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The Joint Oversight Committee HHS on Board of Medicine
Public Testimony, Lori Nerbonne
New England Patient Voices
5 pages with References

Good Morning,

My name is Lori Nerbonne. I'm an RN, currently working as a patient advocate for a small non profit I co-founded in 2005 called New England Patient Voices, which I started after my mother died of an anti-coagulant overdose in 2004 in a hospital ICU. The overdose was not disclosed to our family or listed on her death certificate. We discovered it by reading her medical records. By coincidence, this happened at Catholic Medical Center, although not under the care of Dr. Baribeau.

From 2008-2012, I coordinated public testimony for patient safety legislaton in New Hampshire to increase transparency on hospital infection reporting, adverse event reporting, and a maternal mortality review panel. These laws were passed, have expanded across the country and helped to inform the public, and initiate many effective quality improvement initiatives.

One of the patient-family testimonials we coordinated for the Adverse Event Reporting law back in 2009 came from a women whose husband died after cardiac surgery performed by Dr. Baribeau at CMC. Although hers is not one of the 21 settlements or her husband among the14 deaths we have come to learn about, she did attempt to file suit but found the barriers to do so were exhaustive and too expensive at that time.

Transparency, by way of state legislation has a direct impact by increasing public attention, increasing funding, research and most important; prevention. All of us here know about healthcare infections now. Back in 2004 they were considered to be an unavoidable complication in ICUs. Now we know some hospitals who have gotten them to zero. Mandates and public pressure work.

Although I always see myself as an advocate for patients, I'm also here today as registered nurse who has specialized in patient safety since the death of my mother. More recently, as a nurse patient advocate in acute care hospitals in Massachusetts, investigating and processing patient complaints; many of which involved physician and quality of care issues with and without patient injuries. For one of those years, I coordinated quality improvement projects in hospitals and nursing homes across New England under a contract with Medicare and Medicaid.

I hope to impress upon this Panel and all Legislators the vital role you play in patient safety . As you may know, medical harm and injuries are at the very least, the 3rd leading cause of death in America. Multiple studies have validated this, and a recent OIG report for the second time, calculated preventable medical harm deaths for Medicare beneficiaries alone at 15,000 per month.

This is not to ignore that medical care is advanced and performs miraculous care for many or that the vast majority of healthcare professionals strive every day to achieve the highest standards of care, are hard working, and dedicated. What the data tells us thought is that our healthcare delivery system, for a multitude of reasons, including a lack of mandates and oversight, has a terrible safety record that results in untold preventable, and unnecessary harm and death to vast numbers of people.

Regulatory oversight agencies, as well as state and federal laws play THE most important role in reducing preventable patient harm because they hold the power to ***require*** that healthcare facility leaders

follow well established laws and guidelines for quickly addressing dangerous practices, systems and/or clinicians. This is especially critical in our current environment of smaller community hospitals expanding or merging into large, complex healthcare systems that are performing higher and higher risk surgeries than ever before. These large and very profitable businesses have also created new conflicts of interest, when the reputation and/or profits of a facility can be at stake. Patients lives should never be placed in the balance of those decisions. But many headlines are proving they too often are.

Last week, I happened to attend a Patient Safety Conference that featured a panel presentation by the medical experts & attorneys involved in Dr. Christopher Duntsch's case out of Texas (otherwise knows as 'Dr. Death'). What was very clear, were the many similarities between the Dr. Death case and the one at CMC: both doctors continued to practice for decades, the one difference being that administrators in Texas allowed Dr. Death to offer resignations from his post at each hospital in place of issuing reportable disciplinary actions. They also did not pass along his record of patient harm to other hospitals. As a result, he avoided being reported to the NPDB, and therefore to state Medical Boards. He severely injured 31 patients and 2 died.

Although federal law requires hospitals to report disciplinary actions and/or suspension of clinical privileges to the NPDB, the suspensions or actions must be for over 30 days to be reportable. Unfortunately there is no auditing system in place for this; it is on the honor system, so what we see too often are these loopholes being used. The physician might lose privileges for 29 days, instead of 30. This can happen repeatedly for the same doctor, and it's not reportable.

What is clear is that these loopholes have a direct impact on a Medical Board's ability to track dangerous doctors and when state laws don't allow them to inform the public about them….Well, we now know what happens. One would think that Medical Boards and Hospital Administrative Leaders are working collaboratively to ensure the public is protected from dangerous clinicians. Clearly, this is not the case.

When patients and their families make the difficult decision to have surgery, they are placing their life and well being in not only the surgeon's hands, but hospital administrators who are ultimately responsible for the safe practices in their facility. They are compensated well to put patient safety ahead of all else. We need to be clear that this case of 14 deaths, 8 within one summer, and 21 lawsuits; was not a one-off or a surgeon making one or even 2 or even 3 honest mistakes. Hospitals have entire teams of patient safety staff dedicated to measuring every surgeon's outcomes. They track complications, adverse events, infections and deaths, and data doesn't lie. It would have been virtually impossible for this surgeon not to be a serious outlier and the talk of hospital staff. For him to continue over decades with this kind of record could only mean that data was ignored, and the very policies, guidelines and laws in place to ensure patient safety were skirted

If you have not already had the chance, I urge you to read the Federal Whistleblower's legal filing that was unsealed by Judge Barbadoro last February. I've included a link in my references. It details what happened to some of Dr. Baribeau's patients. It is heart-wrenching, but a necessary perspective to consider for anyone with the power to effect change.

I hope you agree that when bad things happen and the public's safety is at stake, it is all of our responsibility to do whatever we can to ensure it doesn't happen again. We can't ignore or forget that multiple doctors and nurses inside the system sounded the alarm. As a nurse I can't imagine how it felt go to work every day knowing their concerns were not being addressed; knowing another patient would likely be harmed or die under their watch. This is demoralizing. It's why wonderful people leave healthcare. It is also why patients sue; they simply have no other means to get to the truth of what happened to their loved ones. Even thought they know, deep down inside, that something terrible happened.

The following are what I see as remedies to state regulatory issues that inhibit public transparency and/or are barriers to the Medical Board performing it's role to safeguard the public:

(1) As was mentioned in prior testimony by Attorney Holly Haines, please review and change the permissive wording like *'May' to 'Will' or 'are required to'* in the current mandates/RSAs relating to the Board duties. This may also call for changes to the reporting requirements of hospital administrators as it relates to physicians discipline.

(2) As mentioned, Medical Boards and Hospital Credientaling staff are required to query the The National Practitioner Databank (NPDB) for disciplinary actions taken against physicians. However, only 30 day suspensions or more are required to be reported to the NPDB.

To remedy this, state law could require hospitals to report *all disciplinary actions* taken within a 3 to 5 year period *that would cumulatively total more than 30 days* as well any *individual action* taken for more than 30 days. This would be of great value to the Board of Medicine because it would allow staff to track those doctors with repeated actions below the current federal 30 day benchmark.

(3) The legislature should require that all medical malpractice lawsuits, settlements & disciplinary actions to be reported on the medical board's physician profile section of the website.

Patients should be able to decide for themselves whether a doctor's record is cautionary and/or dangerous. We need to do away with the current reality in New Hampshire that only staff inside a hospital has the privilege of knowing which doctors & surgeons are dangerous or practicing below the bar. The public has a right to know before making these important and potentially life-changing decisions. Legislation can also allow for doctors to enter a comment about a lawsuit t or settlement that may provide more detail for the public to consider.

As the panel heard from Sean McGorry, brother of Joan Dimick, who died under Dr. Baribeau's care, his family had no idea about the numerous settlements and details that we have come to know about Dr. Baribeau's record. This panel, and NH Legislators have the power to ensure that doesn't happen again.

(4) The federal law that does not allow information obtained from the NPDB to be publicly reported calls for a *state mandate* that would allow and direct the Board of Medicine to publicly post medmal lawsuits & settlement notifications on their website. As has been discussed in previous testimony, that information can be received from the NH Superior Court, insurance companies or by other local/state notifications. This is how other states deal with this issue.

(5) Fund the Board adequately to hire paid full and part time staff; especially for intake of complaints and then reviews, investigation and processing. The Federal State of Medical Boards (FSMB) has done a survey of staffing for comparison, and I've included that in the references attached to this document. It is apparent from their survey that NH is sorely understaffed.

(6) All complaints should require an equal and complete review as determined by a published, transparent process posted on the Board's website, with opportunity for patient/family input and periodic updates throughout the complaint process.

Also, requiring the Board to post numbers of complaints they receive on a monthly basis and how many resulted in action. At the very least, it should be included in their annual report and complaints could be broken down by type, source, etc. This would go a long way toward transparency. I've included a page from the California Medical Board Website as an example of this.

(7) It will be important to address the fact that NH is a small state in which doctors charged with reviewing complaints and/or issuing disciplinary action may very well have worked with the physician in question, be a neighbor, friend or serve on committees with them. Contracting with out of state medical care review professionals who are not licensed in New Hampshire and have no connection or relationship with physicians or health care institutions in the state would go a long way. This bears in mind that there are NH hospital partnerships aligned with Massachusetts hospitals.

This is also an enormous and well-known problem with protected Peer Review inside hospitals.

(8) Although this doesn't pertain to the Dr. Baribeau case, many recent national headlines have been about longstanding sexual misconduct complaints and/or assaults by physicians on patients that were never reported to Boards of Medicine & when they were, were too often not taken seriously. While the Panel is undergoing it's review, my hope is you will consider being proactive in this space by:

Remedies:

(A) Requiring the Board to inform the local police of all sexual boundary-related complaints if the board believes a criminal law may have been violated.

(B) As was mentioned, IT and website improvement was discussed by the Board Administrator as a long standing goal, with funding set aside for this. During this improvement process, the Board could set a goal of making the website more consumer oriented by dedicating a tab and section for 'Consumers'. They could include information that is educational in nature about what a patient requiring a physical exam should expect under the standard of care. In many of the recent national headline cases of sexual boundary and abuse issues, many patients reported they didn't know if the sexual boundary violations were a normal part of the physician's exam.

Thank you for allowing my testimony today.

Respectfully,

Lori Nerbonne

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Retired Associate Director for Research and Disputes, National Practitioner Databank
Dr. Oshel has given me permission to share his contact information with this Legislative Panel:
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(2) The National Practitioner Databank (NPDB) Codes List
This details what hospitals are required to report to the NPDB by Federal law. **SEE PAGE #1, TABLE 2 (after the Table of Contents pages)**
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(8) The Informed Patient Institure and The Patient Safety Action Network:
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