



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Questionable Medical Treatment and
Suspicious Deaths
VA Medical Center
Alexandria, Louisiana**

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding questionable medical treatment at the VA Medical Center in Alexandria, Louisiana. The complainant alleged that his father and four other veterans received poor care from an Intensive Care Unit (ICU) physician.

We did not substantiate the allegation that the subject physician removed the complainant's father's breathing tube and transferred him from the ICU so he would die. The patient was breathing spontaneously for 3 days before his transfer to the medical ward. We also did not substantiate the allegation that removal of the patient's breathing tube caused brain damage. The patient suffered several strokes and had two episodes when he stopped breathing. When breathing stops, brain cells start to die in less than 5 minutes. Progress notes clearly documented the patient's steadily declining level of consciousness and brain activity throughout his hospitalization.

We did not substantiate that the subject physician paid money to another patient's family so that they could come to the facility to sign forms allowing the physician to remove the patient from the ventilator. The subject physician confirmed that a money order was sent; however, this action was taken 9 days after the wife had already agreed to withdraw life-sustaining treatment. We noted that the physician could have avoided the appearance of impropriety by pursuing established facility procedures for family assistance.

We did not substantiate that the subject physician overdosed patients with morphine in order to euthanize them. All three patients noted in this complaint were terminally ill, had no cerebral functioning, and had "do not resuscitate" orders. The patient's or family's wishes were followed in all cases. We found no evidence of morphine overdose. Further, we did not substantiate the allegation that the subject physician gave steroids to a diabetic patient believing it would kill him. The physician appropriately ordered steroids to treat an allergic reaction. The patient's glucose levels were measured four times daily during this time, and he was discharged in stable condition.

Although the complainant's father has deteriorated both mentally and physically over the 17 months he has been at the facility, we found no evidence that the subject physician did anything to cause that deterioration. We found no evidence that the other patients listed by the complainant were harmed by the named physician. We made no recommendations.



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

TO: Director, VA Medical Center, Alexandria, Louisiana (502/00)

SUBJECT: Questionable Medical Treatment and Suspicious Deaths, VA Medical Center, Alexandria, Louisiana

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding questionable medical treatment and suspicious deaths at the VA medical center (the facility) in Alexandria, Louisiana.

Background

The facility is a primary and secondary care medical center that provides medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, geriatrics, and extended care services. The facility has 114 hospital beds, including 6 intensive care unit (ICU) beds, and a 156-bed nursing home care unit (NHCU). The facility is part of Veterans Integrated Service Network (VISN) 16.

The complainant initially made his allegations to the Federal Bureau of Investigation (FBI), which referred the case to the VA OIG. The complainant alleged that his father received questionable medical treatment from a physician at the facility. The complainant specifically alleged that:

- An ICU physician removed his father's breathing tube and moved him from the ICU to a medical ward on September 23, 2006, knowing this could have fatal consequences.
- By removing the breathing tube, the physician caused his father to suffer permanent brain damage.

He further alleged that the physician provided questionable care, presumably with the intention to harm or cause the deaths of four other patients. Specifically, he alleged that the physician:

- Sent money to the family of a patient so that they could come to the facility and sign “do not resuscitate” (DNR) forms. This action would allow the physician to remove the ventilator, and the patient would die.
- Administered morphine to three other patients (including the above patient) in order to euthanize them.
- Intentionally gave a dose of steroids to a diabetic patient believing it would kill him.

The facility’s ICU has the equipment and medical and nursing staff necessary to provide intensive and continuous observation and treatment to seriously ill patients. Typically, physicians are assigned ICU duties for a month and then rotate to another clinical area. Since 24-hour coverage is required, other physicians cover when the assigned physician is off duty. At this facility, physicians A, B, and C have all cared for the complainant’s father, either in the ICU or on the medical ward. Physician B is the primary subject of this complaint.

Scope and Methodology

In performing this review, we examined the facility’s policies and procedures, ICU admission and discharge criteria, patient advocate reports, documentation provided by the complainant, Physician B’s credentialing and privileging file, and other relevant documents pertaining to the patient and the allegations. We interviewed the complainant, Physician B, the facility Director, Chief of Staff, patient advocate, Quality Management Coordinator, Chief of Inpatient Pharmacy, and others knowledgeable about the issues. We reviewed the medical records of the complainant’s father from July 2006, when he was first treated at the facility, through January 2008. We inspected the patient’s records from the Michael E. DeBakey VA Medical Center (Houston VAMC) related to his August 2006 admission. We visited the facility December 12–14, 2007, and observed the patient. We also reviewed the medical records of the four other veterans named by the complainant.

Case Summary

The complainant’s father is an 85-year-old male who first accessed VA health care services at the facility’s emergency department (ED) on July 13, 2006. He presented to the ED complaining of pain at a former percutaneous endoscopic gastrostomy (PEG), or feeding tube, site. He suffered a cerebral vascular accident (CVA), also known as a stroke, the previous month and had been treated at a private-sector hospital. A PEG tube had been placed and later removed when the patient was able to swallow. The ED physician noted that the PEG site was well healed; he treated the patient for abdominal pain and sent him home with his family. On July 31, the patient presented to the ED with pneumonia, increasingly slurred speech, and episodes of possible aspiration (food or

liquids going into the lungs instead of the stomach). The admitting physician wrote “Impression: S/P [status post] CVA, right hemiparesis (weakness on the right side of the body), possible aspiration, possible worsening ventriculomegaly,¹ possible normal pressure hydrocephalus,² UTI [urinary tract infection] susp [suspected].” He ordered diagnostic tests and started the patient on antibiotics.

A July 31 computed tomography (CT) scan of the brain showed increased ventriculomegaly, cerebral atrophy (a wasting away of brain cells and tissue), diffuse periventricular white matter changes (change in the structure of the white matter near the ventricles of the brain), and an old (greater than 30 days) right cerebellar infarct.³ On August 2, a neurology consultant noted that the patient was alert to self, partially to place, and could follow only simple commands. He observed that the patient had right-sided weakness and was unable to stand or walk without assistance. He recommended a possible ventriculoperitoneal (VP) shunt⁴, but when tests revealed an 80-percent blockage in his right carotid artery (one of the main arteries in the neck that supply blood to the brain) and possible elevated pressure in his brain, the patient was immediately transferred to the Houston VAMC for surgical intervention.

Tests at the Houston VAMC revealed that the patient was aspirating food and liquids and had aspiration pneumonia and a UTI. Houston VAMC neurologists documented that the patient appeared demented, although family thought he was “of sound mind.” Surgeons performed a carotid endarterectomy,⁵ but the patient’s medical problems (aspiration pneumonia and UTI) delayed placing a VP shunt or a PEG. At the family’s request, the patient was transferred back to the facility on August 28 without a VP shunt.

On August 30, surgeons performed an esophagogastroduodenoscopy (EGD)⁶ and inserted a PEG tube. Physician A assumed care of the patient on September 1. On September 7, he wrote, “He refused neb [nebulizer] tx [treatment]⁷ but he really needs it as he is having some difficulty with his secretions.” That afternoon, the patient stopped breathing, and a Code Blue⁸ was called. A certified registered nurse anesthetist (CRNA) inserted a breathing tube (also known as intubation). The patient was moved to the ICU and placed on a ventilator.⁹ Early on September 9, Physician B wrote, “85 y/o [year old]

¹ The four fluid filled spaces in the brain are ventricles; cerebrospinal fluid (CSF) circulates through the brain and spinal cord. Ventriculomegaly is enlargement of those spaces and can occur if the outflow of CSF is blocked.

² Abnormal increase of CSF in the brain’s ventricles because normal flow is blocked.

³ Death of tissue in a portion of the cerebellum due to a sudden loss of arterial or venous blood supply.

⁴ A catheter that drains CSF from the ventricular system into the peritoneal space. VP shunts are placed to reduce pressure in the brain.

⁵ A surgical technique to remove intra-arterial obstructions of the internal carotid artery.

⁶ Examination of the lining of the esophagus, stomach, and upper duodenum with a flexible endoscope that is also used to insert PEGs.

⁷ Treatment with a device for the administration of inhaled medications.

⁸ An emergency response to a cardiac or pulmonary crisis felt to possibly require resuscitation.

⁹ Mechanical ventilation forces air into the lungs.

male with anoxic encephalopathy.¹⁰ Pt. remains with trach¹¹ on vent [ventilator]...Stable...Family requests him to be full code and to remain here.” Later that day the patient removed the breathing tube (extubated) himself, but as he was in no respiratory distress, he was not reintubated. Physician A wrote, “No distress, needs N.H. [nursing home] placement” and noted that he was not a candidate for long term physical therapy.

On September 14, the patient again stopped breathing and a Code Blue was called. Physician A intubated him and transferred him back to the ICU. Between September 14 and September 22, various physicians and nurses documented the patient’s poor response to voice, stimulation, or pain. On September 22, Physician A wrote that the patient had until the following week with the breathing tube before a tracheostomy¹² should be considered. He also wrote, “Other option will be to speak with the son again about reconsidering for DNR.” The patient’s Glasgow coma scale¹³ was 3.

On September 23, Physician B wrote that the patient could be extubated since the patient’s ventilator had been set to the continuous positive airway pressure setting¹⁴ and he had been breathing on his own for 3 days. Physician B had spoken with the patient’s wife about an advance directive¹⁵ but his wife told the physician to call their son. Physician B documented, “Son states he wants everything done...also states he wants CPR [cardiopulmonary resuscitation] done.” Physician B noted the patient needed a skilled nursing facility. Later that day, the patient was extubated and placed on 2 liters of oxygen (O₂) by nasal cannula, which he tolerated well. The ICU nurse noted that the patient was awake but only responded to pain. After the patient was transferred to a medical ward, a nurse documented that the patient was in no respiratory distress.

On September 24, Physician A wrote that the patient had labored breathing and noted that a tracheostomy should be considered. A CRNA intubated the patient without difficulty, and he was transferred back to the ICU.

On September 26, an ICU nurse documented that the patient remained unresponsive with no spontaneous eye opening and that “Pt. will posture when coughing...eyes are deviated downward [signs of brain damage].”

¹⁰ Refers to a lack of oxygen to the entire brain, which typically results in brain damage; can be caused by low blood pressure (B/P), cardiac arrest, choking, paralysis of respiratory muscles, respiratory failure, and other conditions.

¹¹ This note referred to an endotracheal tube down the patient’s throat to assist with breathing.

¹² Surgical insertion of a breathing tube directly into the windpipe.

¹³ The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma.

¹⁴ The flow of air creates enough pressure to keep the airway open during inhalation, thus reducing the work of breathing.

¹⁵ Advance directives are instructions on what kind of care a patient wishes to receive when he or she becomes unable to make medical decisions.

The cardiologist wrote on September 30 that the patient was “barely responsive,” and “he continues on ventilator support.” On October 1 he wrote, “Unresponsive, on ventilator support, O₂ sat [saturation] - 100 %.¹⁶ We need to discuss termination of life support.” On October 3, the neurologist wrote, “New CVA with left hemiplegia [paralysis], old CVA with rt. [right] hemiparesis.” She recommended an anticonvulsant medication, a bedside electroencephalogram (EEG),¹⁷ and supportive management. An EEG completed on October 5 showed diffuse brain dysfunction. The report suggested some possible seizure activity that could be metabolic or hypoxic encephalopathy (brain damage from metabolism malfunction or lack of oxygen to the brain).

On October 6, Physician A documented that the patient’s condition was unchanged and the “problem remains his level of alertness.” Between October 8, when the patient was extubated, and November 6, the patient suffered a complicated medical course including multiple intubations, tracheostomy placement, chest tube placement,¹⁸ and multiple diagnostic tests. The patient remained unresponsive.

On November 6, Physician B wrote that surgeons were planning to remove the chest tube and to observe the patient overnight; if he was stable, the patient would be transferred to the medical ward. On November 8, Physician A wrote, “The family has expressed their concern about [patient] moving to the floor [medical ward] at this time because they are concerned that he may not receive the care/attention he requires at this time.” Then he wrote, “Because I am not absolutely sure that he will be able to receive the attention he requires when he needs it, I will not move him at this time.... Plan: Continue present care.” Physician A treated him through the end of November.

Physician B documented on December 2 that the patient was not tolerating PEG tube feeding, that he was aspirating around the tracheostomy, and that his prognosis was poor. On December 3, Physician B documented “He will cont. [continue] to develop pneumonia...sputum will remain colonized with pseudomonas¹⁹ which will eventually become resistant to all abx [antibiotics]. Pt more than likely will never make it out of ICU or this hospital. His son is primary NOK [next-of-kin] and wants everything done for him.”

On December 6, Physician A wrote that the patient was awake, opening his eyes, and blinking. However, nursing documentation on that date reflected that his Glasgow coma scale was 7, and he was opening his eyes only to pain. The patient’s status did not change and on December 20, Physician B noted that patient needed placement in a long term acute care facility and asked for a meeting with the son to discuss it. The social worker documented multiple attempts to reach the son without success.

¹⁶ Amount of oxygen in the bloodstream.

¹⁷ Measures and records electrical activity in the brain.

¹⁸ To drain fluid, blood, or air from the space around the lungs.

¹⁹ Bacterial infection that presents a serious risk to debilitated and hospitalized people.

On December 29, the patient received a jejunostomy tube²⁰ (J-tube) to decrease the risk of aspiration. Physician B transferred the patient to the medical ward with stable vital signs on January 2, 2007, and documented that the patient was stable for discharge to a nursing home.

On January 4, the son told the social worker that his father was not ready for discharge to a nursing home. The same day, Physician B wrote a lengthy note chronicling the patient's medical history, treatments, and current issues. Physician B documented that the son had requested another physician. Physician C assumed care and on January 5 noted, "Patient is in a chronic unconscious state on J-tube feedings, medications being given through PEG tube." His physical exam showed that "the patient is in a non-cortical [vegetative] functioning state," and noted that at the request of family, "patient remains [a] full resuscitation effort." Later on January 5, the on-call physician transferred the patient to the telemetry (cardiac monitoring) floor at the son's request.

Physician A documented on January 6 that the patient's "condition worsened last night," and transferred him back to the ICU. The patient remained in the ICU from January 6 to October 11, 2007. On Oct. 11, he was transferred to the medical ward, still on ventilator support. As of January 25, 2008, he remained unresponsive and ventilator dependent.

Results

In his allegations to the FBI and the OIG, the complainant's frustration over his father's health status was evident. When we asked how he knew about the situations of other ICU patients (that he cited in his allegations) he told us he had been investigating Physician B's actions regarding other veterans and that people "just told him things."

Issue 1: Removal of Breathing Tube and Transfer From ICU

We did not substantiate the allegation that Physician B removed the patient's breathing tube and transferred him from the ICU on September 23 so he would die. The patient was breathing spontaneously for 3 days before his transfer to the medical ward. The breathing tube had been removed and the patient was not having any difficulty using a nasal cannula with oxygen flowing at 2 liters/minute. He no longer needed ventilator support and his vital signs were stable. As there was no indication that the patient required ICU care, it was appropriate to transfer him to a medical ward at that time.

Issue 2: Brain Damage

We did not substantiate the allegation that removal of the patient's breathing tube caused brain damage. The patient was breathing on his own 3 days before the breathing tube

²⁰ The surgical creation of an opening between the jejunum (a section of the small intestine) and the anterior abdominal wall that allows artificial feeding. Since it provides feeding lower in the intestine, rather than into the stomach, there is a reduced risk of aspiration associated with J-tube than PEG feedings.

was removed. While the patient's breathing tube was hooked up to the ventilator, the ventilator had been set to the CPAP setting since September 20.

The patient's decreasing brain activity was well documented beginning with his first admission on August 2, 2006. He suffered CVAs in the right and the left hemispheres and his brain CTs showed atrophy and changes in the white matter. He also had two episodes when he stopped breathing, both of which required intubation and ventilator support. When breathing stops, brain cells start to die in less than 5 minutes. Progress notes from physicians, respiratory therapists, and nurses documented the patient's steadily declining level of consciousness and brain activity with major declines after his episodes of respiratory arrest or failure.

Issue 3: Payment to Family

We did not substantiate that Physician B paid money to another patient's family so that they could come to the facility to sign forms allowing the physician to remove the patient from the ventilator. The patient suffered metastatic pancreatic cancer involving his lungs and brain. He was placed on a ventilator after a cardiac arrest on April 1, 2006, and was unresponsive to stimuli. On April 17, the wife confirmed that she wanted providers to withdraw life-sustaining support and requested comfort care²¹ only. The wife requested that the physician wait until all family members could be contacted before removing the patient from the ventilator. For more than a week, the patient remained on a ventilator with comfort care only. Documentation reflected that providers were waiting for the family to decide when to withdraw the patient from the ventilator. The patient's condition continued to deteriorate during this time.

Physician B confirmed that she sent a money order so that the wife, who did not have adequate transportation resources, could see her dying husband one more time before he either died naturally or was removed from life support. The wife came to the facility that evening. The next morning, April 27, Physician B removed the breathing tube, placed the patient on nasal cannula O₂, and ordered 5 milligrams (mg) of morphine for pain. The patient expired 3 hours later. As Physician B sent the money order to the wife 9 days after she had already agreed to withdraw life-sustaining treatment, we concluded that the funds were only intended to offset the wife's transportation costs. However, Physician B could have avoided the appearance of impropriety by pursuing established facility procedures for family assistance.

Issue 4: Morphine Administration

We did not substantiate that Physician B overdosed patients with morphine in order to euthanize them. We reviewed the records of the three patients named by the complainant. We found that all three patients were terminally ill, had no cerebral

²¹ Relieving pain and controlling debilitating symptoms, while not preventing the patient from dying.

functioning, and that all had DNR orders. The patient's or family's wishes were followed in all cases. The first patient's case was documented in Issue 3; this patient received morphine as a comfort measure. There was no evidence of a morphine overdose.

The second patient was a 55-year-old male with steadily declining mental status who had been a NHCU patient for 10 years. His diagnoses included neuroleptic malignant syndrome,²² respiratory failure requiring a ventilator, sepsis (blood stream infection), schizophrenia, seizure disorder, and anoxic encephalopathy (from prolonged seizures). Clinicians provided aggressive treatment for him as his family wished, although he was no longer responsive to stimuli. On June 6, 2006, the family agreed that the patient should receive no cardiopulmonary resuscitation, and a DNR order was entered. NHCU physicians transferred the patient to the ED on October 3 with a temperature of 108 degrees, a markedly elevated potassium level (6 milliEquivalents per liter), and a blood pressure of 77/40. When the patient's heart stopped, resuscitation was not attempted as outlined in his DNR order. The patient was in the hospital for 269 days between November 4, 2005, and when he died October 3, 2006. Physician B had not cared for the patient for over 2 months and had no role in discussing or securing the DNR. The patient had not received any morphine before he died.

The third patient was a 59-year-old male who suffered his first stroke in February 2005. He was admitted to the facility's NHCU in August 2005 after suffering a brain stem infarction. He was a total care patient. On June 26, 2006, he had a massive seizure and a CT scan revealed an intracerebral bleed. On July 18, the patient went into respiratory failure and had to be intubated and placed in the ICU. On July 27, Physician B spoke with the patient's wife about the patient's kidney failure and the need for dialysis. Without dialysis, toxins would build up in his body and he would die. His family did not want him to have dialysis and the physician entered a DNR order at approximately 1:00 p.m. on July 29. At 2:00 p.m., Physician B ordered that the patient be removed from the ventilator, put on oxygen, and placed in a private room to accommodate his family. As part of the plan to withdraw aggressive treatment and provide comfort care, Physician B ordered a premixed bag of morphine to be infused intravenously at 8 milliliters per hour (ml/hr). The patient died about 30 minutes later with his family at his bedside. The Chief of Inpatient Pharmacy told us that premixed morphine bags contain 1 mg/ml morphine. Morphine administered at 8 mg/hr is not an excessive dosage for end-of-life care.

Issue 5: Diabetic Patient and Steroids

We did not substantiate the allegation that Physician B gave steroids to a diabetic patient believing it would kill him. The diabetic patient was in the facility having foot surgery. The podiatrist ordered vancomycin, to which the patient had a severe allergic reaction

²² A rare, life-threatening disorder that severely affects the nervous system's ability to regulate heart rate, blood pressure, digestion, muscle tone, body temperature, and consciousness.

that resulted in blisters on his hands and feet and intense itching. Physician B ordered an appropriate and decreasing steroid regimen to treat the allergic reaction. The patient was hospitalized and his glucose levels measured four times daily. His glucose levels remained within normal limits during this time, and he was discharged in stable condition. Steroid administration was appropriate for this patient.

Conclusions

Although the complainant's father has deteriorated both mentally and physically over the 17 months he has been at the facility, we found no evidence that Physician B did anything to cause that deterioration. Although the patient met criteria for discharge to a nursing home, facility managers have kept the patient in the facility at the son's request. We found no evidence that the other patients listed by the complainant were harmed by the named physician. We made no recommendations.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
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Healthcare Inspections

OIG Contact and Staff Acknowledgments

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