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# Poor Performance Records Are Easily Outdistanced

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Gwyneth Vives was excited about becoming a mother for the first time at age 36. She shopped for baby outfits, attended birthing classes and painted moons and stars on the nursery ceiling for the infant she and her husband would name Alex.

But three hours after giving birth to a healthy boy in 2001, Vives, a scientist at Los Alamos National Laboratory in New Mexico, suffered a complication and bled to death. It was four days before Christmas.

Her husband, Ted, wouldn't learn until later that the doctor who tended to his wife that day at Los Alamos Medical Center had a troubled history.

Obstetrician and gynecologist Pamela L. Johnson had been forced to leave a previous job at Duke University Medical Center in North Carolina when questions arose about her surgical skills and her complication rate from medical procedures. Later, Johnson lied to get her New Mexico license, saying she had never lost hospital privileges, according to an order of the New Mexico Medical Board.

After Vives died, Johnson again lied about her past.

Claiming that she had never lost hospital privileges, Johnson was given a license to practice in Michigan, even before New Mexico could discipline her.

Hundreds of other doctors across the country have done the same: Facing problems in one state, they simply moved and restarted their careers. They were able to do so despite a federally imposed tracking system designed to prevent just that.

Among doctors licensed in the District, Maryland and Virginia, nearly two dozen got in trouble in one jurisdiction and then moved elsewhere to practice, according to a Washington Post analysis of medical board records between 1999 and 2004.

Nationally, 972 physicians during that period were disciplined in one state, then moved at least once more and were disciplined again for a separate infraction, according to federal statistics. Nineteen were disciplined in four or more states over five years.

Doctors who find themselves in trouble can move around because many are never reported to a national repository for doctor discipline records, known as the National Practitioner Data Bank. The aim of the data bank is to allow licensing boards and employers to check on doctors' records before they are hired and to prevent problem doctors from state-hopping.

But nearly 54 percent of all hospitals have never reported a disciplinary action to the data bank, according to the federal Department of Health and Human Services, which oversees the system. Even when hospitals or boards report problems, they don't always do it quickly, allowing doctors to move and get a new license before the paper trail catches up with them.

"It's only as good as the information reporters put in," said Cynthia Grubbs, a former acting deputy director and associate director for policy and analysis for the data bank.

Other weaknesses also plague the system:

• Federal law requires, for example, that hospitals and medical boards be penalized if they don't report to the data bank. But no fine or penalty has ever been levied, federal government officials acknowledged.

• Hospitals sometimes agree not to report doctors they are forcing from their staffs. This concession may smooth the way for a physician to leave without a fight, but it also mistakenly signals to other states and medical facilities that the doctor has a clean history.

• In some instances, physicians' names are removed from malpractice settlements to keep them out of the data bank. Only those who are named in the final settlement must be reported.

In Johnson's case, no one told the data bank that she had been forced to leave her job at Duke, according to records and interviews. Her false statement on her New Mexico application went undetected by the medical board for more than a year, records show.

Johnson's history "appeared in none of the routine investigations we did into her background," said Jenny Felmley, a spokeswoman for the New Mexico Medical Board.

Vives's husband and two other patients in New Mexico alleged in lawsuits that, during that time, Johnson was negligent or botched surgical procedures, accusations she denies. In the Vives case, Johnson denied that she contributed to the death and has said that the cause was an unpreventable embolism that was cited in the autopsy, according to court documents.

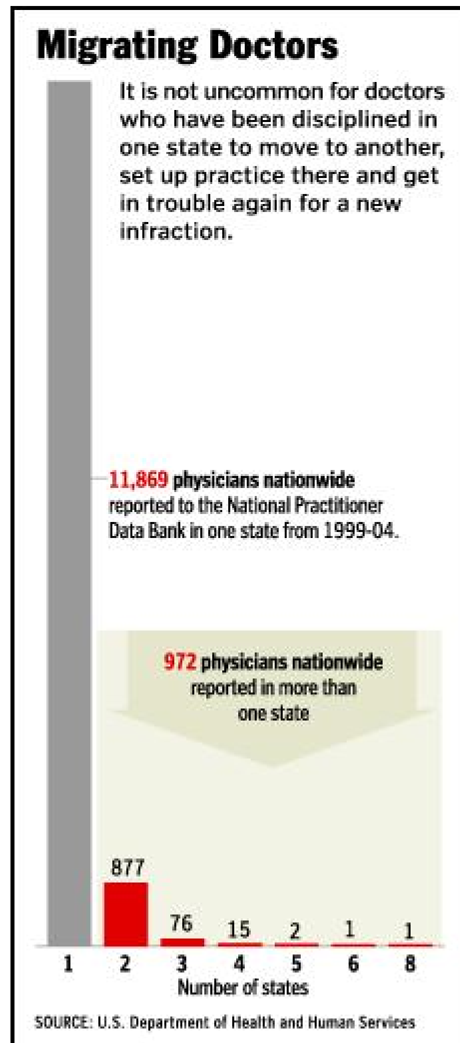
Like the state, officials at Los Alamos Medical Center knew nothing of her problems at Duke, according to Dan Green, a spokesman for Banner Health, which owned the hospital at the time. He said Johnson's record at Duke didn't surface when the medical center checked her out before granting her privileges.

Johnson, 46, said she did not knowingly break the rules. "I didn't think I was lying," she said in an interview from Michigan. "My attorney told me because there was nothing in writing [from Duke] that I didn't have to report that I had withdrawn privileges. I understand now that it should have all been reported."

Three Duke University officials, including the general counsel, would not comment on why the medical center did not report Johnson to the data bank. "It's not Duke's policy to discuss personnel issues," medical center spokesman Richard Puff said.

**Data Bank's Loopholes**

When the National Practitioner Data Bank began collecting reports in 1990, the goal was to stop doctors and some other licensed health care workers from escaping troubled histories by having a central location where any sanctions or malpractice payments could be recorded. Although the names would not be public, they would be available to state licensing boards, hospitals and other health care entities, including federal agencies.




Mark Pincus, who oversees the data bank, said it has "fulfilled its intent" and "does exactly what Congress intended it to do."

But others say that the federal government has done little to ensure that hospitals and others comply with the regulations.

"We have seen efforts to get around it, many of them successful," said Sen. Ron Wyden (D-Ore.), who co-authored the legislation that created the data bank. "There are significant loopholes that need to be closed."

Thomas Croft, who oversaw the data bank from 1991 to 2000, agreed that loopholes exist but said that the system has "added a degree of honesty to the environment." Knowing they've been reported, doctors are less likely to lie about their pasts, he said.

But the sanctions in the law and enforcement are "probably not strong enough," Croft said. "To say we were even aware of 10 percent of the possible violations [by doctors] is probably an exaggeration."

Dale G. Breaden, a spokesman for the North Carolina Medical Board, said hospitals help doctors by limiting discipline to less than 30 days because longer sanctions must be reported.

"Suddenly, everybody was taking action that didn't extend beyond 29 days," Breaden said.

The American Medical Association and other organizations have fought to keep the names of doctors private, arguing that opening the data bank to the public would violate physicians' privacy.

Wyden said he would like to allow the public to get information about "the most flagrant violations." Although that would certainly trigger opposition from the medical community, he said, "I think it's time to end the days when the consumers are the last to know."

**High Complication Rate**

Pamela Johnson had a promising career when she arrived as a 30-year-old resident at Duke University Medical Center in 1989. Records show that she joined the faculty four years later and was named an assistant professor in 1995.

But in 1997, Charles Hammond, head of OB-GYN, wrote to Johnson that she would have to leave Duke if she didn't "make significant progress," Johnson said in a court deposition. Later, Hammond asked her to stop performing surgery, according to the deposition.

In the deposition, Johnson said Hammond told her that her problems included a "high surgical complication rate" and the "worst QA [quality assurance] file of anyone at Duke." There was pressure from the hospital's risk management office to fire her to avoid paying a higher malpractice premium for the department, she said in the deposition. In June 2000, Johnson's Duke hospital privileges were terminated, according to a New Mexico Medical Board record.

In the interview, Johnson said she was a "fairly good" surgeon but acknowledged that she had "a few little" problems at Duke.

Former Duke employee Monia Thomas was one of three patients in North Carolina to file claims against Johnson for malpractice, accusing her of nicking her intestine during a 1997 tubal ligation. Thomas said in an interview and in her complaint that she ended up in the emergency room, which turned into a 10-day hospital stay. Doctors had to perform a colostomy, which was later reversed, Thomas said in the interview.

Thomas, now 45, said she was unable to work for a year. "I had to wrap my side in towels so that no one sitting next to me in church would hear the noise from the [colostomy] bag," she said. "I was just going in to get a tubal ligation. She told me in a couple of days I would be ready to go back to work."

Thomas sued Duke as well as Johnson. In 2000, the case was settled with Duke for an undisclosed amount, she said.

Johnson said in the interview that she didn't remember Thomas or the operation.

Even though Johnson was forced to leave, Duke gave her something that would help her get hospital privileges in three other states: letters of recommendation.

Three months after her Duke privileges were terminated, she was hired at a practice in Danville, Va., and given privileges at Danville Regional Medical Center. Lenworth A. Beaver, the doctor who hired her, said he didn't know about her troubles at Duke at the time. She quit after five months, he said, because "our practice wasn't making enough to pay her what she wanted."

Johnson, a wife and mother of two girls, landed a job with Los Alamos Women's Health Services -- a New Mexico medical group -- and received privileges at Los Alamos Medical Center, records show. Although the hospital was ignorant of her past, an official said, the medical group was not.

Before it hired her, it knew of at least one surgical complication involving Johnson and that she had been asked to leave Duke, according to a handwritten note by one of the group's partners filed in court records.

**Hours After Joy, Tragedy**

By the time Gwyn Vives arrived at Los Alamos Medical Center to give birth in December 2001, Johnson had had her New Mexico license for five weeks. Vives was admitted to the hospital by Johnson. Her labor was induced, and with the help of a midwife, she gave birth just before noon. With her husband at her side, Vives was "holding baby, bonding well," according to a hospital report.

But shortly after, things went wrong.

According to a lawsuit filed by Ted Vives, his wife suffered a vaginal tear and other lacerations during the delivery that caused profuse bleeding. While Johnson was repairing the vaginal tear, Vives's pulse rate soared. She was given several medications to stop the bleeding. Johnson left the delivery room about 1 p.m. to assist with another procedure, turning the repair over to the midwife.

The lawsuit alleged that Johnson's "negligence and recklessness" contributed to Vives's death, saying that after partially repairing the vaginal tear, Johnson ignored Vives's "bleeding, tachycardia, cervical lacerations, repeated alarms and signs of shock, abandoning her patient." Johnson failed to call an anesthesiologist or prepare for a blood transfusion, the lawsuit alleged.

Johnson returned to the delivery room about 1:45 p.m. after being paged and tried to repair the lacerations, then ordered that Vives be moved to an operating room. In the operating room, Vives's heart failed, and doctors could not resuscitate her. She was pronounced dead at 3:06 p.m.

The autopsy said that Vives died from excess blood loss due to an amniotic fluid embolism, "a rare complication of childbirth" that is "unpredictable and unpreventable." Cervical lacerations can make a patient more susceptible to such an embolism, the autopsy said.

A former hospital official familiar with the case said that "there were some amniotic cells found in the lung capillaries" but did not know what caused her to bleed to death.

"The bleeding had been going on, and it wasn't treated appropriately," said the former official, who spoke on condition of anonymity for fear of retribution.

"Obviously, [Johnson] didn't know she had an embolism. The transfusion wasn't done. If it had been done and she had died, no one would have said anything," the official said. "They would have said that [Johnson] gave it her best effort. But there wasn't that best effort, and that concerned the executive committee" at the hospital.

The lacerations occurred during the delivery, for which Johnson was not present. Johnson said at the time that Vives's death was due to the embolism, according to court documents.

"They were looking for a scapegoat," Johnson said in an interview.

Ted Vives sued the medical center and the women's health group, the midwife and Johnson, saying the facilities should not have hired Johnson, given her record at Duke.

"Alex was born at 11:55 a.m. I was on the phone to everyone in the family shouting the wonderful news," Vives wrote in an e-mail to The Post. "Three hours later, I had to deliver to these same people the most unimaginable, saddest news: Gwyn was dead."

**Lie Leads to Suspension**

Gwyn Vives. Jean Challacombe. Tanya Lewis. In each case, patients or their families alleged that Johnson botched what should have been routine procedures at Los Alamos.

Challacombe alleged in a lawsuit that Johnson tore her bowel and uterus while doing a dilation and curettage the same day Vives died. In a separate lawsuit, Lewis accused Johnson of doing an unnecessary hysterectomy. In both cases, Johnson filed documents in court denying the allegations.

Challacombe settled her case in 2003, and the Vives suit was settled last year, both for undisclosed amounts, according to an attorney familiar with the cases who requested anonymity because of confidentiality agreements. The Lewis case is pending.

Johnson's attorney in New Mexico, Ben Allen, did not return two telephone calls seeking comment. Green, the spokesman for Banner Health, said the hospital erred by giving Johnson surgical privileges.

"In hindsight, from a procedural point of view, she probably should not have been credentialed to do procedures in the hospital," Green said.

In March 2002, three months after Vives died, Johnson was told that she must have a proctor present to perform surgery, according to a court deposition.

Los Alamos hospital officials subsequently learned about Johnson's troubles at Duke when questions arose about patient complications and an investigation was conducted. She resigned during the investigation, according to the former hospital official.

In December 2002, 13 months after issuing Johnson a license, the New Mexico Medical Board suspended it for "fraud and misrepresentation," records show, because she lied on her application. But notice of that five-month suspension didn't make it into the data bank until July 2004, after an inquiry from a Post reporter.

"It was an oversight on our part," said Felmley, the spokeswoman for the New Mexico board.

Los Alamos sent a report to the data bank, saying that Johnson "resigned while under investigation," the former hospital official said. But by that time, Johnson had moved to Michigan and been given a license there after, once again, she lied on her application.

When the Michigan medical board discovered the lie more than a year later, it put her on probation and restricted her to practicing in a university residency program in preventive medicine.

State licensing officials acknowledged that they failed to check the data bank.

"We don't check the data bank for new applicants," said Ray Garza, a spokesman for the Michigan Bureau of Health Professions, citing a lack of staff and resources. "We trust people to be honest on their application."

*Staff researcher Bobbye Pratt and database editor Sarah Cohen contributed to this report.*

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