

Lesley Bennett
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Good afternoon, Senator McDonald, Representative Lawlor, and distinguished members of the Judiciary Committee.

My name is Lesley Bennett. I live in Stamford, CT and I am a freelance healthcare writer, and advocate for children with rare disorders.

I am here today in strong support of Senate Bill 1091 an *Act Concerning Complaints Pending in the Department of Public Health Against Physicians and Other Health Care Providers*.

It is time for our state to change the way the Department of Public Health handles patient complaints against physicians. Our current system is outdated and it is designed to protect physicians, not improve the safety and quality of care provided to Connecticut residents. Under the current system patients are not given the opportunity to correct inaccurate information before DPH dismisses the complaint.

I would like to share with you our family's experience with the Department of Public Health's handling of our daughter's complaint. My 18-year old daughter Kelly was the victim of a preventable medical error. Kelly is a handicapped teenager with an identified IgE latex allergy. On July 16, 2007, a surgeon at a Connecticut hospital where my daughter had been treated for 5 ½ years, implanted a tube with a latex balloon in her intestines as a feeding tube during elective surgery. This error NEVER should have happened to Kelly—the hospital and surgeon knew Kelly has an IgE latex allergy and the medical device is clearly labeled as containing latex. The surgeon apparently grabbed this tube off the hospital's supply room shelves without reading the latex warning on the label or bothering to log the device into the hospital's quality control system. Apparently, no one at the hospital noticed the error, and the device remained in our daughter intestines for several days.

Kelly is lucky to be alive—according to the hospital where this incident occurred, she suffered an acute level allergic reaction that resulted in a 21-day hospitalization. According to Kelly's allergists it should have been very easy for DPH to find that the surgeon provided Kelly with substandard care. Since 1998, the standard of care in all US hospitals for an identified IgE latex allergic patient is the strict avoidance of all latex products in any surgical procedure. Yet, on April 15, 2008, DPH dismissed Kelly's complaint against the surgeon.

When we called DPH for an explanation, the Health Care Systems Branch told us that a consultant for DPH had reviewed our daughter's case and found that the latex balloon on the tube used as my daughter's feeding tube was specially coated making it less allergenic—and the latex in this device could not possibly have caused my daughter's acute reaction after her July 16, 2007. DPH classified this incident as an acute reaction due to the patient's disabilities complex medical condition and other allergies but not the latex in the tube—and dismissed Kelly's complaint against the surgeon.

Distinguished members of the Judiciary Committee, DPH dismissed my daughter's complaint based on a product that did not exist! On July 16, 2007, there was no form of latex that was safe

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for an IgE latex allergic patient, and DPH personnel should have known this! The FDA, the device manufacturer, and the device distributor all claim that the tube used in my daughter's surgery is labeled correctly—it contains latex, and should not have been used in Kelly's surgery. If DPH had bothered to contact us before dismissing our daughter's complaint or we had been allowed to provide testimony about the latex in this tube before DPH's dismissal, Kelly's allergists could have corrected this inaccurate, dangerous information.

The way DPH currently handles these complaints must change. Decisions about standard of care, the safety of a patient, the severity of a patient's adverse outcome, or even the allergenicity of latex in a device cannot be made behind closed doors. Patients must be allowed to correct inaccurate information in patient records and be allowed to have their physicians present expert testimony that is not biased against the patient. In our daughter's case we feel that DPH's handling of Kelly's complaint raise very serious concerns about the integrity, competence, and ability of DPH personnel, DPH consultants, and the Medical Quality Assurance Committee to decide complaints filed by patients (especially handicapped or medically complex patients) on the basis of the facts.

After arguing with DPH for 11 months about the standard of care for an identified IgE latex allergy patient; with the help of the Attorney General's office and our state Senator we did finally get our daughter's case against the surgeon reopened (Legal Office). Under the Freedom of Information Act we were able to obtain copies of the medical records, information and consultant findings/opinions DPH used in our daughter's case. FACTS appeared to be lacking in this file—what we found were medical records that were incomplete or incorrect, a consultant with questionable credentials, and a letter from a surgery consultant that appeared to make insensitive remarks about our daughter/family and even offered a psychiatric evaluation of our motives for filing a negligent care complaint against the surgeon. The "scientific" information the consultant used to claim that the tube used in my daughter's surgery was specially coated making it "less allergenic," was product information from the manufacturer describing a coating designed to prevent infection and improve the comfort of urinary catheters.

I believe this bill addresses the need for allowing patients and their representatives the chance to refute inaccurate information before DPH dismisses a complain for no probable cause or violation of care. Thank you for you efforts to improve patient care in our state.