ALLEGHENY
GENERAL HOSPITAL
WEST PENN ALLEGHENY HEALTH SYSTEM
320 EAST NORTH AVENUE, PITTSBURGH, PA 15212-4772
412-359-3131

(8)

March 21, 2002

Donal Warde, MD
President, ECMS
Medical Staff Office

CONFIDENTIAL - Re: Evelyn Berwick, MD

Dear Dr. Warde:

After thoughtful consideration, the Department of Medicine has cause to question Dr. Evelyn Berwick's quality of patient care and compliance with Hospital procedure. As a result of this, and as provided in the Bylaws of the Medical Staff (Article VII, Section 3) Procedure for Actions Involving Medical Staff Members or Holders of Clinical Privileges, I request an evaluation of Dr. Berwick's practice at Allegheny General Hospital. This request for an evaluation is based on a patient care episode that came to my attention last evening, as well as a concern that this episode is not an isolated example of the quality of Dr. Berwick' s medical care. At the time of this incident, Richard Shannon, MD, Chair of the Department of Medicine, was away from AGH on vacation. Therefore, as senior department representative, I was called to respond to this patient care issue and I have done so with considerable counsel, including Michael White, MD, President of the Medical Staff, and members of the Hospital administration. I am writing this letter on behalf of Dr. Shannon.

On March 20, 2003 at 6:00 pm, AGH case management notified me that Dr. Berwick had not evaluated a patient who had been hospitalized on the afternoon of March 19, 2003. The patient had been admitted from the emergency room following several falls at home, and there was a suspicion that she had experienced syncope. The day after admission, a medical director from the patient's insurance company requested initiation of physician peer review and additional physician oversight of this patient's care. The nurse manager informed me that Dr. Berwick had given verbal orders on both 3/19 and 3/20 in response to staff requests, and that a neurology resident was currently evaluating the patient. It was his opinion that the patient was having mental status changes. While attempting to reach Dr. Berwick, I called the floor again to check on the patient. The nursing supervisor informed me that Dr. Berwick had arrived on the floor at 7:15 pm, had seen the patient and had written orders for diet and other interventions. It was his opinion that the patient was stable. Subsequently, I discussed the case with Dr Berwick and it was her opinion that the patient was "ok." However, she admitted that she understood that a history and physical within 24 hours of admission was an AGH standard and that she did not meet that standard. I informed her that formal peer review would take place the following day and she agreed. After peer review today, concerns remained regarding the management of the patient. Following this, I consulted with Hospital administration and President of the Medical Staff, Michael White, MD. Dr. Berwick and I, together with Mr. Frank DiLisi, discussed the concerns brought up in peer review and she voluntarily agreed to transfer the care of this patient, and admit all future patients to the Hospitalist service until this evaluation can be concluded. Dr Berwick voiced an understanding of and agreement to going forward with the evaluation process.

Prior concerns regarding Dr. Berwick's quality of care that were relevant to my request for review by the Executive Committee of the Medical Staff include the following. In August 2002, Dr. Berwick failed to arrange for patient coverage while she was hospitalized. At the time, there were several patients in the Hospital which Dr. Berwick managed via telephone. One patient was discharged from the Hospital via verbal order, another was transferred to the teaching service. On March 21, 2003 the Serious Event Review Panel met after a detailed discussion regarding a case where Dr. Berwick failed to notify a patient in 1999 of a biopsy which was positive for breast cancer. However, Dr. Berwick was aware of the result and notified the cancer registry. In discussion with risk management, Dr. Berwick did not perceive that informing the patient to be her responsibility. The patient learned in 2003 that she had cancer from her new PCP at her initial visit, via old records sent from Dr. Berwick. The patient is under the care of other AGH physicians at this time.

I will be available to you and the committee to discuss this in more detail.

Sincerely yours,

Sharon C. Kiely, MD/ms

Sharon C. Kiely, MD, MPM
Vice Chair, Department of Medicine

cc: Richard Shannon, MD
Connie Cibrone
Jerry Fedele ✓
Michael White, MD