when they need to investigate quality issues, and since the Dal Cielo ruling, key informants report that it is more difficult to obtain needed documents from hospitals[64].

FSMB Standard Eight: State medical boards should review their Medical Practice Act and pursue legislative support for statutory language to validate the board's subpoena authority and provide the board access to external peer review records.

It is our understanding that the MBC has sufficient subpoena authority to access records, but if the requirement for a subpoena is continued, in order to have a complete picture of events related to the complaint, the Board should broaden the scope of the subpoena to include **any** peer review records and other documents related to the history of behavior leading to the complaint.

FSMB Standard Nine: Based on findings, state medical boards should utilize distinct disciplinary tracks in the disposition of quality of care cases.

The MBC has various methods of discipline available (see Appendix VII: Medical Board of California Documents), including license suspension, license revocation, probation, or reprimand. The MBC also can order testing and examination and education, or dismiss the accusations. These decisions depend on the results of the investigation, but the State is deliberate in any investigation to revoke a medical license given that it is the property and mechanism of livelihood of the license holder.

FSMB Standard Ten: State medical boards should identify and utilize available means of physician assessment and remediation.

The MBC piloted the "Practitioner Remediation to Enhance Patient Safety (PREPS) Program" in 2001-02 with funding from the Health Resources and Services Administration. The goal of this program was to improve patient safety and the quality of care through the directed education and training of identified practitioners in need of remedial training. The Board also uses the Physician Assessment and Clinical Education (PACE) program at the University of California at San Diego School of Medicine, an assessment and skills remediation program in which many physicians disciplined by MBC are required to participate.

Although standards eleven and twelve are not applicable to this study, we list them below to show all the FSMB Standards.

FSMB Standard Eleven: The Federation should collaborate with other entities to develop standards for programs offering remedial medical education.

FSMB Standard Twelve: State medical boards should develop programs to enhance overall physician practice.

Requirement III Summary

Given the study time constraints, we focused on the 805 activities of the Medical Board of California, as they relate to Requirement III. Although other agencies and discipline-specific agencies exist, we found no systematic communication among them that involved coordination of patient quality and safety issues.

To assess the MBC in its management of 805 reporting, we applied the standards of the Federation of State Medical Boards (FSMB) of the United States, Inc. A summary of our findings regarding the MBC's performance follows.

- The MBC has numerous public information documents on its Web site (in both English and Spanish), but it is difficult for the general public to obtain the history of a particular physician.
- It is not clear that the Board receives valid and complete information from entities or individuals when investigating 805 reports, even with subpoena power.
- The Medical Board of California procedures for the complaint process, the enforcement process, and the public disclosure rules are complex and multi-layered.
- The investigation process of an 805 is slow as it moves through the MBC bureaucracy, from when the 805 is first referred to the MBC to closing or resolving the complaint.
- The MBC reports double digit vacancy rates for investigators because of workload and salary.

Requirement IV: An assessment of the cost of peer review to licentiates and the facilities that employ them.

We assessed costs of peer review using the survey, focus group, and key informant interview questions. We asked survey respondents to estimate both dollar and time costs to the entity and to individuals. Most respondents estimated that 0-250 hours were spent on peer review activities in the last calendar year (see Table 4.24). For entities that dealt with an 805 report, this likely added up to a significant cost in time for both physicians and support staff members.

Table 4.24: Online Survey - Total Time Spent for 805 or 821.5 Activities by Entity Role
(see below for eligible respondents)

Question	In the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS spent by the following staff for 805 or 821.5 issues		TOTAL AMOUNT of time IN HOURS you lost from practice in related to being reviewed	TOTAL AMOUNT of time IN HOURS you spent related to your work as a physician reviewer	TOTAL AMOUNT of time IN HOURS you spent on behalf of the entity for 805 or 821.5 issues	TOTAL AMOUNT of time IN HOURS you spent in behalf of your clients for 805 or 821.5 issues
Hours	Non MD Staff	Chairs only	Reviewed Physician	Physician Reviewer	Attorney for Entity	Attorney for Reviewed Physicians
0-250 hours	75	19	11	53	13	0
251-500 hours	15	6	3	10	2	2
501-1000 hours	3	1	2	0	3	0
1000-3000 hours	3	0	2	3	0	0
Greater than 3000 hours	3	1	5	0	1	0
Total respondents	**99**	**27**	**23**	**66**	**19**	**2**
Eligible Respondents	**144**	**70**	**28**	**74**	**30**	**4**

Most survey respondents (69%) estimated that the cost of peer review in the last calendar year was between $0-50,000 to the entity, excluding physician costs in time, with 19% estimating $50-100,000 (see Table 4.25). Please note that is excluding physician time (i.e., the physicians who have privileges in the entity are volunteering their time in exchange for being able to use the facilities of the entity). This, of course, carries forward a practice that was begun over a hundred years ago when modern hospitals were begun. Fifty-seven percent of physicians who have been reviewed estimated the cost at $0-50,000 to the individual physician in the last calendar year (see Table 4.26).

Table 4.25: Online Survey - Total Cost of Entity for 805 or 821.9 Activities
(98 eligible respondents; 64 eligible respondents; percentages based on a denominator of 64)

In the last calendar year, estimate the TOTAL COST IN DOLLARS ($) spent by the entity on the 805 or 821.5 peer review process, including legal fees and all other time and staffing costs.	n	%
$ 0-50,000	44	68.8%
$ 50,001-250,000	12	18.8%
$ 250,001-500,000	1	1.6%
$ 500,000-1,000,000	4	6.3%
Greater than $1,000,000	3	4.7%
Total	**64**	**100.0%**

Table 4.26: Online Survey - Total Cost to Reviewed Physician for 805 or 821.9 Activities
(28 eligible respondents; 21 actual respondents; percentages based on a denominator of 21)

In the last calendar year, estimate the TOTAL COST IN DOLLARS ($) you spent being reviewed in an 805 or 821.5 peer review process, including legal fees and all other time and staffing costs.	n	%
$ 0-50,000	12	57.1%
$ 50,001-250,000	6	28.6%
$ 250,001-500,000	0	0.0%
$ 500,000-1,000,000	2	9.5%
Greater than $1,000,000	1	4.8%
Total	**21**	**100.0%**

There are different contractual arrangements between health plans and medical groups regarding responsibility for peer review. Some contracts place the burden of peer review on health plans and other contracts delegate peer review responsibilities to the medical group. Additionally some management service organizations (MSO) manage multiple medical groups and have contractual obligations to conduct peer review.

The variation in responsibility is a potential point of confusion; this point was verified during one of the focus groups. One participant commented that health plans depend on medical groups for peer review; a second participant said that medical groups depend on health plans; and a third person said both health plans and medical groups depend on hospitals. It became clear that entities did not want to be responsible for filing 805 reports and providing 809 hearings because of the cost, time, and contentiousness of the process.

Requirement IV Summary
In summary, our findings yielded the following about cost of the peer review process and its impact on the entities.

- In the last calendar year, an estimated 0-250 hours per individual physician reviewer, reviewed physician and attorney were spent on peer review activities.
- For 68% of survey respondents, the cost estimate in the last calendar year was between $0-50,000 to the entity, excluding physician costs in time, with 19% estimating $50-100,000,
- Costs to 57% of physicians who were reviewed were estimated at $0-50,000 to the individual physician.

Requirement V: An assessment of the time consumed by the average peer review proceeding, including the hearing provided pursuant to Section 809.2, and a description of any difficulties encountered by either licentiates or facilities in assembling peer review bodies or panels to participate in peer review decision making.

Survey respondents estimated 0-250 hours spent by the entity in the last calendar year on 809 hearings, keeping in mind that almost no entities had 809 hearings (see Table 4.27). Estimates by 86% of survey respondents for the cost of 809 hearings in the last calendar year were $0-50,000 for the entity (see Table 4.28). However, focus group participants estimated that an 809 hearing would never cost less than $100,000, excluding estimates of physician costs in time and legal representation for the person being reviewed, and could cost upwards of several million dollars. One individual stated that an 809 hearing took months to complete because of scheduling problems, hundreds of thousands of dollars, and that one notorious hearing lasted for 17 years! (see Appendix IX: Comments About Study).

Table 4.27: Online Survey - Total Time Spent in 809 Hearings by Entities
(322 eligible respondents, 210 actual respondents, percentages based on a denominator of 210)

For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS spent by the entity on 809 hearings:	n	%
0-250 hours	196	93.3%
251-500 hours	9	4.3%
501-1000 hours	2	1.0%
1000-3000 hours	1	0.5%
Greater than 3000 hours	2	1.0%
Total	**210**	**100.0%**

Table 4.28: Online Survey - Total Cost of 809 Hearings by Entity
(214 eligible respondents; 124 actual respondents; percentages based on a denominator of 124)

For the last calendar year, estimate the TOTAL COST IN DOLLARS ($) spent by the entity on 809 hearings:	n	%
$ 0-50,000	107	86.3%
$ 50,001-250,000	8	6.5%
$ 250,001-500,000	5	4.0%
$ 500,000-1,000,000	2	1.6%
Greater than $1,000,000	2	1.6%
Total	**124**	**100.0%**

Participants were asked to indicate the reasons they were willing to serve on peer review committees (see Table 4.29). Based on the responses most physicians serve on the committee because they are willing, they are interested and they have experience in peer review.

Table 4.29: Reasons for Serving on Peer Review Body
(74 eligible respondents, 64 actual respondents; percentages are based on a denominator of 64)

Identify the reason(s) you agreed to serve on the Peer Review Body? (check all that apply)	n	%
Willingness to serve	52	81.3%
Interest in peer review	46	71.9%
Experience in peer review	29	45.3%
Requirement for affiliation/employment	9	14.1%
Other	7	10.9%
Payment is offered by entity	4	6.3%
Scheduled/rotating obligation	3	4.7%
Requirement for hospital privileges	2	3.1%

When participants were asked to indicate potential reasons for non-participation (see Table 4.30), some respondents had comments such as, "conflict with other responsibilities," "refused to agree to a confidentiality agreement," "outside time constraints," "all the above," and "lack of experience" (see Appendix IX: Comments About Study).

Table 4.30: Reasons for Not Participating on Peer Review Body
(214 eligible respondents; 139 respondents; percentages based on denominator of 139)

Indicate reasons for non-participation	N	%
N/A	97	69.8%
Too busy	39	28.1%
Interferes with practice	19	71.9%
Do not like to judge colleagues	7	5.0%

We asked participants whether physicians were willing to serve on peer review committees if asked to do so (see Table 4.31). On average 4 (mean=4.1 sd=6.5) people were asked to serve last year with 1 declining (mean=1.1 sd-2.3) but as indicated by the standard deviation, there was substantial variation in the responses.

Table 4.31: Changes in Peer Review Members
(214 eligible respondents)

In the last calendar year:	n	Mean	sd
How many new members were added to the peer review body?	128	3	5.7
How many individuals were approached to serve on a peer review body?	101	4.1	6.5
If applicable, of those approached, how many refused?	73	1.1	2.3
How many unanticipated member changes have occurred in the peer review body?	127	0.5	1.1

Participants were asked to indicate the reasons for changes in peer review committee membership (see Table 4.32) and most changes were at the expiration of a regular term on the committee. However, over a quarter of the responses indicated that members just dropped out of the committee.

Table 4.32: Reasons for Changes in Peer Review Membership
(214 eligible respondents; 40 respondents; percentages based on denominator of 40)

If applicable, indicate the reason(s) for the changes	n	%
Term expired	20	50.0%
Member moved out of the area	11	27.5%
Dropout	11	27.5%
Member retired	4	10.0%
Moved practice	4	10.0%

Survey participants were asked about the efficiency and effectiveness of the 809 hearing process and reported that it was not efficient but was effective at ensuring physician rights (see Table 4.33). However, 68% (15 of 22) physicians who had been the subject of an 805 reported that they were not offered an 809 hearing (see Table 4.34).

This percentage is substantial and may reflect the confusion among entities about when an 809 hearing must be offered. Some participants understood that an 809 hearing must be offered before any 805 report; others thought it had to be offered before any 805 report, excluding a summary suspension or termination; and others did not know.

Table 4.33: Online Survey - Efficiency and Effectiveness of 809 Hearings
(322 eligible participants)

	n	Mean	sd
How efficient (in relation to timeliness and duration) was the 809 hearing process? (1=Not efficient - 5 = Very Efficient)	48	2.4	1.2
How effective (ensuring individual rights and that the process was followed) was the 809 hearing process? (1=Not Effective - 5 = Very Effective)	48	4.3	1.1

Table 4.34: Online Survey - Opportunity for 809 Hearings for Reviewed Physicians
(28 eligible participants; 22 actual respondents; percentages based on a denominator of 22)

Were you offered the opportunity for an 809 hearing?	n	%
Yes	7	31.8%
No	15	68.2%
Total	**22**	**100.0%**

We asked survey respondents which activities in the following table are required for an 809 hearing (see Table 4.35). The correct response is that all items (except none of the above) are required for an 809 hearing. Based on their responses, many respondents do not know the 809 requirements.

Table 4.35: Online Survey - Requirements of 809 Hearings
(350 eligible respondents; 222 actual respondents; percentages based on a denominator of 222)

Identify requirements of 809 hearings: (check all that apply)	n	%
An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who has not acted as an accuser, investigator, fact finder, or initial decision maker in the matter	161	72.5%
The right of the licentiate to inspect and copy relevant documents	156	70.3%
The parties shall exchange lists of witnesses at the request of either side	143	64.4%
Commencing a hearing within 60 days after receipt of the request	135	60.8%
The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer	128	57.7%
None of the above	45	20.3%

As a method of estimating costs to reviewed physicians and to discover if the peer review/805 processes were functioning as intended, we asked the entities to direct the survey to physicians who had been the subject of peer review (either favorable or unfavorable outcomes), and we also directly surveyed physicians who had been the subject of an 805 in calendar 2007. The responses of reviewed physicians were strikingly different from the responders who had not been the subject of an 805 report and different from the attorneys involved in the peer review/805 processes.

The 805-subject physicians described a process that was highly "political" and was used to eliminate competitors and eliminate peers, based on gender, ethnicity, language, psychiatric illnesses, "get rid of me," or just failure to fit into the culture of a particular medical staff. These 805-subject physicians described not being able to find any position or job after having an 805 report filed and spending three to five years in 809 hearings and other procedures to fight for their reputations, even after the MBC found no wrongdoing on their part. They reported spending thousands of dollars to fight the charges so they could again practice as physicians.

We asked respondents whether they felt the 805 was used for "political" purposes and the variance by who responded is considerable (see Table 4.36). Physicians who had experienced being reported via an 805 stated that having an 805 filed, especially if posted on the physician Web profile, was a "career ender" (see Appendix IX: Comments About Study).

Table 4.36: Online Survey - Use of Peer Review Reporting for Political Reasons
(350 eligible respondents)

How likely is it that 805 reporting is used for "political" reasons in your entity? Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely .	**n**	**Mean**	**sd**
Peer Review Body Chair	44	1	0.2
Physician reviewer for the entity	62	1.1	0.4
Physician who has been reviewed	21	3.4	1.8
Non-physician entity staff	79	1	0
Attorney who has represented the entity in a peer	19	1.2	0.9
Attorney who has represented a physician being reviewed	2	1	0
Total	**227**	**1.3**	**0.9**

One might speculate that these were just "sour grapes" from physicians who had been caught practicing substandard medicine, but the vehemence with which these statements, phone calls, e-mails, and letters were made begs for further investigation and the question of whether at least some of these statements could be accurate.

Additionally, there are entities that support these physicians in their allegations against "sham peer review" (discussed in Chapter II: Background), such as The Center for Peer Review Justice, Inc. (http://www.peerreview.org/), the Semmelweis Society (http://www.semmelweissociety.net/), the Association of American Physicians and Surgeons, Inc. (http://www.aapsonline.org/), and the Alliance for Patient Safety (http://www.allianceforpatientsafety.org/). Again, it is easy to dismiss these entities and claims out of hand, but they raise questions that remain unanswered (see Appendix IX: Comments About Study).

We also asked survey respondents if they perceived any obstacles to the 805 or 821.9 reporting process. More than half of the respondents thought there were no obstacles. One-third were reluctant to take 805 action against a friend or colleague, and a quarter were reluctant to take 821.5 action. One-fifth of the respondents were fearful of being sued for restricting trade or some other potential retribution (see Table 4.37).

Table 4.37: Online Survey - Obstacles for Peer Review Reporting
(248 eligible respondents; 115 and 96 actual respondents; percentages based on a denominator of 115 (for 805 reporting) or 96 (for 821.5 reporting)

Indicate all obstacles applicable to each type of reporting (805 and 821.5) that you have experienced or would predict: (check all that apply)	805 reporting	%	821.5 reporting	%
No obstacles	48	41.7%	40	41.7%
Reluctance to take action against friend/colleague	39	33.9%	26	27.1%
Fear of being sued for restricting trade of a competitor	25	21.7%	16	16.7%
Reluctance to take action because of potential for retribution	23	20.0%	14	14.6%
N/A	15	13.0%	20	20.8%
Entity uses "internal punishment" (resignation, practice restriction) to reduce reporting	9	7.8%	3	3.1%
Entity encourages an "administrative resolution" (MD agrees to resign in exchange for the entity not filing a report)	9	7.8%	3	3.1%
Other	9	7.8%	5	5.2%

We also asked what recommendations people had to avoid the obstacles in the 805/821.5 process. Even though respondents recognized obstacles, 59% recommended that no change be made in the processes (see Table 4.38).

Table 4.38: Online Survey - Recommendations for Removing Peer Review Reporting Obstacles
(350 eligible respondents; 183 actual respondents; percentages based on a denominator of 183)

Indicate your recommendations to avoid the above obstacles: (check all that apply)	n	%
No changes necessary	108	59.0%
Independent body conducts the peer review (independent of the entity)	34	18.6%
Peer review to be completed by physicians outside the geographic area	33	18.0%
Other	25	13.7%
Non licensing body conducts the peer review (independent of state agencies)	11	6.0%

We asked respondents if they had recommendations to improve the peer review process. Most said no change was necessary, but about 20% suggested using an independent (non-government) agency to manage and conduct peer review (see Table 4.40). However, when we evaluated the responses to the question by entity role, we found only 19% of physicians who had been reviewed thought the process should not be changed, and the rest felt that some change should be made (see Table 4.39).

Interestingly, some of the attorneys in the focus groups thought that there was nothing about the 805 or 809 laws that needed to be changed; nothing was missing, and the language was clear and unambiguous. However, other focus group participants did not agree and made a number of suggestions for change/improvement, such as increasing education of the public and physicians about the peer review process, removing all blame from peer review and resolving patient care issues with physician education, or changing the peer review process to be more efficient.

Table 4.39: Online Survey - No Changes Necessary to Current Peer Review Process by Entity Role

Indicated "No Changes Necessary" to improve the current peer review process	Number Responding	Number Eligible	%
Peer Review Body Chair	33	42	78.6%
Physician reviewer for the entity	35	56	62.5%
Physician who has been reviewed	4	21	19.0%
Non-physician entity staff	58	74	78.4%
Attorney who has represented the entity in a peer	8	16	50.0%
Attorney who has represented a physician being reviewed	1	1	100.0%

Table 4.40: Online Survey - Recommendations for Improving the Current Peer Review Process
(350 eligible respondents; 210 actual respondents; percentages based on a denominator of 210)

Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.	n	%
No changes necessary	139	66.2%
Hire an independent entity (non-government) to manage and conduct a peer review	41	19.5%
Other	21	10.0%
Create a statewide government entity that conducts peer review	10	4.8%
Create a statewide government entity that controls credentialing (not just licensing)	10	4.8%
Eliminate peer review	4	1.9%

In some committee minutes, we found indications that an entity would have repeated complaints/allegations against a particular physician without taking action against the individual. We asked survey respondents if that happened in their entity and one third said "yes." (see Table 4.41). When asked why that might happen, respondents checked "other" and provided comments (see Appendix IX: Comments About Study), such as the following two examples.

> "If the allegations are not substantiated, then the physician would be allowed to continue to practice. If the allegations are substantiated, then he/she would not be allowed to continue to practice. Unsubstantiated allegations would not be used to impose a practice restriction but that substantiated allegations would likely result in a practice restriction. The entity does not make peer review and quality decisions based on the amount of revenue a physician brings, on his or longevity with the entity or for any of the other reasons listed on the form."

> "The physician would be allowed to keep their privileges until such time the repeated allegations were investigated and substantiated. If the allegations posed immediate threat to patients the physician would be summarily suspended pending investigation." (see Table 4.42 and Appendix IX: Comments About Study).

Table 4.41: Online Survey - Continued Privileges for Providers with Repeated Allegations
(288 eligible participants; 169 actual respondents; percentages based on a denominator of 169)

In your entity, if repeated allegations are raised against a particular physician, would the entity allow this physician to maintain their practice privileges?	n	%
Yes	55	32.5%
No	114	67.5%
Total	**169**	**100.0%**

Table 4.42: Online Survey - Reasons to Allow Privileges for Providers with Repeated Allegations
(288 eligible participants; 107 actual respondents; percentages based on a denominator of 107)

Please identify potential reasons the entity would allow a physician with repeated allegations raised against them to maintain their practice privileges?	n	%
Other	57	53.3%
The entity would not allow such a physician to practice	30	28.0%
N/A	17	15.9%
The physician is the only specialist of a specific type in the geographic area	9	8.4%
The physician has been with the entity for many years	4	3.7%
The entity cannot find a replacement	4	3.7%
The physician brings in a large amount of revenue	2	1.9%
The physician admits many patients	2	1.9%
Total	**107**	**100.0%**

Requirement V Summary
In summary, our findings indicate that 805 reporting and 809 hearings are a major concern with respondents, not only in the associated costs (in dollars and time) of dealing with an 805 and 809 for both the entity and the affected physician, but also in the potential damage to one's career.

- Survey respondents estimated 0-250 hours and 0-$50,000 spent by the entity in the last calendar year on 809 hearings.
- 805-subject physicians described a peer review process with an agenda to rid entities of certain individuals for various reasons (e.g., ethnicity, gender, language, cultural misfit, etc.).
- 805-subject physicians described the lengthy process being embroiled in 809 hearings (3-5 years) and the difficulty in finding any job much less a physician position, even after MBC found no wrong-doing.

Study Validation Measures
We used a number of mechanisms to ensure the validity and reliability of our study methods and findings. In order to assure entity document evaluation reliability, all minutes, event summaries, and other submitted documents were reviewed by two study staff members; all data analyses were checked by two statistical analysts; data confidentiality was reviewed by a senior statistician; all e-mail comments and letters were reviewed by two staff members; and all focus groups were attended by two to three staff members.

Phase III of the study included site visits to 10 randomly selected entities from our initial site visit sample to check whether entity policies were being followed and to review documents that may not have been submitted. One entity indicated that they used an external audit company for some peer review cases, which extended the length of time required.

Two hospitals indicated that the peer reviews took longer than policies allowed. None of the site visit hospitals provided all the minutes and other documents requested. Two required the site visitor to sign a confidentiality agreement, and two required that she be accompanied at all times during the review. One recently purchased hospital claimed to have access only to peer review minutes that

occurred after the purchase (four months); one hospital only allowed her to review 805 reports with documentation. Given the limited access to documents, it is not clear whether the site visit hospitals are following the policies related to 805 reporting.

Two of the three medical groups and the health plan that were visited provided all documents requested. One medical group had access to only three years of minutes. The health plans and medical groups generally followed the policies and procedures and were meticulous about tracking credentialing. There was variability in tracking in hospitals. All health plans and medical groups used a categorization system that estimated severity of events that occurred and all used the MBC "hot sheets" to check on physicians.

For Phase V of the study, we randomly selected a different 5% sample of the initial sample to use for validation. In the first validation method, the study medical director reviewed patient records and decisions made by peer review committees in the sample entities. We were interested in determining if an independent reviewer would reach the same decision as the committee. Medical records or summaries of cases were made available for review by nine of the ten sampled entities. The entities submitted seven cases in which 805s were filed and five cases of quality concern without 805 filings.

Hospitals generally agreed to supply information on medical staff regulations including privileges, peer review, and disciplinary processes. Few details regarding the extent or nature of peer review were provided. Generally, there was only a brief summary of multiple cases of poor care by a physician, which resulted in a change/restriction/suspension of privileges and then 805 filing. Thus, it was impossible to determine the fairness of the processes for the physician or whether it was effective in eliminating poor care.

The cases demonstrating high level quality concerns (with no 805 filed) usually resulted from a single instance, and remedial actions such as education were prescribed. The role of the medical groups and health plan was generally passive except for removal of offending physician from their physician panel after a hospital filed an 805. They generally did not file the initial 805. The reviews for the individual entities follow.

Entity #1-Hospital (5 cases submitted; 4 with 805/1 not)
Hospital #1 provided copies of the Bylaws and Rules and Regulations of the Professional Staff. It included the investigation and corrective action practices as well as hearing and appeals procedures, including rules of evidence and burdens of proof. These were all separate from 805/809 State processes. Entity #1 then provided a brief summary of four cases for which 805 forms were submitted. Based on the information provided, the Lumetra reviewer found that grounds for filing and 805 were supportable.

Entity #1 also supplied a summary of a high-level quality concern that did not lead to 805. A peer review summary identified issues and MD counseling and educational efforts were planned. The Lumetra reviewer agreed with this decision based on information provided.

Entity #2-health plan (1 case; 0 with 805/1 without)
Entity #2 provided a credentialing department Medicare policy and procedure document, which included peer review committee function and responsibilities. Also noted is an affirmation statement that utilization decisions are based on medical necessity, and no discrimination or conflicts of interest are allowed. The process for filing an 805 is delineated, and the practitioner fair hearing documents are included as well. Peer Review committee minutes from 2006 - 2007 were included

and show the MBC hot sheet review and plan's responses. Entity #2 provided committee minutes of a quality concern that was raised and forwarded to the hospital. The Lumetra reviewer is not sure why this case was identified and reviewed, or what the eventual outcome was.

Entity #3-hospital (1 case; 0 with 805/1 without)
The entity filed no 805 cases in 2007, and there was only one high-level score case that year. A follow-up phone call was made to clarify, and the Lumetra reviewer agreed with the entity action. The entity also provided medical staff bylaws, rules, and regulations that detailed privileges and hearings but did not cite 805 notification or filings. Also included was an 805 report from December 2003, regarding a physician who withdrew his application for staff reappointment following notice of adverse recommendations. No clinical details or case information was provided in this filing.

Entity #4-hosptial (2 cases; 1 with an 805/1 without)
The entity submitted rules and regulations of the governing board, medical staff bylaws (even pages only), hearing procedures, general medical staff rules, and regulations. The entity reported the actions of the medical executive committee regarding the cases. In the first case, mandatory education was imposed first, then summary suspension, and finally termination.

The physician agreed not to practice at hospital pending a hearing and then resigned. This was reported as an 805 twice; first as a suspension and then as a resignation. The Lumetra reviewer agreed with the actions. The second case was a physician who allegedly had physical contact with an employee in the GI lab, which resulted in a two-day summary restriction of privileges to use the lab. The medical executive committee upheld the restriction and provided written warning, and no 805 was filed. The Lumetra reviewer agreed with the action.

Entity #5-medical group (2 cases; 1 with an 805/1 without)
The first example involved one physician and included committee minutes from May 2005 to October 2007 (nearly 2 ½ years). The events included eight case reviews and then ten more, multiple specialty reviews, letters to the physician, and finally termination. There was no information on any hospital actions or reviews during these years. The entity then filed an 805 after their attorney indicated agreement with the action.

The second example involved a physician who refused to see certain patients. The entity review indicated a practice with high compensation and poor patient access. The physician was terminated for not taking a board examination and violating medical group policy; no 805 was filed. The Lumetra reviewer agrees with these decisions.

Entity #6-hospital (4 cases submitted; 2 with 805 and 2 without)

The first example of an 805 event was the denial of reappointment because of failure to disclose suspension and resignation from a nearby hospital in 2005. The second example was a physician who had two years as a provisional staff member but continued to have a low surgical volume and needed additional proctoring. The physician took a leave of absence.

The first example of a non-805 event was two cases for a single physician without any apparent reason for review, peer review, or quality improvement evaluations. The second example was a patient seen in the Emergency Department twice on the same day and admitted; the patient was in jail and was admitted a second time upon release from jail. There was no information provided on the reason for review, peer review, or quality improvement evaluations. Based on very limited information, 805 filings appeared appropriate, and non-805 reviews had no obvious peer review cause for action.

Entity #7-professional society
This entity did not submit records because no peer reviews were performed in 2007.

Entity #8-hospital
This hospital did not submit records.

For the second part of this validation phase we selected a 5% sub sample (10 entities) of the entities and compared the survey responses submitted with the bylaws, policies, and procedures submitted by the entity. We reviewed seven hospitals, one health plan, one medical group and one professional society using a structured format (see Appendix IV: Structured Review Forms) and compared 11 variables.

Surveys from two entities were suspect in that only one person from each entity completed a survey and every response was checked "no" or there was no response. Therefore, these entities had no percentage agreement with the documents. In two entities (one medical group and one hospital) we found 90% agreement between the survey responses (both having six responses) and the documents for the items.

In three entities there was 64% agreement (two entities had one response and the other had one response); and in the last two entities there was 55% agreement in the responses (one entity had two responses and one had one response). These lower percent agreements may indicate that the survey respondents either did not know the entity policies or that the documents provided were not complete. There was one entity (hospital) that failed to provide any records. The high level of agreement between the Lumetra reviewer and the entity reviews provides evidence that some entities are complying with the policies and procedures and complying with the law.

Overall Summary

The overall study response rate for entities was 75.5% and the participants were a clear representation of the medical care entities in the State. Three hundred fifty individuals from 115 entities responded to the on-line survey. Each of the four entity types was represented in the survey respondents, with hospitals representing 62.9%. In summary, our findings revealed the following about "peer review," as it is conducted by entities in California:

1. Variation exists across entities in how they define and conduct "peer review."
    - There is wide variation in all aspects of the peer review/805 processes within different entities, including definition of the term "peer review," policies and procedures, tracking systems, infrastructure (i.e., review and decision-making committees) and responsibilities. Therefore, outcomes are highly variable and specific to each entity.

2. Overall, entities attempt to follow the letter of the law regarding 805 reporting (though perhaps not the spirit of the law).
    - Most entities routinely screen a certain percentage of patient records to check for evidence of substandard care.
    - The most common reasons for cases being referred for peer review to a high level (executive medical staff) committee are 1) disruptive physician behavior/impairment (821.5); 2) substandard technical skills; and 3) failure to document/record patient treatment.
    - Entities screened a large number of cases through the routine monitoring process. However, we estimate that a small percentage of routinely screened cases are forwarded to the

medical executive/decision making committee for further review and even smaller percentage results in an action that limits or terminates a physician's privileges for medical cause or reason, thus triggering an 805 report to the Medical Board.

3. 805 and 809 reporting is subject to interpretation, creates hardship for those affected (e.g., the entity and the physician), and allows many situations to go unresolved.
   - Peer review is lengthy, involving months or years of re-review, review of more records, interviews with the physician, and/or other investigation methods within the entity.
   - The peer review and 805/821.5 reporting processes in entities are highly variable; 805 reports are viewed as something to avoid; the 809 hearing process is inefficient but effective at preserving physician rights.
   - There is disagreement about whether an 809 hearing is required before an 805 report is submitted; 809 hearings for due process can add 2-5 years.
   - Some physicians are allowed to commit multiple disruptive actions over many years before any remediation is required, and it is possible that some physicians are never the subject of peer review.
   - The cost estimate of peer review in the last calendar year was between $0-100,000 to the entity, excluding physician costs in time, costs to physicians who were reviewed were estimated at $0-100,000 to the individual physician.

4. The Medical Board of California procedures for the complaint process, the enforcement process, and the public disclosure rules are complex, circuitous, and multi-layered.
   - The MBC has numerous public information documents on its Web site (in both English and Spanish), but it is difficult for the general public to obtain the history of a particular physician.
   - No systematic communication appears to exist among the various State boards and agencies that would coordinate patient quality and safety issues.
   - It is not clear that the Board receives valid and complete information from entities or individuals when investigating 805 reports, even with subpoena power.
   - The MBC investigation process is slow. In 2007, it took two weeks for an 805 to be referred from the central complaint unit to a field/district office, 1½ weeks for an 805 to be assigned to an investigator; and three to four months to close the complaint in the field office. An administrative action time averaged an additional 7-8 months; an accusation filing took an additional six plus weeks.

Chapter V: Conclusions and Recommendations

Introduction

Peer review and 805 reporting provide a process to review medical care, identify substandard medical care, develop ways to improve physician practice, and report certain events to the MBC for further investigation. The findings of the peer review study demonstrate that these processes have failed in their purpose to ensure the quality and safety of medical care in California. Rather, they allow entities to conduct medical peer review in a clandestine manner, so it is unknown whether the reviews are fair, whether the medical care is judged without bias, or whether or not physician practice is improved.

However, peer review and 805 reporting does succeed in creating the *appearance* of ensuring quality and safety of medical care by generally satisfying accreditation agencies (Joint Commission, Department of Health Services). The processes also cost significant healthcare dollars through actual dollars spent on legal fees, employee salaries, added staff members to ensure compliance with the numerous regulations and requirements, and State agency staff member salaries. Additionally, there are the opportunity costs consumed by these processes: time of physicians away from patient care or in lost off-work/family time; time used by hospital nurses and others in this complex and legalistic system that could be used in more productive patient care activities; and the time, pain, and suffering of patients who may experience injury or death in a system that does not protect them.

In this chapter, we present our conclusions and describe how our medical care quality and safety processes, including peer review and 805 reporting, are not supporting the citizens of California. We also provide for consideration by the MBC and the California legislature recommendations that would improve the peer review and 805 reporting system.

Conclusions

Requirement VI: An assessment of the need to amend Section 805 and Sections 809 to 809.8, inclusive, to ensure that they continue to be relevant to the actual conduct of peer review as described in paragraph (1), and to evaluate whether the current reporting requirement is yielding timely and accurate information to aid licensing boards in their responsibility to regulate and discipline healing arts practitioners when necessary, and to assure that peer review bodies function in the best interest of patient care.

The findings outlined in Chapter IV provide evidence supporting our conclusion that the peer review process, 805 and 821.5 reporting, and 809 hearings do not ensure quality and safety of medical care in California, for the following reasons:

- Excessive variation in policies
- Poor tracking systems
- Potential biased and ineffective reviews
- A too-lengthy process lacking transparency
- Groups of physicians who may never be peer-reviewed
- Burdensome costs to continue the current system

We explore these issues in greater depth in the following section.

Failures of Peer Review

Inconsistency of Peer Review Standards and Policies across Entities

All entities set their own standards for peer review, some more rigorous than others (see Figure 4.3), and some adhere to them more meticulously than others. Additionally, each entity creates its own peer review policies, which can vary substantially. If a physician is found to provide substandard care, that physician may leave or be forced to leave that entity but can practice elsewhere, potentially endangering other patients.

Before a physician's privileges in an entity can be terminated, there is a lengthy (months or years) process during which the potentially substandard care continues to be provided. If an 805 or 821.5 report is eventually filed, there is another lengthy process of investigation designed to protect the legal rights of the physician. Thus, if the physician is providing substandard care, it could be years before a disciplinary action is ever taken.

Lack of Consistent Tracking of Peer Review Events in Entities

In the current system, there is either no tracking or no consistent tracking of peer review events in entities. A physician may have multiple events that indicate substandard care, but the entity has limited ability and resources for follow-up. Peer review events are generally documented within minutes of committees that serve many other functions, such as business functions, monitoring other disciplines, and other entity needs. The tracking of peer-reviewed events requiring entity investigation is buried in these minutes and depends on the persistence and commitment of key individuals in the entity to ensure that the tracking is done and brought back to the attention of the peer review committees.

Lack of Unbiased, Objective, and Confidential Review

Peer review is based on the assumption that the evaluation will be unbiased, objective, and confidential. These requirements are impossible to meet by a medical staff that works together, depends on each other, makes referrals to each other, and provides medical coverage for each other. External reviews are an option but are costly, and typically reserved for events for which the medical staff have limited or no expertise.

Implicit Peer Review Based on Fallacies

"Implicit" peer review (review done by a physician using individual judgment rather than criteria) is based on several fallacies: 1) The science does not exist to determine standards of care in a given situation; 2) You can have a standard based on one person's opinion; and 3) Only a physician can judge medical care. Implicit peer review is not acceptable in a day when there are standards based on science, and we are able to provide a more reliable system of review. At the very least, the reviews must be based on empirical evidence when that evidence exists.

No Standardization in Defining Events that Should Trigger Peer Review

Events, other than routine medical record review, can trigger peer review and lead to reporting, but those events are defined by each entity. There is some consistency in select entities because of requirements of voluntary accrediting agencies (Joint Commission, NCQA), but there is nothing that could be considered standardized. There is evidence from the survey that a number of respondents do not understand what should be reported to trigger a peer review, an 805 report, or an 821.5 report, and that most respondents depend on legal authority or malpractice insurance companies to decide whether or not to report to the MBC.

Lack of Transparency

The peer review and 805/821.5 processes lack transparency, and Evidence Code 1157 is used to protect the entity and the physician. Numerous laws and case law protect information that might harm the physician and entity through litigation. Neither the entity employees (other than the medical staff) nor the public has a right to information regarding peer review, since the activities are proprietary to the entity and are not "discoverable" legally.

Based on our survey and focus group respondents, the MBC is viewed by some as only intermittently responding to 805 reports, focusing particularly on those events that result in patient harm, unacceptably delaying the response, and not reporting public information. Additionally, the MBC is constrained by legislation that requires the agency to strictly limit public information related to 805 reports, including what and to whom the information can be disseminated, whether or not the information can be provided in hard copy, and how long the information can be left on the public Web site (see Table 2.10).

Entities frequently use attorneys to protect proprietary information under the guise of Evidence Code (EC) 1157. The conventional wisdom is that without Evidence Code 1157 protecting physicians from malpractice litigation, practice would not be discussed, mistakes would not be disclosed, and improvement in practice would never occur. Peer review would cease to exist. This assumes that physicians function primarily from the perspective of self-protection. However, because the current peer review system is so opaque, it is not clear what would occur without Evidence Code 1157.

Entities Avoid Following the "Spirit" of the 805 Law

Entities can take multiple steps to follow the letter but avoid the "spirit" of the 805 law by using tactics such as pressuring an offending physician to resign for reasons other than "medical cause or reason," by having summary suspensions less than 14 days, by negotiating with an offending physician privately through attorneys to avoid an 805 report, or by offering extended educational sessions and other remedial opportunities that would not trigger an 805 report.

Several participants reported that health plans and others faithfully review the MBC "Hot Sheets" to see if the MBC has taken an action against any physicians affiliated with their entity (although physicians are supposed to notify all their affiliate entities if an action against them is taken by the Board). If they see an affiliate physician, they then file an 805, although it is redundant and not required. It is reasonable that hospitals should take the major responsibility for peer review because of the rapid and significant injury to individuals that can be caused in the facilities. However, physicians who use hospitals also frequently are members of, or affiliated with, medical groups and health plans, so responsibility should be shared.

It is not ethical to use peer review and 805 reporting for purposes other than intended, such as ridding oneself of a competitor. Given the high rate of recidivism of drug and alcohol abuse, the lack of consistent record for tracking of 821.5 reports of physicians who have used drugs or alcohol, thus endangering patients, is entirely unacceptable.

Beyond initial entity credentialing for which the physician has responsibility, the entities have limited ability or motivation for removing unsafe physicians from the staff. Routine re-credentialing and peer review were designed to be part of the patient quality/safety system, but responsibility rests with the entity to trigger re-credentialing and peer review.

Not All Entities Perform Peer Review

There are medical groups/clinics and health plans that are not required to perform peer review because they do not meet one of the myriad laws defining which entities must report to the MBC. Also, all health plans, medical groups/clinics, ambulatory care centers, outpatient surgery centers, and other facilities where medical treatment is performed and injury to the public can occur, are not licensed by the State, and all physicians are not required to undergo peer review or some type of quality assessment.

Also, the California codes are unclear as to whether an 805 must be reported only after an 809 hearing or can be filed before a hearing; or whether an 809 hearing is only required prior to an 805 when there has been a summary suspension of greater than 14 days or a termination.

Extensive Delays Create Barriers to Public Protection

The delays in the process are extensive and serve as a barrier to the goal of protecting the public. Entity delays through poor tracking, ownership change, hospital staff turnover, reluctance of medical staff to discipline a colleague, ignoring physician behavior, and MBC delays for investigation and decision making and multiple other reasons render the processes impotent in investigating past injury and preventing future injury.

Costs Related to Processes are Prohibitive

The costs of 805, 821.5, and 809 processes are prohibitive, and entities and physicians use all possible means to avoid the time and money that are involved in the lengthy, contentious processes. Some hospitals have suggested that the offending physician split the hospital costs with the entity in addition to the physician's cost of hiring a private attorney and time lost in income.

In summary, these failures of the peer review, 805/821.5, and 809 hearing processes to ensure patient safety call for major changes to the current system. In the following section, we propose recommendations to correct these issues, specifically addressing the last four requirements (VII, VIII, IV, X) of the 805.2 legislation related to recommended changes. Although the legislation asks for what appear to be moderate changes and suggestions to current codes, we recommend major changes and improvements to the peer review/805 system because it cannot be "fixed" with moderate changes.

Requirement VII: Recommendations of additional mechanisms to stimulate the appropriate reporting of peer review actions under Section 805.

As we have indicated, although the entities in the study follow the letter of the 805 reporting law. Recommendations 2, 3, 4, and 5 address changes that would improve the reporting process.

Requirement VIII: Recommendations regarding the Section 809 hearing process to improve its overall effectiveness and efficiency.

The 809 hearing process is rarely used because 805 reports are relatively rare, and the process is inefficient, costly and legalistic, requiring many hours of physician and entity staff time, thousands of dollars, and extensive services of attorneys. Recommendation 7 addresses changes needed to improve the process.

Requirement IX: An assessment of the role of medical professionals, using professionals who are experts and are actively practicing medicine in this State, to review and investigate for the protection of consumers, allegations of substandard practice or professional misconduct.

Creating a system requiring physicians to provide objective and independent review of colleague friends or enemies is an unrealistic expectation. Recommendations 2, 3, 4, 5, and 7 provide a mechanism to engage experts who are practicing medicine in the State and who can be objective, independent and unbiased reviewers. As mentioned, all physicians could be required to provide this service as a requirement of licensure.

Requirement X: An assessment of the process to identify and retain a medical professional with sufficient expertise to review allegations of substandard practice or professional misconduct by a physician and surgeon, if the peer review process is discontinued.

As mentioned previously, Recommendations 2, 3, 4, 5, and 7 provide mechanisms to engage experts who are practicing medicine in the State and who can be objective, independent, and unbiased reviewers. The State could either pay the physicians or require this service as a condition of licensure. Because we have found evidence that the current peer review process, the 805 reporting process, the 821.5 process, and the 809 process are ineffective and inefficient in protecting the public health, we enumerate recommendations to change and improve the entire system.

Recommendations

1. Re-design the peer review process and create an independent review organization [addressing 805.2 (6), (7), (8), (9), & (10)]. Based on the analyses of all data, we recommend that the MBC and legislature change the peer review process in the following ways:
    - Continue to allow healthcare entities to provide first level quality/safety screening of physician practice through random record review of each physician no fewer than twice every year.
    - Define specifically what is required in the first level screens; these could be screens recommended by a professional accrediting agency.

- Refer any physician whose actions related to patient care do not meet the standard of care of the screening, or "fall out" of the screens for any reason, to an unbiased independent peer review organization that has no vested interest in the review outcome except protection of the public.
- The independent organization will be selected by the MBC or the appropriate legislative committee. All further responsibility for making decisions about taking any action toward the physician including 805 or 821.5 reporting would be removed from the healthcare entity.
- After the initial identification by the healthcare entity, the independent organization would take over all further investigation of the issue and make a recommendation to the healthcare entity regarding either filing an 805 report or other action such as recommending physician education and training, recommending PACE (UCSD Physician Assessment and Clinical Education Program, or recommending anger management training. A copy of all recommendations would be sent to the MBC. The healthcare entity would decide to follow or not follow the recommendation.

    - If a healthcare entity has an event (serious event or sentinel event) that requires an expedited or "fast track" review, that event would be reported to the independent entity within five hours. The independent organization would expedite the review/investigation (no longer than three days) and make an action recommendation to the MBC and to the healthcare entity (805, summary suspension if not already imposed, or other action).

    - The independent organization would create a tracking system to follow patient-related care issues by physician over time to monitor trends.

    - If a physician is not affiliated with an entity that performs peer review, the physician is responsible for initiating peer review at least twice annually through a professional entity. There would be substantial financial penalties for failing to being subject to peer review twice annually.

    - All patient, physician, or employee complaints related to patient care would be referred by the healthcare entity to the independent entity for investigation.

    - The independent organization would randomly select entities for assessment of the initial peer review process no fewer than once every three years. The independent entity would perform site audits of quality and safety programs, similar to Medi-Cal site audits.

2. Improve transparency [addressing 805.2 (6), (7), (8), (9), & (10)]
    - MBC would notify complainant and subject immediately when investigation is begun, when the information goes on Web site, and when it is taken off the Web site.
    - The independent entity would be blinded to physician name (using the national ID number). The MBC would be aware of all identifying information.
    - The MBC would increase transparency of reporting to the public by posting on the physician profile on the Web site any action recommendation (including history and outcome) by the independent entity and keep it there indefinitely.

- The MBC would create a user-friendly Web access so that a layperson can understand the sequence of events and find out whether the physician did or did not provide substandard care.

3. Revise role of the MBC [addressing 805.2 (6), (7), (8), (9), & (10)]
   - The independent entity would report all action recommendations to the MBC and to the entity.
   - The MBC would continue to investigate all 805 reports and make a determination about any license action and would be required to initiate an investigation within 48 hours of receiving an 805 report and make recommendations within five days of the completion of the investigation.
   - The responsibility of the 809 hearing would be removed from healthcare entities. The MBC or a designated independent organization would conduct 809 hearings to insure fairness.
   - Through the MBC, oversight for investigations, 809 hearings, and probation monitoring would be under the auspices of a "professional jury" composed of all practicing physicians. This "jury" service would be for a set time period and rotated among all licensed physicians in the State, being sure to only use people who did not have prior direct contact with the parties of the issue.
   - The legislature should either eliminate the requirement for a subpoena by the MBC to obtain needed documents from entities or the MBC should broaden the scope of any subpoena to include all documents related to the history of behavior leading to the complaint and any other relevant documents or medical records related to a patient care issue.

4. Emphasize credentialing [addressing 805.2 (6), (7), (8), (9), & (10)]
   - Routine credentialing and re-credentialing should still occur at the healthcare entity level. The healthcare entity would report any change in credentialing or privilege to practice to the independent entity. The independent entity would investigate and make a recommendation about whether an 805 or other action is warranted.
   - The physician would remain responsible for initiating any credentialing action.
   - The physician would be responsible for notifying the independent organization of any change in certification or credentialing by any professional group or healthcare entity. There would be substantial financial penalties for not reporting to the independent entity.

5. Promote education [addressing 805.2 (6), (7), and (8)]
   - The MBC should create mechanisms to continuously educate and update:

     a) All physicians and employees in entities required to file 805 reports, about the laws regarding peer review, 805, 821.5 and 809.

     b) All California citizens about their rights and how to use the MBC Web site.

     c) All entities about the requirement to not file redundant 805 reports.

6. Clarify codes [addressing 805.2 (6), (7), and (8)]
   - The MBC and legislature should clarify whether or not an 809 hearing is required prior to submission of an 805 report; or whether or not the hearing before the 805 is only waived after a summary suspension of greater than 14 days or a termination/revocation of privileges.

- The MBC and legislature should clarify whether an 805 should be filed for not completing patient records.
- The MBC and legislature should require a consistent and separate tracking system of peer review activities over a five-year period, whether or not the entity is sold or changes ownership; require separate peer review minutes from all other committee or entity business.
- The MBC and legislature should create mechanisms to require all medical groups, clinics, ambulatory care, ambulatory surgical, health plans, and acute care hospitals to perform peer review and report to the MBC through the 805 mechanism.
- The MBC and legislature should create a mechanism to require every licensed physician to submit to peer review.
- The MBC should define peer review and define specifically events that would trigger peer review.

7. Identify Funding Sources

   Funding for the revised peer review system could be handled in a combination of ways without increasing taxes or diverting State funds, including:

   - Increasing physician license fees to support the process and a portion of those fees can be used.
   - Charging malpractice insurance companies a percentage of all policy payments they receive.
   - Attorneys for entities can provide a percentage of their billing income to fund the process.
   - Using a percentage of any malpractice judgment to help fund the process.

Pilot Study and Program Evaluation

Before full implementation of any change to the system, we strongly recommend that a pilot study be conducted, including process evaluations and outcomes evaluations related to patient safety and quality.

Evaluation of a program change is typically ignored because of many reasons, including the desire to be ignorant of the results. However, without a pilot program and an evaluation, the risk is that the change could cost much and gain nothing. With so much at stake in this potential change, every precaution must be taken to assure that the change will yield a great benefit in patient safety and quality. Prior to any change of this magnitude, comprehensive process evaluations must occur to ensure that the changed system is not just a recreation of the current system.

Finally, if there are any changes made, they must and should be phased in over a period of two to three years to provide for adjustment to the many affected systems.

Conclusion

There are negative aspects about the system of peer review and 805/821.5 reporting as mechanisms to ensure patient safety. However, there is one very positive aspect - the people in the system who try to make it function. The vast majority of individuals in the participating healthcare entities, the staff working at the MBC, and the people who provide legal counsel to organizations and individuals try to make this complex, bureaucratic, legalistically dysfunctional system work to protect patients by complying with the complex codes, laws, and regulations.

Multiple and conflicting demands require people to make difficult decisions that often in the end satisfy no one. One physician complained that he lay awake at night worrying that the peer review efforts for which he was responsible had allowed patients or physicians to be harmed. Many attorneys expressed frustration and anger that the system was not working properly, and healthcare administrators wished a better way existed to ensure patient safety and physician rights.

It would be easier and more expedient to make no change at all, and for many participants perhaps no change to the system would be better than changing to something uncertain. No change requires no further costs except to the citizens of California. It is the quality of care that would continue to be impacted by this flawed system.

With any major change to this century-plus old process, there will be widespread opposition from parties vested in the status quo or fearful that a new system might be worse. Based on evidence found in this study, change is imperative to protect the health and medical care of Californians, and it will require the help and support of the people who understand the nuances and complexities of the current system.

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Appendices

DECLARATION OF SERVICE

Re: *Fahlen v. Sutter Central Valley Hospitals, et al.* No. S205568
Court of Appeal No. F063023

I declare that I am over 18 years of age, and not a party to the within cause; my business address is 180 Grand Avenue, Suite 1300, Oakland, CA 94612; I served a true copy of the attached:

RESPONDENT'S REQUEST FOR JUDICIAL NOTICE

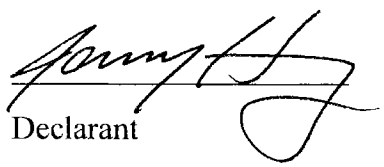
on each of the following, by placing same in an envelope (or envelopes) addressed (respectively) as follows:

Joseph M. Quinn
HANSON BRIDGETT, LLP
425 Market St., 26th flr.
San Francisco, CA 94105

Court of Appeal of California
Fifth Appellate District
2424 Ventura Street
Fresno, CA 93721

The Honorable Timothy W. Salter
Department 22
Stanislaus Superior Court
801 10th Street
Modesto, CA 95353

The envelope was then, on April 5, 2013, sealed and deposited with an overnight delivery service for next day delivery. I declare under penalty of perjury that the foregoing is true and correct. Executed at Oakland, California, this April 5, 2013.



Declarant