Anesthesiologist Innocently Caught in a Hospital Employee's Drug Diversion Scheme Tells Her Story

By Kate O'Reilley, MD

The Story

It was a cold winter day in 2009 when my life changed forever; however, it would be months before I figured that out. On that fateful day, a drug-addicted surgical scrub tech assigned to my operating room allegedly stole syringes of fentanyl, a potent intravenous narcotic, from my anesthesia cart. According to news reports, investigative summaries, and the scrub tech's confession, once she took the syringes, she used them on herself.

It’s hard to fathom, but that’s not even the really sick and twisted part to this tale. The scrub tech had hepatitis C, a blood-borne virus that attacks and, sometimes, destroys the liver. Based on her own testimony, she knew she was positive for the virus. Yet, after supposedly injecting herself with a drug intended for a vulnerable and innocent patient, she then allegedly chose to refill the syringe with saline. Theoretically, the syringe was contaminated with her infected blood. She then allegedly replaced the syringe in my cart. If these allegations are true, and there is no way of knowing, there was no way I could have known that she had tampered with my drugs. The syringes purportedly would have been in the same place where I left them, and both fentanyl and saline look identical. So, on that unfortunate day, it is alleged that I injected a mixture of saline and hepatitis C into my patient’s bloodstream, instead of a painkiller.

The following summer, the story made local and national headlines. At least 5,000 patients were at risk for having been exposed to the virus. Every anesthesiologist in my group secretly prayed that they weren’t involved. The hospital went
into extreme damage-control mode. Tight restrictions and policies regarding the handling and securing of narcotics were strictly enforced. Panicked patients were tested en masse for the potentially lethal virus.

A few months later, I received notice that I was being sued, along with the hospital. Receiving the summons and the two-year ordeal that followed was, by far, the most painful, mortifying, demoralizing, and caustic event of my life. Of course I grieved for the patient, but I had to do so in silence because any discussion of the event was forbidden, on the advice of my attorneys. Never before would I have imagined the depths of shame, guilt, and self-doubt that I was capable of inflicting upon myself.

As the lawsuit evolved, the lawyers and the patient grew nastier and greedier. My initial feelings of compassion and empathy dissolved into rage and betrayal. I suffered through an eight-hour deposition with hostile attorneys where I was belittled, ridiculed, verbally abused, and intimidated. Months later, I was emotionally beaten down, and I made the painful decision to settle. It was at that time, in the middle of settlement negotiations, that I was featured on the local television news station, only to be followed a week later by a front-page headline in the local paper. Statements I made during my deposition were taken out of context. The public commenters on the stories cried for my crucifixion. I will never know this for certain, but the timing of the stories and their prejudicial slant reeked of a couple of reporters on the take. I was made to look like a cold, heartless, reckless villain, whose patient was the innocent victim of my blatant negligence.

I never got my day in court or the opportunity to explain that I’m not a monster. I wish I could have explained that, before this happened I was a caring, compassionate, skilled, and highly qualified physician. The manner in which I secured and stored my narcotics was identical to the manner in which most of my colleagues handled theirs. We were all taught during residency that the operating room was a secure environment. Furthermore, we were taught to have our drugs drawn up in advance of our cases, so as to be able to handle emergent and unforeseen events more expeditiously.

Now I am a shadow of my former self. I’m bitter, defensive, cynical, and wounded. I want to stress that in no way is this article intended to take away from the fact that a patient was hurt. I was as much of a victim of the scrub tech’s crime as was my patient. We just endured different kinds of injuries. Mine were of the heart and soul and will never heal.

Addendum:

Once the news story broke, the hospital immediately released memos, and a new hospital policy, dictating that anesthesiologists could not draw up narcotics until the patient had physically entered the OR. There was zero tolerance for non-compliance, and audits were strictly enforced. This policy remains in effect today.

Within months, each operating room was equipped with its own Pyxis machine. Access to drugs is now controlled by biometrics. All drugs, even non-controlled substances, are locked and secured within the machines. Propofol, once as readily accessible as a local anesthetic, is now treated as a narcotic. Additionally, anesthesia providers are given prefilled, tamper-resistant 5 cc syringes of fentanyl. All other narcotics are still dispensed in vials and require the physician to draw up the drugs into syringes.

Hospital and surgery center rules vary at other facilities within my area. No other facility, other than mine, dictates exactly when narcotics can be drawn up prior to administration. However, most of the hospitals in my region have added individual Pyxis machines within each OR. Security is more tenuous at surgery centers. Although a number of surgery centers provide lock boxes within the anesthesia cart, it’s unclear as to how many keys exist for each box and who has access to those keys. Several of the surgery centers require anesthesiologists to check out an entire box of narcotics for the day. This leaves the physician with the responsibility of securing and protecting more drugs than he or she may require for their cases, thereby increasing their vulnerability.

Over the course of my lawsuit, the plaintiff’s attorneys found an expert witness who testified that narcotics should NEVER be left unattended and unsecured. Interestingly this “expert witness” was no longer practicing anesthesia, and was employed as a consultant in the private sector. In his deposition, he stated that he has never, not once, in his career ever turned his back on his narcotics. This includes times when he was starting lines and tending to critical
matters with respect to patient care. Hmm, what do you think?

The fact remains, if some rogue individual wants access to drugs badly enough, he or she will achieve that goal. Today, I am hyper-vigilant with respect to my narcotics. Even so, I recognize that there still exist moments when my drugs could be diverted. The operating room is an intense, fast-paced and sometimes chaotic environment.

Regardless, I refuse to put my concerns for the integrity of my drugs over the care of my patients.

Note: I would greatly appreciate any feedback. Also, if you have any questions or would like to schedule an interview regarding this or any other facet of life in the operating room, please contact me by email @ kateoreilley@gmail.com [1] or visit my website@ www.kateoreilley.com [2].

Editor’s Risk Management Commentary:

Dr. O’Reilley so graciously and courageously allowed us to print her story for our readers, because despite her discomfort, it is her desire that none of her colleagues nor their patients and institutions endure similar experiences. As Dr. O’Reilley’s story depicts, the theft of drugs and controlled substances by health care professionals is a serious problem that can lead to patient harm and jeopardize patient safety. Numerous instances of hepatitis C transmission from an infected healthcare worker to a patient have been reported in the setting of narcotic diversion, as well as transmission of bacterial pathogens, with fentanyl being the most commonly implicated opioid.12

Current data reveals that rates of drug abuse among health care workers are comparable to the general population.3 The major difference between the general public and medical professionals is the accessibility of a large source of controlled substances, leading to illegal removal from the health system for the purposes of self-administration, selling, or supplying to others. Every health system should have in place a systematic, collaborative process to control the drug diversion problem.

When developing policies and procedures, Carlson and Corsaro suggest involving a multidisciplinary team from all affected departments, including pharmacy, security, human resources, employee health, EAP, and administration. An effective drug diversion policy/system:

- Defines drug diversion
- Defines the methods used in the investigation of suspected diversion
- Appends a “Fitness-for-Duty” policy
- Provides an appropriate chain of contact when diversion is suspected
- Establishes a system that facilitates timely recognition of any diversion of controlled substances, as well as a procedure to quickly identify the individual responsible for diversion
- Requires staff to report suspected drug diversion immediately to his or her department director or manager. All such information ,and the identity of the individual furnishing information, must be confidentiality protected to the extent allowed by law
- Establishes a chain of command for reporting drug diversion, both within the institution and to the appropriate local and federal authorities, if necessary
- Involves facility security and police, if necessary
- Utilizes automated dispensing cabinets and software to analyze usage patterns for diversion.
- Develops a well-defined process that identifies weekly counts and reviews all discrepancies, PCA and epidural usage, and OR processes.
- Considers the placement of cameras in strategic locations

A number of states and hospital systems have been actively addressing drug diversion and effective prevention methods for hospitals and healthcare providers. Very good resources are available from the Minnesota Department of Health (MDH) originating from the work of a coalition of the MDH, Minnesota Hospital Association, area hospitals, providers, law enforcement, licensing and other stakeholders. The coalition issued its final report in April 2012, along with numerous resources for developing programs to effectively prevent and respond to drug diversions. For more information, contact the MDH Division of Health Policy at 651-201-5807.
Summary

Drug abuse is a significant problem in the United States. With the comparable rates of addiction among health care workers, the potential of drug diversion occurring in our health systems is a constant issue. A vigilant approach is required to help prevent, monitor for, and investigate drug diversion. The ideal method is multidimensional, and includes explicit policies, detection methods, investigation processes, and an organizational culture of readiness. Without a systematized approach, hospitals and healthcare providers are vulnerable to major drug diversion and subsequent public and legal repercussions.

The information provided in this resource does not constitute legal, medical or any other professional advice, nor does it establish a standard of care. This resource has been created as an aid to you in your practice. The ultimate decision on how to use the information provided rests solely with you, the PolicyOwner.

Source URL: https://www.magmutual.com/learning/claimslesson/anesthesiologist-innocently-caught-hospital-employees-drug-diversion-scheme

Links
[1] mailto:kateoreilley@gmail.com