

Good morning ladies, gentlemen and distinguished panel.

My name is Teresa Williams, and I am a Health CARE worker.

I come here today to represent the voice of the countless victims of the atrocities that took place at MGH. I speak for the patients, the public and the workers.

I am here to put a face to one of the many who came forward, then and now. Who looked beyond job security and stepped outside their comfort zone and was willing to fight for those who were unaware that their health was at stake, for those who deserved so much better.

In light of all the information that has been uncovered by the State and other Government investigators does it frighten you that only Kristin and I have come forward? If it doesn't, it should. The information that we were privy to pales in comparison to the information that others could and should come forth with. I suppose, that's a cross that they will have to bear.

I don't have to argue as to whether there were problems with the quality of care at MGH, you know that. I don't have to argue as to whether the patients, public and workers were put at risk, you know that. I don't have to argue as to whether the instrumentation malfunctioned and had problems, you know that too.

I am hoping that my experiences, Kristin's experiences along with a few others who are NOW, willing to come forward to speak of what they witnessed at MGH, will once and for all, bring closure to the MGH of then, and will help to prevent this from happening anywhere, ever again.

Hopefully, after this collective body has adjourned, there will be a clearer understanding of the culture and mindset that existed two years ago at MGH, when I worked there.

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There are certain assumptions that we all make on a daily basis. When we board a plane, we assume that the engine is working properly or the airlines wouldn't let it off the ground.

We assume that when we eat at a restaurant that the food is safe for human consumption.

As a healthcare worker, when you work for an organization and you recognize, identify and inform your superiors of impending danger, the assumption is that something will be done to correct the problem.

As a patient you assume and trust that your doctor, the hospital and all those involved with your healthcare will do their best to make sure that you are provided the treatment necessary to enhance your lives.

As a public you assume that there are practices, policies and safeguards in place to prevent harm to you as an unsuspecting public.

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As a new lead Tech at MGH I listened to the voices of those who worked diligently along side me. After working there and through my own observations I found that their concerns and complaints were not without merit.

As a new employee and someone who has worked in an environment that encouraged problems to be reported so that the necessary changes could be made to prevent further harm to those who we were paid to serve, I found this very troubling. One of the documents that I submitted with my March 2004 letter is one from an employee to the then, director, which speaks of her frustrations and despair. She and I along with others talked about the problems and ways to correct them but felt as if no one cared or listened.

My feeling was and still is, if you have legitimate concerns and can prove them and can assist in providing solutions, then there is someone out there who does care, who will listen and who has to act.

We took our concerns to our superiors, individually and collectively, to make them aware of the conditions in the lab and to let them know that this was not fair to the patients. We let them know of the problems with the controls. We complained of our fears about the questionable results, the dangers of the Labotech and other instruments, and how we were fearful of patient harm. This happened on many occasions during my employ at MGH.

As time went on, I realized that this disorder and resultant desperation was so entrenched and had become a culture, a mindset that was resigned to the fact that nothing will change and this must be the norm.

Many said, “don’t make a fuss, just do your job and leave at the end of the day.” How could I do my job? How could any of us do our job? Our

job was to serve our patients. Our job was to provide them the type of care that any one of us would have demanded.

There were many who truly believed that things could be better. So we continued to voice our concerns and to fight.

Kristin and I are but two faces, two lives and two souls committed to quality healthcare at MGH. My question is where are the others? I can only close my eyes and ponder: y tu Brutus?

If some bushes have been shaken, then let the bad fruit fall where it may.

I find solace in the fact that the matter is now in the hands of those who do care. Their health in the hands of those who are committed to fixing the problems. The public can now rest assured that their welfare and health is now being protected by those who are willing to take whatever steps are necessary to protect them.

I applaud Maryland Secretary of Health, Nelson Sabitini, for his relentless efforts to uncover, investigate and eradicate the “broken systems” at MGH. If the State had been furnished all the necessary information and were informed of all the problems, when they made there 2002 inspection of MGH, there wouldn’t be thousands of questionable results, retests and loss of public confidence, and I feel that Kristin Turner would not be HIV positive today.

My understanding of what takes place when the State comes to inspect, was that everyone HAD to provide everything and anything necessary to uncover problems. That workers were automatically protected from retaliation, therefore they were free to speak about their concerns with immunity. If the hospital had taken the lead in being forthcoming when the State came to inspect in 2002, then that would have set the stage for the workers to follow suit. This awful cycle of improper healthcare would have halted two years ago, well before Kristin Turner was infected. The assistance and guidance that is now being provided by the State would

have put in place the proper systems of checks and balances that were not in place then.

But because MGH chose to tie the hands of the State and not ask for the much-needed help that was required to correct the problems, they have created a climate of public distrust and loss of confidence in the healthcare system as a whole.

I would just ask that everyone here today take a moment and think of someone that you truly love, a parent, spouse, child, other family member or friend. Would you have allowed that loved one to be treated at MGH if you knew this was taking place?

Isn't it a Blessing that you have the luxury of being able to make that decision? Unfortunately there are thousands that didn't have that option.

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I have had to grapple with this everyday? What more could I have done? Maybe if I had fought harder, fought longer, screamed louder, maybe it

would have made a difference. The ability to exact change was beyond my reach.

When I left, I was discouraged, distraught and broken.

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This is a golden opportunity for MGH to do the right thing now. If they are truly committed to correcting the problems, then provide a forum where by no one is afraid to expose all their concerns. Allow them to be questioned by State and Government agencies without the presence of hospital administration or hospital lawyers. Take this opportunity to fix the problems that plague the hospital once and for all.

## Recommendations:

1. Make patient, public and employee safety a number one priority.
2. Devise a system that demands and encourages the bottom line to be healthcare driven as opposed to dollar driven.
3. Institute a system of checks and balances on all levels. Where there is direct accountability for problems and their resolution.
4. Create a citizen review board that includes people from all sectors of the community that has some oversight of the hospital operations.
5. Employ a risk management representative in each department who is available to address any complaint or concern at the root level, and let this person be accountable and report directly to the risk management director.
6. Have focus groups where employees can discuss their concerns openly.
7. Develop a problem tracking system that documents a problem and tracks it from the initial complaint to its resolution.

8. Use the SIX SIGMA program as a template for healthcare excellence. This program was started by G.E. in the 1990's and was designed to address and improve issues that are critical to quality. It has already been adopted in the healthcare industry.
9. Include your "ground troupes", the people who actually are responsible for carrying out the duties, in the decisions made regarding each department.
10. Insure that continued monitoring and record keeping of OSHA reportables is present, so that problem areas can be easily identified, addressed and resolved in a timely manner.

These recommendations are easily achieved and extremely cost effective. They will save millions of dollars in litigation, retesting and costs incurred to restore public confidence.

May 16, 2004 Incident

More extensive than uncovered.

Surgical patients, ER patients, nursing homes, treatment centers.

Total CK (cardiac screen) ....The instrument could not detect value because specimen needed to be diluted causing a delay in patient

medical treatment and was the result correct since the controls had failed

Drugs of Abuse .....did this cause someone not to be considered for a job, or lose their job. Were those results used to render a decision in a court case.

Therapeutic Drugs.....Were the patients' dosages correct? Were they under medicated or over medicated?