Sent on September 29, 2011 by Fax and E-mail to:

Attention: Governor Jerry Brown, c/o State Capitol, Suite 1173 Sacramento, CA 95814

FAX: (916) 558-3160 and FAX: (916) 558-3177

Via the Internet at http://govnews.ca.gov/gov39mail/mail.php

Subject: VETO AB 655

To the Honorable Governor of California, Jerry Brown

Honorable Governor Brown,

I would like to present you the Consumer's point of view regarding AB 655.

The most important problem with AB 655 is the fact that it assumes that hospitals in California conduct themselves with "Integrity and Transparency."

You know what happens when one assumes...

Unfortunately, such virtuous behavior is not the norm and can not be expected from any human being, particularly not, when such course of action is not necessarily within their own best interests.

Why should anyone expect hospitals to transfer accurate and complete information to another hospital regarding physicians on their staff, if Hospitals do not even comply with the basic existing laws regarding their mandatory duty to provide all the medical records to any patient that requests them, as mandated by California law ?

In my case, as well as many other cases around the country, we the consumers are victims of spoliation, as hospitals knowingly and willfully fail to provide all the medical records in a timely fashion, particularly the compromising evidence, till after the statute of limitation, so that patients will not be able to successfully pursue their negligence cause of action, see Across USA, anxiety over access to patient records USA Today 4/29/2008, by Robert Davis, http://www.usatoday.com/news/health/2008-04-29-medical-records_N.htm?loc=interstitialskip

So, why would hospitals transfer accurate and complete credential records to other hospitals about physicians on their staff, AB 655's purpose, WITHOUT the concerned physicians knowledge, let alone any possibility of verification?

Yet, that's exactly what AB 655 allows hospitals to do, as AB 655, section (e) states as follows:

The responding peer review body is not obligated to produce the relevant peer review information pursuant to this section,

unless both of the following conditions are met:

(1) The licentiate provides a release, as described in subdivision

(2), that is acceptable to the responding peer review body.

In fact, section (e) does not prohibit the responding peer review body from VOLUNTARILY providing the requested information WITHOUT the licentiate's knowledge, or allow the physician to verify that the documents transferred are complete and not containing any information pertaining another physician all together.

Most troubling, section (e) promotes the Code of Silence, as it opens the door to malicious conduct by the hospital administration who could then spread malicious rumors to other hospitals, when it desires to retaliate against a physician who stands up for patient safety or out of simple personal animus. Unfortunately, such conduct is widespread, see:

Retaliation Against Physicians - Methods and Strategies - Sham Peer Review, http://allianceforpatientsafety.org/retaliation.php

Yet, there is a possible fix, a simple amendment to (e) might do the trick:

"The responding peer review body may not produce the relevant peer review . . . ".

On March 5th of 2006, My Baby Girl, Lehna Jordann Brewer, was stillborn at Kaiser Permanente in Walnut Creek, California.

She died because the Kaiser HMO refused to induce labor, even though I was almost two weeks past my due date and I was nearly 41-years of age, which should have put me in a high-risk category.

"My expert testified that the Baby should have long since been delivered. She commented that we wouldn't be discussing this in Arbitration because the baby would be alive had the standard of care been met and baby been delivered ! She testified that nationwide standard of care of a woman of advanced maternal age is to deliver the baby no later than 39 weeks as there is an increased risk of stillbirth in women of advanced maternal age AND an increased risk of stillbirth in post-term babies. Kaiser is aware of this and they do not care.

One of Kaisers experts said that "Some babies just have to die" ! Even the Kaiser lawyer looked appalled at this cold, heartless comment.

Kaisers new television commercial is all about babies. This makes me sick, knowing what I know and there will be many more babies that die unneccessarily under their "care," because of Kaiser standard operating procedure. SICKENING."

Shortly after Lehna's death I began searching for answers as to why my beautiful 7 lb, 13 oz post-term Baby girl had died.

Kaiser Permanente immediately began witholding critical medical records to escape liability and accountability.

See front page lead story *USA Today*, April 29, 2008, in which I am one of the patients featured:

Patients often struggle for access to medical records
http://www.usatoday.com/news/health/2008-04-29-medical-records_N.htm

I filed a complaint with the California Department of Health, CDH, which conducted an investigation of Kaiser. It was a worthless investigation since the Ca. Dept. of Health told me it was Kaiser witnesses word against mine, so there was nothing they could do. Case closed.

Shortly before the investigation, the High-Risk Doctor on staff the night I discovered my Baby was dead, left Kaiser. He is the one that told me my Baby had died. I'll never forget the look on his face.

Kaiser finally turned over the missing fetal monitor strip, 3 months before my one year Statute of Limitations was set to expire.

I questioned whether or not this fetal monitor strip was even mine, as there was no name, no medical record number, a wrong date and a wrong time.

During my Mandatory Binding Arbitration, required by Kaiser, Kaiser was able to prove that this was my fetal monitor strip.

What Kaiser also proved, without even realizing, is that they were fully aware that my Baby was in trouble at the time of this appointment where my fetal monitor strip later went missing. As the nurse later testified in Arbitration that she was "alarmed" (her words) at what she saw on the monitor and this distracted her from hand-keying in the patient information since the equipment had been malfunctioning at the Kaiser location where I had been receiving my "care".

I was sent home after this morning appointment. I showed up again at Labor and Delivery that same evening complaining of upper abdominal pain and a bad headache. Again, I was rudely and abruptly told that "I was to go home and don't come back unless I was bleeding or my water broke." I was not allowed to see a Doctor this night. My Baby died in utero that night.

It seems in California there is no incentive to keep the patient alive as it is "cheaper" to let the patient die when there is a suspected compromised Baby. One of Kaiser's own expert witnesses, a placental pathologist, testified that had my baby been born alive, she would have been born with an element of brain damage.

What do you suppose would have happened if the attending Doctor this morning had chosen to do the right thing and deliver my Baby in a timely manner without fear of retaliation?

There is no doubt in my mind, my Baby would be a beautiful five year-old little girl today, loved and cherished by her parents.

During my forced binding Arbitration, I encountered Kaiser witnesses, who provided false testimony under oath before the Arbitration "judge." Kaiser almost always prevails in Arbitration, because they control all of the evidence, and the Arbitrators, who are hired and paid by Kaiser, know that they will not be called upon to serve as Arbitrators again if they do not rule in favor of Kaiser and against the patient. Kaiser almost always prevails!

To add insult to injury, the Arbitrator in my case had been arrested in the past for drunk driving and soliciting a prostitute, and had been forced to resign his judgeship, yet this disgraced ex-judge was put in charge of judging wrongdoing of the HMO that signs his paychecks.

Although our evidence strongly demonstrated gross negligence, and our expert testified and is adamant that Kaiser breached the standard of care – not just on one occasion, but on three separate occasions – I lost my case. I feel that it was decided before it ever began, and as I have become all too aware, this is the result in most Kaiser cases that make it to Arbitration.

My testimony in Washington DC, May 14, 2008, before Congresswoman Sheila Jackson Lee:

http://www.youtube.com/watch?v=frz9ZmT3e4A&feature=related

As for medical records, I am not the only one hospitals are hiding their records from, see:

"L.A. County supervisors want to see doctors' peer review documents from hospitals. They cite patient safety and malpractice claims. Hospital administrators are opposed."

By Molly Hennessy-Fiske, Los Angeles Times, August 28, 2010.

"The biggest issue for me is the risk management aspect of it — that is, let's not do it again, "Molina said. "Because if you don't know, you can't correct it."

"Molina said she learned from the board's experience closing troubled Martin Luther King Jr./Drew Medical Center not to trust medical staff to police themselves. She questioned whether there was enough state and county oversight of peer review."

http://www.latimes.com/news/local/la-me-peer-review-20100828,0,7469898.story

Accordingly, you MUST VETO 655, as it accomplishes the exact opposite from what it was supposed to achieve by further promoting the Code of Silence at the detriment of any credible and genuine medical peer review.

Respectfully Submitted,

Beth Stover