Jersey hospitals rarely reveal medical mistakes

Fear of lawsuits drives secrecy, experts say

BY CAROL ANN CAMPBELL
STAR-LEDGER STAFF

New Jersey's 86 acute-care hospitals together log more than 1 million admissions and perform 275,000 surgeries each year.

According to a review of records, here is the total number of serious medical mistakes these hospitals have reported to state officials from May 2000 to June of this year:

Three.

New Jersey hospitals are supposed to report medical errors that kill or injure their patients. But they almost never do.

And patients and their families rarely complain to state officials either, because they and their lawyers often agree to keep quiet as part of legal settlements. The result is a secretive system that prevents hospitals from sharing the lessons they learn when tragic mistakes do happen.

Such as the death of a 12-year-old North Bergen boy given three months of chemotherapy in three days.

Or the death of a 57-year-old Mount Olive man who had medicine injected into his spine instead of his vein.

Or the case of a cancer-free Jersey City man who had his prostate removed unnecessarily because his biopsy was misread.

The state never investigated these cases because the hospitals never reported them. Experts said other mistakes are going unreported and unexamined. They blame an overriding fear of lawsuits.

"We have a mandatory reporting system, but nobody reports anything," said David Knowlton, chairman of the New Jersey Health Care Quality Institute. "It's not working. We have to figure out a fair way to deal with error."

Mistakes happen in hospitals everywhere. A landmark 1999 study by the Institute of Medicine in Washington, D.C., said 98,000 Americans die each year from preventable medical mistakes. Analysts said the figure for New Jersey is likely to be 1,788 deaths each year.

But the New Jersey Hospital Association advises hospitals not to report errors, despite state rules.

Gary S. Carter, president of the hospital

[See **ERRORS,** Page 22]

CONTINUED FROM PAGE ONE

Medical mistakes often go unreported

association, said New Jersey is one of the few states that do not keep error reports confidential. He said doctors, nurses and pharmacists will not talk openly about mistakes if what they say can end up in the file of a malpractice lawyer.

"The system we have has nothing to do with patients and everything to do with lawyers finding cases to make money," Carter said. "We want to make sure that mistakes are not repeated. But we have an environment where we can't do that."

State officials agreed underreporting is a serious problem.

"Anything that is reported in New Jersey is public record. We have a culture of people afraid of getting sued. People don't want to put anything down on paper," said Marilyn Dahl, senior assistant commissioner of the New Jersey Department of Health and Senior Services.

Malpractice lawyers said hospitals simply want to cover up their mistakes. "What they are trying to do is deny the individual they harmed from any recourse," said John Blume, a Chatham attorney.

CRACKING DOWN

The state Department of Health and Senior Services is trying to crack down on hospitals that do not report errors. In May, state Health Commissioner Clifton R. Lacy sent a letter to hospital chief executives saying they should immediately notify the state about "serious reportable events" such as unexpected deaths, falls and suicides.

The hospital may not necessarily be at fault. But the event — such as an unexpected death within hours of surgery or a death during low-risk childbirth — should be reported, the state said.

Hospitals also must report preventable mistakes that kill or seriously injure patients. These are sometimes called "never events" because they are things that should never happen: Patients should never have the wrong operation, or be given the wrong blood type, or receive a fatal overdose of medicine.

State health authorities routinely cite hospitals and surgical centers for deficient staffing, poor infection control, violations of fire [illegible] tions for not reporting when patients fall or wander away. Hospitals have come forward to report these incidents.

Yet a review of three years of state penalty letters found just six investigations into unexpected death or potential medical errors that killed or injured patients. In half of the cases, the hospitals or surgical centers were cited for not reporting the event, which the state learned of in some other way, perhaps through a news report, patient letter or an on-site survey.

Since Lacy's letter, hospital reporting has improved, Dahl said, adding that several incidents were currently under investigation.

NO CANCER

Patients who have been injured by medical mistakes said the state should do more to enforce its own rules.

"What is the sense of a reporting system if nobody says anything?" asked Vincent Caruso of Jersey City. Caruso underwent surgery to remove his prostate and lymph nodes at Bayonne Medical Center in January 2001 — even though he never had cancer.

"When the doctor told me I had an aggressive form of prostate cancer, I remember thinking, 'Am I ever going to see my grandson grow up?'" said Caruso, 55. He agreed to undergo surgery. Afterward, while at home and still attached to a catheter, his surgeon called him.

"He said he wanted to speak with me and my wife immediately. I was scared to death. I thought maybe they didn't get it all," Caruso recalled.

"We went to see the surgeon, and I remember he looked distraught, like something had happened to him. He said, 'I don't know how to tell you this, but you never had cancer,'" Caruso said, his voice cracking at the memory.

Caruso declined to name the surgeon, whom he does not blame. He is suing the hospital, however, and in a sworn deposition, the doctor in charge of pathology at the hospital said that Caruso did not have cancer and that a hospital pathologist had misread his biopsy. Caruso said he still experiences the side effects common to prostate surgery.

The state said the hospital did not report the case.

Lynne Nouvel, a spokeswoman for the Bayonne hospital, said she cannot comment on specific cases. She said, however, that the situation described does not qualify as a reportable event. She declined to elaborate but said Bayonne Medical Center follows state reporting requirements and conducts internal investigations whenever a mistake occurs.

Nevertheless, Lacy's letter states hospitals should report cases of surgery performed on the wrong body part or wrong patient.

NO ONE NOTICED

Newark Beth Israel Medical Center gave 12-year-old Eddie Velasquez three months' worth of a chemotherapy drug in three days. He died 10 weeks later.

A doctor prescribed the drug, doxorubicin, to be given on Jan. 29, 30 and 31, 2002, according to a chemotherapy order sheet contained in court documents. The drug is only supposed to be given once in 28 days.

Another doctor, a pharmacist and three oncology nurses reviewed and signed the order. No one noticed the amount of chemotherapy ordered did not match standard dosages for the drug, according to the family's attorney, Francis X. Dorrity.

After the third infusion, Norma Velasquez, the child's mother, said her son began vomiting blood. Doctors pulled her into a room.

"They told me, 'Norma, Eddie is going to get very sick. We gave him too much chemo. The doctor wrote the wrong instructions.' I said, 'What have you done to my baby? You're killing him!'" Velasquez recalled.

A note on Eddie's chart, part of a court filing, says his mother was informed of the error.

Velasquez said her son's veins and skin erupted. He could not swallow or eat. Once, in a moment of anger and frustration, she said, she grabbed a doctor by his tie, fell on her knees and shouted, "Please! Please, don't let him die!"

The autopsy found evidence of respiratory distress and a hemorrhage in the child's heart. It found no cancer.

The Department of Health and Senior Services said the case was not reported to it. In a response in court documents, the hospital denied any negligence in its care of the child. A lawsuit is pending.

A spokeswoman for the Saint Barnabas Health Care System, which operates Newark Beth Israel, declined to comment except to say that the hospital system follows state reporting regulations.

"There is no longer a willingness on the part of the medical community to enter into an earnest review."

ASSEMBLYMAN JOHN McKEON (D-ESSEX)

VOLUNTARY REPORTING

Hospital administrators said they routinely conduct internal investigations after mistakes take place. Hospitals also can, if they choose, report to the

[Continued on next page]

Joint Commission on Accreditation of Healthcare Organizations, a national accrediting group that surveys hospitals at least once every three years. It has a voluntary and confidential program in which hospitals can report unusual deaths or mistakes.

New Jersey hospitals reported 62 events to the joint commission from 1995 to 2002. The public does not have access to those reports.

Medical experts said voluntary reporting to an accrediting body does not replace good state oversight. Only the state can penalize or fine a hospital, or require that changes be made. Only the state can shut down a dangerous institution.

Experts said mistakes will be repeated if they are not investigated — and the solutions shared.

In October 1999, a doctor at Morristown Memorial Hospital mistakenly injected the chemotherapy drug vincristine into the spine of Charles Brown, the 57-year-old police chief of Mount Olive. He later died. The medicine should be injected into a patient's vein. The error is notorious among people who study medical mistakes because the patients remain alert and aware of their impending death. There is no antidote.

Morristown Memorial did not report the error to the state.

Two and a half years later, the same mistake killed a 49-year-old father of two named Richard D. Fulton at Saint Peter's University Hospital in New Brunswick. Vincristine again was mistakenly injected into the patient's spine instead of his vein.

Would a report from Morristown Memorial have prevented the tragedy at Saint Peter's?

"I think maybe a report would have prevented the other case if we could have presented what we discovered and all the 'best practices' we put in place," said Jack Scharf, vice president of quality management for Atlantic Health System, which operates Morristown Memorial. "The problem is that the malpractice lawyers get hold of it and put it against you. It's a big dilemma," he said.

Scharf, one of the few hospital executives to speak candidly on the reporting issue, said Atlantic Health System does not report errors to the state, although he said the policy is currently being reviewed. He said the state needs to provide confidentiality to hospitals that come forward with detailed internal investigations.

"If you don't, doctors won't participate in these investigations. It's difficult enough now to get them to the table," Scharf said.

Saint Peter's declined to comment on the case. The state said the hospital reported Fulton's death. A spokeswoman for the state said the hospital's report was triggered by an inquiry from the state, which had information about the death.

A review of penalty letters issued by the Department of Health and Senior Services found Virtua West Jersey Hospital in Voorhees did not immediately report the case of a patient given 20,000 units of heparin, a blood thinner, in one hour instead of 1,100 units. The nurse set the infusion pump incorrectly. The hospital, in a prepared statement, said the mistake was immediately caught and corrected and that new precautions have been put in place. The statement said the hospital reported the incident to the state after a full investigation was completed.

MISTAKES REPORTED

In three other cases, hospitals came forward.

Barnert Hospital in Paterson was cited when a pregnant patient was mistakenly given 40 grams of magnesium sulfate, a salt, instead of 4 grams. The patient, who was being treated for pregnancy-related hypertension, died on Dec. 6, 2002. The autopsy blamed acute magnesium sulfate toxicity. A spokesman for Barnert said the hospital knew to report the accident to the state quickly. He said the hospital changed the way it stores magnesium sulfate on patient-floors, and that the nurse who made the error was fired.

Bayonne Medical Center was cited when a patient with O-positive blood was infused with A-positive blood on April 5, 2000. The transfusion was stopped when the patient developed tremors and fever. The patient was treated for a blood reaction. The hospital said it reported the case to the state.

Saint Mary Hospital in Hoboken reported a patient surgical mix-up in January 2001. A surgeon began gallbladder surgery on a patient actually scheduled for surgery on a torn rotator cuff. The surgeon saw the normal gallbladder, recognized the error, and ended the surgery, according to the letter.

RULES ELSEWHERE

Since the 1999 Institute of Medicine report, 45 bills to reduce medical mistakes have been introduced in state capitals.

Reporting of medical errors is mandatory in 15 states. Rules vary. Pennsylvania's reports are confidential except under court order. Washington has confidentiality rules. So does New York, which gets some 30,000 reports of occurrences each year.

"New York is able to do tracking and trending and provide information back to facilities so they can compare themselves to the average," said Jill Rosenthal, a researcher for the National Academy for State Health Policy. The system in Massachusetts is known for its openness. Consumers can get specific incident reports from specific hospitals.

A proposal in New Jersey calls for a new system. Assemblyman John McKeon (D-Essex) wants it to be confidential. He said medical professionals are afraid to speak openly.

"There is no longer a willingness on the part of the medical community to enter into an earnest review," he said.

State Sen. Byron M. Baer (D-Bergen) also supports confidentiality.

"It's hard to get these reports if the people who report them are then subject to huge lawsuits," he said.

Malpractice attorneys said patients have a right to learn about investigations into the mistakes that harmed them or members of their family. They said the system needs more openness, not more confidentiality.

"Hospitals are not reporting

now and we have a law that says they have to. I don't think confidentiality will make any difference," said Gerald O'Connor, a Chatham attorney. He has sued over wrong-site surgeries and infant deaths.

Newark attorney Alan Medvin called the confidentiality plan an "attempt to codify secrecy and suppress the truth."

REDUCING ERRORS

Reporting of errors alone will not solve the problem of medical mistakes. Some hospitals are installing technology, such as bar codes on patient identification bracelets. Others are replacing prescription pads with hand-held computers. Pharmacy computers, meanwhile, can prevent obvious overdoses. Concentrated medicines now are rarely put on patient floors, where nurses may forget to dilute them.

The topic is getting more attention. Last month, the state health department and federal health officials ran a two-day seminar in Princeton on ways to reduce medical error.

"If it's a preventable error, it will happen over and over again until better processes are put in place," said Donald Berwick, a noted expert on medical errors at the Harvard School of Public Health in Boston.

"The tragedies occur because of flaws in the way we do our work," he said.

Berwick said reporting can identify where problems exist. He supports a reporting system that identifies the institution, but not the individuals involved.

"I don't think the anonymity of the hospitals should be protected. Those who lead hospitals should be responsible," Berwick said. "But there is no value in reporting the individuals because they already feel terrible."

Carol Ann Campbell covers medicine. She may be reached at ccampbell@starledger.com or (973) 392-4148.

THE STAR-LEDGER
Newark, NJ

Sunday Circulation - 609,514
Daily

SEPTEMBER 21, 2003