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# QA Malpractice

# After 30 years of service to my community in the Bay area, performing over 3,500 lifesaving complex and cancer procedures at Sequoia Hospital in Redwood City,[[1]](#footnote-1) I was investigated and ultimately expelled by the Sequoia Hospital Staff based on inaccurate data comparisons and misrepresentations about my surgical takeback rate, with accusations that they kept hidden from me for over 2 years. The Hospital had the all the correct data with which to judge my practice, but ignored this data, and initiated a baseless investigation of my practice, breaking its Bylaws or Rules & Regulations in over 25 ways. Minor errors were exaggerated, repeatedly adjudicated and spiraled into a Medical Board of California investigation. This procedural injustice ruined my reputation, and ended my career. This should not happen to another physician.

Summary:

In 2015, the new Quality Assurance Director of Sequoia Hospital in Redwood City, Dr. Anita Chandrasena, printed her QA computer data that compared my surgical complication data with all Sequoia hospital Gynecologists together, and with a national central data base for surgical complications, the National Surgical Quality Improvement Project (NSQIP).[[2]](#footnote-2) NSQIP, as well as every surgical journal, calculates the complication rate by dividing the number of complicated cases, by total cases performed.1,2

There are at least 12 NSQIP publications that document complication, infection and surgical takeback rates in Gynecologic Oncology. A Gynecologic Oncology practice has much higher risk patients and entails more complex procedures, and thus more complications and is not comparable to a non-cancer practice. I have more infections complications and surgical takebacks than

General Gynecologists, but

Dr. Chandrasena told hospital officials that I had higher infections, complications, and takebacks, while she disregarded the accurate and reassuring rates of 4.5% complications, and 3% takebacks. The Sequoia Hospital computer printout, kept secret from me, showed my practice to be safe or even better than average when compared to any comparable Gynecologic cancer practice.

Had Sequoia staff followed their own Bylaws, and informed me of their suspected findings, I could have dispelled their inaccurate suspicions and allayed their worries, but Sequoia’s staff kept their misinformed comparison data and suspected takeback rate secret from me for two years. Despite my emails and letters pleading for their data of concern, asserting that I did not have worrisome practice data (I did not), the hospital refused to re-examine their inaccurate interpretations and allegations, and authorized an Ad Hoc Investigative Committee.

Ultimately, the hospital Chief of Staff and QA Director summarily suspended my privileges, deeming a safe and successfully life-saving uncomplicated surgery a “near miss”. This was determined by a gastroenterologist and a pulmonologist, neither of whom interviewed those present in the case, neither of whom knew Gynecologic Oncology surgical standards. My suspension was upheld by the Medical Executive Committee (MEC) after Dr. Chandrasena told the MEC, after I left the room, that my surgical takeback rate was seven-fold normal, at 20%. This expulsion led my practice to be reviewed by the Medical Board of California (MBC).

The MBC hired a General Surgeon, not a Gynecologic Oncologist, to review the four cases of concern reported by Sequoia, out of the 628 performed. The General Surgeon found multiple deviations from the standard of care. Our consulting Gynecologic Oncologist and former Chief of Staff reviewed the same four cases and found that my care met or exceeded the standard of care in every case except for one, with a mild deviation from the standard of care. It is typical for every surgeon to have rare (<5-10%) complications, which are reviewed monthly by one’s Department for educational and quality assessment purposes. None of my complications warranted expulsion and review by the MBC per a qualified Gynecologic Oncologist. Because I was nearing retirement age and had spent over $200,00 defending my reputation, I gave up and surrendered my license, with the MBC stipulation that they acknowledged that I had a significant defense.

I have provided evidence that Sequoia showed substantial noncompliance with its own Bylaws, which created undeniable prejudice against me among colleagues who formerly respected me. I have provided evidence that the findings of the Ad Hoc Committee and Judicial Review Hearing Committee were not supported by the facts or substantial evidence that were available, but disregarded. I further allege that the bias introduced into their investigation of me by their multiple false allegations affected their decision wrongly, and that incorrect standards were used to wrongly end my career. The footnotes in this section refer to the MEC, AHC, and JRC testimony and meeting minutes showing procedural injustice.

In January, 2016, Dr. Chandrasena misinterpreted the Sequoia Hospital QA computer printout. She informed the Chief of Staff that I had increased infections, complications, and takebacks in my practice, when, compared to my Gynecologic Oncology colleagues, I did not have increased rates.

* Dr. Chandrasena falsely alleged that there was no specific Gynecologic Oncology-specific practice data available for comparison of my practice data “outside of research articles.” (MEC 526), so she compared my data with that of Obstetrician/Gynecologists. This quote shows that she knew it was wrong to compare the practice data of a *sub*specialized Gynecologic Oncologist, of which I am American Board-certified, with the practice data of Dignity-wide Obstetrician/Gynecologists, of whom only 2% are Gynecologic Oncologists. General Obstetrician/Gynecologists are never trained to do cancer surgery or to do complicated benign surgery as we are. Their practice data is very different.
* Dr. Chandrasena failed to obtain even one of the eleven published peer-reviewed, comparable, and accurate “research articles”, reporting complications from subspecialty Gynecologic Oncology practices and procedures, using National Surgical Quality Improvement Project (NSQIP) standards, the established benchmarks for practice quality for Gynecologic Oncologists.
* Dr. Chandrasena ignored my NSQIP complication, infection, and takeback rates in the Sequoia Hospital QA printout, and supported my prosecution with an invalid comparison.

Dr. Chandrasena’s inability to understand QA data resulted the Chief of Staff requesting the Medical Executive Committee to authorize an Ad Hoc Committee investigation of my practice:

* Dr. Chandrasena should have identified the QA computer printout showing my NSQIP takeback rate was 3%. (MEC 523-530: slide deck prepared by Dr. Chandrasena, attached, with commentary).
* Dr. Chandrasena should have known the **only calculation for a surgeon’s takeback rate is that utilized by NSQIP, which was in the Sequoia Hospital QA computer printout**, but disregarded.
* Dr. Chandrasena should have known that the Dignity-unique “MIDAS Inpatient takeback rate” was not a calculation of a surgeon’s takeback rate, and not useful for QA purposes.
* Dr. Chandrasena should not have misinfirmed the Chief of Staff, the Ad Hoc Committee, the Medical Executive Committee, and the Judicial Review Panel that I had a 20% takeback rate, knowing that the “MIDAS Inpatient takeback rate” is not an accurate calculation of a surgeon’s takeback rate.[[3]](#footnote-3)
* Dr. Chandrasena should have known that Sequoia’s tallying of my practice data: 628 total cases, with 15 surgical takebacks, resulted in a 3% takeback rate, and could not possibly result in a 20% takeback rate. Had I truly had a 20% takeback rate, there would have been 132 takebacks, or one every week for the three years under review. Such a terrible surgery rate would be noticed and addressed during the first month.
* Dr. Chandrasena should also have known that it was inaccurate to attribute three of the15 takebacks to me when they resulted from procedures performed and dictated by another surgeon. NSQIP standards affirm that a surgeon performing a procedure is responsible for complications ensuing from it.

Sequoia staff kept their worrisome allegations secret from me for two years;

* Had Sequoia followed its Bylaws, the ObGyn Department Chair should have come to me with this data of concern in January 2016, at which time I could have identified to them their own NSQIP data, and provided appropriate Gynecologic Oncology comparison data that would have shown my practice met all standards of care with appropriately rare errors seen in retrospect.
* Dr. Chandrasena disregarded my letters requesting her to share with me the data she thought that had raised concerns about my practice **for over two years,** until after I had been suspended and expelled. Only after I appealed my expulsion did I find their false allegations about my practice data in the discovery material that prompted my colleagues to expel me.[[4]](#footnote-4)
* Dr. Chandrasena repeatedly propounded the false allegation of a 20% takeback rate to the Ad Hoc Committee and the Medical Executive Committee, prompting initiation of an Ad Hoc Committee and ultimately, my expulsion. [[5]](#footnote-5)
* Dr. Chandrasena propounded the false allegation of a 20% takeback rate at two Medical Executive Committee (MEC) meetings *only when I was not present in the MEC meeting room*, precluding me from addressing this falsehood. Further, only *when I was not in the room*, Dr. Chandrasena told MEC members that I “manipulated” the data to my benefit. In fact, my data entirely concurred with the NSQIP data which she disregarded in the Sequoia Hospital QA printout.[[6]](#footnote-6)
* I directly asked Dr. Chandrasena at two Medical Executive Committee meetings what my practice data of concern was. Twice, she flatly refused.[[7]](#footnote-7),[[8]](#footnote-8) At the October 23 MEC meeting, a member said that they “assumed that you had seen that, the graph showing your complication rate.”[[9]](#footnote-9) I had not, I said. The MEC members should have required her to share my own practice data with me in accordance with Sequoia Bylaws but they did not.

Sequoia staff used their authority to undermine my credibility.

* Dr. Chandrasena testified **under oath** to the Judicial Review Committee that my takeback rate was 20%.[[10]](#footnote-10),[[11]](#footnote-11) Members of the MEC, the AHC, and the JRC all seemed to believe that Dr. Chandrasena had the correct data directly from the Sequoia Hospital QA computer printout, as she insisted, and that she must have interpreted her data correctly and been correct in her allegations.[[12]](#footnote-12)
* No reasonable physician reviewer on any hospital committee would retain the privileges of a surgeon with a 20% takeback rate, seven times the norm in both general surgery and Gynecologic Oncology. Given that Dr. Chandrasena misrepresented this incorrect information for over two years to every reviewer of mine, without my knowledge and ability to correct her, there was impenetrable prejudice against me *ab initio*, tainting my colleagues’ views of my skills and my honesty.
* The biased, one-sided critique from the outside reviewer of seven previously adjudicated complications in my practice was taken as fact by the AHC and JRC. The writer was not made available for cross-examination as required by the Bylaws.
* It was procedurally unjust that the administrative judge refused to allow me to submit exculpatory evidence into the JRC trial discovered during the trial or necessitated by trial testimony.[[13]](#footnote-13)
* The administrative judge refused to allow me to speak, to say that I was not finished providing testimony.[[14]](#footnote-14)

I also see, in retrospect, that the letter I wrote to the Ad Hoc Committee members conveying my extreme indignation about the misrepresentation of my practice data, and my resentment of being investigated without any seeming reason, prejudiced reviewers against me. Physician colleagues, assuming the QA data reported to them was correct, presumed that my indignation reflected an inability to learn, evolve, or grow.

The Chair of Anesthesia at that time, who was very familiar with my practice, attended the MEC meetings. He strongly objected to the mischaracterization that I had a 20% takeback rate in my practice, asserting that such a takeback rate in my practice was entirely impossible. He told the MEC that if I had a 20% takeback rate over three years, Anesthesia colleagues certainly would have known about it and brought their concerns long ago to the QA staff. Dr. Chandrasena again insisted on the Sequoia Hospital’s data’s accuracy to the MEC. He informed me that a new MEC member commented to the effect of "I'm new here, so have no skin in the game either way, but it objectively seems that for some reason you all really don't like this person and refuse to look at actual evidence."[[15]](#footnote-15)  Outvoted by the MEC to expel me, he wrote his objections to Hospital President Bill Graham, but this letter was never brought to light and was never shared with me in discovery, against Sequoia Bylaws.

The JRC said that the decision against me was not based of the statistical data debated before the hearing, but these statistical misrepresentations were *used to initiate the action* against me. Once it became clear to the Ad Hoc Committee that Sequoia QA statistics were probably wrong, the AHC suddenly *switched focus to having some of my previously adjudicated cases micro-dissected* by an outside physician whose allegations were all taken as fact, and who was never made available for cross-examination. When I presented a response to the outside physician’s allegations, admitting what was admitted before in QA meetings, that errors (now apparent upon *looking back* on the outcomes, the purpose of the monthly QA meetings) were made in four of the 28 complications. By this time, the Chief of Staff and QA Director were firmly set against me, as a disruptive and strident physician, and unwilling to see that my appropriately rare complications were handled with appropriate care and response. Then, the focus changed again: *I was viewed as an immediate danger to my patients* and was summarily suspended after a well-planned Gynecologic Oncology-typical case. Based on multiple misrepresentations told to the MEC about my takeback rate, the suspension was upheld, and 4 cases were submitted to the Medical Board of California as evidence.

The JRC trial was neither a full nor a fair review. There were gross procedural injustices by Sequoia’s attorney, the hearing Judge, and the JRC panel that resulted in further prejudice, leading the JRC panel to inaccurate conclusions and a wrong decision.

* The administrative judge precluded me from submitting exculpatory evidence.[[16]](#footnote-16) When I vigorously protested, the judge went off the record to make it further clear to my lawyer and me that I could not introduce evidence in my testimony.[[17]](#footnote-17) When I asked to speak to provide further testimony and that without the further testimony and evidence, I would undoubtedly lose, the hearing officer closed the proceedings.[[18]](#footnote-18)

Had I been allowed to submit evidence,13,14 to provide testimony,[[19]](#footnote-19) the JRC would have come to the same conclusions that our experts, a senior Gynecologic Oncologist, and a former 10-year Chief Medical Officer came to: that I met or exceeded the standard of care in all cases but one, in which I made a minor deviation from the standard of care.[[20]](#footnote-20) These two experts reviewed the charts before the Medical Board of California and confirmed that the quality of clinical decision-making, adequate attention to detail, careful planning and honesty in documentation were never issues in the care I provided at Sequoia. Had there been a Gynecologic Oncologist on the JRC panel, as required by the Bylaws, more accurate decisions would have been made by the JRC. Had there been a Gynecologic Oncologist on the MBC review, a more accurate accusation would have been made.

* The JRC forgot my testimony in the JRC hearings in the case of LO. Dr. Tene said that she read in the chart that I was called by nursing staff about LO’s blood levels. I said that I was not called. Dr. Tene could not show evidence that I was called in the patient chart, but she called me dishonest to the JRC. To prove I was correct and honest, I ordered my phone log for that date and *found myself incorrect.* I immediately corrected this to the JRC at my very next testimony: that my phone logs showed that I *remembered wrongly* and should have said “I did not remember being called” instead of “I wasn’t called.”[[21]](#footnote-21) This is the case in which I made a mild deviation from the standard of care. While it cannot be confirmed when this patient developed internal bleeding after her surgery, a repeat blood count prior to her discharge might have shown if it had already started before she was discharged even though she had all normal vital signs and activities. In retrospect, it may have started after her discharge, later needing a return to surgery.
* The Gynecologic Oncologist and former Chief of Staff who reviewed my charts in my defense to the Medical Board of California confirm that in the case of Patient KM, I met or exceeded the standard of care in every way. A pulmonologist (the Sequoia QA manager) and a gastroenterologist (the Sequoia chief of staff) did not have sufficient knowledge or basis for summarily suspending privileges after a carefully planned and successful Gynecologic Oncology surgery. They never questioned me or the assistant surgeon, who was present for the entire case. Because of Dr. Chandrasena’s insistent and repeated misrepresentations about my takeback rates to the MEC *behind my back*, the MEC upheld my summary suspension.
* The JRC disregarded uncontested witness’s testimony in Patient KM’s case: Nurse Charvonia, Dr. O’Holleran and I all testified that there was no uncontrolled bleeding, and no unanticipated event in the aorta case. As Nurse Charvonia, Dr. O’Holleran and I all testified the surgery went exactly as planned and as stated during the Surgical Pause prior to the surgery. The vascular surgeon, Dr. Zimmerman, also confirmed that he observed complete vascular control. This was no “near miss.”
* The vascular surgeon did not contest that I called him in consultation the day before. The patient did not have any vascular disease per se, but might need a graft, I told him. He asked me for *nothing* in advance (e.g., to see the patient, to view the films, to order his equipment, to request his nursing team). If he felt sub-optimally prepared, he should have taken responsibility for it.

Dr. Zimmerman affirmed to me in my consultative phone call with him that he would be at the hospital all day long, never telling me that he had surgical cases of his own all day. I was surprised that he was so casual in his approach, and texted him the patient’s MR number in case he wanted to confirm the findings of my review of the patient’s MRA.[[22]](#footnote-22)

* Also, in the case of Patient KM, the JRC disregarded Dr. O’Holleran’s and my testimony that we had agreed on an accurate and entirely ethical co-surgeon billing scheme after the very successful surgery. It was entirely ethical that we changed our minds about the billing scheme, even after my two draft dictations, which I never read, never edited, and never signed or dated. It was ethical for me to dictate a third and final dictation that I did edit and sign and date into the chart. It was truthful that Dr. O’Holleran and I mutually wrote and signed a statement about the above facts, and that I presented this signed statement to the MEC. It was unethical that the JRC disregarded our uncontested testimony, and more unethical that the JRC refused to allow me to submit Dr. O’Holleran’s and my signed statement into evidence. The Gynecologic Oncologist and former Chief of Staff who reviewed my charts for the Medical Board of California confirm that there was no dishonesty or breach of ethics in this issue.
* The JRC wrongly decided that the 2mm hole in the aorta was a complication. I knowingly and purposely dissected the cancer that had invaded the aorta wall to remove it completely, consistent with published evidence that such meticulous surgery could be life-saving from an otherwise terminal reoccurrence of cancer. There was no doubt in anyone’s minds that I alone made the hole. The need for vascular graft was not a complication, but a planned possible outcome, as well-described by others in Gynecologic Oncology literature. The patient and our entire staff were always aware that she might need a graft, as both Dr. O’Holleran and I and Beth Charvonia testified and the chart verified. That was the only reason I contacted the vascular surgeon.

It was unethical that Sequoia’s counsel purposely suppressed a second exculpatory document: the QA review of the KM case, in which Sequoia’s randomly assigned QA reviewer, Dr. Tarang Safi, filed the QA case review form finding “no issue with physician care.” I desperately asked that his form be found in JRC’s evidence book, but Mr. Shulman insisted that it was not in evidence, when it was.[[23]](#footnote-23) Dr. Chandrasena also acted as if she did not know about this form generated by her own department.

Dr. Chandrasena issued grossly inaccurate testimony about the KM case. She alleged that the vascular instruments were not available, when Nurse Charvonia’s and my own testimony clearly stated that Nurse Charvonia had obtained them for our room after she heard about the possibility of a vascular graft in the Surgical Pause, keeping them unopened in case we did not need them. Dr. Chandrasena inaccurately said that Dr. Zimmerman rushed over to our OR leaving his own patient on the table. He did not. He was not surprised that we called him.

Dr. Chandrasena inaccurately implied that a vascular scrub team is critical for a vascular case. Every surgeon *prefers* to have their usual team, but such teams are neither essential nor critical.

Dr. Zimmerman had no expertise to suggest to the JRC that my surgical privileges be “trimmed.” He and the JRC knew nothing about the published literature support for typical Gynecologic and Vascular Surgery collaboration in cases such as this one. I tried to submit these articles, but was prohibited from doing so by the JRC trial judge. He and the JRC knew nothing about my procedural or academic expertise that I also was blocked from submitting. Without my being able to submit evidence that I had performed 145 lymphadenectomies at Sequoia during the 32-month time of my investigations, the panel could not know that the procedure was well-established in my armamentarium. Without my being able to submit into evidence my 5 abstracts/posters,[[24]](#footnote-24) my 2 publications,[[25]](#footnote-25) my 3 videos at international meetings,[[26]](#footnote-26) *all on comprehensive lymphadenectomy,* the panel could not know that I was an international and national expert on comprehensive high aortic lymphadenectomy, *even by laparoscopy*. The consulting Gynecologic Oncologist and former Chief of Staff for my MBC defense concluded that my care in Patient KM’s case exceed the established standard of care in this case.

* Regarding the case of Patient SS, whose ovaries were removed without consent: Had Sequoia done a careful review of this patient’s chart, they would have found that there were six areas where the Sequoia nursing staff falsely signed off on the removal of the patient’s ovaries as being in her consent.
* The JRC remained unaware that the sole purpose of the Surgical Pause is that the nursing staff *review the consent themselves*, with the surgeon standing in sterile gown, adjacent to the patient, and remote from the chart. The surgeon relies on the Nurse entirely, as the final and last affirmation of the consent, with the *sole goal of a final prevention of wrong-site surgery.* I did my part to listen to her, to even question her if it was correct, and finally to believe her in this sacrosanct procedure, which the Sequoia Registered Nurses repeatedly abominated.
* Furthermore, it was entirely unethical that the Sequoia QA Staff inquire about this event *only with the Registered Nurse* who used the surgery requisition in place of the consent. When the Registered Nurse accused me of causing “chaos” in the OR with the meticulous Surgical Pause that Sequoia Nursing Staff have routinely conducted in my OR’s for 15 years, and 3,500 cases, certainly I should have been questioned. Additionally, Nurse Charvonia, the Manager for the Gyn OR, should have been questioned, given such an accusation of chaos over 15 years.
* The JRC was wrong to disregard the testimony from Nurse Charvonia, Dr. O’Holleran and me that the Surgical Pauses conducted in my OR are meticulous, thorough, and benefit the patient. The consulting Gynecologic Oncologist and former Chief of Staff for the MBC defense concluded that my care met and exceed the established standard of care.
* In the case of HG, the consulting Gynecologic Oncologist and former Chief of Staff for the MBC defense concluded that my care met and exceed the established standard of care.

All surgeons make mistakes that are noted retrospectively in QA meetings, analyzed, and tabulated. If the mistakes are too frequent or show negligence, the Committee makes a specific plan for correction with the surgeon. Failing this plan, the Medical Board is notified. I made no error that would justify my expulsion or summary suspension from the hospital. It is easy to relook at cases through the “retrospectoscope” and make second-guessing accusations based on the outcomes and results that were not obvious at the time, especially if there is animus toward that surgeon.

There was also no “egregious case,” no “near miss” that resulted in my expulsion and subsequent investigation by the MBC. The senior Gynecologic Oncologist and former long-term Chief of Staff who reviewed these same cases before the MBC identified only one minor deviation from the standard of care, as happens in any practice, and typically is adjudicated at the local hospital’s monthly QA meetings. There was never a practice pattern that warranted MBC alert. Had the MBC used a Gynecologic Oncologist to my cases, instead of a General Surgeon, the MBC would have made more accurate and fewer accusations.

I retired and closed my practice in May 2020, having spent over $200,000 defending my license and my reputation. I did not know that not having an active practice precluded me from receiving a public letter of reprimand or probation as required for *one minor deviation* from the care standard (Patient LO). Realizing that my retirement precluded me from obtaining any desired outcome from the MBC, I negotiated with the MBC to specifically stipulate that our defense was significant and would go unaddressed due to costs. The MBC accepted surrender of my license to reduce costs to both sides.

In the following section, I provide documentation that Sequoia showed substantial noncompliance with the standards or procedures required by these Bylaws, or applicable law, which created demonstrable prejudice against me. I will show that the findings of the AHC and JRC Hearing Committees were not supported by facts or substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Sequoia’s Bylaws. I further allege that the bias introduced into the case profoundly affected the decision. The footnotes in the next section refer to the Sequoia Hospital Bylaws and the Rules & Regulations that were not followed comprising procedural injustice.

**Was there “substantial noncompliance with the standards or procedures required by these Bylaws, or applicable law, which has created demonstrable prejudice”? Yes.**

* There was no *accurate* indication provided for the investigation.[[27]](#footnote-27), [[28]](#footnote-28)
* I was denied access to the available Sequoia Hospital QA rate data of concern.
* The QA data compared my practice data with that of benign non-cancer-gynecologists.[[29]](#footnote-29)
* The AHC was biased by Dr. Torosis and Dr. Chandrasena at their first meeting, inaccurately telling them I had high complications, infections, and takebacks.
* The administrative judge’s prohibition to submit exculpatory evidence during the JRC precluded many truths about my practice.[[30]](#footnote-30), [[31]](#footnote-31), [[32]](#footnote-32), [[33]](#footnote-33), [[34]](#footnote-34) No journal data was allowed to be admitted as evidence that my practice was “literature-based” and norm-compliant.
* There was no Gynecologic Oncologist on the AHC or the JRC panels as required.[[35]](#footnote-35)
* QA Confidentiality was breached.The AHC chair contacted Dr. Dwight Chen who was a remotely prior peer reviewer, but not involved in this AHC.[[36]](#footnote-36) Dr. Chen told a Santa Cruz Gynecologist that my privileges were revoked at Sequoia, who told another Gynecologist. An MEC member, Gregory Engel, told his wife about the MEC meeting information.
* The administrative judge had worked for CHW-Dignity Health) for 17 years.[[37]](#footnote-37)
* The outside reviewer was not made available for cross-examination.[[38]](#footnote-38)
* The Board of Directors Appeal refused to allow for the presentation of evidence that was precluded from the JRC by the administrative judge.[[39]](#footnote-39)

**Were the factual findings of the Hearing Committee supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to this section?**

**No.**

* Dr. Torosis grossly misrepresented the interactions between me and the former and current Chief of Staff to the AHC first meeting. I was highly collaborative in seeking practice data for my meeting with both her and him.
* Dr. Torosis requested an AHC before ever meeting with me.
* Dr. Chandrasena incorrectly alleged my takeback rate was 20%.
* The JRC Decision was not based on facts from peer-reviewed Gynecologic Oncology journal data or comparisons with other Gynecologic Oncology data. The NSQIP published Gyn Oncology evidence would have shown that my complication rates were within or below the published NSQIP Gynecologic Oncology norm, and that my individual cases were reasonably and safely managed.
* There was no ethical lapse in my dictating two “drafts” of the aorta case. Neither was signed or dated, and neither became part of the patients record because they were never read, edited or signed and dated.[[40]](#footnote-40)
* There was never any complication in the Aorta case, no indication for summary suspension. They disregarded and suppressed the favorable review by the QA-assigned physician.[[41]](#footnote-41) The required consultation with vascular surgery was made by text and by personal phone conversation.[[42]](#footnote-42) The Vascular surgeon, Dr. Zimmerman, did not plan for his availability by requesting the necessary equipment or desired nursing team.
* My consultation with Dr. Zimmerman was executed appropriately.[[43]](#footnote-43) He was the consultant and was responsible for providing what he needed for proper car of this patient.
* Dr. O’Holleran’s and my sworn statement about our billing plans and dictations was not allowed into evidence.[[44]](#footnote-44)
* The AHC and MEC received false information about the Aorta case from Dr. Chandrasena influencing them to expel me or to continue the summary suspension.[[45]](#footnote-45)
* Every patient of mine was seen every day by me or a covering physician. I did not write notes on discharged patients whom I was not required to see, in accordance with Sequoia standards, and acknowledged by the AHC. I did not write notes on patients on another physician’s service, without proper consultation.[[46]](#footnote-46)
* The Ad Hoc Committee and the Judicial Review Committee interviewed and disregarded substantial evidence from every single physician that I worked with on a regular basis. Every colleague (O’Holleran, Wilson, Havard, Noblett, Parris, Bradley, Keshavacharya, Fisher, Beingesser, Charvonia, Sueldo, Emeney) confirmed that my practice was respectful, careful, and without undue complication, and that I attended my rare complications with detailed care and attention. Not even one felt that any of my complications were “egregious” as asserted.
* The Ad Hoc Committee and the Judicial Review Committee disregarded all these physicians and nurses most familiar with my work, and put their only credence in a single remote physician reviewer, who could not be cross-examined.
* The panel was required to have had a Cancer-Gynecologist on it. A Cancer-Gynecologist would have offered a more legitimate perspective on the surgeries that none of the panel understood or performed or even knew that I performed routinely.
* Exculpatory evidence was prohibited from submission during the JRC trial.

**Was there any bias introduced into the case that would affect the decision?**

**Yes.**

* The AHC and JRC members’ Decisions were biased by multiple misrepresentations propounded by Dr. Chandrasena and Dr. Torosis.[[47]](#footnote-47)
* The subjective view of the non-Gyn-Oncologist hospital staff members that the Aorta case was a “near miss” should not have constituted an indication for summary suspension. None of the evidence or testimony by all present in the case supported such a decision.[[48]](#footnote-48)
* The JRC disregarded my and Dr. O’Holleran’s objective responses to the outside reviewer, while the subjective reviews of physicians who had little-to-no familiarity with my practice or Cancer-gynecology standards, were accepted.
* The JRC panel refused my request to allow me to submit exculpatory evidence *during the proceedings*, removing any chance to show that my practice was entirely literature-based.
* The hospital’s legal counsel purposely suppressed information about the exculpatory QA review in the Aorta case. (Nov 5 JRC: Mr. Schulman: “There was no peer-review form in evidence—and I would submit there never was one. No form. No peer-review form”)
* The JRC Decision disregarded incontrovertible evidence that my dictated templates which I did not edit or sign into the patient’s medical record were entirely ethical.[[49]](#footnote-49)
* The JRC would not accept into evidence that Dr. Aboian dictated for Dr. Zimmerman at least once (897774, DOS 8/24/2015) which became part of the patient’s record.

**Were the correct standards applied in making the decision?**

**No.**

* It is standard to compare NSQIP practice data of Cancer-Gynecologists with NSQIP data from other Gynecologic Oncology practices. Sequoia had this data. The investigation by an Ad Hoc Committee was never indicated *ab initio* because the allegations sent to the MEC requesting formation of an AHC were based on comparisons with Dignity-wide non-cancer-gynecologists’ data.[[50]](#footnote-50)
* All published NSQIP data on complications, infections, takebacks and enterotomies show that my rates are NOT increased over any of my peers (see attached exhibit).[[51]](#footnote-51)
* Discovery documents provided to me were incomplete. A letter from an MEC member to Bill Graham alleging false evidence and member bias at the MEC was not provided to me.
* Exculpatory discovery was wrongfully prohibited from evidence.[[52]](#footnote-52)

I have provided evidence that Sequoia showed substantial noncompliance with its own Bylaws and Rules & Regulations, which created undeniable prejudice against me. I have provided evidence that the findings of the AHC and JRC Hearing Committees were not supported by the facts or substantial evidence I could have provided, but was prevented from doing so. I further allege that the bias introduced into the case by multiple false allegations affected the decision and that incorrect standards were used to wrongly condemn my career.

Governor Newsom, I would be so grateful if you were to require an investigation into Sequoia’s QA process against me. I believe it constituted procedural injustice and has harmed me immeasurably. Thank you.

Sincerely,



Katherine A. O’Hanlan, MD

1. Sequoia Hospital, 170 Alameda de las Pulgas, Redwood City CA 94062 [↑](#footnote-ref-1)
2. Sequoia is one of 700 US Hospitals that routinely submit their QA data to The National Surgical Quality Improvement Project, (NSQIP), a central database that enables hospitals to compare their surgeons’ complication rates with national averages. There are 65,000 Gynecologists in the NSQIP database, of which 1,157, or 1.5% are Gynecologic Oncologists (like me) and the other 98.5% are General Gynecologists. Thus, the overwhelming data in the central NSQIP database represents that of General Gynecologists’ complication rates. Many publications have been produced to set standards for our GynOnc subspecialty procedures and our patients by teasing out the GynOnc-specific data. By requesting the entire digital data copy from the central NSQIP, and separating out the data from patients who had surgeries specifically performed by Non-GynOncs, (General Gynecologists, Obstetricians, Urogynecologists, Infertility Gynecologists, etc etc) or had particular procedure performed by a GynOnc. These manuscripts establish specific norms for GynOncs’ complication rates in medical journals, establishing the benchmark standards in our subspecialty. [↑](#footnote-ref-2)
3. Minutes of MEC session August 28, 2017: return-to-surgery rate was “20.968% compared to Dignity Health Gyn-Onc of 3.243%.” These are Midas numbers---not takeback rates. [↑](#footnote-ref-3)
4. MEC 150: Chandrasena to third AHC meeting, December 8, 2016: “Dr. Chandrasena reported that the information included in the packet was provided to the Department Chair about 1 year ago.” ((i.e., December, 2015) [↑](#footnote-ref-4)
5. MEC 150: “Return to OR in same hospitalization as 20 out of 110. 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%.” MEC 337: 20.968% Return to OR, compared to Dignity Health 3.243%” JRC Nov5 p103, “This data is the truth. …I’ve shared it with the Ad Hoc Committee, and it was shared with the MEC.”, JRC, Nov 5, p449: p449 “No, because it is accurate. By our definition from Midas, that data is accurate. It's not wrong. You can use -- you can use the numerator and denominator to change the percentage, but that data is by a standard definition from quoted data. It's not something we can change.”. [↑](#footnote-ref-5)
6. MEC session August 28, 2017: return-to-surgery rate was “20.968% compared to Dignity Health Gyn-Onc of 3.243%.” These are Midas numbers---not takeback rates. “Dr. Chandrasena reported that there are inaccuracies in the statements provided by Dr. O’Hanlan as noted below.” [↑](#footnote-ref-6)
7. MEC session August 28, 2017: “I have asked you six times to share your numbers with me and you never shared any.” “People on our medical staff, attorney and our colleague in the department and they collectively advised me not to re-review the data.” [↑](#footnote-ref-7)
8. MEC session October 23, 2017: “Nobody has ever shown me any results of my complications. I’ve asked seven times. Dr. Chandrasena said the lawyers said they didn’t have to show them to me.” “I’m not going to argue with you, Kate.” [↑](#footnote-ref-8)
9. MEC session October 23, 2017 Mp3 audio recording (termed inaudible in typed transcript) [↑](#footnote-ref-9)
10. JRC, Nov5 p103, “This data is the truth. …I’ve shared it with the Ad Hoc Committee, and it was shared with the MEC.” [↑](#footnote-ref-10)
11. JRC, Nov 5, p449: p449 “No, because it is accurate. By our definition from Midas, that data is accurate. It's not wrong. You can use -- you can use the numerator and denominator to change the percentage, but that data is by a standard definition from quoted data. It's not something we can change.” [↑](#footnote-ref-11)
12. JRC, Nov 5, p24: DR. CHANDRASENA: ··This is the data. ··I haven't done anything to it. It is what it is. It's from Midas, which is our database that looks at inpatients only. ··It is designed and used in 800 hospitals across the country. That’s the report that was pulled – that was used to look at Dr. O'Hanlan's performance, so I didn't do anything to it. ··It is just what's pulled from the systems. ··You cannot edit it.” [↑](#footnote-ref-12)
13. JRC, Nov 5, page 166: HEARING OFFICER JOHNSON: ··You can't refer to something that's not in evidence. [↑](#footnote-ref-13)
14. JRC, Nov5 p166: HEARING OFFICER JOHNSON: ··Any more questions from the committee? ··No questions. Any more questions from either counsel? MR. FLEER: ··No. MR. SHULMAN: ··No. HEARING OFFICER JOHNSON: ··Then the evidentiary portion of this hearing is concluded. DR. O’HANLAN: ··May I make a comment? HEARING OFFICER JOHNSON: ··No. Off the record. ·---oOo--- [↑](#footnote-ref-14)
15. Emails from my colleague, on file. [↑](#footnote-ref-15)
16. JRC, Nov 5, page 166: HEARING OFFICER JOHNSON: ··You can't refer to something that's not in evidence. [↑](#footnote-ref-16)
17. JRC, Nov 5, page 166: HEARING OFFICER JOHNSON: ··Well, there's a bigger problem. ··Let's go off the record for a minute. This was where I argued strongly that I could not defend myself if I could not submit journal and chart evidence. [↑](#footnote-ref-17)
18. JRC, Nov 5, page 167: HEARING OFFICER JOHNSON: ··Then the evidentiary portion of this hearing is concluded. DR. O’HANLAN: ··May I make a comment? HEARING OFFICER JOHNSON: ··No. Off the record. [↑](#footnote-ref-18)
19. JRC, Nov5 p166: HEARING OFFICER JOHNSON: ··Any more questions from the committee? ··No questions. Any more questions from either counsel? MR. FLEER: ··No. MR. SHULMAN: ··No. HEARING OFFICER JOHNSON: ··Then the evidentiary portion of this hearing is concluded. DR. O’HANLAN: ··May I make a comment? HEARING OFFICER JOHNSON: ··No. Off the record. ·---oOo--- [↑](#footnote-ref-19)
20. See Baker letter to Mercer at MBC attached. [↑](#footnote-ref-20)
21. JRC, Nov 5, page 158: I checked my phone log, and I was wrong when I reported that earlier. I was reporting what I remembered instead of what the fact was. · [↑](#footnote-ref-21)
22. JRC, Nov 5, page 72: Dr. Chandrasena: So my recollection of this case was there was a complication, and they were very worried about the logistics of the equipment.··So it so happened that the card -- the CV team was actually in a case with the cardiac surgeons and happened to have just finished this case when Dr. Zimmerman, like, rushed from the OR – or from the cath lab to come into this room.··He left a patient on the table to come into this room to do the case, and so it was that they didn't have the right equipment in and they were scrambling to get it. [↑](#footnote-ref-22)
23. JRC, Nov 5, page 66: MR. SHULMAN: ··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. THE WITNESS: ··Reviewed by a peer-review body at Sequoia Hospital? DR. O’HANLAN: ··This is in evidence. ··I just don't know what page it is. ··It's not the page -remember, we got the shuffled pages. ··Yulia can find it. MR. FLEER: ··My question, did you hear it? DR. CHANDRASENA: ··I'd like to see what you’re referring to because I don't know what you're asking me. [↑](#footnote-ref-23)
24. O'Hanlan KA, O’Holleran M. Morbidity of total laparoscopic hysterectomy +/-staging lymphadenectomy for uterine neoplasia. Proceedings from the Society of Gynecologic Oncologists Annual Clinical Meeting. March 22-26 2006.

    O'Hanlan, KA, J. Ferry, M. Chivukula, M. Harrington, M. O'Holleran, Transperitoneal versus retroperitoneal approach for staging aortic lymphadenectomy, poster at Society for Gynecologic Oncologists Annual Meeting, Los Angeles, CA, March 9-12, 2013.

    O'Hanlan, KA, J. Ferry, M. Chivukula, M. Harrington, M. O'Holleran, Impact of obesity on surgical outcomes of laparoscopic radical pelvic lymphadenectomy for women with cervical, endometrial or ovarian cancer, poster at Society for Gynecologic Oncologists, Los Angeles, CA, March 9-12, 2013.

    O'Hanlan, KA, M.S. Sten, N.N. Ford, M. Chivukula, S.P. McCutcheon, Laparoscopic retroperitoneal therapeutic pelvic to infrarenal lymphadenectomy, poster #317 at Society for Gynecologic Oncologists, Chicago, IL, March 27-29, 2015.

    O'Hanlan, KA, M.S. Sten, N.N. Ford, M. Chivukula, S.P. McCutcheon, Laparoscopic comprehensive therapeutic pelvic to infrarenal lymphadenectomy, poster #319 at Society for Gynecologic Oncologists, Chicago, IL, March 27-29, 2015. [↑](#footnote-ref-24)
25. O'Hanlan KA. Comprehensive, therapeutic retroperitoneal pelvic and infrarenal aortic lymphadenectomy for advanced cervical carcinoma. Gynecologic Oncology. 2013;130(3):634-635.

    O'Hanlan KA, Sten MS, Halliday DM, Sastry RB, Struck DM, Uthman KF. Comprehensive laparoscopic lymphadenectomy from the deep circumflex iliac vein to the renal veins: Impact on quality of life. Gynecologic Oncology. 2017;144(3):592-7. [↑](#footnote-ref-25)
26. O'Hanlan, KA, O’Holleran, Michael “Radical Pelvic Lymphadenectomy” video, Society of Gynecologic Oncologists, Miami Beach, FL, March 3-5, 2005.

    O'Hanlan KA. Comprehensive, therapeutic retroperitoneal pelvic and infrarenal aortic lymphadenectomy for advanced cervical carcinoma. Video Gynecologic Oncology. 2013;130(3):634-635.

    O’Hanlan, KA, Comprehensive therapeutic pelvic to infrarenal aortic lymphadenectomy, video, Society for Gynecologic Oncologists Annual Clinical Meeting, San Diego CA, March 19-22, 2016 [↑](#footnote-ref-26)
27. Bylaws, page 21: The President of the Medical Staff, a department chair, the Medical Executive Committee, or the Hospital President may request an investigation of a member whenever reliable information indicates a member may have exhibited acts, demeanor, or 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. [↑](#footnote-ref-27)
28. Bylaws, page 22: A request for action or for an Investigation under the auspices of the Medical Executive Committee must be supported by reference to specific activities or conduct alleged. [↑](#footnote-ref-28)
29. Bylaws, page 33: The practitioner may inspect and copy, at his or her expense, any documentary information relevant to the charges that the Medical Executive Committee has in its possession or under its control. [↑](#footnote-ref-29)
30. Bylaws, page 298: Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or recommended by the bodies whose decisions prompted hearing. [↑](#footnote-ref-30)
31. Bylaws, page 28: discretion is granted to the Medical Staff and Board of Directors to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. [↑](#footnote-ref-31)
32. Bylaws, page 32: The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner. [↑](#footnote-ref-32)
33. Bylaws, page 34: Judicial rules of evidence and procedure relating to the conduct of a trial regarding the examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these provisions. Any relevant evidence, including hearsay, may be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. [↑](#footnote-ref-33)
34. Bylaws, page 36. The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence. [↑](#footnote-ref-34)
35. Bylaws, page 31: Such appointment shall include at least one member who has the same healing arts licensure and practices in the same specialty as the Practitioner involved. [↑](#footnote-ref-35)
36. AHC meeting notes December 8, 2016 [↑](#footnote-ref-36)
37. Bylaws, page 32: An attorney regularly utilized by the hospital or medical staff for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. [↑](#footnote-ref-37)
38. Bylaws, page 34: Within reasonable limitations, both parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents; cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; [↑](#footnote-ref-38)
39. Bylaws, page 58: the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. [↑](#footnote-ref-39)
40. R & R, page 4: The provider’s signature and time stamp will be captured electronically when the provider signs or accepts documentation in the electronic health record; or, if on paper, all entries must be dated, timed, and authenticated in a timely fashion. The use of signature stamps is strictly prohibited. [↑](#footnote-ref-40)
41. Bylaws, page 23: 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. [↑](#footnote-ref-41)
42. R & R, page 4: Consultations should be performed as soon as possible after requested by the attending physician. [↑](#footnote-ref-42)
43. Sequoia R&R, page 4. Consultation is required in the following situations: Where the diagnosis is obscure after diagnostic procedures have been completed. In unusually complicated situations where specific skills or other practitioners may be needed. [↑](#footnote-ref-43)
44. Bylaws, page 34: Any relevant evidence, including hearsay, may be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. [↑](#footnote-ref-44)
45. Bylaws, page 25: The Medical Executive Committee shall reverse any action that was based on a material mistake of fact as to the existence of the grounds for such special action. [↑](#footnote-ref-45)
46. Sequoia R&R, page 1: In instances of absence from practice, the practitioner must provide or arrange for comparable coverage by another qualified staff member, within the same specialty, who has agreed to accept responsibility for care of the patient. [↑](#footnote-ref-46)
47. Bylaws, page 34: 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. [↑](#footnote-ref-47)
48. Bylaws, page 25: This initial written notice shall include a statement of the reasons why the summary suspension was deemed necessary. [↑](#footnote-ref-48)
49. R&R, page 1: The provider’s signature and time stamp will be captured electronically when the provider signs or accepts documentation in the electronic health record; or, if on paper, all entries must be dated, timed, and authenticated in a timely fashion. [↑](#footnote-ref-49)
50. Torosis and Joyce to MEC, October 3, 2016 (MEC 139-140): “series of complications and what seems to be unusually frequent returns to surgery and post-op infections… and what seem to be unusually frequent returns to surgery and post-operative infections.” See also Torosis to AHC#1 meeting, November 3, 2016 (MEC 146), AHC letter to MEC, September 29, 2017 (MEC 007, 023), Dr. Chan to JRC, August 21, 2017 (MEC 321). [↑](#footnote-ref-50)
51. Bylaws, page 22: A request for action or for an Investigation under the auspices of the Medical Executive Committee must be supported by reference to specific activities or conduct alleged [↑](#footnote-ref-51)
52. Bylaws, page 34: In ruling on discovery disputes, the factors that may be considered include: a. whether the information sought may be introduced to support or to defend against the charges; b. whether the information is “exculpatory” in that it would dispute or cast doubt upon the charges, or “inculpatory” in that it would prove or help support the charges and/or recommendation; [↑](#footnote-ref-52)