Down from the

The practice of medicine, traditionally among the most revered — and protected — of professions, is being opened up to public view as never before. Will disclosure lead to more aggressive discipline against bad doctors?

By Sigrid Bathen

Protection of the public shall be the highest priority... Where rehabilitation and protection are inconsistent, protection shall be paramount.
— California Medical Practice Act
Section 2229 (a) and (c)

First, do no harm.
— Hippocratic Oath

In the spring of 1992, nurses at Alameda Hospital observed "Dr. A.," an anesthesiologist, "behaving while on duty as if he were under the influence of narcotic drugs." The first incident, according to an October 1996 ruling against the hospital by the California Supreme Court, occurred in March of 1992, when Dr. A. was on call at the time a patient required emergency surgery. One nurse observed that the doctor's speech was slurred as he interviewed the patient. "In discussing the case with him before surgery," the court said, "[the nurse] saw that his attention and comprehension were impaired."

Dr. A. "subsequently administered a general anesthetic to this patient," and after the surgery, the nurse reported his "abnormal behavior" to her supervisor. The court's account does not include the condition of the patient or the outcome of his or her surgical experience. Hospital officials insist no harm came to any

pedestal

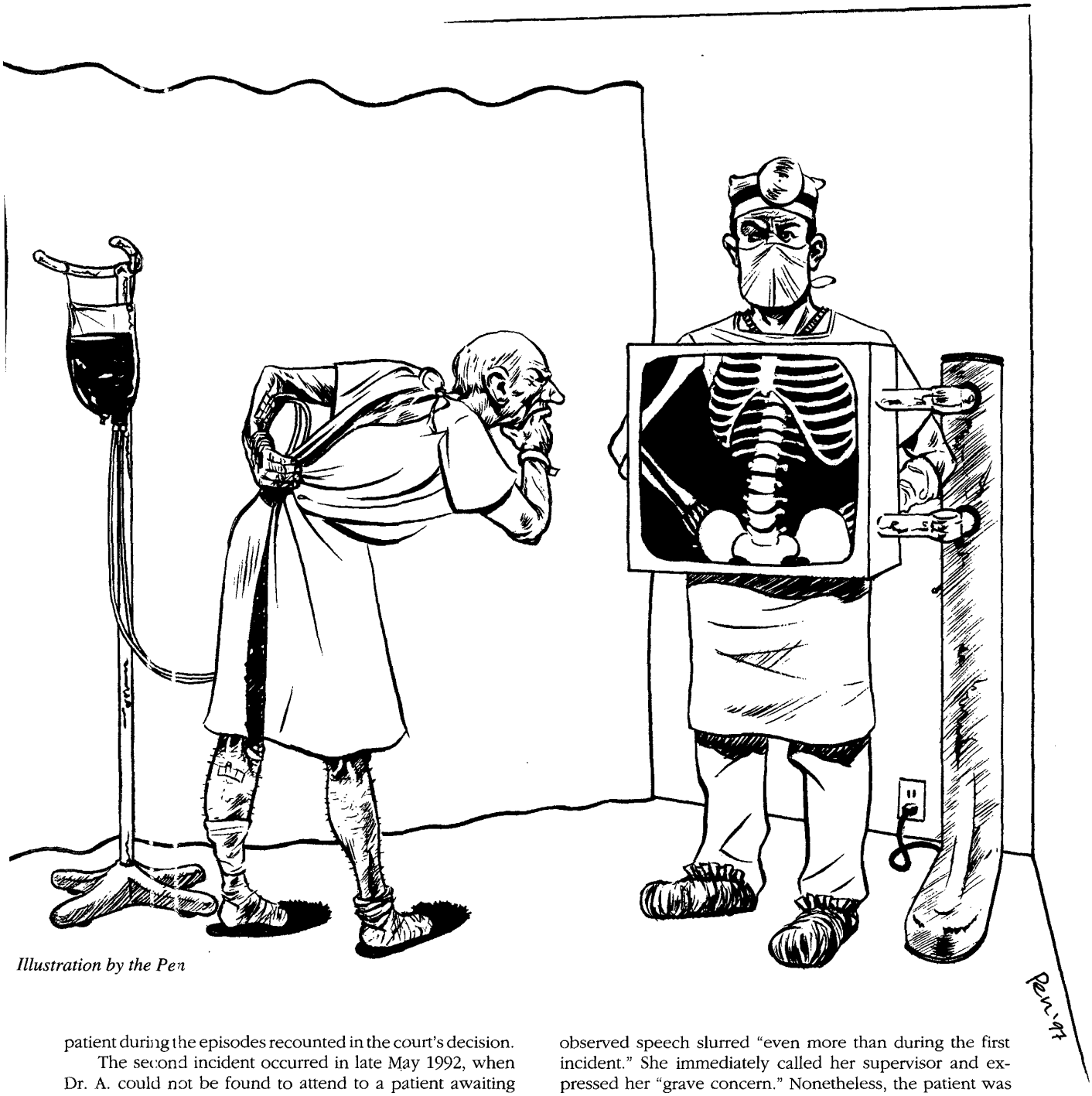


Illustration by the Pen

patient during the episodes recounted in the court's decision.

The second incident occurred in late May 1992, when Dr. A. could not be found to attend to a patient awaiting scheduled surgery. He finally appeared after being paged several times. The same nurse was again on duty, and again observed speech slurred "even more than during the first incident." She immediately called her supervisor and expressed her "grave concern." Nonetheless, the patient was taken into the operating room, where Dr. A. administered intravenous sedation.

I can get more information on my car mechanic than I can about my doctor.

— Assemblywoman Liz Figueroa

Around the same time, another nurse found Dr. A. asleep in a restroom — which had been locked for an inordinate period of time. When a patient needed to use it, the nurse unlocked the door "and found Dr. A. asleep in the room with his surgical pants down around his knees." When he awoke, the nurse said, he appeared disoriented and unsteady. Suspecting the physician was taking drugs, she searched the bathroom for paraphernalia, but found none. Dr. A. went off to the operating room to attend to yet another unsuspecting patient. Later, when the patient was in recovery, a third nurse reported that his behavior was "strange," and that at one point he had to lay his head down on a desk.

The court's account chronicles a bizarre legal journey through that most troubling of medical horror stories — that of a physician whose judgment is clearly impaired, yet continues to practice despite reported incidents of dangerous behavior. In the Alameda case, which is under investigation by the California Medical Board, the court said hospital medical staff undertook an investigation "at some point" during the spring 1992 period of the nurses' complaints. A medical board spokeswoman would not comment on the disposition or status of the board's investigation.

According to the Supreme Court decision — which upheld two lower court rulings ordering the hospital to turn over its investigatory materials to medical board investigators — Dr. A. admitted to injecting himself with Fentanyl, a synthetic narcotic that medical board investigators say is 80 times more powerful than morphine. Used in combination with other drugs in administering anesthesia, it was obtained by Dr. A. from the hospital's drug supplies, presumably in violation of the hospital's inventory protocols.

Confronted by his peers, Dr. A. requested a leave of absence in October and November 1992 to enter an inpatient drug rehabilitation program in Berkeley. In January 1993, he resumed his staff privileges under heavy restrictions, including random supervised urine tests. He is believed to be completely rehabilitated, and hospital officials insist the confidentiality of the internal review process is essential to rehabilitating an otherwise competent physician who voluntarily admitted he had a problem and submitted to treatment. The courts disagreed.

At issue in the case of "Dr. A." — whose name is confidential while he is under investigation by the state — is the age-old system of physician "peer review," and the responsibility of hospitals to keep state medical examiners informed about doctors with problems like Dr. A.'s. Called "805" forms after the Business and Professions Code section which requires them, hospitals must file documentation with the state when a physician engages in conduct "reasonably likely" to be detrimental to patient care or safety. As the Supreme Court notes in its October opinion, Alameda did not make such a report.

The hospital's failure to file a report on serious disciplinary action against a physician is hardly unusual. A 1995 study by the Office of Inspector General in the U.S. Department of Health and Human Services found that 75 percent of all U.S. hospitals "never reported an adverse action" to the National Practitioner Data Bank, which keeps records on disciplinary actions against physicians. In a study of reports made between September 1990 and December 1993, the inspector general found wide variation in states' compliance with the federal Health Care Quality Improvement Act of 1986, which established the national data bank. In California, where the "non-reporting" rate was 63.7 percent, hospitals fared somewhat better than in, say, South Dakota, which had a 93 percent "non-reporting" rate. Nonetheless, of 557 hospitals in California, 355 had filed no reports in the three-year period covered by the study.

"The wide variation in reporting rates from state to state is in itself troubling," concluded the inspector general. "It could suggest differences in the quality of care rendered or perhaps in the capacity or willingness of hospitals to submit reports."

Dorel Harms, vice president of the California Health Care Association, which represents hospitals, said disclosure of information about physicians "is really on the front burner" as a legislative and policy issue. "There is a very involved, formal process that a physician goes through if there is a problem or a suspected problem," she said. "And it takes time." Recent legislation has streamlined and toughened the process, but health care experts say it remains to a great extent a balancing act between a patient's right to know and a physician's reputation.

In California, legislative efforts to include "805" reports in recent laws giving the medical board tough new investigatory tools have failed. A 1993 measure, SB 916 by then-Senator Robert Presley (D-Riverside), included "805s" in material to be submitted by hospitals to the medical board, but after repeated amendments, the requirement was excised — largely because of opposition from the powerful California Medical Association but also to ensure that other elements of the landmark disclosure legislation would survive reasonably intact.

"I remember going to a committee hearing on the bill," said a medical board staffer who asked not to be identified. "I was very impressed with the surgical precision with which the committee excised that portion of the bill."

The sanctity of the physician peer review process is not the only medical sacred cow under examination in a public arena increasingly less sympathetic to incompetent physicians. A bill by Assemblywoman Liz Figueroa (D-Fremont) would place physician disciplinary actions, malpractice judgments and settlements and other information on the Internet. Similar measures are under consideration in other states, following passage last year of a landmark disclosure law in Massachusetts, which became the first state in the nation to require such full public disclosure. "The Internet is an invaluable tool," says Figueroa of her bill. "We don't see why physicians should be excluded, when attorneys and other professionals are not. When it is a life-and-death

situation, people should have as much access. I can get more information on my car mechanic than I can about my doctor."

Health care experts say it is just that "life-and-death" quality to the role of physicians — and their increasingly limited autonomy under managed care — which makes doctor disclosure less cut-and-dried than disclosing information about lawyers or car mechanics. "Attorneys don't deal with people's lives," said one prominent health care lobbyist who asked not to be identified. "There is a huge difference. If Mr. Smith is the best corporate attorney and he has been through a drug diversion program, I don't think I'd care. But with a physician, it's your body, your family."

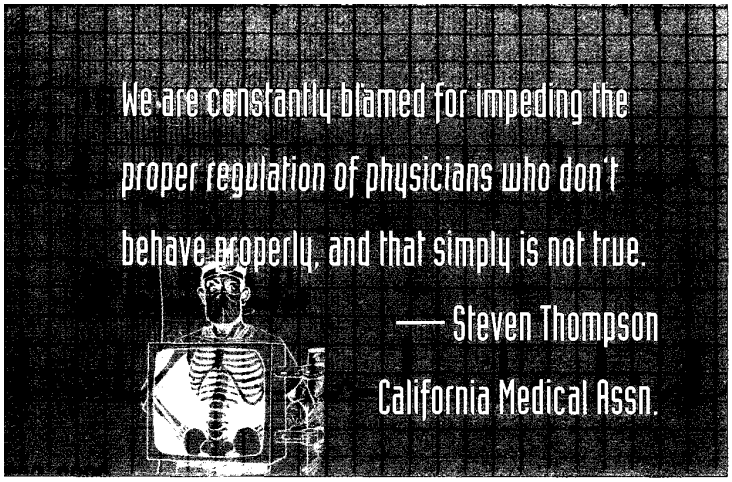
With the exception of rare, particularly egregious cases, critics of the current system say physicians of questionable competence have often gone untouched by effective or timely state sanctions — protected by their own, who preferred to weed out their rare bad apples quietly and behind closed doors. Within the last decade in California, however, that protected status has rapidly eroded. Some physicians are concerned that the enforcement pendulum is swinging too far the other way — driving incompetent doctors, as well as colleagues who might complain about them, deeper into a dangerous silence. Battered on several fronts — from beefed-up state and federal civil and criminal enforcement agencies, to the increasing power of health maintenance organizations (HMOs) — many doctors are taking the smart road politically, questioning the power of the publicly unpopular HMOs and cooperating with policymakers in order to have some control over what, and how much, is revealed about them to prospective patients.

Despite the periodic horror stories, doctors groups say that, largely as a result of recent legislation, California already has among the strongest disclosure and disciplinary policies in the country, including a special legal unit within the state Attorney General's Office solely to investigate and file disciplinary actions against doctors. CMA lobbyist Scott

Doctor Discipline in California 1995-96

Number & type MD action taken by disciplinary case type	Revocation	Surrender	Suspension Only	Probation With Suspension	Probation	Probationary License Issued	Public Reprimand	Other Action	Total Actions by Case Type
Negligence	10	15	0	7	41	0	20	2	95
Inappropriate Prescribing	4	6	0	0	16	0	15	0	41
Unlicensed Activity	0	0	0	0	3	0	0	0	3
Sexual Misconduct	10	9	0	3	10	0	2	1	35
Mental Illness	6	2	0	2	5	0	1	0	16
Self-use of drugs/alcohol	6	6	0	2	18	1	4	0	37
Fraud	4	4	0	3	7	0	10	1	29
Conviction of a crime	3	3	0	5	7	0	0	0	18
• Unprofessional conduct	19	6	1	7	21	0	15	0	69
Misc. Violations	0	1	0	0	1	0	0	0	2
Total Actions by Discipline Type	62	52	1	29	129	1	67	4	345

• Many of the case types classified as "Unprofessional Conduct" are reciprocal action based upon discipline by another state.
Source: Medical Board of California, 1995-96 Annual Report.



Syphax, a former Presley consultant who helped write several bills toughening California physician discipline laws, says consumers and regulators tend to "focus on the hospital" in pressing for disclosure. Syphax said the CMA has "a philosophical objection" to the release of internal hospital peer review reports — the so-called "805s."

"The peer review process ... is something that happens in a private setting," says Syphax. "An individual hospital does not have responsibility for the entire state of California. Their interest is their particular hospital. The physicians act in the hospital as a lay judiciary and take action on things that they believe need to be addressed. When they take that action, that is sent to the medical board." If no formal disciplinary action is taken against the doctor, Syphax says, "CMA believes that the incident has not risen to the level of relevance that calls for public dissemination of that '805'."

Physician groups argue that disciplining an individual physician — or holding him or her up to excessive standards of public disclosure — misses the point in the era of managed care, when medical decisions are often dictated by the bottom-line requirements of HMO managers. "Because the individual physician's authority has been eroded by managed care, controlling the physician is no longer controlling the quality of medical care or services rendered," Syphax said. "The physician-patient relationship is the most sacred aspect of practice to physicians themselves, but every day is a battle to try and maintain that human element."

Insisting that doctors want their incompetent brethren disciplined or put out of business, Syphax acknowledges the horror stories and says the CMA "wants them off the street as badly as the medical board does." The doctors and the medical board that regulates them differ somewhat on how to accomplish that ostensibly shared goal.

"One of the problems that physicians face is that they enjoy a great deal of prestige because they are healers," says Syphax. "But there is a double edge on that sword because they are also expected to be infallible. The place where the CMA and the medical board get into debate is when an individual makes an honest mistake that was not malicious and was out of character on an otherwise sterling record. What is the appropriate level of remediation? How do you make that decision? How do you draw that line?"

The Massachusetts experience is instructive. When the *Boston Globe* in 1994 published a meticulously researched, scathing series of articles — "Malpractice in Massachusetts" — about dangerously incompetent physicians and how poorly they were regulated by the state and the profession, the Massachusetts Legislature was forced to take action. Teachers had been among some of the patients allegedly victimized by physicians in the *Globe* series, and the first bill was pushed by the Massachusetts Teachers Association in a fascinating test of political clout — as in California, two of the most politically powerful groups are teachers and doctors. It was passed by the Legislature over the objections of the Massachusetts Medical Society, but vetoed by Governor William Weld. Seeing the handwriting on the wall, the doctors mobilized to help design the second bill, which was passed and signed by the governor. While still strongly patient-oriented, it contained elements — including detailed explanations of why malpractice judgments or settlements do not necessarily denote a bad doctor — that most physicians could live with.

While other states are also considering Massachusetts-type disclosure bills, none face quite the enormity and complexity of the task in California, where particularly contentious health care politics have in recent years characterized a system with huge numbers of uninsured or underinsured patients, many of them immigrants. Massachusetts, for example, licenses about 30,000 physicians, 18,000 actually practicing. The California Medical Board licenses some 103,000 physicians — about 77,000 of whom are actually practicing — amid a plethora of competing financial and medical interests. A veritable blizzard of health care bills, including Figueroa's AB 103, have been introduced this session, and the stakes — for doctors, insurers and patients — are enormous.

The battle lines are already forming around AB 103. Currently, the California bill contains no ameliorating malpractice-disclosure provisions as are contained in the Massachusetts law, and eliminates the $30,000 threshhold for reporting judgments and settlements in current state law. The CMA is taking a position which CMA chief lobbyist Steve Thompson describes as "gentle opposition." In an uncharacteristic display of political civility — the calm before the storm, perhaps — Figueroa and the doctors' group say they hope to work out their differences and come up with a bill that serves consumers without unfairly damaging the reputations of physicians.

Some specialists — particularly OB/GYNs — are especially vulnerable to malpractice suits. Many say they are forced to settle cases by insurers who don't want to go through the expense of a trial, and often, according to Thompson, the settlements "have nothing to do with the quality of care."

"We are constantly blamed for impeding the proper regulation of physicians who don't behave properly, and that simply is not true," he added. "We are concerned that you don't brand someone professionally."

Dr. Joseph Heyman, a Massachusetts OB/GYN who heads that state's medical society, says the new law appears to be working well. "It allays the anxiety of patients that somehow there is something being covered up," he said. "And it is very fair to physicians. It is easy to access and puts everything in perspective. It doesn't compare me to a pediatrician — it compares me to other physicians in my specialty. It doesn't include complaints, and it doesn't include actions that haven't gone through the entire process."

Currently, those who request physician profiles are sent a faxed profile, although Internet access is planned next month. Some physicians had expressed concern that confidential information, including home addresses and other information that might place their families in danger, would be inadvertently made available, but the state says it has put a computer security system in place to prevent that. Physicians were also concerned about reporters and malpractice lawyers being able to access the computer system for profiles of particular groups of doctors, but the Massachusetts law permits only individual inquiries, and no more than 10 at a time. Accessing the Web site can be accomplished in various ways, Heyman said, by name or specialty, for example, "but not by malpractice settlement."

The clout of the medical board in California has been substantially increased by recent legislation, raising it from its pre-1989 level as an ineffective and understaffed bureaucratic embarrassment. As in Massachusetts, media exposes, including a devastating *60 Minutes* segment in 1992 on the failings of California's medical disciplinary system, helped focus public attention — and public funds — on doctor discipline.

"In 1989, the board was a backwater, where complaints went to rest without ever being heard from again," says one prominent health care expert who asked not to be identified. "It was not oriented toward any consumer board's interests, which are the interests of consumers. It was oriented to processing paper." After several years of working on legislation to toughen lawyer discipline, Presley started looking at doctor discipline. As a result of his legislation, complaints are investigated with considerably more attention and speed.

"There is a much more open atmosphere today," says the board's executive director, Ron Joseph. "Prior to the Massachusetts law, California had one of the most far-reaching disclosure policies in the nation. Massachusetts has moved that light years ahead."

The full board, which includes 12 physicians and seven public members, will hold an unusual special meeting in San Diego April 16th to review disclosure issues, including a discussion of Figueroa's measure. Given public sentiment for greater disclosure by health care professionals — and the business interests behind them — some form of Massachusetts-style disclosure is likely in California.

For Assistant U.S. Attorney Jonathan Shapiro in Los Angeles, who successfully prosecuted an infamous Orange County gynecologist, Dr. Ivan C. Namihas, it's none too soon. Pursued by a beefed-up health fraud investigations unit in the U.S Attorney's Office, Namihas was convicted of misleading patients into believing they had AIDS and cancer, then billing them for unnecessary "treatments." Namihas, 62, was the subject of tenacious investigative work by the U.S. Postal Inspector and the Justice Department — as well as intensive media coverage, including a 1992 series in the *Orange County Register* — resulting in federal charges that he defrauded nine patients. He was sentenced last October in Los Angeles federal court to serve two years in prison and pay $63,000 in fines and restitution.

Even more intriguing about the Namihas case than the fact of his conviction is what was not charged. "Dr. Namihas is the poster child for why we need a law like they have in Massachusetts," said Shapiro. Before he was convicted in federal court, Shapiro said, Namihas was the object of some 160 complaints to the state medical board, starting in 1969, by female patients who said they had been raped and/or inappropriately fondled. "At that time, complaints were purged every five years," said Shapiro. "The totality of the complaints was never investigated." Shapiro also credits publicity about the Namihas case with helping force changes in California enforcement methods.

Shapiro is particularly critical of the so-called peer review system in California hospitals. "Investigators are often stymied by doctors' reluctance to participate in an investigation against a colleague," he said. "The medical profession seriously and understandably defends their right to conduct peer review of their own. And under California law, peer review of hospitals and HMOs allow them to do their work in privileged secrecy.

"Ultimately, they can't keep this stuff secret, but they can force you to jump through any number of hoops. I understand that they are trying to encourage an exchange of views about medical practices and skills. The problem is that very good goal protects bad doctors."