

July 16, 2004

Honorable Thelton Henderson  
U. S. District Court  
450 Golden Gate Ave.  
San Francisco, California 94102

Re: Plata v.Schwarzenegger, 2<sup>nd</sup> report, part 2

Dear Judge Henderson:

This letter is part of our second report.

Credentialing and Physician Qualifications

Based on review of several facilities, there appears to be an emerging pattern of inadequate and seriously deficient physician quality in CDC facilities. As a backdrop for this discussion, it is worthwhile to describe the differences in physician practice. After medical school physicians may do one year of internship and begin practice. Such rotating internships typically consist of one to two months rotation in each of various specialties, such as medicine, surgery, etc. Physicians who complete a rotating internship can legally practice medicine as general practitioners. It is generally at this point that they acquire a license.

Most physicians do not do rotating internships. Rather, they enter residency programs in the specialty of medicine that they intend to practice in. Such residencies are typically 3 to 6 years of training with practical and didactic training in the area of specialty. Such areas of training include Anesthesiology (the practice of giving anesthesia during surgery), Internal Medicine (the practice of diagnosing and treating medical problems), a variety of surgical fields, etc. Training in each of these areas is specialized and does not cross over to include training in other areas. One exception is Family Practice which consists of several months each of training in Internal Medicine, Obstetrics and Gynecology and a variety of surgical specialties.

The CDC by practice treats all physicians equally. Requirements for medical licensure in any state generally only require completion of medical school and internship. CDC only requires licensure in order to perform in any staff position. The Personnel Board selection process treats physicians the same as long as they have a license. Thus the only requirement for hiring is a medical license. There is no further hiring requirement. However, while the medical needs of the patients in the CDC may be satisfied by general practitioners with training in only a rotating internship, most services require some training in general internal medicine. Some positions should be filled by Board Eligible (completed a training program but without passing a certifying examination) or Board

Certified (trained and passed a certifying examination) internists. CDC Health Services Division under Dr. Kanan has recently initiated a process of credentialing physicians that is comparable to what is done in HMOs and other managed care organizations. Credentialing considers not only licensure but other qualitative factors such as moral character, whether a physician is impaired physically or mentally, and the training that a physician has. However, the current CDC credentialing rules are not selective and it is extremely difficult to weed out poor quality physicians. In addition, there are no job description requirements other than licensure. Thus, an incompetent anesthesiologist or a retired neurosurgeon can be hired to see patients for diabetes and coronary heart disease, conditions that they have never been trained to treat. This situation exists at all of the facilities we reviewed to date and results in very poor medical management. In one chart review, for example, at one of the CDC acute care hospitals a patient who was breathing fast because of bilateral pneumonia was seen by a retired neurosurgeon who thought the patient was having an anxiety attack and prescribed anti-anxiety medication and medication for psychosis when instead he needed intravenous antibiotics and oxygen. This was a potentially life threatening mistake that was remedied when the patient was seen by a different physician the next day and admitted to a community hospital.

Credentialing is a process whereby the medical authority or committee of an organized medical staff in a hospital reviews the training of a physician and approves that physician to do certain things. These “things” are called privileges. As an example, physicians may be privileged to do abdominal surgery, facial surgery, read an electrocardiogram, treat a person with rheumatoid arthritis or diabetes or pulmonary function testing, etc. In a typical HMO, credentialing is typically performed by a single physician, usually a Medical Director who has experience and training in evaluating physician quality. In addition, there are training requirements in order to be on staff. As example, one can’t do surgery unless one has trained in surgery or see medical patients unless one has training in Internal Medicine or Family Practice. In the CDC the current policy on Credentialing (Chapter 9) only requires that each “supervisor” ensures that each employee has the correct credentials. This basically means only a license. There is no review of whether the physician has training for the diagnostic and therapeutic endeavors the physician will be engaged in. In addition, in practice, supervisory staff at facilities does not oversee credentialing. Credentialing is managed by committees of physicians that are comprised of all the physicians on staff. This type of arrangement is common in hospital settings. However, typical rules in hospitals are that Board Certification in a specialty is required to practice. Thus in a hospital one would never see an Anesthesiologist practicing Internal Medicine. Yet in the CDC this can and does occur. CDC credentialing-by-committee by staff physicians results in a review process in which physicians mostly approve each other and credential each other. Under the current CDC circumstances, this perpetuates poor physician quality. Physicians without training are approving physicians for practice in which they are not trained. Self-supervision tends to result in inadequate oversight over physician quality and in groups of inadequate physicians approving each other and maintaining a system of poor physician quality. For new hires CDC Central Office has inserted authority to review all hires, however, re-credentialing of physicians is performed locally.

Review of credentials at several facilities revealed that at one facility a physician trained in Obstetrics manages the HIV patients, and a neurosurgeon sees patients for Internal Medicine problems in the ER and in the hospital even though he is not trained, for example, in reading electrocardiograms, a basic function of emergency medicine and internal medicine. None of the physicians managing CTC inpatient units at facilities we reviewed so far had both Board Certification in a primary care field and experience managing medical patients in an acute care setting outside of training. More importantly, at one of the facilities we reviewed, 50% of the 8 physicians had either a prior criminal charge, loss of privileges at community hospitals or had questions of mental health problems. The CDC had tried to fire one of these physicians but he was re-instated by the personnel board. At another facility, of the 20 credentialed physicians, 7 have problems, including mental health disorders, prior alcoholism, or loss of privileges or license because of substance abuse or incompetence or both. Typically, when a problem physician is hired by an HMO or other managed care organization, there are monitoring programs to monitor these types of physicians but such a program does not exist in the CDC. My understanding is that Dr. Kanan has been the first Medical Director to attempt to bring increased control over the credentialing process, but she has had a difficult time with personnel board rulings, the labor union, and a legacy of bad physician hiring practices and institutional inertia.

In regards to problem physicians, the current CDC credentialing policy does not require a review, with documentation of an interview with the employee for issues related to adverse actions. More importantly, physicians are re-credentialed every two years. At these two year re-credentialing exercises, the re-credentialing is done by a committee of staff physicians. Thus, for re-application, adverse actions are entered into the re-application packet and reviewed by the peers of the physician re-applicant, many of whom have the same sort of problems. At one of the facilities reviewed, the Vice Chairman of the committee that oversees credentialing is an Obstetrician who had lost his license for 7 years for incompetence and alcoholism. He is overseeing, in part, the review of physicians practicing Internal Medicine and Surgery in the hospital. He has no experience in Internal Medicine yet is deciding which physicians should be re-credentialed and what they should be allowed to do. In effect, there is inadequate review of problem physicians.

Peer review is a periodic review of physician work and review of possible problem cases to assess the quality of physician work in their field of practice. In fact, at all of the sites reviewed, there was no meaningful peer review of any sort of physician quality. The one facility that had a Chief Physician and Surgeon not only did not have peer review, but the Chief Physician and Surgeon gave unqualified positive recommendations on the re-credentialing form (on the matter of quality) to physicians who Experts feel are not competent. This is compounded by lack of physician leadership. The Chief Physician and Surgeon position is a leadership position of physicians who are practicing primary care internal medicine. At the facilities we reviewed prior to this report, only one Chief Physician and Surgeon position was filled, and this position was filled by a retired ophthalmologist (a doctor who specialized in ocular disorders). That person was supervising and supposed to train the other doctors in the field of Internal Medicine, an

area in which he had no training or experience. At the other facilities where there is no Chief Physician and Surgeon, physicians monitor themselves. Chief Physician and Surgeon positions are not desirable because a staff physician typically makes more money than a Chief Physician and has fewer headaches. Thus, when mistakes are made by staff physicians there is no supervisory physician with experience who can correct or amend mistakes. Therefore, untrained physicians who make mistakes will continue to make them because there is no one to identify and correct their mistakes. Experts recommend that a peer review policy be developed. Peer review, under current circumstances, should be performed by a physician trained in primary care internal medicine who has supervisory authority either at the facility or in Central Office. Peer review should be structured and geared toward primary care medicine and should also include problem cases that typically could have been prevented by appropriate primary care management. Such sentinel event cases are exemplified by the Agency for Health Care Research and Quality (AHRQ) Preventive Quality Indicators. Such review should be included in QMAT scoring. Peer review should become part of the physician's file and repeated adverse scoring should be grounds for increased supervision or discipline including termination.

Regarding new appointments, Central Office is to be notified by facilities for any physician applicant if there is a National Practitioner Data Bank report or if there is a status report on their license. However, by policy, individual facilities may still approve that physician with the approval of the Deputy Director of Central Office. Because the Deputy Director is a lay person, Experts deem this policy flawed. The final authority on hiring and firing physicians should be a physician. As well, there are other matters that must be considered in hiring and retaining physicians including moral conduct, past criminal behavior, misconduct with patients, and incompetence. Current policy and job descriptions for the personnel board are inadequate in this regard. There does not appear to be effective and practical review and action on impaired or incompetent physicians or physicians with moral or other personal conduct problems. Finally, because of Title 22, CTC Bylaws proscribe credentialing. It may be that CDC is of the opinion that Bylaws can not be modified. Experts are not certain that bylaws of CTCs can not be modified to include a managed care type credentialing process. In any case, Experts believe that the job performance requirements for hiring should be modified so that physicians have training in the area in which they are practicing. This is especially important because the CDC has a collective bargaining agreement with the physicians union and disciplining poor quality physicians is harder than it is in other health care sectors. Ideally, CDC could have separate credentialing for CDC physicians outside the scope of CTC rules and regulations. CTC credentialing could remain as is, but staff credentialing requirements of the CDC, above and beyond CTC requirements would include a more thorough Central Office review. This should be done by management in a fair and equitable manner. Experts also recommend that physicians covering CTC units have Board Certification or Eligibility in a primary care medicine field (Internal Medicine or Family Practice) preferably with experience in managing hospital patients. In a separate vein credentialing should include a requirement that DEA licensure be required of all CDC physicians.

Current CDC practice is to treat all physicians equally and make assignments based on concerns other than training, experience and ability. This is bad practice. For example, at one facility, the physician in charge of the CTC is a retired surgeon. He is treating patients with complex internal medicine problems and does not do a good job. The CMO, who is trained in internal medicine, writes all of the discharge notes because the surgeon is not competent to do so. However the CMO does not see the patients and this practice results in bad management and causes patient harm. At another facility, a neurosurgeon saw a seriously ill patient with internal medicine problems that resulted in life-threatening problems. At a third facility, an incompetent retired cardiothoracic surgeon manages complex internal medicine patients and makes serious life-threatening mistakes on a continual basis. QMAT training for these physicians is very difficult because they have no knowledge base or training upon which to improve. The check-box format of answering questions makes it easy to cover up bad care and may give an impression of knowledgeable care where none exists. As an example, a poorly trained physician at one of the facilities who did not know how steroid inhaler medication was to be prescribed or used by the patient was checking the box that he educated the patient in how to use the medication. This same incompetent physician is managing most of the sickest patients at that facility. QMAT has a physician trainer who is a pathologist. He is a good person. However, he has no training in internal medicine. Can he be expected to train some of the physicians described above in proper diagnostic and therapeutic decision making? Experts therefore, under the existing circumstances, recommend that physicians be assigned based on abilities. Physicians should be graded by skills, training and ability. Those with the greatest ability in the area of their expertise, and best training and skills should see the sickest patients. The sickest patients should be determined by an acuity ranking that is devised mutually by Experts and CDC hierarchy.

Finally, the Central Office has inherited a legacy of autonomous functioning by individual CDC facilities who independently manage their physician staff. Greater authority should be vested in the Central Office to manage physician practice and credentialing. This will permit for standardization of policies on credentialing, peer review, discipline procedures, job descriptions and assignments that do not now seem to be in place.

#### Summary of Recommendations

1. Establish a peer review process that is performed by a supervisory physician trained in Internal Medicine
2. Use Agency for Health Care Research and Quality (AHRQ) Prevention Quality Indicators as a sentinel event monitoring system to track care. Reviews of these sentinel events should be performed by supervisory physicians trained in Internal Medicine.
3. The Central Office Medical Director or equivalent should have final approval on all physician credentialing and hiring.
4. Modify the job description of physicians to improve physician selection.
5. Correctional Treatment Center (CTC) physicians should be required to have Board Eligibility in either Internal Medicine or Family Practice.

6. Require DEA licensure of all physicians except CMO or those doing only administrative work.
7. Assign physicians by ability and training.
8. Reinforce the supervisory authority of the Central Office Medical Director or lead physician.

Sincerely for the Experts,

Michael Puisis, D. O.

Joe Goldenson, M.D.

Madie LaMarre CNP