



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Quality of Care Issues VA Ann Arbor Healthcare System Ann Arbor, Michigan

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Executive Summary

The purpose of this inspection was to investigate allegations that VA Ann Arbor Healthcare System (the system) staff negligently or intentionally allowed a patient to die prematurely, that there was a disparity in treatment of the patient between University of Michigan (UM)-affiliated physicians and VA physicians, and that the patient's medical records and desire to receive all life-saving and supportive measures in case of an emergency were falsified.

We concluded that staff provided appropriate care to the patient, including testing and diagnosis, treatment planning, and consultation with the patient and his family. We did not identify any disparity in treatment between UM-affiliated and system physicians since most physicians held dual appointments. Alternative treatment options were considered for the patient, but his physicians determined that because of the advanced stage of his liver cancer, he was not an appropriate candidate for such treatments. The patient's code status matched his wishes when he was competent and his wife's wishes when he was not. We made no recommendations.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N11)

SUBJECT: Healthcare Inspection – Quality of Care Issues, VA Ann Arbor Healthcare System, Ann Arbor, MI

Purpose

The purpose of this inspection was to investigate allegations that the VA Ann Arbor Healthcare System (the system) staff negligently or intentionally allowed a patient to die prematurely, that there was a disparity in treatment of the patient between University of Michigan (UM)-affiliated physicians and VA physicians, and that the patient’s medical records and full code status¹ were falsified.

Background

The system is a tertiary care center for veterans in the lower peninsula of Michigan and in northwestern Ohio. The system provides medical, surgical, mental health, geriatric, and rehabilitation services as well as advanced specialty care, which includes cardiology and cardiothoracic surgery, neurosurgery, comprehensive cancer care, and specialty imaging services. The system has 100 hospital beds, 38 nursing home beds, and is part of Veterans Integrated Service Network (VISN) 11. The system is affiliated with the UM Schools of Medicine, Dentistry, and Nursing and supports 112 medical resident positions in 28 training programs. Other affiliations include nearly 40 colleges and universities. More than 1,100 people receive training each year through the system’s programs.

The widow of a deceased veteran alleged that the care her husband received while a patient at the system was negligent and contributed to or caused his untimely death. The complainant also alleged that the UM-affiliated physicians who worked at the system and cared for the patient provided aggressive treatment, but the VA physicians offered pain relief and “let him die.”

She further alleged that the patient’s medical records were changed without her or the patient’s consent from a full code status to a do not resuscitate (DNR) status. The patient

¹ Full code status tells caregivers that a patient should receive all lifesaving and supportive measures should an emergency arise.

was transferred to the system from a community hospital and admitted to Medicine Service for treatment of severe constipation, further management of his encephalopathy,² and evaluation of multiple liver lesions noted on an abdominal computerized tomography (CT) scan completed at the community hospital. The patient had been followed in primary care at a VA facility near his previous residence prior to moving to Michigan.

During the first week of hospitalization at the system, the patient underwent numerous diagnostic tests and procedures to determine the source and identity of the reported liver lesions and to ascertain if and to what extent the liver lesions had spread to other locations within his body. As results of the tests and procedures became available, the patient received a diagnosis of terminal hepatocellular carcinoma (liver cancer) with metastases³ to his spine and pelvis. Gastroenterology, Oncology, Nephrology, Neurosurgery, and Pulmonary Services' physicians documented their opinions that the patient's life expectancy was significantly limited. Six days after admission, he developed acute kidney failure, a urinary tract infection, and a neck infection with positive blood culture. Concurrent with his worsening medical condition, the patient's mental status deteriorated to the point where he was responsive only to painful stimuli. The patient was transferred to a Medical Intensive Care Unit (MICU) for 3 days for closer monitoring and treatment with antibiotics and intravenous fluids (IVF).

The patient's acute medical problems improved, and he was transferred back to the medicine unit. The treatment team concluded that because of the extensive spread and advanced stage of cancer, treatment options, including surgery and chemotherapy, were limited. Physicians recommended radiation therapy to the spine and pelvic metastases as a palliative⁴ treatment to relieve pressure and pain. The patient began radiation therapy while on the medicine unit. Physicians, the patient, and his family agreed that he would stay in the Extended Care Center (ECC) to complete palliative radiation therapy treatments and to arrange for hospice home care prior to discharge.

The patient remained in ECC a total of 9 days. While in ECC, the Palliative Care Team (PCT), composed of a physician, physician's assistant, clinical social worker, and registered nurse, coordinated the patient's care. He continued to receive antibiotics and palliative radiation therapy. He developed symptoms of low fluid volume (dehydration) and received IVF. His appetite was characterized as poor. The patient had expressed his desire to return home to his farm with his family, to be kept comfortable, and to pursue available treatment options. ECC staff and the PCT counseled the patient regarding

² Encephalopathy is a condition characterized by altered brain function and structure. It may be caused by advanced and severe disease states, infections, or as a result of taking certain medications. The associated symptoms can include subtle personality changes, inability to concentrate, lethargy, progressive loss of memory and thinking abilities, progressive loss of consciousness, and abnormal involuntary movements.

³ Metastases are cancer growths that originate from a primary site in the body and travel and grow in other sites.

⁴ Palliative treatment, also called comfort care, is primarily directed at providing relief to a terminally ill person through symptom management and pain management.

management of his terminal illness and prepared him and his family for his return home. The patient was discharged on July 8 and died at home the following day.

Scope and Methodology

Prior to the site visit, we interviewed the complainant by telephone. We also reviewed the patient's electronic and hard copy medical records, medical center and service-level policies, and other applicable system documents. We conducted a site visit to the system April 3-5, 2007, and interviewed staff involved in the care of the patient.

We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Issue 1: Staff Negligently or Intentionally Caused the Patient's Premature Death.

We did not substantiate this allegation.

The patient was admitted to the system with a diagnosis of severe constipation and encephalopathy and a medical history that included hepatitis C. He also had suspicious lesions on his liver. Within the first week of his admission to the system, the patient had received a diagnosis of terminal metastatic hepatocellular carcinoma. During the second and third weeks of his hospitalization, the patient experienced several episodes of encephalopathy, multiple infections, and pain. At each point in the patient's care, medical specialists were consulted to determine diagnoses, recommend courses of care, follow up on treatments, and arrange for the patient's eventual discharge to his home. Specialists from the following disciplines were involved in the patient's care: gastroenterology, general surgery, geriatrics, infectious diseases, nephrology, neurosurgery, oncology, palliative care, and radiation oncology. In most instances, these specialists were attending physicians and senior staff members at the system and at UM.

The patient's wife alleged that the discontinuation of her husband's diuretic medications (diuretics) by ECC physicians caused or contributed to his premature death. She believed that the patient suffered unnecessarily from fluid overload because of this action, and that his physicians were negligent in not re-starting the diuretics sooner than the day before his discharge. According to medical record documentation, diuretics were ordered for the patient upon admission to the medicine unit and continued until June 24, when he developed acute renal failure (ARF) and his encephalopathy worsened. The attending gastroenterologist discontinued the diuretics and ordered "aggressive hydration" via IVF. At this time, the patient was transferred to MICU. IVF was continued throughout the remainder of the patient's hospitalization. Medical record documentation shows that on a daily basis, physicians in MICU, the medicine unit, and ECC continued to evaluate the patient's renal status, mental status, and hydration and considered re-ordering diuretics "when appropriate." On July 5, an ECC physician noted the patient had developed

orthostatic hypotension⁵ and edema (fluid build-up) on his side and lower extremities. On July 7, ECC physicians requested that the patient be re-evaluated by Gastroenterology Service. The gastroenterologist determined that the patient's renal function had returned to normal and recommended therapeutic paracentesis (removal of excess fluid from the abdomen) and treatment with diuretics for comfort. Diuretics were ordered and administered on July 7, and paracentesis was completed on July 8 prior to the patient's discharge.

Medical record documentation shows that the patient's condition was monitored. On the medicine unit, the patient was undergoing diagnostic testing and procedures in addition to receiving routine care to address his medical issues. When his mental status began to deteriorate and he developed systemic infections, the patient was transferred to MICU where he received more intensive medical interventions. When the patient's mental status began to improve and his infections began to heal, he was transferred back to the medicine unit. The patient began palliative radiation therapy while on the medicine unit. To continue receiving this therapy and prepare him and his family for his return home, the patient was transferred to ECC. While in ECC, his medications, medical condition, and mental status were monitored.

Documentation in the medical record shows consistent and timely intervention each time the patient's medical condition changed, and timely communication with the patient and his wife regarding these changes and their significance to the patient's quality of life. In the opinion of the specialists treating him, palliative radiation therapy was the only treatment option the patient had to address his terminal condition. After receiving several palliative radiation treatments on the medicine unit and ECC, the patient and his wife elected to discontinue them because he had become very weak and unable to move without assistance. The PCT assisted the patient's wife in arranging for the patient to return to his home and receive hospice care.

Issue 2: Disparity in Treatment of the Patient between University of Michigan Affiliated Staff and the System Staff.

We did not substantiate this allegation.

Attending physicians in gastroenterology, geriatrics, oncology, nephrology, neurosurgery, palliative medicine/general surgery, pulmonary, and radiation oncology who treated the patient in the medical unit, MICU, and ECC held dual appointments to UM School of Medicine and the system. Residents in these specialties were UM employees under the supervision of system attending physicians. During the first week of admission to the medicine unit, the patient underwent numerous diagnostic tests and procedures to determine the causes of his severe constipation, low potassium level, fluid distension in

⁵ Orthostatic hypotension is a sudden fall in blood pressure that occurs when a person assumes a standing position. It may be caused by hypovolemia (a decreased amount of blood in the body), resulting from the excessive use of diuretics, vasodilators, or other types of drugs, dehydration, or prolonged bed rest.

the abdomen, and encephalopathy, and to evaluate the liver lesions identified by providers in the community hospital.

While on the medicine unit, the focus of the patient's care was on maintaining and improving his mental status, managing his fluid and electrolyte problems, confirming a diagnosis with respect to the lesions, and determining the extent of disease invasion in the patient's body. When the patient was transferred to MICU, because of his worsening mental status, ARF, and infections, physicians focused on resolving acute conditions and ascertaining a definitive diagnosis. Within the first week of admission as tests and procedures were completed, physicians determined a diagnosis of terminal metastatic liver cancer, and also concluded that the patient was not a candidate for surgical or chemotherapy treatment. Physicians informed the patient's wife of the grave nature of her husband's health, and she requested that they search for research protocols and other "possibly curative options" for which the patient might qualify. Attending physicians determined that there were no appropriate research protocols for which the patient qualified, and the results of the search were reported back to the patient and his family.

The patient's wife alleged that "some" of the staff in ECC and Palliative Care Unit were not interested in pursuing aggressive and curative treatments for her husband. On June 30, physicians on the Palliative Care Unit and ECC teams accepted the patient for admission to ECC to complete a 10-day course of palliative radiation therapy treatment to his spine and pelvis. Although his acute medical conditions had improved by the time of transfer to ECC, infections were still present, and the patient continued to receive oral and intravenous antibiotics. On July 5, he developed symptoms related to dehydration, and IVF were continued.

Medical record documentation shows that throughout his stay in ECC, the patient's medical and mental health status were closely monitored by staff, and his pain and comfort levels were assessed and documented. Morphine (pain management medication) was ordered and offered to the patient for relief of symptoms. When the patient or his wife asked for an alternative medication or a smaller dose, their request was honored. The medical record also shows that the patient's wife and family were informed of changes in the patient's medical and mental status. Physicians honored the wife's request for follow-up consults for re-evaluation of the patient's condition prior to discharge.

Issue 3: Falsification of the Patient's Medical Records and Full Code Status.

We did not substantiate this allegation.

Each time the patient's mental status deteriorated, and he was unable to express his wishes, his wife was consulted as to her wishes for him. The medical staff documented when the patient was competent to make an informed decision as to his code status, and when he was not able to make such a decision. Staff also documented consultations with the patient's wife and her decisions on her husband's behalf.

At the time of the patient's admission to Medicine Service on June 19, his mental status was stable, and on June 20 and 21, his physicians documented that the patient was in full code status. On June 24, the patient was transferred to MICU because of worsening mental status and medical condition; he was found to be obtunded (mentally dulled). A physician spoke with the patient's wife, and she affirmed continued full code status. She also requested to talk with the PCT. Another physician documented on this date that the wife was aware of the patient's poor prognosis and wished to "get him home to say her good byes."

Medical record documentation shows that on June 25, the patient was encephalopathic and responsive only to pain. In consultation with the on-call team of physicians, the patient's wife decided to change his code status to DNR/do not intubate (DNI). A nurse also recorded in the medical record that the patient's wife stated she was satisfied with her decision to change her husband's code status. The DNR/DNI medical record documentation was co-signed by physicians from Medicine, Pulmonary, and Nephrology Services.

The patient's code status was documented as DNR/DNI on June 27 in a transfer note to the medicine unit and in a Geriatric Extended Care referral note for ECC placement and home hospice. On June 28, the patient's mental status was improving, but he remained confused. A physician documented that the patient's mental status was unstable, and he was at high risk for recurrent encephalopathy. The patient's body appeared "wasted and fragile," and his "overall prognosis was very poor." The physician also documented that the patient's wife continued to struggle with his DNR status and diagnosis. The physician further documented that the staff "will continue to work with the patient and (his) wife to understand his diagnosis and the limits of treatment under the circumstances." The patient's code status remained DNR/DNI.

On June 29, the physician completing a Geriatric Medicine Outpatient Consult documented the patient's code status was DNR/DNI. Later that same day in an addendum to the consult, another physician changed the patient's code status from DNR/DNI to full code. However, there was no evidence of a discussion or a signed standard DNR/DNI form present in the medical record to document this change from DNR/DNI back to full code status.

The patient was transferred to ECC on Friday, June 30, and remained in full code status over the weekend. A Geriatric Service clinician documented a discussion with the patient on July 3 regarding his code status. The patient's wife was not present for this discussion. The patient was described as able to verbalize details about his illness and his limited time to live; and reportedly stated his goal was to return home to his farm. He also stated his wish was to be in DNR/DNI status. He wanted to be kept comfortable and pursue any treatment options he might have. A Geriatric Service physician wrote an order for DNR/DNI on July 3. On July 6 on a standard DNR/DNI form, the physician referred to the discussion and stated that the patient was "competent."

On July 8, the day of the patient's discharge, the patient's wife saw a prescription pad note with orders for DNR/DNI for the patient's trip home and asked that it be changed to full code status. System procedures require that DNR/DNI status is documented on a prescription pad and given to the driver of the transporting ambulance prior to transport. A nurse manager worked with medical staff and managers of the ambulance company to reach an agreement to change the patient's code status to full code for the ambulance ride. The drivers would take the patient to the nearest hospital if he experienced an unstable medical condition with deteriorating vital signs or arrest while being transported to his home. The patient returned to his home on July 8 without incident and died at home on July 9.

Conclusion

We concluded that staff provided appropriate care to the patient, including testing and diagnosis, treatment planning, and consultation with the patient and his family. We did not identify any disparity in treatment between UM-affiliated and system physicians since most physicians held dual appointments. Alternative treatment options were considered for the patient, but his physicians determined that because of the advanced stage of his liver cancer, he was not an appropriate candidate for such treatments. The patient's code status matched his wishes when he was competent and his wife's wishes when he was not. We made no recommendations.

Assistant Inspector General Comments

The VISN and Healthcare System Directors agreed with the findings. (See Appendixes A and B, pages 8–9 for the full text of their comments.)

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 4, 2007

From: Director, Veterans Integrated Service Network 11 (10N11)

Subject: **Healthcare Inspection – Quality of Care Issues, Ann Arbor Healthcare System**

To: Director, Chicago Office of Healthcare Inspections

The draft report has been reviewed and VISN 11 concurs with the report's findings and conclusions.



Linda W. Belton, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 4, 2007

From: Director, VA Ann Arbor Healthcare System (506/00A)

Subject: **Healthcare Inspection – Quality of Care Issues, VA Ann Arbor Healthcare System**

To: Director, Veterans Integrated Service Network 11 (10N11)

1. We appreciated the opportunity to review the draft report of Quality Care Issues – Project #2006-03145-HI-0957, and concur with the report's findings.

2. If additional information or assistance is needed, please contact Bonnie M. Johnson, Staff Assistant to the Director, at (734) 845-3403.

(original signed by:)

LOU ANN ATKINS

OIG Contact and Staff Acknowledgments

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Acknowledgments	Wachita Haywood, Associate Director Leslie Rogers, Team Leader Michael Shepherd, MD Judy Brown, Program Support Assistant

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