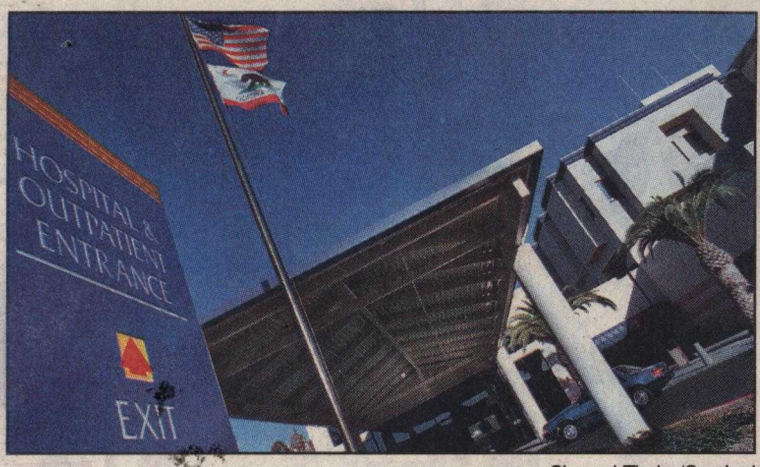

Shmuel Thaler/Sentinel

Watsonville Community Hospital was the target of a special federal inquiry.

Watsonville hospital faulted in federal probe

10.24.99

Hospitals - Watsonville Hospital

Death of patient prompts review that finds 'significant' violations

By MARINA MALIKOFF
Sentinel staff writer

WATSONVILLE — A federal investigation of Watsonville Community Hospital uncovered flaws in the credentialing and peer-review of doctors, a pattern of loosely enforced emergency room policies and an unusually high number of surgeries for ruptured appendixes.

The special inquiry was prompted by the March 9 death of patient Robert Ryan, who wandered outside the hospital and died of an untreated infection stemming from colon surgery.

In a surprise visit in April, investigators representing the state Department of Health Services and federal Health Care Financing Administration discovered some doctors were not properly supervised before being granted privileges, and that Ryan's surgeon had been given operating privileges before demonstrating competency to perform a different type of surgery.

The surgeon, Dr. Steven C. Smith, says it was simply a paperwork problem and that he is fully credentialed for the colon surgery.

The inspection team found the hospital's surgery department was headed by a podiatrist, a nonphysician, in violation of federal regulations.

Though Albert Quintero, district manager of the state Department of Health Services regional office in San Jose, termed the violations "significant," his office has accepted the hospital's plan

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Hospital sees high rate of appendix ruptures

'Troubling' statistical anomaly cited

Neither hospital officials nor state health regulators had a definite explanation for rupture rates at least three times higher than the norm.

By MARINA MALIKOFF and TRINA KLEIST
Sentinel staff writers

WATSONVILLE — A disproportionate number of ruptured appendix surgeries performed at Watsonville Community Hospital raises concerns about the delivery of health care in the Pajaro Valley.

Medical experts say the rupture rate could be caused by lack of health insurance, cultural issues or the possibility that either the hospital or its surgeons are slow to schedule surgeries.

Hospital officials say they are not to blame, but neither they nor state health regulators had a definite explanation for rupture rates at least three times higher than the norm at other hospitals. The rupture rate is least 16 times higher than the figure at a Salinas hospital that serves a similar population.

"The hospital has to look internally to see what else may be going on," said Dr. Robert Watson, who was part of the team that surveyed the

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Watsonville hospital after a surgical patient died of an untreated infection.

The hospital serves the Pajaro Valley's 105,000 residents, 50 percent of whom are Latinos, and a sizable migrant population. An estimated 18 percent of the permanent residents live below the federal poverty level.

Investigators reviewing the appendectomies performed over a 39-month period ending early this year initially concluded 104 of 145 appendectomies involved ruptures, 71 percent.

Surgeons and pathologists elsewhere called that figure staggering. They said the rupture figure at other hospitals in California averages less than 10 percent.

Barry Schneider, the Watsonville hospital's chief executive officer, said the percentage was later reduced to 33 percent because not all the appendectomies had been entered into hospital computers when the survey team visited in April.

The actual number performed was 363, including 120 ruptures, he said. That would lower the rupture rate to 33 percent — still more than three times the expected rate.

State officials involved in the investigation would not confirm the figure is 33 percent but agreed it is lower than 71 percent.

In a report the Sentinel obtained under the federal Freedom of Information Act, the survey team criticized the hospital for not adequately reviewing appendectomy cases to ensure the diagnoses and patient care were appropriate.

"With this high number of ruptured appendixes, the hospital was supposed to be reviewing this," said Albert Quintero of the state Department of Health Services.

The appendix is a tiny, useless piece of the bowel. When it becomes infected, it can cause fever and pain in the abdomen.

Standard treatment is removal, which is usually prescribed within 24 to 48 hours of the onset of symptoms. If treatment is delayed, the appendix is likely to rupture, releasing fecal matter and other toxins into the body.

Appendicitis is easily diagnosed in most adults but can be difficult to detect in the very young or very old.

Dr. Marvin Matlock, an internal medicine specialist in Fresno who has diagnosed hundreds of cases of appendicitis, said a hospital's rupture rate is a good barometer of a community's access to health care. He said he found the 33 percent figure "troubling."

Schneider agreed that 33 percent is high but said the explanation was rooted in Latino culture, not any barriers erected by the hospital or health-care providers.

"Our population base waits much longer to seek medical care," Schneider said. "It was their failure to promptly and timely seek medical care. It points to a great need for education in our community."

Other health-care workers agreed that cultural factors are likely to contribute to the statistic.

"The Latinos, they wait a long time. Even the people from Europe wait a long time," said John S. Bratkowsky, executive director of the Pajaro Valley Medical Group.

A debate over the issue rages among county health-care workers, said Dr. Michelle Violich, medical director of the Watsonville Health Center operated by Santa Cruz County.

One theory, she said, is that some Latinos believe health "is a God-given (thing), good or bad, so that influences how they take health care into their own hands."

The other, she said, is that it is an economic problem.

"Going to a doctor without insurance is frightening. It can cost hundreds and hundreds of dollars," she said.

Mary Lou Alejo, a county nurse and member of the Latino Affairs Commission, dismissed the spiritual angle but noted that some Latinos are prone to trying herbal home remedies before going to the doctor.

That scenario played out in her own family, Alejo said, when her sister seemed to be experiencing severe menstrual cramps. Their mother treated her with herbs. When the symptoms got worse, she was taken to a hospital.

"She was diagnosed with an appendix that was about to rupture and they did surgery right away," Alejo said. "It has to do with lack of medical knowledge and the economic issues."

That could explain the decidedly lower rupture rate at Salinas Valley Memorial Hospital, which serves a comparable but slightly more affluent population. The burst appendix rate there fluctuates between zero and 2 percent, said Dr. Ralph Keill, the hospital's medical director.

Keill said some cases are attributable to misdiagnosis by physicians, but "the vast majority are people who arrive in the emergency room

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of correction.

As a result of the inquiry — which led to temporary suspension of the hospital's accreditation — the 100-bed facility has made sweeping changes, according to Barry Schneider, the hospital's chief executive.

"We believe that we now have processes and systems and procedures in place that will provide ongoing, stronger assurance that there will not be any untoward events ... such as we had in March," Schneider said. "We feel our facility is in full compliance with life-safety codes."

One of the most dramatic findings in April was the rate of surgeries for ruptured appendixes, a problem not necessarily attributable to hospital procedures.

Investigators initially reported reviewing 145 appendectomies over a 39-month period and determining 104 involved appendixes that had already ruptured. That amounted to 71 percent, a figure medical experts elsewhere found shocking.

Hospital officials later found that 363 appendectomies actually had been performed, 120 of them involving ruptures, lowering the percentage of surgeries involving ruptures to 33 percent. That figure is still more than three times higher than the norm at hospitals elsewhere.

A report of the investigative team's findings — obtained through the federal Freedom of Information Act — does not indicate which of the substandard practices may have been in place before the hospital changed ownership a year ago. After more than 100 years of operating as a publicly owned, non-profit, the hospital was purchased by a for-profit hospital chain, Community Health Systems of Tennessee, in September 1998.

The April survey was intended to verify that the hospital is qualified to receive Medi-Cal and Medicare funding.

A team of three nurses and a physician interviewed hospital staff and reviewed department logs, doctor's credential files and patient charts. The group documented several violations of federal regulations, primarily in the supervision of new emergency room physicians and surgeons, the granting of medical privileges to area doctors, and credentialing of top level medical staff.

"If they are having problems with their privileging, that is a red flag," cautioned Dr. Sean Mulvihill, chief of the general surgery department at the UC San Francisco Medical Center.

The violations led to a four-month suspension of the hospital's good standing with the Joint Commission of Accreditation of Healthcare Organizations. That opened the hospital to additional inspections and briefly jeopardized its ability to collect Medi-Cal and Medicare payments, which account for 40 percent of its income.

But full status was restored after a follow-up survey Sept. 21 concluded that tightened controls had brought the hospital into compliance with federal standards.

Among the changes was the appointment of a board-certified surgeon, Dr. Arthur Schwartz, to head the surgical department. The inspectors found it had been inappropriately headed by a podiatrist, Dr. William Hopkins. Podiatrists, who specialize in treating the foot, are highly trained but are not medical doctors.

"A podiatrist cannot be the head of surgical services," said Quintero of the Department of Health Services. "The federal regulations are very specific on this. He doesn't have the expertise or the competency to tell a surgeon that he is doing something wrong."

The inquiry also uncovered failings in how the hospital verifies the competency of surgeons before granting them operating-room privileges.

In its written plan of correction filed with the state and federal agencies, the hospital acknowledged its "privileging process was not as thorough as it needed to be."

The investigators found that Smith, the general surgeon who performed Ryan's colon operation, was allowed to perform carpal-tunnel surgery without recent documented experience. Carpal-tunnel surgery generally involves nerves and ligaments in the hand and wrist.

Smith said last week he had performed carpal-tunnel surgeries for 12 years and was properly credentialed but that the paperwork was not in order.

"It was an oversight," he said.

Schneider said Smith was allowed to perform the procedure without written documentation because the medical staff considered it a "very basic procedure that all surgeons would be capable of doing."

The hospital now has proof Smith had the appropriate training and is monitoring his work as an extra precaution, Schneider said.

Mulvihill of UCSF disagreed with Schneider's assessment of the skill level required.

"In our hospital a general surgeon would not have privileges to do carpal-tunnel procedures," Mulvihill said. "There is a nerve very close to the place where the incision is made. It can be damaged, causing very serious injury."

Mulvihill said each hospital sets its own standards for its surgical staff. Top-flight hospitals, he said, require their surgeons to be certified with the American Board of Surgery.

Schneider said the Watsonville hospital requires surgeons to be eligible for board certification but does not require actual certification.

Investigators said they were hesitant to allege any pattern of inappropriate privileging but said even a single incident is cause for concern.

"Improperly granting privileges to someone performing surgery affects the public health and safety," Quintero said. "That one doctor could be doing a lot of surgeries. And he did quite a bit of surgeries."

Much of the review focused on procedures related to the care of Ryan.

The 67-year-old Watsonville man had been admitted to the hospital for colon surgery. Five days later, hours before his scheduled release from the hospital, Ryan was found at 2 a.m. face down in a rainstorm outside the locked entrance to the hospital.

After a nurse found no sign of a pulse, no life-saving measures were attempted and there was no documentation that other vital signs were checked, a violation of hospital policy, according to the federal report.

The Santa Cruz County coroner determined Ryan died from post-surgical infections known as peritonitis and septicemia. An autopsy found the peritonitis had developed days earlier and was caused by leakage from the colon surgery. The coroner ruled that exposure contributed to the death.

Ryan's family has formally notified the hospital and Smith that it intends to sue, according to the family's lawyer, Andrew Kreeft of Salinas.

Kreeft said the Ryans have a "very, very valid claim."

Smith said Kreeft was wrong but said he wasn't surprised by the threat of litigation.

"People do that sort of thing when someone dies unexpectedly," he said.

Ryan's son, Watsonville firefighter Robert Ryan Jr., said though the family is still in shock, he hopes the tragedy will bring about better health care for the community.

"I think the hospital is somewhat safer now .. and attempting to make changes," Ryan said. "The hard part is that we had to lose somebody."

The hospital sent Ryan's case — and 18 other colon surgery cases resulting in complications — to the UCSF medical staff for review. The staff's findings are now being reviewed by the hospital's peer-review committee.

"At this point, we have no findings of any variations that would warrant any corrective or disciplinary action," Schneider said.

He said he could not discuss the Ryan case in detail because of the potential litigation and confidentiality of personnel matters.

An earlier internal review reportedly found Smith had provided adequate care to Ryan.

Smith said in a March interview that Ryan had heart trouble and that the post-surgical complications would not have killed him if he hadn't left the hospital.

While the earlier hospital review cleared Smith, the federal investigation revealed flaws in the hospital's quality control process and inadequate oversight of the surgery department.

According to the hospital's plan of correction, the emergency room doctor on duty when Ryan died received a written reprimand because he failed to go outside and initiate cardiopulmonary resuscitation or verify a nurse's assessment that Ryan was indeed dead, as required by hospital policy.

All emergency department doctors have since reviewed emergency room procedures and a series of drills will be conducted over the next several months to ensure appropriate responses in the future, according to the hospital's plan of correction.

Following Ryan's death, hospital officials said they refined their life-saving procedures, added exit-door alarms and installed a telephone linking the lobby to the emergency room.

The survey team also reported that that emergency room physicians were not proctored to evaluate their competency. Proctoring entails an experienced physician supervising and mentoring a new physician or one requesting new privileges.

"Every physician who wants privileges at a hospital has to meet certain criteria ... and must have been proctored by someone," Quintero said. "When we looked at the credentialing process, they were not doing this."

Schneider said emergency room doctors were being proctored but it was not documented on the standard forms used in other departments. He said the documentation was not immediately available to the investigators because the person in charge of the files was on vacation.

Schneider said the hospital has expanded the proctoring of emergency room doctors.

The report also detailed organizational and security violations, and incidents of the nursing staff failing to follow pain-assessment procedures. A lingering issue in Ryan's death was the treatment he received after the infection set in, an infection likely to have caused considerable pain. Employees, including nurses, who did not follow proper procedure on administering pain medication were reprimanded, hospital officials said.

As a result of the survey, Schneider said, the hospital has dismantled portions of its quality-control programs and created a new system to assure objective and thorough case review.

The restructuring includes a peer review committee representing each of the six hospital departments. Previously, each department reviewed its own cases and staff.

The reconstituted committee meets monthly to review cases selected by quality-review nurses.

"If there is a problem with an individual case or individual physician, it will start to show up," Schneider said.

The committee can send cases to an outside specialist for review, Schneider said. If disciplinary action results, such as restriction of privileges, the physician is entitled to appeal to another committee of physicians.

tions, primarily in the super-

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with ruptures."

One of the most common theories is that lack of insurance is the biggest cause of delayed treatment.

"Of course the rupture rate is high," said Dr. Steven C. Smith, who performed colon surgery on the patient whose death set off the federal investigation. Smith also performs appendectomies.

"The patients don't have insurance. They are afraid they will get stuck with an emergency room visit that will cost them thousands of dollars, so they stay away until they are very ill," Smith said.

At the Watsonville hospital, Schneider said an internal review of the rupture cases concluded neither the hospital nor the medical staff was to blame.

What the statistics show him, he said, is that people need to be educated to seek medical attention early.

The Watsonville hospital was a non-profit, government-operated hospital until it was purchased in September 1998 by the for-profit Community Health Services Inc. of Brentwood, Tenn.

Before the $55 million transaction, some area residents and health-care advocates argued the community's health care would suffer. The survey prompted by the surgical death does not compare the quality of care before and after the changeover.

Hospital trustees said the sale was the only way to ensure quality care because of rising costs of medical equipment and other necessities.

John Martinelli, a veteran trustee who remains on the hospital's local advisory board, said he believes the new owners are doing a good job.

"I feel very confident in CHS," Martinelli said.

Community Health Systems owns, leases or manages 45 hospitals in rural or semi-rural areas in 15 states.