COMMENTARY

Public Disclosure of Physician Information: Who Knows What's Best for Whom?

By Robert C. Fellmeth and Julianne B. D'Angelo

The "public disclosure policy" of the Medical Board of California (MBC) has always borne a misnomer. It has traditionally been MBC's policy to disclose *nothing* about its licensees to inquiring consumers except its own disciplinary actions, which have been few and far between in comparison to the number of complaints and reports about physician misconduct which merit attention. This policy has resulted in the dissemination of misleading information to patients—the very constituency whose protection is the Board's *raison d'etre*. For example, we know of a physician in San Diego who has been sued for medical malpractice six times in the past ten years, suffered a $50,000 malpractice settlement in 1983 and another in excess of $1 million in 1989, and has had his privileges revoked by three hospitals in the San Diego area in the past ten years. Last spring, we called the Medical Board to check on his record. We were given his California license number and told he has "no disciplinary actions against him—his record is clean."

This example illustrates two problems with the Medical Board's discipline system: the facts that (1) he has no disciplinary record, and (2) the Medical Board—a public agency—won't tell consumers any of this very relevant information (most of which is *public information*) about serious misconduct directly related to patient care and this person's competence to practice medicine.

For five years, we have focused significant time and energy on pressuring the Board and the legislature to enhance and strengthen MBC's disciplinary performance. Until that performance substantially improves, however, public disclosure of information about physicians by the Medical Board remains a critical component of the public protection function with which MBC is charged.

THE MEDICAL BOARD'S "PUBLIC DISCLOSURE POLICY"

Let's review the Medical Board's traditional public disclosure policy:

• ***MBC Investigations***. With regard to complaints made to the Medical Board, the Board has not disclosed any information to an inquiring member of the public until they have been fully investigated and formal charges are filed by the Attorney General's Office. Let's assume that the Medical Board is completing most investigations within an average of six months, as is contemplated under Business and Professions Code section 2319. We know that it then takes the AG's Office over one year to prepare an accusation in any given case, because it is understaffed and severely backlogged. That's a minimum of eighteen months, during which the physician is usually free to practice. And during twelve of those eighteen months, a completed investigation which apparently warrants disciplinary action is sitting at the AG's Office awaiting processing. Yet, during those eighteen months, a consumer who has the initiative to telephone the Medical Board to inquire about her physician will be told nothing. That is affirmatively misleading and leaves the consumer with a false sense of confidence in the physician.

• ***Other Misconduct***. With regard to other known physician misconduct or negligence, the Board's traditional policy has been to conceal the following information: criminal charges and convictions, medical malpractice settlements and judgments, and discipline by other state medical boards—*all of which is public information.* This means that a physician could have three malpractice judgments each in excess of $1 million, three malpractice settlements each in excess of $1 million, three felony convictions directly related to patient care, three misdemeanor driving-under-the-influence convictions, and discipline by three other states, but the Medical Board—the public agency charged with protecting patients from incompetent, impaired, and dishonest physicians and which *knows* all of this—will never disclose *any* of this information.

• ***Adverse Peer Review Actions***. Finally, with regard to one of the most relevant pieces of information a consumer could receive—the fact that a physician's hospital privileges have been revoked, suspended, or denied by a committee of his or her peers at a hospital or other health facility, section 805 of the Business and Professions Code *prohibits* the Board from disclosing this information to an inquiring consumer.

THE BOARD MOVES IN THE RIGHT DIRECTION

Last spring, at a wide-ranging "Medical Summit" called by the Medical Board and the Department of Consumer Affairs, we urged the Board to change its public disclosure policy in all three of these areas. Staggering to recover at least some of its integrity after the January 1993 release of a harshly critical audit of its enforcement program, the Board finally agreed with some of these public disclosure suggestions at its May 1993 meeting.

• ***MBC Investigations***. With regard to MBC disciplinary proceedings, we called on MBC to disclose completed investigations to an inquiring consumer at the time the Board turns the case over to the AG's Office. By moving disclosure up to the point at which the completed investigation is *referred* to the AG's Office for accusation drafting, the Board would enable inquiring consumers to learn about very serious and fully investigated misconduct about one year earlier than they presently can. According to the AG's Office, an accusation is filed in 95–99% of the cases referred by the Medical Board, and formal discipline results in a vast majority of those. Thus, there is little or no reason to fear that the information being disclosed will turn out to be erroneous; however, a disclaimer that "no official findings have been made" could accompany the disclosure.

MBC agreed to this change, reasoning that it could feel comfortable about releasing the results of an investigation that its own investigators have completed, that such a matter is no longer "under investigation" and that, at the very least, there is probable cause to believe that the accused physician has committed a disciplinable offense. The Board agreed that consumers should be informed that it has done its job.

• ***Other Misconduct***. We also urged the Board to disclose to inquiring consumers other pieces of public information that the Board collects about physician misconduct and negligence. Currently, the Board routinely receives in-

formation on felony charges against physicians, criminal convictions against physicians, medical malpractice judgments and settlements in excess of $30,000, and reports of professional discipline by other states. **All of this information is *public information*.** Consumers could get most of it at a county courthouse, but they shouldn't have to. Patients rightly believe that the Medical Board is the primary repository of information about physicians licensed in California, and that its job is to protect consumers from physicians who don't measure up to standards.

After much debate, the Board voted to change this policy in three respects. MBC decided to disclose information about discipline in other states, felony convictions, and medical malpractice judgments in excess of $30,000. However, it reserved the right to identify and conceal certain categories of these disciplinary actions, felony convictions, and malpractice judgments which might be "unrelated" to competence in the practice of medicine. The Board also agreed to accompany the disclosure of this information with disclaimer statements noting, for example, that these decisions were not made by the Board and that they may not necessarily be dispositive on the issue of incompetence.

• ***Adverse Peer Review Actions.*** We also argued that the Board should sponsor legislation authorizing it to disclose certain "section 805 reports" of adverse peer review actions against physicians. Every year, approximately 200 California physicians suffer an adverse peer review action—that is, their hospital admitting privileges are revoked or restricted by a private panel of their physician peers because of incompetence or serious misconduct. These actions are not taken often or lightly, and—under federal law and judicial decision—must be accompanied by full procedural due process for the accused physician. This means the physician is legally entitled to written notice of the charges, an opportunity to be represented by legal counsel, an ability to confront and cross-examine witnesses at a hearing, the right to put on a defense, a written decision, and review by a court.

As you might imagine, doctors do not routinely kick colleague doctors out of hospitals. Among other things, their fear of civil liability for antitrust violations inhibits peer review action in all but the most egregious cases. The Medical Board recently compiled a summary of 65 adverse peer review actions taken during a six-month period. The reasons cited include the following: "failed to diagnose and treat, resulting in patient's demise," "multiple unnecessary procedures performed," "subject's continued exercise of privileges would present an imminent danger to the health and welfare of hospital patients," "subject diverted drugs," "examined and treated patients while under the influence of alcohol."

So, through the peer review process, individual hospitals and the physicians who run them can protect themselves from financial liability due to the incompetence of other physicians. Do we patients have access to this information, so we can protect our bodies and our lives from the same group? Absolutely not. The information is strictly confidential. While section 805 of the Business and Professions Code requires health facilities to report adverse peer review actions to the Medical Board (thus the name "section 805 reports"), it also prohibits the Medical Board from revealing that information to an inquiring consumer.

Thus, we argued that consumers should be told of adverse peer review actions where the cause of the private discipline is medical in nature and is directly relevant to patient care. On a 9–4 vote, the Board agreed to seek statutory authority to disclose "certain final actions by health care facilities or other bodies falling under the provisions of section 805 of the Business and Professions Code involving involuntary limitation or termination of clinical privileges, when those actions are based on issues of medical competence which in the judgment of the Board may compromise the delivery of patient care or patient safety." Again, MBC agreed that this information should be accompanied with a disclaimer noting that the decision was not made by the Board.

THREE STEPS FORWARD, TWO STEPS BACK

Because the Board's prior public disclosure policy was so stegosaurean,[1] these decisions were deemed "historic" and "unprecedented" by the press. Indeed, we supported the Board's moves as in the right direction. But we see these changes as minor, long-overdue corrections to an offensive policy, and merely the first steps in the long journey toward fulfillment of the Board's statutory charge. And more decisive and courageous Board action is now required, because the California Medical Association (CMA)—which opposed almost all of MBC's public disclosure decisions—has taken direct aim at the Board's new policy and has already succeeded in derailing an important part of it.

CMA Thwarts the Board on Peer Review Disclosure. After the Medical Board decided to support the disclosure of section 805 reports, Senator Robert Presley amended his then-pending SB 916, a wide-ranging physician discipline system reform bill, to include a provision requiring MBC to reveal to an inquiring consumer the fact that a physician's privileges have been revoked or restricted by a health facility. This provision was supported by the Wilson administration, many consumer groups which have fought long and hard to pierce the veil of secrecy in the medical profession, and the Medical Board.

Who would oppose such a provision? Only CMA, a wealthy trade group representing less than one-half the physicians in California. CMA opposed it with a vengeance, and CMA talks the monied language of Sacramento—politicians do not need translators. At CMA's behest, nine members of the Senate Business and Professions Committee (Senators Dan Boatwright, Ruben Ayala, Bill Craven, Leroy Greene, Gary Hart, David Kelley, Lucy Killea, Milton Marks, and Herschel Rosenthal) unanimously stripped SB 916 of this important provision on June 14, preferring to protect 200 incompetent physicians per year at the expense of 30 million California patients.

What happens when a physician's hospital privileges are revoked? Not a thing. It is absolutely secret, so patients can't learn of it. Does the Medical Board revoke that physician's license to protect us from that doctor? Usually not. In 1991–92, health facilities revoked or restricted the privileges of 178 physicians in California for poor patient care or substance abuse; during that same year, the Medical Board took action against only 51 licenses for the same reasons. Nothing prevents a physician whose privileges are revoked at one hospital from obtaining similar privileges at another hospital in the same locality or a new residence.

CMA argues that the Board should follow up on peer review actions and discipline licenses where appropriate to protect consumers. We couldn't agree more. But at the same time, CMA has opposed needed license fee increases and adequate authority for the Board to do so. In 1992, it successfully opposed a proposal to increase MBC license renewal fees by $25 per year (to $275 annually; attorneys pay $500 per year). In 1993, CMA grudgingly agreed to a $50 annual increase (to $300 annually) included in SB 916. But CMA also loaded the bill with contingencies which would cancel that fee increase, one of which

has now occurred, wiping out the additional revenue so desperately needed by MBC's enforcement program. At the same time, the medical profession's local/state/national trade association conglomerate charges well over $1,200 a year in professional dues for lobbying and campaign contributions. While CMA argues that (1) peer review should remain secret, (2) the Board should act where a physician is truly incompetent, and (3) the *Board's* action (not the peer review result) should be disclosed to the public, the Board suffers due to CMA's refusal to agree to increased resources. Simultaneously, MBC benefits due to the secrecy demanded by CMA—the Board can ignore hospital reports with impunity since nobody knows about them.

CMA's orientation, of course, is with physicians who in good faith wish to protect the profession's standards by policing their own. CMA argues that hospital peer review activity should be protected and encouraged. If peer review actions are disclosed, peer review committees would be inhibited from imposing minor, "wake-up call"-type sanctions for fear that publicity of any negative judgment at all about a physician would shatter a career. The CMA conclusion: Let peer review proceed unfettered, stimulate it, and require the Board to follow up where warranted.

In fact, consumer advocates are not averse to minor peer review sanctions remaining private (*e.g.*, advice to a colleague to review an area of deficiency). But we are not talking about this type of action. We are talking about decisions to limit or revoke the right of a physician to *practice* in a facility *specifically because of his or her incompetence. Those* decisions should be available to the public.

The removal of a physician's hospital privileges is a serious matter. In many communities, it forces the physician to relocate because small towns may have only one hospital—usually a necessity in the full practice of medicine. It may lead a physician to send a patient to an unfamiliar facility where he or she still has privileges—with the patient not knowing why, and perhaps at some peril. The point missed by CMA is as follows: Either the peer review process is a reliable method of judging and assuring competence for public protection, or it is not. If it provides adequate due process and involves sufficient objectivity to properly result in the deprivation of a practitioner's access to a (perhaps *the*) major medical facility needed to practice medicine, why is it suddenly suspect when it comes to public disclosure? How can practitioners say the process is fair when it enables a hospital to remove a bad doctor and the concomitant liability exposure for the benefit of the institution, but that same decision is too ephemeral and unreliable a judgment for anyone else to know about?

We concede that a strong argument can be made that peer review is not a minimally acceptable substitute for the state's decision about whether one should practice a trade or profession. To be sure, we believe that the majority of peer review decisions to revoke privileges are both valid and made in good faith. But that is not the point. The judges in peer review are often colleagues or competitors of the one being judged. Economics is frequently involved. Further, the privileges of many physicians are *not* acted upon because of personal relations, income generation, etc. The persons adjudicating peer review have little knowledge of applicable law, virtually none of the rules of evidence, and uncertain familiarity with decisions made in similar cases by other institutions. Although many may be qualified to evaluate the competence of a colleague, they are not qualified to make the final judgment about whether that person should practice on behalf of the people of the state. That judgment requires the skills listed above, and some feeling for other decisions being made, so there is a consistency which is an aspirational hallmark of any system of justice.

Reduced to its essentials, peer review is either reliable as an indicator of incompetence or it is not. If it is, its final judgment should be made public. If it is not, it should not be taking place. In its stead, those playing "king for a day" and denying access to the "sovereign's forests" should play a useful role as providers of evidence and expert testimony to an agency of the state. Such an agency can theoretically provide the independence needed to give a decision credibility and consistency with other similar decisions. And, perhaps as important, it can create an effective bar to practice for those who would endanger the public.

Criminal Charges and Convictions. As noted above, MBC has agreed to reveal felony convictions against physicians. Not misdemeanor convictions. And neither felony nor misdemeanor charges, both of which are public information. Further, the Board believes it should continue to suppress information about felony convictions which are "unrelated" to physician performance. What? Can you think of a *felony conviction* you would not want to know about before entrusting your health, life, and money to a physician? We can't. And what about serious offenses which are (or could be) charged as felonies but are plea-bargained down to misdemeanor convictions? Driving under the influence of alcohol or narcotics? Assault and battery? Medicare or Medi-Cal fraud? Wouldn't you want to know? Wouldn't you want to know that the physician who will operate on your daughter next week in Sacramento plead guilty to a misdemeanor DUI charge last week in Los Angeles? What if it were his third such conviction? Under the Board's new policy, you and your daughter won't get that ***public*** information.

Malpractice Judgments and Settlements. Under its new policy, MBC intends to reveal medical malpractice judgments in excess of $30,000. Not judgments below $30,000, even though they have been rendered after a full civil trial complete with all its due process-protective trappings, and even though the Medical Board has access to them through the National Practitioner Data Bank. And not malpractice settlements, no matter what the amount and no matter how many there are.

Give us a break. This is all ***public information***—even in cases where court files (including settlement amount) have been sealed, the fact of a malpractice settlement or judgment is public information, and its secretion by the Board charged with public protection is offensive to our judicial system. Consistent with their fear and loathing of trial lawyers, judges, and juries, the Board and CMA argue that most malpractice cases are frivolous and that all malpractice settlements are simply "business decisions by insurance companies" which are irrelevant to a physician's competence. They also note that, in medical malpractice cases, one act of simple negligence may qualify as a cause of action while that same act of simple negligence is insufficient to justify discipline against the license of a physician; gross negligence or an established pattern of negligence must be proven in a physician discipline case. Finally, they argue that the burdens of proof vary between malpractice cases and physician discipline proceedings: In the former, the plaintiff's attorney need only prove negligence by a preponderance of the evidence, while in the latter the Board must prove gross negligence or other statutory violation by "clear and convincing evidence to a reasonable certainty."

The short answer to this tiresome tirade is: So what? Malpractice judgment and settlement information is ***public information*** about conduct which is rele-

vant to a physician's competence, and which is tried or otherwise tested in the context of a judicial system in which the physician's interests are fully represented. Should consumers have to pay for the fact that the AMA and CMA have helped in no small measure to fashion the laws which make it easy for a physician to hide her misconduct and difficult for the Board to discipline her? And won't the Board's new policy (disclose judgments but not settlements) simply encourage all physicians to settle and seal all cases, so malpractice proceedings will never see the light of day? While this may have a salutary effect on the dockets of trial courts and the pocketbooks of trial lawyers (a result no doubt unintended by CMA), we consumers will never know when our physician has settled one, five, or 25 malpractice cases.

We agree that physicians in some specialties and subspecialties are sued for malpractice more frequently than are others, simply because of the nature of what they do. We agree that one or more settlements (or even judgments) in some specialties over the course of a career may not be particularly indicative of a physician's competence. And we agree that many malpractice cases are not meritorious. However, we *also* know that only one in about ten incidents of physician negligence ever become the subject of a lawsuit.[2] And we do not agree that the Board should conceal from the public *all* malpractice settlements—*whatever* the amount paid—*and* all fully litigated judgments of liability under $30,000.

Even in high-risk specialties, it is possible to draw a line—in terms of number of judgments/settlements per career—where statistical probability blurs into questionable competence. We believe the Board has an obligation to determine that line, even if it means specialty-by-specialty scrutiny, and begin both to (1) *act* in those cases and (2) *disclose* malpractice judgments *and* settlements where their combination indicates a problematical pattern. For example, would you rather know whether your anesthesiologist has suffered one malpractice judgment of $35,000 over a 25-year career, or four settlements in excess of $500,000 in a ten-year career? The Board's past performance indicates that it is unlikely to take action in either case; and even if it decides to take action in the latter case, it may take MBC anywhere from three to eleven years to discipline that physician. Meanwhile, under the Board's new policy, you'll find out about the former case, and you'll never know about the latter.

Predictably, CMA patronizingly argues that all consumers are unsophisticated rubes who will go or not go to a physician because of a single malpractice judgment or settlement. Maybe so, maybe not. But that problem could be ameliorated if the Board, using statistical data which it can easily gather through its biennial survey of California physicians, determines the point at which a *pattern* of malpractice actions (both judgments and settlements) indicates a problem, and discloses these actions only when that pattern is demonstrated.

CMA also warns that the Medical Board's disclosure of this information stamps it with an "imprimatur" of trustworthiness. And well it should. The Board is merely passing on *public* information which happens to be *true* and *accurate*, and *may* be relevant to a consumer in choosing a physician. Consumers, by the way, pay for the collection of this information—both as patients of physicians who pass their MBC licensing fees on to us in the form of an indirect tax, and as taxpayers who directly support government entities (*e.g.*, district attorney's offices) which must act when the Board fails to act. The Board and the medical profession should drop the paternalistic approach, disclose ***public information*** to consumers with accurate explanatory information, and let the consumer who has paid for the compilation of this information make up his or her own mind.

CONCLUSION

Physicians are trained in a hierarchical system of authority. Especially in their respective areas of specialty, they expect their judgments to be accepted without question. And they coextensively suffer from the horizontalization of society—they empathize strongly with each other, with their occupational "peers." Most genuinely believe that only physicians can judge physicians. Such is the trade and profession tribalism of the 1990s.

What some of them do not understand is the nature of the body politic, the basic integrity of the state. Physicians are not philosopher-kings and we do not live in a Platonic society. And physicians are not judges. They are not the "parents" of consumers, appropriately presuming not to allocate already public information based on their collective judgment of our inability to maturely understand it or any disclaimer explaining it. Let's get real about who they are and who the rest of us are. Some of these particular licensees know some things about some problems with our bodily functions. Period. Some are smart. Some are incompetent. Some are dangerous. Some are dedicated to their oath. Some are greedy. Whatever the percentages, they warrant no deference in the exercise of determinative police power on behalf of the general populace. They certainly should participate in such decisions; their advice and counsel should be expected. But what many of them seek instead is the general recognition of a kind of medieval guild where *they* decide; end of discussion. And *they* control what we know about that decision. This notion of the expert "guild-meister" advancing human well-being and providing beneficent self-regulation has long been rejected by the human experience, and has been the subject of periodic pillorying by the great writers and artists of history, from Chaucer to Voltaire to Wagner.

This nation has instead cast its fate with the following and substantially contrary legal and egalitarian principles. We are a nation guided by laws applying equally to all of us; we conduct our governmental affairs in public; whether one is allowed to practice a trade or profession is a public decision properly made by public institutions. It is certainly alluring to replace such a system with a private "thumbs up" or "thumbs down" made by a secret "club"—that is, it's alluring if you're in the club. But America has long since arrived at a different arrangement—and almost all of us have agreed to it. Almost all of us.

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ENDNOTES

1. Stegosaurus is the dinosaur with large protective armor plates which, when threatened, would allegedly respond by lowering his head to the ground and turning his back toward his adversary.

2. We have also argued that the Board should disclose medical malpractice filings, as these are also public information which any consumer could obtain at any courthouse. The Board has solved this problem by *refusing to even gather the information*. The Board/CMA position is that such filings are so irrelevant that the Board charged with protecting health and safety should not even *know* about them—even if a pattern of thirty to forty such filings exists. In fact, about one in five such lawsuits results in a judgment well beyond nuisance value (over $30,000), making these filings a relatively rich source of useful information. Only one in thirty or forty consumer complaints leads to a serious investigation.