Nicholas D. Jurkowitz, State Bar No. 261283
njurkowitz@fentonlawgroup.com
Dennis E. Lee, State Bar No. 164360
dlee@fentonlawgroup.com
FENTON LAW GROUP LLP
1990 S. Bundy Drive, Suite 777
Los Angeles, CA 90025
Telephone: 310-444-5244
Facsimile: 310-444-5280
Attorneys for Petitioner
KATE O'HANLAN, M.D.

SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF SAN MATEO

KATE O'HANLAN, M.D.,

Petitioner,

vs.

DIGNITY HEALTH SEQUOIA HOSPITAL dba SEQUOIA HOSPITAL, REDWOOD CITY; MEDICAL STAFF OF DIGNITY HEALTH SEQUOIA HOSPITAL dba SEQUOIA HOSPITAL, REDWOOD CITY; GOVERNING BOARD OF DIGNITY HOSPITAL SEQUOIA HOSPITAL dba SEQUOIA HOSPITAL, REDWOOD CITY; and DOES 1 through 10, inclusive,

Respondents.

CASE NO. 23-CIV-00725

VERIFIED PETITION FOR WRIT OF ADMINISTRATIVE MANDAMUS PURSUANT TO CODE OF CIVIL PROCEDURE SECTION 1094.5

By this verified petition, Petitioner Kate O'Hanlan, M.D. (Petitioner or Dr. O'Hanlan) seeks a writ of administrative mandamus pursuant to Code of Civil Procedure section 1094.5, ordering that Respondents set aside, in its entirety, the decision by the Governing Board of Sequoia Hospital, Redwood City, which upheld the decisions of the Judicial Review Committee

to: (a) summarily suspend Dr. O'Hanlan's medical staff privileges, and (b) continue that summary suspension past fourteen days, at which point it became reportable to the Medical Board of California; and (c) adopt the recommendation by the Medical Executive Committee (MEC) to revoke Dr. O'Hanlan's privileges.

The basis for this Petition is that Dr. O'Hanlan was denied a fair hearing and also that none of these actions by Respondents (summary suspension, continuation of that summary suspension past fourteen days, or revocation) were reasonable and warranted because the adverse findings are not supported by substantial evidence.

The unfairness of the procedures is set forth in detail herein. The basis for these adverse actions, as set forth in Respondents' final decision and the hearing committee decision upon which the final decision was largely based, relied primarily on three "milestone" cases, and was, in brief summary, as follows: (a) Dr. O'Hanlan's "inattention to important details, both preoperatively and postoperatively, has exposed patients to an unreasonable and unacceptable risk of serious injury;" (b) Dr. O'Hanlan demonstrated a "lack of veracity" in her documentation for what is referred to as the "aorta case;" and (c) Dr. O'Hanlan is "especially challenged" when she needs to seriously consider the advice of her peers and to adjust her practice patterns to applicable professional standards.

In fact, the evidence and testimony reveal that Dr. O'Hanlan is very attentive to pre- and post-operative details that might expose her patients to risk of serious injury, collaborates well with peers, learns and improves her practice from her complications, exhibits consistent veracity, and has never posed an imminent risk to her patients.

PARTIES

1. Petitioner Kate O'Hanlan, M.D. is an eminently qualified physician and surgeon who at all relevant times was duly licensed in the State of California, G-070108.

2. Petitioner is informed and believes, and on the basis of such information and belief alleges, that Respondent Dignity Health Sequoia Hospital dba Sequoia Hospital, Redwood City is a private hospital and corporation located in 170 Alameda de las Pulgas, Redwood City CA 94062 and incorporated in the State of California.

3. Petitioner is informed and believes, and on the basis of such information and belief alleges, that Respondent Medical Staff of Dignity Health Sequoia Hospital dba Sequoia Hospital, Redwood City Medical Staff (Medical Staff) is an unincorporated association consisting of the Medical Staff members of that hospital.

4. Petitioner is informed and believes, and on the basis of such information and belief alleges, that Respondent Governing Board of Dignity Health Sequoia Hospital dba Sequoia Hospital, Redwood City is the controlling Board of that hospital.

5. Respondents Does 1 through 10, inclusive, are other persons and entities who are responsible in some measure for the actions complained of herein. Their names are unknown at this time and they are therefore being sued under their fictitious names. At such times as their true names are ascertained, this petition will be amended to so reflect.

6. Respondents are collectively referred to hereinafter as "Respondents," "Sequoia," or "the Hospital."

FACTUAL BACKGROUND

A. Dr. O'Hanlan's Exceptional Qualification and Experience

7. Dr. O'Hanlan has been a successful practicing physician and surgeon in California for approximately 30 years, from 1990 to 2020. She was a subspecialty Board-Certified Gynecologic Oncologist whose surgical research, teaching, and clinical work helped establish the use of laparoscopic (four tiny incisions) techniques in Gynecology. For three decades, she successfully performed hundreds of operations each year involving exceptionally

complex and otherwise untreatable gynecological conditions. She is qualified at the highest level of laparoscopic surgical skill by the American Association of Gynecologic Laparoscopists (AAGL). She has published over 65 peer-reviewed journal publications, mostly on laparoscopic surgical techniques, which have been cited by other medical authors over 3,000 times. She taught advanced laparoscopic surgery at over 30 international venues and is internationally recognized as a stellar leader in her field of laparoscopic surgery and oncology surgery. She produced nineteen annual Continuing Medical Education courses on advanced laparoscopic and oncology surgery, certified by both the American College (ACOG) and American Board of Obstetrics and Gynecology (ABOG), training 2,600 surgeons from 43 countries around the world. She was founding Chair and subsequently co-Chair of the Diversity and Inclusion Committee of the Society for Gynecologic Oncologists and a member of the Board of Directors for the American Association for Gynecologic Laparoscopy. From the final decision (Exhibit 5 hereto, Appellate Review Committee Decision, p. 12, quoting the Hearing Committee Decision): "Dr. O'Hanlan's training, experience and skill in performing the physical and mental act of surgery, especially laparoscopic surgery, is excellent-perhaps even exceptional."

B. <u>Dr. O'Hanlan's Practice at Sequoia, from 1992, in Leadership Positions</u>

8. Dr. O'Hanlan joined the Medical Staff of Sequoia Hospital in 1992 while she was on the faculty at Stanford University Hospital. She began her full-time surgical practice at Sequoia in January 2003. She performed about 78 percent of the hysterectomy cases at Sequoia and 94 percent of the cancer debulkings during her last three years at Sequoia. She served on the Pharmacy and Therapeutics Committee for two years and became Chair of that committee for the next 12 years.

9. Dr. O'Hanlan's grateful patients have made over 43 donations to the Sequoia Foundation in her honor. Dr. O'Hanlan has been invited to six "Guardian Angels" dinners

celebrating her patient care by the Sequoia Foundation. Dr. O'Hanlan and her wife have donated $10,000 to Sequoia's Foundation themselves. She has received two letters from the Hospital president for generous donations commending her care, and one letter in 2017 nominating her for the Dignity Human Kindness Award.

10. Dr. O'Hanlan's practice has been suspended and she was expelled from Sequoia Hospital in February 2020, having been accused of increased complications, infections and take-backs (referring to having to take a patient back to surgery due to complications arising post-operatively).

11. As a result of the Hospital's suspension and expulsion of Dr. O'Hanlan, she could not operate locally and could not support the costs of her office, which she closed in May, 2020. An automatic investigation by the Medical Board of California, triggered by the B&P Code section 805 report filed by the Hospital, resulted in a Medical Board Accusation against Dr. O'Hanlan based on suspension by the Hospital. Because Dr. O'Hanlan could no longer operate locally, and after spending hundreds of thousands of dollars defending her Sequoia practice, she had to surrender her license with the stipulation that the Medical Board acknowledge that she had a reasonable defense. As a result, Dr. O'Hanlan has lost her reputation and international standing, five years of practice income, her double board certification by the American Board of Obstetricians and Gynecologists, her Board of Directors membership in the American Association of Gynecologic Laparoscopists, and her ability to provide expert testimony, an additional source of income.

C. <u>Long History of Sequoia's Bias against Dr. O'Hanlan</u>

12. In 2003, Dr. O'Hanlan transferred her surgical practice at Stanford to Sequoia after she resigned her privileges at Stanford. Dr. O'Hanlan had previously called a Sequoia staff physician who was her representative to the California Medical Association (CMA). Dr.

O'Hanlan was the then-president of the Gay and Lesbian Medical Association. She asked this Sequoia physician if she would ask the CMA to officially oppose Proposition 8, a voter initiative to prevent marriage equality in California. The doctor refused.

13. While Dr. O'Hanlan was at Stanford, she initiated and led a successful initiative to get the Stanford administration to provide a benefit package to same-sex couples that was equal to the benefits Stanford provided to married couples. This program was initiated in January 1992 and spread across the country in academic institutions thereafter. While Dr. O'Hanlan was at Stanford from 1990 to 2002, she was harshly criticized by community doctors for her activism on behalf of gay and lesbian people.

14. When Dr. O'Hanlan began her surgical practice at Sequoia, she noticed that none of the gynecologists were performing advanced laparoscopic procedures, a less intrusive approach then traditional surgical procedures. She suggested that they have a monthly meeting to teach each other advanced laparoscopic procedures, but they all declined. In 2007, Dr. O'Hanlan produced her first course on advanced laparoscopic procedures and has subsequently presented this course 19 times, training 2600 surgeons from around the world. Not a single surgeon from Sequoia has attended this course. Since then, over one million surgeons have viewed her teaching videos. 251,000 have viewed "Step by Step Instructions for Laparoscopic Suturing" alone.

15. When Dr. O'Hanlan began her surgical practice, she thrice asked each and every Sequoia gynecologist to assist her in the operating room, but each refused every time. Out of the 3,500 surgical cases Dr. O'Hanlan has performed at Sequoia, only three patients were referred to her by a Sequoia gynecologist. When each of the three referring gynecologists, all former or future chiefs of the department, attempted to perform their side of the hysterectomy,

as is customary, they were unable to do so due to administration and medical staff pressure and had to ask Dr. O'Hanlan to complete their side.

16. When the other gynecologists at Sequoia have patients who are diagnosed with cancer, they refer their patients to two gynecologic oncologists who take the patients to El Camino Hospital, 15 miles away, and operate on the patients there.

17. At Sequoia, Dr. O'Hanlan's caseload is comprised of 78 percent *major* procedures. The general gynecologists in the Sequoia OB/GYN Department perform 86% *minor* procedures. Dr. O'Hanlan performs 85 percent of her cases by laparoscopy, a less intrusive approach, while the general gynecologists perform only 47 percent of their hysterectomies laparoscopically. She was performing more cases than all the other gynecologists combined and was the second busiest surgeon at the Hospital for many years prior to her investigation. This led to resentment of Dr. O'Hanlan, especially as about 45 percent of her practice involves *benign* cases, referred by general gynecologists from outside of the local area who respect Dr. O'Hanlan's skills.

18. On average, gynecologic oncologists' practices consist of 35 percent benign cases, as per a 2020 survey of the Society of Gynecologic Oncology. Given that gynecologic oncologists have an additional two to three years of cancer surgical training, they are typically able to perform the more complex benign surgeries that are deemed high-risk and employ more less-intrusive laparoscopic approaches. These skills engender more referrals from other specialties, further engendering resentment from general OB/GYNs.

19. Dr. O'Hanlan regularly attended the Quality Assurance (QA) meetings of the OB/GYN Department at Sequoia every time that she was in town. She informed the Department at one of the 2003 meetings that, since she was doing about 250 operations a year

and had a 4 percent complication rate, well within the standard of care for gynecologic oncologists, probably equating to having one complication before them every month.

20. When Dr. O'Hanlan started teaching in UCSF-Fresno on a monthly basis in 2015, the four-day stays in Fresno were often during the times of the monthly departmental QA meeting, making Dr. O'Hanlan miss the meetings. Dr. O'Hanlan missed many meetings due to her teaching commitments at UCSF-Fresno but respectfully tried to collaborate with the QA staff to attend. Dr. O'Hanlan was precluded at the hearing before the Judicial Review Committee (JRC, also referred to as the Hearing Committee) from submitting a copy of 34 of her emails with the QA staff regarding mutual efforts to arrange for QA review of Dr. O'Hanlan's complicated cases.

THE UNDERLYING DISPUTE

A. The Faulty Investigation, Where Information Was Not Provided to Dr. O'Hanlan, Leading to Formation of an Ad Hoc Committee, and in Which Dr. O'Hanlan Did Not in Any Way Attempt to "Evade" Responding

21. On June 10, 2016, the then-Sequoia Chief of Staff, Dr. Talebian, emailed Dr. O'Hanlan to meet with her about " 'fall out' on some of your cases as compared with the standard benchmark for your specialty." That same day, Dr. O'Hanlan asked if she could prepare for the meeting by obtaining the patient cases at issue and the 'fall out' categories under concern. Dr. Talebian reassured her that no preparation was needed, but on June 13, 2016, Dr. O'Hanlan again asked to receive information about her complication list and rates. On June 24, 2016, Dr. Talebian reassured Dr. O'Hanlan that she would provide this information during their meeting but that she could not email protected patient information. That same day, Dr. O'Hanlan wrote again asking for the data on her practice so that she could prepare. All told, she had politely asked five times for the "fall out" information that they had. Dr. O'Hanlan was not

allowed to submit these emails into evidence at the JRC hearing that later arose, where an adverse finding was her alleged refusal to meet with the Chief of Staff, which was untrue.

22. On August 25, 2016, after the prior Chief had termed out, the new Chief of Staff, Dr. Torosis, called Dr. O'Hanlan to meet with him, again alleging that there was a problem with her practice quality. She requested that he provide her with a list of her complications and their complication rates that underlie their specific concerns so that she might prepare for the meeting. He insinuated to Dr. O'Hanlan that she had never met with the former Chief of Staff, so Dr. O'Hanlan sent him a copy of the cordial emails between the two of them and was still waiting for information as the former Chief of Staff was termed out of office.

23. On August 25, 2016, Dr. Torosis emailed Dr. O'Hanlan, stating, "*Got it, sorry I misunderstood you about the letter.*" (5:11 pm). "*I know that you indicated you first wanted to have the opportunity to review your cases* that have been discussed in peer review with the department of Ob/Gyn. You wanted to review them before we met so I am providing you with the list of medical record numbers…." (4:30 pm). Attached hereto as **Exhibit 6** is a true and correct copy of Dr. Torosis' August 25, 2016 emails of 4:30 pm and 5:11 pm. Yet, Dr. Torosis would later repeatedly and falsely accuse Dr. O'Hanlan of resisting meeting with either himself and or the former Chief of Staff to the Ad Hoc Committee and the Medical Executive Committee, and the Decision also reflected this falsehood. (Exhibit 4, Hearing Committee Decision, pp. 11-12.)

24. In the August 25, 2016 email, Dr. Torosis gave Dr. O'Hanlan a list of the medical record numbers (MRNs) of 28 complicated cases, all of which had been previously adjudicated by the Ob/Gyn Department monthly Quality Assurance (QA) meetings over the last 33 months. Of the 28 cases, 21 were designated by QA review as involving "appropriate" care; three were deemed "controversial for "decision-making" issues; two were deemed

"controversial" for "documentation" issues; one was deemed "inappropriate" for "technique." He included a letter sent to Dr. O'Hanlan dated April, 2016, which he said was about Dr. O'Hanlan's Ongoing Professional Practice Evaluation (OPPE) results, but this letter described only one complication suffered by a patient of Dr. O'Hanlan on February 18, 2016, deemed "inappropriate" in the OPPE system. The six cases in which physician care was controversial or inappropriate comprise 1% of Dr. O'Hanlan's practice and is the material on which improvement is routinely promoted by monthly QA Review of Dr. O'Hanlan's cases.

25. The Decision quotes the Chief of Staff in the above email that "the intent of meeting is for your benefit so that we can have a better plan for improved patient outcomes. It is not meant to be punitive or put a 'black mark' (as you stated) in your file." (Exhibit 4, Hearing Committee Decision, p. 12.) Despite this seeming disclaimer, the Decision used Dr. O'Hanlan's alleged (non-existent) refusal to meet as reflecting part of her pattern of resistance to constructive criticism and feedback.

B. <u>Dr. O'Hanlan's Complication Rates Are Provably Within the Standard of Care for Gynecologic Oncology</u>

26. Dr. O'Hanlan reasonably wanted the OPPE tally of her appropriate and inappropriate complications because she had not kept track of Sequoia's designations, only of the event of a complication in her practice. Since she had been publishing journal teaching articles on surgery, she knew her complication rates and quickly recalculated them for the 33-month period of review but not how they were coded by Sequoia.

27. Dr. O'Hanlan hand-counted her surgeries from her office charts and calendars for that period, finding 647 total cases. Because subsequent discovery would reveal that Sequoia had counted 628 cases, this number 628 will be used as denominator in this and future calculations for the 33-month period, called the total overall rate. The 28 complicated cases

identified out of the count of 628 total cases amounted to 4.5%, this "overall hand-counted" complication rate was provably normative in published literature in gynecologic oncology readily available online.. These complications were coded by Dr. O'Hanlan using commonly published categories : 11 cases of infection (1.8%); three cases of post-operative hemorrhage (.4%); two urological organ injuries (.3%), eight intestinal organ complications (1.3%), and four management issues (.4%).

28. Among the above 28 cases were 15 take-backs, meaning returns to surgery (2.4%), which is the most serious sort of complication, and is provably normative in Gynecologic Oncology and provable by online Gynecologic Oncology sources. Dr. O'Hanlan's NSQIP[1] rate of take-backs was 3.3% and was withheld from Dr. O'Hanlan and is also normative in Gynecologic Oncology, readily available online. The average take-back rate is General Gynecology is 2*% and for Oncologists, it is at least* 3%, and 3.5% in general surgery.

29. The infection rate at 11 of 628 (1.8%) was provably normative in published literature in Gynecologic Oncology, readily available online. The NSQIP infection rate of 3.3% was withheld from Dr. O'Hanlan and is also normative in gynecologic oncology, readily available online.

30. Further attempts by Dr. O'Hanlan to gaingain information so she could prepare for the meeting with the Chief of Staff were rebuffed. On September 12, 2016, Dr. O'Hanlan reassured the Chief of Staff that she was studying her charts and would get back to him soon.

///

[1] National Surgical Quality Improvement Program (NSQIP) run by the American College of surgeons maintaining data for 700 hospitals to provide norms, through publications of its data. NSQIP only includes cases with hysterectomies performed for any reason, NSQIP does not count successful repairs of organs operated for cancer removal or *planned* returns to the operating room. NSQIP attributes a complication to the surgeon who performed the surgery, even though the data follows the patient, per se.

C. The Hospital's Obstinate Refusal to Provide Dr. O'Hanlan with the Basis for its Claims that She Had Concerning High Complication Rates

31. Dr. O'Hanlan all along had known that her practice complication rates were normative, because she kept her own practice complication data, having reported them in several of her surgical publications and in her patient information pamphlet. When the QA Department refusing to provide her with rate data, she obtained her total number of surgical cases by counting surgeries in her office calendars and charts, and the counted the case numbers assigned by the Sequoia Operating room. She calculated complication rates using simple arithmetic: complications divided by total cases. She compared her current and older practice data[2] with comparable data from other gynecologic oncology and laparoscopic surgery publications, and still could not understand the Administrations' alleged concerns about infections, complications, and takebacks in her practice.

32. On September 24, 2016, Dr. O'Hanlan emailed her preliminary analysis to the Chief of Staff, providing her comparable data from published references showing that her total complication, infection and surgical takeback rates were safe and normative.

33. Dr. O'Hanlan's further requests for *their rate source information* of their allegations about her complication rates on September 30, 2016 and on October 6, 2016 were ignored, in violation of Sequoia Bylaws. On October 3, 2016, unbeknownst to Dr. O'Hanlan, the Chief of Staff, Dr. Torosis, and the Chief of the Department of Obstetrics & Gynecology, Dr. Beverly Joyce, wrote a confidential memorandum to ask the Medical Executive Committee (MEC) to authorize formation of an Ad Hoc Committee (AHC). A true and correct copy of this

[2] Dr. O'Hanlan published an analysis of her laparoscopic complications in 2007 in *Journal of the Society for Laparoscopic Surgeons*. She had performed over 3,500 surgeries at Sequoia between 2003 and August of 2017. Between 2014 through 2017, the years under scrutiny, her complication rates were actually lower than in 2007.

October 3, 2016 memorandum is attached hereto as **Exhibit 7**. The memorandum alleged, "Over the years, [Dr. O'Hanlan] has had a series of complications, and what seem to be unusually frequent returns to surgery and post-operative infections" while providing no documentation or comparison with gynecologic oncology standards as the Bylaws require. The memorandum misleadingly stated that Dr. Talebian and Dr. Torosis had attempted to meet with Dr. O'Hanlan, but she "resisted and raised procedural obstacles, as a result of which the meeting never occurred. More recent efforts by [Dr. Torosis] have also been rebuffed." The memo further took Dr. O'Hanlan's requests for the statistical basis for the allegations of high complication rates as "support[ing] our concerns about her practice."

34. Sequoia Bylaws require that the Chief of Staff provide the MEC with specific data of concern for them to make an informed decision, but Dr. Torosis did not do so. On October 20, 2016, the next communication Dr. O'Hanlan received from Dr. Torosis announced that an AHC had been authorized to investigate her practice, regarding "rates of infection, rates of surgical complication, and rates of return to surgery, and the manner in which you communicate with patients, their families and other physicians."

D. <u>The Hospital's Completely Inaccurate Determination of Complication Rates Based on Absolute Numbers Rather than Rates and Repeated Ignoring of Dr. O'Hanlan's Explanations and Requests for Clarification and Correction</u>

35. The discussion herein the take-back rate issue is relevant because the completely inaccurate information relied on by the AHC badly biased the MEC and the Hearing Committee to see Dr. O'Hanlan as a dangerous and substandard physician, almost, by itself, 'forcing' the rulings against her, even though the Hearing Committee and Appeal Decisions expressly stated they were not relying on the rates. As such, the abject failure of the Hospital to properly understand the altogether elementary nature of the point that Dr. O'Hanlan was trying to make

is a significant part of the overall unfairness of the proceedings against her, which is a ground for setting aside the final decision of the Hospital.

36. On November 4, 2016, Dr. O'Hanlan wrote to Dr. Torosis about her practice standards and complication rates. Dr. O'Hanlan wrote: "Per your advice, I met with Mary Christen in the Risk Management office to go over those cases. For 12 of them, an examination of the QA printouts showed that there was 'no issue' from the OB/GYN Departmental review. Mary told me that they should not be of concern any longer. The remaining 16 cases over the past two years warranted review, and I participated in those reviews and agreed with the severity determinations. These cases are not in dispute. The Sequoia Bylaws at Article VII, section 1, sets out the justification for such an investigation. Neither of these two issues of which I have been informed by you would seem in the least to warrant an Ad Hoc Committee formation for investigation." Based on Ms. Christens instructions, she estimated her complication rate to be 3.7% which was normative in her field, providing references for their confirmation that the normal rate is 4.5%.

37. Dr. O'Hanlan had asked for Sequoia's data about her practice many times by this point and still could not understand how she could have such concerning data to warrant investigation. She provided a list of Sequoia staff which knew her practice well and requested that they be interviewed by the AHC.

38. On November 16, 2016, Dr. O'Hanlan received a letter from Dr. Torosis notifying her that she did not meet the expected threshold for Ongoing Professional Practice Evaluation (OPPE) instead of an AHC investigation. She had two inappropriate (only one was allowed) designations and three controversial designations (only two allowed), and four risk events (only three allowed) from January to June, 2016.

39. The Sequoia OPPE standards use absolute numbers, not a rate of events per total number of cases performed. Evidence improperly not allowed in the hearing showed that other hospitals, such as the University of California, Fresno use an OPPE system but employ percent rates rather than absolute numbers; for example, at Fresno, Dr. O'Hanlan had two returns to the operating room out of 201 cases, or one percent. Nearly all the Sequoia general gynecologists were low-volume surgeons. Dr. O'Hanlan was considered a high-volume surgeon, and in studying how the OPPE system worked, she observed that the system would find high-volume surgeons with low rates of complications "falling out," and would miss low volume surgeons with higher rates of complications, all because the OPPE system used absolute numbers and not rates.

40. Dr. O'Hanlan obtained the Sequoia OR absolute numbers of surgeries for the entire department, showing 354 surgical cases over the 6-month OPPE period, and subtracted the 90 that she had performed. There were 15 gynecologists at the time at Sequoia (a number that varied over time; there are more now) performing the 264 cases, averaging (264/15), 18 surgeries per general gynecologist in these 6 months. A surgeon performing 18 cases over 6 months would not be flagged as failing OPPE expectations with one inappropriate designation at (1/18) or 5.5%, or two controversial designations at (2/18) or 11%, and three risk events at (3/18) or 17%. If there are 20 gynecologists, then each gynecologist performed only 13 surgeries in 6 months, and the allowed categories are even higher (7.7% for one inappropriate, 15% for two controversial, and 31% for three risk events).

41. Dr. O'Hanlan counted from her office and surgery calendar that she had performed 90 major procedures in those 6 months. Dr. O'Hanlan had two "inappropriate" designations at 2.2%, three "controversial" designations at 3.3%, and four "risk events" at 4.4%. In all three categories, Dr. O'Hanlan had lower complication designations than her colleagues

who did not fall out, but she was still considered to have "fallen out" of these quality assessment categories because the system used absolute numbers and not rates. She sought to change the system to a fairer, equal basis using percent rates, not absolute numbers, which is the standard in hospitals.

42. On December 28, 2016, Dr. O'Hanlan wrote to Dr. Torosis and the members of the AHC showing them that her complication rate of 4.5% had *improved*, not worsened, since her 2007 publication on her own complications and provided many other journal comparisons. She again explained that 12 cases were removed from the list of 28 total complications, "which excludes the 12 "no issue" cases, per Mary Christen" thinking she was following instructions. She wrote, "I have analyzed data from my practice along with data given me by Dr. Torosis and Sequoia officials. I have also obtained similar data from published journal articles for comparison of complication rates. All complication rates in every journal are reported as number of complications divided by total number of patients treated. I continue to ask you what numbers Sequoia has been working with that specifically triggered this Ad Hoc Committee."

43. On February 10, 2017, Dr. O'Hanlan wrote to the QA Director and the Chief of Staff to request that the OPPE system calculate a percent rate, rather than using an absolute number to identify surgeons who were outliers in the system, so as not to inaccurately penalize high-volume surgeons. She suspected that neither the department chairs and not the administration knew that she had such a busy practice and explained that she would be expected to have a higher number of complications than others in the department, but should have a similarly low rate, or percentage, of complications. On February 9, 2017, Dr. O'Hanlan asked Mary Christen to consider the OPPE system by percent, as other hospital do.

44. Dr. O'Hanlan sent a February 7, 2017 communication pointing out the misleading nature of using absolute numbers vs. percentages. On February 15, 2017, Dr.

O'Hanlan wrote a letter to her colleagues in the ObGyn Department, which she provided to attendees at the Gynecology department QA meeting in March 2017, and requesting a revision of the OPPE system, asking they use a percent rate as is done at the UCSF-Fresno, but her request was tabled immediately. One of the members of the Department (Dr. Hoff, a former chair) said to Dr. O'Hanlan that he thought that Dr. O'Hanlan had a *17% takeback rate*. This stunned Dr. O'Hanlan, as it was as inaccurate as it damning. She immediately said her takeback rate was never 17%, an unacceptably high rate, but the chair instructed attendees to return Dr. O'Hanlan's copies of her letter to her and adjourned the meeting.

45. On February 16, 2017, the AHC meeting minutes show that members suspected "Dr. O'Hanlan [is] requesting to change OPPE metrics and make it retroactive so she would not fall out," showing no understanding of the reasonableness and fairness of Dr. O'Hanlan's query. Dr. O'Hanlan tried to clarify the totals for her surgical cases for the relevant periods in a March 3, 2017 email to Mary Christen and the QA Director, but clarification was never forthcoming.

46. On March 14, 2017, Dr. O'Hanlan emailed Mary Christen and the QA Director: "I never received the surgical numbers that I have been requesting for three months now." On March 21, 2017, Dr. O'Hanlan emailed Mary Christen and the QA Director: "I still do not have the hospital's version of my numerator and denominator…." On March 21, 2017. Dr. Chandrasena responded: "Dear Kate, [a]t this point I believe that all information pertaining to the work of the committee needs to be obtained and reviewed through the medical staff. I am sorry I cannot be of further assistance to you on this issue. My best, Anita."

47. On April 10, 2017, at 9:14am, Dr. O'Hanlan sent an email to the Chief of Staff at "Torosis, James - SEQ" James.Torosis@dignityhealth.org, with an attached PDF letter, entitled "Dr. Torosis from O'Hanlan," asking that he "deliver [it] to the members of the Ad Hoc Committee." Dr. O'Hanlan's letter sought to address the concerns that were raised in Dr.

Torosis' announcement of the formation of the AHC to investigate her regarding her rates of complications, infections, returns to surgery, complications, infections, returns to surgery, professionalism and communication. He did not respond to the email or to the letter, and this letter did not appear in the discovery or in the evidence file.

48. The very respectful letter addressed many issues, including: (a) needing to calculate her complication rates; (b) asking for their help generating a numerator and denominator to understand their concerns; (c) providing comparison of her data to nine publications in Gynecologic Laparoscopy and Oncology; (d) showing that her complication and takeback rates had improved since her publication about complications in 2007; (e) demonstrating how the OPPE system unfairly harmed high-volume surgeons.

49. Dr. O'Hanlan would not see the actual Sequoia QA concerns and data until 16 months after her investigation was initiated. The Sequoia Bylaws mandate that Dr. O'Hanlan should have been provided these specific allegations in June, 2016, when the concerns were first brought to Dr. O'Hanlan. By the time she was afforded a due process hearing, the damage to her career and professional reputation was devasting and irreparable.

50. On June 9, 2017, Dr. O'Hanlan attended a Gynecology Departmental QA meeting, Attending the meeting were the Chair of the AHC and the QA Director and the departmental Chair, Dr. Joyce, who along with Dr. Torosis had requested the AHC. Two of her complications were presented by the gynecologist whom Dr. O'Hanlan had asked long ago to endorse marriage equality at the annual California Medical Association meeting. She refused to do so, even though medical literature supported equal marriage as healthful. Dr. O'Hanlan had presented literature evidence that she had performed the procedures correctly and used correct judgment. One case was cancer-related, and the doctors, none of whom were gynecologic oncologists did not know cancer staging guidelines. The other case was in an area of Dr.

O'Hanlan's expertise and publications and the members were not aware of current literature. The members voted to designate both issues as "controversial." She wrote a letter of complaint to the chief of staff, and provided specific references to the gynecologic oncology guidelines for care and to a published manuscript about appendectomies. She felt that they had made incorrect designations of "controversial" based on inadequate knowledge of gynecologic oncology and on infectious complications. She provided evidence of her care and proof that the patients were handled within the standard of care.

51. The QA Director criticized Dr. O'Hanlan's personality for defending her practice against spurious QA findings. Dr. O'Hanlan was criticized for disagreeing or objecting heartily to findings that were inconsistent with the literature that led to invalid decisions that were subsequently used to expel her.

E. <u>The Completely Inaccurate Take-Back Rate Repeatedly Stated During the AHC Investigation Badly Biased the Investigation And Ignored the Objectively Reliable NSQIP Data That Most Hospitals, Including Sequoia, Rely Upon</u>

52. The AHC met 18 times from November 3, 2016 to September 18, 2017. The minutes of these meetings, described below, were revealed to Dr. O'Hanlan with the discovery, after her expulsion.

53. At the first meeting, November 3, 2016, the hospital's lawyer provided information that was heavily redacted for discovery. Dr. Torosis opened the meeting biasing the AHC by alleging falsely, that 1. "Numerous attempts were made" by the former Chief of Staff to meet with Dr. O'Hanlan….to no avail." 2. "Dr. O'Hanlan never made herself available to meet…" 3. "Dr. O'Hanlan had increased complications, returns to OR, infection rates."

54. On December 8, 2017, at the third AHC session, the QA Director falsely alleged that the "Return to surgery for Dr. O'Hanlan was 17-26% January 2015 through December 2015 compared to other Dignity Health Gyn-Onc 3.46 – 3.57%." A return to surgery (also called a takeback) rate this high is a blatant indication of gross incompetence, introducing severe bias.

55. NSQIP is widely recognized as an important objective measure of nationwide complication rates in various surgical subspecialties and is recognized as such by Sequoia. Dr. O'Hanlan's NSQIP take-back rate was *3 percent*, not 17-26 percent.

56. The discovery file of her information packet *showed no evidence* of such a terrible 17-26% rate. This false allegation, coming with the presumed credibility of a QA Director, and the presumed credibility of the QA computer printout, would bias every reasonable staff member into believing Dr. O'Hanlan was truly a danger to her patients and must be expelled.

57. NSQIP data overlooked in the QA Director's presentation showed that Dr. O'Hanlan's had normative infection and return to surgery, or takeback, rates. The discovery file of the QA director's information packet shows that Dr. O'Hanlan's infections complications and take back rates had been compared with those of *all* Dignity hospital system gynecologists. Members of the AHC knew that Dr. O'Hanlan was a subspecialist providing care for both cancer patients and referral complex gynecology patients, making her practice higher risk. Not obtaining the benchmark rates *in her subspecialty* for infections, complications, take-backs in Dr. O'Hanlan's subspecialty was inherently faulty.

58. On January 12, 2017, in session four, the Chief of Staff provided more exculpatory evidence that was ignored or overlooked. He had Dr. O'Hanlan's operative reports printed for the 33 months of review, and hand counted a total of 628 surgeries. Members had the list of Dr. O'Hanlan's 28 total complications in the AHC folders. These 28 total cases

included all the infections, enterotomies, and take-backs or returns to the OR in the 33-month period, for an accurate overall complication rate of 28/628 = 4.5%. The mathematics required was mind-bogglingly simple, yet inexplicably, Dr. O'Hanlan's take-back rate was falsely stated to be in the range of 17 to 26 percent.

59. In sessions 5 to 12, the Ad Hoc Committee interviewed and received substantial evidence from every single physician that Dr. O'Hanlan worked with on a regular basis. One was Dr. Mike O'Holleran, who has assisted Dr. O'Hanlan on about 2,500 cases. He indicated that doctor O'Hanlan has very difficult cases resulting in complications that the other gynecologists would not experience.

60. On July 13, 2017, Dr. O'Hanlan met with the AHC. At the meeting, Dr. Torosis emphasized "the severity of the complications" and Dr. O'Hanlan's alleged refusal to speak with Dr. Talebian or himself, saying an investigation probably would not even have occurred but for her 'refusal' even though he knew she never refused. Dr. O'Hanlan disagreed with many inaccurate gynecologic oncology assumptions and assertions of the AHC members and addressed all 28 complications in the meeting, which lasted 90 minutes.

61. Dr. Beverly Joyce, chair of the OB/GYN department, concluded the AHC meeting after Dr. O'Hanlan had left the room, saying: "Well, she obviously thinks this is my personal vendetta against her." Dr. Joyce's statement indicates bias and negative personal animus against Dr. O'Hanlan.

62. On July 14, 2017, Dr. O'Hanlan sent her detailed responses about Dr. Chapman's accusations to the Chief of Staff and the AHC explaining each of her agreements and disagreements with the reviewer. She again provided published complication rates showing hers were similar, and an editorial by a gynecologic oncologist about the difficulty of cases in which ovary cancer surgeries caused bowel complications. Dr. O'Hanlan acknowledged some

valid constructive criticisms of her care that were made, but she provided evidence that the other complications were unavoidable and unfortunate derivatives of appropriately careful surgery.

F. The Outside Reviewer, Dr. Chapman, Was the Only Gynecologic Oncologist Consulted with by the AHC and MEC But Did Not Testify at the Hearing

63. The Hospital's outside reviewer was Dr. Chapman, the only Gynecologic Oncologist that the AHC and the MEC consulted. The Hospital relied on herher report without making herher available as a witness at hearing for cross-examination, and peer review proceedings have no subpoena procedure for Dr. O'Hanlan to have compelled herher attendance at the hearing. This was grossly unfair procedure.

64. The AHC never sent Dr. O'Hanlan's responses to be rebutted by Dr. Chapman and accepted all of his criticisms as fact. The Hospital relied only on Dr. Chapman's written critique of six cases of Dr. O'Hanlan's 628 cases without bringing Dr. Chapman to the JRC for cross-examination, a violation of fair procedure.

65. In contrast, Dr. O'Hanlan presented the expert testimony of Dr. Micha, a Gynecologic Oncologist who was Director of Gynecologic Oncology Associates, a Medical-Surgical Corporation in Los Angeles at hearing. Dr. Micha had reviewed every operative note from every case by Dr. O'Hanlan for 22 years. He confirmed that Gynecologic Oncologists have more severe complications than General Gynecologists because only Oncologists operate on the bowel, bladder, liver, spleen, nodes and ureters. He disagreed with Dr. Chapman, endorsing Dr. O'Hanlan's care of JS, SW, TT, and KW (Patient 9). He affirmed that it is not a complication when a hole is made and successfully repaired during removal of cancer nodules that invade an artery, the bowel, bladder, ureter or other organs. The NSQIP standards are the same. He said, "it's an inevitable consequence of these types of ultra-radical surgeries" and that

it was appropriate for an Oncologist to be aggressive in removing all visible cancer nodules to obtain the highest probability of cure. "This was all appropriate, and I think if Kate had done less, I would be disappointed in her." He repeatedly endorsed Dr. O'Hanlan's patient care, dictations of her H&P's, and management of her complications, stating that with "the advanced laparoscopy she does here, she's better than the GYN/oncologists at Stanford, UCLA, USC, Cedars, UCI, and so on. I mean, she really – I know, it's probably hard for you to believe, how can this be? Well, it is. And I think she's very persistent, very smart, and – but I think it's great she's continuing to go, you know, look to improve things."

G. <u>The Case Relied on for the Summary Suspension, Patient 9, MRN 920824, Was Demonstrably Handled Properly, and Exculpatory Evidence Was Improperly Denied from Being Referred to at Hearing, Denying Dr. O'Hanlan a Fair Hearing</u>

66. On August 9, 2017, Dr. O'Hanlan performed a curative surgery for a patient later designated as Patient 9 (MRN 920824), who had an otherwise terminal recurrence of cancer, located on the aorta, the major blood vessel in the back of the abdomen. This case was the sole basis for the summary suspension that was imposed shortly thereafter. However, this surgery was handled properly at all times. The alleged concerns by the MEC are demonstrably baseless and ran counter to uncontested testimony by the expert surgeons and the Hospital staff present in the procedure. None of the reviewers had the credentials to discredit Dr. O'Hanlan's care or were present for the case and made findings contrary to all evidence and testimony, with a reckless regard for the truth, and counter to published literature in Gynecologic Oncology.

67. On August 14, 2017, five days after this operation, the Chief of Staff, Dr. Torosis, called Dr. O'Hanlan to inform her that she was summarily suspended from the hospital, based on Patient 9's procedure on August 9, 2017, calling the case itself a "near miss," a risk to

the patient's life, and labelling Dr. O'Hanlan as dishonest for her two unsigned draft operative dictations. The discussion in this section pertains to the appropriateness of the medical care provided. Baseless allegations of dishonesty are further discussed *infra* at section M herein.

68. Written notice of summary suspension was sent to Dr. O'Hanlan on August 22, 2017. A true and correct copy of the August 22, 2017 notice is attached hereto as **Exhibit 1**. The August 22, 2017 summary suspension notice stated, that it was "based on your conduct relating to the care of Patient M.K., MR # 920824, on August 8 and 9, 2017, in the context of pre-existing concerns about the safety of your surgical practice. … The case of Patient M.K. resulted in the consideration of summary action at this time because it is representative of the types of judgmental and ethical problems that have been identified repeatedly in your practice, and because it demonstrates the seriousness of the risks that your patients face. … [D]espite knowing that your planned surgery on this patient would expose her to a danger of life-threatening vascular complications, *you did not arrange to be assisted by a vascular surgeon or even make concrete arrangements for a vascular surgeon to be immediately available* in the event of a problem. During the procedure, the patient *experienced a rent in the aorta* which would likely have been fatal but for the coincidental presence of a vascular surgeon in the hospital and his ability to break away from another procedure that he was performing and come to your aid. Following the procedure, *you dictated operative reports for both yourself and your assistant, which was highly irregular*. The rent was not mentioned in either of those reports, and was noted only in your third dictation, which was prepared after the event was described in the vascular surgeon's report. There were other concerns, as well, that I will not undertake to describe here."

69. Discovery produced by the hospital would later reveal that, on August 10 to 11, 2017, the CMO and COS called the assistant surgeon and the vascular surgeon, querying about

this case and took notes. The QA director never called Dr. O'Hanlan for information about this case, nor did she contact another gynecologic oncologist for perspective about the indications and management.

70. Later discovery produced by the Hospital also showed that the CMO was called by a "CV [cardiovascular] nurse pulled in to help felt underprepared," [sic] unexpectedly by Dr. Zimmerman, who had apparently not apprised the nurse, nor had he requested his instruments for a possible repair. Dr. Zimmerman elected to require that a cardiovascular nurse stay late after he had finished a case in another room and scrub in for the case. Dr. Gillon, also a Sequoia vascular surgeon, suspected Dr. Zimmerman was simply caught off-guard and was not expecting to be called for the "possible" repair. When Dr. Zimmerman came to realize that he was actually going to be needed by Dr. O'Hanlan, he attempted to shift blame to Dr. O'Hanlan, complaining that "she shouldn't be doing these kinds of cases," surely a non-sequitur that had nothing to do with whether he has been informed ahead of time.

71. The COS set forth many blatant inaccuracies in his report to the MEC: that Dr. O'Hanlan's "finger was in the hole of the aorta;" there were "inadequate instruments;" she "should have been assisted by a vascular surgeon;" "she inappropriately puts other peoples' names in the chart to substantiate what she does;" she "did not remove all remaining tumor;" and she had an "inadequate assistant surgeon."

1. <u>Dr. Zimmerman Had Been Contacted Ahead of Time Properly</u>

72. All of the alleged concerns were obviously and demonstrably false. She had, in fact, arranged in advance for a vascular surgeon to assist if necessary.

73. The evidence showed that, pre-operatively, Dr. O'Hanlan had indeed made *"concrete arrangements for a vascular surgeon to be immediately available"* to perform a vascular repair if necessary, providing proof to the MEC in her texting and phone records with

him. Dr. Zimmerman read her first text to him, sent the morning before the planned surgery, to the JRC panel in which Dr. O'Hanlan stated that this patient may have invasive cancer into the vessel wall, but "no suggestion of invasion through the wall into the lumen," "only the suggestion of an extrinsic mass effect" possibly requiring repair, similar to a prior patient of hers in which he had previously been called *unexpectedly* to place a graft. Dr. Zimmerman also confirmed her mention of the possible graft.

74. Dr. Zimmerman admitted in JRC testimony that "she said she might need my help and I said I would be around" then he ridiculously contradicted himself saying that Dr. O'Hanlan was just asking if he would be around *out of curiosity.* Dr. Zimmerman contradicted himself again testifying that she had, in fact, arranged to be available for possible repair and that he agreed to be available for that "all day.". Dr. O'Holleran also testified to his statement of availability. Since he had said he would be available all day, Dr. O'Hanlan did not ask him to be available at a specific time, nor did she specify to him what time she might need him. Dr. O'Hanlan reasonably interpreted Dr. Zimmerman's response of "I'll be around all day" as assurance that he could replace the segment of a non-diseased (no plaque or aneurism to increase risk) aorta as needed without much difficulty. Everyone in the OR that day concurred that it was not *"coincidental"* that the Vascular Surgeon came to Dr. O'Hanlan's OR with a calm mood, indicated he was already aware of the case, and calmly replaced the cancer-damaged segment, expressing no surprise or dismay when he entered Dr. O'Hanlan's operating room, per Head Nurse Charvonia and Dr. O'Holleran. He had no reason to say that he was surprised when he received a call.

75. Generalist Dr. Chan, after stating that aortic node involvement "is very scary to me" at hearing, opined that Dr. O'Hanlan should have obtained a formal consult, but Dr. Zimmerman testified that a *formal* consult is *not* needed when he is contacted "ahead of time

about *the possibility* that your services may be needed." Dr. Zimmerman stated that other Sequoia doctors also have requested "possible" services from him in similar fashion. During her telephone conversation, Dr. O'Hanlan asked the vascular surgeon if he wanted to see the patient prior to the surgery, a formal consult, but he declined, seeming confident it would not be a big deal to perform a vascular repair in a patient with no history of vascular disease. All he wanted to know was *whether she knew* that she might get a graft or not. Dr. O'Hanlan confirmed to him and sent him a copy of her dictated history and physical stating that the patient was aware of the possible need for vascular graft. Dr. Zimmerman requested nothing further. The Hearing Committee Decision, affirmed by the Appellate Review Committee, credited his testimony in ultimately finding that Dr. O'Hanlan had engaged in "poor planning for support from a vascular surgeon." (Exhibit 4, p. 17.)

76. Everyone actually present for the procedure testified that Dr. O'Hanlan described all of the above in her part of the Surgical Pause, and the Head Nurse Charvonia ordered Dr. Zimmerman's usual instruments in their operating room in case they would be needed, even though he had not requested them. The CMO knew the instruments were retained in the OR for possible repair.

77. The x-rays, reviewed by both Dr.'s O'Hanlan and O'Holleran together, showed only an "extrinsic mass effect" (compression from outside) and possible invasion into the thickness of the wall, no evidence of invasion *through the wall or into the lumen,* as inaccurately alleged in the AHC synopsis. The Hearing Committee Decision, affirmed by the Appellate Review Committee, finding that "adjacent intima of the aorta was irregular" is not supported by any testimony or evidence. (Exhibit 4, p. 16.)

78. The documents at hearing, including medical record documents, acknowledged that the vascular instruments were already in the room; the x-rays were properly reviewed ahead

of time; and there was no evidence at that time of invasion through the vascular wall that the vascular surgeon had been contacted for possible repair. CMO Chandrasena initiated a Root Cause Analysis (RCA) and contacted the assistant surgeon and the vascular surgeon but not Dr. O'Hanlan, for no good reason.

79. The Appellate Review Committee Panel was wrong to ignore every one of the four doctors interviewed by the AHC and the five doctors testifying to the JRC who were extensively familiar with Dr. O'Hanlan reported that she had no *judgmental or ethical problems that have been identified repeatedly* in her practice.

2. <u>There Were No Dangerous "Rent Holes," and Dr. O'Hanlan Handled the Case Entirely Appropriately, with Excellent Results</u>

80. Dr. Zimmerman testified that he has operated with Dr. O'Hanlan three times, all due to vascular complications, which he acknowledged were a "known complication of node dissections." He felt free to opine that "Dr. O'Hanlan has poor judgement about what she is getting into." He cavalierly advised the Chief of Staff that "you need to do something about limiting her privileges" with no idea that she had performed hundreds of aortic node dissections at Sequoia.

81. The Sequoia administration also appeared not to know that Dr. O'Hanlan had performed over 450 such operations at Sequoia since 2002 and 145 during the time of her investigation (precluded from evidence), most of which were located high up on the aorta, and most by laparoscopy, which is far more difficult. Dr. O'Holleran accurately testified that he had done "hundreds" of aortic node dissections with Dr. O'Hanlan.

82. Published literature, precluded from evidence, confirms that a lymph node dissection may result in unexpected vascular repair in 4% of cases. Dr. O'Hanlan had the insight to anticipate this possibility and plan for it.

83. The Sequoia administration appeared not to know that the procedure was well within Dr. O'Hanlan's approved credentials showing that she had done at least 100 node dissections in the past 24 months in both January 2015 and in January, 2017. Her CV shows that she has taught this difficult procedure at international meetings and has made peer-reviewed videos, and published her techniques for high aortic lymph node dissections and on the quality of life of her patient having this procedure.

84. There was never a "*dangerous rent in the aorta."* This small hole would never *"likely have been fatal"* because it was anticipated and addressed properly with all necessary staff. The patient had perfect vascular control at all times per testimony of every person in the operating room that day, as confirmed by Dr. O'Holleran and even Dr. Zimmerman. Dr. O'Holleran even testified that there was not only a total lack of imminent danger, but that the control was so perfect that even if Dr. Zimmerman had never shown up, he could have cross-planted and replaced the aorta himself. The Hearing Committee Decision, affirmed by the Appellate Review Committee, conclusion that there were dangerous "rent holes" in the aorta (Exhibit 4, p. 17: Dr. Zimmerman "found rent holes in the aorta") was not supported by substantial evidence or even Dr. Zimmerman's own testimony. Nor was the Hearing Committee Decision supported by substantial evidence

85. At one point, Dr. Zimmerman testified that, when he entered the operating room where Dr. O'Hanlan's procedure was ongoing, "someone, I don't know who had it for sure" had "a hand in the aorta, which was bleeding." But he contradicted himself later in his testimony by admitting that when he arrived, there was "no active bleeding. Under control." Yet, with no substantial evidence to support it, the JRC, affirmed by the Appellate Review Committee, found that, when Dr. Zimmerman entered, "one of the surgeons had a hand in the aorta which was bleeding." (Exhibit 4, Hearing Committee Decision, p. 17.)

86. The blood loss for the procedure was minimal, as per Dr. O'Holleran's testimony as well as Dr. O'Hanlan's operative note. The patient was transferred to the ICU after the surgery as a routine decision after any graft is placed. The ICU doctor, in her intake note, stated that she planned to remove the breathing tube from the patient's throat the very next morning, signifying that the patient was in good condition after the operation. The patient was discharged on post operative day 6 and has been cured.

87. Yet, The MEC minutes falsely stated, based on faulty assumptions made by Dr. Torosis, that the patient's surgery "resulted in a rent in the aorta with active bleeding." There was never any active bleeding per testimony of every surgeon in the room. The estimated blood loss, printed in Dr. O'Hanlan's and in the anesthesiologist's surgical reports, was falsely doubled in the MEC report to 3,000 cc when it was 1,500 cc in reality.

88. There has never been any doubt that Dr. O'Hanlan's surgical dissection, as she herself testified, removing all of the deeply invasive cancer, resulted in a two-millimeter hole (about one-twelfth of an inch), which she plugged with the tip of her index finger. The adjacent tissue could not be sewn into a reliable closure, so the vascular surgeon was called, while control of all vessels was maintained at all times. There is no testimony to the contrary by anyone present that day. There was never any emergency. The patient was stable the entire case and there was never any rush for the vascular surgeon.

89. The Sequoia Administration summarily suspended Dr. O'Hanlan without knowing that her credentials included high aortic node dissections. Either Dr. O'Hanlan or another gynecologic oncologist, at the very least, should have been consulted. The case was properly planned based on literature. The case was well within Dr. O'Hanlan's experience and credentials, who has performed 145 lymphadenectomies during the time of her investigation, most of which were high aortic, and most by laparoscopy, which is far more difficult. Dr.

O'Hanlan was highly published on this procedure. The standard of care is for vascular surgery to collaborate with gynecologic oncologists because in upup to 44% of the cases, a vascular complication will develop.

90. Regarding the allegedly 'irregular' dictated operative reports, Dr. O'Hanlan did absolutely nothing improper. This issue is discussed in greater detail at section M, *infra*. Briefly, her assistant surgeon, Dr. O'Holleran, participated in the surgery and provided important collaboration. Accordingly, Dr. O'Hanlan offered to bill as "co-surgeon" with him, so that she and he would be compensated similarly, instead of as a surgeon with an assistant surgeon. An assistant surgeon receives one fourth the compensation that a surgeon receives. She dictated a *draft* operative note for each of them, but he changed his mind stating that his billers would not know how to post the billing as a "co-surgery." Dr. O'Hanlan requested *deletion* of the two unsigned drafts, breaking no Sequoia Rules and Regulations, and then dictated a *final* dictation with herself as surgeon, and her colleague as assistant, which she signed officially into the chart. There was absolutely no irregularity or impropriety in the submitted final and signed dictation.

3. Sequoia's Internal Peer Review of Patient 9, MRN 920824, Was Improperly and Unfairly Excluded at Hearing, a Prejudicial Error Denying Dr. O'Hanlan a Fair Hearing

91. A critical piece of evidence that was not presented at the MEC meetings, and not allowed to be introduced or referred to at the JRC Hearing was a peer review report of Patient 9 by a QA-appointed physician (perchance a Cardiac Anesthesiologist) and by Dr. Tarang Safi, on August 18, 2017. A true and correct copy of this report is attached hereto as **Exhibit 8**.

92. Dr. Safi's report confirmed that Dr. Zimmerman was consulted ahead of time and indicated his availability if needed. The report confirms that Dr. O'Hanlan properly planned the

surgery, having addressed pre-operative concerns for the aorta, due to the location of the tumor, which made it very difficult to safely remove without the possibility of perforation and possible graft. Dr. Safi concluded that there was no breach of care rendered and no issue identified with Dr. O'Hanlan.

93. Dr. Safi's report should have been allowed to have been referred to and discussed at the MEC consideration of Dr. O'Hanlan's summary suspension on August 21, 2017, 3 days after that report had been signed.

94. Dr. Safi's report should have also been referred to and discussed before the MEC would vote to uphold her suspension on August 28. The MEC should have found that it was not reasonable and warranted to continue suspension past 14 days, at which point it became reportable to the Medical Board of California pursuant to Business and Professions Code section 805(e). Sequoia QA ignored their own unbiased hospital-wide procedure for QA, which Dr. Torosis touted as "incorporating a 'just culture' approach."(June 16, 2017)

95. Dr. Safi's report also should have been referred to and discussed at the JRC hearing, months after it was signed. Sequoia counsel falsely insisted at hearing that it did not even exist. In fact, this document was submitted by the MEC as one of its own Exhibits at the JRC hearing, but as part of an Exhibit admitted into evidence but misfiled by the MEC under the Exhibit for Patient 1's records, rather than under Patient 9. These records are voluminous, and the mis-filed document was buried within the record for Patient 1.

96. Dr. Safi's report should have been allowed to have been referred to and discussed at the JRC hearing. The improper exclusion was prejudicial error, denying Dr. O'Hanlan a fair hearing. That report indicated that the Hospital's own internal peer review had deemed the patient case *not a concern before* written notice of summary suspension was sent to Dr. O'Hanlan based solely on that case.

97. Simply put, the MEC, and later the JRC, had no reasonable basis for deeming Dr. O'Hanlan to be such an 'imminent risk' to patient safety as to justify the severe step of a summary suspension, which was continued past 14 days, at which point it became reportable, based on the case of Patient 9. The summary suspension must be set aside as not reasonable and warranted.

H. The MEC Voted to Continue the Summary Suspension on August 29, 2017 Despite Receiving Evidence that Patient 9 Was Properly Handled in Every Respect and That There Was No Dishonesty Whatsoever

98. On August 21, 2017, the MEC met for 3 hours, and included the AHC members' presentations without Dr. O'Hanlan present. The minutes and the concerns were not provided to Dr. O'Hanlan until four months later, but they showed startling inattention to the testimony they had already obtained. As just one example, the minutes represent that the patient surgery "resulted in a rent in the aorta with active bleeding." Testimony from Dr. O'Holleran and Dr. Zimmerman was that there was no uncontrolled bleeding at any time during the operation.

99. On August 22, 2017, the Chief of Staff wrote to Dr. O'Hanlan inviting her to meet with the MEC to defend against her Summary Suspension.

100. On August 24, 2017, Dr. O'Hanlan wrote to the Chief Medical Officer and the Chief of Staff, recounting her experience of Patient 9's surgery. She had also asked Dr. Zimmerman for his support in writing the above letter so that the MEC would know that Dr. O'Hanlan intended to collaborate with all the Sequoia specialties. Dr. O'Hanlan also recounted that she had texted the vascular surgeon asking for his possible help repairing or replacing the segment of the aorta and then he had said he would be around all day. He declined to see the patient in a formal consult. The letter added that she would've done whatever he had suggested for this patient but she was reassured by his reassurance. The letter confirmed that gynecologic

oncologists perform resections of cancer invading many organs in the abdomen and that their complications can occur in each of these organ systems, albeit rarely, as exemplified in the publications using NSQIP data by Gynecologic Oncologists.

101. The vascular surgeon, Dr. Zimmerman, shared a text with the QA Director that he received from Dr. O'Hanlan in which she asked for his support in writing the above letter so that the MEC would know that Dr. O'Hanlan intended to collaborate with all the Sequoia specialties. He had responded by trying to make it appear as if Dr. O'Hanlan surprised him with the request for his assistance when he had really been caught off-guard, not having ordered the equipment or alerted the staff that he might possibly be called upon.

102. The Medical Executive Committee met on August 28, 2017. The Chief of Staff and the Chief Medical Officer presented information about Dr. O'Hanlan and her practice for 70 minutes, which Dr. O'Hanlan was precluded from hearing. This was patently unfair as Dr. O'Hanlan still did not know the accusations that she would need to respond to or address. The minutes show that the CMO gave the same slide presentation to the Committee once again alleging the terrifying falsehood that Dr. O'Hanlan's take-back rate was 17-26 percent. The minutes further show that the CMO's presentation completely ignored the correct and normative NSQIP rate of 3% and again demeaned its reliability by grossly misrepresenting how the data is obtained. Dr. Safi's favorable QA report was not reviewed at this meeting, even though it was completed 10 days before. At this meeting, Dr. Bruno would allege that Dr. O'Hanlan was also resistant to participating in a series of meetings about her infection rate, never having shared this information with her, and unaware that her NSQIP infection rate was entirely normative for her subspecialty.

103. Once allowed into the meeting room, Dr. O'Hanlan explained that the surgery was carefully planned and undertaken collaboratively, detailing the x-ray review, the

discussions with the vascular surgeon, the consenting of the patient, the time-out, and the procedure. She told them the surgery went just as it was planned with a likely curative result.

104. Dr. O'Hanlan presented the MEC with a letter signed by her and by Dr. O'Holleran, explaining their mutual effort to bill as co-surgeons which she thought required them to dictate the two parallel operative report drafts. (This issue is discussed in greater detail infra at section M.) This statement explained the legitimate rationales of two discarded draft dictations, and was read and affirmed by members of the MEC and handed back to her. Each deleted dictation was nonetheless included in the JRC evidence book: "In error report. Delete per Dr. O'Hanlan phone call at 2:35, She will redictate her own report." and "In error report" "Delete per Dr. O'Hanlan phone call today at 2:35. Dr. O'Holleran will dictate this own report." The second deleted report stated "Surgeon: Dr. Michael O'Holleran" as evidence that Dr. O'Hanlan had attempted to dictate a *draft* for Dr. O'Holleran to re-dictate as co-surgeon.

105. She stated that she had a safe rate of complications in her Gynecologic Oncology practice and asked for at least the sixth time for her data, but the CMO said "people on our medical staff, attorney and our colleagues in the department … collectively advised me not to re-review the data." The MEC members did not require the CMO to provide Dr. O'Hanlan with her complication data. The CMO again accused Dr. O'Hanlan of manipulating the data "this is Kate's interpretation of the data."

106. What Dr. O'Hanlan did not know then was the CMO's terrible and false allegation of a 17-26% takeback rate, literally damning her to every reasonable member of the MEC. The discovery file shows that, after Dr. O'Hanlan left the MEC meeting, members received a slide presentation by the QA Director, and discussed Dr. O'Hanlan's practice for another 1.75 hours, providing the exact information they had refused to share with Dr. O'Hanlan that the CMO had disseminated since December, 2105.

107. The QA director faulted Dr. O'Hanlan for trying to understand her complication rates (the original accusation), falsely claiming that Dr. O'Hanlan did not know how to calculate them from the QA assessments. Calculation of complication rates is a simple matter that anyone would know how to do. As already discussed, it involves simply dividing the number of cases with complications over the total number of cases. NSQIP and all medical journal reports of complications use this same standard rate calculation. The MEC instead just accepted the CMO's totally erroneous statements that Dr. O'Hanlan's complication rate was ridiculously high, when simple arithmetic made it obvious that it was not.

108. At the JRC, Dr. O'Hanlan adamantly disputed the allegation of a 20% takeback to surgery rate, saying that if this takeback rate were true, the anesthesia team would have stopped Dr. O'Hanlan from operating long, long ago.

109. In an August 21, 2021 email to Dr. O'Hanlan, Dr. Bradley, the Chair of Anesthesiology, said that he told the MEC that he and his Anesthesia team had attended every one of Dr. O'Hanlan's surgeries since 2002, and he vigorously disputed the CMO's data. Dr. Bradley said that if this take-back rate were true, the Anesthesia team would have noticed this and stopped Dr. O'Hanlan from operating long, long ago. In response, the CMO stubbornly defended her false assertions and the MEC upheld Dr. O'Hanlan's suspension.

110. In an October 28, 2021 email to Dr. O'Hanlan, Dr. Bradley wrote that Dr. Ryu, a neurosurgeon on the MEC stated: "I'm new here, so have no skin in the game either way, but it objectively seems that for some reason you really don't like this person and refuse to look at actual evidence." Dr. Bradley stated that he wrote a letter to Hospital President Bill Graham to this effect, but it was not included in the discovery, and his Dignity email record was migrated and lost.

111. On August 29, 2017, the MEC voted 12-3 to uphold and continue the Summary Suspension.

I. The MEC Voted to Recommend Revocation, Providing Written Notice on November 21, 2017

112. On September 29, 2017 the AHC voted to recommend revocation Dr. O'Hanlan's privileges and sent notice to the MEC. She was invited to address the MEC. She was informed that complications and disciplinary events from 2002 while at Stanford and at Mills Peninsula Hospital would be included in their investigation of her would be incorporated into the decisions about her privileges in 2017.

113. These issues included cases arising at Stanford in 2002 and a case in 2003 at Mills-Peninsula Hospital.

114. On October 6, 2017, Dr. O'Hanlan received a Notice of Charges in support of her continuing summary suspension, which was based solely on Patient 9. A true and correct copy of this October 6, 2017 Notice of Charges is attached hereto as **Exhibit 2**.

115. On October 23, 2017, Dr. O'Hanlan met with the MEC to give her side of the story. An MEC member asked Dr. O'Hanlan if she knew her complication rates. Dr. O'Hanlan reported that her rates were similar to published standards, but that she still did not have Sequoia's data that justified her investigation. She again asked for this information, and was again denied it.

116. On November 21, 2017, Dr. O'Hanlan received written Notice of Charges supporting the proposed revocation, which listed Patient 9 as well as eight other patient cases, designated Patients 1-8. A true and correct copy of this November 21, 2017 Notice of Charges is attached hereto as **Exhibit 3**.

///

J. The JRC Hearing

117. Ultimately, the JRC hearing occurred in 14 sessions from February 7, 2018 to November 5, 2018.

118. The JRC (aka Hearing Committee) issued its decision on January 11, 2019. It specifically discussed three "milestone" cases, which included Patient 9, as well as Patients 5 and 8 as forming the primary basis for revocation. It also listed vague generalized concerns with Dr. O'Hanlan. A true and correct copy of the JRC (aka Hearing Committee) Decision of January 11, 2019 is attached hereto as **Exhibit 4**.

K. The Three "Milestone Patient Cases Underlying the Revocation: Patient 5 (Ovaries Case, MRN 903133)

119. Patient 5, a so-called milestone case, was MRN 903133, and involved Dr. O'Hanlan's admittedly incorrect removal of the patient's ovaries on February 18, 2016. The originallyoriginally scheduled procedure was for hysterectomy with ovary removal in a 43-year-old cancer patient. Her ovaries fell into a grey area regarding the decision for retention or removal since the patient did not have a cancer, with the decision based on the patient's preferences after she had received extensive medical information to make her choice, which she of course had the right to change at any time. The patient subsequently decided to keep her ovaries after Dr. O'Hanlan's office had already sent in the scheduling and equipment request to the OR scheduling office. Dr. O'Hanlan modified the consent form according to the patient's wish. Dr. O'Hanlan met with the patient in the pre-operative area and reconfirmed with nursing staff present that the choice was hers to make.

120. In the operating room, Dr. O'Hanlan initiated the surgical pause, as she had for 14 years, in every case, with every OR nurse. Every person spoke their part in the usual order. At the conclusion, Registered Nurse Lau concluded the standard surgical pause procedure, as

usual, which requires that she read aloud the consent form. However, she improperly read from *the wrong document*, an administrative scheduling document sent much earlier, which is not even part of the patient chart. Nurse Lau therefore wrongly informed Dr. O'Hanlan that the "consent" said that the ovaries were to be removed. Dr. O'Hanlan was puzzled that the patient had again changed her mind and asked Nurse Lau if she was certain that it said that the ovaries were to be removed. Nurse Lau pointed to the paper on her desk, looked up and reconfirmed that the ovaries were to be removed according to the "consent" she had supposedly just read aloud. The operation then commenced. Dr. O'Hanlan removed the patient's ovaries. As soon as Dr. O'Hanlan became aware of the error, she reported the event to the OR Director and a root cause analysis (RCA) was initiated. She informed the patient, taking full responsibility, and apologized to her. Sequoia staff watched silently as Dr. O'Hanlan took all the blame when she met with the family a few months after the operation for one more debriefing session.

121. The administrative scheduling form that Nurse Lau read from is a request to reserve the surgical room and equipment for a proposed procedure on a particular date. It is created by office staff, unseen by the doctor, and faxed to the hospital staff. It is neither a medical document nor part of the clinical chart. It is stored in the back of the chart with other non-medical, administrative, financial, insurance, admission and accounting forms. It is never even seen by Dr. O'Hanlan or most physicians.

122. Sequoia OR Nurse Lau simply did not follow OR policy and falsified the chart 6 times with her signature acknowledging that she followed policy by checking the consent with the patient. She stated that the procedure included removal of the ovaries and confirmed removal of the ovaries, when asked by a dubious Dr. O'Hanlan. Looking back, Dr. O'Hanlan readily admits that she did not check to see *if the nurse was following hospital policy and*

reading from the correct consent form, something that never occurred to her to do or would have reasonably been expected to have been done, nor was this required to have been done.

123. The patient continued to see Dr. O'Hanlan after the operation and has felt normal on her hormone patches. Dr. O'Hanlan has paid for the patients patches ever since, even in her retirement from practice.

124. The fact that other surgeons at Sequoia have performed wrong-site surgery may further suggest that there is a nursing problem.

1. The Dignity Universal Protocol Policy and Procedure Was Not Followed

125. A true and correct copy of the Dignity protocol for timeouts, referred to as the Universal Protocol Policy and Procedure (suppressed from evidence by the Hearing Officer) is attached hereto as **Exhibit 9**. The policy states, "The purpose of the Universal Protocol Policy and Procedure is to promote patient safety by ensuring that processes are defined and followed to ensure the correct surgical or invasive procedure is performed for the correct patient at the correct side/site/level. Staff and Licensed Independent Practitioners (LIP's) participating in a surgical or invasive procedure will *actively participate* (italics ours) in these processes and document the processes," (Exhibit 9, p. 1) as Dr. O'Hanlan always did since 2002. In this procedure, just before starting the operation, everyone in the OR pauses, the surgeon, gowned and gloved, stands next to the patient. Each person in the OR with any role in patient care must state their function, equipment, medications, and concerns. The nurse conducts it and asks, "Any questions or concerns? Pause is complete."

126. "This policy applies to *all staff* … time out to involve an *interactive communication* among the team members during which the correct procedure is verified," (Exhibit 9, p. 3) as Dr. O'Hanlan begins the procedure reporting the patient's medical history,

requests for extra instruments, and includes any anticipated problems before anesthesia and then the scrub nurse perform their parts of the policy.

127. "Any team member is able to express concerns about the verification procedure," (Exhibit 9, p. 3) as Dr. O'Hanlan did. She stated that she did not think the ovaries were supposed to come out and asked for clarification. The nurse did not check the consent to clarify. "If there is any discrepancy of the verification, as Dr. O'Hanlan voiced during the verification process, the person discovering the discrepancy will re-verify all of the previously completed steps against the schedule history and physical and the consent for the procedure. The procedure will not begin until clear verification of the patient and the procedure." (*Ibid.*) Dr. O'Hanlan relied on the hospital policy to have been followed meticulously as it had been done for 15 years. Dr. O'Hanlan was not wrong to rely on the surgical pause to clarify the surgical plan.

2. <u>The Decision Fails to Mention That at Least Three Sequoia Nurses Did Not Follow the Surgical Pause Policy But Signed That They Did</u>

128. The Evidence File clearly describes how preoperative nurses RN1 and RN2 admitted that they did not verify the H&P and consent per policy during the Pause. The supervising nurse, Arlene Lau, or RN3, acknowledged that "I did not see any documents…I never had Patient 1's medical Record." Yet, Arlene Lau, RN 3, signed her name into the chart falsely attesting that she had conducted and verified the procedure with the H&P and consent.

129. When confronted with the World Health Organization Surgical Safety Checklist which Nurse Lau signed and dated on February 18, 2016, Nurse Lau abdicated her responsibility stating "my signature was for the patient identification only, the doctor MD led the timeout." Nurse Lau, RN3, attempted to blame her own error on Dr. O'Hanlan by falsely suggesting that Dr. O'Hanlan's participation in the surgical pause caused chaos in the room and

somehow altered Nurse Lau's role as the circulator nurse and relieved her from her responsibility to follow hospital protocol.

3. The Hospital Did Not Interview Material Witnesses such as Head Nurse Beth Charvonia, Dr. O'Holleran or any Anesthesiologists

130. Suppressed evidence at the hearing included a report of an investigation of the Hospital by the California Department of Public Health (CDPH) triggered by the Patient 5 case. Dr. O'Hanlan was never interviewed as part of that investigation nor provided with the CDPH report until long after the fact, obtained during the discovery process in the JRC hearing. She was prohibited from even discussing the report at the hearing even though it was part of the MEC's submitted and admitted exhibits. This exclusion of evidence constituted a gross violation of her right to a fair hearing. This document is attached as **Exhibit 10** hereto.

131. In response to the CDPH action, the Hospital was required to submit a plan of corrective action, included in Exhibit 10. The Hospital submitted its Plan on *October 4, 2016*. The Plan falsely stated that the entire operating room team was interviewed and counselled (Exhibit 10, p. 4), but Dr. O'Hanlan and Ms. Charvonia were never interviewed. Had Ms. Charvonia been interviewed, she would have explained that they were intimately familiar with how the surgical pause in Dr. O'Hanlan's surgeries differed from those of other surgeons only because she fills in the patient's medical history and operative concerns. They could each have clarified that every Pause in her OR is entirely consistent with the Sequoia Hospital sanctioned Safety Checklist and the World Health Organization Surgical Safety Checklist. Dr. O'Holleran testified that the Policy is followed in Dr. O'Hanlan's OR. There is concern about whether the four other surgeons at Sequoia who had performed wrong-site surgery were disciplined as well.

132. The Hospital's Plan of Correction falsely stated that Dr. O'Hanlan, the attending surgeon, was "immediately counseled" about the Universal Protocol policy and told she

supposedly "cannot lead" the Time-Out procedure. (Exhibit 10, p. 10.) In fact, Dr. O'Hanlan was never interviewed or even aware of the CDPH investigation until discovery in her proceedings months later. If she had been, she would have disputed the allegation and affirmed that she already follows the protocol meticulously.

133. Her pause participation exceeds the standard of care and confuses no one. No one has complained in 3,500 cases, except Nurse Lau, a senior nurse who has worked with Dr. O'Hanlan for 14 years and has never complained about Dr. O'Hanlan in any way, until this case, when she needed to deflect blame for her error. The CDPH fined Sequoia $45,000 for Nurse Lau's errors, and could have, but did not, refer Dr. O'Hanlan to the Medical Board for investigation of this incident.

134. Dr. O'Hanlan was never informed of the CDPH findings and report, and had no idea how she could have made such an error. But Sequoia QA Staff knew years before the peer review proceedings against Dr. O'Hanlan, and shortly after the patient case, that Nurse Lau failed to follow policy and falsified the chart. Ruthlessly, Sequoia QA staff kept the truth from Dr. O'Hanlan, watching silently as she took all the blame when she met with the family a few months later for another debrief.

135. Head Nurse Charvonia, in charge of OR Gynecology Services, having observed Dr. O'Hanlan since 2003, testified to the JRC that she has always complied with the timeout procedure. She has brought students in to observe Dr. O'Hanlan's meticulous timeout. Ms. Charvonia acknowledges that the Pause checklist requires active participation, a discussion about patient's pertinent medical issues, by everybody in the operating room: surgeon, anesthesia, and the scrub nurse. No nurses have ever complained to her about Dr. O'Hanlan's Pause.

136. Dr. O'Holleran, has operated with Dr. O'Hanlan for 2,500 cases over 14 years, and endorsed Dr. O'Hanlan's inclusion of all the basics, saying it adds safety.

137. Three Anesthesiologists, Dr. Parris, Dr. Bradley, and Dr. Keshavacharya, whose teams have participated in every pause in all Dr. O'Hanlan's 3,500 Sequoia cases, find her to be careful, professional and certainly not disruptive. No anesthesiologist has ever complained of Dr. O'Hanlan's pause or of Dr. O'Hanlan.

4. The Decision Wrongly Blamed Dr. O'Hanlan and the Case Scheduling Form Instead of Nurse Lau's Error

138. The protocol states: "At time of procedure scheduling: When a procedure is scheduled at the physician's request, the person responsible for scheduling the procedure will confirm that the posting includes the following elements: the correct patient*, intended procedure* (italics ours) and site/side/level." (Exhibit 9, p. 2.)

139. The Sequoia investigation reveals the Director of Perioperative Services admitting "That was just a request for a time slot from the doctor's office." Registered Nurse Lau improperly substituted it for the consent in the Pause. It is neither a medical document nor part of the clinical chart. It is stored in the back of the chart with insurance statements and other non-medical, administrative, financial, insurance, admission and accounting forms. It is never even seen by Dr. O'Hanlan or most physicians, and plays no role in the operating room.

140. The Sequoia investigation states: "However, in error, the surgeon scheduled the case with the hospital's OR scheduler as including the removal of the ovaries." The Decision makes frequent reference to the administrative scheduling form in an attempt to place more blame on Dr. O'Hanlan.

141. The Policy recognized that changes in the intended procedure may be necessitated by patient's choice, or as new findings or pre-operative testing may indicate. The

standard of care does not require notifying the hospital scheduling department if a woman changes her mind about whether or not to have her ovaries removed, because neither the reservation for the OR timeslot, nor the equipment needed is affected. This is likely why the World Health Organization requires confirmation of the procedure using only the Signed Consent.

5. The Decision Wrongly Found That Dr. O'Hanlan Did Not Learn from Her 2002 Experience of "Forgetting And Not Reviewing"

142. At Stanford, in 2002, before the Universal Protocol was established, Dr. O'Hanlan was indeed at fault because during that operation she totally focused on the difficult surgery and forgot the consent, wrongfully removing the ovaries. She took honest and full responsibility for her error. There was no Pause policy at that time.

143. Dr. O'Hanlan took blame before the family, and when she met with the AHC, she clearly said the error was unforgiveable. But she also firmly blamed the OR Nursing staff for failing the "fail-safe" policy on which she reasonably relied. While Dr. O'Hanlan is the captain of the surgical ship and must take outward responsibility, the staff are required and reasonably expected to do their job, follow policy and not let the boat sink. Dr. O'Hanlan did not check to see *if the nurse was following hospital policy and reading from the correct consent form*, something that never occurred to her to do or would have reasonably been expected her to have been done, nor was required to have been done in all of the 15 years of working with Nurse Lau.

144. Ruthlessly, Sequoia QA staff would also later try to blame Dr. O'Hanlan of "again forgetting" the consent,(Mar 20 p59) and making the same mistake 14 years and 3,500 cases later. The AHC, MEC, and JRC, were all the while aware that a patient can change her mind up to the last minute, as they knew Dr. O'Hanlan reiterated to her in pre-op. Dr. O'Hanlan did not forget this time—she was misled.

L. Second "Milestone" Patient Case: Patient 8 (San Luis Obispo Case, MRN 910425)

145. Patient 8, MRN 910425, referred to by the JRC as the "San Luis Obispo case," was another 'milestone' case that was, in fact, properly handled in all ways by Dr. O'Hanlan. Dr. O'Hanlan performed the patient's gynecologic surgery, where she saw a diseased appendix. She asked her assistant, Dr. O'Holleran, a General Surgeon, to perform a necessary appendectomy. The patient later had abdominal bleeding a few hours after surgery. Dr. O'Hanlan took the patient back to the operating room and examined her abdomen for 45 minutes, finding no signs of ongoing abdominal bleeding, as is often the case. The hemoglobin blood level after the surgery was good at 35. The patient was approved for discharge, opting to stay overnight due to the distance of the Hospital from her home. Dr. O'Hanlan briefly talked to the patient informally the next morning. The patient was feeling fine, with consistently normal vital signs throughout the night. With bags packed, she was preparing to leave with her husband.

146. On the drive back home, which is many hours away from the Hospital, the patient's husband called Dr. O'Hanlan, advising her the patient was not feeling well. Dr. O'Hanlan took his report seriously and did not allege that the patient was having a panic attack as the patient later wrote in her complaint. Dr. O'Hanlan and the husband agreed to watch the patient a bit more, and when he later called again, indicating she had blood-tinged stool at a rest stop along the way, Dr. O'Hanlan suspected intestinal bleeding had developed after she had been discharged. Dr. O'Hanlan gave them the option to either come back to Sequoia, which was Dr. O'Hanlan's preference as she was intimately familiar with the patient's anatomy and history, or, if they felt it was too urgent for that, go to a nearer hospital about an hour away. The Decision incorrectly found that Dr. O'Hanlan "instructed" them to return. As the patient did not testify, the unrebutted testimony and documentary evidence was that Dr. O'Hanlan did not "instruct"

the patient to return. The patient chose to return to Sequoia, and Dr. O'Hanlan fixed the intestinal bleeding site. JRC testimony from Dr. O'Holleran, the only General Surgeon to testify, supported this decision as safe, reasonable and standard of care.

147. Dr. O'Hanlan treated the patient when she returned with no problems of any kind. The criticisms were that she supposedly 'instructed' the patient to return to Sequoia, which is simply false; and that she failed to get a repeat hemogram before the patient was discharged. Dr. O'Hanlan did get a hemogram after the surgery and it was normal. A series of repeated hemograms is only required if the patient has symptoms suggestive of ongoing abdominal bleeding occurring after surgery, such as low blood pressure, high heart rate or pain. Her vital signs were normal at time of discharge. The discharge orders signed the previous day permitted the patient to depart when she had entirely normal vital signs and organ function. There was no indication, as the Decision (p14) wrongly alleges, to repeat the hemogram again the next morning. The Decision does not provide *any* basis for the allegation of poor clinical judgment. No other surgeon has provided any testimony that Dr. O'Hanlan showed poor clinical judgment. Dr. O'Hanlan regrets this patient's unfortunate outcome and is glad that she could repair the intestinal leak laparoscopically.

M. <u>Third Milestone Case, Patient 9 (Aorta Case), Did Not Involve *Any* Dishonesty</u>

148. Patient 9, the 'aorta' case, has already been discussed, indicating Dr. O'Hanlan properly handled it within the standard of care. This further discussion expands on the lack of dishonesty of any kind.

149. The Appellate Review Committee incorrectly affirmed the Hearing Committee's false finding (Exhibit 5, p. 17), stating, "Intentional dishonesty... demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine."

150. The Appellate Review Committee affirmed the Hearing Committee's finding that Dr. O'Hanlan was guilty of a "perfidious pursuit of obfuscation, in attempting to cover up the truth in the operative reports" (Exhibit 5, pp. 16-17), which is not remotely supported by substantial evidence and is shockingly inaccurate.

151. The Hearing Committee, affirmed by the Appeal Review Committee, found that Dr. O'Hanlan was dishonest in her operative report dictated for Patient 9 (Aorta case, MRN 920824). It made a finding that Dr. O'Hanlan had attempted to falsify the record by altering her original report by attempting to "erase" the first two operative reports of Patient 9 (Aorta Case, MRN 920824). What actually happened, as both Dr. O'Hanlan and Dr. O'Holleran, her assistant surgeon, testified, is as follows: Dr. O'Holleran had participated significantly in the surgery and provided important collaboration. Dr. O'Hanlan, as she told the MEC on August 28, 2019, wanted Dr. O'Holleran to receive equal remuneration and offered to bill as "co-surgeon" with him. The assistant surgeon usually gets 20% of the billing that goes to the primary surgeon, which is 100% (out of a total compensation by insurance of 120%). Because Dr. O'Holleran, Dr. O'Hanlan's assistant surgeon on that case, contributed significantly, Dr. O'Hanlan wanted to bill as co-surgeons so both would get 60%, for the same total compensation, more evenly allocated to Dr. O'Holleran.

152. Both Dr. O'Hanlan and Dr. O'Holleran explained to the MEC before the recommended revocation and testified at the hearing that Dr. O'Holleran did not know how to bill as co-surgeons, nor did Dr. O'Hanlan. In an attempt to implement this, Dr. O'Hanlan offered to dictate a *draft* operative note for each of them to subsequently revise and redictate into their own operative reports as co-surgeons. Later, when they did not think that billing as co-surgeons would work as they had hoped, Dr. O'Hanlan deleted the *drafts* by herself and Dr.

O'Holleran. The Chief of Staff inaccurately stated that Dr. O'Hanlan's deleted operative reports had been signed by her and Dr. O'Holleran, when neither had been.

153. Both Dr. O'Holleran and Dr. O'Hanlan testified under oath that they were trying to bill as co-surgeons but ultimately decided against doing so. The draft she made for Dr. O'Holleran states "Dictated for Dr. O'Holleran. It was dictated in first person for Dr. O'Holleran and uses third person for Dr. O'Hanlan. There is no mistaking that this draft was intended for Dr. O'Holleran. Dr. O'Holleran changed his mind just after she had created the drafts, stating that his billers would not know how to post the billing as a "co-surgery," and that they might lose the entire billing. There was never any testimony to the contrary. However, the MEC and the JRC decided to review the *unsigned, undated drafts* which were never part of the patient's record and which Dr. O'Hanlan had requested to be deleted and which had never been submitted anywhere. These discarded drafts were never read or edited or dated by Dr. O'Hanlan or Dr. O'Holleran, were never intended to be used, and were never a part of the patient's chart. *The only reason the MEC even had the drafts was that they were produced by the dictation department when a request was made for the operative report*; they produced the *unsigned, undated* deleted drafts along with the report she actually signed, dated, billed from, and that was legally a part of the patient's record.

154. In the actual and final operative report, Dr. O'Hanlan took full responsibility for the small rent in the aorta. There was absolutely no dishonesty of any kind.

155. Based on these *drafts*, despite Dr. O'Hanlan and Dr. O'Holleran's explicit written explanation and oral testimony prior to and at the JRC hearing, the JRC made the shockingly erroneous and damning finding that she had engaged in "a perfidious pursuit of obfuscation, in attempting to cover up the truth in the operative reports." (Exhibit 4, Hearing Committee Decision, p. 19.) The Appellate Review Committee affirmed this finding, stating,

"Intentional dishonesty... demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine." (Exhibit 5, p. 17.) These astounding leaps to condemn Dr. O'Hanlan's moral character are plainly not supported by substantial evidence and must be set aside.

156. These astounding leaps to condemn Dr. O'Hanlan's moral character are plainly not supported by substantial evidence and uncontested testimony and must be set aside.

N. Other Patient Cases

157. Though they were not discussed in any detail in the Hearing Committee Decision or the Appeal Review Committee Decision, the other patient cases in the charges are discussed herein to some extent.

158. Dr. O'Hanlan is accused of poor compliance with consent issues. She had already agreed to amend her consent procedure in three instances:

a. On May 8, 2015, Dr. O'Hanlan was staging a patient with unexpected cancer and removed her appendix without consent, taking the risk that the patient would appreciate the thorough staging, which she did.

b. On May 24, 2016, Dr. O'Hanlan failed to create a new consent form and simply amended the existing consent to include port placement. *She indicated she would not do this again.*

c. On August 16, 2016, Dr. O'Hanlan asked a pre-operative nurse to ask a patient, whom she had extensively counselled about her choice to remove or keep her ovaries as purely her choice, to find out the patient's decision. She did not ask the nurse to counsel the patient. *She indicated she would not do this again.*

d. On September 20, 2016, Dr. O'Hanlan was asked to rewrite a consent that included removal of the uterus and ovaries, but did not include removal of the tubes, and she

declined. because the tubes are connected to and in between the ovaries and uterus and would necessarily be removed with them. *She indicates she would not do this again.*

e. On March 13, 2017, Dr. O'Hanlan did not remove a retrocecal appendix incidentally because it was dangerous to do so. The patient agreed.

O. <u>The Overwhelming Evidence For Dr. O'Hanlan's Competence, Carefulness, and Attention to Detail</u>

159. Of the 10 physicians (O'Holleran, Parris, Bradley, Keshavacharia, Wilson, Havard, Noblett, Beingesser, Micha, Gillon) providing testimony who were familiar with Dr. O'Hanlan's practice standards and care, there were two medical oncologists, who refer only to Dr. O'Hanlan, specifically for her cancer surgery skill and aggressiveness, one for 12 years, and one for 20 years. They both confirmed that her surgery is planned properly in conjunction with the timing of chemotherapy and that they continue to consult closely in her cases while the patients are in Sequoia. They applauded her for providing nutritional supplementation, placing intraperitoneal ports, and providing good follow-up information.

160. Among the 10 physicians providing testimony were three former or current Chiefs of Staff who affirmed that Sequoia Administration failed to meet Quality Assurance standards of care by not providing Dr. O'Hanlan at the start of proceedings with all concerns and data about her care. One, a Chief for 10 years at UC-Irvine, testified "there was no reason the data should not have been shared with her." She affirmed the validity of NSQIP, that a 4.5% complication rate was normative, and had never heard of the MIDAS computation that alleged a 20% takeback rate, affirming that Dr. O'Hanlan's correct rates of complications did not indicate need for investigation, much less summary suspension. She stated, "I think she's one of the most outstanding surgeons I've ever been able to observe.

161. The senior-most General Surgeon at Sequoia, who had operated in over 2,500 cases with Dr. O'Hanlan affirmed all of the above and gave overwhelming and thorough positive testimony about Dr. O'Hanlan's quality of care. The 10 physicians included a vascular surgeon who affirmed that Dr. O'Hanlan had good skill, was well mannered, appropriately aggressive in her treatment approach, and has the most difficult cases at Sequoia.

162. The 10 experts included three anesthesiologists who have assessed her pre-operative planning for every one of her 3,500 cases since she started at Sequoia, with the Anesthesia Chair saying that she represented the consensus of her group endorsing Dr. O'Hanlan's preoperative planning and consultations with them to optimize intra-operative and post-operative care, saying that everybody respects her and likes working with her and that she is a good team player.

163. The 10 experts included three senior Gynecologists. One of these had Dr. O'Hanlan perform surgery on herself and a family member. She considers Dr. O'Hanlan a mentor, with 25 years of observing Dr. O'Hanlan's care and 15 years of operating with her. She confirmed that it is impossible that Dr. O'Hanlan had a 20% take-back rate and that Dr. O'Hanlan is amongst the very best among the community of all gynecologic surgeons. She affirmed that Dr. O'Hanlan's care of patient DD, LO, and CH was correct and suggested that Dr. O'Hanlan obtain extra blood counts in complicated bleeding cases. She reported that Dr. O'Hanlan reflects and learns from each of her complications to maintain the highest standard of patient care.

164. Dr. Micha, the only Gynecologic Oncologist providing testimony, stated that "she really is one of the top five advanced laparoscopic surgeons in the country -- in the whole country. I mean, that's probably how I ended up meeting you because some of our partners have gone to her courses… it's really amazing what she does, and she does it at this hospital." ."

165. Every one of the 10 experts regarding Dr. O'Hanlan's practice standards and care has testified that she has the hardest cases which none of the other doctors at Sequoia could do. Every one has said that they would refer their family members to her for her appropriately aggressive, potentially lifesaving surgical care. Every one has said that Dr. O'Hanlan is appropriate in her interactions with staff, collaborating and consulting when needed. Every one has said that she has good preoperative preparation and follows her patients well, including those few with complications.

166. These 10 colleagues have also collectively affirmed the specific care of LO, SW, TT, DD, CH, JS, HG, SS, and every aspect of KM's care; and that CH and SS complications were due to Sequoia nursing errors. Among the 28 complicated cases and 4 added to the list having occurred after initiation of the AHC, making 32 all told: 19 (59%) had a malignancy, and 22 (69%) of them had already been adjudicated as having been handled within the standard of care. These files were subjected to a repeat retrospective biased microdissection of the hospital chart resulting in the rebuttable criticisms of Dr. O'Hanlan's care. Three experts stated that a patient could not have had a higher caliber of care than that offered by the combination of a Gynecologic Oncologist operating with a General Surgeon. In what is shown by September 2017 to be 47 complications out of 641 patients, or 4.9% of Dr. O'Hanlan's cases by which she said she should judge Dr. O'Hanlan, there is no repetitive error, no negligence, and no threat to future Sequoia patients.

167. The AHC Chair admitted to the Hearing Committee that the positive reviews of Dr. O'Hanlan were ignored and instead the negative ones "were the things that persuaded us to make our decision. But the rates really do matter and really do reflect quality of patient care, planning and follow-through.

168. If Dr. O'Hanlan were a poor physician, she would have high rates of infections, complications and takebacks. If Dr. O'Hanlan were *unreflective* as alleged by Sequoia, the evidence would show more complications from her care over the prior 15 years. If she *lacked insight*, or was *poorly prepared for surgery,* the evidence would show complaints by Anesthesiologists, and more unexpected ICU admissions for medical, not surgical, complications. If she had *poor judgment,* or even one of the *character defects* Sequoia accuses Dr O'Hanlan of, the evidence would show higher infection rates, higher take-backs, poor patient reviews, complaints from those familiar with her care, or deaths.

169. These Sequoia "findings" are, in fact, criticisms of Dr O'Hanlan's strong personality, as perceived by those biased aforehand to think she has dangerous 17-26% take-back rate, who remained unaware that the Sequoia CMO and COS had misled them throughout the proceedings. The Sequoia Chief of Staff testified that Dr. O'Hanlan lacked remorse at her meeting with the AHC, but that was merely a reflection of Dr. O'Hanlan's absence of guilt about her normative complication, infection and takeback rates or even severity of her complications. Instead of acknowledging their error, and retracting their allegations, Sequoia dug in and retrospectively micro-dissected 1.4% of Dr. O'Hanlan's cases, assaulting her personality in the process and ignoring Dr. O'Hanlan's completely favorable data consistently shown in Sequoia's data. While Dr. O'Hanlan benefits from attending QA meetings, and learns from her complications, under no circumstances was there ever an objective reason for her expulsion, or suspension.

170. The governing board, via the Appellate Review Committee, issued its final decision on February 14, 2020 (Exhibit 5). The present writ petition is timely filed.

///

///

CAUSE OF ACTION FOR WRIT OF ADMINISTRATIVE MANDAMUS (Code Civ. Proc., § 1094.5)

(Against All Respondents)

171. Petitioner refers to and incorporates by reference each and every allegation of the prior paragraphs.

172. Respondent committed prejudicial abuse of discretion pursuant to Code of Civil Procedural section 1094. 5, subdivision (b), in that Petitioner was not provided a fair hearing, Respondents failed to proceed in the manner required by law, Respondents' decisions are not supported by the findings, and the findings are not supported by the evidence.

173. Petitioner was not provided a fair hearing for many reasons, including but not limited to the following: (a) the faulty data used in determining her complication rates, which were grossly erroneous and badly biased the investigation and hearing, with such bias further reflected in the stunningly erroneous findings that Dr. O'Hanlan was a perfidious and immoral liar; (b) the improper exclusion of evidence of or even discussion about key evidence, particularly (but not only) the CDPH report regarding Patient 5 and the peer review report of Dr. Safi regarding Patient 9; and (c) the reliance on an external reviewer as the only gynecologic oncologist consulted while declining to call her as a witness at hearing, depriving Dr. O'Hanlan of any opportunity to cross-examine her.

174. Substantial evidence does not support any of the adverse findings on any of the patients raised in the charges or made by the JRC, ARC, or governing board.

175. Respondent failed to proceed in the manner required by law, for many reasons, including but not limited to the following: (a) Respondent's refusal to abide by the Bylaws when they investigated Petitioner's medical practice, and (b) the JRC to include a physician who

practices gynecologic oncology even though it was easily feasible to have included such a physician.

176. Respondents' decisions upholding the summary suspension and its continuation by the MEC past fourteen days are not supported by the findings for various reasons, including but not limited to the absence of imminent danger to patient safety, required under Business and Professions Code section 805..

177. None of the JRC or Governing Board's adverse findings against Petitioner are supported by substantial evidence.

178. Petitioner has exhausted all available administrative remedies.

179. Petitioner does not have a plain, speedy, and adequate remedy at law.

PRAYER FOR RELIEF

WHEREFORE, Petitioner prays for judgment as follows:

1. That a peremptory writ of mandamus be issued pursuant to Code of Civil Procedure section 1094.5;
2. For reasonable attorney fees pursuant to Government Code section 800;
3. For reasonable attorney fees pursuant to Code of Civil Procedure section 1021.5;
4. For costs of this action; and
5. For such other and further relief as this court deems just and proper.

DATED: February 14, 2023 FENTON LAW GROUP, LLP

/s/ Dennis E. Lee
Nicholas D. Jurkowitz
Dennis E. Lee
Attorneys for PETITIONER
KATE O'HANLAN, M.D.

EXHIBIT 1

Dignity Health
Sequoia Hospital

Medical Staff Services
170 Alameda de las Pulgas
Redwood City, CA 94062-2799
(650) 367-5554

James Torosis, M.D., FACP
President of the Medical Staff

CONFIDENTIAL

August 22, 2017

Katherine O'Hanlan, M.D.
4370 Alpine Road, #104
Portola Valley, CA 94028

Re: Notice of Summary Suspension

Dear Dr. O'Hanlan:

This is to confirm our telephone conversation of August 21, 2017, in which I informed you of the Medical Executive Committee's ("MEC's") decision that evening to summarily suspend your clinical privileges at Sequoia Hospital. The suspension is effective immediately, and will remain in effect pending the results of the ongoing Ad Hoc Committee ("AHC") investigation.

Article VII, Section 7, of the Medical Staff Bylaws ("the Bylaws"), gives the MEC the authority to summarily suspend a practitioner's clinical privileges upon determining that "the failure to do so may result in an imminent danger to the health or safety of any individual, including current or future patients." The MEC has made that determination in this case, based on your conduct relating to the care of **Patient M.K., MR # 920824**, on August 8 and 9, 2017, in the context of pre-existing concerns about the safety of your surgical practice. Those concerns are reflected in a recent report from an outside expert who reviewed 7 of your cases, and in other cases that the AHC has discussed with you as part of its investigation. The AHC is in the process of preparing its written report to the MEC, but it is not yet completed.

The case of Patient M.K. resulted in the consideration of summary action at this time because it is representative of the types of judgmental and ethical problems that have been identified repeatedly in your practice, and because it demonstrates the seriousness of the risks that your patients face. More specifically, you obtained only "curbside" consults on issues that were of critical importance, without appropriate presentations of relevant data and documentation. Then, despite knowing that your planned surgery on this patient would expose her to a danger of life-threatening vascular complications, you did not arrange to be assisted by a vascular surgeon or even make concrete arrangements for a vascular surgeon to be immediately available in the event of a problem. During the procedure, the patient experienced a rent in the aorta which would likely have been fatal but for the coincidental presence of a vascular surgeon in the hospital and his ability to break away from another procedure that he was performing and come to your aid. Following the procedure, you dictated operative reports for both yourself and your assistant, which was highly irregular.

The rent was not mentioned in either of those reports, and was noted only in your third dictation, which was prepared after the event was described in the vascular surgeon's report. There were other concerns, as well, that I will not undertake to describe here.

Pursuant to Article VII, Section 7.3 of the Bylaws, the MEC will convene in a special meeting on Monday, August 28, 2017, at 5:45 p.m., to determine whether to continue, modify or lift the summary suspension. The meeting will be held in the Sequoia Room, at Sequoia Hospital. You are hereby asked to attend for the purposes making a statement on your own behalf and responding to questions from the MEC. You may also present a written statement or other materials, if you wish, either at or before the meeting.

Your meeting with the MEC will not be in the nature of a "hearing" as that term is used in Article VIII of the Bylaws; accordingly, none of the procedural rights or requirements of that section shall apply, and no attorneys may be present. Please contact Yulia Kennedy, CPCS, Director, Medical Staff Services, as soon as possible, at (650) 367-5710, or Yulia.Kennedy@DignityHealth.org, to confirm that you will attend.

Following your meeting with the MEC, you will be informed of the results as soon as possible. If the MEC decides to leave the summary suspension in effect for more than 14 days, it will be reported to the Medical Board of California in accordance with California Business & Professions Code §805, and you will be notified of your right to request a hearing under section VIII of the Bylaws. A report will also be filed with the National Practitioner Data Bank if your privileges remain suspended or otherwise restricted for more than 30 days.

If you have any questions regarding this process, please feel free to contact me, in writing, in the care of the Medical Staff Office.

Sincerely,

James Torosis, M.D.
Medical Staff President

EXHIBIT 2

CONFIDENTIAL

MEDICAL STAFF HEARING
AT SEQUOIA HOSPITAL

IN THE MATTER OF KATHERINE O'HANLAN, M.D.

NOTICE OF CHARGES IN SUPPORT OF MEDICAL EXECUTIVE COMMITTEE DECISION TO SUMMARILY SUSPEND CLINICAL PRIVILEGES PENDING RESULTS OF INVESTIGATION

I. Background Statement

Katherine O'Hanlan, M.D., is a member of the Department of Obstetrics & Gynecology ("the Department"), specializing in Gynecologic Oncology. In a memo to the Medical Executive Committee ("MEC") dated October 3, 2016, Beverly Joyce, M.D., Chair of the Department, and James Torosis, M.D., Medical Staff President, jointly requested that the MEC initiate an investigation of Dr. O'Hanlan's practice under the relevant provisions of the Medical Staff Bylaws ("the Bylaws"). The concerns revolved around Dr. O'Hanlan's rates of infection, surgical complication and return to surgery, as well as her professionalism and communication skills.

Based on the information presented, the MEC determined that an investigation was warranted. An Ad Hoc Committee ("AHC"), comprised of Virginia Chan, D.O., Chair, Sigal Tene, M.D., and Kent Adler, M.D., was appointed to conduct the investigation and report back to the MEC.

Despite the substantial concerns that precipitated the investigation, it was the assessment of the Medical Staff leadership that Dr. O'Hanlan should be allowed to continue to exercise her clinical privileges at Sequoia Hospital pending the results of the investigative process. This was based on the following standard for taking "summary action," as described in Article VII, Section 7.1.a., of the Medical Staff Bylaws ("the Bylaws"):

> "A member's clinical privileges may be summarily suspended or restricted where the failure to take such action may result in an imminent danger to the health or safety of any individual, including current or future hospital patients."

On August 21, 2017, the MEC held a special meeting to consider certain events that occurred on August 8-9, 2017, regarding Dr. O'Hanlan's care of a particular patient. Based on those events,

in the context of the pre-existing concerns, the status of the ongoing investigation, and the preliminary findings of the AHC, the MEC changed its assessment of the risks presented by Dr. O'Hanlan's practice and decided to summarily suspend her clinical privileges.

On August 28, 2017, the MEC convened another special meeting for the purpose of giving Dr. O'Hanlan an opportunity to comment on the issues and respond to questions relevant to the summary suspension. Following her presentation, which included a written statement, the MEC decided to keep the suspension in effect, under the original terms. Dr. O'Hanlan was so informed, and requested this hearing to challenge the MEC's decision. The Charges in support of the MEC's decision are stated below.

II. Charges in Support of the Summary Suspension of Dr. O'Hanlan's Clinical Privileges

The MEC's decision is supported by the following:

1. Dr. O'Hanlan's Care Of Patient M.K., MRN 920824

Patient M.K. was admitted to Sequoia Hospital on August 8, 2017, with recurrent endometrial cancer for tumor de-bulking from the aorta. A pre-operative CT scan showed a tumor with mass effect on the aorta, with irregularity of the adjacent intima.

Dr. O'Hanlan obtained only "curbside" consults on issues that were of critical importance, without appropriate presentations of relevant data and documentation. Then, despite knowing that her planned surgery would expose the patient to a danger of life-threatening vascular complications, she did not arrange to be assisted by a vascular surgeon or even make concrete arrangements for a vascular surgeon to be immediately available in the event of a problem. During the procedure, the patient experienced a rent in the aorta which would likely have been fatal but for the coincidental presence of a vascular surgeon in the hospital and his ability to break away from another procedure that he was performing and come to the aid of Dr. O'Hanlan's patient. Following the procedure, Dr. O'Hanlan dictated operative reports for both herself and her assistant, Dr. Michael O'Holleran, which was highly irregular. The rent was not mentioned in either of those reports, and was noted only in her third dictation, which was prepared after the event was described in the vascular surgeon's report.

2. The Context In Which The Case of M.K. Arose

The case of M.K. arose in the context of an ongoing formal investigation that was precipitated by serious concerns about Dr. O'Hanlan's professional performance. She was aware of the concerns, which focused on a manner of practice similar to that seen in the M.K. case.

For example, on June 13, 2017, the AHC had sent Dr. O'Hanlan a letter inviting her to address the following:

(a) The written report of an outside expert in Gynecologic Oncology who evaluated 7 specific cases and identified a pattern of problems with Dr. O'Hanlan's judgment, technique and documentation.

(b) Two other cases that did not require and were not sent for outside expert review, but were of concern to the AHC based on general principles of professional practice.

When Dr. O'Hanlan met with the AHC on July 13, 2017, she rejected the validity of all or most of the concerns in the cited cases. Subsequently, she submitted a letter dated July 19, 2017, insisting that her performance was within the standard of care and describing the entire peer review process as being inappropriate and attributable to unprofessionalism or lack of knowledge.

The details of the above-referenced cases and Dr. O'Hanlan's responses to the concerns will be discussed at the hearing to show that Dr. Hanlan is unreceptive to peer review input and unlikely to modify her manner of practice, which subjects patients to unreasonable risks of harm or substandard care.

3. The Status The AHC Investigation As Of August 21, 2017

At the MEC meeting on August 21, 2017, where the decision was made to summarily suspend Dr. O'Hanlan's privileges, the members of the AHC appeared for the purpose of commenting on the case of Patient M.K. They also described the status of their investigation, making specific reference to the following cases that underscored their concerns about Dr. O'Hanlan's practice:

- Patient C.H., MRN 888062
- Patient S.O., MRN 902469
- Patient S.S., MRN 903133
- Patient H.G., MRN 910425

All of the above cases have been discussed with Dr. O'Hanlan during the course of the AHC's investigation, and she is familiar with the issues and concerns. These cases, and Dr. O'Hanlan's responses, will be discussed at the hearing.

4. Dr. O'Hanlan's Presentation To The MEC On August 28, 2017

On August 28, 2017, Dr. O'Hanlan appeared before the MEC to address the issues resulting in the summary suspension of her privileges on August 21, 2017, including her care of Patient M.K., and the context in which that case arose. Prior to the meeting, she submitted a written statement dated August 24, 2017, making certain commitments regarding future vascular consultations, and offering her perspectives on the calculation and significance of her complication rates. Her presentation was duly considered, but it failed to resolve the MEC's concerns about her judgment and ethics based on the information that was available. A strong

majority of the MEC members continued to believe that allowing her to practice at Sequoia Hospital at this time may result in an imminent danger to the health or safety of patients.

This Notice of Charges may be amended or supplemented at any time prior to the completion of the hearing, subject to Article VIII, Sections 4.3. and 4.7.b. of the Bylaws.

October 6, 2017

James Torosis, M.D.
President of the Medical Staff

EXHIBIT 3

CONFIDENTIAL

MEDICAL STAFF HEARING
AT SEQUOIA HOSPITAL

IN THE MATTER OF KATHERINE O'HANLAN, M.D.

SUPPLEMENTAL NOTICE OF CHARGES IN SUPPORT OF MEDICAL EXECUTIVE COMMITTEE DECISIONS TO RECOMMEND REVOCATION OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES AND CONTINUE SUMMARY SUSPENSION OF CLINICAL PRIVILEGES PENDING FINAL ACTION ON THE REVOCATION RECOMMENDATION

I. Background Statement

On August 21, 2017, the Medical Executive Committee ("MEC") summarily suspended Dr. Katherine O'Hanlan's clinical privileges. This decision was based certain events that occurred on August 8-9, 2017, regarding her care of a particular patient, in the context of pre-existing concerns about her professional performance, which were then under investigation by an Ad Hoc Committee ("AHC").

On August 28, 2017, the MEC convened a special meeting for the purpose of giving Dr. O'Hanlan an opportunity to comment on the issues and respond to questions relevant to the summary suspension. Following her presentation, which included a written statement, the MEC decided to keep the suspension in effect, pending the results of the AHC investigation. Dr. O'Hanlan was so informed, and requested a hearing to challenge the MEC's decision.

On September 29, 2017, the AHC completed its investigation and submitted an 18-page report, including a recommendation that Dr. O'Hanlan's Medical Staff membership and clinical privileges be revoked. A copy of it was sent to Dr. O'Hanlan that day, with an invitation to meet with the MEC and discuss it on October 23, 2017. She was advised that the MEC would also consider certain historical information relevant to the validity of the current concerns, her credibility and professional integrity, her receptiveness to peer review input, and her demonstrated ability to learn from her mistakes and improve her performance.

After meeting with Dr. O'Hanlan on October 23, 2017, the MEC decided to adopt the AHC's recommendation that her Medical Staff membership and clinical privileges be revoked, and to continue the summary suspension of her clinical privileges, as initially imposed on August 21, 2017, pending final action by the Sequoia Hospital Board of Directors on the revocation recommendation. Dr. O'Hanlan was so informed in a letter dated October 24, 2017. She has made a timely request for a hearing to challenge those decisions.

Dr. O'Hanlan's requested hearing on the initial summary suspension was originally scheduled to commence on October 30, 2017. A Notice of Charges was issued on October 6, 2017, for use in that hearing. However, on October 10, 2017, Dr. O'Hanlan and the MEC stipulated, through legal counsel, that the hearing on the initial summary suspension was to be held in abeyance pending the outcome of the AHC investigation. Then, if the MEC were to take any further adverse action against Dr. O'Hanlan, and if she were to request a hearing regarding that action, the initial summary suspension and the subsequent action would be consolidated for review at a single hearing. This proceeding is the consolidated hearing.

The October 6, 2017, Notice of Charges in support of the initial summary suspension remains pending for purposes of the consolidated hearing. This supplemental Notice of Charges is in support of the decisions made by the MEC on October 23, 2017, to recommend revocation of Dr. O'Hanlan's Medical Staff membership and clinical privileges and keep the initial suspension in place.

II. Charges in Support of the MEC's Decisions to Recommend Revocation of Medical Staff Membership and Clinical Privileges and Continue the Pre-Existing Summary Suspension of Clinical Privileges Pending Final Action on the Revocation Recommendation

1. The October 6, 2017 Notice of Charges in Support of the Initial Summary Suspension on August 21, 2017, is incorporated herein by reference.

2. The MEC's October 23, 2017, decision to recommend revocation of Medical Staff membership and clinical privileges and continue the pre-existing summary suspension are further supported by the following:

   (a) The Ad Hoc Committee's final report and recommendation dated September 29, 2017, a copy of which accompanies this Notice as Attachment 1 and is incorporated herein by reference.

   (b) The MEC's determination, after speaking with Dr. O'Hanlan on October 23, 2017, regarding the issues described in its letter to Dr. O'Hanlan dated September 29, 2017, that she cannot be relied upon, going forward, to exercise good clinical judgment and otherwise provide patient care that meets the standards of quality required of physicians who practice at Sequoia Hospital. The MEC's letter dated September 29, 2017, accompanies this Notice as Attachment 2 and is incorporated herein by reference.

November 21, 2017

James Forosis, M.D.
President of the Medical Staff

ATTACHMENT 1

CONFIDENTIAL

MEMORANDUM

TO: **Medical Executive Committee, Sequoia Hospital**

FROM: **Ad Hoc Investigative Committee ("AHC"):**

Virginia Chan, D.O., Chair
Sigal Tene, M.D.
Kent Adler, M.D.

DATE: **September 29, 2017**

RE: **Katherine O'Hanlan, M.D.**

I. INTRODUCTION

Katherine O'Hanlan, M.D., is a member of the Department of Obstetrics & Gynecology ("the Department"), specializing in Gynecologic Oncology. In a memo to the Medical Executive Committee ("MEC") dated October 3, 2016, Beverly Joyce, M.D., Chair of the Department, and James Torosis, M.D., Medical Staff President, jointly requested that the MEC initiate an investigation of Dr. O'Hanlan's practice under the relevant provisions of the Medical Staff Bylaws ("the Bylaws"). The concerns revolved around Dr. O'Hanlan's rates of infection, surgical complication and return to surgery, as well as her professionalism and communication skills.

Based on the information presented, the MEC determined that an investigation was warranted. This Ad Hoc Committee ("AHC"), comprised of Virginia Chan, D.O., Chair, Sigal Tene, M.D., and Kent Adler, M.D., was appointed to conduct the investigation and report back to the MEC.

We convened for the first time on November 3, 2016, and met as a committee on 18 occasions. During and between our meetings, we reviewed all 28 cases that were evaluated previously in the Medical Staff's routine peer review process, plus additional cases that were brought to our attention during the investigative process. In many instances, the cases could be evaluated adequately internally, based on our collective expertise and the nature of the issues. However, for 7 of the cases, the AHC decided to obtain outside reviews by an independent expert. The expert, who was identified through a health care consulting firm, is an Associate Professor and Director of the Division of Gynecologic Oncology within the Department of Obstetrics & Gynecology at

a major University Medical Center outside of California. Her qualifications were carefully reviewed by the AHC before the engagement was finalized. We received her written report in late May, 2017. In addition to the specific case reviews, we personally interviewed 5 physicians and 7 Sequoia Hospital staff members.

Dr. O'Hanlan took an active part in the investigation from the outset, by submitting letters and accompanying materials defending her practice. She was sent a copy of the outside expert's report, and given an opportunity to address it personally at a meeting with us on July 13, 2017. Her comments were supplemented by a 13-page letter dated July 19, 2017.

Doctors Torosis and Joyce monitored the investigation and provided support. We also had support from the Medical Staff's attorney, Mr. Harry Shulman, and the Director of Medical Staff Services, Yulia Kennedy, CPCS.

The results of the investigation are set forth below.

II. FINDINGS

A. OVERVIEW

After reviewing Dr. O'Hanlan's cases that went through Department Peer Review between 2014-9/2016, we quickly recognized some of her recurrent problems surrounding her judgement and professionalism. We question her judgement preoperatively, intraoperatively, and postoperatively. We are concerned about her patient selection for surgery and preoperative clearance and workup. In the operating room, we are concerned about how aggressive she is as a surgeon and her high number of complications. Postoperatively, Dr. O'Hanlan has made poor decisions regarding patients' medical conditions and has discharged patients who might not have been stable for discharge.

We sent some cases to an outside expert to evaluate, and her overall impression was that Dr. O'Hanlan had poor documentation, that she does not review discharge labs and other findings which resulted in complications that required readmission, and that she was reluctant to seek help from other subspecialties. We also received complaints, both formally and informally, regarding her behavior with staff and patients.

During our interview with Dr. O'Hanlan, she was very defensive and disagreed with almost all of the points made by the outside reviewer. After this interview, she followed up with a 13 page letter to the Ad Hoc Committee criticizing our committee, the Chief of Medical Staff, the Obstetrics/Gynecology Department Chair, particular members of the medical staff and administration, and discrediting our outside reviewer. Throughout this process, she repeatedly blamed others for most of her bad outcomes and did not assume responsibility as we expect any admitting doctor and primary surgeon would.

Below is a list of cases that illustrate our concerns regarding her judgement and patient care. These cases are listed chronologically and demonstrate a recurrent pattern of concerns.

B. SPECIFIC CASE EXAMPLES

1. Patient C.H., MRN 888062, Events 11/11/14 to 11/18/14

SYNOPSIS

In November 2014, C.H. was an 89 year old woman from Hanford, CA with insulin pump-dependent diabetes mellitus and a history of coronary artery disease (requiring stent placement). On 11/11/2014, C.H. was admitted by Dr. O'Hanlan as a 23-hour stay for resection of a 22 cm pelvic mass associated with elevated CA-125. The H&P describes a baseline creatinine of 2.0 and a hemoglobin of 10.8 gm/dl (results not in Cerner). Dr. O'Hanlan performed diagnostic laparoscopy, exploratory laparotomy with resection of right ovarian tumor and bilateral salpingo-oophorectomy. (Eventually the pathology report described a benign tumor, cystadenofibroma of the right ovary). Initially, there was no pre or peri-operative involvement of a hospitalist or endocrinologist. Dr. O'Hanlan wrote orders for the insulin pump to be started after surgery; this did not occur. Naproxen and Celebrex were used as pain medications (relatively contraindicated with renal insufficiency). At 2103 on 11/11/14, blood glucose was 391. By 2300, C.H. was persistently hypotensive. By the morning of 11/12/14, C.H. continued to be hypotensive and was less responsive. At 0510 on 11/12, creatinine was 3.10, bicarbonate was 19 and hemoglobin was 7.9 gm/dl. At 0747, glucose had reached 413. By mid-day on 11/12, consultations with hospitalist, intensive care and endocrinology services were obtained. Chest x-ray showed a possible infiltrate. C.H. was transferred to the ICU. Her creatinine eventually reached 4. During her ICU stay, she required vasopressors and antibiotics. C.H. recovered, and was able to be discharged home on 11/18/14. There were no progress notes from Dr. O'Hanlan (or a covering physician) on 11/12, 11/13, 11/16 and 11/17/14.

CONCERNS

The outside consultant described C.H. as at "...high risk of post-operative morbidity." The consultant went on to add, "In patients who are at high risk for post-operative morbidity due to known health issues....involving other services such as hospitalist, endocrinologist, would have potentially avoided this problem." The ad hoc committee strongly agrees with these statements. In addition, the ad hoc committee has concerns that, potentially, C.H. should not have been admitted as a 23-hour stay; a full admission should have been planned from the start. During the ad hoc committee's interview with Dr. O'Hanlan on 7/13/17, she stated that her management was not the

cause of C.H.'s clinical deterioration. She described C.H.'s diabetes as stable, and defended the idea that a 23-hour stay was an appropriate initial plan. She also continued to feel that planned peri-operative hospitalist and/or endocrinology was not necessary.

Given the circumstances and Dr. O'Hanlan's very recent responses to the ad hoc committee, the AHC feels that similar episodes are likely to continue to occur.

2. Patient J.S., MRN 716341, Events 3/31/15 to 4/22/15

SYNOPSIS:

The patient was a 74-year-old woman who was diagnosed with advanced adenocarcinoma of the ovary in January/February 2015. CA125 was over 300. CT on 2/4/15 confirmed extensive widely metastatic tumor, and on exam, there was invasion into the vagina by a 5cm mass. She was treated with 2 cycles of Carboplatin/Taxol and was taken to the OR either 6 or 11 days after cycle #2, on 3/31/15. Surgery involved diagnostic laparoscopy, exploratory laparotomy, optimal and extensive tumor debulking (about 2 hours of resection on small bowel nodules alone), small bowel resection, subtotal colectomy, ileosigmoidostomy, posterior exenteration, repair of cystotomy and diaphragm. Estimated blood loss was 1500ml, and patient received 4 units of packed RBC intraoperatively. Due to acidemia and concern for small bowel ischemia, on 4/1/15, POD#1, she was taken back to the OR for small bowel perforation, small bowel ischemia, as well as ischemia of the ileocolic anastomosis. 2 additional small bowel segments and the ileocolonic anastomosis were excised, as well as repair of multiple small bowel "enterotomies." She was intentionally brought back to the OR on 4/2/15 for repeat re-exploration, repair of possible ischemic areas, and creation of an end-ileostomy. Dr. O'Hanlan also placed an intraperitoneal port-a-cath. Levaquin and Flagyl were stopped on 4/3/15.

On 4/11/15, patient's WBC was 18.4 with a left shift. She was afebrile and feeling better. Overnight, her temperature rose to 38.3, but WBC dropped to 16. A CT showed extraluminal contrast in the left anterior upper pelvis with associated abscess. She was also restarted on Levaquin and Flagyl.

She went back to the OR on 4/12/15. Findings showed a perforation of the small bowel, and the IP port was removed. Cultures obtained showed heavy growth streptococcus viridian's group and rare candida albicans. Her final surgery was on 4/13/15 to irrigate and place retention sutures. This was a scheduled surgery as follow up from her abscess on 4/12/15. ID was consulted on 4/13/15 due to culture findings and gram negative rods. She was started on aztreonam, Flagyl, linezolid. She apparently was on Vancomycin as well at this time, which was stopped. She was extubated on 4/14/15 and modifications were made to IV antibiotics per ID based on cultures. Her WBC was down to 18. Fluconazole was added 4/15/15 due to cultures. WBC was 14.5 on

4/15/15. On 4/16/15, the aztreonam and linezolid was discontinued and levofloxacin was started due to culture results. Her NGT was discontinued on 4/17/15 after passing stool. She was started on oral diet on 4/20/15. She was on TPN prior. She was changed to oral antibiotics on 4/21/15 when her WBC was down to 10.5. Her drains were removed, and she was scheduled to be discharged with oral antibiotics x 7 days. She had a questionable appetite on 4/21/15, and she was discharged to home the next day.

CONCERNS:

Based on Dr. O'Hanlan's operative report details, there was so much disease in the abdomen and pelvis. It is hard to believe someone would continue to operate. We are not gynecology oncologists, but interestingly, our outside reviewer had also questioned her judgement to continue with surgery and stated, "the surgeons should have followed their initial instinct that the 'disease was not resectable' and ended the procedure...she was taken back to the OR with at least 24 areas of concern." These areas were oversewn. This patient had 5 operations during this admission.

The timing of surgery with respect to neoadjuvant chemotherapy was also in question. Checking hematologic factors preoperatively is done to ensure adequate bone marrow recovery and assess the response to the chemotherapy prior to surgery. Dr. O'Hanlan clearly stated that the patient had 2 cycles of neoadjuvant chemotherapy, but no dates were given, and that "a CBC will be performed within the week prior to surgery and will be appended to the chart" per her preoperative H&P. We see postoperatively a WBC of 3.6 on POD#0 and 2.1 on POD#1. Upon reviewing Dr. Tene's (the ICU physician's) and Soda's (the ID consultant's) notes postoperatively, the last chemotherapy was actually given only between 7 to 11 days prior to surgery, when "a relatively compromised bone marrow function ultimately will place the patient at higher risk. There is no risk to the patient to delay surgery until adequate bone marrow function is documented," per our outside reviewer. Generally, a 3 to 4 week period of recovery after the last chemotherapy administration would be utilized to optimize bone marrow recovery prior to an interval debulking surgery; the recovery period was clearly shorter (estimated at 7 to 11 days); suboptimal blood count recovery from the chemotherapy would place the patient at higher risk of serious perioperative infection and poor wound healing. During our interview with Dr. O'Hanlan, Dr. O'Hanlan was not aware of this recent chemotherapy treatment 7-11 days prior to surgery. It turns out Dr. Wilson (the patient's medical oncologist) had given the patient a "half dose chemo" in addition to the 2 prior cycles of chemotherapy. If she had paid closer attention to the patient's multidisciplinary care, she should have noted this preoperatively, or at least during her hospitalization since both Dr. Tene and Dr. Soda had documented this in their notes. In addition, Dr. O'Hanlan quickly deferred the responsibility and said Dr. Wilson should have told her this. Here we see that she does not ultimately take responsibility.

3. Patient S.O., MRN 902469, Events 1/14/16 to 1/17/16

SYNOPSIS

64 yr old who presented with irregular vaginal bleeding and was found to have endometrial carcinoma by endometrial biopsy. Her preoperative imaging did not show evidence of metastatic disease, and she had normal preoperative labs.

On 1/14/16 she was admitted and underwent total laparoscopic hysterectomy and bilateral salpingo oophorectomy as well as Colpopexy (for uterine collapse). EBL was documented as 300cc (high by the surgeon's standards for this type of case). Hemostasis was confirmed at the end of the case by the surgeon. The patient was extubated and transferred to the recovery room and to the floor.

Early AM the next day(1/15/16 1:00AM) when the patient attempted to get up she fainted and was briefly hypotensive(67/55) but quickly recovered. This occurred again about an hour later, and a rapid response team (RRT) was called after the nurse informed the surgeon- who advised to call the RRT. The patient had normal vitals while resting in bed. A stat hemogram was done at 2:35 AM , hemoglobin was 8.9 gm/dl (preop14 gm/dl).NO new orders were given. Blood pressure 2 hours later noted at 90 systolic, and the patient was kept at bed rest. In the morning, the patient was ambulating with initial dizziness that resolved. She was noted to have a low urine out put ~6hours(even though she was drinking/eating). The bedside nurse called the surgeon though advised to proceed with discharge and the patient was eventually discharged at 13:30pm.

The patient presented to the emergency room that evening (1/15/16) after another syncopal episode at her local hotel room. By the paramedic notes she was orthostatic initially and was given fluid bolus. On arrival to the emergency room she had a tender abdomen/and mild lower abdominal wall ecchymosis. Her labs showed hemoglobin level of 5.8g m/dl. Blood was ordered and en route to a diagnostic CT she had another fainting spell. CT confirmed hematoma. She was taken to the operating room on 1/16/2016 at 13:37pm for evacuation of hematoma. It is noted that during the clot removal the right uterine artery started bleeding and required further cauterizations (this area was cauterized 'multiple times' during the first surgery by the operative report).

The patient received total of 3 units of blood between 1/15/16 and 1/16/16, and was discharged home on 1/17/16 with hemoglobin of 7.2 gm/dl. There were no notes in the chart by the admitting surgeon for the morning of 1/15/16, readmission on 1/15/2016 pm, nor discharge day 1/17/16.

CONCERNS

This case was reviewed by the outside reviewer, who expressed concerns in regards to the care provided by Dr. O'Hanlan. The reviewer stated that Dr. O'Hanlan failed to meet the standard of care by not following up on the first night's events/labs, which had a severe impact on the patient's well-being. Concerns were raised regarding Dr. O'Hanlan's clinical judgment in discharging the patient initially despite the preceding night's events and after being informed of low urine output (categorized as 'missed opportunities'). This view is strongly shared by the committee members, who agree, that the failure to meet the standard of care resulted in significant negative short term impact on the patient's wellbeing with the potential for an even more severe outcome (if the patient would not have stayed locally after her first discharge). The documentation (or lack of it) was graded as unacceptable.

When the case was discussed with Dr. O'Hanlan on 7/13/17, she stated the bedside nurse never informed her about the low hemoglobin level on 1/15/2016 AM. Note, that the Rapid Response Team note in electronic Medical records states that since Dr. O'Hanlan asked for the RRT- the charge nurse on the surgical floor called her with the result - which is the standard of care at Sequoia. When asked about the very low urine output during the morning of 1/15/2016 before the patient was discharged the first time - Dr.O'Hanlan stated it was not a concerning fact in a 'small senior woman', although the patient was 64 years old and healthy, of average size (72 kg). When asked whether she saw the patient on the morning of 1/15/2016 - first day of discharge - she stated that she did a social visit and did not check the computer for vital signs or the labs. She stated that she would document her AM visit in the future though also stated that she saw the patient and 'she was fine'. During her interview with us, Dr. O'Hanlan stated that she routinely makes a social visit without reviewing the chart or documenting her visit.

By Dr. O'Hanlan's responses, we are concerned that similar "missed-events" will happen again, especially, when even in hind sight she continued to state that the "patient was fine" and that the nurses were to blame about not informing her of the low hemoglobin level after the second fainting spell, in the early morning of 1/15/2016.

4. Patient D.D., MRN: 902920, Events 2/2/16 to 2/9/16

SYNOPSIS

The patient was a 53-year-old woman with history of Peutz-Jeghers syndrome who was admitted to the hospital on 2/2/16 for surgery. Pelvic ultrasound showed a large cystic and solid mass measuring 15x15x10cm of indeterminate origin. MRI showed a 17x13x14cm heterogeneous mass with both cystic and solid components. CT confirmed no adenopathy. Preoperative CA125 was 168. CEA was elevated. She had a history of chronic anemia on Venofer. On exam, the patient was a thin woman, BMI of

25, with midline scars and pelvic mass extending up to approximately 18-week size. Her past surgical history includes an exploratory laparotomy for bowel intussusception and apparent small bowel resection, wedge resection of her left ovary, and appendectomy.

On 2/2/16, she underwent a colonoscopy with polypectomy in the AM, followed by an operative laparoscopy, extensive lysis of adhesions, radical oophorectomy with completion of bilateral salpingo-oophorectomy, ureterolysis, total laparoscopic hysterectomy, and uterosacral ligament colpopexy. On postoperative day #1, the patient was noted to have drainage on her dressing gown, which was noted by the nurse. Dr. O'Hanlan was called while she was in the OR; a callback was done. Dr. O'Holleran, her assistant for the initial surgery, was contacted and came to see the patient. Consent for surgery was signed. She was taken to the OR that afternoon and he identified a through-and-through trocar injury to the small bowel at the level of the umbilicus. After the patient was able to tolerate food by mouth and had a bowel movement, she was finally discharged home on 2/9/16.

CONCERNS

When Dr. O'Hanlan was questioned about the trocar injury, she stated that trocar injuries are a known complication of surgeries. She admits she had missed it, even though she had placed the trocar under direct visualization. The outside reviewer had made some suggestions on ways to avoid trocar injuries. Dr. O'Hanlan could have dissected the adherent bowel to the anterior wall. Dr. O'Hanlan dismissed this and said that they do not dissect any bowel that is not essential to the case being done. In this case, this bowel dissection was obviously essential since this was in the way of surgery and was injured during the operation. Dr. O'Hanlan should have done the anterior wall dissection to create access for the trocars. In her operative note, Dr. O'Hanlan did include a sentence stating "the bowel was inspected and it was noted to be intact." The outside reviewer questioned whether this really happened. If she did inspect the bowel and remove the trocar under direct visualization, she should have seen the through-and-through injury to the bowel.

5. Patient S.S., MRN 903133, Event 2/18/16

SYNOPSIS

In February 2016, S.S. was a 41 year old premenopausal woman. She was admitted by Dr. O'Hanlan for a planned laparoscopic hysterectomy for massive uterine fibroids and ureterovaginal prolapse. In the pre-operative H&P, it is stated clearly by Dr. O'Hanlan that "we will save the ovaries." The plan to leave the ovaries in place is confirmed in the operative consent. However, on the surgical schedule, S.S.'s case is described to include a "BSO." (bilateral salpingo-oophorectomy). This is what was noted just prior to first incision. The actual surgery was "Total laparoscopic hysterectomy, **bilateral**

salpingo-oophorectomy, ureterosacral ligament colposuspension and incidental appendectomy." This error resulted in a tragic and irreversible outcome for S.S., a substantial fine to the hospital, a great deal of scrutiny from the California Department of Public Health (CDPH) which resulted in a substantial fine to the Hospital, and, in constructive fashion, revision of the pre-incision time out and consent review procedure.

More recently, a less dramatic but similar incident occurred. The incident is, in itself, a technicality and no adverse patient outcome could result, but it is notable given S.S.'s situation. Dr. O'Hanlan had consented a patient for an appendectomy (not a "possible appendectomy") as part of a surgery. The appendectomy was not performed. Because there was a discrepancy between the consent form and the operation that was performed, a report needed to be made to the CDPH if a correction was not added to the hospital chart by a very specific deadline time. When the hospital recognized the situation, the deadline was approaching and Dr. O'Hanlan was at a medical conference (attending it and not making a presentation). Calls were made to Dr. O'Hanlan by the Director of Risk Management and the Chief Medical Officer. They informed Dr. O'Hanlan of the need for the chart correction and the approaching deadline. Dr. O'Hanlan declined to deal with the issue at the time, prioritizing her attendance at a lecture. The deadline passed, and Sequoia Hospital had to report the consent discrepancy to the State of California.

CONCERNS

It should be acknowledged that Dr. O'Hanlan has dealt with the unintended oophorectomy in an open manner with S.S. However, the error is inexcusable. Despite the importance of hospital support structures and systems, the RESPONSIBILITY of performing the correct surgery on the correct patient is the surgeon's.
In terms of the recent "technical" consent error, it is instructive. Dr. O'Hanlan chose to prioritize her attendance at a lecture over assisting Sequoia Hospital in correcting a consent error of her making. The ad hoc committee feels that this was arrogant and unprofessional, especially with the understanding that the increased scrutiny on the hospital is due to Dr. O'Hanlan's initial consent error.

6. Patient S.W., MRN 906008, Events 5/5/16 to 9/5/16

SYNOPSIS

In Spring and Summer 2016, S.W. was a 63 year old woman. She had clear cell ovarian cancer and underwent six operations over three separate encounters between May 5, 2016 and Sept 5, 2016. She incurred multiple bowel perforations and intra-abdominal abscesses.

Surgery #1 occurred on 5/5/16. S.W. presented with a 7.5cm solid and cystic left adnexal mass and elevated CA-125. Her past history was significant for endometriosis

causing colonic obstruction with subsequent bowel resection, diverting colostomy and, later, re-anastomosis. (All of this made the existence of multiple abdominal and pelvic adhesions highly likely.) On 5/5/16, Dr. O'Hanlan performed a total laparoscopic hysterectomy and bilateral salpingo-oopherectomy. She described extensive adhesions and "over the course of two more hours, only the necessary adhesions to approach the pelvis were taken down." The pathology report described a 6.7cm clear cell carcinoma involving the left ovary, parametrium and uterine serosa. S.W. was discharged on 5/6/16.

Surgery #2 occurred on 8/18/16. In the pre-operative H&P, Dr. O'Hanlan described 2 cycles of chemotherapy but did not specify the specific drugs or timing with respect to surgery. She described pre-operative blood counts with white blood count of 3.5, hemoglobin of 12 gm/dl and platelets of 220,000, but no date relative to chemotherapy administration or surgery was provided. The surgical procedure was "Enterolysis for 4 hours, omentectomy with lysis of adhesions and over-sew of small and large bowel x 4 and resection of tumor nodules from small and large bowel." A port for administration of intraperitoneal (I.P.) chemotherapy was placed. Dr. O'Hanlan described extensive adhesions and inability to do a lymphadnectomy. The entire procedure was done laparoscopically. There was no description of running the bowel or any extensive evaluation of the condition of the bowel at the end of surgery. The pathology report described no residual cancer. On post-operative day 1, 8/19/16, white blood count was 1.5. S.W. was discharged; there was no documentation of a visit that day by Dr. O'Hanlan.

Surgeries #3-6 occurred during a hospital admission from 8/22 to 9/5/16. S.W. was re-admitted to Sequoia Hospital with abdominal pain, lethargy, CT scan evidence of enterotomy on post-operative day 5 in reference to her 8/18/16 surgery. On 8/23, 8/24, 8/25 and 8/30/16, 4 operations (mainly repair of multiple enterotomies and drainage of abscesses) were performed with Dr. Michael O'Holleran as the primary surgeon. S.W. was discharged on 9/5/16 in good condition. A discharge summary was dictated by Dr. O'Holleran.

CONCERNS

S.W.'s series of operations raises multiple issues regarding Dr. O'Hanlan's judgment and care of S.W. The outside reviewer points out, regarding the 5/5/16 surgery, that "...with approximately two hours of adhesiolysis and several small bowel serosal defects that required repair, that any additional laparoscopic surgery would be difficult at best." Dr. O'Hanlan still chose to perform the 8/18/16 surgery laparoscopically.

The outside reviewer also states, regarding the 8/18/16 surgery, "The degree of difficulty of the procedure with over four hours of adhesiolysis such that four separate sites of serosal injury were over-sewn, should have confirmed a degree of concern for other areas at risk...There is no evidence to suggest that they [Drs. O'Hanlan and

O'Holleran] either laparoscopically 'ran' or evaluated the bowel, beyond using irrigation." During the ad hoc committee's interview with Dr. O'Hanlan, she expressed that she had thoroughly evaluated the bowel even though it is not documented.

Toward the end of the 8/18/16 surgery, Dr. O'Hanlan chose to place an intraperitoneal (I.P.) catheter for chemotherapy. One of the contraindications to I.P. chemotherapy is the existence of extensive adhesions; Dr. O'Hanlan detailed such adhesions in her operative notes.

There is no documentation of Dr. O'Hanlan seeing S.W. on the date of discharge (8/19/16). At Sequoia Hospital, there is no requirement for a discharge visit on a 23-hour stay. However, it is the opinion of the ad hoc committee that the complexity of S.W.'s situation, including the need to over-sew multiple sites of serosal injury, called for a visit prior to discharge from the hospital. During her interview with the ad hoc committee, Dr. O'Hanlan stated that she did see S.W. "socially" on the day of discharge but did not feel the need to document it in the chart.

Finally, the documentation of the pre-operative chemotherapy is poor. An "interval debulking" surgery is elective and should not be performed until 3-4 weeks after the preceding chemotherapy. The fall in white blood count to 1.5 on post-operative day 1 raises the possibility that there may not have been full blood count recovery at the time of surgery. (There are other possible explanations for the fall in white blood count; the lack of data in the H&P regarding the timing of chemotherapy and the pre-operative blood count precluded the ad hoc committee from reaching a firm conclusion.) Dr. O'Hanlan has been vehement in her disagreement with the outside expert's concerns regarding Dr. O'Hanlan's surgical decision making for the 8/18/16 surgery. She adamantly defends her surgical decision making and care of S.W. These two factors lead the ad hoc committee to conclude that Dr. O'Hanlan's future patients will be at risk for similar complications.

7. Patient T.T., MRN 908963, Events 7/22/16 to 8/11/16

SYNOPSIS

63 years old, Jehovah's Witness, Central Valley resident, who presented 7 weeks earlier to her physician with a year-long symptoms of abdominal pain/undocumented duration of constipation and was found to have extensive disease on initial CT in 6/16/2016. Her preoperative blood work (the only labs that are documented in the chart) were done on 6/17/16, with low normal hemoglobin level (12.3 gm/dl). Tumor marker level for ovarian carcinoma was very high, consistent with the diagnosis of ovarian carcinoma. She received 'one portion' of Taxol/Carboplatin Chemotherapy between the initial CT scan and the time she was admitted for surgery-7/22/16. The exact notation of the timing of chemotherapy is missing from the pre- operative history note. The patient

refused all blood products – which was well documented, including risks associated with her refusal to get transfusions.

On 7/22/2016, the patient underwent extensive optimal debulking, which included posterior exenteration and recto colonic anastomosis due to tumor involvement. Estimated blood loss during surgery was 1000cc. Postoperative hemoglobin was 5.9 gm/dl. She had low urine output in the recovery room and was transferred to the ICU. After 3 days in the intensive care unit (on TPN and antibiotics, received intravenous Iron x 1) she was transferred to the medical surgical floor with Hemoglobin of 4.8 gm/dl still on total Parenteral nutrition and intravenous antibiotics. Due to abdominal pain and elevated white blood cell count, an abdominal CT scan was obtained on 8/1/16. That showed possible anastomotic leak/abscess-which was confirmed by Gastrographin enema on the following day. On 8/3/2016 the patient had a diverting colostomy and on 8/4/17- the abscess was drained via CT in a percutaneous fashion. The patient was discharged with hemoglobin 5.7 gm/dl on 8/11/16.

CONCERNS

The external reviewer raised concerns regarding the care provided for the patient by the surgeon and whether the standard of care was met. The reviewer noted that there was a deviation from the standard of care of moderate concern with a considerable negative impact on the patient's wellbeing. Documentation again was deemed unacceptable- regarding preoperative history/ the reason to proceed with surgery earlier than originally intended and documentation of the timing of the chemotherapy course.

The reviewer pointed out that in the preoperative note there was no mention of the timing of the chemotherapy course in regards to date of surgery, noting that typically one would wait 3-4 weeks before surgery after chemotherapy to allow bone marrow recovery. The reviewer also raised question in regards to the duration of chemotherapy pre operatively (neo adjuvant) which would typically be 3 cycles of chemotherapy in order to reduce the post-operative complications, and in this case the patient received only one course. If there was a reason why surgery was pursued earlier – it was not documented on the notes available in the medical records. The concerns included the lack of a documented multidisciplinary approach or plan of care to a patient with known blood transfusion restriction who is to undergo surgery that would involve extensive blood loss (as was the case here- 1000 cc).

The committee shared the reviewer's concerns- especially, the absence of immediate pre-operative hemoglobin level and no hemoglobin levels available until after the patient's extensive surgery. We suspect that if the Hemoglobin level was followed more closely – it might have changed the surgical plan, and possibly steps that involved high bleeding risk would have been avoided. We were also surprised by the absence of close hematologist follow up during the hospitalization- in an attempt to optimize

hematopoiesis/faster rise in hemoglobin, which might have helped to achieve a faster post-operative recovery.

During our meeting with Dr. O'Hanlan on 7/13/17, she stated that the surgery was done earlier than originally intended due to increase in the patient's abdominal symptoms- "per referral from the oncologist- the patient was not doing well"- and she noted that indeed, the patient was found to have a partial large bowel obstruction during the time of surgery. Although the presence of bowel obstruction would be an indication for early surgery- this was NOT known or documented in the history. Dr. O'Hanlan stated the a blood count and updated hemoglobin level immediately preoperatively was not going to change her plan of care- as one course of chemotherapy does not alter immunity. Dr. O'Hanlan continued to state that she was following the iron levels, Hemoglobin and reticulocytes count through the post-operative period and administered vitamins by TPN, intravenous iron when needed- while communicating with the patient's own oncologist (who is not a Sequoia physician and practices far away). Dr. O'Hanlan felt she provided 'all the care that was needed'. The surgeon felt that the extent of surgery would not have changed (including the extent of lymph node dissection) even if she knew what the hemoglobin level was-despite the large amount of blood loss. The concerns in regards to the documentation of the timing of chemotherapy were not addressed.

Dr. O'Hanlan's responses again illustrate that she is likely to repeat the same approach in similar cases in the future, as she did not see the reason to involve a local hematology expert's help in the management of this extremely anemic individual, a fact that might have helped to achieve quicker post-operative recovery, and would be the standard of care in patients like this one.

8. Patient H.G., MRN 910425, Events9/13/2016 to 9/17/16

SYNOPSIS

42 years old, Central Coast resident, who was found to have an ovarian cyst on ultrasound. Her preoperative labs showed minimally elevated ovarian carcinoma tumor marker, and normal hemoglobin (12.8 gm/dl), as well as normal coagulation study (Protime) and platelet value.

She was admitted for surgery on 9/13/16 (laparoscopic unilateral oophorectomy, bilateral salpingectomy and appendectomy). During surgery, it was noted that the appendix appeared inflamed and was adherent to the small bowel. The assistant surgeon (Michael O'Holleran) performed appendectomy and small bowel resection. Estimated blood loss was documented < 50cc. Lavage was clear at the end of the case.

3-4 hours after, when the patient was still in the recovery room, she attempted to sit and nearly fainted. The surgeon(Dr. O'Hanlan) was called and ordered a current hemogram- when the hemoglobin level was noted to be low (7.9 gm/dl). Shortly thereafter, the patient was seen by Dr. O'Hanlan and was taken urgently to the operating room, with presumed intra peritoneal blood collection/active bleeding or clot. Two units were transfused; in the operating room clot was evacuated (650 cc) but no active bleeding seen. Immediate postoperative hemoglobin level was as expected after the transfusion- with hemoglobin of 11.5 gm/dl.

On 9/14/2016/6 AM- the patient reported feeling weak when attempted to stand up. Lovenox administered at prophylactic dose. Vital signs recorded stable an hour later (while in bed). No blood work was done. The patient ambulated and was discharged at 11:35 am. The patient presented to the emergency room that night complaining of shortness of breath, dizziness, rectal bleeding (bright red blood) and near fainting. She was tachycardic. Hemoglobin level noted as 8.3 gm/dl. CT showed free air and was suspicious for intra peritoneal bleeding. During surgery, bleeding was noted below the anastomotic staple line. A short segment bowel resection was done. Intra operative blood loss was 800 cc. Post-operative hemoglobin level was 6.7 gm/dl. She received a total of 3 units of blood (one unit in the emergency room before surgery) and was sent home on 9/17.

The patient and her husband complained later, that when the husband called the surgeon earlier (while on the road back to the Central Coast) on 9/14/2016- reporting that his wife feels poorly, weak and looks pale, he was told she might have a panic attack. Only when she was passing blood per rectum (3 hours away) and he called back, he was advised to drive to the emergency room. No physician note documented on first day of discharge (9/14 in AM).

CONCERNS

In this case the committee felt strongly that there was deviation from standard of care at high level of concern, and that the physician's behavior imposed great danger to the immediate well-being of the patient. The root cause issue appears to be poor clinical judgment, i.e., the decision to send the patient home on the morning of 9/14 without repeat hemogram (the patient was driven to the Central Coast in a private car all the way from the Bay Area). The initial response of the surgeon to the husband's concerns- while he is on the road, demonstrates lack of professionalism as well. This case was not sent for outside review, because no special expertise is needed to understand the issues it presents . Lack of physician's visit documentation (on 9/14/2016 AM) by Dr. O'Hanlan is unacceptable- as the patient had a unexpected second urgent surgery the night before (when no source of bleeding was identified), and this was unusual enough that she should have been examined and seen by the surgeon before her discharge home.

Dr. O'Hanlan was questioned why she did not repeat a hemogram on 9/14 am, and stated she did not feel it was indicated as the patient ambulated. She did not feel that measuring orthostatic vital signs would add to the care. She further said that she paid a social visit (not documented) and did not feel compelled to write a note.

This case illustrates another missed opportunity, as, if the patient's hemogram was measured on 9/14 in the morning, it would have suggested, that the patient is still bleeding and her discharge might have been cancelled/her life would not have put in danger. The lack of professionalism when communicating to the patient and her family, which was described above, would be below the standard of any practicing physician at Sequoia or elsewhere.

As in the case of SO (1/16, #3 above), Dr. O'Hanlan failed to follow on events on the night leading to the morning of discharge (the fact that the patient felt weak that morning when asked to move) and did not take the extra expected measures to ensure safe discharge. Her poor judgment and clinical decision making coupled with the lack of insight- especially when the above case (HG 9/2016) happened only 8 month after the first case of post-operative bleeding – are concerning, and suggest that similar events are predictable.

9. Patient K.M., MRN 920824, Events 8/8/17 to 8/9/17

SYNOPSIS

K.M. was admitted with recurrent endometrial cancer for tumor debulking from the aorta. A CT scan was performed preoperatively that showed a tumor with a mass effect on the aorta, but adjacent intima of the aorta was irregular. She had called Dr. Zimmerman and asked him if he would be available in case she needed him in the operating room, but she did not ask him to assist or to be available at any specific time. Her preoperative hemoglobin was 9.8 gm/dl, but that was 2 months prior to surgery. During the surgery, she had Dr. Michael O'Holleran as her assistant as usual. As they were removing the tumor, they made a "hole" in the aorta. They immediately held pressure and requested Dr. Zimmerman to come for repair. At that time, he was in another case, had to quickly stabilize his patient so he can arrive in time. Fortunately, patient did well despite a large blood loss and multiple blood transfusions.

CONCERNS

This case lies outside of our time frame contemplated for our investigation period between 1/2014-9/2016 and was primarily addressed through the MEC, not our Ad Hoc Committee. However, due to the substantial concerns that arose from this case, we felt it was important to consider this case in our recommendation.

In a case like this where Dr. Zimmerman is highly likely to be needed, Dr. O'Hanlan should have requested a formal consult with Dr. Zimmerman prior to the surgery and made him the assistant surgeon for the case, rather than a surgeon who "should" be available on the day of surgery. There is also a high risk for blood loss as stated in her history and physical. A recent complete blood count is very important to help assess the patient's baseline hematologic status. Here, her preoperative hemoglobin was 9.8 gm/dl, but was from 2 months ago. The usual standard preoperative labs should be done within 30 days before surgery. In a case with high risk for blood loss, this does not appear even nearly appropriate.

What shocked us the most was how she dictated her own operative report and dictated Dr. O'Holleran's operative report for him. Supposedly, she wanted to bill the surgery as co-surgeons. Dr. O'Holleran told her he was just an assistant. She was then asked to withdraw both dictations and re-dictate a new operative report with Dr. O'Holleran only as an assistant. So without his consent, she went ahead and tried to dictate a report for him. This is highly unusual and, in our opinion, improper. In addition, the operative reports between the initial dictations and the later dictation were different when describing whether there was a "hole" in the aorta made by her prior to Dr. Zimmerman's arrival.

Dr. O'Hanlan knew she was under investigation and she knew our concerns regarding her preoperative evaluation and our suggestions to include specialists earlier. Despite this, she again made the same judgmental error of not including a subspecialist, in this case Dr. Zimmerman, earlier on. She also inappropriately tried to dictate for someone who clearly did not ask her to. The difference between the operative reports she dictated seems to have implied she did not make a "hole" in the aorta at first, but the 2nd report states that there was a hole.

After this surgery, Dr. O'Hanlan left town and had her assistant manage the patient while she was gone. And, she had managed the TPN (total parenteral nutrition) without seeing the patient herself, as she had done in other cases as well.

This case raised too many red flags in addition to all our existing concerns. At this point, we do feel that her patients are in immediate risk, and we expressed this opinion to the Medical Executive Committee. She incorrectly prepared for surgery, incorrectly performed surgery, did not involve a specialist early on, managed patient without seeing the patient, and created improper and initially misleading documentation.

III. DISCUSSION AND RECOMMENDATION

Our outside reviewer concluded that the cases she reviewed showed patterns of technique or behavior that had a recurring theme: poor documentation, lack of attention to details such as discharge labs/findings and preoperative chemotherapy/workup, poor

medical and surgical judgment, and reluctance to seek help. We recommend that the outside reviewer's complete report be reviewed along with this report.

What partially prompted the Medical Executive Committee to initiate this investigation was Dr. O'Hanlan's high complication rates compared to other surgeons at Sequoia Hospital as well as other gynecological oncologists across the country within the Dignity Health System. The Dignity Health system uses a standardized approach to calculate physician's complication rates. During the investigation, Dr. O'Hanlan provided us her version of her calculations of her complication rates, which omitted many cases for various reasons. Rather than figuring out if her "system" of calculating the complication rate is better than the Dignity Health system that applies in a standardized way across the country, we decided to focus our attention on the actual cases in hand and look for any patterns that may lead to recurrent complications and her responses to problems. As we all know, complications occur with all medical practice, surgical and non-surgical. But, as physicians, it is our judgment and response to problems that can optimize safe medical practice.

As we explored the many cases in hand, we quickly noticed a pattern of negligence, lack of attention to details, blame of others for her complications and bad outcomes, poor judgment, unwillingness to include hospitalists and subspecialists early on, and abrasive personality towards the medical staff, especially towards the administration.

Throughout the past year, as Dr. O'Hanlan knew she was under investigation, she continued to show these patterns of practice. There were an additional 17 cases of complications that arose after our investigation period that ended 9/2016. She did not show up for most of her cases that underwent peer review. And more recently, when she did attend the peer review of her cases, she attacked the presenters and outwardly attempted to embarrass and discredit them. It is obvious that she thinks the Obstetrics/Gynecology department is far too inferior to provide any kind of comments on her cases. This demonstrates that she is unreceptive to input from others regarding the deficiencies in her performance and how they might be corrected. We are concerned she is unable to evolve and change to give us the confidence that she can become a safer physician.

Dr. O'Hanlan may argue that despite her severe complications, these patients usually do well and survive the surgery and immediate postoperative recovery. We would have to thank our wonderful specialists at Sequoia who had consistently saved her patients' lives. This does not excuse her bad judgment that had led to the bad outcomes in the first place. Prevention is key. During the interview, she had consistently stated she had made the right decisions and disagreed with our suggestions to improve her practice. The letter she sent us after our interview illustrates her belief that she had done nothing wrong and that the "standard of care was delivered by me," when there was definitely room for improvement to provide a safer medical and surgical practice.

Dr. O'Hanlan has criticized us for not interviewing people who she worked with on a day-to-day basis. Actually, we did interview a variety of people, some who worked with her more regularly than others. Since this was a highly confidential investigation, we had asked our interviewees not to disclose our interview to anyone including Dr. O'Hanlan.

Dr. O'Hanlan has been in practice for several decades. Her complications are not only more frequent, but also more severe. Her continued goal to get down to "zero residual" tumor to help improve chemotherapy outcome is commendable, but we question whether her aggressive operative techniques are more risky than beneficial.

Since Dr. O'Hanlan is a solo gynecologist oncologist, and she has told us herself that no other gynecologist oncologist would be willing to work with her, we cannot see how restricting her privileges, adding a proctor, or finding someone responsible to oversee her work is feasible. For these reasons, we unanimously recommend that her medical staff membership and clinical privileges be revoked at Sequoia Hospital.

Respectfully submitted,

Virginia Chan., D.O., Chair

Sigal Tene, M.D.

Kent Adler, M.D.

ROBERT W. LUNDY, JR.
PATRIC HOOPER
[illegible]YD A. BOOKMAN
[illegible]RADLEY TULLY
[illegible]N R. HELLOW
LAURENCE D. GETZOFF
DAVID P. HENNINGER
TODD E. SWANSON
LINDA RANDLETT KOLLAR
MARK E. REAGAN
DARON L. TOOCH
GLENN E. SOLOMON
CRAIG J. CANNIZZO
SCOTT J. KIEPEN
MARK A. JOHNSON
STEPHEN K. PHILLIPS
HOPE R. LEVY-BIEHL
JODI P. BERLIN
STACIE K. NERONI
CHARLES B. OPPENHEIM
ROBERT L. ROTH*
DEVIN M. SENELICK
DAVID A. HATCH
M. STEVEN LIPTON
HARRY SHULMAN
PAUL T. SMITH
MATTHEW CLARK

ALL ATTORNEYS ARE ADMITTED IN CALIFORNIA AND NOT D.C. OR MASSACHUSETTS UNLESS NOTED

* ADMITTED IN WASHINGTON, D.C., MARYLAND & PENNSYLVANIA ONLY
** ADMITTED IN WASHINGTON, D.C., & MARYLAND ONLY
*** ADMITTED IN WASHINGTON, D.C. & PENNSYLVANIA ONLY
****ADMITTED IN WASHINGTON D.C.
*****ADMITTED IN MASSACHUSETTS
******ADMITTED IN WASHINGTON, D.C., MARYLAND & MASSACHUSETTS ONLY

HOOPER, LUNDY & BOOKMAN, P.C.
HEALTH CARE LAWYERS & ADVISORS
575 MARKET STREET, SUITE 2300
SAN FRANCISCO, CALIFORNIA 94105
TELEPHONE (415) 875-8500
FACSIMILE (415) 875-8519
WEB SITE: WWW.HEALTH-LAW.COM

OFFICES ALSO LOCATED IN
LOS ANGELES
SAN DIEGO
WASHINGTON, D.C.
BOSTON

KARL A. SCHMITZ
JENNIFER A. HANSEN
**JAMES F. SEGROVES
ROSS E. CAMPBELL
**PRECIOUS MURCHISON GITTENS
*****JOSEPH R. LAMAGNA
AMANDA L. HAYES-KIBREAB
KATRINA A. PAGONIS
ERIC D. CHAN
*****DAVID S. SCHUMACHER
SANDI KRUL
TERRI WAGNER CAMMARANO
NINA ADATIA MARSDEN
TRACY A. JESSNER HALE
KATHERINE M. DRU
*****AMY M. JOSEPH
BEN A. DURIE
****DAVID J. VERNON
STANTON J. STOCK
***KELLY A. CARROLL
RUBY W. WOOD
SANSAN LIN
BRIDGET A. GORDON
JONATHAN H. SHIN
JORDAN KEARNEY
BRETT MOODIE
VINAY KOHLI
KEVIN N. ROYER
ANDREA L. FREY
ALICIA W. MACKLIN
DAVID J. TASSA
******JEREMY D. SHERER
CATHERINE S. WICKER
STEPHANIE A. GROSS
ROBERT F. MILLER

WRITER'S DIRECT DIAL NUMBER:
415-875-8514

WRITER'S E-MAIL ADDRESS:
RWOOD@HEALTH-LAW.COM

FILE NO. 78175.901

January 19, 2018

VIA EMAIL AND U.S. MAIL

John Fleer, Esq.
1850 Mt. Diablo Boulevard, Suite 120
Walnut Creek, CA 94596

Re: Fair Hearing Proceedings for Dr. O'Hanlan

Mr. Fleer:

I write on behalf of the Medical Executive Committee of Sequoia Hospital in connection with the above referenced proceedings. As you are aware, the Ad Hoc Committee Report ("AHC Report") is attached to the Supplemental Notice of Charges dated November 21, 2017. It has come to our attention that a typo is contained in the AHC Report. On page 11, reference to "Patient T.T." inadvertently lists the wrong MRN. Instead of "MRN 908963" the cite should be to "MRN 908964." While the other information provided makes it clear which case is being identified, especially given Dr. O'Hanlan's familiarity with the case, the MEC does acknowledge the error. This letter serves as notice of the correct medical record number.

Please let me know if there are any questions relating to this issue.

Best regards,

Ruby W. Wood

RWW/ln

2096820.1

EXHIBIT 4

SEQUOIA HOSPITAL MEDICAL STAFF

HEARING COMMITTEE

IN THE MATTER OF:

Katherine A. O'Hanlan, M.D.

FINDINGS, CONCLUSIONS & DECISION

This Proceeding:

Dr. O'Hanlan has been a member of the medical staff at Sequoia Hospital since 1997 specializing in gynecologic oncology, with emphasis on laparoscopic surgery. On August 21, 2017, the Medical Executive Committee (MEC) voted to summarily suspend all of Doctor O'Hanlan's clinical privileges and advised her of the opportunity to meet with the MEC on August 28, 2017. Dr. O'Hanlan met with the MEC members, explained her position and requested that the summary suspension be rescinded. By a vote of 11 to 6, the committee voted to continue the summary suspension pending receipt of a report from a special Ad Hoc Investigating Committee which had been appointed and convened the prior year.[1]

In a memorandum dated October 3, 2016, James Torosis M.D., the Chief of Staff, and Beverly Joyce M.D., Chief of the Department of Obstetrics & Gynecology asked the MEC to appoint an Ad Hoc Investigating Committee (AHC) to examine the professional practices of Dr. O'Hanlan.[2] She was advised in writing of the appointment and purpose of the AHC by letter dated October 20, 2016.[3] The

[1] The MEC submitted more than 700 pages of documentation in support of its charges. The MEC Exhibits are contained in two three-ring binders and each page is numbered sequentially preceded by the designation "MEC." Dr. O'Hanlan submitted several exhibits which are generally designated with "MD Exhibit" and a number. All exhibits offered by the MEC and most of Dr. O'Hanlan's exhibits were admitted into evidence by the hearing officer. The minutes of the MEC meeting of August 28, 2017, can be found at MEC 00335 and a transcript of the interview of Dr. O'Hanlan is in the exhibit binder at MEC 00339.

[2] MEC Exhibit p. 00139.

[3] MEC Exhibit p. 00142.

committee consisting of Kent Adler, M.D., Virginia Chan, D.O. and Sigal Tene, M.D. first met on November 3, 2016 and continued meeting thereafter for 18 sessions.[4] The AHC delivered its report to the MEC on September 29, 2017, in which the members unanimously recommended that the medical staff membership and clinical privileges of Dr. O'Hanlan be revoked.[5] A copy of the report was sent to Dr. O'Hanlan that same day.[6]

On October 23, 2017, the MEC met to consider the report of the AHC and Dr. O'Hanlan was interviewed. A transcript of that interview was presented as MEC Exhibit 00505. The MEC then consulted with attorney Harry Shulman by phone and voted 10 to 6, with one abstention, to adopt the report of the AHC recommending termination of all clinical privileges.[7]

The MEC issued two notices of charges in this matter. The first notice was dated October 6, 2017, and dealt only with the decision to summarily suspend the physician's privileges.[8] In the second notice of charges dated November 21, 2017 the MEC acknowledged receipt of the AHC report, incorporated it by reference and adopted the AHC recommendation that the physician's medical staff membership and clinical privileges be revoked.[9] Dr. O'Hanlan made a timely request to have the MEC's decisions reviewed by a hearing committee as provided in the Medical Staff Bylaws (The Bylaws)[10] and a committee consisting of the following members of the medical staff was appointed: C. Dale Young, M.D.-Radiation Oncology; Mary Larson, M.D.-Cardiology; Olga Fortenko M.D. –Pulmonary and Critical Care Medicine; Adam Harmon, M.D.-Cardiothoracic Surgery and Jagdip Powar, M.D.-Obstetrics/Gynecology. Dr. Harmon was appointed to serve as chair of the hearing committee. Pursuant to stipulation by the attorneys for the MEC and Dr. O'Hanlan, Robert L. Johnson, a retired healthcare lawyer, was appointed to serve as hearing officer. John Fleer, the attorney for Dr. O'Hanlan and Harry Shulman, the attorney for the MEC, stipulated that review of the summary suspension and the recommendation for termination of privileges would be combined into a single hearing.

Twelve evidentiary sessions were held on the following dates: February 7, 8; March 20; April 10; May 9, 14, 31; June 5; September 5, 6; October 3 and November 5. The hearing committee met privately, with the hearing officer present, on November 27, 2018 to deliberate and decide this matter. This is the report of the committee's findings and decision.

---

[4] MEC Exhibit p. 00146.
[5] MEC Exhibit p. 007-0024.
[6] MEC Exhibit p. 0005.
[7] MEC Exhibit 00780.
[8] MEC Exhibit p. 0001.
[9] MEC Exhibit p. 0005.
[10] The Bylaws, Article VIII, Section 3.

Dr. O'Hanlan's Education, Training and Experience

Dr. O'Hanlan completed her undergraduate education in 1976 at Duke University with a Bachelor of Science degree in zoology and psychology.[11] She attended the Medical College of Virginia where she obtained a medical degree in 1980.[12] This was followed by a residency at the Atlanta Medical Center in OB/GYN completed in 1984. After that, she had a fellowship in gynecologic/oncology at Thomas Jefferson University Hospital in Philadelphia.[13]

Upon completion of her formal education and training, she became a member of the faculty at Albert Einstein College of Medicine in New York where she spent four years teaching gynecologic/oncology surgery and caring for gynecologic/oncology patients. She then moved to Stanford where she taught on the faculty from 1990 through 1996.[14],[15]

In 1987 Dr. O'Hanlan became board certified in obstetrics & gynecology, a certification which she currently maintains. In about 1989 she also became certified by the specialty board in gynecologic/oncology.[16] She testified that since 1996 she has completed about 2300 laparoscopic hysterectomies and over 200 other laparoscopic minor surgeries.[17]

The issues presented and the legal parameters:

The hearing officer instructed the hearing committee members that our function is not to act as the initial decision makers but rather to conduct an unbiased review of the MEC's actions, judging those actions by the standards established in California law and the Sequoia Hospital Medical Staff Bylaws. The most pertinent Bylaw provision states:

---

[11] O'Hanlan, Tr. 5/31/18 p. 87.
[12] *Id.* at 88.
[13] *Ibid.*
[14] *Ibid.*
[15] Dr. O'Hanlan's time at Stanford was not without controversy. In our view, in her zeal to comfort a critically ill, terminal patient she exercised extremely poor judgment in obtaining potassium chloride which she intended, momentarily, to give to the patient for self-administration. The potassium chloride was never delivered to the patient, but this episode did result in a $10,000 fine, a revocation of her medical license for 30 days and three years probation. As a result, she had to resign from the Stanford staff. O'Hanlan, Tr. 5/31/18 p. 95; MEC Exhibit 00375-400. In our view, Dr. O'Hanlan made a full disclosure of this episode when applying for staff privileges at Sequoia (See MEC Exhibit 00375) and therefore we considered this "past history" and did not take the Stanford situation into consideration in deciding the matters before us in this proceeding.
[16] O'Hanlan, Tr. 5/31/18 p. 89.
[17] *Ibid.*

> Except as provided above, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Hearing Committee. If the Hearing Committee finds, based on the evidence presented at the hearing, that the action being challenged is not within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, the Hearing Committee may recommend a different result, which may be either more adverse or less adverse to the practitioner than the action that prompted the hearing. (Emphasis added.)[18]

Consistent with the forgoing, the hearing officer defined the issues before us as follows:

1. Was it reasonable and warranted, based upon the information available at the time, for the MEC to impose summary suspension on August 21, 2017?
2. Was it reasonable and warranted, based upon the information available at the time, for the MEC to continue the summary suspension in effect, as it did on August 28, 2017?
3. Based upon the evidence available at this time, including the evidence produced at the hearing, was it reasonable and warranted for the MEC to recommend termination of Dr. O'Hanlan's medical staff membership and clinical privileges?

We were also advised that as the trier of fact in this proceeding, we are required to consider all of the evidence but it is also our responsibility to determine the persuasive value of each piece of evidence. That is what is contemplated by The Bylaw provision stating that our findings and decision must be based upon "the preponderance" of the evidence. We were, from time to time, presented both with exhibits and testimony of witnesses which were directly contradictory. In those situations, we endeavored to determine which evidence was the most reliable and the most persuasive.

The Evidence:

In a proceeding such as this which took almost one year to complete, with twelve evidentiary sessions, the testimony of fifteen witnesses and more than 700 pages of

[18] The Bylaws, Article VIII, Section 6, paragraph 6 (c); California Business & Professions Code, Section 809.3 (b) (3).

exhibits, we faced a daunting task in trying to distill that body of information into a relatively concise statement of the factual bases for our decisions. In approaching this task, we concluded that there were essentially three "milestone events" which were significant, in and of themselves, but which also took on additional importance in marking notable turning points in this peer review journey. They were:

Milestone Events:

> 2/18/16 "The Ovaries Case," patient S.S. This 41 year old premenopausal patient was admitted for a laparoscopic hysterectomy. The consent and preoperative notes indicated that the ovaries "would be saved." Due to mistakes that are discussed in much more detail below, the ovaries were removed, a major investigation was conducted by the California Department of Public Health and the hospital was fined in excess of $50,000.[19]
>
> 9/13/16 "The San Luis Obispo Case," patient H.G. This 42 year old resident of San Simeon, California, on the central coast near San Luis Obispo, was admitted for a laparoscopic unilateral oophorectomy, bilateral salpingectomy and appendectomy. She was taken to the operating room a second time on the first day in order to try to find a source of internal bleeding. The source could not be found. The patient was discharged the following day with clearance to be driven to her home, by her husband, a trip of more than three hours. During the drive, the patient was not feeling well and when she stopped for a rest room visit she passed a great deal of blood. Her husband telephoned Dr. O'Hanlan who advised them to drive back to Sequoia Hospital (a three hour drive) as opposed to going to the emergency room of the closest hospital at San Luis Obispo (a one hour drive).[20]
>
> 8/8/17 "The Aorta Case," patient KM. This patient was admitted with recurrent endometrial cancer for tumor debulking from the aorta. During the surgery a hole was made in the aorta, the repair of which required the urgent and immediate assistance of a vascular surgeon. Truthful and accurate documentation was a major issue in this case.[21]

We have designated these three cases as milestone events because between the Ovaries Case and the San Luis Obispo Case there was a concerted effort by the quality assurance staff of the hospital and the leadership of the medical staff to involve Dr. O'Hanlan, in a focused and meaningful way, in the quality improvement process. The objective was to aid the physician in improving her practice patterns. When the San Luis Obispo Case occurred, the chief of staff and the chair of the OB/GYN department concluded that the attempts to engage Dr. O'Hanlan in the

[19] AHC Case #5, MEC Exhibit 00014.
[20] AHC Case #8, MEC Exhibit 00019; Letter to Patient Advocate MEC Exhibit 00622-627.
[21] AHC Case #9, MEC Exhibit 00021; Patient record MEC Exhibit 00654-706.

quality improvement process were not being successful, and therefor they asked the MEC to appoint an Ad Hoc Investigating Committee (AHC) to study the Dr. O'Hanlan's practice patterns in more detail. Although the AHC had not totally completed its work by the time of the Aorta Case, the details of that case and questions about the documentation of events, caused the medical staff leadership to be concerned that future patients might be in "imminent danger" and therefore the MEC was asked to summarily suspend the clinical privileges of Dr. O'Hanlan until the AHC final report could be received and evaluated. This was done.

The Ovaries Case, Patient SS, AHC case #5.

Before addressing the details of this case, in which the patient's ovaries were removed contrary to the patient's consent, we concluded that the mistakes in this case needed to be viewed in the context of events that had occurred earlier.

January 25, 2002 Event:

In this peer review hearing, Dr. O'Hanlan testified concerning a malpractice case that was filed against her on January 24, 2003.

> Dr. O'Hanlan: Case number 2 was a wrongful removal of a lady's ovaries in 2002. I was sued 1.75 million dollars, and I settled that with an extensive apology offered by me, and I bought her Premarin. She was 48 years old, and I should not have removed her ovaries without permission. It was wrong. I thought I remembered the consent, and I didn't. (Emphasis added.)[22]

The details of this litigation are contained in the MEC Exhibit binder starting at p. 00461. Dr. O'Hanlan supplied the Sequoia MEC with excerpts from her office records, including her notes of the pre-operative meeting at her office on January 23, 2002.[23] Relevant statements from that document include:

- She (referring to the patient) informed me on 1/23 that her preference was to keep the ovaries unless cancer was present. In response to that, I changed the consent form that day and I planned to follow her request and leave her ovaries intact if no cancer was found.[24]
- Dr. O'Hanlan spoke to the patient in the holding area just before the surgery, explaining the procedure and noting "(I had already forgotten our discussion, and I had not reviewed her consent)"

[22] O'Hanlan, Tr. 5/31/18 p. 115.
[23] MEC Exhibit 00465.
[24] MEC Exhibit 00466

- "I then did her hysterectomy and with focus on safely getting margins around her large cervix, forgetting that she wanted to keep her ovaries unless there was cancer, removing her ovaries in the process."[25]

On October 17, 2003 Dr. O'Hanlan wrote a long letter of apology to the patient in which she said the following:

- When I started your surgery, I was only thinking about the cervical segment, and, without recalling your expressed wishes or the fact that I had changed your consent, I did the standard thing most 48 year old women elect to have done. I did not even recall that I was supposed to retain your ovaries until your husband reminded me in the waiting room.[26]
- I was actually in as much shock as you were, unable to believe that I had done what I had done.
- In summary…I am still so very sorry for my error in assuming I recalled our plan, in not reviewing the consent, in not reviewing the plan more specifically with you, and for removing your ovaries against your will.[27]

The case was settled on April 29, 2004 when Dr. O'Hanlan's insurance company paid the patient $29,999.00[28]

January 2004 Event:

In January 2004 Dr. O'Hanlan performed surgery on a patient at Mills-Peninsula Hospital and in March 2004 her clinical privileges at the hospital were summarily suspended.[29] The MEC at Mills-Peninsula (which is referred to in their system as the PSEC) cited several bases for this action, including the statement that "…you removed the fallopian tubes in a patient without appropriate informed consent…."[30]

The medical staff told Dr. O'Hanlan that they would re-examine the summary suspension but that in order to do so, they would need access to the Stanford documents concerning her termination there. She responded that she was not "interested in doing that" and chose to resign.[31]The notice to the National Practitioner Data Bank states:

> Voluntary surrender of clinical privilege(s), while under, or to avoid, investigation relating to professional competence or conduct…

---

[25] MEC Exhibit 00467.
[26] MEC Exhibit 00469.
[27] MEC Exhibit 00470-471.
[28] MEC Exhibit 00480.
[29] MEC Exhibit 00404.
[30] *Ibid.*
[31] O'Hanlan, Tr. 5/31/18 p. 100.

> As part of a negotiated settlement, the physician resigned from the professional staff and the professional staff executive committee withdrew the summary suspension against the physician. The judicial review committee process was not completed, and there were no final findings rendered.[32]

This resignation became effective December 7, 2004.

The Ovaries case at Sequoia

It is against that factual background that we considered the "Ovaries case" at Sequoia, a surgery that occurred in February 2016. In our evaluation of this case, we recognized that twelve years had elapsed between the physician's resignation from Mills-Peninsula, the settlement of her lawsuit and the operation at Sequoia. This procedure caused permanent and major damage to the patient as well as a major fine against the hospital. Nonetheless, we concluded that the lapses and mistakes made in the Sequoia case became even more inexcusable when viewed in the context of Dr. O'Hanlan's prior experience with "forgetting and not reviewing" important patient consent forms.

Dr. O'Hanlan's inattention to important details, both preoperatively and postoperatively, was of major concern to the AHC, the MEC and this hearing committee. This case took on added significance, in our view, because the record before us demonstrates that at times Dr. O'Hanlan "steps up to her mistakes," takes responsibility for them and voices a commitment to avoid similar mistakes in the future—while at other times she appears to reject responsibility for errors that occur under her control, preferring to shift responsibility to staff members and nurses. This case illustrates both attitudes.

When Dr. O'Hanlan was interviewed by the AHC on July 13, 2017 she described her actions in removing the ovaries as "unforgiveable." She explained that the original plan had been to remove the ovaries, but after conferring with her gynecologist the patient decided that she wanted to keep her ovaries. Therefore, Dr. O'Hanlan wrote the consent to state the patient would keep her ovaries. Then the day of surgery arrived:

> So I go into the operating room like a week later and I'm in scrub and I'm about to –you know, I'm about to operate with her—on her. And I conduct my own code…but I mean my own pause and say, …are we removing her ovaries? I forget. We're removing the uterus and the appendix and tubes, but ovaries? And I looked over at the circulating nurse and she looked down and she said bilateral salpingo-oophorectomy and looked up at me, and I

[32] MEC Exhibit 00456.

> said, okay, we're taking out the ovaries, and I didn't question it further at the time, and I should have.[33]

Dr. O'Hanlan was asked by an AHC committee member if the nurse was reading from the consent form, and she responded that the nurse was looking at the scheduling form. She added:

> And so I removed her ovaries. And I should have questioned it. You know, I'll never stop regretting that.[34]

Six days later, on July 19, 2017, Dr. O'Hanlan wrote an extensive letter to the chief of staff and the AHC explaining her view of the issues previously discussed with the AHC.[35] Because Dr. O'Hanlan draws an analogy between her situation in the peer review process and the plight of a Macedonian farmer whose goat dies, this letter is often referred to in the testimony and this report as the "Dead Goat Letter." In this letter, the physician excuses her performance by saying:

> The case of wrongful removal of the ovaries was reviewed and I shared all the changes that <u>our office has already made</u> to prevent reoccurrence. There is no suggestion the standard of care was not rendered <u>by me.</u> There was evidence of a mistake that should never happen that was the <u>fault of the Sequoia staff</u> on whom I relied. (Emphases in original)[36]

Also, in the Dead Goat Letter she made general observations about peer review, quality assurance and the OBGYN department:

> But this AHC process has been unwarranted. Our OPPE process for QA remains unfair…
>
> The last QA meeting I attended was an evidence-free kangaroo-court…
>
> Clearly, something must be done to resolve the lack of ethics in Sequoia's QA and OPPE systems.[37]

The physician reverted to admitting her error in this case by August 19, 2018, when she composed a memorandum entitled "Chronology of events" which she distributed to all of the people she and her legal counsel intended to call as witnesses.[38] There she noted items she considered to be valid criticism of her care including: "1. Wrongful removal of a patient's ovaries without consent. (my error.)"

---

[33] MEC Exhibit 00269.
[34] *Ibid.*
[35] MEC Exhibit 00290-00301, The "Dead Goat Letter."
[36] MEC Exhibit 00292, "The Dead Goat Letter."
[37] MEC Exhibit 00302.
[38] MEC Exhibit 000302a.

Dr. O'Hanlan explained this document in her testimony before this committee on September 6, 2018. She said she wanted her witnesses to know that she acknowledges making mistakes, and that she is continuing to learn and grow.[39] She also observed that she will never excuse herself for this event and that it was a "terrible mistake."[40]

Our findings and conclusion based on this case will be stated later in this report in the section entitled "Findings & Conclusions."

The Quality Assurance/Peer Review Effort

In the eight-month period between the Ovaries Case and the decision by the Chief of Staff Dr. Torosis to request the appointment of the AHC, there were multiple attempts to involve Dr. O'Hanlan in the quality improvement/peer review process. The key events included the following:

- 2/3/16 Meenu Arora, the quality improvement leader, email to O'Hanlan advising that one of her cases would be reviewed at the OB/GYN department meeting scheduled for 2/17/16,[41]
- 4/20/16 @ 11:38 a.m. O'Hanlan to Meenu: "sorry to miss meeting. When is next?
- 4/20/16 @ 2:46 p.m. Meenu to O'Hanlan: "Thanks for letting me know. The next meeting is on Wednesday, May 18 at 12:30 pm. Since the peer review cases can be deferred once and were not discussed last time, two cases out of the three were discussed in today's meeting (the one where the ovaries were removed without consent and the other one with postop hematoma were both discussed." (Emphasis added)[42]
- 4/22/16 O'Hanlan to Meenu: "Great. But I cannot make the May 18 date. I am teaching in Fresno that day. Fine if it will be discussed anyway." (Emphasis added)[43]
- 4/25/16 @ 2:08 p.m. Meenu to O'Hanlan: Dr. Joyce has asked if you can come to the June meeting, which is June 15 at 12:30.
- 4/25/16 @ 9:27 p.m. O'Hanlan to Meenu: "I cannot be there that date either. I teach in Fresno monthly and that is another time I will be there. If the next meeting is July 20, I can make that one."[44]

[39] O'Hanlan, Tr. 9/6/18 p. 69.
[40] *Id.* at 70.
[41] MEC Exhibit 0077.
[42] MEC Exhibit 0076.
[43] MEC Exhibit 0075.
[44] MEC Exhibit 0074.

- 4/27/16 @ 8:59 a.m. Meenu to O'Hanlan: Dr. Joyce would like to discuss the case in May and since you cannot be there, you can provide a written summary.[45]
- 4/27/16 @ 10:29 a.m. O'Hanlan to Meenu: "I will let the op report speak for itself. But here are some of the slides from our LIGO course that support what is done."[46]

In explaining this Quality Improvement effort to the hearing committee, Dr. Torosis noted that "…various people tried to engage with her to discussing some of her complications, and they were deflected…."[47] In the late Spring and Summer of 2016 the communications from Dr. O'Hanlan to the Quality Assurance staff began to take on a bit of an "edge." Much of this conversation related to NSQIP data which was submitted to a NSQIP/GYN subgroup. NSQIP is the acronym for the National Surgical Quality Improvement Program, a network of many hospitals throughout the entire country that share surgical data on several areas, including OB/GYN. Nurse Teresa Murphy is the NSQIP coordinator at Sequoia hospital.[48] The trend of these communications can be summarized as follows:

- 6/17/16 @ 2:31 p.m. O'Hanlan to Murphy: Can you send me the list of patients who had sustained some kind of infectious complication, which we reviewed in the earliest meetings of the committee?[49]
- 6/20/16 @ 11:18 a.m. Murphy to O'Hanlan: I cannot send the list, but you can review it in the Quality office.[50]
- 6/20/16 @ 4:25 p.m. Murphy to O'Hanlan: Dr. Chandrasena (the Chief Medical Officer of the hospital) would like to meet to go over the cases when you come to the Quality office.[51]
- 6/20/16 @ 6:53 p.m. O'Hanlan to Murphy: "I simply want the handout that you gave at the initial meeting (referring to a meeting of the NSQIP subgroup that occurred on May 26, 2016) It had no clear patient identifiers, so it can be sent though the email. <u>I do not need to see the good Dr. Chandrasena for that."</u> (Emphasis added)[52]
- 6/21/16 @ 4:54 p.m. Murphy elevates the communications to the next highest level in the organization and involves Mary Christen RN, the Director of Quality Services. She writes to Dr. O'Hanlan explaining why the NSQIP documents cannot be sent to her, but adds: "If you would like to review the case review document that was discussed at the NSQIP Committee, you are

[45] MEC Exhibit 0073.
[46] MEC Exhibit 0072.
[47] Torosis, Tr. 2/7/18 p. 69.
[48] Torosis, Tr. 2/7 p. 77; MEC Exhibit 00092.
[49] MEC Exhibit 00092.
[50] *Id.*
[51] MEC Exhibit 00091.
[52] MEC Exhibit 00091.

> very welcome to review it with either Dr. Chandrasena or Dr. Talebian."[53] Dr. Talebian was, at that time, the Chief of Staff.

In August of 2016 Dr. Talebian's term of office as Chief of Staff was ending and Dr. Torosis was preparing to assume this role. They discussed the quality issues involving Dr. O'Hanlan:

> So. Dr. Talebian said that I tried on a couple of occasions to engage her to come and talk about some of the outcomes, and she kind of gave me, like, I want to know all the cases, exactly what they are, and you'll see this here, and she never got to it and never was able to get her to come in and talk. And so—the end of her term was up. And so she said, you know, you really should try to figure this out. See if you could help her.[54]

By August 25, 2016 Dr. Torosis had telephoned Dr. O'Hanlan suggesting a meeting, and he followed up the call with an email at 4:30 p.m. that day.[55] Dr. O'Hanlan had requested a list of her cases that had been reviewed at the OB/GYN committee, in order to prepare for an eventual meeting with Dr. Torosis, and this email included a list of 28 cases which had been reviewed. The email concludes with: "Kate, I want to stress that the intent of meeting is for your benefit so that we can have a better plan for improved patient outcomes. It is not meant to be punitive or put a 'black mark' (as you stated) in your file."[56]

In an email to Dr. Torosis dated September 15, 2016 Dr. O'Hanlan says: "I obtained my surgery case totals so that she (Mary Christen) can accurately assess if we will actually need to meet. Don't get me wrong, I think you're a nice guy, but I don't want to meet with the Chief of Staff about my complications *if there is no reason to do so.* A stain I do not need"[57]

On September 28, 2016 Dr. O'Hanlan writes to Dr. Torosis about "our meeting" and says:

> Frankly, you should be outraged that the (*sic)* dumped this in your lap without providing you with numeric evidence that this kind of corrective action was needed. I can tell you now that I will want an apology from the QA department for the sloppy way that they have handled this. It verges on slander.[58]

---

[53] MEC Exhibit 00090.
[54] Torosis, Tr. 2/7 p. 83.
[55] MEC Exhibit 00110.
[56] MEC Exhibit 00111.
[57] MEC Exhibit 00109.
[58] MEC Exhibit 00123.

Dr. Torosis noted in his testimony before this committee: "So somehow she has this thing if she meets with me, there's going to be a stain. So, again, I was not able to really engage her to come and talk."[59] Dr. O'Hanlan also wrote a letter to Dr. Torosis in September, 2016, in which she alludes to having been "summoned by" him and concludes with:

> If you or she (referring to Mary Christen) document some problem in my practice that exceeds documented norms, please let me know all about it and we will meet. If no documentation is identified, an apology from the QA department to us both would be in order….[60]

Dr. Torosis summed up this effort by saying: " I mean, the data as though—there's a lot of numbers of cases that fell out, a lot of peer-review cases, and just wanted to reach out to her…"[61] He added: "That was kind of like a good defense is a good offense because we're just trying to reach out and help her and, basically, she was offended and discredited everything…."[62] Dr. Torosis did not continue with his attempts to meet with Dr. O'Hanlan because the San Luis Obispo Case occurred and that, in the context of all that had occurred before, caused him to conclude that he, together with the department chair, should go to the MEC requesting a more detailed investigation through an Ad Hoc Investigating Committee.[63]

The San Luis Obispo Case AHC Case #8.

This 42 year old patient, a resident of the Central Coast, was admitted on 9/13/16 for laparoscopic unilateral oophorectomy, bilateral salpingectomy and appendectomy. As the AHC report notes, during surgery it appeared that the appendix was inflamed and adherent to the small bowel. The assistant surgeon Michael O'Holleran performed an appendectomy and small bowel resection.[64] Three to four hours later the patient, while still in the recovery room, almost fainted when she tried to sit. It was determined that the hemoglobin level was extremely low, so she was urgently returned to the operating room. In the operating room, Dr. O'Hanlan evacuated clot but no active bleeding was seen.[65]

On the following day the patient reported feeling weak when attempting to stand up. An hour later, vital signs were stable, she ambulated and was discharged even though no additional blood work was done.[66] The patient's perspective on the

---

[59] Torosis, Tr 2/7 p. 89.
[60] MEC Exhibit 00119.
[61] Torosis, Tr. 2/7 p. 94.
[62] Torosis, Tr. 2/7 p. 96.
[63] *Ibid.*
[64] MEC Exhibit 00019.
[65] MEC Exhibit 00020.
[66] MEC Exhibit 00020.

events that followed discharge were very persuasive. This was described in detail in the patient's letter to the hospital patient advocate.[67]

> …I was discharged and within an hour after leaving the hospital, I had symptoms of internal bleeding. At the time, I didn't know what was happening, but it was painful to take a deep breath, I felt clammy, and had tingling at my extremities. We called Dr. O'Hanlan to make sure my symptoms were normal and we should continue home. She said it was a panic attack and I would be fine….
>
> During the three hours that we drove towards home, I was becoming pale and couldn't walk because I felt like I would pass out. At 6 PM, my husband helped me to a rest area bathroom where I had a bowel movement consisting of a lot of blood and clots. My husband had to carry me back to our vehicle because I was so weak. We called Dr. O'Hanlan and told her we were going to head to a hospital in San Luis Obispo about an hour away from the rest area. Initially, Dr. O'Hanlan agreed with this plan, but she changed her mind and said to drive back to Sequoia Hospital (a three hour drive) rather than drive an hour to our local ER because she knew she could fix the problem…[68]

The patient and her husband drove back to Sequoia and she was immediately taken back to the OR where Dr. O'Hanlan noted bleeding below the anastomotic staple line. A short bowel resection was done.[69] The AHC reported its conclusions as follows:

> In this case the committee felt strongly that there <u>was deviation from standard of care at high level of concern,</u> and that the physician's behavior imposed great danger to the immediate well-being of the patient. The root cause issue appears to be poor clinical judgment, i.e., the decision to send the patient home on the morning of 9/14 without repeat hemogram.[70]

We concur with that analysis, but are also of the opinion, based upon a preponderance of the evidence presented, that the even greater error was the decision to have the patient and her husband drive three hours back to Sequoia hospital rather than go one hour to the emergency department at the San Luis Obispo hospital. Had that happened, the ER doctor in San Louis Obispo could have examined the patient, performed the necessary tests and called Dr. O'Hanlan so that an informed decision could have been made about the importance of returning her to Sequoia hospital. We view this as poor clinical judgment which does not meet the minimal standards of the profession.

---

[67] MEC Exhibit 00622.
[68] *Ibid.*
[69] MEC Exhibit 00020, AHC report p. 14.
[70] MEC Exhibit 00020.

The Ad. Hoc Investigating Committee Process.

Dr. Torosis explained the thinking behind his decision to ask for the AHC in his testimony of February 7, 2018. He said he and the department chairperson were aware of the Bylaws provision permitting the appointment of an investigating committee:

> Let's get the data. Let's get the facts. Is this behavior appropriate or inappropriate? And certainly I or Dr. Joyce didn't want to make that decision, so we—that's why we went to the MEC requesting to initiate this ad-hoc committee and have a through formal review to understand her practice and out outcomes.[71]

In our view, the investigative work of the AHC was orderly, objective, detailed and fair. The committee held 18 meetings, reviewed 28 cases that had been identified in the department's peer review process, sent 7 of those cases for an outside review by a gynecologic/oncologist, interviewed 5 physicians and 7 staff members.[72] The outside review was conducted by Julia A. Chapman M.D., an assistant professor at the University of Kansas Medical Center.[73] Her report dated May 13, 2017 is found at MEC 00182.

Following receipt of Dr. Chapman's report in May and before the AHC rendered its final report in September, two significant events occurred in July. On July 13, 2017 Dr. O'Hanlan met with the AHC committee and the transcript of that meeting is found at MEC 264. At times during the interview, Dr. O'Hanlan was contrite, admitting to mistakes and promising to do better., i.e. The Ovaries Case. At other times she was indignant that she would be subjected to such close scrutiny. Near the end of the interview she said:

> And I feel like I'm being targeted. I feel like, you know, this is something of a high-tech witch hunt, because I have a very low complication rate and it's not due to negligence, it's due to patients having complications.[74]

This interview was followed up with the writing of the Dead Goat Letter[75]about which much has been said already. In the minds of the AHC members, however, this letter played a significant role in their final decision that self-scrutiny, taking responsibility for mistakes and practice improvement by Dr. O'Hanlan was

---

[71] Torosis, Tr. 2/7 p. 103.
[72] Tene, Tr. 4/10 p. 8.
[73] Dr. Chapman's extensive CV is found at MEC 00248. In addition to her teaching duties, Dr. Chapman is a practicing gynecologic oncologist.
[74] MEC Exhibit 00287.
[75] MEC Exhibit 00290.

unlikely—especially in view of the Aorta case.[76] Dr. Adler added that the Dead Goat Letter was "ridiculous" in attempting to lay blame at the feet of the staff and said he thinks "it leaves future patients at significant risk."[77]

The Aorta Case, AHC Case #9.

This patient was admitted on August 8, 2017 with recurrent endometrial cancer for tumor debulking from the aorta. The AHC reports that a CT scan was performed preoperatively that showed a tumor with a mass effect on the aorta, but adjacent intima of the aorta was irregular.[78] In her testimony before this committee, Dr. O'Hanlan gave the following description of the procedure:

> We did the case exactly as planned. I don't think that there was a complication. I went after the cancer that was invading the medialis of the aorta exactly as we discussed. We had a small hole, we stopped when we were supposed to. We got vascular. The patient is still NED and very grateful. I just saw her a month ago. So I don't feel like I did anything wrong on that case except now I'm going to take into account making sure that my associate has his equipment.[79]

Her description of the case, when she met with the MEC on August 28, 2017, provided more detail. She sent Dr. Zimmerman a text asking that he call her.

> Our phone conversation was me saying I'm worried about her aorta and so is Hollett and O'Holleran, and so he said don't worry. I'll be there. I can be there if you need me. I'll be around the hospital.[80]
>
> He came over, he ordered up his staff, he ordered up his equipment, he replaced the aorta, because the dissection that we had done—we did what we planned to do. We were skimming the cancer off the aorta. We thinned one area and then we were right next to that area and made a hole, and the hole extended and became bigger. And I just put my finger there and both of us said—no, we're replacing this, call Dr. Zimmerman.[81]

Dr. Zimmerman, a vascular surgeon on staff at Sequoia, recalled the events somewhat differently. The day before the surgery, he received either a telephone call or a text from Dr. O'Hanlan in which she briefly described a case she was going to have the following day, noting that it involved potentially the abdominal aorta

---

[76] Tene, Tr. 4/10 p. 18, 55; Adler Tr. 4/10 p. 140-141; Adler, Tr. 5/9 p. 33-34; Chan, Tr. 5/4 p. 39.
[77] *Ibid.*
[78] MEC Exhibit 00021.
[79] O'Hanlan, Tr. 9/6/18 p. 86.
[80] MEC Exhibit 343.
[81] MEC Exhibit 343.

and the inferior vena cava. She said she might need my help and I said I would be around. Later on she texted me the medical record number, should I choose to review it.[82]When asked by counsel what she was asking him to do, he responded:

> She was asking me from my standpoint whether I'd be around, not to specifically help on the case, not to specifically review the case with her or with anyone else, not specifically to see the patient, but only if I was potentially around, and I said I was around.[83]

On the day of surgery, Dr. Zimmerman received a call while he was doing a case in the Cath lab telling him that Dr. O'Hanlan's room needs help and she has bleeding. He stabilized the patient he was working on, and went to the operating room where Dr. O'Hanlan was. When he entered, one of the surgeons had a hand in the aorta which was bleeding. He asked for operating room nurses who do cardiac and vascular cases, asked for blood products and the special instruments he needed in order to repair the aorta.[84] He found rent holes in the aorta and replaced the segment with a piece of Dacron graft.[85]

In addition to the problems encountered with the poor planning for support from a vascular surgeon, this case became very significant in shaping our findings and conclusions because of documentation issues. The record indicates that Dr. O'Hanlan dictated three operative reports, two on August 9th the day of the surgery, and one the following day on August 10th. While Dr. O'Hanlan tries to offer a plausible explanation for this strange series of events, we found her credibility lacking. Her initial explanation was that she wanted Dr. O'Holleran to be adequately compensated for four hours of work, so she suggested that they code the procedure as co-surgeons. She told Dr. O'Holleran that she would dictate a report for him, as co-surgeon, and if he liked it he could sign it. She would also dictate a separate report for herself as co-surgeon.[86] She said that later on she saw Dr. O'Holleran again and he said that no one was going to be able to bill as co-surgeons, so "let's just do it the regular way."[87]

The actual operative reports which are in evidence shed a different light on this episode. The first report, on behalf of Dr. O'Holleran, was dictated by Dr. O'Hanlan at 12:16 on August 9th and transcribed at 14:13. That report made ***no mention of the rent in the aorta*** and included the following statements:

> However, at the level of the inferior mesenteric artery and above up to the renal vein, the matted lymph nodes appeared to be invading the muscularis

---

[82] Zimmerman, Tr. 5/14 p. 109.
[83] *Ibid.* at 110.
[84] Zimmerman, Tr. 5/14/18 p. 112.
[85] *Id.*
[86] MEC Exhibit 344.
[87] *Id.*

> of the aorta itself. When brisk bleeding ensued (note there is no mention of the rent) and we identified that the muscularis of the aorta was indeed invaded, Dr. Zimmerman was consulted to resect the aorta itself…. (A)s the aorta was being rolled to the left side, it became evident that the posterior right aspect of the aorta was deeply invaded by the tumor even though the MR angiogram had shown no luminal invasion. When it became clear that none of this area could be repaired and that in fact did require resection, I asked Dr. Zimmerman to scrub and resect the aorta.[88] (Comment added.)

Dr. O'Hanlan dictated her own initial report at 12:26 on August 9th and it was transcribed at 14:58.[89] This report also ***makes no mention of a rent to the aorta*** and describes the procedure as follows:

> At this point, I asked Dr. O'Holleran to scrub and to resect these lymph nodes because even these lymph nodes were densely adherent to the distal aorta, and he kindly removed the bilateral inferior mesenteric aortic lymph nodes. As he was removing the upper aortic lymph nodes, however, it became apparent to us both from multiple vasculotomies that the tumor had invaded through the muscularis of the aorta, and the aorta was needed to be resected. Dr. Zimmerman was called into the room, and he very kindly transected the renal vein. Then he removed the tumor invaded aorta and sutured in a graft.[90]

Dr. Zimmerman's operative report dictated at 13:19 makes it clear that a rent occurred that was not a "planned" event:

> The patient is a 65-year old female, who presents to the Cancer service for recurrent lymph node dissection. She was undergoing an open lymph node resection and during the resection the aortic wall was traversed. I was called emergently to the room….[91] The aortic bifurcation had been dissected out. Manuel pressure was being placed on the aortic rent.[92]

A physician's note written by Dr. O'Hanlan at 8:19 on August 10th states:

> ICU admit note states aorta "damaged by dissection" which is incorrect. The aorta was invaded by cancer, and during removal of the cancer, it became evident that the damage from the cancer required resection of the aorta itself, as planned and discussed with Dr. Zimmerman pre-operatively.

---

[88] MEC Exhibit 658.
[89] MEC Exhibit 656.
[90] MEC Exhibit 655.
[91] MEC Exhibit 673.
[92] MEC Exhibit 674.

Dr. O'Hanlan's ultimate operative report was dictated on August 10th at 11:55. This report includes a discussion of the aorta rent. Salient parts of the report include:

> As these were being dissected free, it became clear that the muscularis had been invaded by the tumor, and there was too much tumor destruction of the aorta to remove only the tumor. During the dissection, a hole was encountered in the aorta, and it became clear that the aorta required reconstruction not repair…. (Then she proceeds to a discussion of calling Dr. Zimmerman.)[93]
>
> As I attempted to skin the tumor off the aorta, it became apparent that the muscularis of the aorta had been invaded. The rent in the aorta was created and immediately a finger was applied to stop the bleeding…. (Then Dr. Zimmerman was called)[94]

Dr. O'Hanlan attempted to "erase" the first two reports by telling the MEC in August 2017:

> I said, okay, I'll dictate the whole thing. So without ever reviewing the first two-and I take no responsibility for what's in them—I discarded them. I called medical records and said, this is what I was trying to do. I was trying to arrange billing in a legal way for my associate but we're not going to do that anymore so discard both of those and here's my real op report….[95]

Dr. Tene, a member of the AHC, testified that she had reviewed the initial dictation in the Aorta case, and thought that the omission of any reference to the rent of the aorta in the first report was significant. She agreed that there was a credibility issue with Dr. O'Hanlan.[96] We agree. Although Dr. O'Hanlan tried to put a positive face on her multiple reports, we are reluctantly drawn to the conclusion that this exemplifies a perfidious pursuit of obfuscation, in attempting to cover up the truth in the operative reports.

Complications and statistical analysis.

The various systems of statistical analysis used by health care professions in order to provide metrics of the quality of patient outcomes, patient complaints and related care issues such as length of stay, was a subject of considerable dispute in this proceeding. As noted in a previous section of this report, Dr. O'Hanlan held the view that the analytical systems used by the Sequoia Hospital Quality Assurance Department, and the medical staff, were faulty and presented a misleading picture of her complications rate. For reasons explained below, to a limited extent Dr.

---

[93] MEC Exhibit 676
[94] MEC Exhibit 677.
[95] MEC Exhibit 344.
[96] Tene, Tr. 4/10/18 p. 119.

O'Hanlan made a legitimate point because most of these systems are constructed in a manner to collect a large mass of data and then compare overall results of the subject hospital with a large number of hospitals throughout the country. These systems are not tailor-made to fit the exact parameters of a specific medical practice. Dr. O'Hanlan points out that a significant portion of her patients are cared for as outpatients (on a 23 hour hold) and do not constitute "in-patient" admissions. In these situations, a system that measures only in-patient admissions would not accurately demonstrate her complications rate. The MEC does not dispute this point. Where the parties differ, however, is in understanding the role and function of these statistical systems. Dr. O'Hanlan's argument goes something like this: what your system views as a complication is not a complication, in my opinion, nor is it my responsibility nor is it my error, and therefore should not be counted; my complication rate (using my system of counting) is about 4% and not 20% as the hospital's method would indicate; since my complication rate is not "outside the norm" there is no reason for me to meet with Dr. Chandrasena, the Chief Medical Officer; there is no reason for me to meet with Dr. Torosis, the Chief of Staff and there is no reason for the appointment of an Ad Hoc Investigating Committee. On the other hand, the MEC's evidence points out that the statistics do not automatically lead to a conclusion as to the quality of care or compliance with professional standards. We are persuaded by the MEC's evidence that these statistical programs are intended to function like an "early warning system," rather than a conclusive indication of failure to meet professional standards. The statistics generated by these processes may simply point to an area of practice that is of concern and merits more careful scrutiny.

Dr. Chandrasena explained the function of statistical analysis at the very beginning of the Ad Hoc Committee process, and gave a more detailed explanation of this process to the MEC and to this hearing committee. On November 3, 2016, at the very first meeting of the AHC, the minutes of the committee note:

> Dr. Chandrasena requested that the Committee not be bogged down by statistics and look beyond to trends in the data and also into events.[97]

In her testimony before this committee, Dr. Chandrasena explained her rationale:

> So we're a hospital—we're a community hospital. We are not a research center. We collect rates based on numerators and denominators based in our data sets. We do not look at statistical significance. It's not possible. Our numbers are too small. And so I didn't want—my advice to the committee was not to get stuck on looking at this rate versus that rate, this person's rate versus that person's rate, but to look at the practice and the clinical decision-making as a whole….It's really about how a physician makes clinical decisions and how they use their resources, their consultants, to manage their patients,

[97] MEC Exhibit 00147.

> how they actually manage their complications. To me, as a chief medical officer, it's far more important than the rate of complications.[98]

Almost one year later, when the MEC was considering whether summary suspension of Dr. O'Hanlan should be continued, Dr. Chandrasena offered a detailed explanation of the different statistical systems used, and their respective strengths and weaknesses.[99]

> So when—in the previous MEC meeting where Dr. O'Hanlan's case was discussed, there had been a lot of questions raised about rates and data, and so I wanted to be very clear about where the information comes from and what the data's strength and weaknesses are so that the MEC could have the standard data that we look at in our hospitals and in our systems in front of them in a kind of clear way….[100]

Dr. O'Hanlan offered the testimony of Dr. Karen Noblett as an expert on peer review processes and systems. She acknowledged that the NSQIP system, used by Sequoia, is nationally recognized, and that many of the national standards are based on NSQIP data. She admitted, however, that she was not familiar with the MIDAS system, also used by Sequoia, and noted "It might be a really great system. I just know nothing about it…."[101]

With the NSQIP system, the data is reported to the American College of Surgeons (ACS) as a part of the National Surgical Quality Improvement Program. It includes both inpatients and outpatients, whereas the MIDAS system tracks only inpatients, and is based upon 40 patients randomly selected every eight days. Chart review and requirements for submission are standardized through ACS and patients are followed for 30 days postoperatively for complications. There is no GYN-Oncology specific data comparison outside of research articles available.[102]

We were unanimously drawn to the conclusion that Dr. O'Hanlan's focus on statistics as a major part of her "defense" to the MEC charges, largely missed the point. The point is the quality of clinical decision-making, adequate attention to detail, careful planning and honesty in documentation. In these areas she often failed to meet applicable standards.

Findings and Conclusions.

Based upon the preponderance of evidence presented in the hearing, we unanimously make the following findings:

---

[98] Chandrasena, Tr. 6/5 p. 47-48.
[99] MEC Exhibit 00523
[100] Chandrasena, Tr 6/5 p. 94.
[101] Noblett, Tr. 10/3 p. 68.
[102] MEC Exhibit 00525-526, Chandrasena power point presentation.

Finding #1:

Dr. O'Hanlan's training, experience and skill in performing the physical and mental act of surgery, especially laparoscopic surgery, is excellent-perhaps even exceptional.

Finding #2:

Dr. O'Hanlan's inattention to important details, both preoperatively and postoperatively, has exposed patients to an unreasonable and unacceptable level of risk of serious injury. Illustrative of the factual basis for this finding include:

- A variety of failures to follow established policies and practices regarding obtaining the patient's informed consent and failure to conform the actual procedure to the consent given;
- Insufficient preoperative planning;
- Failure to order timely and adequate imaging studies and laboratory tests;
- The practice of engaging the patient in a "social visit" prior to discharge without examining and considering relevant information in the medical record.
- Advising a patient with substantial and obvious bleeding to drive three hours to return to Sequoia Hospital, when other adequate hospital facilities were within a one-hour drive.[103]

Finding #3:

In spite of Dr. O'Hanlan's protestations that she only needs "a tap on the shoulder" in order to bring her practice patterns into conformity with applicable professional standards, the record in this case supports the MEC contention that Dr. O'Hanlan is especially "challenged" when she needs to seriously consider the advice of peers, evaluate the wisdom of their suggestions and adjust her practice patterns to applicable professional standards. We concur with the observations made by the AHC and the MEC that Dr. O'Hanlan's ability or willingness to change her practices are so questionable that patient safety requires that a "leap of faith" not be made by the medical staff by continuing her privileges in the hope that change would occur.[104]

---

[103] The AHC report (MEC Exhibit 0023) makes this observation: "As we explored the many cases in hand, we quickly noticed a pattern of negligence, lack of attention to details, blame of others for her complications and bad outcomes, poor judgment, unwillingness to include hospitalists and subspecialists early on, and abrasive personality towards the medical staff, especially towards the administration." We concur in that observation.

[104] Chandrasena, Tr. 6/5 p. 67; Tene, Tr. 4/10 p. 18; Adler, Tr. 5/9 p. 126.

Finding #4:

Considering the information which was presented to the MEC at and before its meeting of August 21, 2017, and especially in view of the lack of veracity exhibited in the documentation of the Aorta Case, it was reasonable and warranted for the MEC to summarily suspend Dr. O'Hanlan's clinical privileges on that date.

Finding #5:

Considering the information presented to the MEC at its meeting of August 28, 2017, including the presentation of Dr. O'Hanlan, it was reasonable and warranted for the MEC to continue the summary suspension in effect until completion of all applicable peer review processes, because this information demonstrated that there was a legitimate basis for fearing that to do otherwise would expose future patients to imminent danger.[105]

Finding #6:

Based on the preponderance of evidence produced and admitted at the hearing of this committee, and after having given all of the evidence careful and objective consideration, it is the unanimous conclusion and decision of this committee that the medical staff membership and clinical privileges of Dr. O'Hanlan should be revoked.

Finding #7:

Having carefully reviewed and considered the record of the peer review activities that preceded this hearing, it is the conclusion of this committee that the actions of the Clinical Department, the Quality Improvement staff of the hospital, the Ad Hoc Investigating Committee and the Medical Staff Executive Committee were fair and appropriate, both substantively and procedurally.

Decision:

For the reasons and upon the bases set forth above, it is the unanimous decision of this hearing committee that the medical staff membership and clinical privileges of Katherine A. O'Hanlan should be revoked, and we recommend such action to the Hospital Board.

APPEAL:

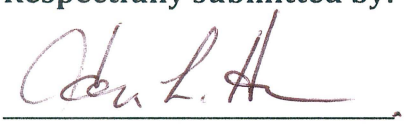
Article VIII, Section 7 of the Medical Staff Bylaws specifies the timing, procedural and substantive requirements for appealing the decision of this hearing committee to the Hospital Board, which provisions are hereby incorporated herein by reference. Without limiting the foregoing, this section includes:

[105] The Bylaws, Article VII, Section 7.

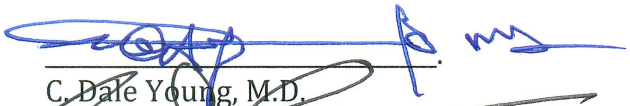
- 10 days following receipt of this decision is the deadline for requesting an appeal;
- The request for appeal must be in writing;
- The request must be delivered to the Hospital President and the opposing party.
- The request for appeal must state the grounds upon which the appeal is requested, which grounds must comply with the provisions of Article VIII, Section 7, paragraph 2. p. 37.

The Foregoing report, findings, conclusions and decision of this hearing committee were unanimously approved and adopted by the members of the hearing committee this 11th day of January, 2019.

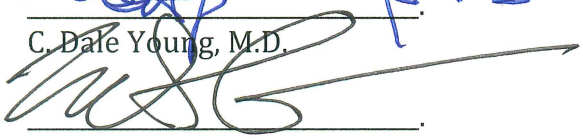
Respectfully submitted by:



Adam Harmon, M.D., Chair

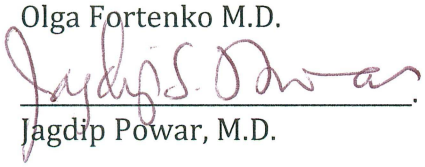


C. Dale Young, M.D.



Mary Larson, M.D.

Olga Fortenko M.D.



Jagdip Powar, M.D.

EXHIBIT 5

manatt
manatt | phelps | phillips

Doreen Wener Shenfeld
Manatt, Phelps & Phillips, LLP
Direct Dial: (310) 312-4346
E-mail: dshenfeld@manatt.com

February 14, 2020

Client-Matter: 14658.1901

Harry Shulman, Esq.
Hooper, Lundy & Bookman, P.C.
575 Market Street
Suite 2300
San Francisco, CA, 94105
hshulman@health-law.com

Shannon Baker, Esq.
Rothschild Wishek & Sands LLP
765 University Avenue
Sacramento, CA, 95825
sbaker@rwslaw.com

Re: Dr. Katherine O'Hanlan: Decision of the Board

Dear Counsel:

Attached please find the final decision of the Appellate Review Committee ("ARC") of the Hospital Community Board of Sequoia Hospital denying Dr. O'Hanlan's appeal on all grounds asserted, and affirming the summary suspension, the continuation of the summary suspension and adopting the recommendation to revoke Dr. O'Hanlan's Sequoia Hospital Medical Staff membership and clinical privileges.

Pursuant to Article IX, Section 7.6 of the Bylaws of the Medical Staff of Sequoia Hospital, the decision of the ARC "...shall constitute the final decision of the hospital" and is "...effective immediately". Accordingly, effective as of 11:30 am today, Dr. O'Hanlan's Sequoia Hospital Medical Staff membership and clinical privileges have been revoked.

Sincerely,

Doreen Wener Shenfeld

DECISION OF THE APPELLATE REVIEW COMMITTEE OF THE BOARD OF DIRECTORS OF SEQUOIA HOSPITAL, REDWOOD CITY, IN THE MATTER OF KATHERINE A. O'HANLAN, M.D.

Dr. Katherine A. O'Hanlan, ("Dr. O'Hanlan") has appealed to the Board of Directors (the "Board") of Sequoia Hospital (the "Hospital" or "Sequoia") the decision of the peer review Hearing Committee of the Sequoia Hospital Medical Staff (the "Medical Staff") that heard her challenge to the summary suspension of her clinical privileges, the continuation of that summary suspension, and the recommendation that her Medical Staff membership be revoked. That Hearing Committee decision is the subject of the appeal and is attached to this decision and incorporated herein by this reference. In accordance with Article VIII, Section 7.4 of the Medical Staff Bylaws (the "Bylaws") the Board appointed this Appellate Review Committee (the "ARC") to hear and decide Dr. O'Hanlan's appeal. In accord with the charge of the Board, the ARC submits its decision as the final decision of the Board in the peer review matter of Dr. O'Hanlan.[1]

I. SUMMARY OF DECISION.

Initially, the ARC notes its appreciation for the time and commitment shown by the Hearing Committee in connection with this peer review matter. The Board is ultimately responsible for patient care and safety at Sequoia and it determines who gets to practice within the walls of this Hospital. The ARC would be derelict in its obligations if it did not carefully review the Hearing Committee decision, exercise its ultimate authority and come to a decision regarding Dr. O'Hanlan's membership on the Medical Staff. This requires a careful and deliberate consideration of the Board's primary responsibility to Hospital patients. The ARC also has a responsibility to Dr. O'Hanlan to ensure that the peer review decision affecting her practice at the Hospital was the result of a fair hearing and supported by substantial evidence. The ARC further understands its obligation not to unduly interfere with the Medical Staff's peer review process. In particular, California law requires the ARC to (a) give "great weight" to the Medical Staff's peer review decisions; (b) accept findings of fact from the Hearing Committee if supported by substantial evidence; (c) not reweigh the evidence submitted to the Hearing Committee; and (d) accept determinations made by the Hearing Committee as to the credibility of witnesses. As to the disposition, the ARC may independently determine the appropriate remedy, if any, based upon facts found true by the Hearing Committee and supported by substantial evidence.

The ARC denies Dr. O'Hanlan's appeal on all grounds asserted, affirms the summary suspension, the continuation of the summary suspension, and revokes Dr. O'Hanlan's Medical Staff membership and clinical privileges, effective immediately.

As explained in greater detail below, the ARC finds that Dr. O'Hanlan received a fair hearing before the Hearing Committee in accordance with the Bylaws and California law and denies Dr. O'Hanlan's appeal on any such procedural grounds.

---

[1] The Bylaws provide that the ARC's decision is the "final decision of the Hospital". Bylaws Article IX, section 7.6. Accordingly, the "Board" and the "ARC" are used interchangeably in this decision.

On the merits, the ARC also finds that there is substantial evidence in the administrative record to support the Hearing Committee's finding that "Dr. O'Hanlan's inattention to important details, both preoperatively and postoperatively, has exposed patients to an unreasonable and unacceptable level of risk of serious injury", (Hearing Committee Finding # 2), thereby establishing that the recommendation of the Medical Executive Committee ("MEC") to revoke Dr. O'Hanlan's Medical Staff membership and clinical privileges is reasonable and warranted. Accordingly, the ARC finds that Dr. O'Hanlan does not meet the qualifications for Medical Staff membership and clinical privileges as set forth in Article III, Section 2 of the Bylaws and that the criteria for such corrective action under the Bylaws has been met. *See* Bylaws Article VII, Section 1 identifying the criteria for corrective action as: "...conduct reasonably likely to be 1) detrimental to patient safety or to the delivery of quality patient care within the hospital; 2) unethical; 3) contrary to the Medical Staff Bylaws, Rules and Regulations, or Medical Staff and Hospital administrative policy; 4) below applicable professional standards; or 5) disruptive of hospital operations."

The ARC further finds that there is substantial evidence to support the Hearing Committee's finding that the summary suspension, and the continuation of the summary suspension of Dr. O'Hanlan's Medical Staff privileges, were reasonable and warranted. The summary suspension and continuation of the summary suspension related primarily to Dr. O'Hanlan's conduct in connection with what has been referred to as the "Aorta case", including but not limited to the "...lack of veracity exhibited in [her] documentation..." of that case. The ARC agrees with the Hearing Committee that a summary suspension was immediately necessary in light of the facts in existence at that time, in order to proactively protect the health and safety of patients at the Hospital. *See* Bylaws, Article VII, Section 7.1. The summary suspension and its continuation therefore are affirmed.

II. FACTUAL AND PROCEDURAL SUMMARY.

Dr. O'Hanlan was a member of the Medical Staff at Sequoia beginning in 1997 specializing in gynecologic oncology, with emphasis on laparoscopic surgery. Over a two-year period (2014-2015), 28 of Dr. O'Hanlan's cases fell out of quality assurance for peer review by the Department of OB/GYN at its meetings. (SH-KO-ADM 002852-002863.) However, in February of 2016, an incident occurred that set this particular peer review matter in motion. A 41 year old premenopausal patient was admitted for a laparoscopic hysterectomy. The consent and preoperative notes indicated that the ovaries would be saved. Due to mistakes by Dr. O'Hanlan, the ovaries were removed, a major investigation was conducted by the California Department of Public Health, and the Hospital was fined in excess of $50,000. (SH-KO-ADM 003084: 7/13/17 interview before the Ad Hoc Investigative Committee, pg. 19:5-21:17; SH-KO-ADM 002367, 002829, 003120.)

The Medical Staff leaders tried to engage Dr. O'Hanlan in the quality improvement/peer review process regarding this case and other concerns, but she consistently was unavailable and so Dr. O'Hanlan avoided the opportunity to learn from her mistakes. (SH-KO-ADM 002887-92; 002907, 002907a, 002907A, 002905, 001156, 002925, 002925A, 002926, 002938, 001160, 002934, 001165, 001167.) In July and September of 2016, two other concerning cases by Dr. O'Hanlan occurred and concerns formed that she had an inordinately high complication/take-back rate. Accordingly, on October 3, 2016, incoming Chief of Staff Dr. Torosis and Chief of the OB/GYN Department, Dr. Joyce, formally requested that the MEC appoint an Ad Hoc Investigative Committee to look at her overall

performance at Sequoia Hospital and make a recommendation to the MEC. (SH-KO-ADM-002954-56). The MEC agreed. (SH-KO-ADM 002957.)

The Ad Hoc Investigative Committee held 18 meetings, reviewed 28 cases that had been identified in the department's peer review process, and sent 7 of those cases for an outside review that was conducted by a gynecologic/oncologist, Julia A. Chapman M.D., an assistant professor at the University of Kansas Medical Center. The Ad Hoc Investigative Committee also interviewed 5 physicians, including Dr. O'Hanlan and 7 staff members. (SH-KO-ADM 002997-3076; 002961-002996, 002822- 2939, 003079-3104, 003131-3146.)

Before the Ad Hoc Investigative Committee issued its report and recommendation, an incident occurred which, combined with preliminary information received from the Ad Hoc Investigative Committee, resulted in the decision to summarily suspend Dr. O'Hanlan's Medical Staff privileges. (SH- KO-ADM 003131-3146.) On August 8, 2017, Dr. O'Hanlan admitted a patient with recurrent endometrial cancer for tumor debulking from the aorta. Dr. O'Hanlan was performing an open lymph node resection, and during the resection the aortic wall was traversed. This required the urgent and immediate assistance of a vascular surgeon. (SH-KO-ADM -003482-3534; 002836-37; 003131-3146.) In addition to the quality of care concerns presented by this case, concerns arose regarding Dr. O'Hanlan's truthfulness and the accuracy of her documentation in the same case. (SH-KO-ADM 3501-02, 003504-05, 003483-84, 003486, 003163.)

As required by the Bylaws, Dr. O'Hanlan met with the MEC to consider her request that the summary suspension be lifted. Following an in-depth review of the facts, including the MEC's interview with Dr. O'Hanlan, the MEC voted to continue the summary suspension. (SH-KO-ADM 003154-3186.) In accordance with the Bylaws and applicable law, Dr. O'Hanlan was informed of her right to request a peer review hearing to challenge the summary suspension, which she did. (SH-KO-ADM 003185-86; 000041.) A Notice of Charges relating to the summary suspension was issued. (SH-KO-ADM 002816-19.)

On September 29, 2017, the Ad Hoc Investigative Committee issued a report and unanimous recommendation that Dr. O'Hanlan's Medical Staff membership and clinical privileges be revoked. (SH-KO-ADM-002822-39.) On October 23, 2017, the MEC interviewed Dr. O'Hanlan and voted to adopt the recommendation of the Ad Hoc Investigative Committee to revoke her Medical Staff membership. (SH-KO-ADM 03322-003359.) Dr. O'Hanlan was notified and she timely requested a peer review hearing to challenge the recommendation. (SH-KO-003360-61.) Her challenge to the summary suspension was consolidated with her challenge to the revocation recommendation and a supplemental Notice of Charges issued. (SH-KO-ADM 003360-61; 002820-42.)

Twelve evidentiary sessions were held before a Hearing Committee of Dr. O'Hanlan's peer physicians, with both the MEC and Dr. O'Hanlan presenting documentary evidence and live witness testimony. The MEC submitted more than 700 pages of documentation in support of the Charges. (SH-KO-ADM 002813-2015 being the MEC index of exhibits, with the actual exhibits ranging from SH-KO-ADM 002816-3606, not including the audio transcripts of Dr. O'Hanlan's interview with Ad Hoc Investigative Committee and her two interviews with the MEC.) Dr. O'Hanlan submitted 11 pages. (SH-KO-ADM 003610-20.) The Hearing Committee issued its 24 page report on January 19, 2019 affirming the summary suspension and its continuation, and recommending that the Board revoke Dr. O'Hanlan's Medical Staff membership and clinical privileges. (SH-KO-ADM 000734-757.)

Dr. O'Hanlan timely appealed to the Board asking it to reject the Hearing Committee's decision. Following submission of the parties' appellate briefs, Dr. O'Hanlan replaced her attorney. (July 8, 2019 letter of representation.) New counsel asked for a continuance of the appellate oral argument as well as permission to submit a supplemental brief. (August 9, 2019 "Motion to Continue Oral Argument and Request For Leave to File Supplemental Brief".) Following briefing on the issue, the ARC decided to continue the appellate oral argument and not allow a supplemental brief. But, the ARC also ruled that, at oral argument, new counsel would be allowed to expand on arguments made in the brief. The MEC would thereafter be allowed to submit a supplemental brief if it chose to do so. (August 13, 2019 Letter from Doreen Shenfeld (Manatt, Phelps & Phillips, LLP), legal advisor to the Board.)

Oral argument took place on October 3, 2019. The MEC chose to file a supplemental brief to respond to expanded arguments of Dr. O'Hanlan's counsel that the ARC had allowed her to present at the oral argument. (Transcript of Proceedings of October 3, 2019; November, 11, 2019 Supplemental Brief of the MEC.)

III. APPELLATE REVIEW PROCESS.

A. Grounds for Appeal.

Pursuant to Bylaws, Article VIII, Section 7.2, there are two permissible grounds for appeal by a physician of a Hearing Committee decision:

1. Substantial non-compliance with the standards or procedures required by the Medical Staff Bylaws or applicable law which has created demonstrable prejudice. (This refers to whether or not Dr. O'Hanlan received a fair hearing); and

2. The factual findings of the Hearing Committee are not supported by substantial evidence based upon the hearing record or such additional information as may be permitted under the Medical Staff Bylaws.

Dr. O'Hanlan has appealed on both grounds.

B. Legal Standards Applicable To The Issues.

1. Alleged Denial of a Fair Hearing.

Because California hospitals have a legal duty to protect the public, "a physician's right to pursue his livelihood free from arbitrary exclusionary practices must be balanced against other competing interests: . . . the duty of the hospital to its patients to provide competent staff physicians."[2] To strike the proper balance between these competing concerns, California courts have held that a hospital may not deny a physician access without providing "fair procedure" – which consists of "*adequate notice of the administrative action taken by the group or institution, and a reasonable opportunity to be heard.*"[3] It is not "due process" of law.[4] Rather, as the Supreme Court has explained,

---

[2] *Rhee v. El Camino Hospital District*, 201 Cal. App. 3d, 477,489 (1988).

[3] *Tiholiz v. Northridge Hospital Foundation,* 151 Cal. App. 3d 1197, 1202 (1984) (emphasis added).

physicians must only be provided "...rudimentary procedural and substantive fairness,"[5], which "does not compel formal proceedings with all the embellishments of a court trial, nor adherence to a single mode of process. It [fair procedure] may be satisfied by any one of a variety of procedures which afford a fair opportunity for an applicant to present his position...."*[F]air procedure' requires ... the reason for the proposed rejection and ... a fair opportunity to defend.*." [6] In this case, because the recommendation for revocation of Dr. O'Hanlan's Medical Staff membership, if adopted by the ARC, would be reported to the Medical Board of California, additional requirements for the hearing are set out in California's peer review statute, Business & Professions Code Section 809 *et. seq.*[7] Dr. O'Hanlan's appeal does not complain of any violation of this statute.

2. Alleged Lack of Substantial Evidence to Support the Hearing Committee's Findings of Fact.

Dr. O'Hanlan asked the ARC to decide whether the Hearing Committee's findings of fact are supported by substantial evidence. (The actual findings are discussed below and are set forth on pages 19-20 of the Hearing Committee decision.) The ARC understands that "'[s]ubstantial evidence' is evidence which, if true, has probative force on the issues. It is more than a mere scintilla, and means such relevant evidence as a *reasonable mind might accept as adequate to support a conclusion.* . . . It must be *reasonable in nature, credible, and of solid value* . . . ."[8] Substantial evidence does not mean "any evidence" – but substantial evidence also does not mean the evidence is uncontradicted or not in dispute.[9]

The ARC began its review of the findings mindful that it is "... without power to judge the effect or value of the evidence, weigh the evidence, consider the credibility of witnesses, or resolve conflicts in the evidence or in the reasonable inferences that may be drawn from it."[10] The testimony of "one credible witness may constitute substantial evidence".[11] We were careful not to "substitute [our] judgment for that of the [Hearing Committee],"[12] nor did we at any time resolve evidentiary conflicts, re-weigh evidence or reject the Hearing Committee decision because we believed that another finding was equally or more plausible.[13] Rather, as required by law, we gave "great weight" to the Hearing Committee's findings which generally meant those findings should be upheld "unless the administrative findings . . . [were] so lacking in evidentiary support as to render [them] unreasonable."[14]

---

[4] *Natarajan v. Dignity* Health, 42 Cal. App. 5th 383, 388, (2019), as modified on denial of reh'g (Nov. 20, 2019), review filed (Dec. 23, 2019); *Oliver v. Board of Trustees*, 181 Cal. App. 3d 824, 827 (1986); *Goodstein v. Cedars-Sinai Medical Center*, 66 Cal. App. 4th, 1257, 1265 (1998).

[5] *Ezekial v. Winkley*, 20 Cal. 3d 267 (1977).

[6] *Pinsker v. Pacific Coast Society of Orthodontists*, 12 Cal. 3d 541, 555 (1974) (emphasis added).

[7] As required, the summary suspension was already reported to the Medical Board of California, thereby providing Dr. O'Hanlan with statutory hearing rights under the Bylaws.

[8] *Insurance Co. Of North America v. Workers' Comp. Appeals Bd.* 122 Cal. App. 3d. 905, 910 (1981) (emphasis in original).

[9] *Huang v. Board of Directors*, 220 Cal. App. 3d 1286, 1293 (1990).

[10] *Huang,* 220 Cal. App 3d at 1293-94.

[11] *Kearl v. Board of Medical Quality Assurance,* 189 Cal. App. 3d 1040, 1052 (1986).

[12] *Cipriotti v. Board of Directors of Northridge Hosp. Fdtn. Med. Ctr.*, 147 Cal. App. 3d 144, 155 (1983).

[13] *Id.*

[14] *Id.*

In sum, as an appellate review committee we understood our charge to be that we

> ".. must consider all of the evidence in the light most favorable to the prevailing party [the MEC], giving it the benefit of every reasonable inference, and resolving conflicts in support of the judgment. [Citations.] [We] must accept as true all evidence and all reasonable inferences from that evidence tending to establish the correctness of the [Hearing Committee's] findings and decision, resolving every conflict in favor of the judgment. It is not [our] task to weigh conflicts and disputes in the evidence; that is the province of the [Hearing Committee]. [Our] authority begins and ends with a determination of whether, on the entire record, there is any 'substantial' evidence, contradicted or uncontradicted, which will support the judgment."[15]

An additional issue concerns Dr. O'Hanlan's failure to discuss all of the relevant evidence in her brief to the ARC. Her brief mostly discusses only evidence that she believes supported her position, leaving out copious evidence that supported the Hearing Committee's findings. While this omission might be deemed a waiver of her appeal on the supposed lack of substantial evidence,[16] the ARC does not rule on this basis that Dr. O'Hanlan has waived this ground for her appeal.

IV. DR. O'HANLAN RECEIVED A FAIR HEARING.

A. Dr. O'Hanlan's Arguments On Appeal Lack Merit.

1. There was no prejudicial reference to inaccurate information.

Dr. O'Hanlan's appellate brief argues that the Hospital CMO, Dr. Chandrasena, admitted that the statistics used by the Hospital for Dr. O'Hanlan's alleged high complication/take-back rates were inaccurate but that she (Dr. Chandrasena) continued to reference the numbers during the Hearing Committee sessions thereby "creating and maintaining a severely negative bias." (Appellant's Brief, pg. 4:26-27.) There is no clear citation in her brief to the administrative record where Dr. Chandrasena allegedly made this admission, or where she allegedly continued to reference the numbers.[17] Dr. O'Hanlan argues that it was this inaccurate information that resulted in the investigation that led to the adverse action. (Appellant's brief, pg. 5:1-9.) Although not clearly stated, it is presumed that this is being advanced as a fair procedure issue – that the entire peer review proceeding was not fair because it was initiated and prosecuted based on false information.

The problem with Dr. O'Hanlan's argument is that it is clear that the Hearing Committee

---

[15] *Villafuerte v. Inter-Con Security Systems, Inc.*, 96 Cal. App. 4th Supp. 45, 49-50 (2002).

[16] *Foreman & Clark Corp. v. Fallon*, 3 Cal. 3d 875, 881 (1971) ("[I]f, as defendants here contend, some particular issue of fact is not sustained, they are required to set forth in their brief all the material evidence on the point and not merely their own evidence. Unless this is done the error assigned is deemed to be waived.".)

[17] Unfortunately, in the body of Dr. O'Hanlan's brief, where the specific arguments are made, there are virtually no specific citations to the administrative record. Rather, at the end of the brief there are references to portions of the record for specific issues. Testimony excerpts are cited in this list as "germane to the appeal" but there is no indication to what issue the cited testimony is "germane".

decision upholding both the summary suspension and the revocation recommendation were ***not*** based on the statistical data debated during the hearing, and therefore this is irrelevant to this appeal. To the contrary, the Hearing Committee decision states:

> "Dr. O'Hanlan's focus on statistics as a major part of her 'defense' to the MEC charges, largely missed the point. The point is the quality of clinical decision-making, adequate attention to detail, careful planning and honesty in documentation. In these areas she often failed to meet applicable standards." (Hearing Committee Decision, page 20.)

2. The Medical Staff was not improperly allowed to add information at the hearing that was never considered by the Ad Hoc Investigative Committee, and the information allowed was relevant.

Dr. O'Hanlan argues that the Medical Staff, during the hearing, sought to add to its case issues regarding (1) Dr. O'Hanlan's 2002 resignation from Stanford Hospital and a related Medical Board of California action, (2) a 2002 case at Mills-Peninsula Hospital that resulted in a medical malpractice action against her that she settled, and (3) her 2004 resignation from Mills-Peninsula Hospital. According to Dr. O'Hanlan, this was improper because this information was never considered by the Ad Hoc Investigative Committee and related to matters dating more than 10 years ago. (Appellant's Brief, pg. 6:18; 7:3-23.)

Dr. O'Hanlan argues that it was prejudicial error for the Hearing Officer to have allowed testimony "....regarding this stale Medical Board matter." (Appellant's Brief, pg. 7:13.) Dr. O'Hanlan argues that, while the MEC only claimed to use this information to show Dr. O'Hanlan had "exercised extremely poor judgment", this "inevitably biased the conclusions regarding her character." Dr. O'Hanlan concludes that: "Presenting extensive documents, testimony and cross-examination on irrelevant and highly prejudicial matters is a bell that cannot be unrung. Dr. O'Hanlan was damaged by the admission of such evidence and the unrestricted argument and questioning re same." (Appellant's Brief, pg. 7:20-23.)

Dr. O'Hanlan's argument reveals a fundamental lack of understanding of the peer review process. Whether or not the *Ad Hoc Investigative Committee* considered certain facts in its recommendation to the MEC to revoke Dr. O'Hanlan's privileges is irrelevant to any alleged unfair procedure in the *Hearing Committee*. Dr. O'Hanlan was on notice that the MEC intended to raise these matters and she was afforded a full opportunity to defend against them. (SH-KO-ADM 002820-21-attaching and incorporating by reference SH-KO-ADM 002841-42.) Moreover, the Hearing Committee Decision specifically states that Dr. O'Hanlan's problem at Stanford and results of that incident were not taken into consideration when deciding this matter and therefore the Hearing Officer ruling allowing this evidence in could not have been prejudicial. (Hearing Committee Decision at pg. 13, fn. 15.)

The Hearing Committee did, however, clearly consider the circumstances of the 2002 case wherein she wrongfully removed a patient's ovaries as to which Dr. O'Hanlan was sued and settled, and an incident at Mills-Peninsula Hospital wherein she removed a patient's fallopian tubes without proper informed consent, resulting in her summary suspension and thereafter voluntarily resigned while under investigation rather than provide Mills-Peninsula with documentation as to her termination from Stanford. (Hearing Committee Decision at pp. 15-17.) These cases did affect the Hearing Committee's

evaluation of the case at Sequoia where she did the same thing – removing organs without proper informed consent. (Hearing Committee Decision, pp. 17.) The Hearing Officer admitted the evidence regarding what happened at Mills-Peninsula after hearing testimony that the MEC had reviewed it when arriving at their recommendation. (SH-KO-ADM 000182-188; 000229-31.)

The Hearing Officer made the correct ruling. The Hearing Committee was charged with evaluating the recommendation of the MEC. Without knowing what information the MEC had, that evaluation would not be complete. Additionally, given that what is referred to as the "Ovaries case" involved removing organs without the patient's consent, prior similar cases would be relevant to the MEC's stated concern that Dr. O'Hanlan does not learn from her mistakes. Moreover, even if the ruling was erroneous, the Hearing Committee did not make its decision affirming the revocation recommendation solely on the Ovaries case. The law does not require that all Charges be proven in order for a Hearing Committee to affirm an MEC recommendation.[18]

3. The Hearing Officer Did Not Make Erroneous Evidentiary Rulings.

At the appellate oral argument, Dr. O'Hanlan's attorney argued that she was denied a fair hearing because of two rulings by the Hearing Officer that sustained objections to questions asked by Dr. O'Hanlan's attorney at the Hearing Committee hearing that allegedly resulted in:

(1) Dr. O'Hanlan being prevented from presenting evidence to the Hearing Committee that when the California Department of Public Health investigated the case of removal of the patient's ovaries without consent, it found that nursing staff had erred and fined the Hospital; (Appellate Hearing Transcript at 9:11-19; 11: 22- 12:10; 18:13-16.)[19] and

(2) Dr. O'Hanlan being prevented from presenting evidence to the Hearing Committee that a Medical Staff internal peer review of what is referred to as the "Aorta" case found no problem with Dr. O'Hanlan's handling of that case. (Appellate Hearing Transcript at 9:19-24; 14:8-15:13; 18:13-18.)

The ARC asked itself two questions in connection with both arguments: (1) Did the purported error occur? (2) If the error occurred was it "demonstrably prejudicial" such that the Hearing Committee decision should be reversed? As the MEC's supplemental brief noted, not only is "demonstrably prejudicial" the standard in the Bylaws, but it is what the law requires: *i.e.,* reversal is not appropriate if the error is *harmless.* [20] The relevant excerpts from the Hearing Committee hearing at

---

[18] *Breneric Assocs. v. City of Del Mar*, 69 Cal.App.4th 166, 176 (1998).

[19] Dr. O'Hanlan's attorney also argued that she was not entitled to present this evidence to the Ad Hoc Investigatory Committee or to the MEC; however, that is not relevant to whether she had a fair hearing before the Hearing Committee.

[20] *El-Attar v. Hollywood Presbyterian Medical Center*, 56 Cal.4th 976, 990 (2013) ("Not every violation of a hospital's internal procedures provides grounds for judicial intervention. In applying the common law doctrine of fair procedure, we have long recognized that departures from an organization's procedural rules will be disregarded unless they have produced some injustice"); *Thornbrough v. Western Placer Unified School Dist.* 223 Cal.App.4th 169, 200 (2013) ("And it is well-settled that the improper admission or rejection of evidence at an administrative hearing does not provide 'grounds for reversal unless the error has resulted in a miscarriage of justice. [Citation.] In other words, *it must be reasonably probable a more favorable result would have been reached absent the error.*' ") (citations omitted, emphasis added).

issue are attached as exhibits A and B to the MEC's supplemental brief, and incorporated herein by this reference.

a. Dr. O'Hanlan was not prevented from asking about the CDPH investigative report and fine against the Hospital in connection with the Ovaries case; and regardless, the alleged error was not *demonstrably prejudicial.*

Regarding the CDPH investigation of the Ovaries case, the Hearing Officer ruling at issue was not because the CDPH investigation document was not in evidence. Dr. O'Hanlan's attorney admitted that the document was in evidence. (Appellate Hearing Transcript at 12:23-4; 48:13-21.) Rather, in substance, the objection was sustained because of the form of the question. Dr. Adler was asked, without objection, if he knew that the Hospital had been fined because of the incident, and he answered that he did. The question where the objection was sustained is as follows:

Question: And it [CDPH] investigated the situations that the hospital was at fault to some extent?

Objection: Assumes facts not in evidence.

Ruling: Sustained. We don't know what part of the hospital, whether it's Dr. O'Hanlan or clerk or nurse or anyone else. Hospital is a big phrase.

(SH-KO-ADM, pg. 110:2-8.)

While the Hearing Officer sustained the objection, he explained that it was because of the vague, ambiguous and overbroad use of the word "Hospital". Nothing prevented Dr. O'Hanlan's lawyer from rephrasing the question to be more specific if he really cared to press the matter. Similarly, there was nothing preventing the attorney from questioning Dr. Adler using the actual CDPH report which Dr. O'Hanlan's attorney concedes was in evidence. (Appellate Hearing Transcript at 12:23-4; 48:13-21.) Moreover, there can be no dispute that the Hearing Committee knew of, and considered, the CDPH report and the fine issued, as it was referenced in its decision, and so no one was lacking for information about the CDPH's findings. (Hearing Committee Decision at pg. 5.) The fact that the Hearing Committee referenced the CDPH report and the fine levied against the Hospital also belies any claim that the Hearing Committee would have ruled otherwise had the objection been overruled.

b. Dr. O'Hanlan was not erroneously prevented from asking about the internal Medical Staff peer review form done in connection with the Aorta case; and regardless, the alleged error was not *demonstrably prejudicial.*

As with the CDPH investigation report, the Hearing Officer did not sustain objections during the questioning about an internal Medical Staff peer review form because of any belief that the peer review form was not in evidence. Rather, the objections were sustained because of the form of the questions to Dr. Chandrasena:

Question: Whether you remember the details or not, did you look at peer review of this case, the one that led to the emergency suspension of Dr. O'Hanlan?

Objection: I object. There was no peer-review form in evidence and I would submit

there never was one. No form—no peer-review form considering this case, so these questions don't make any sense;

Ruling: John [Fleer – Dr. O'Hanlan's attorney], I'm going to sustain the objection unless you define peer review. I mean, that encompasses a multitude of things.

Dr. O'Hanlan's attorney made no attempt to rephrase the question.

(SH-KO-ADM 002709-10, pp. 65:24-66:10.)

Following this question there is a discourse between the attorneys and the Hearing Officer regarding whether this peer review form had been produced and was in evidence. In fact it was, and there is no contention on appeal that this peer review form was improperly excluded from evidence. The next set of questions/objections and rulings at issue are:

Hearing Officer: John [Fleer – Dr. O'Hanlan's attorney], are you asking: Was the aorta case reviewed by any segment of the organized medical staff?

Question: I'm only asking if she [Dr. Chandrasena] knows if it was, and if she looked at it.

Dr. Chandrasena: I actually don't remember. I'm pretty certain it was.

Question: Did you look at it?

Objection: What is the "it" that we're talking about? I object to this. It's a nonsense line of questioning. The medical executive committee is the peer-review body. What peer-review body is Mr. Fleer referring to? If there's a document that he wants to draw Dr. Chandrasena's attention to, then fine, let's do it.

Ruling: Sustained.

(SH-KO-ADM 002710-1, pg. 66:24-25; 67:4-10.)

The attorney made no attempt to clarify what "it" referred to.

Following the above questioning there is another extended discussion about whether the peer review form is in evidence and two more lines of questions where objections were sustained:

Question: Would it have made a difference to you if you knew that the matter had been peer reviewed?

Objection: Objection. You can't read from a document that's not in evidence. I object to that.

Ruling: The objection is sustained on the basis it calls for speculation.

Question: Did you care about peer review being done in this case?

Objection: Argumentative.

Ruling: Sustained.

(SH-KO-ADM 02714, pg. 70: pg. 15-22.)

At this point Dr. O'Hanlan's attorney stated: "That's all I have." (SH-KO-ADM 02714, pg. 70: pg. 15-23.) He made no attempt to rephrase either question. There was nothing preventing Dr. O'Hanlan's lawyer from asking proper questions or using the peer review form in questioning Dr. Chandrasena – or for that matter asking any other witnesses about it. Even if Dr. O'Hanlan's attorney could not find the document at the time of this particular questioning, he could have asked Dr. Chandrasena to be recalled as a witness at a later time.

Nor has there been any showing that the Hearing Committee's decision regarding the Aorta case, whether in connection with the revocation recommendation or the summary suspension, would have been any different if these rulings relating to the peer review form had been different.

The Hearing Committee's decision as it relates to the Aorta case was not based only on Dr. O'Hanlan's failure to plan for a vascular surgeon, but also was based on the documentation issues surrounding the three operative reports. The Hearing Committee concluded: "Although Dr. O'Hanlan tried to put a positive face on her multiple reports, we are reluctantly drawn to the conclusion that this exemplifies a perfidious pursuit of obfuscation, in attempting to cover up the truth in the operative reports." (Hearing Committee Decision at pg. 19.) In other words, because the clinical judgment issue was not the only basis for the JRC finding vis-à-vis the Aorta case, it cannot be said that it is "...reasonably probable a more favorable result would have been reached absent the error'. ")[21] That of course also assumes there was an error which does not clearly appear.

As California courts have recognized, "an act of dishonesty cannot be divorced from the obligation of utmost honesty and integrity to the patients whom the physician counsels, as well as numerous third party entities and payors who act on behalf of patients."[22] Similar statements from courts include: "[i]ntentional dishonesty . . . demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine."[23] Indeed, physician dishonesty is grounds for denial or revocation of a California physician's license to practice altogether.[24]

B. The Peer Review Process Followed the Bylaws.

Neither in her written submission nor her attorney's oral argument did Dr. O'Hanlan identify any Bylaw that was not followed. The ARC considers this issue waived.

---

[21] *Thornbrough,* 223 Cal.App.4th at 200.
[22] *Krain v Medical Board,* 71 Cal. App. 4th 1416,1426 (1999).
[23] *Matanky v. Board of Medical Examiners*, 79 Cal. App. 3d 293, 305 (1978).
[24] Bus. & Prof. Code §§ 475(a)(1), 480 and 498. These statutes do not require that the Medical Board's power to take such action be tied to charges of incompetent clinical practice.

C. Dr. O'Hanlan Had Notice of the Charges Against Her and A Full Opportunity to Respond.

As stated in Part III, above, in the context of physician disciplinary action, in order for the ARC to conclude that Dr. O'Hanlan received a fair hearing, the evidence must show that she had "*adequate notice of the administrative action taken by the group or institution, and a reasonable opportunity to be heard.*"[25] In this case, there can be no doubt that this standard was met. The two Notices of Charges unambiguously informed Dr. O'Hanlan what the issues were that were the basis for the summary suspension and the revocation recommendation. (SH-KO-ADM 002816-42.) And in light of the twelve evidentiary sessions held, there can be no serious argument that she did not have an opportunity to be heard.

V. SUBSTANTIAL EVIDENCE SUPPORTS THE FINDINGS AND CONCLUSIONS OF THE HEARING COMMITTEE.

The ARC is cognizant of the limitations imposed upon it by California law in connection with this asserted ground for appeal. Those limitations are set forth above. Suffice it to say that ARC approached its review with the understanding that the Hearing Committee's findings should be upheld "unless the administrative findings . . . are so lacking in evidentiary support as to render [them] unreasonable."[26] As the appellant, it was Dr. O'Hanlan's burden to show that the stated findings of fact of the Hearing Committee are "...so lacking in evidentiary support as to render [them] unreasonable."[27] As explained below, Dr. O'Hanlan did not meet her burden in this regard and she neglects even to mention and confront ample evidence that supports the Hearing Committee's findings.

A. Hearing Committee Findings And Conclusions.

The findings and conclusions that are supported by substantial evidence are stated at pages 19-20 of the Hearing Committee decision as follows:

> "Finding #1:
>
> Dr. O'Hanlan's training, experience and skill in performing the physical and mental act of surgery, especially laparoscopic surgery, is excellent-perhaps even exceptional.
>
> Finding #2:
>
> Dr. O'Hanlan's inattention to important details, both preoperatively and postoperatively, has exposed patients to an unreasonable and unacceptable level of risk of serious injury. Illustrative of the factual basis for this finding include:
>
> - A variety of failures to follow established policies and practices regarding obtaining the patient's informed consent and failure to conform the actual procedure to the consent given;

---

[25] *Tiholiz*, 151 Cal. App. 3d at 1202 (emphasis added).
[26] *Id.*
[27] *Id.*

- Insufficient preoperative planning;
- Failure to order timely and adequate imaging studies and laboratory tests;
- The practice of engaging the patient in a "social visit" prior to discharge without examining and considering relevant information in the medical record;
- Advising a patient with substantial and obvious bleeding to drive three hours to return to Sequoia Hospital, when other adequate hospital facilities were within a one-hour drive.

Finding #3:

In spite of Dr. O'Hanlan's protestations that she only needs "a tap on the shoulder" in order to bring her practice patterns into conformity with applicable professional standards, the record in this case supports the MEC contention that Dr. O'Hanlan is especially "challenged" when she needs to seriously consider the advice of peers, to evaluate the wisdom of their suggestions, and to adjust her practice patterns to applicable professional standards. We concur with the observations made by the AHC [the Ad Hoc Investigative Committee] and the MEC that Dr. O'Hanlan's ability or willingness to change her practices are so questionable that patient safety requires that a 'leap of faith' not be made by the Medical Staff by continuing her privileges in the hope that change would occur.[28]

Finding #4:

Considering the information which was presented to the MEC at and before its meeting of August 21, 2017, and especially in view of the lack of veracity exhibited in the documentation of the Aorta Case, it was reasonable and warranted for the MEC to summarily suspend Dr. O'Hanlan's clinical privileges on that date.

Finding #5:

Considering the information presented to the MEC at its meeting of August 28, 2017, including the presentation of Dr. O'Hanlan, it was reasonable and warranted for the MEC to continue the summary suspension in effect until completion of all applicable peer review processes, because this information demonstrated that there was a legitimate basis for fearing that to do otherwise would expose future patients to imminent danger.

Finding #6:

Based on the preponderance of evidence produced and admitted at the hearing of this committee, and after having given all of the evidence careful and objective consideration, it is the unanimous conclusion and decision of this committee that the medical staff membership and clinical privileges of Dr. O'Hanlan should be revoked.

---

[28] Chandrasena, Tr. 6/5 p. 67 (SH-KO-ADM 002028); Tene, Tr. 4/10 p. 18 (SH-KO-ADM 001428); Adler, Tr. 5/9 p. 126 (SH-KO-ADM 001679.)

Finding #7:

Having carefully reviewed and considered the record of the peer review activities that preceded this hearing, it is the conclusion of this committee that the actions of the Clinical Department, the Quality Improvement staff of the hospital, the Ad Hoc Investigating Committee and the Medical Staff Executive Committee were fair and appropriate, both substantively and procedurally.

(Hearing Committee Decision at pp. 19-20.)

B. Dr. O'Hanlan's Arguments Regarding Substantiality of the Evidence Lack Merit.

1. Whether or not Dr. O'Hanlan's complication/take-back rate was problematic is irrelevant to this Appeal.

Dr. O'Hanlan's appellate brief focuses extensively on statistical analysis of complication or "take back" rates and her argument that her rates are not as high as claimed by the Medical Staff. Dr. O'Hanlan argues that during the hearing she established that her complication/take-back rate was within appropriate limits and actually quite good. Her appellate brief claims that "[d]uring the course of the hearing, it was established by un-contradicted testimony that Dr. O'Hanlan had complications that were within the acceptable range for her profession in both frequency and severity." (Appellant's Brief, pg. 4: 11-13.) However, there is no reference to the administrative record where this was "established."

It does appear that these statistics played a significant role in the initial concerns and creation of the Ad Hoc Investigative Committee. However, neither the accuracy of the statistics nor Dr. O'Hanlan's complication rate are relevant to this appeal. The Hearing Committee decision is not based on the statistics. The Hearing Committee decision goes out of its way to make this point: "Dr. O'Hanlan's focus on statistics as a major part of her 'defense' to the MEC charges, largely missed the point. The point is the quality of clinical decision-making, adequate attention to detail, careful planning and honesty in documentation. In these areas she often failed to meet applicable standards." (Hearing Committee Decision, page 20.) Indeed, not a single of the Hearing Committee's *Findings and Conclusions* even references these statistics.

2. Three Cases are sufficient to revoke Medical Staff membership and clinical privileges.

Dr. O'Hanlan argues in her written brief that, because the Hearing Committee made no findings on six of the nine cases presented to the Hearing Committee, the Hearing Committee found these cases insufficient to support the Charges. She argued that three cases of the thousands of patients she treated is insufficient to support revocation of her Medical Staff membership and clinical privileges. (Appellant's Brief, pg. 6:7-9.)

Dr. O'Hanlan's speculation as to why the other cases were not discussed in the Hearing Committee decision is just that – speculation. It is equally as likely that the Hearing Committee simply felt that the three cases discussed were so egregious, that there was no need to discuss the others.

Regardless, as noted above, a single case charged is sufficient to support the action taken.[29]

3. The revocation recommendation was not based on a "pseudo-psychological analysis of Dr. O'Hanlan".

Dr. O'Hanlan argues in her appellate brief that the "primary thrust of the Committee members' decision was to negatively characterize Dr. O'Hanlan's attitude and willingness to accept criticism." (Appellant's Brief, pg. 6:12-13.) She argues that she was merely defending herself and that her "incredulity about the indications for each step of the review was misinterpreted as resistance to review." (Appellant's Brief, pg. 6:15-16.) The brief does not reference any particular page or sentence or paragraph in the Hearing Committee's decision to support this argument. The brief argues that the Hearing Committee's criticisms of Dr. O'Hanlan's attitude towards peer review was improper because Dr. O'Hanlan was just expressing her frustration with the unfair process – arguing that "[h]ad Dr. O'Hanlan meekly accepted the unfair criticisms and false allegations thrown her way, she might not have been in her current situation. She should not be shunned for being a strong person, standing up for herself and contesting false claims made against her." (Appellant's Brief, pg. 13:9-11.)

The Hearing Committee's concerns about Dr. O'Hanlan's resistance to criticism and her unwillingness to participate in the peer review process was not the "primary thrust" of the Hearing Committee's decision to affirm the actions of the MEC. Rather, legitimate concerns about substandard patient care were identified, and therefore, evidence of her unwillingness to change supports the decision that revocation is reasonable and warranted. *See e.g.,* report of the Ad Hoc Investigative Committee, SH-KO-ADM 002822-40); report of outside expert Dr. Chapman, SH-KO-ADM 002997-3076; summaries of various concerns, SH-KO-ADM 003122-3130.) The Hearing Committee heard Dr. O'Hanlan testify, and the ARC cannot reassess her credibility. After hearing her testify, the Hearing Committee stated: "We concur with the observations made by the AHC [Ad Hoc Investigative Committee] and the MEC that Dr. O'Hanlan's ability or willingness to change her practices are so questionable that patient safety requires that a 'leap of faith' not be made by the medical staff by continuing her privileges in the hope that change would occur." (Hearing Committee Decision, pg. 20.)

4. The ARC cannot and will not reweigh the evidence or reconsider issues of credibility.

Dr. O'Hanlan argues in her written appellate brief that the written outside review of Dr. O'Hanlan's cases should be virtually disregarded because the reviewer did not consider Dr. O'Hanlan's responses and because she did not testify before the Hearing Committee to be cross-examined. She argues that without Dr. Chapman's report, the only evidence that remained were her expert and physician witnesses presented by her that supported the care she provided. (Appellant's Brief, pg. 8:7-28.) She made a similar argument at the appellate oral argument. (Transcript of Proceedings of October 3, 2019, pg. 9:2-10.)

Dr. O'Hanlan cannot ignore Dr. Chapman's report and asking the ARC to do so is an improper request that the ARC reweigh the evidence presented.

---

[29] *Breneric,* 69 Cal.App.4th at 176.

5. The concerns re: Patient KM – the Aorta Case – were more than mere "miscommunication".

Dr. O'Hanlan's appellate brief argues that the concerns regarding her care of Patient KM – the Aorta case that led to the summary suspension – were insufficient to establish that failure to act might present an "imminent danger" to any person at the Hospital, the standard for summary suspension. Rather, she argues that the concerns were "at most attributable to miscommunication between the consulting vascular surgeon and Dr. O'Hanlan, and the Medical Staff's misrepresentation of a draft of the operative report prepared by Dr. O'Hanlan. There has been no presentation of any hospital-wide QA criticism of the medical care provided to this patient, because none exists. The patient appears cured at 2 years." (Appellant's Brief, pg. 6:24-7:2.) Again, as with other issues, her appellate brief does not provide citation to the administrative record to support this argument. Dr. O'Hanlan's arguments that the success of the case matters, and that there was no evidence that there was any negative peer review of this case is wrong.

Peer review is prophylactic and therefore whether or not this case was successful is irrelevant.[30] Regardless, Dr. O'Hanlan is simply wrong that there was no negative peer review of this case. The Ad Hoc Investigative committee stated: "She incorrectly prepared for surgery, incorrectly performed surgery, did not involve a specialist early on, managed patient without seeing the patient and created improper and initially misleading documentation." (SH-KO-ADM 002837.) And, of course, the Hearing Committee heard from Dr. Zimmerman, the surgeon called in to repair the tear in the aorta. (SH-KO-ADM 001789-1824; 001837-1909.) The Hearing Committee clearly found Dr. Zimmerman to be more credible as to the substandard care provided by Dr. O'Hanlan. The ARC is without authority to reject the Hearing Committee's witness credibility determination.

6. It is undisputed that Dr. O'Hanlan dictated three operative reports in the Aorta case and the Hearing Committee's concern as to her honesty was legitimate and supports the disciplinary action taken.

Dr. O'Hanlan's appellate brief provides the same explanation for why she dictated three operative reports that she offered when testifying at the hearing – a reason that the Hearing Committee simply did not believe. As the Hearing Committee Decision states: "Dr. O'Hanlan dictated three operative reports, two on August 9th the day of the surgery, and one the following day on August 10th. While Dr. O'Hanlan tries to offer a plausible explanation for this strange series of events, we found her credibility lacking." (Hearing Committee Decision, page 15.) "Although Dr. O'Hanlan tried to put a positive face on her multiple reports, we [the Hearing Committee] are reluctantly drawn to the conclusion that this exemplifies a perfidious pursuit of obfuscation, in attempting to cover up the truth in the operative reports." (Hearing Committee Decision, page 15.) As explained in the section as to the applicable law, the ARC must accept the Hearing Committee's credibility determinations. Moreover, as also explained above, dishonesty in a physician is a quality of care issue that endangers patients.

---

[30] *See Marmion v. Mercy Hospital and Medical Center*, 145 Cal. App. 3d 72, 88 (1983) (hospital could suspend the doctor summarily from its residency program based on indications that "future patients may indeed suffer . . . . It is not necessary to wait until a patient dies to find that the quality of medical care has suffered."); *see also Medical Staff of Sharp Memorial Hospital v. Superior Court (Pancoast)*, 121 Cal. App. 4th 173, 182 (2004) (hospital need not wait until someone is either harmed to act, or be able to identify specific patients who may be in danger).

"Intentional dishonesty . . . demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine."[31]

Dr. O'Hanlan's appellate brief does not address the honesty issue that is actually posed by the three reports - that the first two omitted mention that Dr. O'Hanlan tore a hole in the aorta, and it was not until after the vascular surgeon submitted his report that the third version mentions it. Rather, her brief argues that there was no evidence that the quality of care was substandard and that the Hearing Committee's statement that "the 'multiple reports' exemplified 'a perfidious pursuit of obfuscation'.... alone demonstrates the great lengths to which the Hearing Committee was willing to go in impugning Dr. O'Hanlan's integrity." (Appellant's Brief, pg. 12:8-10.)

It simply is not true that there was no evidence that the quality of care provided by this patient was substandard. *See e.g.,* Ad Hoc Investigative Committee Report at SH-KO-ADM 002837; testimony of Dr. Zimmerman at (SH-KO-ADM 001789-1824; 001837-1909.)

7. Expert testimony was not needed to prove the Charges against Dr. O'Hanlan.

Dr. O'Hanlan argued at the appellate hearing there was no expert testimony to establish that Dr. O'Hanlan breached the standard of care in any of the three cases that are relied upon for the Hearing Committee Decision. Her attorney argued that the failure to present any such expert testimony means there was not substantial evidence to support the MEC's case, and therefore the MEC did not meet its burden of proof. (Transcript of Proceedings of October 3, 2019, pg. 9:2-10.) She also argued that the testimony of Dr. Zimmerman should not have been accepted over the testimony of Drs. O'Hanlan and O'Holleran as it relates to the Aorta case. (Transcript of Proceedings of October 3, 2019, pg. 13:19-23.) However, the JRC apparently believed Dr. Zimmerman over the others, and the ARC cannot reject that credibility determination.

Upon further questioning at oral argument, Dr. O'Hanlan's lawyer conceded that experts might not have been needed and if needed it was unclear as to what type of expert she thinks should have been presented to the Hearing Committee. (Transcript of Proceedings of October 3, 2019, pg. 21:18-20.) While the rules of evidence are not applicable to an internal peer review hearing, it is notable that in a civil trial, experts are only allowed if needed because there is an issue beyond the common knowledge of the fact finders.[32] Here, the "jury" is comprised of physicians. Had this been a civil trial it is likely that expert testimony would not have been allowed, much less required. An expert was not required for the issues presented in these cases, none of which presented a unique gynecological oncology issue. Moreover, the JRC panel included both a cardiothoracic surgeon and an OB/GYN. There is no legal or factual basis to argue that the lack of an expert witness testifying at the Hearing Committee hearing on any of these three cases means there is no substantial evidence to support the Hearing Committee's findings.

---

[31] *Matanky,* 79 Cal. App. 3d at 305; *See also* attached letter from Darryl Gray, 2009 Director, Division of Practitioner Data Banks, stating that the National Practitioner Data Bank "....views intentional misrepresentations to the hospital body making determinations about the clinical competence of providers almost *per se* as having the potential to adversely affect the health or welfare of a patient."

[32] California Evidence Code, Section 801 (a).

C. Substantial Evidence Supports the Hearing Committee's Report.

As discussed above, it was Dr. O'Hanlan's burden, as the appellant, to show that there was no substantial evidence to support the Hearing Committee's findings. Dr. O'Hanlan did not meet this burden. But the ARC notes that the failure to carry her burden is not the result of inadequate briefing or oral argument, but rather it is the result of an abundance of substantial evidence, both documentary and testimonial, supporting the Hearing Committee's findings and conclusions that the MEC had proven its Charges and that the summary suspension, its continuation, and the revocation recommendation all were reasonable and warranted. There are 105 footnotes to the Hearing Committee decision setting forth with particularity the evidence it relied on for the decision. This included the 19 page report of the Ad Hoc Investigative Committee (SH-KO-ADM 002822), the 65 page outside review by expert Dr. Julia Chapman (SH-KO-ADM – 002997- 003060), and the extensive documentary evidence submitted by the MEC (SH-KO-ADM 002813- 5: the MEC's Exhibit List). And of course there is copious testimony over twelve days of hearings.

The record also includes admissions by Dr. O'Hanlan of errors in five of the cases that were included in the Charges. In Dr. O'Hanlan's own words:

> "1. Wrongful removal of a patient's ovaries without consent. **(my error)**
>
> 2. Failing to attend to notes and labs from prior night that would have revealed post-operative patient with hemoperitoneum, whom I allowed to be discharged, only later to be re-admitted and operated on. (**my error**).
>
> 3. Failing to obtain q6hour H/H's after takeback showed no bleeding anywhere, of patient having postoperative bleed after appendectomy/enterotomy stapled/BSO, which would have revealed persistent bleeding newly into her small bowel. Failing to recognize danger of suggesting that this patient return on long drive back to Sequoia for laparoscopic care. (**my error**)
>
> 4. Failing to accurately visualize abdominal wall causing secondary trocar insertion with enterotomy diagnosed next day. (**my error**)
>
> 5. Failed to dictate date of WBC obtained during the pre-op week, or chemo history in three patients' HxPE."

(SH-KO-ADM00334, emphasis added.)

V. CONCLUSION.

The ARC agrees with the Hearing Committee that the MEC met its burden of establishing by a preponderance of the evidence the facts underlying each of the Charges, and that the summary suspension, the continuation of the summary suspension, and the revocation recommendation were reasonable and warranted. Dr. O'Hanlan has not established that she did not receive a fair hearing. Nor did she establish that there was not substantial evidence to support the factual findings of the Hearing Committee as they relate to the summary suspension,

the continuation of the summary suspension, and the revocation recommendation. Accordingly, Dr. O'Hanlan's appeal is denied, and the summary suspension and the continuation of the summary suspension are affirmed and Dr. O'Hanlan's Medical Staff membership is revoked.

Dated: _____

Timothy Wu, Chair

Dated: _____

Daniel Rengstorf, M. D.

Dated: 2/13/2020

Jason Wong, M. D.

325847435.1

Dated:

Timothy Wu, Chair

Dated: 2/13/2020

Daniel Rengstorf, M. D.

Dated:

Jason Wong, M. D.

325847435.1

the continuation of the summary suspension, and the revocation recommendation. Accordingly, Dr. O'Hanlan's appeal is denied, and the summary suspension and the continuation of the summary suspension are affirmed and Dr. O'Hanlan's Medical Staff membership is revoked.

Dated: February 14, 2020

/s/

Timothy Wu, Chair

Dated: _____

Daniel Rengstorf, M. D.

Dated: _____

Jason Wong, M. D.

325847435.1

EXHIBIT 6

Torosis, James - SEQ <James.Torosis@dignityhealth.org>

Thu, Aug 25, 2016 at 4:30 PM

To: "kate.ohanlanMD@gmail.com" <kate.ohanlanMD@gmail.com>
Cc: "Kennedy, Yulia - SEQ" <Yulia.Kennedy@dignityhealth.org>

Kate,

Thanks you for taking my call yesterday. I know that you indicated you first wanted to have the opportunity to review your cases that have been discussed in peer review with the department of Ob/Gyn . You wanted to review them before we met so I am providing you with the list of medical record numbers (see below). At your request I have also included the clinical indicators that your department has chosen to review cases. For your info I also included the OPPE score card that every physician on staff at Sequoia has and is produced every 6 months.

You may review these cases at your convenience. You also asked me if the NSQIP data is available so that you can compare your rates compared to national data. This data is available in the Quality office downstairs in the hospital and Mary Christen- Director of Quality can review this data with you. Mary will also be able to provide you with some of the numerator and denominator numbers that you were asking me for.

Kate you also alluded in our phone conversation that you have never received communication that a case of yours has fallen out. I have included a sample of one of the letters that was sent to you recently.

I hope I have provided you with enough information that you need. More information should be available in the Quality dept and cannot be sent via email, mainly for you protection under peer review. I invite you to reach out to Mary to review this information.

Kate, I want to stress that the intent of meeting is for your benefit so that we can have a better plan for improved patient outcomes. It is not meant to be punitive or put a "black mark" (as you stated) in your file.

In order to proceed with this in a timely fashion I would hope you could complete the review of your own cases and review of your data with Mary Christen by Sept 30. I will reach out to you near that time so that we can schedule a meeting and review the information.

List of MR# of cases

MR#'s
884139
883128
884582
885134
872362
886068
888062
882819
722477
835092
896411
897974
409412
897508
682181
900106
891259
890560
889390
716341
890070
890288
902469
900688
902920
903133
901512
905197

Thank you again,

Respectfully

Jim Torosis, MD

President of the Professional Staff, Sequoia Hospital

Kate O'Hanlan, MD <kate.ohanlanmd@gmail.com> Thu, Aug 25, 2016 at 5:04 PM

Reply-To: Kate@ligocourses.com
To: "Torosis, James - SEQ" <James.Torosis@dignityhealth.org>

Dear Jim,
I will study those cases and get back to you very soon. Here is a copy of my correspondence with Dr. Talabian that signifies my strong willingness to participate with with QA system. I do not ever recall telling you I had not received any single letter about a patient. I just never received a formal letter detailing the summary of cumulative issues that lead me to have to meet with the chief of staff, as I wrote to Dr. Talabian. (please read attached pdf)
Looking forward to meeting with you,
Kate

Torosis, James - SEQ <James.Torosis@dignityhealth.org> Thu, Aug 25, 2016 at 5:11 PM
To: "Kate@ligocourses.com" <Kate@ligocourses.com>
Cc: "Kennedy, Yulia - SEQ" <Yulia.Kennedy@dignityhealth.org>

Kate,

Got it, sorry I misunderstood you about the letter.

Talk to you soon

Jim

Kate O'Hanlan, MD <kate.ohanlanmd@gmail.com> Mon, Sep 12, 2016 at 8:30 PM

Reply-To: Kate@ligocourses.com
To: "Torosis, James - SEQ" <James.Torosis@dignityhealth.org>

Dear Jim,
Just sending you a short note to update you so that you don't think I have forgotten this. I have researched every one of the MR#'s and am making my own chart of the complications and getting my OR numbers to obtain a denominator.
Getting back to you soon. But just so you don't worry, we have already begun greater care and attention to the infectious part of the surgery....and I am always acutely aware of my part, the surgical injury part of the surgery, but still, I must get back to you soon.
Thanks,
Kate

EXHIBIT 7

Dignity Health.
Sequoia Hospital

Medical Staff Services
170 Alameda de las Pulgas
Redwood City, CA 94062-2799
(650) 367-5554

James Torosis, M.D., FACP
President of the Medical Staff

CONFIDENTIAL

MEMORANDUM

TO: Medical Executive Committee, Sequoia Hospital

FROM: James Torosis, M.D., Medical Staff President
Beverly Joyce, M.D., Chief, Department of Obstetrics & Gynecology

DATE: October 3, 2016

RE: Katherine O'Hanlan, M.D.

Katherine O'Hanlan, M.D., is an Obstetrician & Gynecologist with an active practice at Sequoia Hospital. Over the years, she has had a series of complications, and what seem to be unusually frequent returns to surgery and post-operative infections. The concerns are illustrated by the following recent cases:

1. MR# 910425, which involved a 42-year-old woman who had laparoscopic oophorectomy and appendectomy on September 13, 2016, and experienced post-operative intra-abdominal bleeding requiring reoperation two times over the next 48 hours. Initially no source of bleeding was found, despite 650cc blood in abdomen. She was transfused and discharged home. Eventually she returned after complaining of rectal bleeding, and had 800cc blood in her abdomen. Bleeding was identified from small bowel staple line. She was transfused a second time.

2. MR # 908964, 63-year-old woman, Jehovah Witness, with preoperative evidence of widespread ovarian cancer who underwent laparotomy with debulking, colon resection with primary reanastomosis, on July 22, 2016. She required return to OR for pelvic abscess and underwent colostomy August 4, 2016. She additionally required CT-guided drainage of abscess. She was profoundly anemic postoperatively (hemoglobin 5). QA reviewer questioned not doing colostomy in first operation.

There have also been complaints of unprofessional conduct by Dr. O'Hanlan in her interactions with patients, families, hospital staff members, and other physicians.

Mojdeh Taleblan, M.D., former Chief of Staff, attempted to arrange a meeting with Dr. O'Hanlan to discuss the issues. However, Dr. O'Hanlan resisted and raised procedural

obstacles, as a result of which the meeting never occurred. More recent efforts by James Torosis, M.D, the current Chief of Staff have also been rebuffed.

Dr. O'Hanlan has challenged the validity of the complication rate and infection rate statistics produced by our Quality Assurance Department, which support our concerns about her practice, and has produced her own data that, according to her, show there is no problem with her practice. She is demanding an apology from the QA Department for its "sloppy work."

With reference to specific cases, Dr. O'Hanlan has admitted committing errors in some instances, and then concluded unilaterally that her apologies resolve the issues and obviate the need for those cases to receive further attention by the Medical Staff. In some instances, she has questioned the validity of concerns expressed in peer review because of the specialized nature of her practice (which includes many cancer patients), claiming that her peers lack the qualifications and expertise to assess her performance. Similarly, she has claimed that her cases are complicated and her patients are sicker and cannot be compared to those of her peers in the OB/GYN section. In some instances, she has suggested that others are responsible for complications that might be attributed to her as the primary surgeon.

As President of the Medical Staff and Chief of the Department of OB/GYN, we are concerned about the quality of Dr. O'Hanlan's practice. Her complaints about the data that are currently available from the QA Department may be valid to some extent, but her own data, which are based on her own methodology and assumptions, are not necessarily more reliable and certainly do not demonstrate that there is "no problem" with her practice. She might also have valid responses to the results the peer review process in specific cases, but there is legitimate cause for concern about the frequency with which her patients experience complications, require returns to surgery, and suffer post-operative infections. Special expertise might be need to review certain cases or issues, but we do not believe this is true in every instance.

Under Article VIII, Sections 1 through 3, of the Medical Staff Bylaws ("the Bylaws"), the Medical Staff President and/or a Department Chair may ask the Medical Executive Committee to initiate an "Investigation" whenever reliable information indicates that a member of the Medical Staff may have exhibited acts, demeanor, or conduct reasonably likely to be (among other things) detrimental to patient safety or to the delivery of quality patient care within the hospital, below applicable professional standards, or disruptive of hospital operations. The Investigation may be performed by an Ad Hoc Committee ("AHC"), if the MEC decides to proceed in this manner.

We are hereby invoking the above provision to request that an AHC be convened to conduct an investigation of Dr. O'Hanlan's professional performance at Sequoia Hospital, and make a report and recommendation to the MEC. We request authorization to appoint members who are impartial, have not been involved in the underlying controversies, and are willing to invest the time and effort in this important task. We will also monitor the progress of the investigation and provide whatever

support the AHC needs, including access to an outside expert for consultation regarding specific cases or issues, as well as access to legal counsel.

Respectfully,

James Torosis, M.D.
Medical Staff President

Beverly Joyce, M.D.
Chief, Department of OB/GYN

EXHIBIT 8

Peer Review Case Rating Form

MR #:920524 **D/C Date:** 08/18/2017 **Referral Date:** 08/15/2017 **Provider #:** 532-898 **Type:**Complication, surgical
Referral Source: Check the corresponding box

	Screen	x	Risk		HIM		Nursing		Pharm		Pt. Relations	x	Med Staff		Other _____

Review Criteria/Referral Issue: Intraoperative Aortic Injury
Quality Screener/Date: db 8/28/2017 **Date Submitted for Physician Review:** 8/28/2017

Case Summary Reason for Review: Surgical Complication -Aortic Injury

Description: This is a 65 year old female with recurrent endometrioid adenocarcinoma of the uterus. Per history, patient's original abdominal hysterectomy was 1/2014. The patient was treated with external beam teletherapy over a 5 week period and has been followed every 3 months. In 2016, patient noted increasing right hip pain which was attributed to arthritic changes. CT abdomen and pelvis showed a a mixed attenuation mass in the periaortic tissue. Abdominal MRI showed the takeoff in the inferior mesenteric artery was obscured, but the distal portions of the IMA appeared to be patent. The mid to distal infrarenal abdominal aorta showed mass or pseudo aneurysm, displacing the aorta and creating a ovoid configuration. An MR Angiogram showed the common iliac arteries fill normally. An MR angiogram of the abdomen confirmed the aorta was normal deviated to the left by a right periaortic retroperitoneal mass that was only faintly visualized.

Per the Pre-op History and Physical, films were reviewed with Dr. Hollett and Dr. M O'Holleran and we concur with their findings, which raise concern for invasion of the wall of the aorta, even though there has been no suggestion of invasion through the wall into the lumen. Our mutual conclusion was that if the mass cannot be peeled off the aorta, then it would be enucleated with and treated with the argon beam coagulator and tagged, so that the chemo radiation can be administered later. Surgeon's pre op history indicates "I spoke with Dr. Zimmerman about the possibility of needing his services, and he voiced his availability."

Pre Op labs included creatinine 0.4, hemoglobin 9.8, hematocrit 31, platelets 272. CEA 1.1 and CA-125 was elevated at 50. The patient reported weight loss of 30 pounds in the last 7 months that was not intended.

During Second Look Laparotomy, the aortic wall was traversed and Vascular Surgeon was emergently called. Patient required Resection of abdominal aorta and replacement with 12 mm Dacron tube graft. EBL 1500cc. Per Dr. O'Hanlan's progress note dated 8/10/17, "the aorta was invaded by cancer, and during removal of the cancer, it became evident that the damage from the cancer required resection of the aorta itself, as planned and discussed with Dr. Zimmerman pre-operatively

Key Concerns for Physician Reviewer: see above. Since aortic concerns were known ahead of surgery, why wasn't a vascular surgeon present during case, instead of being called on emergently?

General Questions for Reviewer: Were appropriate tests, treats, medications or consults ordered/done? Were they done in a timely manner? Were appropriate preventive measures taken? Were care decisions/plan communicated?

To be completed by Physician Reviewer

Reviewer:___Tarang Safi_____ Date: __8/28/17__ Conflict of Interest? _X_No __ Potential

		Overall Practitioner Care: Check one
X	1	No breach in care rendered
	2	Breach – human error
	3	Breach – at-risk behavior
	0	Breach – reckless behavior

Note: If Overall Care = 1, then Issue must = (A);
If Overall Care = 2, 3 or 0,
then Issue must = (B) through (O)

		Issue Identification
X	A	No issues with practitioner care
		Practitioner Care Issues: Check all that apply
	B	Diagnosis (Pt Care)
	C	Clinical Judgment/Decision-making (Pt Care)
	D	Technique/Skills (Pt Care)
	E	Planning (Pt Care)
	F	Supervision: House Physician or AHP (Pt Care)
	G	Knowledge (Medical Knowledge)
	H	Timely/Clear Communication (Comm/IP Skills)
	I	Responsiveness (Professionalism)
	J	Follow-up/Follow-through (Professionalism)
	K	Policy Compliance (System based Practice)
	O	Other:

Complete on all cases

EXHIBIT 9

Dignity Health.
Sequoia Hospital

170 Alameda de las Pulgas
Redwood City, CA 94062
Direct 650. 369-5811
sequoiahospital.org

October 4, 2016

Doris Jordan, District Administrator
California Department of Public Health
150 North Hill Drive – Suite 22
Brisbane, CA 94005

Delivered via Sequoia Hospital staff courier

RE: Plan of Correction for Penalty Number 220012590

Dear Ms. Jordan,

Attached is our Plan of Correction for Penalty Number 220012590 which is submitted now for your review and approval. Please do not hesitate to contact me, or Carolyn Gyermek, Risk and Patient Safety Manager, should you require further information or clarification.

Best regards,

Mary Christen

Mary Christen, RN
Director of Quality Services
Sequoia Hospital
Phone: 650.367.5598
Mary.Christen@DignityHealth.Org

Received on 9/26/16
Sequoia Hospital - Mehrieten

State of California -- Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

EDMUND G. BROWN JR.
Governor

REQUEST FOR PLAN OF CORRECTION FOR STATE DEFICIENCIES

September 21, 2016 **CERTIFIED MAIL**

Dignity Health
185 Berry Street, Suite 300
San Francisco, CA 94107

Dear Dignity Health:

FACILITY ID: 220000025 **PENALTY NUMBER: 220012590**

An exit conference has been conducted regarding deficiencies found during a visit to this facility to determine compliance with state licensing regulations and/or federal requirements for certification as a provider of health care services.

California Health and Safety Code section 1280(b), requires a plan of correction for all deficiencies. A rebuttal of a deficiency is not a plan of correction. The plan of correction must be developed for all deficiencies and returned to the California Department of Public Health (CDPH) within 10 days of reciept of the Statement of Deficiencies.

The plan of correction must be submitted on the enclosed Statement of Deficiencies form. CDPH will not accept the plan of correction on attachments. The facility administrator or appropriate individual must sign and date the plan of correction before returning it to CDPH, and the submitted plan of correction must meet the approval of CDPH.

A plan of correction for each deficiency listed must contain the following:

A. The corrective action to be taken for each individual affected by the deficient practice, including any system changes that must be made;

B. The title or position of the person who will monitor the corrective action and the frequency of monitoring; and

C. Dates each corrective action will be completed.

CDPH will notify the facility of the approval or rejection of the submitted plan of correction. If CDPH does not approve the plan of correction, CDPH may request additional information or a more specific plan. If necessary, CDPH will hold an informal conference with the facility to obtain a satisfactory plan of correction.

By providing a plan of correction, a licensee or designee does not necessarily admit guilt for any alleged violations nor does this interfere with the right to contest or appeal any alleged violations. If you disagree with any deficiency, you may request, in writing (on the Statement of Deficiencies form, if you desire), an informal conference with the district administrator/district manager of this office.

A refusal to provide a plan of correction may affect your licensure.

Sincerely,

Louis Jordan HFEM I for

Diana Marana, District Manager
San Francisco District Office
150 North Hill Drive, Suite 22
Brisbane, CA 94005
Diana.Marana@cdph.ca.gov
(415)330-6353

Alfredo Abarca, HFEN	May 10, 2016
Signature of Health Facilities Evaluator	Date of Exit Conference
Mary Christian RN	10/4/2016
Signature of Facility Representative Receiving Letter	Date Letter Returned With Plan of Correction

NOTE: Sign, date, and return this letter with the plan of correction.

Enclosure

cc: Glenna Vaskelis
SEQUOIA HOSPITAL
170 Alameda De Las Pulgas
Redwood City, CA 94062

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00477434 - Substantiated Representing the Department of Public Health: Surveyor ID # 33819 The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.3(g): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. Glossary of Definitions: Hysterectomy: Surgical removal of the uterus. Salpingectomy: Surgical removal of the Fallopian tubes, the tubes through which an egg travels from the ovary to the uterus. Oophorectomy: Surgical removal of the ovaries, the part of a woman's reproductive system that stores and releases eggs for fertilization and produces female hormones. Appendectomy: Surgical removal of the appendix, a small tube connected to the digestive system and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s). 1 thru 15*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	located at the junction of the small and large intestines. Symptomatic leiomyomata uteri: benign muscle tumors of the uterus. Universal protocol: a procedure requiring a time out prior to beginning surgery, a practice that has been shown to improve teamwork and decrease the overall risk of wrong-site surgery. Time Out: The pause right before surgery begins and is intended to make everyone slow down and check what they are about to do. The Time Out confirms site, patient, and procedure. OR: Operating Room RN: Registered Nurse Circulator RN: a registered nurse whose function is to monitor the procedures in operating rooms during surgery. During operations and other surgical procedures, the circulator assists by acting as an intermediary between the operating room staff and the rest of the hospital. H & P: Called a "history and physical", is part of a medical record that documents the patient's status,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	reasons why the patient is being admitted for to a hospital or other facility, and the initial instructions for that patient's care. Operative Report: A document produced by a surgeon or other physicians who have participated in a surgical intervention, which contains a detailed account of the findings, the procedure used, the specimens removed, the preoperative and postoperative diagnoses. Pathology Report: the document that contains results of the examination of tissue removed during a biopsy or surgery. Health and Safety Code 1279.1(c) "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made. Health and Safety Code 1280.1(c) (c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. Health and Safety Code 1279.1(b)(1)(A)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	(b) For purposes of this section, "adverse event" includes any of the following: (1) Surgical events, including the following: (A) Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent. T22 DIV5 CH1 ART3-70223(d) Surgical Service General Requirements (d) Prior to commencing surgery the person responsible for administering anesthesia, or the surgeon if a general anesthetic is not to be administered, shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record: This RULE: is not met as evidenced by: Based on interview and record review, the facility failed to perform the correct surgery for one sampled patient (Patient 1), when: 1. There was no verification of the correct procedure and site/side/level, with the physician or physician's office staff when the scheduling request was received. Therefore, the surgical procedure was not entered correctly in the surgical schedule according to the History & Physical (H & P), and consent. 2. The admitting Registered Nurse (RN 1), did not		Issue 1- No verification of correct procedure and site/side/level, at the time of procedure scheduling. Corrective Action Plan: Verification of the correct patient and procedure at the time of scheduling by the physician's office staff is not considered a reliable process for procedural verification. Therefore, Sequoia Hospital's Universal Protocol for Surgical and Invasive Procedures policy does not all use of the Procedural Schedule to conduct the final verification of patient, procedure, and site/side/level 100% of medical staff members and surgical staff members involved in the wrong surgical procedure were counseled and re-educated about requirement to use the signed consent form and H&P to correctly verify the patient, surgical procedure, and site/side/level, on the day of the error was known. 100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs were re-educated never to rely on the surgical/ procedural schedule to verify the patient, surgical procedure, and site/side/level. Instead, the Hospital's policy requires use of the signed consent form and H&P to correctly verify the patient, surgical procedure, and site/side/level	02/19/16 04/01/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	document the procedure verification based on H & P and consent; and did not document the same prior to moving Patient 1 to the procedure area. 3. A Registered Nurse (RN 2), who received Patient 1 into the procedural area, did not verify correct patient, correct procedure based on H & P and consent. 4.The facility did not follow their policy and procedure when the surgeon was allowed to lead the Time Out procedure instead of the circulator nurse. This adverse event constituted an immediate jeopardy which placed the health and safety of Patient 1 at risk when Patient 1's ovaries were mistakenly removed during surgery, and as a result she will need to be on estrogen replacement therapy for life. Findings: Patient 1 was admitted on 2/18/16 with diagnosis of symptomatic leiomiomata uteri(benign muscle tumors of the uterus), for surgery to remove the uterus, fallopian tubes and appendectomy. Record review of a facility form titled "Consent to Surgery or Special Procedure" showed Patient 1 signed on 2/17/16 at 4:30 PM for the indicated handwritten procedure: "Laparoscopic hysterectomy- removal of both fallopian tubes - appendectomy".		Our Universal Protocol for Surgical and Invasive Procedures policy was revised and approved by the Medical Staff to indicate that when the physician or physician office staff contacts the Hospital's surgical scheduling staff; the correct patient name, the date of the intended procedure, and the name of the intended procedure is obtained from the physician or physician staff in order to schedule the appropriate date, time, surgical supplies and equipment. Per Universal Protocol for Surgical and Invasive Procedures policy revision, the surgical/procedural schedule will never be relied on to verify the procedure, patient, and site/side/level during the procedural "Time Out". Education regarding requirement to use the signed consent form and H&P to correctly verify the patient, surgical procedure, and site/side/ level was provided to anesthesiologists and surgeons at multiple meetings of the Departments of Anesthesia, Surgery, 100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were required to review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy. RN's working in these procedural areas that have not reviewed the revised policy, because they are on LOA or otherwise not working, will review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy prior to returning to work. 100% of surgical and anesthesiologist members of the Medical Staff received written notification of the requirement to use the signed consent form and H&P to correctly verify the patient, surgical procedure, and site/side/level. Person Monitoring Corrective Action: Director of Surgical Services	08/17/16 09/08/16 09/30/16 09/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Record review of a form titled "Request for Surgery Booking" dated 1/27/16 3:06 PM, identifying Patient 1 medical record number, name and date of birth, indicated under "Surgery date: 2/18/16..." and under "Procedure with laterality: TCH (total complete hysterectomy), BSO (bilateral salpingo oophorectomy), appy (appendectomy)...". Record review of a document titled: "Surgery Case Statistics" dated 02/18/16 containing the roster of surgeries for the day, indicated Patient 1 was scheduled for "Procedure: Laparoscopic hysterectomy, BSO (bilateral salpingo oophorectomy, appendectomy". Record review of a printed copy of the electronic record titled "Preop H&P" signed by the surgeon (MD) on 02/18/16 at 12:11 PM indicated under "Plan: A total laparoscopic hysterectomy with bilateral salpingectomy is planned. We will save the ovaries and incidental appendectomy will be performed...She (Patient 1) has decided on the above plan...". Record review of a printed copy of the electronic record titled "Operative Report" signed by the MD on 02/19/16 at 17:08 PM, indicated under "Title of Operation: Total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, ...and incidental appendectomy...".		Issue 2 – The admitting nurse (RN 1) did not verify the correct patient and procedure based on the written informed consent and the H&P when the patient came into her unit and when moving the patient to the procedure room. Corrective Action: The admitting nurse involved (RN 1) was immediately counseled and re-educated to verify the patient, surgical procedure, and site/side/level based on the written informed consent and the H&P. 100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were re-educated to correctly verify the patient, procedure and side/site/level based on the written informed consent and the H&P. RN's working in these procedural areas that have not received the education, because they are on LOA or otherwise not working, will receive this education prior to returning to work. 100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were required to review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy. RN's working in these procedural areas that have not reviewed the revised policy, because they are on LOA or otherwise not working, will review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy prior to returning to work.	02/19/16 04/01/16 09/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Record review of a facility policy titled: "Universal Protocol Policy and Procedure" dated "3/2014" indicated under "Purpose: ...is to promote patient safety by ensuring that processes are defined and followed to ensure the correct surgical or invasive procedure is performed for the correct patient at the correct side/site/level...". Under "Verification Process:...A. At the time the procedure is scheduled... C. At the time of admission or entry into the facility for a procedure D. Before patient leaves the pre-procedure area E. Upon arrival to the procedure area E. Immediately prior to the procedure...". During a 4/27/16 at 12:45 PM interview with Director of Quality Services(DQS), Risk Manager(RM), and Director of Perioperative Services (DPS), DQS acknowledged from the moment of scheduling the procedure the documentation had the wrong procedure: "...BSO (bilateral salpingo oophorectomy) was written and that was the wrong procedure...". Asked about the verification of the procedure from the time the "Request for Surgery Booking" facility form was faxed to the scheduling office from the physicians office, DQS stated: "That was just a request for a time slot from the doctor's office...". RM stated: "The documentation is less than optimal...we need to change the language in our Universal Protocol Policy...".		Immediately following the event, a checklist/tracer tool was developed and ten (10) surgical cases per month are observed and monitored by the Peri-operative Director or Manager using the tracer tool/checklist to ensure 100% compliance with the verification process of utilizing the written informed consent and H&P to correctly verify the patient, procedure and side/site/level at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. In June 2016, the checklist/tracer tool was revised and implemented as a checklist for O.R. staff to utilize for validation of all elements of the Universal Protocol. The checklist/tracer is used for all patients undergoing procedures in the Operating Room. The Peri-operative Director audits a minimum of 50% of the checklists (randomly selected) to ensure documentation of appropriate verification of the patient, procedure and side/site/level based on the written informed consent and the H&P at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. Audits will continue until 100% compliance is achieved for four (4) months. Person Monitoring Corrective Action: Director of Surgical Services.	On-going 06/30/16 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	During a concurrent interview with DQS, RM and the Director of Perioperative Services (DPS), on 4/27/16 at 12:45 PM while reviewing a 7 pages facility copy of the electronic Patient 1 Pre-Operative Nursing Assessment form dated "02/18/16 7:21", completed by a Registered Nurse (RN 1); DQS acknowledged RN 1 "...was the RN admitting Patient 1...". The same document failed to indicate the verification of the correct patient, correct procedure and correct site/side/level using the H & P and the procedure consent during admission and prior to moving Patient 1 to the procedural area. The document indicated on page 4, under "Pre-Op/Procedure Checklist: Report Given to:" a Registered Nurse (RN 2) in the OR, dated "02/18/16 at 8:25". DPS stated: "Yes, RN 2 received that report". Both DQS and DPS acknowledged the document did not contain a verification of H&P and consent. During a 4/27/16 at 12:45 PM interview with DQS, RM and DPS, while reviewing a 8 pages facility copy of the Intra-Operative nursing assessment; DQS and DPS acknowledged the record indicated in page 2 under "Surgical Procedures/ Procedure Detail: Hysterectomy, BSO, Appendectomy", and failed to document a review of Patient 1 H&P and consent upon arrival in the procedural area and immediately prior to the procedure; and that the same document indicated RN 2, RN 3 and RN 4 were present in the procedural area. Record review of a facility policy titled: "Universal		Issue 3: A Registered Nurse (RN 2), who received Patient 1 into the procedural area, did not verify correct patient, correct procedure based on H & P and consent. Corrective Action: The nurse (RN 2) receiving the patient in the OR was immediately counseled and re-educated to verify the correct patient, procedure based on the written informed consent and the H&P. 100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were re-educated to correctly verify the patient, procedure and side/site/level based on the written informed consent and the H&P. RN's working in these procedural areas that have not received the education, because they are on LOA or otherwise not working, will receive this education prior to returning to work 100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were required to review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy. RN's working in these procedural areas that have not reviewed the revised policy, because they are on LOA or otherwise not working, will review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy prior to returning to work.	02/19/16 04/01/16 09/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Protocol Policy and Procedure" dated "3/2014" indicated, "...Verification immediately prior to moving the patient to the procedural area:...Pre-Procedure Checklist:...B. Accurately completed, signed, procedure consent form... Under "Verification at the time of arrival in the procedural area: The nurse receiving the patient will verify the correct patient, correct procedure and correct site: a. Using..b. The history and physical c. The procedure consent... Under "Verification Immediately prior to the procedure (aka time out)...the time out has the following characteristics: A. All team members will stop al other activities to complete the verification process. B. The circulating or procedure nurse will lead the time out...D. The basic elements of the time ouit/procedural pause are: ...c. Correct procedure is verified...". During an interview with an operating room Registered Nurse (RN 3) on 04/27/16 at 12:05 PM, RN 3 stated she was a circulator nurse "as a resource..." on 02/18/16 for Patient 1's scheduled surgery. Asked how and who lead the time out, RN 3 stated: "the surgeon is the only one that leads the time out..., I did not see any documents...I never had Patient 1's medical record...". RN 3 was shown a facility form signed by her on 2/18/16 and titled: "World Health Organization Surgical Safety Check" that described in three		Immediately following the event, a checklist/tracer tool was developed and ten (10) surgical cases per month are observed and monitored by the Peri-operative Director or Manager using the tracer tool/checklist to ensure 100% compliance with the verification process of utilizing the written informed consent and H&P to correctly verify the patient, procedure and side/site/level at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. In June 2016, the checklist/tracer tool was revised and implemented as a checklist for OR staff to utilize for validation of all elements of Universal Protocol. The checklist/tracer is used for all surgical patients undergoing procedures in the Operating Room. . The Peri-operative Director audits a minimum of 50% of the checklists (randomly selected) to ensure documentation of appropriate verification of the patient, procedure and side/site/level based on the written informed consent and the H&P at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. Audits will continue until 100% compliance is achieved for four (4) months. Person Monitoring Corrective Action: Director of Surgical Services	On-going 06/30/16 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	columns: "Before Induction of Anesthesia /Sign In-Circulator Leads, After Draping/ Before Skin Incision Time Out- Circulator Leads, Before Patient Leaves Operating Room Team Debriefing-Circulator Leads", at in each column steps to follow; RN 3 acknowledged her signature on the form and stated: "My signature only means I was part of identifying the correct patient and date of birth, not the right procedure", as she pointed to the first column initial step. RN 3 said, "...I did not read the consent or other document...". During an interview with an operating room Registered Nurse (RN 4) on 04/27/16 at 12:25 PM, RN 4 stated she was "A circulator nurse having finished orientation and my training was not finished...", present on 02/18/16 for Patient 1 scheduled surgery. RN 4 stated "The time out was lead by the Dr.[surgeon] MD. The MD stated the name of the patient, the procedure and asked for questions...". Asked if she saw Patient 1 signed consent, or H & P, RN 4 stated: "No, I never saw the consent or the H&P...". RN 4 was shown the "World Health Organization Surgical Safety Check" form used at the facility and signed by her on 2/18/16. RN 4 acknowledged her signature on the form and stated: "My signature was for the patient identification only, the doctor MD lead the time out...". (At http://www.who.int/patientsafety/safesurgery/ss_ch		Issue 4: The facility did not follow their policy and procedure when the surgeon was allowed to lead the Time-Out procedure instead of the circulator nurse. Corrective Action: The attending surgeon and surgical staff involved in this event were immediately counseled that per Hospital policy, surgeons cannot lead the final Time-Out procedure immediately prior to commencing the surgical case. The attending surgeon and surgical staff involved in this event were immediately informed that per Hospital policy, the Circulating Nurse is accountable to lead the Time-Out procedure immediately prior to commencing the surgical case. Further, the Circulating Nurse is required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the surgical case. Education was provided to anesthesiologists and surgeons at multiple meetings of the Departments of Anesthesia, Surgery, Orthopedics, Obstetrics and Gynecology, Internal Medicine and Cardiovascular regarding requirement that per Hospital policy, surgeons cannot lead the final Time-Out procedure immediately prior to commencing the surgical case; that the Circulating Nurse is accountable to lead the Time-Out procedure immediately prior to commencing the surgical case; and that the Circulating Nurse is required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the surgical case	02/19/16 09/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	ecklist/en/ World Health Organization website and according to a publication titled "Implementation Manual Surgical Safety Checklist", the Checklist divides the operation into three phases, each corresponding to a specific time period in the normal flow of a procedure - the period before induction of anesthesia (Sign In), the period after induction and before surgical incision (Time Out), and the period during or immediately after wound closure but before removing the patient from the operating room (Sign Out). In each phase, the Checklist coordinator must be permitted to confirm that the team has completed its tasks before it proceeds further). During a concurrent interview with the Director of Quality Services (DQS) and the Patient Safety Risk Manager (RM) on 04/01/16 beginning at 11 AM, DQS stated: "There were many misses on this event...There was a new Operating Room circulator nurse in charge of the time out.... Dr.[name of physician] (MD), is a doctor who leads her own time out. We interviewed the MD and she said she is not perfect and she forgot the correct procedure...". RM added: "Our Policy was not followed, it has been revised..., the consent was correct but it was entered incorrectly by a clerk doing the surgical schedule..., the documentation brought in to perform the time out was wrong...". During an interview with the Director of Perioperative Services (DPS) on 04/27/16 at 1 PM, DPS stated: "I would expect that each RN reviews the patient's		100% of surgical and anesthesiologist members of the Medical Staff received written notification of the requirement that Circulating Nurses are accountable to lead the Time-Out procedure immediately prior to commencing the surgical case, and that the Circulating Nurses are required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the surgical case. 100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were re-educated that surgeons cannot lead the final Time-Out procedure immediately prior to commencing the procedure; that the Circulating Nurse is accountable to lead the Time-Out procedure immediately prior to commencing the procedure; and that the Circulating Nurse is required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the procedure. RN's working in these procedural areas that have not received the education, because they are on LOA or otherwise not working, will receive this education prior to returning to work.	09/30/16 09/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	H & P and the consent for surgical procedure, from the moment of patient admission and every hand off time in the process...", and added: "The circulator nurse has to lead the time out and reads from the patient's consent and obtains a verbal agreement from all present in the operating room, as it is in the policy...". Record review of a printed copy of the electronic record titled "Progress Note" signed by the surgeon MD on 02/19/16 at 5:08 PM indicated, "This morning I visited the patient for my postsurgical rounds....At that very point, she (Patient 1) reminded me that the ovaries were not supposed to come out. I recalled immediately that she was actually quite correct...and told her that I had wrongfully removed her ovaries...I mistakenly conducted the surgical pause and said that I would remove the uterus, tubes, and ovaries, and proceeded to do so". Record review of a facility policy titled: "Universal Protocol Policy and Procedure" dated "3/2014" indicated under "Verification at time of Procedure Scheduling: ...the person responsible for scheduling the procedure will verify the correct patient, correct procedure and site/side/ level with the physician or physician's office staff or nursing staff scheduling the procedure...". Under "Verification at Admission or Entry into the Facility:.....A. The nurse admitting the patient will verify the correct patient, correct procedure and correct site/side/level using the		Immediately following the event, a checklist/tracer tool was developed and ten (10) surgical cases per month are observed and monitored by the Peri-operative Director or Manager using the tracer tool/checklist to ensure 100% compliance with the verification process of utilizing the written informed consent and H&P to correctly verify the patient, procedure and side/site/level at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. In June 2016, the checklist/tracer tool was revised and implemented as a checklist for OR staff to utilize for validation of all elements of Universal Protocol. The checklist/tracer is used for all surgical patients undergoing procedures in the Operating Room. . The Peri-operative Director audits a minimum of 50% of the checklists (randomly selected) to ensure documentation of appropriate verification of the patient, procedure and side/site/level based on the written informed consent and the H&P at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. Audits will continue until 100% compliance is achieved for four (4) months. Person Monitoring Corrective Action: Director of Surgical Services	On-going 06/30/16 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	...b. The history and physical c. The procedure consent..." The policy's last page indicated under "Approval Bodies: Department Manager/Director, Medical Executive Committee, Board...". At http://www.who.int/patientsafety/safesurgery/ss_checklist/en/ World Health Organization website and according to a publication titled "Implementation Manual Surgical Safety Checklist: The ultimate goal of the WHO Surgical Safety Checklist is to help ensure that teams consistently follow a few critical safety steps and thereby minimize the most common and avoidable risks endangering the lives and well-being of surgical patients. In this manual, the "operating team" is understood to comprise the surgeons, anesthesia professionals, nurses, technicians and other operating room personnel involved in surgery. In order to implement the Checklist during surgery, a single person must be made responsible for checking the boxes on the list. This designated Checklist coordinator will often be a circulating nurse, but it can be any clinician or healthcare professional participating in the operation. The Checklist divided the operation into three phases, each corresponding to a specific time period in the normal flow of a procedure - the period before induction of anesthesia (Sign In), the period			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	after induction and before surgical incision (Time Out), and the period during or immediately after wound closure but before removing the patient from the operating room (Sign Out). In each phase, the Checklist coordinator must be permitted to confirm that the team has completed its tasks before it proceeds further. Therefore, during "Sign In" before induction of anesthesia, the person coordinating the Checklist will verbally review with the patient (when possible) that his or her identity has been confirmed, that the procedure and site are correct and that consent for surgery has been given. The team will pause immediately prior to the skin incision to confirm out loud that they are performing the correct operation on the correct patient and site and then verbally review with one another, in turn, the critical elements of their plans for the operation using the Checklist questions for guidance. Having a single person lead the Checklist process is essential for its success. In the complex setting of an operating room, any of the steps may be overlooked during the fast-paced preoperative, intraoperative, or postoperative preparations. Designating a single person to confirm completion of each step of the Checklist can ensure that safety steps are not omitted in the rush to move forward with the next phase of the operation. Until team members are familiar with the steps involved, the Checklist coordinator will likely have to guide the team through this Checklist process."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050197	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEQUOIA HOSPITAL	170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The hospital's failure to perform the correct surgery for Patient 1 constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c). This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.3(g).			

EXHIBIT 10

Dignity Health. Sequoia Hospital	Page 1 of 8 including Attachments: 2
POLICY: Universal Protocol Policy and Procedure	
Last Revision/Review: 11/14/2016	**Next Review: 11/14/2019**

PURPOSE:
The purpose of this policy is to promote patient safety by ensuring that processes are defined and followed to ensure the correct surgical or invasive procedure is performed for the correct patient at the correct side/site/level. Staff and Licensed Independent Practitioners (LIP's) participating in a surgical or invasive procedure will actively participate in these processes and document the processes.

SCOPE AND AVAILABILITY:
This policy applies to all staff and Licensed Independent Practitioners (LIP's) participating in a surgical or invasive procedure in all locations including bedside invasive procedures. The processes should include the patient's active involvement whenever possible.

DEFINITION OF AN INVASIVE PROCEDURE:
Any procedure performed which involves a puncture or incision of the skin or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterization, central venous catheter placements, epidural catheter placements, peripheral nerve/nerve plexus catheter placements and endoscopies. It does not include:

A. Venipuncture
B. Peripheral intervention line placement
C. Insertion of nasogastric tube
D. Urinary catheter placement
E. Dialysis (except surgical insertion of the catheter)
F. (see Attachment A)

VERIFICATION PROCESS:
Verification of the correct person, correct procedure and correct side/site/level occurs at the following times and involves the patient whenever possible:

A. At the time of preadmission testing and/or assessment
B. At the time of admission or entry into the facility for a procedure
C. Before the patient leaves the pre-procedure area
D. Upon arrival in the procedure area
E. Immediately prior to the procedure
F. Anytime the responsibility for care of the patient is transferred to another member of the procedural care team
G. Anytime there are two separate and distinct procedures and with separate teams

The surgery schedule is only a guide; the signed consent is the definitive procedure

I. AT TIME OF PROCEDURE SCHEDULING:

When a procedure is scheduled at the physician's request, the person responsible for scheduling the procedure will confirm that the posting includes the following elements: the correct patient, intended procedure and site/side/level. Any procedure involving laterality/level will be written out fully; i.e. Left or Right or spinal level.

II. VERIFICATION AT PREADMISSION TESTING AND ASSESSMENT:

If the patient presents for pre-admission testing and/or assessment, the person responsible for performing the testing and/or assessment will verify it is the correct patient, correct procedure and correct site/side/level.

III. VERIFICATION AT ADMISSION OR ENTRY INTO THE FACILITY

At the time of admission or entry into the facility for a procedure:

A. The nurse admitting the patient will verify the correct patient, correct procedure and correct site/side/level using the
   a. Surgical/procedure room/cath lab/endoscopy department's procedure schedule
   b. The history and physical
   c. The procedure consent
   d. The physician's order

B. The procedure site/side/level will be verified on the procedure consent with the patient and the patient will initial the procedure consent form next to the written side if laterality applies.

C. If the patient is cognitively impaired and a legal guardian is not available, two licensed Nurses will confirm that the patient, procedure, side /site/ /level are correct and document this in the patient's medical record

IV. VERIFICATION IMMEDIATELY PRIOR TO MOVING THE PATIENT TO THE PROCEDURAL AREA

If the patient is to be transported to the procedural area for the procedure, immediately prior to moving the patient to the procedural area the person responsible for sending the patient will verify it is the correct patient, correct procedure and correct site/side/level.

Pre-Procedure Checklist:

In addition, the person will utilize a standardized checklist to review and verify that the following items are available (if required) in the procedure area and are matched to the patient using the patient identifiers of name and DOB:

A. Relevant documentation including H&P, nursing assessment if applicable, pre-anesthesia assessment if applicable
B. Accurately completed, signed, procedure consent form.
C. Relevant, correct diagnostic radiology, and pathology test results are available and properly labeled
D. Procedural side/site/level is marked by the proceduralist when required
E. Required blood products, implants, devices are available
F. Availability of special equipment for the procedure
G. The items that are to be available in the procedure area are matched to the patient

V. VERIFICATION AT THE TIME OF ARRIVAL IN THE PROCEDURAL AREA:

The nurse receiving the patient will verify the correct patient, correct procedure and correct site.

a. Using the surgical/procedure room/cath lab/endoscopy department's procedure schedule
b. The history and physical
c. The procedure consent
d. The physician's order

VI. VERIFICATION IMMEDIATELY PRIOR TO THE PROCEDURE (a.k.a TIME OUT)

Immediately prior to the skin incision or initiation of the invasive procedure, after the patient has been prepped and draped, all those who will be participating in the procedure at its beginning will perform a time out. The time out has the following characteristics:

A. All team members will stop all other activities to complete the verification process
B. The circulating or procedure nurse will lead the time out
C. The time out will involve interactive communication among the team members
D. The basic elements of the time out/procedural pause are:
    a. Correct patient name and date of birth
    b. Correct side/site/level is verified, marked and visible after draping
    c. Correct Procedure is verified
    d. Each team member verbally communicates agreement with all of the elements of the time out
E. The basic elements of the time out will be conducted in the same manner in all locations.
F. Additional elements of time outs for surgical procedures performed in the main OR and C-section OR will be defined per the WHO Surgical Safety Check form
G. Additional elements of time outs for non-surgical procedures (cath lab, specials lab, endoscopy, procedure room procedures, bedside procedures) will be defined per the Universal Protocol form in the electronic health record.
H. Any team member is able to express concerns about the procedure verification.(See discrepancy process below)
I. The completed components of the time out are clearly documented using the hospital's defined documentation tools.
J. An event report will be completed if the time out does not occur or if the site is not marked (if required).

VII. VERIFICATION ANYTIME THE RESPONSIBILITY FOR CARE OF THE PATIENT IS TRANSFERRED TO ANOTHER MEMBER OF THE PROCEDURAL CARE TEAM

Anytime the responsibility for the care of the patient is transferred to another member of the procedural care team, the correct patient, correct procedure, correct side/site/level and patient signed consent form is verified with the outgoing team members and the incoming members of the procedural care team. This includes a nurse, clinician, physician or LIP coming in to participate in the procedure after the time out was performed.

VIII. VERIFICATION ANYTIME THERE ARE TWO SEPARATE AND DISTINCT PROCEDURES AND WITH SEPARATE TEAMS

If there are two separate and distinct procedures and with separate teams, a time out will occur immediately prior to the first procedure and a second time out will occur immediately prior to the second procedure.

DISCREPANCY OF VERIFICATION:

Anytime there is a discrepancy in the verification process, the person discovering the discrepancy will re-verify all the previously completed steps against the schedule, the history and physical, the procedure consent, the physician order, radiology films, consultations and any other information available to validate the discrepancy. The procedure will not begin until clear verification of the patient, procedure; site/side/level is completed. The original consent should not be altered or modified with any changes listed. If consent for the procedure(s) change, a new consent form should be written and signed by the patient.

SITE MARKING

A. In Radiology, site marking will occur where the procedure will be performed and takes place with the patient involved, if possible.

B. The procedure side/site/level is:
1. Marked by a physician/LIP or other provider who is privileged or permitted by the hospital to perform the intended procedure and who will be involved directly and present during the procedure and who is ultimately accountable for the procedure
2. After identifying correct patient, site/side/level, and procedure, the authorized person shall place his/her initials near or at the procedure or incision site using a marker that is sufficiently permanent to be visible after completion of the patient positioning, prep and draping.
3. The non-operative site will NOT be marked in any fashion
4. For spinal procedures, in addition to the pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level (s). Two Licensed physicians will verify the intraoperative radiographic marking. The physician will document the verification in the post-operative note.

Alternative Site Marking

Patients with the following circumstances will have an ORANGE BAND placed on the wrist corresponding to the correct lateral side by the proceduralist instead of having the site marked with his/her initials.

A. Minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice (i.e.: ovary, renal artery, ureter, lung, etc.).
B. Cases in which it is technically or anatomically impossible or impractical to mark the site including (i.e.: mucosal surfaces, testes, labia, etc)
C. Patients who refuse site marking: after the pre-procedure nurse has educated the patient and the family regarding the reason and safety precautions in completing the site marking, the pre-procedure nurse will re-confirm with the patient the refusal for site marking, notify the physician and document the information shared with the patient and patient's family, as well as, the reason for patient's refusal
D. Premature infants for whom the mark may cause a permanent tattoo.

E. Surgery of the teeth:
The operative tooth name(s) and number(s) are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images and/or diagrams are available in the procedure room before the start of the procedure

EXCEPTIONS TO SITE MARKING AND TO ALTERNATIVE SITE MARKING:

The following procedures are exempt from site marking and alternative site marking:

- Procedures without laterality (i.e.: endoscopies)
- Interventional procedures for which the catheter/instrument insertion site is not predetermined
- Procedures that have a midline approach intended to treat a single, midline organ
- Single organ procedures
- Procedures in which the individual performing the procedure is in continuous attendance with the patient from the time of decision to do the procedure through to the performance of the procedure
- Site marking may be waived in critical emergencies at the discretion of the physician, but a Time Out/Procedural Pause must be conducted unless there is more risk than benefit to the patient. Failure to pause will be documented with rationale on a notification form

MULTIPLE SITES/SIDES/LEVELS

If the procedure involves multiple sites/sides/levels during the same operation, each site/side/level will be marked.

MANAGEMENT FOLLOWING DISCOVERY OF WRONG SITE/SIDE/LEVEL PROCEDURE

Immediately contact the area manager and the Risk Manager and complete a notification form. In the event of a wrong patient, wrong procedure or wrong site procedure, the physicians and department staff involved in the case will document on the appropriate medical record forms the event and action taken.

PERFORMANCE IMPROVEMENT

A. Periodic medical record reviews will be conducted to assure the site verification process was correctly documented.
B. Periodic observation of the verification process to validate that policy is being followed will be conducted in all departments.
C. Data will be aggregated and reported to the appropriate clinical and medical staff departments.

COMPETENCY

Department staff will participate in competency assessment initially and periodically thereafter. Competency assessment will be included in the new staff orientation process.

ADDENDUMS/ATTACHMENTS:

Attachment A: Procedures Requiring a Time Out
Attachment B: Guidelines for Circulator Nurses: Continuity of Care for Quality and Safety

REFERENCES/DOCUMENTATION:

1. Title 22: §70233(d)
2. Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery, TJC (The Joint Commission), 2008
3. Guidelines for Implementing the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery, Dignity Health 2009
4. TJC's 2009 Frequently Asked Questions about the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Patient Surgery
5. Sentinel Event Alert-Wrong Site Surgery
6. Physician Insurer's Association of America (PIAA). Claims Data
7. American Academy of Orthopedic Surgeons: Report on Wrong-Site Surgery 2008
8. World Health Organization Surgical Safety Checklist 2008
9. The Institute of Healthcare Quality Improvement Surgical Safety Sprint Program Website
10. AORN Position Statement on Correct Side Surgery

ATTACHMENT A

PROCEDURES REQUIRING A TIME OUT

Including, but not limited to all of the invasive procedures below. All procedures that require moderate sedation:

- Biopsies
- Bone marrow aspirations or biopsy
- Bronchoscopy procedures
- Cardioversion procedures
- Central Venous Catheter Insertions
- Chest tube insertions
- Circumcisions
- Endoscopy Procedures (EGD, Colonoscopy)
- Epidural catheter insertions
- Laser eye procedures
- Lumbar Punctures/Spinal Anesthetic Administrations/Myelography/Peripheral Nerve/Nerve Plexus Local Anesthetic Injections/Catheter Placements
- Nephrostomy procedures
- Pacemaker insertions
- PICC lines
- Thoracentesis
- Transesophageal Echocardiograms

Procedures NOT within the scope of the Universal Protocol and this policy:

- Venipuncture
- Peripheral vein insertion
- Insertion of nasogastric tube
- Urinary catheter placement
- Dialysis (except surgical insertion of the catheter)

ATTACHMENT B

Guidelines for Circulator Nurses
Continuity of Care for Quality and Safety

- The Primary Circulator will always be identified when there are more than one involved in the care of the patient.
    - Responsibility to interview, review, and verify pertinent medical record documents
        - H&P
        - Consent
        - Other relevant documents required for the care of the patient.
        - Any discrepancies are rectified:
            - Posted surgical procedure matches H&P, consent, and patient understanding of what surgical procedure to be performed
    - Receive hand off report either from primary nurse in the PreOp area or patient care unit
    - Responsibility for conducting the Universal Protocol in the Operating room suite*
        - Announce the time out
        - Verify that team is ready and is actively participating
        - Follow the Universal time out checklist
        - Use the patient's consent and H&P to verify:
            - Correct patient using First and last name and DOB as the two patient identifier
            - Intended procedure
            - Laterality
            - Any pertinent information related to the procedure such as presence of an implantable device
            - Blood product availability if pertinent
            - Each team member participating in the time out shall acknowledge that all information presented is accurate. Surgeon, assistant if present at the time out, scrub(s), Anesthesiologist, and any other staff in the room participate in the time out.
    - If assistant joins the case after the time out, brief the assistant verifying patient name and the verified surgical procedure to be performed using the patient medical record such as consent and H&P.
    - Conduct additional time outs for multiple procedures by different Surgeons on the same patient

**The RN who interviews and verifies the surgical information will be responsible for conducting the time out procedure. Breaks and other types of case relief need to be delayed if it interferes with the time out. If there is a need to do a change in primary circulator responsibilities prior to the time out, a full hand off report must be conducted verifying all the information again.*

VERIFICATION

STATE OF CALIFORNIA)

FOR THE COUNTY OF SAN MATEO)

I have read the foregoing Verified Petition for Writ of Mandamus and know its contents. I am a party to this action. The matters stated in the foregoing document are true of my own knowledge except as to those matters which are stated on information and belief, and as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on February12, 2023, at Portola Valley, California.

KATE O'HANLAN, M.D.