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I. PURPOSE

The purpose of this policy is to guide the Medical Staff as it carries out its duty to oversee professional practice evaluation activities that measure, assess, and improve the quality of health care at Stanford Health Care, in accordance with the Medical Staff Bylaws, Rules and Regulations, and applicable policies. The following core competencies, identified by the Joint Commission, provide the standard of professional practice by which a privileged practitioner competency is evaluated:

- A. Patient Care: patient care is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life
- B. Medical and Clinical Knowledge: knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others
- C. Practice-based Learning and Improvement: use of scientific evidence and methods to investigate, evaluate and improve patient care practices
- D. Interpersonal and Communication Skills: interpersonal and communication skills that support the establishment and maintenance of professional relationships with patients and families, and working effectively as a member or leader of a health care team.
- E. Professionalism: behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward patients, profession and society
- F. System-Based Practice: understanding contexts and systems in which health care is provided and applying this knowledge to improve and optimize health care.

II. POLICY STATEMENT

This policy provides the framework by which the following goals are accomplished:

- A. Professional competence of all privileged practitioners is monitored and evaluated on an ongoing basis, including the practitioner's understanding of how human, team and system factors impact a practitioner's practice;
- B. A positive approach to Professional Practice Evaluation identifies opportunities for improvement, including both technical abilities and the

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- practitioner’s behaviors that support teams and systems and mitigate his/her potential for human error;
- C. Processes for professional practice evaluation are consistent, fair, and timely.

Each clinical service will have a mechanism for peer review operationalized through their Care Review Committee (CRC). The findings of the committees defined in this policy will be included in the information used to assess the quality of care of each practitioner at the time of reappointment to the Medical Staff and on an ongoing basis as appropriate.

The Care Improvement Committee (CIC) will supervise the work of the CRCs and adjudicate inter-CRC opinions and issues. The CIC will report to the Medical Executive Committee (MEC) annually. (See **Appendix A**).

This policy also applies to Advanced Practice Providers (APPs), including nurse practitioners, physician assistants, certified registered nurse anesthetists and clinical nurse specialists. These committees’ findings will also be forwarded (with safeguards to ensure confidentiality of individual practitioners) to the appropriate venues for potential system improvements.

III. DEFINITIONS

- A. **Care Improvement Committee (CIC)**: designated as the parent CRC and is ultimately accountable to the Medical Executive Committee for oversight of the Professional Practice Evaluation processes of all clinical services.
- B. **Focused Professional Practice Evaluation (FPPE)**: a time-limited process to evaluate the privilege-specific competency of individual practitioners upon:
1. Initial appointment to the medical staff or granting of privileges;
 2. When privileged practitioners request new privileges; or
 3. When a professional competency concern arises.
- Note:** See Initial Focused Professional Practice (IFPPE) Policy for 1 and 2 above.
- C. **Ongoing Professional Practice Evaluation (OPPE)**: the routine monitoring of data metrics and core competencies for current medical staff members. **Note:** See Ongoing Professional Practice Evaluation (OPPE) Policy.

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- D. **Peer:** a practitioner with competencies equal to or greater than the practitioner whose practice is being reviewed.
- E. **Care Review:** conducted by the medical staff using its own members to perform review of professional competence of privileged practitioners for performance improvement and provision of safe and quality patient care.
- F. **Care Review Committee (CRC):** any committee designated by the medical executive committee, medical staff bylaws, or medical staff policy, to conduct a review of privileged practitioner’s professional practice utilizing FPPE, OPPE and other Professional Practice Evaluation processes. CRCs are subcommittees of the Care Improvement Committee.
- G. **Physician:** a doctor of medicine or osteopathy, dental surgery or dental medicine, or podiatric medicine licensed to practice in California.
- H. **Practitioner:** a person for whom the Medical Staff evaluates credentials and recommends clinical privileges.
- I. **Professional Behavior:** as defined in the Medical Staff Code of Professional Behavior Policy, a high standard of professional behavior, ethics, and integrity is expected of each individual member of the Medical Staff at SHC in order to promote an environment conducive to providing the highest quality of care.

IV. CARE REVIEW

- A. Care Review is an activity structured to evaluate actual or potential harm to patients resulting from circumstances that include, but are not limited to:
 - 1. Failure to follow hospital or medical staff policy
 - 2. Behavior that detracts from optimal clinical team function
 - 3. Failure to comply with processes designed to reduce human errors, enhance clinical teams or strengthen care delivery processes and systems
 - 4. Unmet standards of care or care otherwise determined inappropriate
 - 5. Unexpected death or disability
 - 6. Referrals from a hospital or clinic, or committee
 - 7. Staff or patient/family requests

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B. Care Review findings:

1. May recommend enhancement of technical skills and/or training or coaching in communication, team participation, professionalism and the importance of systems that protect patients and mitigate the potential for practitioner human error.
2. May lead to a focused professional practice evaluation (FPPE) for individual performance improvement; and
3. Are included in the metrics reported in ongoing professional practice evaluations (OPPE).

C. Care Review activity is a confidential, collegial activity.

V. CARE RATINGS

A. Teams and Human Factors. Despite the enormous talents of our physicians and staff, adverse events do occur. Key to improvement is determining why an event occurred, which requires in depth analysis of the elements which affect individual and team performance. These can be characterized as Human and Team Factors and subclassified as follows:

1. Competency
2. Consciousness
3. Communication and Information Processing
4. Critical Thinking

B. Systems and Processes Factors. Understanding the impact of the environment in which individuals and teams perform and identifying processes and systems that contribute to an adverse event is also important to improvement. These factors can be characterized as Systems and Processes Factors and subclassified as follows:

1. Structure

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2. Culture
3. Process
4. Policies and Procedures
5. Technology and Environment

C. The complete Taxonomy of Human and Team Factors, and Systems and Processes Factors can be found in **Appendix B**.

VI. CARE REVIEW PROCESS/PROCEDURE

A. An overview of the process can be found in **Appendix C**.

B. Individual Case Reviews:

1. Cases for individual case review will be based on individual CRC selection and may be identified by:

a) Review indicators: each CRC identifies relevant indicators for its divisions and/or services. Cases will be pre-screened by the CRC Quality liaison from Quality, Patient Safety, and Effectiveness (QPSED) and applicable cases will be presented to the CRC chair or designee and a second CRC member for screening.

b) Case referrals identified by:

- (1) SAFE reports
- (2) Patient/family complaints
- (3) Sentinel/adverse events
- (4) Regulatory agencies
- (5) Practitioners
- (6) Morbidity and Mortality conferences
- (7) Risk Management

2. Individual case reviews may also be performed when a threshold for an indicator is exceeded.

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C. Indications for Focused Professional Practice Evaluation (FPPE)

1. Any single egregious or sentinel event, as judged by the relevant CRC, CIC, Service Chief, APP Administrator, MEC or Chief of Staff may be referred to the CIC for consideration of a FPPE.
2. When indicator thresholds are exceeded within the agreed upon time:
 - a) The gross number of cases involving a provider exceeds a threshold for concern as determined by the relevant CRC or in consultation with the CIC.
 - b) An indicator exceeds a threshold as determined by the CRC. However, exceeding those indicators does not result in automatic referral to CIC for consideration of FPPE. The CRC will consider whether referral is indicated based on the individual circumstances. FPPEs are personalized and individualized to the specific physician and the present issues. The CIC or the specific CRC delegated by the CIC identifies a timeframe and individualized plan for the completion of the FPPE process, monitors the physician's compliance with the process, and communicates directly with the physician regarding the expectations and timeline.
3. Upon referral, the CIC will determine whether FPPE is warranted.

D. Care Review Process

1. CRC-specific metrics will be utilized for case identification on an ongoing basis. These metrics will include CRC aggregate rates such as mortality, complications, Patient Safety Indicators and others. Identified cases may undergo screening or full review as determined by the CRC chair or designee. If the CRC chair is the attributed provider, the co-chair or designee will screen the case. All cases will initially be blinded to minimize bias.
2. Those cases not selected for presentation will be compiled along with a brief reason for referral and submitted to the CRC membership for review. A CRC member may propose review of a non-selected case which, upon approval by a simple majority of the voting membership of the committee, will necessitate review at the next meeting.
3. Each case for review will be assigned to an appropriate CRC member for presentation to the committee.

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4. Additional review will be performed based on individual CRC thresholds. After analysis, the CRC can recommend the following:
 - a) No Further Action
 - b) Invited Review
 - c) Referral to the appropriate Quality Council
 - d) Referral to the Patient Safety Committee
 - e) Referral to Other Committees
 - f) FPPE
5. The attending physician(s) and APP(s) identified in a case for invited review will be notified and invited to attend the CRC meeting and/or submit their written perspectives of the case.
6. The assigned reviewer will review the medical record. The reviewer may recommend that further information be obtained before further committee review. If the provider is an APP, an APP Administrator and at least one peer APP will review the case and be in attendance during the CRC meeting.
7. The reviewer will present the case to the committee and, if applicable, the attending physician(s) or APP(s) involved in the case may provide additional information.
8. If the attending physician(s) or APP(s) did not attend the meeting and further information is needed, the attending physician(s) or APP(s) will be asked to respond in writing or in person at the next CRC meeting.
9. The CRC will classify the adverse event according to the Human and Team Factors/Systems and Processes Taxonomy. The attending physician(s) and APP(s) may participate in the classification process and case discussion at the discretion of the CRC chair. In cases when the provider is an APP, the APP Administrator and the peer APP(s) will also participate in the classification process. In the rare situation that the adverse event cannot be classified according to the taxonomy, the event will be adjudicated as “No Factors Identified”.
10. Decisions of the CRC will be determined by simple majority vote.

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11. The attending physician(s), APP or other licensed independent practitioner will be notified in writing of the outcome. The applicable Service Chief will be copied on same.

12. If a practitioner disagrees with any finding of the CRC, he or she may submit written comments that will be filed with the committee’s findings, and may make an appeal to the CRC regarding the decision.

13. If corrective action is recommended by the CRC and the practitioner disagrees, the case will be referred to the CIC. In such a case, one member of the CIC or a designee will be asked to review the case.

14. If one CRC disagrees with the decision of another CRC on an issue that is of concern to both committees, that issue may be referred to the CIC.

15. All recommended coaching, education, or other corrective measures will be conveyed to the practitioner by the CRC Chair and will be tracked by the quality liaison and the results will be reported to the CRC and Chief of Staff.

16. Any corrective measures beyond counseling recommended and accepted at the CRC level will be reported to the CIC before and after completion of those measures.

17. Care provided by resident physicians will be attributed to the attending/supervising physician during the evaluation and rating process. However, concerns about house officer performance issues will be referred to the appropriate Program Director for that particular residency program, as will any process issues relating to house officer supervision. The Program Director will be asked to provide feedback to the quality liaison and/or the CIC directly as to the results of any such referrals.

E. Reliability and Consistency of the Review Process

1. Care Review will be conducted in a manner that is objective, equitable, and consistent.

2. The CIC will monitor reliability and consistency of each CRC based on semiannual activity reports submitted to the CIC and will in turn report its findings to the MEC at least annually.

F. Participants in the Review Process

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1. CRC members will normally be recommended by the Service Chief(s), subject to review and acceptance by the CIC and Chief of Staff. CIC membership is described in the Medical Staff Bylaws. Every CRC must include at least three active Medical Staff members in good standing.
2. Services that have a substantial population of patients who have community attending physicians should have at least one community attending physician as a committee member.
3. The Service Chief(s) will consider rotation of members at least once every three years, or membership may be extended
4. The CRC chairs will be appointed by the Service Chief(s) with the approval of the Chief of Staff, CIC and MEC.
5. A quality liaison from the QPSED will be assigned to support the CRCs.
6. Service Chiefs are encouraged to appoint resident physicians as non-voting members of CRCs.
7. Support staff and APPs will participate in the review process as deemed appropriate based on their job responsibilities.

G. Case Review Time Frames

1. The case reviews will be conducted by the CRCs in a timely manner. The goal is for routine cases to be completed as quickly as possible and within 120 days from the referral date. This requires committee meetings at least quarterly.
2. Complex cases may require additional review time beyond 120 days. The status of complex cases will be monitored by the quality and the practitioners involved will be kept apprised of the process. A complex case may be one in which multiple services are involved, or one that prompts external review.
3. Cases requiring a response to an external agency (e.g. The Joint Commission (TJC), Centers Medicare Medicaid Services (CMS), insurance agencies, etc.) may need an expedited review process:
 - a) The case will be sent to the CRC chair to be screened and assigned to a physician reviewer (and/or to an APP reviewer if the provider is an APP).

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b) If possible, an *ad hoc* CRC meeting will be scheduled to accommodate the deadline. If an *ad hoc* meeting is not feasible, the following steps will take place:

- (1) A physician reviewer will provide a written response within the allotted time frame that addresses the questions asked by the referring agency, if applicable.
- (2) The CRC chair will review the response and if sufficient, send it to the QPSED liaison.
- (3) The QPSED liaison will forward the response to the requesting department/body for submission.
- (4) If applicable, the case may proceed with a full CRC review at the next scheduled meeting.

H. Oversight and Reporting

1. Direct oversight of the care review process is delegated by the MEC to the CIC.
2. The CIC will meet regularly to review the findings of the CRCs.
3. The CIC will report to the MEC at least annually.
4. The CRC activities will be reported to the MEC semi-annually by the QPSED.

VII. EXTERNAL REVIEW

A. A person or body responsible for overseeing Care Review may request the services of a peer who is not a member of the medical staff for any reason, including, but not limited to:

1. when no peer on the medical staff has sufficient expertise to evaluate a practitioner's competence;
2. peers on the medical staff have conflicts of interest that could be reasonably perceived as affecting the objectivity of their review; or
3. internal review has produced ambiguous, inconclusive, or conflicting results.

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B. The body/committee authorizing the external review will determine the process for, and communication of, that review.

C. The Chief of Staff will inform the MEC when there is a request for external FPPE. Input from the relevant Service Chief, as well as the practitioner being reviewed, should be solicited and considered prior to engaging external evaluation, when appropriate.

VIII. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A. An overview of the FPPE process can be found in **Appendix D**.

B. A FPPE is a systematic, time-limited process for evaluating an individual practitioner's competence to perform the clinical privileges granted to them. FPPEs occur under the oversight of the Service Chief (or designee, applicable PPEC), and Medical Staff Services Department as applicable, when the following occurs:

1. Initial or expanded privileges are granted.
2. A question arises as to a practitioner's ability to competently exercise the privileges granted to them.
3. Data indicating an incident or pattern in a practitioner's practice raises a question as to the practitioner's ability to competently exercise the privileges granted to them.
4. Results of any Professional Practice Evaluation activity indicate the need for performance improvement.

C. A physician specific focused professional practice evaluation may be requested by the Chief Medical Officer (CMO), Chief of Staff (COS), service or section head, medical director, Credentials and Privileges Committee, or Care Review Committee.

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D. It must be approved by the Care Improvement Committee. Insofar as Medical Board/Data Bank/ reporting requirements are concerned, it should be considered an investigation.

E. The Chief of Staff, or designee, with the assistance of the Service/Section Chief of the service in which the practitioner practices, and with the assistance of the Credentials and Privileges Committee is responsible for overseeing the practitioner for the FPPE period and making recommendations on their competency to exercise the privileges granted. Focused evaluations will specify the competency being evaluated and identify performance indicators to measure improvement. The following methods of evaluation may be used:

1. Personal observation
2. Chart review
3. Interviews with colleagues and peers
4. Simulation
5. Other approaches determined appropriate by the applicable PPEC

F. Following completion of the FPPE, results will be reported to the Care Improvement Committee.

G. Conflict of Interest

1. A member of the Medical Staff asked to perform a professional practice evaluation has a conflict of interest if, for example, he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or holds a relationship with the practitioner as a direct competitor or partner.
2. It is the individual reviewer's obligation to disclose any potential conflict. The CRC chair's determination will prevail in any disagreement regarding the existence of conflict.
3. Procedures for addressing potential conflicts of interest are outlined in the "Conflict of Interest for Medical Staff" policy.

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IX. ADVANCED PRACTICE PROVIDERS

Professional practice evaluation of non-physician practitioners granted Advanced Practice Provider (APP) status by the medical staff and hospital board is conducted in the same manner as the professional practice evaluation of physicians as applicable to the licensing/certification of the APP. The input of the Executive Director of Advanced Practice will be sought if needed.

X. CONFIDENTIALITY OF REVIEW ACTIVITIES AND MATERIALS

A. All activities carried out under this Policy are authorized by the Health Care Quality Improvement Act of 1986, codified at 42 U.S.C. § 11111, et seq., or California Evidence Code, § 1157, or both, and are subject to the provisions of the medical staff bylaws and applicable policies of the medical staff (**Appendix E**).

B. E-mail communication of confidential OPPE proceedings or documentation should generally be encrypted and any communication containing Protected Health Information (PHI) must be encrypted. Communications should be labeled as protected information using the following designation or similar language: CONFIDENTIAL Information: This information is protected by California Evidence Code Section 1157.

C. Practitioners and committees participating in the OPPE/FPPE processes must not disclose what transpired in their meetings except to the extent necessary to carry out one or more purposes of the process.

D. All minutes, documents and information received or produced under this Policy are confidential Medical Staff materials protected by California Evidence Code Section 1157 and other applicable law. Documents should be labeled as confidential, but such labeling is not required for the confidentiality protections to apply.

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E. Access to confidential material. Those authorized to have access to Review Organization materials include the following:

1. Members of the administrative staff who need access to the information in order to perform their functions.
2. Consultants, attorneys, or other professionals engaged by the Hospital to the extent necessary for them to assist in performing its function.
3. Representatives of regulatory or accreditation agencies who are entitled by law to have access to the information.
4. A practitioner does not have a right to access to materials, including materials related to the practitioner's own practice, except as authorized by law or as provided for in the Medical Staff Bylaws.

XI. Related Documents

1. Medical Staff Bylaws, Rules and Regulations, and Policies of the Medical Staff
2. Ongoing Professional Practice Evaluation (OPPE) policy
3. Initial Focused Professional Practice Evaluation (IFPPE) policy
4. Administrative Policy Manual
5. Joint Commission Accreditation Standards: Medical Staff

XII. Document Information

1. Legal Authority/References
 - a) The Joint Commission Accreditation Standards
 - b) California Evidence Code Section 1157
2. Author/Original Date

December 11, 2006
3. Distribution and Training Requirements
 - a) This policy resides in the Medical Staff Office Policy Manual for SHC.

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b) New documents or any revised documents will be distributed to physicians through the Medical Staff Office.

4. Review and Renewal Requirements

a) This policy will be reviewed and/or revised every three years or as required by change of law or practice.

5. Review and Revision History

a) Medical Staff Quality Assurance and Improvement Activities
October 2002

b) Medical Staff Professional Practice Evaluation Policy December 2006

c) Chief of Staff, Care Improvement Committee, March 2020

6. Approvals

a) Care Improvement Committee – 5/13, 4/16

b) SHC Medical Executive Committee – 6/13, 4/16, 3/20

c) SHC Board of Directors – 6/13, 4/16, 3/20

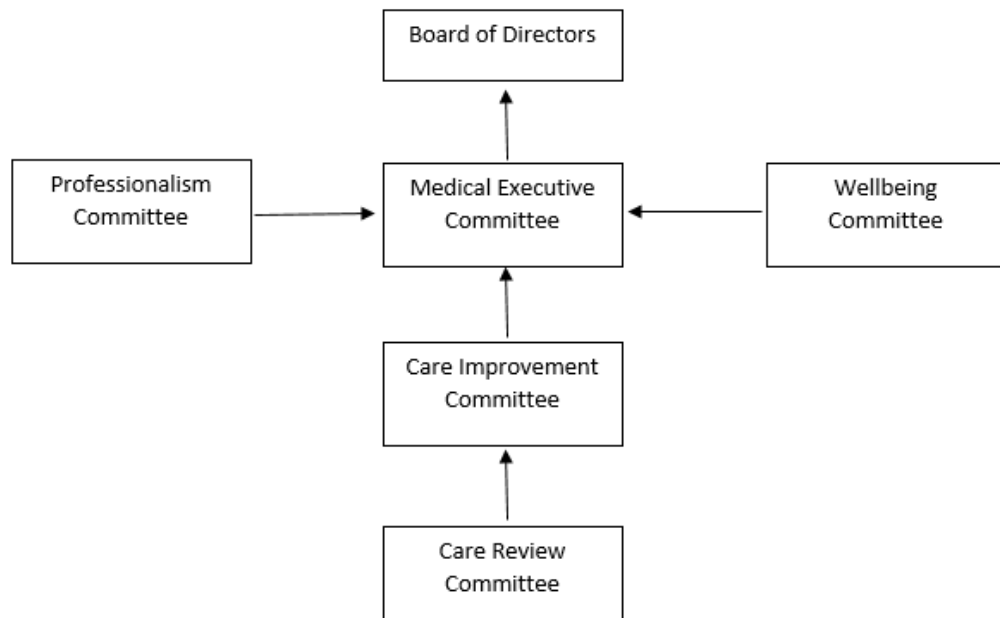
Reference and Credit: The original PPEC policy dated 2006 was done in collaboration with Lucille Packard Children’s Hospital and was based on the Sample Medical Staff Peer Review Policy location in Effective Peer Review: A Practical Design to Contemporary Design was done with written consent. ¹

¹ Effective Peer Review: A Practical Design to Contemporary Design, Second Edition, HCPro, Massachusetts

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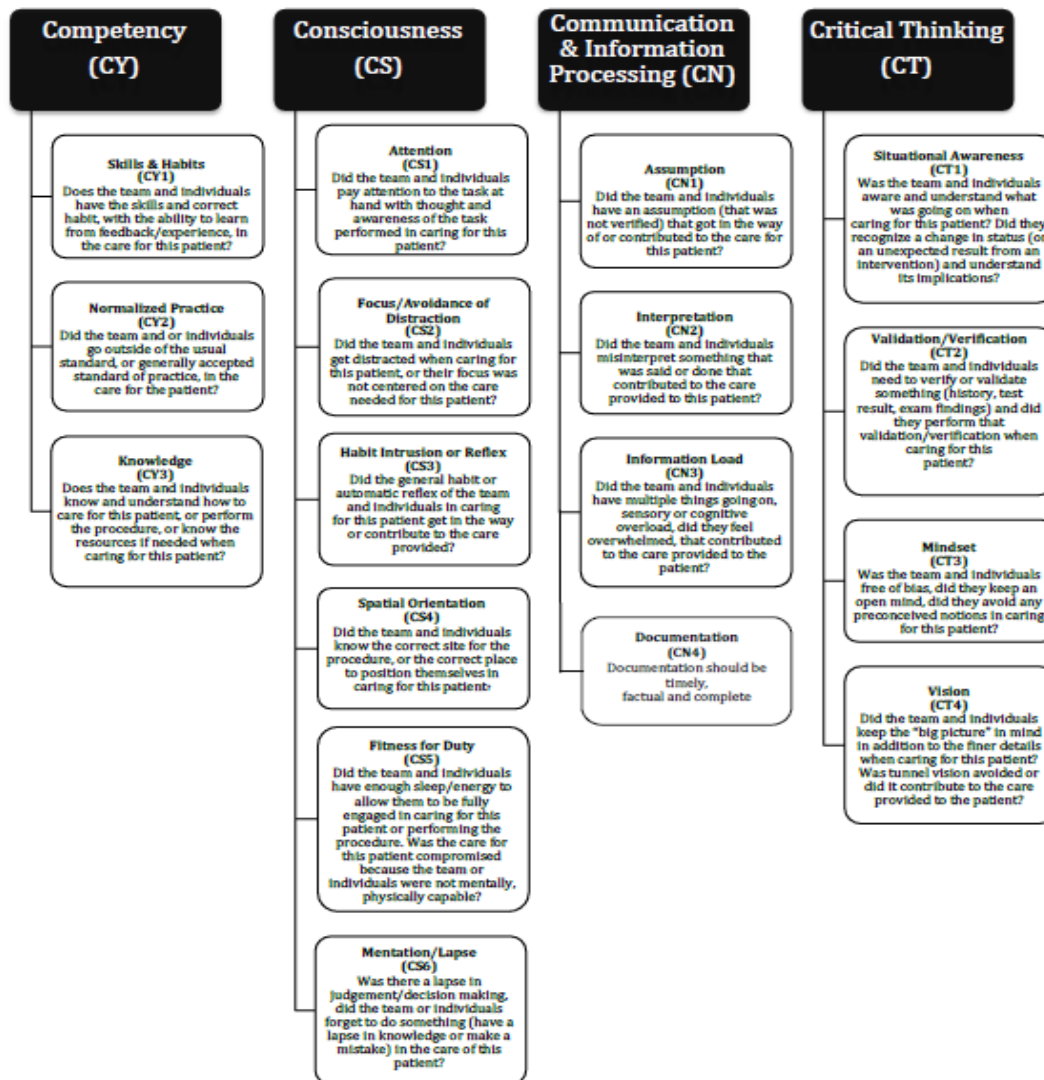
APPENDIX A
CARE REVIEW COMMITTEE REPORTING STRUCTURE



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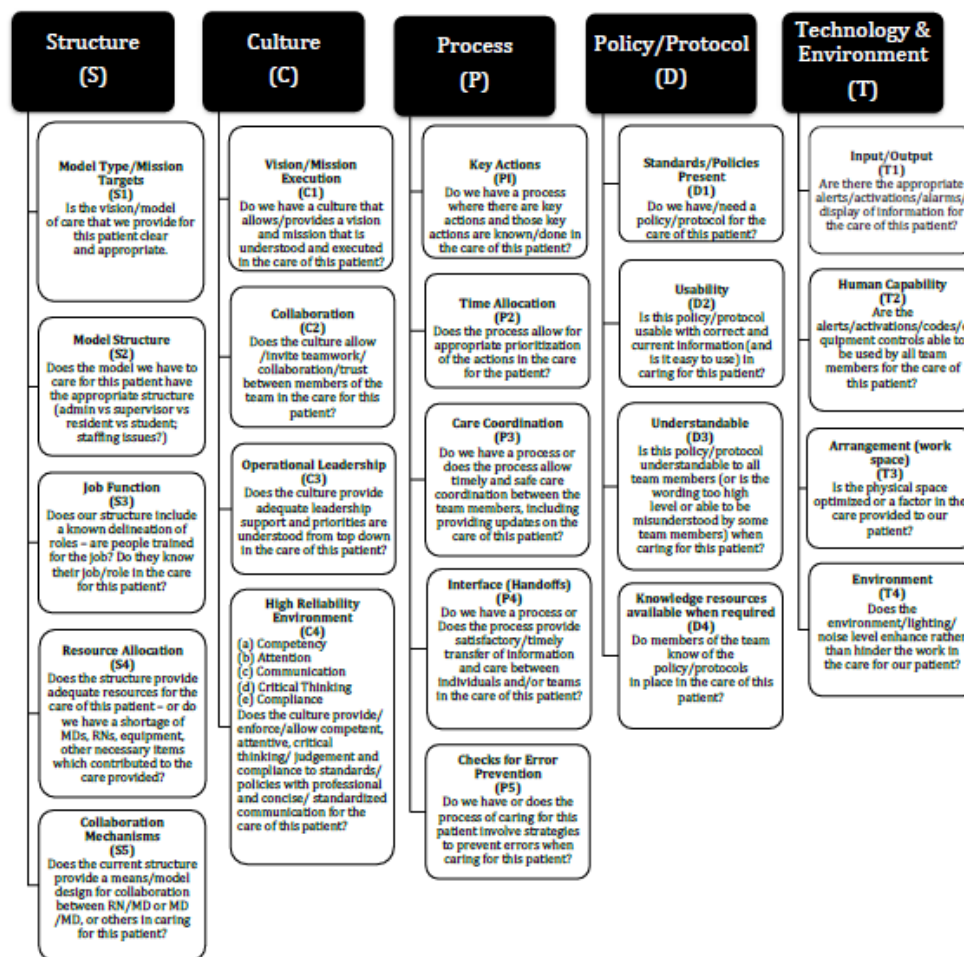
APPENDIX B

Taxonomy of Teams & Human Factors



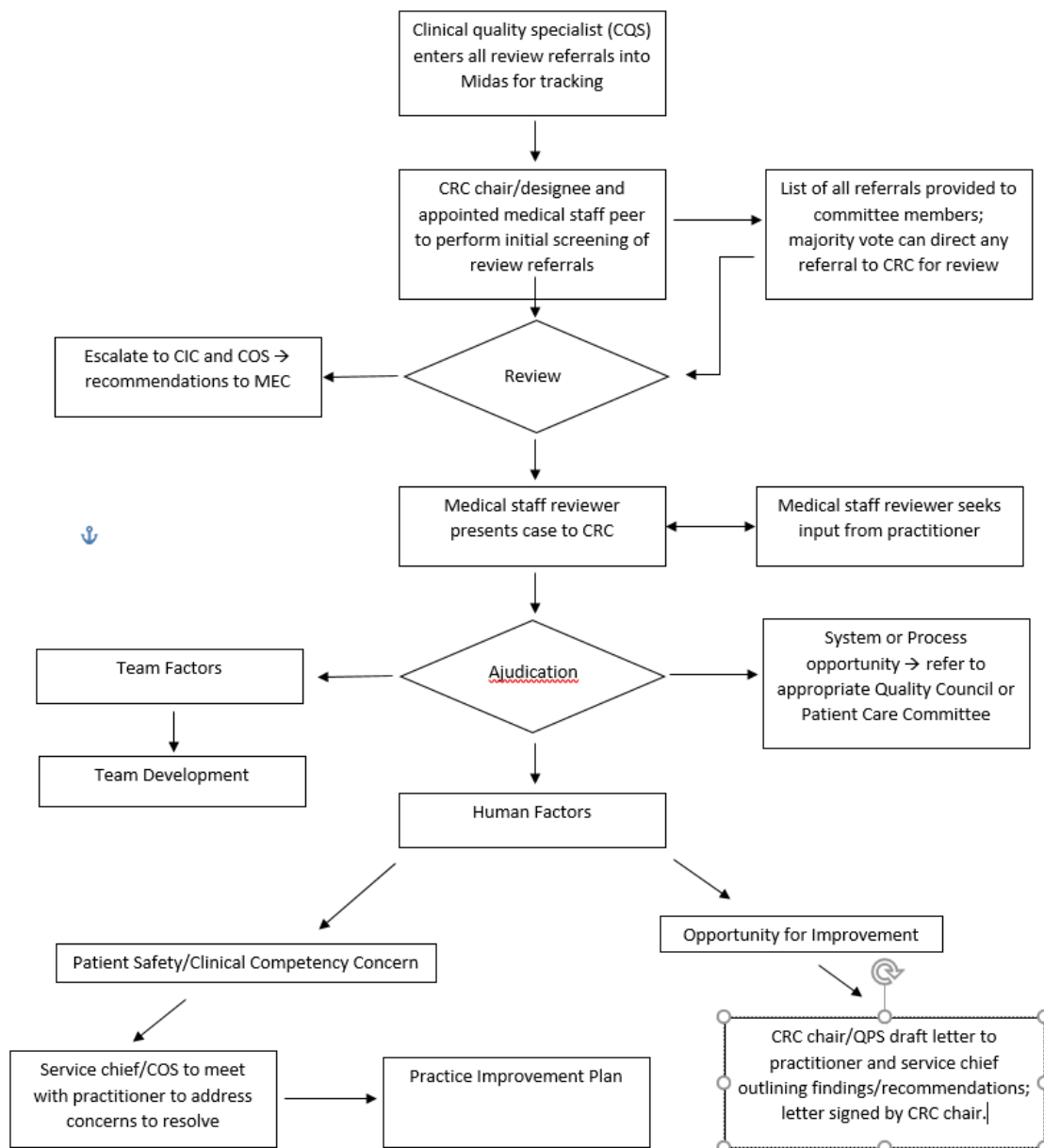
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Taxonomy of Systems and Processes



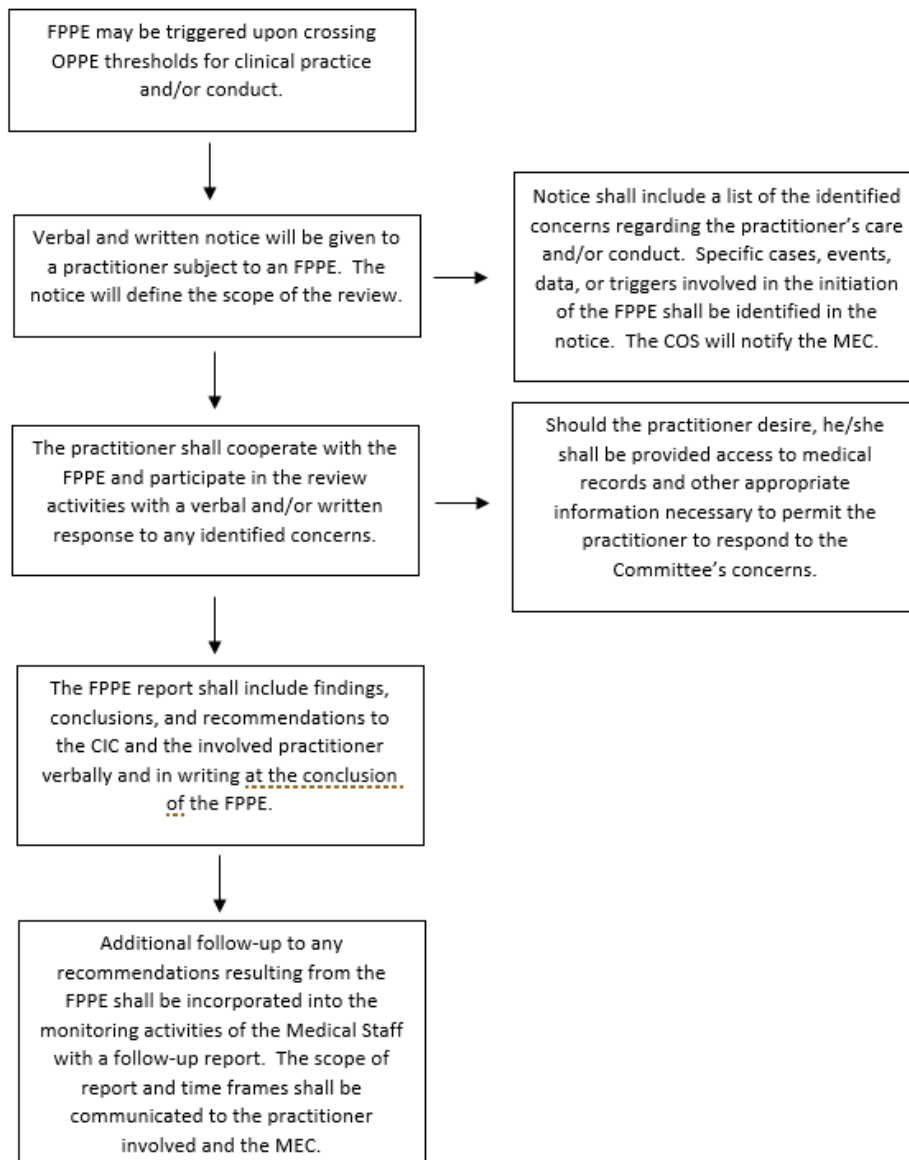
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APPENDIX C
CARE REVIEW COMMITTEE (CRC) WORKFLOW



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APPENDIX D
FPPE PROCESS



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APPENDIX E
EVIDENCE CODE 1157

Evidence Code 1157
Protection from Discovery of Peer Review Records & Proceedings

Neither the proceedings nor the records of organized committees of medical [...] staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code, having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, [...] shall be subject to discovery.

Cal. Evid. Code, § 1157, subd. (a)

What Is Evidence Code Section 1157?

- Section 1157 prevents “discovery” in litigation and most formal and informal administrative proceedings and preserves the confidentiality of the **proceedings and records of peer review bodies and their organized committees** charged with **evaluating and improving the quality of care** rendered by certain health care professionals.¹
- The purpose of Section 1157 is to improve the quality of medical care in hospitals by encouraging candor among medical staff members evaluating patient care (note that it applies to all quality improvement activities, not just peer review), without the worry that participants may be compelled to testify or provide information in most legal proceedings.
- Section 1157 generally provides broader protection than the attorney-client privilege as information can be shared for a valid purpose without waiving its protections. Its application and limitations are summarized in this document.

§ 1157 Checklist

- Information regarding records or proceedings
- Organized Committee or Peer Review Body
- Concerning evaluation and improvement of quality of care

What Does Section 1157 Protect?

- “Proceedings” and “Records” protected by Section 1157 include:
 - Records and minutes of peer review bodies (such as Medical Staff Committees, many foundations, health plans, group practices of a certain size).
 - Credentials/quality and/or peer review files concerning individual practitioners.
 - Applications for privileges.
 - Records of all performance improvement activities.
 - Discussions and deliberations within the confines or direction of Medical Staff Committees.
 - The identity of Medical Staff Committee members.
- “Proceedings” and “Records” **do not** include:
 - Hospital files (but clearly marked Medical Staff documents in hospital files remain protected).
 - The fact that peer review occurred.
 - Information not derived from an investigation into and review of quality of care.
 - Patient charts.

¹ “Organized committees of medical staffs” include all committees focused on evaluation or improvement of quality of care, e.g., not just the Medical Executive Committee or Credentialing Committee, but would include Well-being committee, Departmental committees and Quality Assurance committees.

This policy applies to: <input checked="" type="checkbox"/> <i>Stanford Health Care</i>	Draft Date Written or Last Revision Revised 3/3/2020
Name of Policy Peer Review and Focused Professional Practice Evaluation (FPPE) Policy for Medical Staff and Advanced Practice Providers (APPs)	<p style="text-align: center;">Page 22 of 21</p>
Departments Affected: All Departments	

APPENDIX E
EVIDENCE CODE 1157 (CONTINUED)

Limitations On The Protection Provided by Section 1157

- Section 1157 is a bar to discovery in state civil actions but California case law is split as to its applicability in criminal proceedings.
- Section 1157 does not automatically apply to civil actions in Federal Court, though a court may choose to apply Section 1157 depending on the circumstances of the case at hand.
- Section 1157 protection does not apply to a physician subject to discipline involving hearing rights.
- Section 1157 does not apply to disclosures required by law. For example, requests from other peers review bodies under Bus. & Prof. Code section 809.08 or in response to requests from the California Medical Board, CDPH, CMS, NPDB, or Joint Commission.
 - While there is no Section 1157 protection when responding to requests from authorities like the Medical Board, access to information generally protected by Section 1157 does not extend to otherwise privileged information. For example, attorney-client privilege, where applicable, must still be asserted.
- This discovery bar is not absolute and can be waived by voluntary disclosure or carelessness in identifying or asserting the protection.
 - While protected under Section 1157, voluntary testimony by peer review participants about proceedings and records² is generally permissible, though most Medical Staff and Peer Review Bylaws prohibit such disclosure.

Section 1157: Practice Pointers

- Always assert protection under Section 1157.
- Maintain documents under “custody and control” of Medical Staff Offices.
- Limit access to necessary persons (that is, individuals with a legitimate reason for having access to the information such as legal counsel to the medical staff or hospital, members of the Board of Directors when reviewing the recommendations of a fair hearing committee, or administration to the extent necessary to conduct or be aware of peer review).
- Require requests for access to be made through designated person within Medical Staff Office.
- If copies are necessary, only release uneditable PDF copies.
- Password protect electronic access.
- Utilize/institute training programs.
- Mark or stamp any committee or peer review documents as “CONFIDENTIAL”.
- Avoid over-designating information as specifically protected by Section 1157 when the same information is otherwise required to be disclosed.
- Avoid summarizing or mischaracterizing information: where possible quote actual language or produce redacted documents.

Please contact Stanford University’s Office of the General Counsel Alice Ho at 650-723-0457 or Andrea Fish at 650-721-1953 with any questions about Section 1157 and its application.

² Voluntary disclosure can occur, for example, when the peer review body or a member provides information (e.g. a committee member tells protected information to those not involved, a response is given to an inquiring entity which is not a peer review body, or disclosure is made to a physician under review which is outside the review process) or fails to properly assert the protection.