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Peer Review Immunity: AB 2856

Senate Judiciary Committee

Assembly Judiciary Committee

CALIFORNIA LEGISLATURE

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BILL LOCKYER, CHAIRMAN

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Joint Hearing on

PEER REVIEW IMMUNITY: AB 2856

October 15, 1990
State Capitol
Sacramento, California

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LIST OF WITNESSES AS THEY APPEARED

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Opening Remarks: Senator Bill Lockyer
Assemblyman Phil Isenberg

Comments:

* Timothy J. Shannon, Jr., Associate Vice President
  Kathryn Hanson, Legal Counsel
  California Medical Association

* Tracy Beckwith, California Chiropractic Association

* Doug DeVries, California Trial Lawyers Association

* Dr. Richard Kendall, California Optometric Association
  Norma Dillon, Director
  Governmental Affairs

* Michael Hawkins, Kaiser Foundation Health Plan, Inc.

* Herb Dorken, Ph.D.
  California Psychological Health Plan

* Christine Hall, California Association of Hospitals and Health Systems

* Brenda S. Reid, General Counsel
  Cooperative of American Physicians, Inc.

* Stanley M. Wieg, Legislative Advocate
  California Association of Realtors

* Judy W. Pulice, California Dental Association

* Dr. Dean Hillsman, Union of American Physicians and Dentists of California
  Gary Robinson, Executive Administrator
  Union of American Physicians and Dentists of California

SENATOR BILL LOCKYER, CHAIRMAN: Who doesn't know Senator Marks here? Everybody knows Senator Marks. But we'll acknowledge Senator Marks and Senator Lockyer as present for the interim committee discussion on Assembly Bill 2856 by Mr. Isenberg. Mr. Isenberg is both here, the author and the chair of this committee, why don't we encourage you to open with any remarks you may wish to...

ASSEMBLYMAN PHIL ISENBERG, CHAIRMAN: All right.

CHAIRMAN LOCKYER: ...of which one you want to use.

CHAIRMAN ISENBERG: Thank you very much Mr. Chairman. As you know from the material there is somewhere between 15 and 17 groups and organizations that are allegedly conducting peer review and as a result receiving either immunity from liability for doing so or have protections from discovering their activity that ranges from the more traditional medical profession peer review which is in institutional settings for doctors and so on but runs through veterinarians and lawyers and accountants and physical therapists and engineers and hospital governing boards and as nearly as I can tell two or three new groups of individuals or professions every year as everyone decides that you can't truly be a first rate organization unless you have immunities or discovery protection. I think it is fair to say that my frustration in dealing with what I perceive to be an endless number of bills by organizations who have to have this protection or the world will come to an end led me to start to examine the peer review laws. And the first that you can say about them is that they are by and large incomprehensible. Certainly, no intelligent college graduate could easily read the code sections and make sense out of them. The other things that seems to me is fairly clear is that although the hospital institutional setting where physicians conduct peer reviews is probably the prototype it is--it may well be the only circumstance under which something approximating what the Legislature might have wished in peer review is actually going on. There are undoubtedly arguments, commotions and objections, but by and large as far as I can tell only in the institutional setting do you have something approximating the ideal view of peer review. Of course, the ideal view of peer review is unclear in the statutes, since we no where define it. But basically, I suppose it starts from the notion that pro-

fessionals will review themselves to assure the quality of care. And implicitly the trade-off of that is, should the Legislature encourage it it means that we wish to rely less heavily on disciplinary boards for the equivalent of peer review. Of course, peer review is not necessarily leading to disciplinary action but in some cases it may. The other thing we discovered very early on in our hearings were that by and large most organizations don't do peer review at all. Lawyers, for example, have nothing that could be called a peer review. Real estate agents we heard in testimony there's never been a real estate agent ever expelled from a board of realtors for any reason, except the non-payment of dues which is a crime of its own level but, perhaps, not as important as others. On the other hand, it's reasonably clear that we're extending these protections and discovery of protections and immunities to organizations with no guarantee that they actually do peer review. In any event, what we tried to do in the bill that came out of the Assembly, is to present a couple of suggestions to the Legislature. First, why don't we try to rewrite the peer review statutes in a way that are more understandable. Secondly, why don't we try to create some basic principles. One of the first principles would be that in order to keep these protections that you at least ought to do something called peer review. And perhaps one evidence of that should be that the Legislature would insist that at least a certain level of improper conduct once discovered must be reported to the disciplinary boards. That seems to me to be bare minimum if you believe that peer review is designed to improve the quality of care. Beyond that we had a variety of other suggestions running the range from a shot at a definition of peer review to other ideas, comments and revisions. The issue that received a great deal of attention is whether or not you should extend immunity protections or protections from discovery beyond what peer review started out to be which is a voluntary review without compensation. Because, by and large, the trend now in all of the fields is that you hire people and pay them. You either hire them or you pay them independently in one form or another for conducting peer review. Most of the groups and organizations will tell you Mr. Chairman that without the compensation you can't get any peer review done. One would think that if that were the case that you would not need immunities or discovery protection because presumptively malpractice insurance and various defenses would be available, but that seems not to be the case. We had suggested in the bill that the immunities also not extend to what are classically insurance underwriting activities. This is particularly prevalent in area of the physicians insurance firms that Mr. represents where they, as a matter of the very nature of the insurance business,must do peer review in one form or another. In any event, from the public viewpoint my guess is that this is a largely Archaen discussion, however, at least in two areas it strikes me that the public would probably wish to at least have some legislative review. The first if a question, even in the area where I think there is the most honest attempt to develope and implement and enforce a reasonable peer review which is the

medical side. It's reasonably clear to me that the enforcement is present in an institutional setting and it's not present in private practices in individual offices. Certainly in our hearings allegations of medical societies do much investigation for in office practice. We're not supported by anything I found to be terribly factual. Secondly, and beyond that, as more and more organizations that are not medical in nature ask for and receive from the Legislature these protections , we are implicitly representing to the citizens of California that they are engaged in a diligent pursuit of their own peers and we have no way of course to guarantee that. And I would think from an ordinary citizens point of view that would present itself to be a second consideration.

I thank you very much for scheduling this hearing. I appreciate the opportunity to go into the subject.

CHAIRMAN LOCKYER: All right, why don't we just start running through the list of commentators, I guess beginning with Mr. Shannon and you may wish to...Ms. Hanson.

TIMOTHY J. SHANNON, JR.: Mr. Chairman and members, Tim Shannon representing the California Medical Association. This is a continuation of a ongoing dialogue that we have been having with Mr. Isenberg for well over a year now about a notion that he has that there is something terribly wrong with the peer review system that we have and that it seems to be extending to people who don't really warrant the protections that the existing code sections have. We agree with at least with him in one respect and that is in Section 43.7 of the Civil Code, which is the cornerstone immunity, is probably an incomprehensible statute at least linguistically very difficult to read. I share some of the blame in that, in that I was a committee consultant for this--your committee, Mr. Lockyer, when a lot of these were added and we just kind of rubberstamped these bills. I went through the history over the weekend of Section 43.7 and the 19 amendments that have been made since 1961 read like a veritable who's who of the Legislature. You have Mr. Antonovich and Mr. Berman, Mr. Levine, Alatorre (twice), Watson (twice), it goes on and on, and as these were added there was very little attention paid and I can vouch for this as a staff member, to how the statute looked after it was all complete. Nevertheless, although it is a difficult statute to read, I wouldn't say it's incomprehensible, I would say it's Archaean, barely comprehensible. There is a scheme in the immunities that we now have that the scheme fits together pretty well. I think you could say that there are basically three things that peer review--that peer review is being promoted in three different ways by the statutes we have.

We have statutes that encourage people to participate in it, and those are the immunity statutes such as 43.7. We have statutes such as 43.8 of the Civil Code which make folks who are out there in medical settings want to report, it gives them immunity for

making reports. And finally, there's a statute which is also very important Section 157 of the Evidence Code which protects the records and proceedings of peer review committees --makes them confidential. And that encourages candor, and frank discussion--without those protections I can assure you that very little of those activities would go on and we think it's good that they do go on. And just to say that the proceedings and records are not discoverable does not mean someone can't get at the underlying facts, those are still there. And I think that is an important point to note, it's not as though you are closing off entirely the conduct which led to the peer review proceeding; certainly an attorney can discover in the usual method by depositions and whatever the facts that led to the reason that the peer review committee was convened. In any event, I want to note also, about these immunities, they are not to be viewed in our estimation as rewards, something in other words that a physician's going to say, "Gosh, if I serve on one or these peer review committees I will be rewarded with some kind of immunity." That's not the-- peer review would take place anyway. What we're trying to do is to encourage doctors to do it. And, rather than being seen as a reward for doing it, it should be seen as an inducement to get people to participate. One other point on that, is that the immunities are not so great that they're even that large of an inducement. Every single immunity except now Section 43.8 which has been changed by Senator Presley's bill--become an absolute immunity. All the other immunities are qualified immunities and a good trial lawyer can plead around them and certainly make a case that something was done maliciously. So they're not complete immunities or qualified immunities. And we think that they do provide inducements for people to participate and to that extent they should be preserved.

Turning to the bill itself, we wrote a letter to Mr. Isenberg, and I believe we shared this letter with members of the committee. We have some problems with the approach that has been taken in this bill. First of all, although it sounds intellectually--I think that maybe in some way provocative to say that for some reason peer review immunity should be limited to voluntary activities--we really fail to see the reason for that. We want to encourage as much peer review as possible and the way to encourage it is to provide to the broadest extent possible the inducements in which I spoke about earlier. Mr. Isenberg's bill talks about immunities not applying if there is indirect or direct compensation. You can get into a whole discussion about what is indirect compensation. And our concern is that (1) the--we fail to see the rationale for limiting it to volunteer, and even beyond that, if you do go that route it's going to be very, very difficult to determine when there is indirect compensation or direct compensation.

CHAIRMAN ISENBERG: Did I say that?

CHAIRMAN LOCKYER: Mr. Shannon.

MR. SHANNON: Any questions on that point?

CHAIRMAN ISENBERG: Well no. As you know before this bill was set for hearing in the committee we have written a letter and sent copies to all the parties involved indicating that on the voluntary issue I was prepared to compromise on that.

MR. SHANNON: I wanted to hear you say that. Thank you.

CHAIRMAN ISENBERG: I--I said it in writing Mr. Shannon. It didn't say...

MR. SHANNON: Oh no--I was going to get to that. But, we're talking about the bill as written now. You are going to, as I understand it, correct me if I'm wrong--you are still going to make direct compensation that will...

CHAIRMAN ISENBERG: Yeah, the argument, the argument that you have made in your letter and our conversations were--that doctors who receive a per diem or incidental expense shouldn't be penalized for doing that--and I agreed with that. In July, as you know, I wrote a letter and addressed that to you, among others, saying that. I do think however, that full time paid professional persons offer a different circumstance. It's a dialogue I've had with Mr. Cologne, but not necessarily with the CMA directly.

MR. SHANNON: The full-time aspect/I don't believe that was addressed in your letter, but I do want to point out that currently CMA has consultants that go out to rural hospitals, places that can't afford to set up their own peer review committees and they do for a fee peer review in these outlying areas. Now, one of the reasons that this has become even more important is the passage of SB 1211 by Senator Keene, which provides that you need to have unbiased peer reviewers participate in the peer review of colleagues. We don't/want people who have some kind of bias doing the peer review, so in a rural setting you would probably be less likely to find that neutral individual. And so CMA is in the process of having paid consultants go out and do the peer review. Now that would qualify, or at least question, enough question to discourage the activity, that would qualify as direct compensation. It may not be full-time, that's another notion we haven't discussed, but it is a problem.

CHAIRMAN ISENBERG: Mr. Shannon, putting aside that for a minute, which seems to me easy to be resolved--Is it CMA's position that even if you retained by a physician full-time, and paid them $195 thousand a year for peer review activity, then in those circumstances the physician should always receive both discovery protection and immunity.

MR. SHANNON: I'd want to hit you on that a little bit. One, if it's entirely quality of care review, in other words it's not review for other purposes, such as utilization, I would say if you want to encourage peer review, if that is the public policy you would want to promote--I don't see any reason why you would want to limit it. However, if you're talking about other kinds of full-time paid review--CMA we're looking at that whole question. That's something that we haven't really come down on. If you're doing review for other purposes in a full-time paid basis, some kind of utilization review--that's a different question then if you're doing quality/of care review I believe.

CHAIRMAN ISENBERG: And that's because you view that quality assurance and quality--the other reviews are possibly leading to constraints on medical practice that a doctor would find adverse...

MR. SHANNON: No, no, that's maybe your interpretation of my answer. Actually we believe that the public policy for having immunities is to promote quality of care. And if it is quality of care review that is being/done then those activities should/be immunized whether they're paid or not.

CHAIRMAN ISENBERG: The issue is, then the hospital setting becomes in--at least from my point of view it becomes increasingly unclear as to where the dividing line is between peer review, quality assurance, utilization review or all the other nomenclature that we use on the activity--and I could be wrong, but it seems to me that those activities tend to blur in the real world. However, we draw distinctions here.

MR. SHANNON: That is--you've raised a good question and it is something as I say we are reviewing. It is a difficult area. It's becoming ever more so with the various kinds of reviews that are emerging, and I think it's something that I think we're going to have to look at very carefully. But, I think the--I don't know if there's a bright line.

CHAIRMAN ISENBERG: Well, let me ask you...

MR. SHANNON: It's certainly a line of quality review is important and if it can be established as the review is being taken place for quality then the public policy for the immunities still applies.

CHAIRMAN ISENBERG: Let me ask you a question. If the start of peer review was to to encourage private physicians for participating in the review of their peers and if we

are inching toward a program where hospitals and medical groups and so on may well retain paid service to do the same thing.

Why is it that you don't see any distinction between those two things? I mean, why should a full-time physician who presumptively would not be practicing medicine, but is being paid by a hospital to engage in peer review? Why should that person have full immunities from his or her conduct?

MR. SHANNON: He--or she doesn't have full immunities.

CHAIRMAN ISENBERG: Well, immunities that exists within the law.

MR. SHANNON: Qualified immunities.

CHAIRMAN ISENBERG: I understand.

MR. SHANNON: Frankly, to be honest, if I may say so, and I may get some objections from the trial lawyers later--if these immunities were as complete as they have been represented at times, I don't think they would be on the books, I don't think we would have ever gotten them. Certainly when these additions to 43.7 were made in the Judiciary Committee over the years--I can't recall that there was any strong trial lawyer opposition at those points, and as they were added I think you found that they were pretty much accepted by all parties. I think that's one other notion that I wanted to discuss here--is that if peer review really isn't going on, then to immunize the activity results in nothing--no harm done, no damage, there's no foul. No harm, no foul. If you're not doing peer review certainly there can be no circumstance / under which any immunity would be afforded because you aren't doing the peer review well.

CHAIRMAN LOCKYER: I recall on this one--and I assume part of the point is not to simply to discuss whether or not immunity should be conferred, but to discuss whether peer review is effective. And, so the purpose of the inquiry about it not going on is to say well, it's not effective in this circumstance. Then when you talk about some different kind of inducement...

MR. SHANNON: Yeah, in Mr. Isenberg's opening statement he did mention/a that lot of the groups that have been added weren't really doing it. And, frankly, and I agree with one other thing that Mr. Isenberg said, and he said before, and that is in the medical setting

it is working extremely well. And it is slowly, but surely, that same kind of review is going into the non-institutional settings--it is not by any means perfect, of course, in the hospital review situation you have a formalized structure, but there is review going on at the county medical societies, there is some review at the specialty societies, and certainly we don't want to foreclose that activity from taking place because some question has been raised by a new statute that maybe there aren't adverse actions being reported or maybe it's not being done voluntarily--I think you want to encourage those who are not currently doing peer review to start doing it. And if there is any serious question that the activities that they commence are not going to be protected, I doubt that they'll do it.

CHAIRMAN LOCKYER: On the private office practice of physicians, Mr. Shannon, how many medical societies have an extensive review and what percent of physicians and their office practice are reviewed on a yearly basis?

MR. SHANNON: Well, as far as the county medical societies--we did research that a little bit, and I don't have hard figures--but most of the counties do do quality review -- when complaints are brought to them they set up committees...

CHAIRMAN LOCKYER: But that's a complaint generated. But peer review is traditionally not a complaint generated. Normally we say that the disciplinary system is a complaint generated system and peer review is something that's designed to head off complaints--to avoid complaints.

MR. SHANNON: I agree. A lot of--actually, this is another aspect of peer review that I need--that you just touched on something that I think we raised in our letter also, and that is, that peer review if it's working really, really well is not going to result in a lot of bodies being reported to a medical board--it's going to be preventive in nature. And this kind of leads into another aspect of your bill which talks about adverse action reporting. I didn't want to touch on that. We have a system, the 805 reports made in the Business and Professions Code, where medical disciplinary causes or actions of discipline have to be reported to the medical board. That is kind of the--that's really, that's the fairly drastic situation. What you want is someone to be able to take a doctor aside and say,"We noticed a deficiency;we'd like you to take some continuing medical education, or some other preventive step.

CHAIRMAN LOCKYER: What is going on now that you can give us in terms of facts in the

medical societies that get them on a periodic basis into the individual offices, where I still assume the preponderance of medical care is still given in California?

MR. SHANNON: I don't believe that there is any formal system that allows medical societies, which most of them don't have--the vast majority of them don't have the resources to do that.

SENATOR LOCKYER: One of the interesting parts of an earlier hearing we conducted is that the American Association of Accountancy in the California branch came in and announced that they had in fact set up a requirement that as a condition of membership--you had to open your offices to periodic reviews, in terms of quality of services provided to accountants, and my recollection is that they funded $1 million for the program and they go in at least once every few years--I can't remember the details--why would that not be something that if we truly want to do, peer review, throughout the entire field of medical practice that ought to be done by--as a matter of requiring it to be done by the medical profession?

MR. SHANNON: Do you want to do this?

Kathryn Hanson from our legal counsel might want to address that at this time.

MS. KATHRYN HANSON: I think the point that you raise is an important one, and it's one that the medical association has been looking at for some time. It was a huge problem in the past because there was so much medical care that was being provided in individual physician offices by solo practitioners. Now, frankly, at this point in time the amount of medical care being provided by solo practitioners is dropping off at an extraordinary rate. And what is happening is you're getting more and more group practices. You're also getting more sophisticated services being provided on an out patient basis. And the combination of those factors, as well as the general concern that the medical association has had about physicans who practice either primarily or exclusively outside of the hospital arena and, therefore, are not subject to peer review in the hospital setting has resulted in the establishment of a major ambulatory care review program , which really has geared up this year for the first year. It provides a service very similar to that of--well, I shouldn't say it that way--I should say its modeled on the joint commission review of hospitals. Although, obviously, we're trying to deal with some of the problems that have come up in the joint commission review process in that program. But, in any event, this is a--it is an effort, it is a voluntary accreditation effort on behalf of the profession to try to establish some type of formal medical review program within these ambulatory care facilities particularly where surgery is being provided on an out-patient basis. I think that ulti-

mately that will be certainly a defacto mandatory requirement just for liability concerns for professional reasons. I think that trying to mandate that right now would be premature. I think you need to have some opportunity to see how the accreditation program works, what things end up being workable. Obviously, there's an initial--it's always the case that you start with what you know, and so there's a tendency to take what's going on in the hospital setting and try to put that on the ambulatory care facility. And, while that is certainly a good model to work from it may be that as a matter of practical reality it's not possible to establish that same type of system on an ambulatory care basis. But, I think that the concerns that you raise are absolutely right on and we certainly are doing out utmost to try to work out a workable system that will get to those folks who aren't in the hospital system.

We have one last point which is that to the extent that physicians work in hospitals and certainly the vast majority of them do, their practices are being reviewed in the hospital peer review process. And so the...

CHAIRMAN ISENBERG: Well, to the extent the patient gets into the hospital. The hospital...

MS. HANSON: Well, right.

CHAIRMAN ISENBERG: The hospital doesn't review a doctor--unless there's something extraordinary the hospital doesn't go outside the patient admitted...

MS. HANSON: That's right.

CHAIRMAN ISENBERG: ...for treatment there.

MS. HANSON: But the odds that a physician who's a part of an ongoing hospital continuing education quality review process is doing totally bizarre things in their private practice that don't get picked up in the hospital basis is probably low.

CHAIRMAN ISENBERG: Well, but let me make sure I understand your statement. The outpatient surgical centers and what do you call them in your less polite moments--doc in the bo operations? Those facilities do have immunities, right? Under the law?

MS. HANSON: To the extent that they are doing...

CHAIRMAN ISENBERG: Doing it. And there is a concern that they may or may not be doing it. I would assume that all the out patient surgery centers will say they do they do it more scrupulously than hospitals. But put that aside for a minute. It's clear, am I correct that there is no direct peer review of a private physician's private office practice?

MS. HANSON: That's right,outside of the PR unless they are subject to PRO review...

CHAIRMAN ISENBERG: I understand.

MS. HANSON: ...which they might be if they're doing HMO work.

CHAIRMAN ISENBERG: I understand, but there's no direct review? I would--based on your statements I assume the organization is moving in the direction of trying to address that issue. Although, I can understand how much--how complicated it would be and how much resistance you must get from the remaining sole practioners who don't like anybody's interferrence, let alone the CMA's interferrence.

MS. HANSON: Also, I think that the reception to this ambulatory care accreditation program has been very positive. I think that the general physician is trying to provide first class care to the extent that they can get some assistance in how to set up key way programs and recommendations about how they can do things differently, they tend to view that very positively. So actually the program has been well received, although this is really the first year that we've been doing it.

MR. SHANNON: I think--if I may add on to that. I think that when you're getting down to the individual physician's offices as sole practioner, who doesn't even have partners, and who can by the way do a kind of peer review, it's not formalized. It's going to be very difficult to get a system that is going to be able to interject some other group, and have that group, first of all, be neutral--that's a problem that I alluded to earlier under the SB 1211 problem of peer review. You're going to have a system, I think for the sole practioners, at least at the time it's going to be largely complaint free. And I think at least for now that's unavoidable.

CHAIRMAN LOCKYER: I will only add--I guess the author's sort of given up on the distinction between voluntary and paid review, but except for perhaps that extreme case that you cited /of the full time $190 thousand compensation. Just for purposes of the analyses I haven't sorted this all out in my own mind yet, but I tend to think of these discussions as kind of

a teeter-totter, with the social purpose on one side and the uncompensated injury on the other And to see whether there is sufficient weightiness of the social purpose to cause the plaintiff injury to go uncompensated. When you add getting paid to the social purpose I think it diminishes the worthwhileness of the purpose. That is, it becomes just like every other private entrepreneurial effort, and there are different values attached to those than pure voluntary activities. It also makes it more likely that the defendant can in fact pay for injuries caused here . . .

MR. SHANNON: I think that's the issue. I'm not sure you'd be able to pay somebody enough to have them take on the responsibility of liability for an aggreive position--and remember these are punitive damages situations in many cases as well. And I just don't think you would get the same--and that's just something to kick around in your mind when you talk about the balance.

CHAIRMAN LOCKYER: Yeah, and I don't know how to....

MR. SHANNON: And it is a qualified immunity also, you have to put that on the scale...

CHAIRMAN LOCKYER: Qualified in what?

MR. SHANNON: The immunity--there's a malice provision. It has to be done without the review, it has to be done without malice, it has to be based on--and I don't have the exact language--but I believe a reasonable inquiry into the facts. Making sure that the facts are correct; in other words, it can't be done maliciously and I have--I can get the language. I can retrieve it in a second, but all the immunities are qualified and fairly well watered down.

CHAIRMAN LOCKYER: Except we were talking about the Presley bill...

MR. SHANNON: The Presley bill...

CHAIRMAN LOCKYER: What's the number of that bill?

MR. SHANNON: It's SB 2375, that changes Section 43.8 of the Civil Code. And that actually is an immunity--that now being complete in any--it actually--what it does, is it provides a complete immunity to someone who provides information to a peer review body, whether maliciously or not.

CHAIRMAN LOCKYER: So that's the reporting?

MR. SHANNON: Yes. It's not...

CHAIRMAN LOCKYER: Right.

MR. SHANNON: Yes, it's the whistle blowing in...

CHAIRMAN LOCKYER: Not the peer review board?

MR. SHANNON: Not the real peer review.

CHAIRMAN ISENBERG: Okay, Mr. Chairman, the last point for me--I think the most interesting thing that we've discovered this morning is that Mr. Shannon is personally responsible for including a lot of these groups and organizations into the code. When he was staff to this committee.

MR. SHANNON: Yeah, we did the committee analyses a little differently in those days. We worked and said well did they do something like this before? Yeah, they did they must of liked it. And actually we did it--I did some of these bills myself, and I think I raised some of the sorts of questions that Gene mentioned in his analysis about having the root bottom line is a status enhancement. That is what a lot of this is about.

CHAIRMAN ISENBERG: Perhaps we could get to the...

CHAIRMAN LOCKYER: Now was Gordon Cologne chairing this committee when you...

MR. SHANNON: No, no, it wasn't--we don't go back that far.

CHAIRMAN LOCKYER: Who was chairing this committee when you...

MR. SHANNON: Senator Al Song. You remember Al Song.

CHAIRMAN LOCKYER: Right.

MR. SHANNON: Just quickly on 43.7 the qualifications for your enlightenment is--the action has to be taken without malice after reasonable effort to obtain the facts, and in the reasonable belief the action was warranted by the facts found. So, it's a

fairly reasonable inquiry.

CHAIRMAN LOCKYER: So it's a fairly reasonable inquiry?

MR. SHANNON: Reasonable inquiry, yes.

Just briefly I want to touch on some other things I started to get in to. The adverse action reporting--we have--doctors have an 805 system that works pretty well. As a matter of fact it's also been strengthened by the Presley bill. Now, failure to make an 805 report is punishable by a $10 thousand fine. It was formerly only $1200. The problem--the difficulty we see with your bill, even though there has been an attempt made to grandfather in 805 reports, I don't think it's done--it's really a matter of drafting. I think it could be better. And our concern is that we want to make sure that what is called an adverse action isn't something as simple as--you know, you might want to take some continuing medication, something like--we would want to make sure that it is something that it is a medical disiplinary cause or action, as in 805 and to the extent that the bill blurs that--we do have some concerns.

There's also the health care quality improvement act which is the peer review, or the peer reporting statute enacted by the Federal government which needs to be melted into this. There is a section that you've added to--there's a sentence that you've added to Section 157 of the Evidence Code which would provide that the licensing board be able to get records and proceedings of peer review committees--we would resist that. They are already entitled to summaries of those meetings and they can get the conclusions that have been drawn in those meetings under-I believe/it's Section 805.1 of the Business and Professions Code. Once again, the reason we have a problem with this is we want to encourage physicians to be part of these meetings, which are very free flowing and lots of things get said and to allow the medical board to do this would really basically make participants arms of the state and I don't think you'd get a lot of participation from physicians in these kinds of committees if everything that they said was going to be handed over transcript form to the medical board.

In your bill--and I don't know if this is intentional or not, but I guess--I'm assuming that it is, you sunset all the immunities. What you've done is created kind of a five year pilot program for your set of immunities and then at the end of that--that is sunsetted, and then there is nothing on the books. We obviously have a problem with that. That eliminates, in other words, all the immunities after January 1, 1996. I'm assuming

that that was your intent, but that is certainly something that goes to our basic problem which is--we don't think the system is currently broke, at least for doctors.

CHAIRMAN LOCKYER: How do you feel, Mr. Shannon, about being thrown in among others with real estate agents?

MR. SHANNON: If you want to take us out and put us in our own code section, I don't think we'd have any problem with that. But, there has been very little case law on 43.7. I think the immunities, even though the thing is extremely pro-ex(?) it is a complicated section. I think it is well understood in the medical community and by the courts. If you ca clean it up and make it better and reword it a little bit, I don't think we have any problem with that. And if you want to tease out the various other groups and put them in their own sections--we don't have a problem with that. It's all those other things we have a problem with.

Do you have any questions? Kathryn and I would be happy to answer.

CHAIRMAN LOCKYER: Members just interrupt.

We acknowledge Assemblyman Leslie from Assembly Judiciary Committee.

Did you want to add any thing further Kathryn? Did you want to add anything?

MS. HANSON: No.

CHAIRMAN LOCKYER: Okay, thank you.

I guess we'll keep moving and see if Mr. Kuneo wants to talk now.
Oh.

MS. TRACY BECKWITH: Well, I'm obviously not Gary Kuneo. My name is Tracy Beckwith. I'm with the Calfiornia Chiropractic Association.

I apologize if I don't have all the answers to some of your questions today. The original notice was sent to Mike Schroeder, who's our legal counsel in L.A. So we knew about this particular event, but I didn't know that we'd be testifying and so forth. Let me say that CCA is willing to help with this kind of bill. We wish to strengthen peer

review. And we're even to some extent in agreement with the California Medical Association. To the extent that the peer reviewer is a volunteer, we feel that immunity should be granted. And to the extent that the reviewer is not being paid full time, we would like to be able to offer compensation for transportation and that kind of thing to the peer review.

We are set up a little bit differently then the medical professionals in that a lot of our practitioners are so low they don't--they aren't allowed in the hospital facility. But the California Chiropractic Association does have a peer review system set up that we feel works very well.

CHAIRMAN LOCKYER: How does it work?

MS. BECKWITH: Basically a complaint is sent in and we have a review body that meets I believe six times a year and they review the particular complaint that's sent in.

CHAIRMAN LOCKYER: How many complaints to they review a year?

MS. BECKWITH: This I don't know. This I can get to you. And again I apologize, I don't have all these facts and figures like I should. I can follow up with written testimony.

CHAIRMAN LOCKYER: Yes, I guess the other thing we would want to find out is whether the result of the peer review examination is to report to the licensing folks, whether there's some need to review a license or a discipline?

MS. BECKWITH: If it's reported to the state board?

CHAIRMAN LOCKYER: Yeah.

MS. BECKWITH: And even what happens from there?

CHAIRMAN LOCKYER: Yeah.

MS. BECKWITH: Okay.

CHAIRMAN LOCKYER: So, we'd like to know what you do, and what the results are.

MS. BECKWITH: Okay. Thank you.

CHAIRMAN LOCKYER: Okay, thanks.

The trial lawyers, who's going to comment for them?

MR. WILL GLENNON: Good morning, Will Clennon for the California Trial Lawyers Association and Nancy Peverini.

This seems to be a morning for screwed up notices. We gave our...

CHAIRMAN LOCKYER: Why don't we just hear from whomever's here and . . .

MR. GLENNON: Okay. Forget the disclaimers.

CHAIRMAN LOCKYER: And forget the excuses. I don't want to be here either.

MR. GLENNON: Peer review--the whole issue of peer review has been somewhat of a long running nightmare for us, for a number of reasons. And probably the sort of longstanding bureaucratic reason is that the statutes are extremely confused and convoluted and you're never quite sure who has immunity under what particular section and different groups have different language--it makes it a little difficult to practice law under those circumstances.

The points that we want to make this morning will be fairly brief. The first one is that we would encourage the committee to hold on to the volunteer notion. It just makes sense within the context of longstanding California policy that the immunities should be restricted to people who are volunteering and not people who are being paid for it. Second point is that the concept of peer review immunity existing in a vacuum when it's not being/used, doesn't make a whole lot of sense. And it raises the, perhaps paranoid prospect that an immunity will sit out there, peer review will not take place until there's a time to hide something under a peer review procedure. And then suddenly peer review pops into place and you find yourself in a situation where records are hidden and they never were before and the process was never used--the supposed benefits of peer review were never being utilized. All of a sudden they're being utilized at a time, when just coincidently you need to get some records and suddenly this thing pops on to the screen. The other...

CHAIRMAN LOCKYER: Can you document those kinds of occurrences where there's inactivity

and then suddenly there...

MR. GLENNON: I don't think at this point, you know, I could give any particular stories. I think it's more of a fear than anything else. It's like well they exist out there--they've never been used and you just know damn well that when your case comes up someone's going to say...

CHAIRMAN LOCKYER: I thought it was only deep pockets that legislated for their fears, rather than actual...

MR. GLENNON: This is reverse, however. I think one of the most serious problems with the whole area of peer review is of course that there is a strong tendency for it to become overbroad, and for more and more documents, records, and proceedings to be tucked under the purview of peer review sometimes properly, but sometimes improperly. and we feel that there's really a need to be very specific and very narrow about what proceedings are covered, what proceedings are protected from discovery, what types of records. A particular problem that there is a very well-documented problem with--is attempting to get hospital records relative to requests for and denial of staff privileges. And the routine procedure is when you attempt to get these records the hospital attorney sends back a notice saying, 1157, this is protected under peer review as part of the records. You send back a letter saying no, this has nothing to do with peer review, this is administrative function, and they send back a letter saying yes it has everything to do with peer review--it's all part of the hospital records. And it's been extremely difficult to get those records. There is a recent case that dealt with that issue and in fact properly dealt with that issue. But it has not put the issue to rest. And we feel if this bill goes forward, it is an appropriate time to hopefully put that whole issue to rest once and for all. And...maybe I sh...well...

MS. NANCY PEVERINI: Just as far as...

CHAIRMAN LOCKYER: The Hospital Association perhaps will later comment or any of those folks on whether there's any legitimate claim to closing those kind of records, if you'd help us with that when you... Nancy.

MS. PEVERINI: Thank you. Just specifically I think on that issue which we'll mention, we'd like to see language that states that the application for staff privileges and also whatever action or inaction was taken by the committee should not fall within the purview or

1157, so whether they denied privileges, etc.

MR. GLENNON: The other point is that in order to, I think, assure that peer review is taking place in a way that it's expected to, and that it is conferring the proper benefit that the policy is asking to be conferred, we would request that all existing peer reviews statutes require the outcome be submitted to the appropriate licensing board. I know that's done in some, but not all. And secondly, that there be an annual report of each one of those licensing boards to the Legislature, so that the Legislature can actually see whether something is taking place--whether there is in fact a benefit being conferred or whether nothing is happening at all, and instead being used as a cover.

CHAIRMAN LOCKYER: Okay, comments from anyone? Thank you. Who's next here? I have Dr. Kendall...Linda Lucio from Kaiser...Do any of those folks want to talk? Anyone else from the Optometric Association that was going to come with you? Oh please...

MR. MICHAEL HAWKINS: Mr. Chairman and members, Michael Hawkins representing Kaiser Health Plan.

I wanted to make a few comments that basically parallel what the CMA made comments on. The first has to do with limiting the immunity to voluntary. In a group practice health plan such as Kaiser, none of the doctors ever practice alone. They may be in a room alone with a patient, but as far as being off in a facility alone or in an office alone, they are not. The same goes in the hospital. So, from the standpoint of the problem that was indicated earlier of having individual doctors that are in private practice, that's not something that's a problem in Kaiser and can't because of the nature of the system. The Mr. Isenberg referred earlier to not being paid independently, and I'm not exactly sure what you meant by that. Our doctors, with the exception of a few that are in administrative positions where some of their activities are peer review related or quality assurance related, they are given time off from the kind of duties that they would normally have as a pediatrician or whatever kind of doctor they are. And, therefore, they're not paid independently. So, I'm not sure how you would put in statute how we would separate out exactly how they were paid, or how much and if they did it 1% of the time, if they did it 20% of the time, we see that as a real problem. We're not sure what the logical relation is. It certainly, in relationship to a plan like Kaiser, where in fact we feel we have a very good peer review program in place, our doctors do not practice alone, the

number of 805 reports that we turn in are comparable to the rest of the medical community now--you may not feel that that's adequate, although we would certainly be willing to discuss some method other than reporting of adverse actions to assure that there's some process going on there. We do feel that the 805 reports are adequate when the action that's taken rises to a particular level that affects the practice, there's a report that's filed. There probably should be some discussion regarding the difference between peer review, between quality of assurance, between utilization. Those terms are a lot of times used interchangeably and I'm not sure that everyone's talking about the same activities. And in fact, within our organization this bill has prompted us to take a look at both regions and all the different areas where it takes place, to see how consistent we are and how we're using those terms and how the different actions that are taken are reported. The discovery of all peer review committee records would be a real problem for us. We feel that that would have a severe chilling affect on participation by the physicans.

CHAIRMAN LOCKYER: You mean by the regulatory agents?

MR. HAWKINS: Exactly.

CHAIRMAN LOCKYER: Even if those weren't the basis for subsequent law suits?

MR. HAWKINS: I guess depending on how well protected they were and that if it was only basis for the regulatory agency initiating some action, although then what kind of inquiries would they be performing? That could be a potential problem because you could have an inquiry take place that would have the perception that there was something wrong with the physician's practice and if nothing took place you would still have that perception among the colleagues. That's a concern depending on how far an investigation would go by a regulatory agency based upon adverse actions that we would consider now to be diminimous(?).

CHAIRMAN LOCKYER: Well, I thought you had a stronger argument with respect to the necessity of paying them in your system then you do in not revealing information to the regulatory agencies, but go ahead.

MR. HAWKINS: Okay. Under the bill the existing Section 1370 and, I'm not sure, maybe there's some confusion about how this works. It's repealed and then a new 1370 is put in place, I believe in 1996. And that does not--that eliminates provider peer review protection as I understand it. And Kaiser Foundation Health Plan does not perform the peer

review. And, therefore, in situations where the medical groups are the only groups in a facility which are medical office buildings, they completely control those buildings. There would be the potential for eliminating a significant amount, if not all, depending on how the physicians felt about performing peer review without the immunity. The--you know, our program is such that the doctors' concern about performing peer review would not have to do with them having a personal legal liability for paying for what they do, because contracturally that's taken care of. That's provided. There are certain situations where depending on the kind of actions they take, if it was malicious and the contract provides that they can be put outside of the system to defend themselves but, to be quite honest that's never happened.

Those are all of my comments, unless there are any questions.

CHAIRMAN ISENBERG: Mr Hawkins, is it--am I not correct that in Kaiser when you bring a new doctor in they are on probation for a certain period of time ?

MR. HAWKINS: Yes, they are an employee-at-will; they do not have a contract for two years and then at that point...

CHAIRMAN ISENBERG: I'm sorry. During that two-year period you evaluate people in the medical group I guess. And let's see--Medical Group up north and I forget how you do it down south.

MR. HAWKINS: No, they're both medical groups.

CHAIRMAN ISENBERG: Both medical groups.

MR. HAWKINS: Yes.

CHAIRMAN ISENBERG: They decide whether to offer permanently a contract, right?

MR. HAWKINS: Yes.

CHAIRMAN ISENBERG: I assume you occasionally say you don't want to offer a contract to a doctor ?

MR. HAWKINS: Absolutely.

CHAIRMAN ISENBERG: All right. Does that lead--does that automatically lead to an 805 report?

MR. HAWKINS: No, because the reasons for that, I mean, I have been told that one of the significant reasons is that the doctors personally do not have a good way with patients--they don't get along with the patients, and they are simply told that that's a problem in Kaiser, it's a perception with the public and therefore we're very sensitive about it. That does not rise to the level of an 805 report. Therefore, significant number of "adverse actions" if that--if those came under that definition it would be for personalities rather than...

CHAIRMAN EISENBERG: But what about...What about adverse action or actions? Denials of the offering that are not based upon a bad personality?

MR. HAWKINS: Well, if in fact we waited 'til that 2 year period we would be remiss from the standpoint of not before that time taking some action that would limit their practice in one manner or another, and if we did that which we should be doing, then in fact a report would have to be processed.

CHAIRMAN ISENBERG: So the argument is that every doctor--every doctor who is being not offered a contract at Kaiser is being offered a contract--or not offered a contract for reasons other than the quality of medical care. And since Kaiser's a reputable organization there is not reason that the disciplinary agency should have any qualms or questions about that, and no reason why Kaiser should be required to provide any information on the grounds for denial of the offering?

MR. HAWKINS: Not just based upon the denial of offering, because if in fact we're not offering them a permanent or a contract as a Permanente physician then, and that is based upon a professional shortcoming...

CHAIRMAN ISENBERG: mmmhuh.

MR. HAWKINGS: ...which now would be reported under 805, it would have been reported. There could be the situation where just at the time the two years is up, is the time that they completed an investigation and at that point in time the two--the times would coincide. But theoretically, if the problem with the physician's professional practice took place

before the two year review, whether or not they were offered a contract, and 805 report should have gone--should have been sent in before. So, just to base in on the fact that they are not offered a position in the Permanente Medical Group would be very troublesome.

CHAIRMAN ISENBERG: What is the objection to recording the reasons for the denial to the licensing board?

MR. HAWKINS: Because in many cases they have nothing to do with the doctor's professional capabilities of practice.

CHAIRMAN ISENBERG: Would you--would you object to reporting and certifying that fact to the licensing board?

MR. HAWKINS: I believe I can represent to you that we would not have a problem with that. The other point that I would make along those lines is that, and it goes along with the voluntariness, the individuals that review these are first the doctor that's in charge--the physician in charge of the department, and it moves up the line. It finally gets to the place where it's a doctor. Most of them, which are also happen to be attorneys sit in positions where they practice maybe one day a week. And there again that brings up the problem of--if they're practicing that little and providing that much input into the peer review system, are they going to have any immunity? My point being, is that there is a number of individuals along the way that review this doctor's performance over the first two years before they're offered that position in the medical group.

CHAIRMAN LOCKYER: Any other questions? Thank you.

MR. HAWKINS: Thank you.

CHAIRMAN LOCKYER: Optometrists? Who was going to comment for them? Any one for optometrists? Why does it take so long to... inaudible ... speak softly...gentle retiring sort.

DR. RICHARD KENDALL: I'm with the Optometic Association and on staff here in Sacramento. Of course, we're in favor of the immunity for peer review. And in the case where there is no reimbursement to the individuals that are working in peer review and that's

basically how we function at the present time. We do have a system of peer review; primarily it's a complaint review and that's about as far as we go at the present time.

CHAIRMAN LOCKYER: Can you tell us how many complaints you get in a year or whatever, and what happens to them?

DR. KENDALL: My guess is that there are about sixty. They're conducted by the local society and at the present time the state organization does not have a reporting system from the local society.

CHAIRMAN LOCKYER: Okay. So sixty would be Sacramento County, or...

DR. KENDALL: No, combined, with all the societies.

CHAIRMAN LOCKYER: Statewide?

DR. KENDALL: Yes.

CHAIRMAN LOCKYER: They only get sixty complaints a year?

DR. KENDALL: That's correct. I said, that's my guess.

CHAIRMAN LOCKYER: How about the Board -- the State Board?

DR. KENDALL: Now, the State Board, of those complaints that appear to be a violation of some statute or regulation are referred by the peer review committee, or by the State Association, if they get that far -- to the State Board of Optometry. We do not involve ourselves in any regulatory violations.

CHAIRMAN LOCKYER: Do you have any recollection of how many complaints there are annually before the State Board?

DR. KENDALL: Not at the present time. I can find that out for you.

CHAIRMAN ISENBERG: Okay. Dr. Kendall, if an Optometrist were expelled from the Sacramento Board of Optometry after an investigation, is there any procedure whereby other County Boards of Optometry would be notified of that or associations rather?

DR. KENDALL: There is no procedure for that.

CHAIRMAN ISENBERG: Would it not make some sense?

DR. KENDALL: Yes, it would.

CHAIRMAN ISENBERG: To at least -- at least, on that level notify the other associations?

DR. KENDALL: You're referring to losing membership in the local society?

CHAIRMAN ISENBERG: Presumptively, it's the local society that does the peer review?

DR. KENDALL: That is correct.

CHAIRMAN ISENBERG: And, one would assume that if you practice in El Dorado and Sacramento County and you get booted out of El Dorado, the Sacramento County might like to know about that.

DR. KENDALL: That would be true, yes.

CHAIRMAN LOCKYER: Do you remember anyone getting booted out?

DR. KENDALL: No, I do not. I don't think it happens a lot. But..

CHAIRMAN LOCKYER: Okay. Thank you. Okay. Assembly Member Mojonnier, thank you for joining us. Let's see, I guess Mr., Dr. Dorken is next on the list. Good morning sir.

DR. HERB DORKEN: 'Morning Mr. Chairman and members. I'm Dr. Dorken representing the California Psychological Health Plan, and if I might wear a second hat, also two psychiatric health facilities....California. The bill, in its current version leaves us with a number of problems. Although I appreciate that this hearing is more to get ideas than to critique particular provisions in the bill, one of the other people has mentioned the issue of Sunset, and of course that's worrisome. The hope is that if we go through this exercise and generate a reconceptualization of peer review, then it might stay in place and not just disappear and have to be all -- let's say reargued all over again in another four or five years and perhaps disappear without anything there.

So, that's a worrisome feature. The other is that this year as you know AB 1841 did pass and we would certainly appreciate it if on page sixteen, line seven the word Psychologist could be inserted. So, that in effect, the bill is not chaptered out. I wonder if the whole issue of interindemnity, reciprocal, or insurance contracts that are under the sections seven and eight, that's sort of not an issue that is,.... character logically, quite different from what we're really talking about in peer review and if that might not be better dealt with as a separate bill. Now coming to the main feature I guess of this bill, is the volunteerism aspect, that only volunteers would get the protections.

CHAIRMAN LOCKYER: Well, you've heard the author say that's not his intention.

DR. DORKEN: Okay.

CHAIRMAN LOCKYER: I would want to argue a bit with him, but you know...

DR. DORKEN: Well, I'd like to describe certain situations that I've experienced professionally. And, if you are on an ethics committee of a professional association the number of complaints that come to you are relatively few, and every association that I've been involved with they deal with that on a voluntary basis and that's fine. And the same sort of thing happens in health facility settings. But when you get into something like the California Psychological Health Plan, which is a -- where, in effect, almost all cases seen are reviewed, the volume is such, that it makes a voluntary arrangement unworkable. On the other hand I think that there are some reasonable trade offs. We did review the law. We're required by the Department of Corporations to have a quality assurance mechanism in place and it's audited, and now the Department has just issued a couple of days ago a new set of proposed rules to strengthen the quality assurance arrangements, to require not only that these be in place, but that they be approved by the board; that there be a reporting of all incidents and actions and that it be accountable. That should, you know, strengthen those features considerably. I sought clarification last year from Legislative Counsel as to whether a health care service plan is required to enter into 805 reports because we've had the experience of having some contract Psychologist whose performance we thought was very marginal and we jaw-boned them into departure, so to speak, but those were not reported, and the law seemed a little unclear and it took six months to get an opinion back, and the opinion did say that yes, 805 reports are required. So, that's in the process of being implemented. But I think

that the language of the statute could be better in that respect. The problem is that it ought to be a two-way street before we appoint anybody whether to a psychiatric health facility or as a participating provider in a health care service plan, you check with the licensing board and they're supposed to respond to you. The time which they take to respond is often they -- encumbers the process -- I mean, weeks can go by, not a matter of days or a week but weeks even a month. So, while we might have to be required to report adverse actions on a prompt basis I think something has to be in statute that requires that the licensing agencies promptly reply to requests for information from legitimate agencies like this. We are also concerned that the reviewers must be professional peers and we know that there are some organizations that hire others to do this or have clerks, or some kind of fiscal administrator, and we don't believe that that's the intention of peer review and we would agree that that sort of review should not qualify for immunity from liability. We also have the view that if an organization, be it a health facility or a health care service plan, is not willing to do the work and take the responsibility to develop an integral quality assurance review system of its own then it wants to hire so to speak an outside gun to do it, then perhaps there is some merit in those people not having the immunity. We notice also that utilization is proposed to be eliminated--utilization review and it's very difficult to separate that from any discussion of quality assurance. At both extremes there can be a--excessive treatment and actually that is a misdemeanor under the licensing act. The other is terms of sufficiency, either a denial, or too limited care, so the extent to which services are used is I think an integral aspect of the quality of care that is going to be provided.

CHAIRMAN LOCKYER: Mr. Isenberg wants to comment but I just want to say I absolutely and ferverently disagree.

DR. DORKEN: Okay.

CHAIRMAN LOCKYER: Utilization reviews are not at all what is contemplated by the immunity statute. There is no reason to confer -- that I can understand -- to confer an immunity because of allocation decisions that are made about medical resources. I just -- it boggles my mind that someone would claim that those decisions should be immune from discovery and liability. Has nothing to do with negligent treatment or the social purposes involved in peer review, so I feel very strong about the issue and I remember in 1984 Senator Keene conducted a hearing of this committee to discuss that exact issue and the same parade that we've heard from today by and large were, of course, saying then, "Oh, it's not our intention to try to extend immunity to

utilization review issues, but I guess it's happening and some people think that it's defensible." I have yet -- I'll listen but the saying that it's fuzzy and that the things sort of overlap that I can understand, but arguing for utilization review procedures to be immunized runs contrary -- I will coauthor or author a bill on that subject. I'm real clear about my own personal values there. Now, Assemblyman.

CHAIRMAN ISENBERG: You made my point better than I could.

CHAIRMAN LOCKYER: Go ahead.

DR. DORKEN: Basically, what I am trying to say is that the extent to which services are used is an integral aspect of quality of care and -- so -- I have for a decade lectured and written on what I call the industrialization of health care and it's emerging more and more that we're seeing managed care today that the solo practioner is disappearing, and of course, the whole purpose of a -- something such as the psychological health plan is to have an organized service and setting. And with that we ought to be able to not only organize the delivery of services but assure their quality and we would like to be in a position to assure that and to be able to use participating members in the review process. If they can't have immunity from liability and protection for discovery, I think the whole public intent will be defeated. And, one final comment, minor, on page nine in lines fourteen and seventeen the peer review is applied to licensing hospitals and psychiatric health facilities are twenty-four hour acute care state licensed twenty-four hour residential acute care state licensed non-hospitals and there are othan than psychiatric health facilities and hospitals which have organized professional staffs, so it might be broader to just change the word hospital and have licensed health facility -- do -- have the umbrella somewhat larger.

CHAIRMAN LOCKYER: Questions? Okay, thank you Dr. Dorken. Should I just keep running down the list here? Alright, Assemblywoman Jackie Speier will also acknowledge being with us. Let's see, I guess the Engineers -- anyone here from those folks? Not yet. Hospitals?

MS. CHRISTINE HALL: Hi, my name is Christine Hall I'm general counsel for the California Association of Hospitals and Health Systems and today many people have gone before me and rather than repeat their testimony or to read a prepared statement to you, I've asked that you have a copy of our testimony today and also a letter we prepared for Assemblymember Isenberg earlier regarding 2856 as amended in June, and also an example from the UC system of what the compensation issue means to them.

I'm pleased to hear that Assemblymember Isenberg is willing to work with us and other people interested in this issue on the voluntary compensation issue and would like to start off now -- the motivation for hospitals to conduct effective peer review stems from much more than the professional and ethical considerations. We also have a case named Elam which provides that we can be held to be corporately negligent if we fail to put in place effective mechanisms of peer review to establish the competence of a professional both at appointment and on reappointment. Hospitals as we had a tremendous amount of experience with both Mr. Isenberg and his staff and Mr. Keene's staff on Senate Bill 1211 have been intimately involved with the modification of the peer review system. In the last two years we've been also experiencing the growing pains of the health care quality improvement act, the national park district data bank and other modifications to the system to hopefully screen out those people who have potentially unsafe practice behaviors. The hospitals are in an interesting position that, although, we are required by case law statutes, both federal and state levels, we are required to do peer review, there's not a statute per se that says a physician has to participate so you can understand where we're fairly nervous when physicians who are particpants usually as a condition one of the basic duties of being on a medical staff is to participate in peer review activities, so we get nervous when other people -- physicians, governing board members, etc., are concerned about the qualified immunity for peer review activities being altered in some way. I agree with Tim Shannon and many of the remarks that were made on behalf of the CMA. I'm all in favor for doing anything that can be done to clarify some of these statutes. I sometimes look for translation myself after several years of dealing with them and still get headaches. As I mentioned before I'm pleased to hear that the voluntary peer review activities and the question of compensation will be re-visited and I look forward to working with Assemblymember Isenberg and other members of his staff and legislators on establishing what parameters we can live with there. It's very difficult, for example, when SB 1211 went into effect there's a requirement that there not be any economic competition between practitioners and so, for example, in a rural hospital area you would have to-- it has turned out that there's a requirement that you compensate someone and rightly so for their time and efforts to come to what is often a protracted hearing and discussion regarding cases. Cases are pulled, cross sections of cases are pulled at random not necessarily just for disciplinary cause or reason in the hospital setting. I'm also very heartened that in previous remarks from Assemblymember Isenberg that there was some recognition of the fact that we are working very hard to make sure the system works in acute care facilities and hope that we can gain your confidence in that. I want to address a couple of concerns that were brought up in the the paper...

CHAIRMAN ISENBERG: I'm confident -- right? This is not a personal assault on hospitals or doctors. This is a critique of a system that is barely comprehensible in its important parts and it is radically changing.

MS. CHRISTINE HALL: Some of the concerns I wanted to address or raise in the White paper that was prepared for today, for example, there was a concern that there'd be "quiet resignations" of physicians and just to reassure this committee that the section of the Business and Professions Code section 805 (b) (3) prohibits, or actually it requires the 80 disciplinary report to be filed and -- I mean, I'm reading the quote is, "has a duty to report under this section if a licentiate's resignation or leave of absence from membership staff or employment follows a notice of an impending investigation based on information indicating medical disciplinary cause or reason". There's a very important change of the law that was made to make sure that these quiet resignations did not occur. Specifically to a question that was raised before by the committee, they asked whether or not if a licentiate was denied staff privileges whether that should require some sort of reporting mechanism and section 805 (b)--(b) sub 1 requires that an 805 report be submitted to the Medical Board of California if a licentiate's application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason. So that is a mandatory reporting mechanism. As far as reporting, opening up the books to of all peer review to the medical board or regulatory agency, we echo sentiments of the CMA and the others that have appeared today, that we don't want to do anything that would chill full and candid discussion of peer review participants. There is already a provision 805.1 which requires that the Medical Board of California be given the statement of charges, any document medical chart or exhibits in evidence, any opinion, findings, or conclusion when an action has resulted in a medical disciplinary cause or action. Other concerns are that we report to the regulatory agency; I know that this may directed to other professions, but we do have a mandatory reporting requirement to the NBC. A question that I had and a concern that was raised was a use it or lose it test that there be some sort of a number -- magic number somehow picked that would suggest that efficient peer review and -- you know adequate was being performed. I'm concerned about that just that it would be very difficult -- hopefully as a peer review system is established, modified and fine tuned -- you know as something that is supposed to be a trouble shooter and is supposed to help make sure nothing happens that would adversely impact patient care, the number of adverse actions should go down. So, I'm concerned that there is a double whammy there that as we improve the system we may lower the number and actually do ourselves a disfavor, many people fearing that if they don't find something wrong that they're going to have an adverse action come on the body or a scrutiny come on their activities. We do have and this is in a letter that we have

before you a concern of trying to take a generic peer review model and apply it to lawyers, architects, and other similar professions. The hospitals twenty-four hours a day, are faced with life and death decisions, we don't often -- you know -- often don't have the choice of whether we're going to treat a patient in an emergency situation. It's a very different type of a business and with an incredible responsibility and duty, but it's very different from let's say an architect, or whatever who has you know several months to design something -- I mean I'm not going to get into their -- you know the purview of their profession but I am deeply concerned about trying to apply across the board one system -- the medical peer review system for -- you know acute care facilities has been fine-tuned, worked over. We're right now trying to implement some of the more recent changes and although we would look forward to and offer our services in helping to develop a system for other professionals, we do not feel that the acute care hospital facility peer review mechanism is broken and needs to be fixed now. In fact, we'd like the opportunity to work with the recent changes and see how that works out. And, if there's any questions that the committee has, I'd be happy to discuss it -- oh, by the way, Senator Lockyer, you mentioned one thing about abuse of 1157 protection on application -- I am not aware personally of any examples but would be open to receiving them so we could focus on those.

DURELL FREEMAN: My name is Durell Freeman. I'm also with the California Association of Hospitals and I represent the professional services side of this. As a former hospital administrator for ten years, I also would support the fact that voluntary versus the non-voluntary would be very detrimental in the rural sector. I know this has been visited several times but this is the type of thing that I would also support, and I would very much look forward to working with Senator Lockyer on a bill regarding peer review immunities under the utilization review process too in the future.

CHAIRMAN LOCKYER: Okay, thank you. It may be that there is if we think about it, Gene tends to come up with these kind of creative new schemes. There may be a way if compensation is present that permits a greater likelihood of piercing the various shields, either to discovery or immunity shields that -- that maybe there would be a lower, still an immunity but the qualified immunity would become a little bit narrower or something that we might think about that there perhaps some way to satisfy both sides of the argument. Well, thank you both. Any Questions? Yes, Ms. Speier.

ASSEMBLYWOMAN JACKIE SPEIER: Ms. Hall, you commented that you felt that trying to create a model that would apply to all professionals is difficult and may be inappropriate.

I'm amused by that only because it's the same interest whether they're doctors or hospitals or the like that come to us each year and say, "Why are you singling us out? Why aren't you doing this to all the professions?" So, my only point to you is you can't have it both ways. Either we treat everyone alike, generally, or we'll treat everyone differently and you'll have to deal with the vicissitudes of that kind of a system. In your comments you make the reference to the fact that there is no statute that imposes mandatory participation in peer review activities and I want to know if you think maybe we should require that as a part of one's service to the community.

MS. CHRISTINE HALL: At the present time if hospitals -- right now we've been able to enjoy the participation of physicians and other members on the peer review committee without that type of stick, but if the immunities were removed -- whatever, there may be no choice for hospital but to look for that type of legislation.

ASSEMBLYWOMAN SPEIER: From a public policy prospective, where is -- what injury is there to anyone to just require that as a -- as part of doing business in a hospital setting?

MS. CHRISTINE HALL: I don't see where that's a -- that there would be an injury, I'm just saying at this point it may not be necessary but you have a very good point I think and we've looked at it too, whether or not in the future one day it may be necessary to mandate it if people do not voluntarily as part of medical staff privileges in peer review activities.

ASSEMBLYWOMAN SPEIER: Mr. Isenberg, have you considered that in your legislation?

CHAIRMAN ISENBERG: No, but I have so much else on the legislation that generates adverse reaction that that's certainly an acceptable suggestion to add -- in for a penny, in for a pound.

ASSEMBLYMAN TIM LESLIE: Yes -- for those that are receiving compensation rather than the voluntary ones, could you characterize the typical person that's involved in -- I mean is this like a once a month deal where he's getting like a per diem sort of thing or is this someone who is making a substantial part of their income doing this on a regular basis?

MS. FREEMAN: As far as I'm aware, there's no one that actually does this full time because that kind of defeats the purpose. What you have is someone in practice, hopefully, that can do a true peer review, but you can have a situation where they involved anywhere from two hours a month working perhaps in a small hospital but because of the fact that nobody, at this point, wants to do it that

they are compensated for their effort. Or you could have, say a medical director in a major facility where maybe 20 hours, 30 hours a week is spent in some type of peer review process.

MS. HALL: Just to add to that--because of the rather nebulous or--we have not come to a final definition of compensation. I mean, our concern is that, you know, how do draw the line of--as to what compensation is, you know. Is your medical director who may be compensated, or a member of the board who may be compensated. If they participate, does that jeopardize immunity?

ASSEMBLYMAN LESLIE: Is the medical director spending 20 or 30 hours a week as the administrative workload and processings and so forth, or is he acutually one of the reviewers per se?

MS. FREEMAN: He would probably be actively reviewing also.

ASSEMBLYMAN LESLIE: Do you--I think I noticed that the California Optometric Association said that they supported the immunities for volunteer only. Do you--how would you see that you differ from the situation that they're in?

MS. FREEMAN: Well, first of all, when you have a hospital setting you are asking these people who you really have no jurisdiction over, say the MD's to do something--take their time, look at their peers, it's not a very pleasant situation for them to do it. And so many of them are compensated. If they were not compensated, we would not have them doing the utilization review process. And yet the board in the hospital is still responsible to make sure this is accomplished.

ASSEMBLYMAN LESLIE: What is typical compensation?

MS. FREEMAN: I don't think you can pay a typical compensation. Coming out of the rural sector, I know that my utilization--not utilization, quality assurance director got $500 a month. I'm sure that that can go--be much higher than that.

ASSEMBLYMAN LESLIE: That was the medical director?

MS. FREEMAN: No, that was the head of the quality assurance committee.

ASSEMBLYMAN LESLIE: Okay. So, it was however many a month came up, and it was a

flat $500 a month fee?

MS. FREEMAN: Yes.

ASSEMBLYMAN LESLIE: Are--in other situations is it a per case, per meeting, per hour--what's, what would be in an urban setting, what would it be?

MS. FREEMAN: Well, again it varies from, you know, hospital to hospital. I'm not aware--I know that there is someone that I'm aware of in southern California that receives $60,000 a year; has also a practice. But, he does a lot of administrative things, one of them is medical quality assurance.

MS. HALL: Just to add to that, a typical thing--there's a program by the way, I would be happy to provide the committee with more information, it's called the Beta Network--which is--was formed after Senate Bill 1211 to provide hospitals with a pool of practitioners who could be called upon to come in and do effective peer review without any concern regarding economic competition. As you can imagine in a rural setting, where there's, you know, one "orthopod" you're going to have a real problem with trying to get someone in that area. So this is set up in a way...

ASSEMBLYMAN LESLIE: He has only to review himself, I guess.

MS. HALL: ...and that hasn't been amended into the bill yet, to allow. So--but anyway, you know, in those cases, you know, there would be issues such as travel, you know, meals, maybe some compensation--the idea is to try to keep to a minimum, because as we know rural hospitals are not able to afford tremendous expenses.

ASSEMBLYMAN LESLIE: If I can, let me just go back to this one example that you gave of the $60,000 person.

MS. HALL: Uh huh.

ASSEMBLYMAN LESLIE: You say that they have--could you explain their practice a little bit more, so I can understand that?

MS. HALL: Their practice, what they're doing besides the medical directorship?

ASSEMBLYMAN: Yeah.

MS. HALL: They have an internal medicine practice, and then they work with the hospital to work with the medical--they are paid by a hospital to work with the medical staff for the administrative functions that are becoming very complex at this point in time.

ASSEMBLYMAN LESLIE: So this is a physician...

MS. HALL: Correct.

ASSEMBLYMAN LESLIE: ...who apparently is an internist, and he has his regular practice...

MS. HALL: Correct.

ASSEMBLYMAN LESLIE: But in addition, he's branched out to where he's also providing administrative services to a hospital?

MS. HALL: Yes. The position of chief of staff at this point in time has, as I said, has become very complex. And many times you'll have a chief of staff, now, but then to deal with all of these various administrative functions and work with the commi--the committee chairman and people like that, they will bring in a physician that works as a medical director, even some of the smaller hospitals are looking at a paid medical director now. And I think there's something like 25% of the hospitals in the state have a paid medical director.

ASSEMBLYMAN LESLIE: Okay, thank you.

CHAIRMAN LOCKYER: Could--maybe it would be one of the prior witnesses, if they would help me out, I--or those present. I guess I'm trying to figure out how a lawsuit could be conducted, when you're allowed the--if the immunity is qualified and if there wasn't reasonable inquiry into the facts, or there was malice, then the lawsuit can proceed? How do you--how does a plaintiff find out whether there was reasonable inquiry or malice if you can't discover? How do they go about that? Maybe I should ask some plaintiff's lawyer? Can you...

ASSEMBLYMAN LESLIE: Enthusiasm.

CHAIRMAN LOCKYER: Well, or can you folks...

MS. FREEMAN: I can address that...

CHAIRMAN LOCKYER: ...tell what happens.

MS. FREEMAN: ...somewhat. What happens is the information under the system now is still now discoverable, but they do a discovery.

CHAIRMAN LOCKYER: Meaning what?

MS. FREEMAN: Meaning they go through a similar process. The attorney can answer this better that I can I'm sure. But they go through a process just like they would if there was a poor outcome for example, then they can go through their patients chart, they can do--they just don't have privilege to the information in the peer review process.

CHAIRMAN LOCKYER: Will, on that.

MR. GLENNON: Yeah.

CHAIRMAN LOCKYER: Ever done one of these lawsuits?

MR. GLENNON: No, I haven't. I have talked to a number of people...

CHAIRMAN LOCKYER: People that do it?

MR. GLENNON: ...who have done it...

CHAIRMAN LOCKYER: Okay.

MR. GLENNON: ...and the comments I get is that it's that it's an absolute maze and a nightmare, it's sort of a catch-22. Because you do find out in doing your normal discovery with the medical records and so forth, that there has been a problem there, but then you're never able to get within the inner circle and find out what happened in the peer review portion itself. And, you know, the letters go back and forth and say well there wasn't proper inquiry, there was, you know--and you never get it. That's the problem.

CHAIRMAN LOCKYER: Well, if anyone else present can help with--okay. Come back. Do you ever--do you ever defend these lawsuits Kathyrn?

MS. HANSON: Umm.

CHAIRMAN LOCKYER: Or have you talked...

MS. HANSON: We've been...

CHAIRMAN LOCKYER: ...or have you talked to some people that did it?

MS. HANSON: ...busy on both sides of these lawsuits.

CHAIRMAN LOCKYER: Say that again.

MS. HANSON: We've been amicus curiae on both sides of these lawsuits.

CHAIRMAN LOCKYER: Yeah, okay. What--some day I'm going to find a lawyer who actually either defends or prosecutes these suits, and see what they have to say. But...

MS. HANSON: The--the...

CHAIRMAN LOCKYER: Yeah, yeah--it's hard.

MS. HANSON: What--what--the time that the peer review immunities come into play is where there is--well, I'll only talk about the medical profession.

CHAIRMAN LOCKYER: Please.

MS. HANSON: Where a physician is disciplined in a peer review proceeding...

CHAIRMAN LOCKYER: Right.

MS. HANSON: ...and is unhappy and files a lawsuit. It's basically the same thing as a wrongful termination lawsuit.

CHAIRMAN LOCKYER. Uhmm.

MS. HANSON: And in the course of that there is access to information, both--remember that before the physician can file a lawsuit at all they have a judicial review committee hearing. And in the course of that hearing, they are entitled to all of the information that went in to the adverse action...

CHAIRMAN LOCKYER: This is on the hiring, firing question?

MS. HANSON: ...well, or any kind of discipline of medical staff privileges.

CHAIRMAN LOCKYER: Okay, but that's--so that's discoverable to medical folks?

MS. HANSON: That's right. Well, that's the only time...

CHAIRMAN LOCKYER: But...

MS. HANSON: ...that peer review immunity is going to come into play, is where a physician is--feels that the peer review process was improper in some fashion and sues the medical staff and hospital saying that you've wrongfully terminated or restricted ...

CHAIRMAN LOCKYER: Yeah, what if some medical consumer, a patient, wants to bring an action for negligence?

MS. HANSON: If a consumer brings a med...

CHAIRMAN LOCKYER: ...And they want to discover peer review records?

MS. HANSON: They can't discover them.

CHAIRMAN LOCKYER: Even if they would claim that the peer reviewers didn't reasonably investigate the facts, for example? Or, maybe acted with malice or

something?

MS. HANSON: They can bring a "med-mal" suit against...

CHAIRMAN LOCKYER: Yeah.

MS. HANSON: ...the physician involved by looking at the records, getting other experts to come in and say this care wasn't provided appropriately

CHAIRMAN LOCKYER: They would...

MS. HANSON: They would also bring an action against the hospital on the theory...

CHAIRMAN LOCKYER: Right.

MS. HANSON: ...that the peer review process...

CHAIRMAN LOCKYER: May suggest...Okay.

MS. HANSON: ... was not adequate. And the basis for that lawsuit is going to be the peer review process documents itself. I think we've got several cases now that say that they can get access to whether or not a decision was made -- I can't, I can get all this stuff for you. But there is some access that they can get, but what they can't do, is they can't use the peer review process as their discovery in the "med-mal" proceeding. It gets back to an issue which it's clear you have a lot of difficulty with, but we think is critical which is that these people that are doing the peer review are doing it as part of a voluntary...

CHAIRMAN LOCKYER: A paid...

MS. HANSON: Well, it's generally unpaid.

CHAIRMAN LOCKYER: Okay.

MS. HANSON: But--or low pay process...

CHAIRMAN LOCKYER: Yeah.

MS. HANSON: ...to increase the quality of care...

CHAIRMAN LOCKYER: Only in voluntary is it well...

MS. HANSON: Well they're not..

CHAIRMAN LOCKYER: ...I don't want to get back into issue, but everyone here has been arguing against making it voluntary, so let's not try to use the "kiddie" flag.

MS. HANSON: Well, the point is is they are not doing it as a part of the state investigation, or as part of a "med-mal" investigation...

CHAIRMAN LOCKYER: Right.

MS. HANSON: ...against another person. Their purpose is not, generally punitive...

CHAIRMAN LOCKYER: Well, I guess I would like to see from lawyers who practice "med-mal" something other than whining about "micra-caps"? which is about all I ever hear from them, as to the practical application of the various discovery rules to their ability to bring an action and maybe you'd ask somebody to comment for us on that issue.

MR. GLENNON: Yeah, I think we can do that in this particular case the crux of this issue, the catch-22 is not with the malice issue obviously, but it's with the inadequate peer review.

CHAIRMAN LOCKYER: Right.

MR. GLENNON: And you don't get to find out it's been inadequate, you may know it has been, but then you can't get the documents to show that it has been, so you can't pierce the immunity, it's a catch-22. But I think we can provide some materials and witnesses who can speak...

CHAIRMAN LOCKYER: Now, it may be in most "med-mal" circumstances you get that information, in other ways.

MR. GLENNON: ...sometimes...

CHAIRMAN LOCKYER: I suspect that's true. But I'd like to hear some comment on that.

MR. GLENNON: Right, sometimes you can, but again you then end up having to infer that there was inadequate peer review, because look at all this evidence out here and there's a hole in the middle.

CHAIRMAN LOCKYER: It may make it hard to join the hospital...

MR. GLENNON: Right, exactly. Right, that's the key to it is when you're talking about in a long case where you're trying to join the hospital...

CHAIRMAN LOCKYER: Do you get a lot of lawsuits?

MS. HANSON: Definitely, yes. We need to pick up on that one if there's a way to...

CHAIRMAN LOCKYER: I've seen a lot of the surveys of, you know, how many claims are brought against medical practitioners and with what degrees of success and all that sort of thing. I don't know that I've ever seen those with hospitals, do you have those kind of statistics?

MS. HANSON: No, not off the top of my head. But I'll be happy to though...

CHAIRMAN LOCKYER: No, but I mean have they done those studies, or something it...

MS. HANSON: I'm fairly sure they have.

CHAIRMAN LOCKYER: ... and you know...

MS. HANSON: Yeah, when the hospital has been joined in the lawsuit and all, yes. I think I could get that for you and the committee's use.

CHAIRMAN LOCKYER: Okay. Thank you.

MS. HANSON: Thank you.

CHAIRMAN LOCKYER: Who was next? Brenda, Ms. Reid.

CHAIRMAN ISENBERG: Mr. Chairman.

CHAIRMAN LOCKYER: Yeah.

CHAIRMAN ISENBERG: The land surveyors weren't here...

CHAIRMAN LOCKYER: Oh, we miss them, yeah.

CHAIRMAN ISENBERG: ...well, they weren't here but we do have a letter from them on July 24th, which is worth noting. I think we sent a copy to you. This is the one that said that although they like the immunity protection, they point out that none of their professional organizations qualify, because none of them have a large enough membership as a proportion of their profession to qualify, and therefore, they'd like me to delete the provision that says membership associations if they represent 25% of the liceniates may have the immunities. They'd like to drop that to zero, I guess.

CHAIRMAN LOCKYER: Well, they don't have enough members to be here either, so...

CHAIRMAN ISENBERG: They have enough members to write a letter.

CHAIRMAN LOCKYER: Okay, this is true.

MS. BRENDA REID: Good morning. I'm Brenda Reid, General Counsel for the Cooperative of American Physicians. CAP-MPT, we're in at Los Angeles and we provide medical malpractice protection to 3,500 physicians. But we provide it through a statutorially established inter-indemnity arrangement; we are not an insurance company, nor do we classically operate as an insurance company, and in fact we're one of those inter-indemnity arrangements that the gentleman who testified before for the Psychological Plans thought should be in another bill.

Our enablying statute is in the Insurance Code, it's Insurance Code section 1280.7. You're probably familiar with it now because it's about oh, pages 18 through 54 of Assemblyman Isenberg's bill. And I guess that would mean that we would argue certainly for a shorter bill. However, our enabling statute is in there. That statute mandates that we perform peer review as part of our operation, and it does provide immunity in 1280.7 for that function.

I'm here today because peer review and the performance of it is essential to our company's ability to provide malpractice coverage. Because it's a mechanism to control the risk for our member physicians who have unlimited personal liability for malpractice

protection or for the--and by signing on for malpractice protection. We believe that the present statutory system of immunity is necessary for us to be able to recruit physicians to perform peer review and to discourage the proliferation of lawsuits. We do very active peer review at the Cooperative and even though it is an essential part of our function, we already have some difficulty recruiting physicians to participate in the peer review.

Under the present statute like many of the others who testified if a peer review action is taken with malice, it's only a qualified privilege, so the aggreived physician could bring an action under that. We do report, although we do not report to the business and professions--under the Business and Professions Code, we already report all settled malpractice claims that come to settlement or judgment. And now under the National Practitioner Data Bank we even report those settlement or judgments down to the first dollar toward the state board and to the National Practitioner Data Bank.

CHAIRMAN ISENBERG: That's a change in your position from the July letter, where you said you were not covered by the national reporting requirements?

MS. REID: Oh, no, that's incorrect. We are covered by the malpractice provisions of the reporting requirements.

CHAIRMAN ISENBERG: Your letter said, "It is our position that we are also not required to report peer review actions to the National Practitioner Data Bank."

MS. REID: That is correct. And that is still our position. We report all settled malpractice actions both to the National Practitioner Data Bank and to the Board of Medical--or NAVA Medical Board of California.

CHAIRMAN ISENBERG: Of course...

MS. REID: There are two actions, malpractice or peer review actions. They are interrelated in our structure. We do report all the malpractice actions.

CHAIRMAN ISENBERG: ...or if it leads to a malpractice action then you report it as you've required but if it does not lead to a mal-practice action.

MS. REID: Generally it doesn't operate quite that way. We report malpractice actions whether they are seen by the peer review committee we report them as a matter

of course. A physician who has a number of malpractice actions that have been filed and settled against him, may or may not be involved in peer review at a certain period of time in our company.

CHAIRMAN ISENBERG: Mr. Chairman, Ms. Reid and Mr. Cologne abused me substantially for a long period of time at various meetings on this subject. If you let--well in fact I did like it. And it was--it was informative. They made one point that I thought was compelling. I don't think they expressed it quite this way and they should not be held to my characterization, but I think they argued that in many ways the only effective peer review of individual, private, in office practices may well be the insurance type functioning. And I thought that was probably correct, that's--they might not want to take on local medical associations quite that directly, that's the conclusion I drew and I thought that was a...

CHAIRMAN LOCKYER: That would be an argument against the exclusion the sort of underwriting function, is that the point?

CHAIRMAN ISENBERG: Yeah, I thought their best--the best point in the argument was that although they say we're not really an insurance company--put that aside for a moment, even if they are, they presently provide the major foundation for review of individual practitioners. Even though malpractice isn't legally required, it's a practical matter, virtually almost all physicians require...

CHAIRMAN LOCKYER: Why are they not an insurance company? I mean is that -- you mean by technical definition in the insurance code, or by what you-

MS. REID: It's by more than a technical definition in terms of membership but we were also as with many of --

CHAIRMAN LOCKYER: Isn't that what you do.

MS. REID: We provide medical malpractice protection, but in a different way. I think the fact that was essential, but our members have unlimited personal liability; it is not like any insurance company that I'm insured with for example; it is a membership cooperative organization. There is a different structure in terms of the involvement of the physicians and they are on the hook for an adverse or for underfunding. It came out of the malpractice crises though, you are correct, at the same time as the physician insurance companies.

CHAIRMAN LOCKYER: What is the reason for someone to join, what motivates them?

MS. REID: Oh, I love that! What an opportunity, absolutely.

CHAIRMAN LOCKYER: Insurance basically, isn't it?

MS. REID: Malpractice protection.

CHAIRMAN LOCKYER: Not doing Burmuda travel and cheap autos, or something like these other people.

MS. REID: No. Absolutely, the motivation is malpractice protection and the difference is that it is a membership organization and we have a different mechanism for providing it and for signing up.

CHAIRMAN LOCKYER: Any more questions from anyone. Al right thank you. I guess we are going to shift to some -- yeah, Gordon. We had a little prior agreement which was to abuse you enough to draw you to the table, so I am glad it worked.

MR. GORDON GOLOGNE: Let me tell you, we selected the young man to serve as our committee consultant -- was picked out of the Legislative Counsel's Office who went on to bigger and better things, and that was Bion Gregory, so I can't apologize for the caliber.

CHAIRMAN LOCKYER: Our consultant's dispute whether that was bigger and better things, but --

MR. COLOGNE: The other thing is that I want to compliment Senator (sic) Isenberg on coming to San Francisco and meeting with our doctor-owned insurance companies and I have to admit that was abuse, but it was a voluntary abuse.

CHAIRMAN ISENBERG: It was fun, I liked it.

MR. COLOGNE: Well I thought you did very well, and you impressed our people over there.

CHAIRMAN ISENBERG: Yeah, but their still opposed to the bill in all of its forms.

MR. COLOGNE: I have to confess that's true. But, one thing I wanted to explain was, that in 1972 when I was chairman of the Judiciary Committee...

CHAIRMAN ISENBERG: How many years did you chair?

MR. COLOGNE: Two years. But, during that period you have to understand that at that time there were no such things as doctor owned insurance companies. The insurance provided for physicians at that time was strictly done by commercial carriers. And what they did was when there was a liablity in exposure, they would just pay it. And not worry about it. In 1975, when this became a crisis situation and the carriers just pulled out, they didn't want anymore, want any part of it. They left the whole field and so the doctor-owned insurance companies were established to protect, one the doctors, and two to protect the public. And these are carriers now provide about ninety percent of the insurance for physicians. And they embarked in a program of loss prevention and these are all, the board of directors of all these companies are physicians, and they're more interested in cutting the cost of insurance down, then they are in just paying a claim. And so, they all established their loss prevention program, and one of these is underwriting. That's why you have now, which was not established in those days in '72, but is established now some protection for these doctors. And, they're all fulltime practicing physicians. They do get compensation, and I appreciate Isenberg's (sic) agreement to modify this aspect. They do get compensation, but it's a per diem, it's five hundred dollars a day in most of these cases for a physician to take off from his practice; in some cases it's as much as seven hundred dollars a day, per diem. But, they do the work of the insurance companies, and they do the underwriting. When the problem raises to a level that's very serious, which could amount to a licensing problem, it's easy for them just to not renew the insurance and they can do that at the end of the policy period--which is now a six-months period. So they can can terminate it and that's the end of it and incidentially when they do terminate it they give notice then to the hospital, because ninety-nine percent of the hospitals now require insurance or the protection of the co-op. They require this, and so they ask for a Certificate of Insurance for any doctor that has staff privledges. And when we cancel a policy we have to give the hospital notice and then that goes onto the record, that the hospital then is required to notify the licensing carrier when they terminate because the doctor didn't have insurance. So, those that do raise to that level

do get notified, notification to the state board. But, most of these cases, and I would say ninety-nine percent of them do not raise to that level where it affects their license. Most of them are procedures that need some instruction, the doctor needs some instruction on where he hasn't had the background, where he's going into a new procedure. And you must understand that these new procedures develop every-day today with the technology that's developing--if he's going into a new procedure where's he's had none of this training and experience, he's comes to our attention either through his colleagues or through the hospital of some other way we get notice of it. And they sit down with the doctor, now these are all practicing physicians who sit down with him and ask him about his procedures, and so forth and in most of the cases they do not give any discipline, they simply tell a doctor that if he wants coverage for that particular procedure that he must go back and take the training. It's a loss prevention program, but it is part of the under-writing facility, in that they're goingto say that this doctor is covered or is not covered for this particular thing and as a result just to give you an example of what's been done in anesthesiology, for example, we've cut the cost of insurance for an anesthesiologist down tremendously, it used to be in the same category as OB and neurosurgeons, now it's cut down to where it's in the third category. And this is the loss prevention program that we've been developing and trying to develop--not to discipline doctors but to keep the quality of care up. If this were raised to the level where it was a licensing procedure our people would have no trouble. They just terminate the insurance at the end of the period, which is three months. But ninety-nine percent of these cases are quality insurance--assurance, and are designed to prevent injuries which would raise to the level where a lawsuit would be involved. One last point I'd like to make is that we're not under 1157 if... something we do, everything we do is discoverable.

CHAIRMAN LOCKYER: Questions?

CHAIRMAN ISENBERG: Mr. Chairman, just one of the things that I had occurred to me after dialogue with Mr. Cologne's people in San Francisco, is that you clearly don't want to have everything reported to a licensing agency. But there must be a definition that's possible to develop that covers that one percent of the cases, that might otherwise kind of drop through the holes somewhere. And that's one of the things I'm going to be taking a look at.

MR. COLOGNE: I think we'd be willing to work with you if it raises to a

level where they're going to cancel the insurance. For example, we don't mind reporting that 'cause we do report them to the hospitals.

CHAIRMAN LOCKYER: Thanks. Okay, Mr. Wieg.

MR. STAN WIEG: Thank you Mr. Chairman and members. I'm Stan Wieg from the California Association of Realtors. Before I speak to some of the conceptual issues we had, just to key on what Mr. Isenberg just said about reporting adverse actions to the regulator, we're concerned about that issue too. Because of the nature of the, the different nature the kind of panels that we have and the code of ethics that we have that doesn't necessarily mesh with the Business and Professions code restrictions in B and P 10176 and 77, we'd like to see the a definition that's tailored toward things that the Department of Real Estate is actually empowered to enforce. We've had some informal discussion with the department. I think there's some concern out there also on their enforcement people, on that issue. To speak to the issue of separation, the Chairman mentioned earlier in talking to the physicians, that would they object to being separated out from the other types of groups. They didn't mind we wouldn't mind either. We're currently separated out and we're pleased to see that you kept that distinction in the statute and simply carried over into a new section number. I think it's 17306 in your bill. We don't see that the local Boards of Realtors panels are the same as for example, a hospitals panel or a local physicians group panel. But, our folks do do a substantial amount of activity, we believe that they are somewhat excessive, a thousand cases actually go before a full panel a year. And in most of those cases there is some informal resolution there are, I must dispute, there are actual expulsions from the local board, and from the local activity, even though people have paid their dues. That's not the only reason we expel people.

CHAIRMAN ISENBERG: How many realtors are there in California?

MR. WIEG: There are approximately 140,000, that's about a third of the real estate licensees.

CHAIRMAN ISENBERG: Right, and how many belong to the various associations?

MR. WIEG: About 140,000. It's a vertical membership, if they belong to the local board they belong to CAR and the National Association.

CHAIRMAN ISENBERG: And the thousand cases a year, are complaint driven?

MR. WIEG: Yes, they are. Our system relies on a complaint to come into the process and typically about half of those I understand are non-board member complaints, public member complaints to the local board.

CHAIRMAN ISENBERG: Of the 140,000 members how many are denied membership per year?

MR. WIEG: I'm sorry, I don't have an answer for that. Like I say...

CHAIRMAN ISENBERG: A guess?

MR. WIEG: Umm, no, I can't. I would say though that it's a relatively small percentage of the thousand. That's effectively capitol punishment on that membership.

CHAIRMAN ISENBERG: How many members annually are kicked out of membership on grounds other than nonpayment of dues?

MR. WIEG: I don't know. Certainly anyone who's had his license revoked by the department...

CHAIRMAN ISENBERG: Well, sure, of course. Okay.

MR. WIEG: Independently--I don't know. I don't have that statistical information Until recently, our NAR Charter would not permit us to share information between chapters; you and I discussed that earlier. We have had a change in the NAR charter under which we operate so that we can do that information sharing. But, until recently we were not keeping those kind of records, I'm sorry I just can't tell you.

CHAIRMAN LOCKYER: Did you mention how many are disciplined by the state board? That is...

MR. WIEG: Umm, my understanding from the DRE staff is that have something on the order of 10,000 complaints a year come in and out of that they come to a closing of the case on about a third of those.

CHAIRMAN LOCKYER: Does the director just decide that? Or how does that work in the, in relation...

MR. WIEG: Well, they use an administrative hearing officer approach, and it is in effect, an appealable...

CHAIRMAN LOCKYER: Someone within the department...

MR. WIEG: Yes, oh yes. No question about that. They contract, I think with OAL to to that.

CHAIRMAN LOCKYER: And, how many again? Ten thousand come in, and what's the result?

MR. WIEG: About a third of those are closed, not necessarily with discipline, they may be exonerated. There's not necessarily discipline or sanction applied on all of those, but they close that many cases.

CHAIRMAN LOCKYER: What is the two-thirds?

MR. WIEG: Well, some of them are resolved prior to hearing. And some of them are still pending. I mean, they don't, they're not on an annual cycle so, as of the last year --

CHAIRMAN LOCKYER: You going to add something to that issue for us?

MR. ROBIN WILSON: Robin Wilson, with the Department of Real Estate. We had some concerns with this bill, and we noted that no one here, really spoke to it from the point of view of a public agency. With respect to the statistics, we take in approximately, 10 to 11 thousand complaints a year, of those, we set up approximately over half for investigation. Approximately, one third are closed, but, three thousand last year were closed. We'll look at the facts and determine that they don't really involve a matter which we can enforce, or there may be some other, for some other reason the matter may be disposed of. It doesn't relate to something in license activity. Of those 5,400 investigations, last year we sent over 1300 to the legal section for disciplinary action of one form or another, against a real estate licensee.

CHAIRMAN LOCKYER: And, what final result was there? 1300 went in --

MR. WILSON: ...1300 -- just a minute, let me pull out the file; I can tell you how many different orders.

MR. WIEG: Those would have been sanction orders, at that point.

CHAIRMAN LOCKYER: The thirteen hundred?

MR. WIEG: Yes. Whether they were appealed --

CHAIRMAN LOCKYER: Then it would have gone to the administrative hearing?

MR. WILSON: We would have had, those that, formal filings were over 1,300 last year, of idfferent things. But we actually, totally, let see, we suspended a total of 40 licenses; we revoked a total of 417; 46 were dismissed; we had two public reprovals; we had miscellaneous orders issued, totalling over 400; we denied 79 licenses outright, there were a total of 138 people who were given probationary licenses, there were a number, 41 of the statement and applications were dismissed.

CHAIRMAN LOCKYER: Of the 400 plus that are revoked -- what's the can you tell us what caused that?

MR. WILSON: We don't have that kind of statistical breakdown, Senator.

CHAIRMAN LOCKYER: Would anyone have an impression of what the reasons would tend to be?

MR. WILSON: They are broad and varied. That's all I can tell you. We just have never, we are in the process right now. One of the reasons, we're testifying, we have interest in this bill, is that we're in the process of developing what we call a file tracking system, to tract all of the complaints and all of our filings. One of the requirements of this bill, would be to impose upon the department reporting to the Legislature the result of complaints made to the department, from these various peer review boards. And we would have to have some kind of way of tracking the source of the complaints. So we have some very, we have some interest -- we are almost in the process of completing the program, and now we may have to go back to try to rewrite this thing to add another piece of information. That, the cost of this bill is a major concern to the Department.

CHAIRMAN ISENBERG: Mr. Wilson, out of the 11,000, roughly, complaints you receive a year, how many come your way from professional associations?

MR. WILSON: I have no idea, my, I don't believe there are that many, that come to us, Assemblyman. We are concerned, in part we believe, Mr. -- said there

are approximately 1,000 cases that come to us. The closest thing that we have as a comparison basis for the actual whether or not they involve solid violations. It is our experience with the real estate recovery account, and in the recovery account we receive anywhere from 175 to 200 applications per year. And when we corrolate those filings--the filings are made on the basis of a civil judgement on fraud, misrepresentation, deceit or conversion of trust funds--we find that less than twenty-five percent of those cases have been referred to the department prior to the time that we received the judgement in the civil action. Normally, the statute of limitations is already run on those cases. But, yet they involve very substantial facts of misconduct by licensees, and we expect that a higher percentage of the kinds of complaints that come from the boards would result in some kind of action by the department, for the same reasons that there are some kinds of real problems. Although, not all of them deal with the actions or complaints which we can generate a disciplinary action from.

CHAIRMAN ISENBERG: Anything further?

MR. WIEG: Just a couple of the technical quibbles or concerns about that reporting of adverse actions. For example, there may be things that the local board would discipline for, that do not arise to the type of activity that the DRE would discipline. Ms. Speier had a bill last year , dealing with disclosures of personal interest in property that , while it was contrary to the code of ethnics, and the local board might have disciplined for a violation of that, it was not actually statutorily in place, as an issue that DRE would take up. Another example, just off the top of my head might be a refusal to participate in sub-agency agreements, which is part of the way our national association has set up the multiple listings services, yet, that's not a violation of the Business and Professions Code. It's simply a way that the trade associations have contacted by voluntarily agreeing to be members, have contracted with one another to operate. That's the sort of thing that we have concerns about in reporting of adverse actions. We make sure that we're really looking at things that endanger the public. Finally, I wanted to speak to the concern that was raised earlier, we don't want to see the statute go the direction of only using one model and attempting to force the non-medical, non-hospital oriented industry into a medical mold, and we appreciate the fact that the Assemblyman has still separated that out.

CHAIRMAN ISENBERG: Okay.

MR. WILSON: If I may, Robin Wilson again, from the Department of Real Estate, just to raise one of several concerns that we have with the bill. It all stems from public expectations of what the Department is about, our duties and responsibilities. And, we have a concern about the timing and submission of reports to the Department, because we are subject to statutes of limitations which specify the timeframe within which, we must bring an action to file discipline. We are also concerned about the adequacy of the information provided to us unitially. In these adverse action reports, I know there was a reference to the statutes in the Health Code, I think, what the hospitals or the doctors are supposed to provide when they refer cases to the respective boards. We think that something like that is very necessary here so that we have adequate information. Because we will, dealing with short timeframes within which we will have to act because of time-lags again, to complete our investigation. So, therefore we think we need to know who are the witnesses who testified against a person. We need to know, have it spelled out in some kind of detail about the type of information which should be given to the various boards. And finally, we think we ought to have, and we're in total disagreement with all the private groups, we ought to have access to the information in those proceedings where disciplinary to the peer review proceedings. We find there may be one thing about a chilling effect about a member of the public bringing a complaint, but when you have a professional who is asked to exercise his or her judgement as to whether or not a person in performance of his duties and responsibilities met certain standards, we think that that information ought to be available to us, for the the purpose of being able to carry out our own duties and responsibilies, in the public expectations.

CHAIRMAN ISENBERG: What are the statutes of limitations applicable to your...

MR. WILSON: We have a general three-year period. However, for fraud, misrepresentation, false promise, there is a one-year limitation, is within ten years. It's either three years, or if it's beyond three years, if you find out, then one year of disclosure or identifying the problem, and then up have up to ten years. So it depends on the nature of the cause of action; generally it's three years.

MR. WIEG: I believe this concern comes out of the fact that the Department has been scorched more than once, by having somebody who's clearly in violation of the law. It was, it came through the civil courts for example, action was brought, meanwhile the clock was running and by the time the claim actually

came to the Recovery Fund and -- and got to the Department, that's how the Department found out about it. It was too late for the Department to go after the license of the person for that action.

CHAIRMAN LOCKYER: So that the fiduciary type violations there's this delayed discovery up to ten years if brought a year from discovery?

MR. WIEG: Within, yes.

CHAIRMAN LOCKYER: And is it actual discovery or should have...

MR. WIEG: Yes, well it's sort of vague, but it's generally discovery. It says of the cause or of the false promise--

CHAIRMAN LOCKYER: Which would mean some official or some notification of the Department, not that you should be tracking all the civil...

MR. WIEG: -- Well, there could be a--maybe they'll come to us with a complaint and sometimes we'll only have, for instance, six or seven months to complete an investigation because they just found out that they have been defrauded in more than three years from the occurrence of the event but they only have one year in which we can act. We are very concerned about that impact upon our operation and public expectancy of what we do.

CHAIRMAN LOCKYER: Does the department want to extend that one year?

MR. WIEG: There are times when we'd like to see it a little longer, yes. But, we think, we've been trying to do a good job. We've increased the number of--complaints have gone up. But, we've also substantially increased by about 50 percent the number of complaints actually being for disciplinary action in the past five years. So we've trying to improve our record too, as we go along.

CHAIRMAN LOCKYER: Thank you. Anything else? Okay, thank you. Let's see, anyone here from the dentists. Yes?

MS. JUDY PULICE: Good morning. Judy Pulice, from the California Dental Association. Before I get into a couple of things, I'd like to comment about the bill. I would like to just tell you a little bit about how our system works.

I think we've testified on this before. But, we'd like to think that we're one of the premier peer review systems in the country, both in dentistry and without. Our program is based on our Quality Assurance Manual which has been in place now for about 7 or 8 years, and that is the basis for which both the Department of Corporations and the Board of Dental Examiners does it's disciplinary actions also. We have 32 local dental societies. And each of those has a peer review committee, made up of a minimum of 3 volunteers, and of course, more depending on the work load. The dentist agrees to abide by the peer review decision, and that is a condition of membership. They meet monthly, all year round, and for the last two-year period that I've got statistics on which ended in the middle of 1989, we do about 1500 cases, or 750 a year. Of those cases, remarkably are resolved, just about 50 percent in favor of the patient, 50 percent in favor of the dentist. The patient recovery...

CHAIRMAN LOCKYER: Are these fee disputes?

MS. PULICE: No, we do not do fee disputes. These are quality of care disputes. The average patient recovery is just over $1,000. The peer review is primarily initiated by the patient and often that is at the suggestion of a second dentist who says, "I think you need to go back and get into the peer review system." Or it can also be initiated by an insurance company. If they feel that there's been over-treatment. There is an additional unquantifiable amount of money which is returned to the patient through a mechanism whereby the treating dentist would absorb treatment by another dentist. So let's say for example, there was a failure to diagnose, the dentist would just then pay a second dentist to treat that patient and would never actually come through our peer review statistics. The patients are actually examined by a panel of three dentists, after a patient interview, so, the patient is very integrally involved in this peer review system. The decisions are forwarded by the local Dental Society to the California Dental Association, and if there is an appeal that is through the California Dental Association also. The patient, of course, then has court as a recourse but the dentist does not; he or she has agreed to abide by the decision. There is no attorney participation in any of this. The only time an attorney would get involved would be if there was a _____ hearing on membership, suspension, or expulsion. We have expelled members for failure to abide by the peer review decision. We are also bound by the 405 reporting. And, now of course by the National Data Bank too. We have a protocol set up with the Board of Dental Examiners, whereby a member can be reported to the board, and I should say too, we do non-member peer review too, if the non-member dentist is willing to pay for it. We report actions to the board, if we either

suspend the person's membership, or if it's an egregious case or if there is a pattern of practice, as evidenced by three cases in a two-year period.

CHAIRMAN LOCKYER: I guess we want to interrupt and ask how many dentists are a member of CDA and...

MS. PULICE: Well, we have about 70 percent of the active practicing dentists in the state. Our membership of active practitioners is about 12,000. As far as the bill itself goes, on this question of what is compensation, our members are only compensated in the event they would have to say, travel to Sacramento on an appeal or something like that, in which case they would get their travel expenses only; there is no compensation for being a member of the local society. And I hope, and I don't think that is included in the definition of indirect compensation, because that's really just expense reimbursement. Secondly, we strongly feel that the records need to be protected from discovery, even from the licensing board. For the reasons that have been stated here, which it would affect the candor of the committee members, as well as their willingness to serve on a peer review committee. I think as Mr. Shannon mentioned, and as I've also said too, we're subject to the 805 reporting. And then, the last thing I want to point out is on the sunsetting we would hate to see a situation where there would be a void left after 1996, as far as the immunity, and we'd like to see that removed from the bill. The only other thing is, I did get some statistics this morning to tell you that we have expelled probably in the last dozen years or so, six members for noncompliance with peer review. And one person resigned rather than comply with the decision. Since our protocol was put into effect, we have referred seven / people to the state board for action against their license (void in tape) Oh, yes it's a voluntary membership and like the realtors we also have that tripartite thing where they belong locally, statewide and nationally. So there's no requirement that you belong to the Dental Association. (Void in tape) Unless the state board took action against their license, yes.

CHAIRMAN LOCKYER: How many of those are there do you recall?

MS. PULICE: I don't know.

CHAIRMAN LOCKYER: How many complaints? Okay. Questions?

ASSEMBLYWOMAN SPEIER: For that individual who choose to resign, rather than be disciplined I guess through the association, did you inform the state board of that resignation?

MS. PULICE: Yes, that would be something that would be included in our protocol with the state board.

ASSEMBLY WOMAN SPEIER: And when you expel someone from the association you refer that information to the state board as well?

MS. PULICE: Yes.

ASSEMBLYWOMAN SPEIER: Thank you.

CHAIRMAN LOCKYER: Okay, thanks. Dr. Hillsman.

DR. DEAN HILLSMAN: Thank you Mr. Chairman. I'm Dr. Dean Hillsman. I represent the Union of American Physicians and Dentists of California. I'm the Chairman of the Peer Review Committee of that organization. I'd like to say at the onset that we're all in favor of peer review. We do have some concerns about other parts of this whole process, and that is the peer review abuse problem. We're a fairly small organization perhaps 2 or 3 thousand active members. We receive, roughly two calls a week, of members in distress over hospital priviledges generally. And we estimate that the half or more are instigated for reasons of economic abuse. Getting rid of the competition. We perceive this problem as growing, and we're interested in rights for our members. We're very concerned about the indirect compensation question. We agree that physicians should be compensated. Indirect compensation has virtually no meaning, in that hospitals can reward physicians by many ways. For example, hospital contracts, committee appointments and so on, these are very valuable. We think that the indirect compensation question should be looked at very carefully. We'd like to suggest that this concern about rural peer review, which requires outside reviews, as we've heard many times, may very well fade in the near future into outside review, even in large cities with large hospitals. The conflicts of interest even within large hospitals and large cities is so acute that we predict that it will be virtually impossible for physicians to get hearings within their own hospitals, and that in the near future it'll all be outside review of one kind or another. As to the immunity level, we would part company with the CMA, the physician getting $190,000 a year, should be held accountable and responsible for his actions. If your're paid that much money we think he should not recieve immunity, even if he is conducting peer review in the purest sense, as defined by CMA. Whether the $60,000 a year physician should be comp--should receive immunity perhaps that's arguable. We're also concerned about the voluntary basis thing. In practical reality, there is no volunteer peer review. Most physicians are reasonable sane and very few sane people would undertake in a voluntary fashion a

lengthly unpleasant process which is going to subject them possibly to legal action later on. Peer review is done as a hospital duty, that is--out of the hospital--a of by-laws to maintain your priviledges you have to do it. And the word voluntary really has no meaning, and you might wish to rework that language.

CHAIRMAN LOCKYER: ...with the peer review of your bill.

DR. HILLSMAN: On the section regarding the Evidence Code 1157, whether or nor it should be discoverable, we've assumed a watch position. That is a very, very difficult issue, with two sides to the sort and we would like to submit evidence on that later on when we've worked that through more completely. On two small areas to clean up, a suggestion, on page 13, Section 1730.7 Subsection B, on the diversion program, if those physicans names placed into a diversion program for substance abuse and so on, are put in the public domain right away it would have a very chilling effect on a very good program which has been sponsored by the way by CMA, and our medical board. Perhaps you might like to change the language so that in some way those physician names are kept confidential within this stucture, not make it public record, to encourage this very worthy program. We'd also like to suggest on page 13 also, 1730.7 Subsection D, there is a section requiring reporting of this action taken to the professional involved. We worked some years ago, to get a section in the B and P code 800, in sequence. which said that after--with that reporting to the physician, the physician was also notified that he had 30 days to respond to the medical board of California. We would not to see that chaptered out by this present legislation. And we would suggest that it be written in that he have an opportunity to respond within 30 days, when so notified. If you have any questions, I'd be glad to try to help you respond.

ASSEMBLYWOMAN SPEIER: Your reference to indirect compensation, are you referring to indirect compensation, by virtue of being compensated for peer review or indirect compensation, by virtue of referring patients? Or indirect compensation in some other...

DR. HILLSMAN: Indirect compensation is such a subtle question it's awfully hard to define, what it is. Let's just say, appointments to various committees. whether you're involved in peer review or whether you're involved in any kind of hospital activity, can be an exceedingly valuable asset to any particular physician. And the way the hospitals and medical staffs appoint physicians to various committees can be a matter of great influence.

ASSEMBLYWOMAN SPEIER: I guess I'm missing your point then. Are you saying that there should be immunity, or should not be immunity?

DR. HILLSMAN: There should be immunity, but in the question of defining what indirect compensation is, I would hope the committee would very carefully think this one out; because there are methods to compensate, and therefore to influence in many many ways in the hospital setting. Hospitals and medical practices by their nature, involve large amounts of money, and how you distribute the influence, attributes a great deal about how things are done or not done within that setting.

ASSEMBLYWOMAN SPEIER: You reference the program for diversion, and suggested that is was an outstanding program. Are you aware that there are only about 250 persons who are physicians who are in that diversion program out of the 70,000 physicians in the State of California?

DR. HILLSMAN: I'm aware, and we wish that program could be expanded. We think it's a worthy program and we believe that the many troubled physicians--and there are many troubled physicians out there--do need to have help and correction. And alcohol and drug abuse is one unfortunate significant problem We'd like to see that program expanded.

ASSEMBLYWOMAN SPEIER: Well, my evaluation of it has been that it's a program in name only. If only 250 physicians out of 70,000 are participating in it, most of whom are self referred, which means that there is no accounting of that by the medical board, and they can come and go as they please without any kind of assessment as to whether or not they have been rehabilitated -- it's a program that you consider to be excellent -- I don't consider it as a program at all.

DR. HILLSMAN: We share your concerns. We wish the program was more active and better used and was doing more good for the way in which it was intended to be used.

MR. GARY ROBINSON: Gary Robinson, I'm the executive administrator for the organization. The dealings we've had with the diversion program, in many cases have been very good. I think what often happens is that by the time a doctor gets into the situation where they're having such an "alcohol problem, for example that it becomes obvious to everyone, they're into the disciplinary aspect, and they don't get the opportunity. So, if there was some way of identifying that earlier and getting people into the program earlier, I think it would be good, rather than

immediately getting into the disciplinary aspect. That's unfortunately true with almost any job. By the time it becomes obvious a person has a problem, they're already they've already caused enough problems that they're into a disciplinary aspect as opposed to a helpful aspect.

ASSEMBLYWOMAN SPEIER: Well, my only point is that if we're doing all of this peer review, providing all these protections, and we know that anywhere between 10 to 15 percent of the general population, and physicians I don't think are immune, if anything there are people that argue that they are more susceptible to abusing these various drugs. That if 10 - 15 percent are abusers and need some kind of help well, and you're looking at 70,000 physicians, we're nowhere near the 7,000 fugure for instance, and my question I guess is, in the peer review setting, how do we reach those physicians and get them into a diversion program, still providing the protections to them, the anonymity to them, but get them in the -- what we've got going isn't working.

MR. ROBINSON: Yeah, well I think.

DR. HILLSMAN: I don't know how to answer that question, we agreed the program should be magnified, what I am trying to express is that if those physicians names were put in the public record immediately, that is without immediate protection, I think it would predictably -- and make that program even more subject to difficulties.

ASSEMBLYWOMAN SPEIER: Thank you.

CHAIRMAN LOCKYER: I'm sorry. Did you want to add anything?

DR. HILLSMAN: One tiny comment. I'm not an attorney, but I'd like to comment briefly on the discovery aspect of the agrieved physicians who try to go to court and the problem of getting at the hospital records. What happens is that the physician goes to court, and under Civil Code 1094.5 there is not permitted independent review of the records. The courts must have a substantial evidence type test, and because the courts do not have the actual records, what they do in practice is they defer to the peer review committees. And they assume that the peer review committees have done good evidence gathering, fair judging etc. We would note that the CMA defined these peer review sessions as free flowing; we would like to suggest free flowing as spelled S-L-O-P-P-Y. And some very bad things happen in those hearings and they're not being exposed to the light of day.

CHAIRMAN LOCKYER: Any other comments? Gary you'd finish?

MR. ROBINSON: Yeah, yeah I have.

CHAIRMAN LOCKYER: Okay, thank you gentleman. I have on our agenda, members of ASTA, I think we're going to wrap in up shortly, but I have perhaps some comment from someone from the Center for Public Interest Law or from UC. Are either here? I didn't see anyone, but we'll suggest that they provide us with any written comments. Is there anyone else present that had wanted to correct, add or supplement any comments? If not, we would hope that you'll do that in some future time, if you deem it appropriate. And I'll just thank the members for participating, and those who've supplied us with information in numerous cases, who I think we'd like to get greater specificity for the record, if you'll help us with that. We were going to conclude with a peer review of Assemblyman Isenberg's bill, if not Assemblyman Isenberg.

CHAIRMAN ISENBERG: But Bill, but you asked for full immunity and we didn't have the chance to get that before.

CHAIRMAN LOCKYER: Well actually we have that in -- . We have a absolute immunity while the hearings going. But anyhow, thank you all very much.