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Horwitz: Shift salary dollars into safety

The recent news of a Connecticut hospital's misuse of injection devices -- a practice that potentially exposed more than 3,000 patients to blood-borne disease -- makes us wonder whether or not our hospitals truly have patients' best interests at heart or if finances may be coloring proper judgment.

With at least 15 Connecticut hospital executives reportedly earning in excess of $1 million, and with at least two said to be receiving total pay packages of more than $3 million, it seems logical that the bottom line, profit and loss statements, might be given excessive weight in our state's healthcare system.

The question is: Do finances weigh more heavily than patient safety?

In the incident at hand, a nurse asked a hospital pharmacist whether insulin injection devices, or pens, were used on multiple patients even though they were designed for use on individuals only. The question was brought up during a routine safety meeting and a subsequent investigation by hospital officials uncovered a six-year pattern of misuse of the devices.

Using these devices on multiple patients is certainly one way to contain costs. Was the inappropriate and potentially dangerous use of these devices conveniently overlooked by individuals charged with monitoring costs? What else might be overlooked in an attempt to save money?

The use of insulin injection devices is not new. Ease of administration, accuracy, and convenience has made the insulin pens increasingly popular over the past 10 years. But these devices were designed to be used multiple times for just one person, with a new needle for each injection.

Because backflow of blood and other biologic material into the insulin cartridge can occur after injection, insulin pens, like other injection devices, must never be used by more than one person.

In the last three years there have been several reported cases nationwide in which patients had to test for blood-borne pathogens because individual insulin pen devices were inappropriately reused for multiple patients.

Now, one Connecticut hospital has issued a letter to more than 3,000 patients, prompting an avalanche of frantic phone calls from worried patients who now must schedule tests for HIV and hepatitis.

This incident was preventable. It occurred in spite of clear package instructions stating that insulin pens were not to be shared.

Removing the devices from use in the problematic hospital should not have been necessary. What is required there, and perhaps elsewhere, is a massive overhaul in the training of the medical staff and a commitment to safety over profits.

A series of alerts issued by the FDA and other groups warned against the use of multi-dose pen injector devices, including insulin pens. Back in January of 2012 the U.S. Centers for Disease Control and Prevention issued a warning that the devices must never be used on more than one person and a reminder that infection can occur even if the needles are changed.

The CDC now leads the Safe Injection Practices Coalition, which developed an educational campaign regarding the safe use of insulin pens to help educate both health care personnel and patients.

Clearly, supervision was needed in Connecticut to ensure that these warnings and reminders were heeded. Just as clearly, that supervision has been lacking.

Once they open their letters, thousands of people will undergo severe emotional trauma as they wait to find out if they have contracted a serious disease because of the hospital's error. We hope that each and every one of them will test negative in the end.

Perhaps the large salaries and bonuses paid to hospital executives should be redirected to ensuring patient safety.

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