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Before the
United States Senate's
Committee on Finance

Hearing on
"Physician-Owned Specialty Hospitals: Profits Before Patients?"

Wednesday, May 17, 2006

Chairman Grassley, Ranking Member Baucus, and distinguished members of this committee, thank you for allowing us the privilege of being here to address you today and to share our family's story. I count it an honor to have been asked to come to Washington to testify before this committee. My name is Michael Wilson and I am from Portland, Oregon. Accompanying me is my wife, Ramel. I have also brought with me a photograph of my parents, Doyle and Helen Wilson. This picture was taken shortly before my mother's death on August 1st, 2005. They had been married for 69 years.

I believe you have heard my mother's name, because her case has already come before you several times in your discussions of physician-owned, for-profit, specialty hospitals. I am here today to give you the details of her death, in the hope that you can help make certain that no one else dies the way she did.

My mother, Helen Wilson, checked in at Physicians' Hospital in Portland, Oregon a little before 8:00 AM on Wednesday, July 27th, 2005. Physicians' was a new hospital, in business only since December 2004, its owners having purchased and remodeled the old Woodland Park Hospital that had operated in Portland for forty-three years.

My mother was 88 years old, but was in good health for her age. She had gone through a heart surgery 15 years earlier, but had had no serious coronary issues since then. She was also diagnosed with age-related type II diabetes, but kept that well under control with diet and medication. Her surgeon stated that he was confident that she was a good candidate for the relatively simple procedure and that he was certain that she would make a quick and full recovery.

The reason she was at Physicians' Hospital was to correct a problem in her lower spine. For quite some time she had suffered from a constriction of the spinal nerve in her lower back, which was causing back and leg pain and reducing motor function in her legs, making it difficult for her to walk. Her primary care physician referred her to an orthopedic surgeon named Dr. Mark Metzger.

After examining her, Dr. Metzger scheduled her for a lamenectomy to correct the problem. The surgery was scheduled for Physicians' Hospital where he had privileges. He planned to make a 1½-2 inch incision to free up pressure on the nerve bundle that controlled her legs and lower back. He told my parents that he estimated that the procedure would last 1-2 hours, and he told my mother to plan for one overnight stay in the hospital.

They finally wheeled Mom out to surgery at about 11:00 AM, an hour later than the scheduled time. Dad and I went down to the surgical waiting area where we sat and visited. Finally one of the nurses came and told us that the surgery was over and that my mother was in the recovery room. She reported that Mom was experiencing quite a bit of pain, however, and that her blood pressure was somewhat high, but they told us that she was doing well and not to worry.

The surgeon, Dr. Metzger, came out to the waiting area and told Dad and me that the surgery had been a complete success. He explained that the only problem he had encountered was a slight tear in the *dura*, the tough outer covering of the spinal cord, which he was able to suture and correct with no more leakage of spinal fluid. He said that she would need to spend one night in the hospital, and possibly two, depending on how well she

was feeling and how well she recovered from the effects of the anesthesia and surgery. He said that if we wanted to we could go upstairs to await her arrival from the recovery area.

The nurses wheeled Mom into her room at approximately 4:30 PM. They quickly got her settled in and connected to a blood pressure monitor. They also checked her oxygen levels. They did not, however, connect her to any kind of heart monitor, in spite of the fact that she was elderly and had gone through heart surgery years earlier, putting her at somewhat higher risk. We thought this odd at the time, but assumed that the heart monitor would be hooked up soon. However, it never was.

My mother was groggy but responsive. She perked up as soon as she saw us and began speaking, though with difficulty because of the effects of the anesthetics. At first only Dad and I were there with her. I questioned her about her pain level. She responded by saying that she had experienced severe pain in the recovery room but that it was subsiding now, and as long as she didn't try to move she was able to handle it. She had a dry mouth so I began feeding her ice chips, one at a time. At about 4:35 PM, approximately 5 minutes after Mom was wheeled into the room one of the elders from their church, Bem Walker, came to visit her. The three of us men stood around Mom's bed talking and laughing with her, trying to cheer her up and take her mind off the pain. She was alert and aware of her surroundings. She was not complaining of pain and none of the staff questioned her about her pain level.

After leaving work at Portland Police Bureau's Northeast Precinct my wife, Ramel, arrived in the room about 5:30 PM, approximately 15 minutes after Bem had left. Dad, Ramel, and I stood by Mom's bedside and continued to visit with her. She was doing well, was alert and laughing at our jokes and coming back to normal as the anesthetics gradually wore off.

Just minutes after Ramel got to the room, a nurse came in and prepared to inject medication into Mom's I/V line. The nurse used a large syringe to slowly inject a clear liquid into the line. We found out later that the drug used was Dilaudid, a powerful hydromorphone hydrocloride. We thought it odd at the time for them to give her more pain meds even though Mom had not asked for anything. And all three of us who were there are certain that none of the staff, including the nurse that administered the last dose, ever asked Mom about her level of pain after she was brought into the room from the recovery area. Moreover, that is the only injection she received while we were in the room with her so we are certain that there was a direct connection between the medicine and the almost immediate effect that it produced.

Once the pain medicine was fully dispensed (having taken not more than a minute), the nurse left and we continued to stand there by Mom's bedside. However, she quickly became droopy and obviously began having trouble keeping her eyes open. We were still talking with her, but she seemed to be falling asleep. Just then, a young nurse stepped into the room. At that moment Mom's eyes closed and she went clear out. We were a little concerned because it happened so quickly—less than 2 minutes after the medicine was put into her I/V. We asked the nurse if this was normal and she said, oh yes, that many times patients fall asleep quickly with pain medicine. She then walked out of the room. Mom seemed to be sleeping peacefully. Ramel and Dad and I continued to visit about various things, not alarmed in the least.

Suddenly, my mother made a strange little choking cough. All three of us immediately looked at her but we could see no signs of crisis at that time. Her arms and legs were still and she seemed to be breathing normally. We went back to our conversation. Approximately 30 seconds later, she once again made a strange, choking sound, but this time her mouth was hanging open and I could see and hear that she was gurgling in her throat. From the time the nurse finished injecting the Dilaudid into Mom's I/V line until she was into full respiratory arrest could not have been more than two, or two and a half minutes. I stepped immediately to the head of Mom's bed and observed that she was not breathing. I quickly checked her carotid artery for a pulse but could detect none. Seeing that she was in arrest I yelled for help, telling the nurses to come quickly, that my mother had stopped breathing.

The first nurse to arrive on the scene acted as though she had all the time in the world, and gave off the distinct impression that she thought we were being over-reactive in calling for help. After a tense minute of the nurse checking Mom's vitals, Ramel stepped out of the room into the hallway, across from the nurse's station, and hollered that we needed help quickly because Helen had stopped breathing and didn't have a pulse. I could not understand why no Code Blue was being called over the hospital PA system, and why the staff people were acting with such lack of speed, teamwork, and expertise. The next few minutes were some of the worst of my whole life. The three of us stood there and watched the most egregious example of gross incompetence and negligence that I have ever witnessed or heard of. We could not believe what was happening.

I yelled for help a second time and nurses finally began to show up. One took her place at the head of Mom's bed and began to use a resuscitation bag on her, trying to get air into her lungs. However, her tongue had fallen back into her throat and no air was getting past. Her cheeks were inflating and the air was escaping around the outside of the mask. I quickly told the nurse she needed to clear Mom's airway—that her chest was not rising. The nurse looked up at me panic stricken. About that time Ramel yelled, "Get the paddles on her, NOW!" The first nurse on the scene called for the Crash Cart. But they had to go down the hall, back behind the nurses' station to get the Cart. Then when they finally got it into the room the nurse began furiously searching through the drawers to find the various things she needed to prepare the defibrillation unit. She kept yelling, "Where are the paddle covers?" Someone went running to find some. The rummaging continued. Eventually they managed to get the paddles on Mom and shocked her three times, but to no avail. They tried chest compressions but that wasn't working because my mother was still in her bed, without a backboard. Both Ramel and I asked the nurses <u>several times</u>, "Has a doctor been called?" We just got stares and mumbles. Finally, several minutes later, one of them said, "We've called someone." Of course, we assumed that she was talking about a doctor.

As it turned out, they had called 911. The fire department quickly dispatched the paramedics who rushed into the room some 10-11 minutes after the start of the crisis. The contrast between them and the hospital staff was striking. They quickly were able to get Mom breathing and her heart stabilized enough to transport her. **However, by that time the damage had already all been done**. <u>Through gross professional incompetence my mother was left without oxygen for so long that she was already brain-dead</u>. The paramedics transported her by ambulance to Adventist Hospital's CCU, where she remained for the next five days, never regaining consciousness.

On July 31st, after twice running diagnostic tests to determine her level of brain function, the specialists at Adventist told us that there was absolutely no upper brain function remaining due to oxygen starvation. They advised us that it was time to wean her off the respirator and entrust her into God's hands. She was removed from the ventilator on Sunday, July 31st at 3:00 PM. To our surprise and amazement Mom's body responded and she began breathing on her own. She was transferred out of CCU to a room on one of the regular nursing floors. We maintained our constant vigil by her side until she slipped quietly away from us on Monday, August 1st at 3:12 PM. There with her at the time of her death was my father, Doyle, my sister, Janis, her daughter, Mona, and myself.

This was a tragic, needless death. Had my mother received the quality of care at Physicians' that she later received at Adventist she would still be with us today. **No hospital should ever have to call 911 to come and save one of their patients!!** Hospitals, doctors, and nurses are paid to know how to resuscitate a person who goes into post-surgical respiratory or cardiac arrest. Moreover, as patients and family members of patients we have a right to this assurance. What happened to my mother on July 27, 2005 was unconscionable and inexcusable. As a result of their blundering my father lost his wife of 69 years, my mother's 4 remaining siblings lost their beloved sister, my sister and I lost our wonderful mother, our 11 children lost their "Grammy," and our children's children lost a wonderful great-grandmother. My daughter, Simoni, gave birth to Mom's newest great-grandbaby, Billy, on August 25th, weeks after Mom's death, but Billy will never have the joy of knowing her because her life was cut short. That breaks my heart.

My mother was a wonderful, godly woman. Many years ago she placed her total faith in Jesus Christ as her Savior and Lord, and she was ready to go to be with Him at any time. And it has been our relationship with the Lord and the comfort of the Scriptures that have brought my father and the rest of our family through this difficult experience. We know that God, in His sovereign plan, allowed this to happen, and my mother was ready to go. However, that does not take away the fact that the immediate cause of her death was the negligence of a hospital that has a moral obligation to do everything possible to save lives.

In summary,

- The nursing staff at Physicians' evidently did not know how to intubate my mother with an endotracheal tube to get her breathing again.
- They did not administer the antidote, naloxone hydrochloride, which is the specific published treatment for an overdose of Dilaudid.
- They did not have a properly supplied "Crash Cart."
- The Cart they did have was not stationed close by, as it should have been.
- No Code Blue was called to summon help.
- There was not a Code Team trained for this type of emergency.
- The nurses were obviously unskilled in handling a respiratory arrest such as this.
- There was no doctor in the hospital available to respond to this emergency.

My mother is the poster child for what can happen when the foxes own and operate the hen house for their own benefit. We did not know until after my mother's death that the doctor who performed her surgery was one of the owners of the hospital. We did not discover until later that Physicians' Hospital was only marginally prepared to do this kind of surgery. We did not know that no emergency physician would be on the premises. We did

not know that it was the hospital's policy to call 911 in case of a post-op medical emergency. Patients trust their doctors. We never guessed that my mother was in such grave danger from the incompetence of the very people who took an oath to protect and heal, and above all, to do no harm.

One of the most troubling things that occurred was that when we got my mother's records we discovered that her med chart had been "doctored" to make it look like she had received that last dose of Dilaudid 40-minutes prior to her going into respiratory arrest, to make it seem like the two events were unrelated. You could see where the time had been erased with the new numbers written over the top. Moreover, the nurse wrote that my mother was sleeping when she administered the medicine. At another place in the nurses' report it said that my mother had reported a pain level of six out of ten. There were three of us with her the whole time and she was never asleep, and no nurse ever came in and asked about her pain level. Those were pure fabrications.

One of the hurtful attitudes that we have encountered in the process of trying to hold Physicians' Hospital legally accountable is the idea that my mother's death <u>was a result of her age</u>. That is simply not true. Even if she had been 40 years younger the same irresponsible treatment she received could have killed her. Her death was preventable!

- A review of her charts shows that she had already received multiple doses of pain medication while still in the recovery area, pushing her to the edge of her physical tolerance. That had nothing to do with her age.
- The dose administered in our presence, unsolicited and unneeded, pushed her over the edge into full respiratory failure and cardiac arrest, exactly as described in the drug literature. This reaction was not age related but triggered by an overdose.

It appears that Physicians' Hospital may be going out of business, now that their Medicare/Medicaid funding has been cut. For us that is good news. The four primary owners, plus the thirty-five other physicians who own stock are in the process of trying to sell the corporation. Our concern is that there are still 99 other hospitals similar to Physicians' operating across this country.

It is our opinion that when the doctors own the hospital and operate it to their benefit, when the almighty dollar rather than quality patient care is the bottom line, when physicians can pick and choose who they will treat, and when the hospital has no one holding everyone's feet to the fire, then patients will not be well-served. My mother is an example of what can happen if no one is looking over the doctors' shoulders.

If my mother's death results in raising public awareness of this problem, and results in this Senate committee closing some of the existing loopholes, and in so doing perhaps saves someone else's life, I'm certain that she would say that it was worth it. Please, make it so. Thank you for this opportunity to address the committee. I will be happy to take your questions.

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