



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Alleged Deficiencies in a  
Hospitalist's Interactions with  
a Patient at the Veterans  
Health Care System of the  
Ozarks

Fayetteville, Arkansas



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of allegations regarding a hospitalist's interactions with a patient and family when obtaining consent for do not resuscitate (DNR) status and determining discharge plans at the Veterans Health Care System of the Ozarks (facility), Fayetteville, Arkansas.<sup>1</sup>

Prior to the initiation of this review, the facility was asked to respond to the allegations, and provide its findings to the OIG. The facility response did not adequately address the following allegations, resulting in the OIG conducting an inspection:

1. A DNR order was written for a patient who was without capacity to consent.
2. The facility failed to evaluate, plan, and coordinate the patient's discharge to meet the needs of the patient and family.
3. A hospitalist's behavior with the patient and family in the Hospice Palliative Care Unit was inappropriate and unprofessional.

During the site visit, the OIG learned of three additional patients for whom facility staff expressed concerns with the way the hospitalist presented prognoses and end-of-life treatment options to the patients and families.<sup>2</sup> The OIG also reviewed the facility's oversight process regarding physicians' professional behavior.

The OIG was unable to determine whether the patient referred to in the original allegation had the decision-making capacity to consent to a DNR status at the time the hospitalist discussed life-sustaining treatment. The hospitalist acted in accordance with policy when determining and documenting that the patient had decision-making capacity at the time of consent. However, documentation in the electronic health record indicated the patient exhibited intermittent confusion and received medications that may have altered the patient's mental status at times throughout the admission.

The OIG evaluated the three additional patient cases involving the hospitalist's approach when determining the patients' DNR status and the eventual reversal of a DNR order. The OIG determined that the hospitalist's interactions as documented in the electronic health record lacked evidence of collaborative discussions to include patients' preferences and quality of life. This

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<sup>1</sup> Facility Policy 2016-11-074 *Do Not Resuscitate (DNR) Protocol including State Authorized Portable Orders*, June 9, 2016. The terms do not resuscitate, DNR, DNAR, No-CPR, and No Code are synonymous. The abbreviation DNR is used in this report. Cardiopulmonary resuscitation (CPR) is artificial respiration and external cardiac massage.

<sup>2</sup> After the OIG's on-site visit, the hospitalist left employment at the facility.

likely led to patients' and families' requests for other providers to reverse DNR orders. If the hospitalist had addressed these elements during discussions, facility staff may not have had concerns with the way the hospitalist presented prognoses and end-of-life options to patients and family members.

The OIG did not substantiate that the facility failed to evaluate, plan, and coordinate a patient discharge to meet the needs of the patient and family. The patient was discharged earlier than estimated to honor the patient's wishes to die at home. The discharge plan addressed the patient's medication, nutrition, and fluid needs, and included dietary restrictions and aspiration precautions. When discussing home-hospice care with the patient and family prior to discharge, the hospitalist provided inaccurate information about home hospice not providing ventilator support services. The family declined home-hospice services based on this information. The OIG concluded that due to the patient's shortened length of stay, the Palliative Care Consult Team did not have the opportunity to educate the patient and family that home-hospice agencies may accept ventilator-dependent patients. After discharge, the family requested, and the patient received, home-hospice services with mechanical ventilation and a nasogastric tube.

The OIG was unable to determine whether the hospitalist demonstrated inappropriate and unprofessional behavior with the patient and family in the Hospice Palliative Care Unit due to insufficient evidence. Recollections differed regarding the discussion when the alleged behavior occurred. Other documentary or testimonial evidence was not available.

The OIG determined that the facility had processes to provide oversight of physician behavior.

The OIG made no recommendations.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report (see appendixes A and B). No further action is required.



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## Contents

Executive Summary .....	i
Abbreviations .....	iv
Introduction.....	1
Scope and Methodology .....	4
Patient Case Summary .....	6
Inspection Results .....	12
1. Alleged Patient's Incapacity to Consent to DNR.....	12
2. Alleged Failure to Evaluate, Plan, and Coordinate a Patient Discharge .....	19
3. Alleged Inappropriate and Unprofessional Behavior of a Hospitalist .....	23
Conclusion .....	27
Appendix A: VISN Director Memorandum .....	29
Appendix B: Facility Director Memorandum.....	30
OIG Contact and Staff Acknowledgments .....	31
Report Distribution .....	32

## Abbreviations

DNR	do not resuscitate
EHR	electronic health record
HPU	hospice palliative care unit
ICU	intensive care unit
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of allegations regarding a hospitalist's interactions with a patient and family when obtaining consent for do not resuscitate (DNR) status and determining discharge plans at the Veterans Health Care System of the Ozarks (facility), Fayetteville, Arkansas.<sup>3</sup>

## Background

The facility, part of Veteran Integrated Service Network (VISN) 16, operates six community based outpatient clinics. VA classifies the facility as a Level 1c—High Complexity facility.<sup>4</sup> In fiscal year 2018, the facility served 53,268 patients with 72 authorized hospital beds, including 52 inpatient beds and 20 domiciliary beds. Services include primary care, mental health care, specialty care, women's clinic, pharmacy, social work, surgery, and nutrition services.

## DNR Order

A DNR order instructs health care personnel to withhold cardiopulmonary resuscitation in the event of cardiopulmonary arrest. A DNR order is written by the practitioner in charge of the patient's care and must be accompanied by a progress note that minimally includes the patient's diagnosis, prognosis, consensual decision of the treatment team, an assessment of the patient's decision-making capacity, and the patient's wishes.<sup>5</sup>

Facility policy requires that when a patient with decision-making capacity requests DNR status, the patient's physician must discuss this decision with the patient prior to entering the DNR order. The patient will also be advised by the physician to discuss DNR status with family

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<sup>3</sup> The terms do not resuscitate, DNR, DNAR, No-CPR, and No Code are synonymous. The abbreviation DNR will be used in this report. Cardiopulmonary resuscitation (CPR) is artificial respiration and external cardiac massage. Facility Policy 2016-11-074 *Do Not Resuscitate (DNR) Protocol including State Authorized Portable Orders*, June 9, 2016. Decision-making capacity is a clinical judgment about a patient's ability to make a particular type of health care decision at a particular time. VHA Handbook 1004.3, *Do Not Resuscitate (DNR) Protocols within the Department of Veterans Affairs (VA)*, October 24, 2002. This handbook was rescinded and replaced by VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

<sup>4</sup> The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

<sup>5</sup> Facility Policy 2016-11-074. "The treatment team includes the patient's attending physician, chief of the service to which the attending physician belongs, or the Chief of Staff."

members; however, concurrence of family members is not required.<sup>6</sup> Patients who wish to receive cardiopulmonary resuscitation do not need an order and are full code.<sup>7</sup>

## Life-Sustaining Treatment

A life-sustaining treatment is “a medical treatment that is administered in an attempt to prolong the life of a patient who would be expected to die soon without the treatment.”<sup>8</sup> Life-sustaining treatments may include artificial nutrition and hydration, mechanical ventilation, antibiotics, chemotherapy, and dialysis.<sup>9</sup> Veterans Health Administration (VHA) policy states a commitment to supporting and sustaining life with clinical techniques and therapeutic measures. Patients with decision-making capacity have the right to accept or refuse medical treatments or procedures and the right to state their preferences in advance.<sup>10</sup> VHA recognizes that the application of life-sustaining treatments and other therapeutic measures may not cure or reverse the progression of a patient’s disease.<sup>11</sup>

## VHA Life-Sustaining Treatment Decisions Initiative

The Life-Sustaining Treatment Decisions Initiative (initiative) is “a national VHA quality improvement project led by the [VA] National Center for Ethics in Health Care... The aim of the initiative is to promote personalized, proactive, patient-driven care for Veterans with serious illness by eliciting, documenting, and honoring their values, goals, and preferences.” The initiative includes standardized “practices related to discussing and documenting goals of care and life-sustaining treatment decisions” and provides tools, resources, and education “to support

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<sup>6</sup> Facility Policy 2016-11-074.

<sup>7</sup> Merck Manuals. A code is the “summoning of professionals trained in [cardiopulmonary resuscitation] to revive a person in cardiac, respiratory, or cardiopulmonary arrest.”  
<https://www.merckmanuals.com/home/fundamentals/legal-and-ethical-issues/do-not-resuscitate-dnr-orders>. (The website was accessed on April 16, 2019.)

<sup>8</sup> Facility Policy 2016-11-074.

<sup>9</sup> VHA Handbook 1004.03. “Mechanical ventilation is a life support treatment.” American Thoracic Society. A machine called a mechanical ventilator or respirator helps people breath when unable to breath on their own.  
<https://www.thoracic.org/patients/patient-resources/resources/mechanical-ventilation.pdf>. (The website was accessed on April 15, 2019.). Merriam-Webster. Dialysis is “the process of removing blood from an artery (as of a patient affected with kidney failure), purifying it by dialysis, adding vital substances, and returning it to a vein.”  
<https://www.merriam-webster.com/dictionary/dialysis>. (The website was accessed on April 26, 2019.)

<sup>10</sup> VHA Handbook 1004.03. “Decision-making capacity is a clinical judgment about a patient’s ability to make a particular type of health care decision at a particular time.” VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013. This handbook was due for recertification on or before December 31, 2018, and has not been recertified.

<sup>11</sup> VHA Handbook 1004.3, *Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA)*, October 24, 2002. This handbook was rescinded and replaced by VHA Handbook 1004.03.

clinicians and facilities in making practice changes.”<sup>12</sup> VHA issued a new policy on January 11, 2017, that outlined these standardized practices and allowed 18 months for implementation.<sup>13</sup>

## **Allegations and Related Concerns**

On June 14, 2018, the OIG Hotline Division received a complaint alleging multiple failures with the quality of a patient's care. The OIG reviewed the patient's electronic health record (EHR) and sent a request to the facility on July 27, 2018, to evaluate the patient's care and respond to OIG queries.

The OIG reviewed the September 20, 2018, facility response and determined the information provided did not adequately address the following allegations:

1. A DNR order was written for a patient who was without capacity to consent.
2. The facility failed to evaluate, plan, and coordinate the patient's discharge to meet the needs of the patient and family.
3. A hospitalist's behavior with the patient and family in the Hospice Palliative Care Unit (HPU) was inappropriate and unprofessional.<sup>14</sup>

On November 21, 2018, the OIG opened a hotline inspection to further review the complainant's allegations. During the inspection, the OIG team learned of three additional patients for whom staff had expressed concerns with the way the hospitalist presented the patients' prognoses and end-of-life options to the patients and families.<sup>15</sup> Additionally, the OIG reviewed the facility's oversight process regarding physicians' professional behavior.

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<sup>12</sup> VA National Center for Ethics in Health Care, *Life-Sustaining Treatment Decisions Initiative*, <https://www.ethics.va.gov/LST.asp>. (The website was accessed on March 19, 2019.)

<sup>13</sup> VHA Handbook 1004.03.

<sup>14</sup> Facility Policy 2017-111-05, *Palliative Care Program*, June 21, 2017. The HPU is an inpatient setting for persons with advanced life-limiting diseases that provides comfort-oriented and supportive services by an interdisciplinary team.

<sup>15</sup> Since the time of the OIG's onsite visit, the hospitalist left employment at the facility.

## Scope and Methodology

The OIG initiated the inspection on November 21, 2018. A site visit was conducted from January 29 through January 31, 2019, that included a tour of the HPU.

While on-site, OIG team members met with the Facility Director to discuss the scope of the review. Interviews were conducted by telephone and on-site with the complainant, Chief of Staff (formerly Chief of Medicine), Assistant Chief of Medicine, two hospitalists, a palliative care physician, a staff physician specializing in pulmonary and critical care, a primary care provider, a respiratory therapist, nurse managers for the intensive care unit (ICU) and HPU, a licensed clinical social worker, registered nurses from ICU and HPU, speech pathologists, community health nurses responsible for hospice coordination, a medical staff coordinator, and a risk manager.

The OIG team reviewed the EHRs of four patients who were hospitalized between spring 2018, and early 2019. Relevant documents were reviewed including VHA directives and handbooks; facility policies and procedures including medical bylaws; provider credentialing and clinical privileging files; National Practitioner Data Bank information; patient incident reports, and a peer review; external oversight standards; and select literature including the American Medical Association Principles of Medical Ethics.<sup>16</sup>

VHA Handbook 1004.3, and facility Policy 2016-11-074 were used as criteria in this report when reviewing the original patient's care.<sup>17</sup> The care of the additional three patients was reviewed using criteria from VHA Handbook 1004.03 (January 2017).<sup>18</sup>

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue (s).

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<sup>16</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. Credentialing "refers to the systematic process of screening and evaluating qualifications." Clinical privileging is the process by which a licensed independent practitioner is permitted by law and the medical facility to provide medical care services within the scope of the individual's license. This handbook was due for recertification on or before October 31, 2017, and has not been recertified. "The National Practitioner Data Bank (NPDB) is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers." <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp>. The OIG reviewed a provider's patient incident reports and peer review for the time frame September 2017–January 2019.

<sup>17</sup> The care reviewed for the original patient occurred during the 18-month implementation period from the previous VHA Handbook 1004.3 (October 2002) to the new VHA Handbook 1004.03 (January 2017). The facility's DNR Policy 2016-11-074 (June 2016) was also in place at the time and was based on requirements in VHA Handbook 1004.3.

<sup>18</sup>VHA Handbook 1004.03.

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

## Patient Case Summary

In 2018, the patient, who was in their 80s, was transferred to the facility from another VA facility after moving to the area to be cared for by family.<sup>19</sup>

The patient's past medical history was significant for severe chronic obstructive pulmonary disease (emphysema).<sup>20</sup> The patient was previously admitted to the other VA facility in late 2017. During that admission, the patient required mechanical ventilation and a tracheostomy.<sup>21</sup> The patient received nutrition through a feeding tube into the stomach (percutaneous endoscopy gastrostomy tube). The patient continued stomach-tube feedings and mechanical ventilation at home. The patient had multiple other chronic medical conditions including hearing loss.

On a day in early 2018 (day 1), the patient was seen for the first time as an outpatient at the facility by a primary care provider who ordered home health care, physical therapy, and occupational therapy for the patient's debility. A dietitian also evaluated the patient's nutritional status and noted the feeding tube needed to be replaced. The primary care provider placed a speech consult to assess the patient's swallowing ability to ensure the patient was able to get adequate hydration and nutrition.

Also on day 1, a lung specialist (pulmonologist) assessed the patient for management of respiratory issues, chronic respiratory failure, and home ventilator management. The pulmonologist discussed the diagnoses and care plan with the patient and family as well as the need for hospital admission to accomplish the patient's expressed desire to be off the ventilator. The patient and family agreed with the plan however declined admission at that time.

Approximately one week later (day 6), the patient was electively admitted to the facility to evaluate if the patient could breathe off the ventilator. The pulmonologist recommended

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<sup>19</sup> The OIG uses the singular form of they (their) in this instance for patient privacy purposes.

<sup>20</sup> Mayo Clinic. Chronic obstructive pulmonary disease is a lung disease that causes chronic inflammation, which blocks airflow from the lungs. Most often the disease is caused from smoking cigarettes. <https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679>. (The website was accessed on April 15, 2019.) Emphysema is a condition in which the air sacs at the end of the smallest passages of the lung are destroyed. <https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679>. (The website was accessed on April 15, 2019.)

<sup>21</sup> Mayo Clinic. Tracheostomy is a hole created in the front of a person's neck at the windpipe, that provides an air passage to help one breath when the usual route is obstructed or damaged. A tracheostomy is often needed when a person requires long term mechanical ventilation. <https://www.mayoclinic.org/tests-procedures/tracheostomy/about/pac-20384673>. (The website was accessed on April 15, 2019.)

continued tracheostomy and oxygen use at night off the ventilator. During this admission, the social worker noted the patient did not want to address an advanced directive.<sup>22</sup>

The speech pathologist saw the patient on day 7 and noted the patient could continue oral intake. The feeding tube was removed the following day and the patient was discharged home (day 8).

On day 13, the patient presented to the facility Emergency Department following two to three days of fluid retention and shortness of breath. The family reported that the patient had not been able to be off the ventilator at night. The patient received treatment for emphysema and fluid retention and returned home.

On day 24, the patient presented to the facility's Emergency Department to have the tracheostomy evaluated because of pain and bleeding during tracheostomy care and was discharged home after the evaluation. Three days later, a facility pulmonologist spoke with the family after the patient went to a non-VA Emergency Department for similar complaints. The family reported increased secretions. The pulmonologist ordered additional medications and discussed possible further evaluation of the patient's airway including an ear, nose, and throat consultation or bronchoscopy (a procedure to look inside the airway with a long tube with a light and camera at one end).

The family spoke with the pulmonologist on day 34, regarding the patient's ongoing breathing difficulties. The pulmonologist scheduled an outpatient tracheostomy tube change and a bronchoscopy for the following day to further evaluate the tracheostomy. The pulmonologist noted the patient had decision-making capacity and was not "DNR." The pulmonologist changed the tracheostomy tube and noted improved airflow; therefore, decided not to do the bronchoscopy and recommended the patient remain on the ventilator at night.

On day 40, the patient presented to the facility Emergency Department for evaluation of wheezing, fast heartrate, and high blood pressure. After receiving treatment, admission was recommended by the medical staff and the patient declined. The following day, one of the patient's family members contacted the primary care clinic regarding questions about a new medication from the Emergency Department visit. Medication counseling was provided by the primary care clinic nurse, and the primary care provider ordered a palliative care consult.

On day 57, the patient was admitted to a non-VA hospital for worsening shortness of breath. The physician documented the patient had suspected pneumonia, sepsis, low blood pressure,

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<sup>22</sup> VHA Handbook 1004.02. "An advance directive is a written statement by a person who has decision-making capacity...about future health care decisions in the event [the person is no longer able] to make those decisions." A DNR order "or other life-sustaining treatment orders are not considered advance directives" (underlined emphasis is in the original text).

respiratory failure, and heart failure.<sup>23</sup> The physician documented that the patient wished to be full code at the time but stated “might change my mind in the future.” The records noted the patient was intermittently encephalopathic and received a medication that causes sedation (medication A) for delirium.<sup>24</sup> On day 62, the family requested transfer to the facility because they were unhappy with the care provided at the non-VA hospital. On the morning of day 63, the patient received 1 mg of medication A for delirium.

In the afternoon of day 63, the hospitalist accepted the patient for transfer to the facility ICU to treat pneumonia and ventilatory failure.<sup>25</sup> EHR documentation at the facility shows the patient was initially assessed mid-afternoon by the hospitalist. The transfer record noted the patient did not have an advance directive.

The hospitalist documented the patient was “awake, responsive appropriately knods [*sic*] head yes and no,” oriented, understood the issues of advance directives. Per the hospitalist, the patient “nodded yes” when asked about allowing facility staff to let the patient die in peace if the patient’s heart stopped. The hospitalist also documented discussing this decision with the Assistant Chief of Medicine, who concurred. Multiple consults were ordered the day of admission including pulmonary, speech pathology, social work, and wound and skin care.

A few hours later on day 63, an ICU registered nurse documented the patient was alert, oriented, calm, cooperative, and had decreased hearing but was not wearing hearing aids. The ICU registered nurse noted the patient did not have or wish to create an advance directive and identified barriers to the patient’s learning as hearing deficit and poor memory. A second hospitalist ordered 5 mg of medication A by injection every six hours as needed, as well as 2 mg tablet of medication A every two hours as needed, both indications were for agitation or

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<sup>23</sup> Merriam-Webster Medical Dictionary. Sepsis is a systematic response to a localized infection, especially of bacterial origin leading to fever, high white blood cell count and rapid heart rate and breathing. <https://www.merriam-webster.com/dictionary/sepsis#medicalDictionary>. (The website was accessed on April 15, 2019.)

<sup>24</sup> National Institute of Neurological Disorders and Stroke. “Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure...[t]he hallmark of encephalopathy is an altered mental state.” <https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page>. (The website was accessed on April 16, 2019.) Delirium is a mental disturbance characterized by confusion, disordered speech, and hallucinations. *Merriam-Webster Medical Dictionary*. <https://www.merriamwebster.com/dictionary/delirium#medicalDictionary>. (The website was accessed on April 16, 2019.)

<sup>25</sup> Ventilatory failure results when the respiratory system does not function normally to oxygenate blood and eliminate carbon dioxide from the body. B. Chakrabarti, PMA Calverley, “Management of acute ventilatory failure,” *Postgrad Med J.* (July 2006): 82(969):438-45. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563765/>. (The website was accessed on April 15, 2019.)

delirium. The patient received a 2 mg tablet of medication A on the evening of day 63 and a 5 mg injection on day 64 mid-afternoon; both doses were for agitation.

The pulmonologist assessed the patient in the morning on day 64 noting confusion likely due to a combination of causes including infection, respiratory issues, the ICU environment, and drugs; a concern for aspiration was noted.<sup>26</sup> The pulmonologist's recommendations included continuing antibiotics, night-time ventilator support, and nutritional and speech therapy evaluation.

Approximately one and a half hours after the pulmonologist's assessment, the speech pathologist documented that the patient was not alert enough to be evaluated. The speech pathologist recommended changes in the consistency of liquids for safety, and further evaluation when the patient was more stable and alert. The speech pathologist also noted a nasogastric tube could be considered to ensure adequate hydration and nutrition, but it was not to replace oral intake.<sup>27</sup>

The palliative care physician also assessed the patient on day 64, noting the patient was sleepy, nodding head yes or no and with variable decision-making capacity due to delirium. The order for DNR was noted along with the goals of care to discharge the patient home and continue in-home physical therapy to gain strength. The palliative care physician noted a poor prognosis but that the patient had survived longer than expected.

The social worker who saw the patient and family on day 64, documented the patient was sleepy and unable to participate in an advance directive discussion but was DNR according to the EHR palliative care note.

On day 64, the hospitalist ordered a medication used to treat delirium that has a potential to cause sedation (medication B) 0.25 mg by mouth twice a day and 0.5 mg at bedtime. The patient received one dose of medication B in the early evening of day 64 and two doses on day 65.

During discharge planning rounds on day 65, an ICU registered nurse documented the estimated discharge date would be day 68. The hospitalist documented that the patient was awake, alert but not responsive, and decreased the dose of medication B to twice a day for subacute delirium. The hospitalist noted that the family was amenable to home-hospice care and arranged a transfer to HPU on day 65. The pulmonologist also saw the patient, noting the patient's confusion and that medication adjustments were being made by the hospitalist. The palliative care physician documented that the patient's discharge planning was to be addressed by the assigned social

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<sup>26</sup> Cedar Sinai. Aspiration is when an object enters the "airway or lungs by accident. It may be food, liquid, or some other material." <https://www.cedars-sinai.org/health-library/diseases-and-conditions/a/aspiration-from-dysphagia.html>. (The website was accessed on April 26, 2019.)

<sup>27</sup> National Institute of Health. A nasogastric tube is a small feeding tube placed through the nose into the stomach to provide nutrition into the digestive system. This allows patients to receive supplemental nutrition or delivery of part or all daily requirements. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/enteral-nutrition>. (The website was accessed on August 1, 2019.)

worker. A speech pathologist re-evaluated the patient and recommended the aspiration precautions remain in place.<sup>28</sup>

One of the patient's family members expressed concern to an HPU registered nurse that medication A was increasing the patient's confusion and impairing the patient's ability to swallow. The HPU registered nurse documented crushing the patient's medications and giving the medications with pudding. The HPU registered nurse noted the patient had coughed pudding out of the tracheostomy.

On day 66, the hospitalist documented that the patient's family members were upset that the patient was aspirating food and medicines again. Although the family members believed medication A was causing the aspiration, the hospitalist opined to the family that it was not the medicine but part of "Imminent Death Syndrome."<sup>29</sup> The hospitalist noted thinking the family understood the discussion but did not appear to be "accepting of the inevitable." The hospitalist documented that home hospice would take away the home ventilator and that the family did not want this. Although noting the patient was weak, the hospitalist believed the patient had decision-making capacity and agreed for the hospitalist "to keep [the patient] comfortable and ...die in peace" by nodding yes. Family members were present for this discussion and asked the patient about dying at home rather than in the facility; the patient again nodded yes. Discharge orders were written by the hospitalist.

The patient left the facility in the early afternoon of day 66. A family member called the HPU about four hours later and asked a registered nurse if HPU staff could issue the patient a nasogastric tube. The HPU registered nurse informed the family the "request will need to be forwarded [*sic*] to [the] doctor." The family member declined.

On the day after discharge (day 67), the Administrative Officer of the Day received a call from a local hospice organization stating the patient's family was requesting home hospice. The Administrative Officer of the Day notified a social worker of this request. The hospitalist on duty was contacted and agreed to order a home-hospice consult. The social worker was also contacted by one of the patient's family members, who requested a nasogastric tube for the patient. The social worker forwarded the call to HPU. The family spoke with the HPU registered nurse and restated the patient's need for a nasogastric tube and that the family was "watching [the patient] starve to death."

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<sup>28</sup> State of Connecticut, Department of Developmental Services. Aspiration precautions are interventions to reduce the risk of food, liquids, and/or secretions entering a person's lungs during the swallowing process. <https://portal.ct.gov/-/media/DDS/Health/AttachHAspirationandRefluxPrecautions.pdf?la=en>. (The website was accessed on April 25, 2019.)

<sup>29</sup> Palliative Care Dictionary. Imminent Death Syndrome is when a patient goes "through a stereotypical pattern of symptoms and signs in the days prior to death. This trajectory is often referred to as 'actively dying' or 'imminent death.'" <https://pallipedia.org/syndrome-of-imminent-death/>. (The website was accessed on April 16, 2019.)

On day 68, the palliative care physician spoke with the patient's family members. The physician was told they were distressed following the discussion with the hospitalist regarding Imminent Death Syndrome and that the patient was upset. A nasogastric tube was requested, and the palliative care physician agreed to have it available for the family.

The Assistant Chief of Medicine also spoke with one of the patient's family members on day 68, and offered a nasogastric tube placement in the facility's Emergency Department; however, an ambulance took the patient to a non-VA hospital where the nasogastric tube was placed. The patient died at home on day 69, with home-hospice services.

## Inspection Results

### 1. Alleged Patient's Incapacity to Consent to DNR

The OIG was unable to determine whether the patient had decision-making capacity to consent to a DNR status at the time the hospitalist discussed life-sustaining treatment with the patient. The hospitalist acted in accordance with VHA policy when determining and documenting that the patient had decision-making capacity at the time of consenting to DNR status. However, documentation reviewed indicated intermittent confusion and administration of medications that may have altered the patient's mental status at times throughout the admission.

#### Capacity to Provide Informed Consent

VHA requires that a patient's decision-making capacity be determined by the practitioner prior to obtaining informed consent for clinical treatments, including a decision for DNR status.<sup>30</sup> The facility's policy states, for patients who are alert and understand the implications of illness and the DNR order, that a discussion with family is advised, but not required.<sup>31</sup>

The allegation included concerns that the patient was not cognitive enough and lacked decision-making capacity to consent to DNR status. The family stated they were not aware of the status, the patient's cognition was impacted by medication A that was administered prior to the DNR discussion, and the hospitalist acted unilaterally to write a DNR order. Documentation in the EHR indicated that the hospitalist determined the patient had decision-making capacity at the time of admission, the patient wished to be DNR, and the hospitalist had a discussion with the Assistant Chief of Medicine who concurred with the DNR status.

To assess the potential impact of medication on the patient's decision-making capacity at the time of admission, the OIG team reviewed medication administration records from both the non-VA hospital and the facility, focusing on medications that may contribute to altered mental status.<sup>32</sup> The patient received three doses of medication A for delirium over four days at the non-VA hospital. The medication administration records indicate the patient received the last dose of medication A at the non-VA hospital approximately five and a half hours prior to admission to the facility and the hospitalist's assessment of the patient's decision-making capacity. During an interview, the hospitalist stated that the patient could answer questions

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<sup>30</sup> VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, revised September 20, 2017, was in effect at the time of the events discussed in this report related to the original patient. On April 4, 2019, VHA Handbook 1004.01 was amended and re-issued as VHA Handbook 1004.01(2), *Informed Consent for Clinical Treatments and Procedure*; VHA Handbook 1004.03.

<sup>31</sup> Facility Policy 2016-11-074.

<sup>32</sup> The patient was admitted to a non-VA hospital six days prior to transferring to the facility.

appropriately, and the medications the patient received prior to arrival did not alter decision-making capacity. The OIG team determined that the amount of medication A given to the patient prior to admission to the facility would not be expected to cause delirium; however, other medication side effects including drowsiness or central nervous system depression may have impaired the patient's mental abilities. The first order for medication A on day 60, states "Reason for Medication: Delirium" indicating that symptoms of delirium preceded the medication. The medication is used to treat agitation and/or delirium. The patient received three additional doses during admission to the facility. The amount of medication A administered to this patient would not be expected to cause confusion. The OIG team's consensus was the delirium was most likely linked to the patient's medical condition, not caused by the medication.

To gain an understanding of the patient's mentation and decision-making capacity, OIG team members reviewed EHR documentation throughout the patient's facility admission. On the day after admission (day 64), decision-making capacity was documented by the palliative care physician as variable due to delirium and a surrogate was named.<sup>33</sup> The palliative care physician also documented the patient's poor prognosis, and the availability of home hospice was discussed and declined by the surrogate. Two days after admission (day 65), the patient's mental status was documented by the physical therapist as more responsive and able to participate with therapy; the palliative care physician noted the patient was still confused, sleepy but arousable, and responding appropriately to simple questions.

The DNR order did not impact the clinical outcome for this patient because the need for resuscitation for cardiopulmonary arrest did not occur during the inpatient stay. Lacking sufficient evidence of the patient's decision-making capacity at the time of admission and in conjunction with the medication review, EHR documentation, and interviews, the OIG team was unable to determine whether the patient had decision-making capacity at the time of DNR consent.

## **Other Patient Cases of Concern**

During the inspection, the OIG team received the names of three additional patients from staff who had concerns with the way the hospitalist presented the prognosis and end-of-life options to patients and families. Specifically, staff reported that the hospitalist was very direct when providing current medical status and told, rather than asked, patients about their DNR status.

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<sup>33</sup> VHA Handbook 1004.01; VHA Handbook 1004.01(2). A surrogate is defined as a decision maker authorized to make healthcare decisions for patients who lack the capacity to make decisions for self.

VHA policy, in place at the time of each case, required a DNR order be written by a physician or licensed independent practitioner and the practitioner in charge of the patient's care has a discussion with the patient prior to entering a DNR order.<sup>34</sup>

The American Medical Association provides ethics guidance for physicians regarding caring for patients at end-of-life. When discussing medically ineffective interventions, it is noted, there will be times when the care the patient wishes to receive may be judged as medically inappropriate by the physician. These situations challenge physicians to balance their obligation "to respect patient autonomy and not abandon the patient" with their obligation to be caring, yet honest about their medical opinions.

Physicians are advised to

...only recommend and provide interventions that are medically appropriate—i.e., scientifically grounded—and that reflect the physician's considered medical judgment about the risks and likely benefits of available options in light of the patient's goals for care. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care.<sup>35</sup>

To better understand the concerns shared by staff and determine if the patients' needs were met, the OIG team reviewed the patients' EHRs and interviewed staff who expressed concerns with or were aware of the patients' care.

### *Patient A*

This patient, who was in their mid-60s with a history of inoperable non-small cell right lung cancer, was unable to tolerate chemotherapy. After being admitted to the facility in fall 2018, with a combination of metastatic lung cancer, necrotizing pneumonia, and atelectasis, the patient was started on antibiotics.<sup>36</sup> During the admission, the patient initially improved but was then transferred to the ICU and developed progressive respiratory failure. A computerized

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<sup>34</sup> VHA Handbook 1004.3.

<sup>35</sup> American Medical Association. Code of Medical Ethics Opinions: Chapter 5. February 14, 2019.

<sup>36</sup> Merriam-Webster Medical Dictionary. Metastasis is the spread of a disease-producing agency (such as cancer cells) from the initial or primary site of disease to another part of the body. <https://www.merriam-webster.com/dictionary/metastatic>. (The website was accessed on April 15, 2019.) YF Tsai, YH Ku, "Necrotizing pneumonia: a rare complication of pneumonia requiring special consideration," *Current Opinions in Pulmonary Medicine*. Necrotizing pneumonia is a complication of pneumonia resulting in areas of lung tissue being filled with liquid instead or death of the lung tissue. (May 2012): 18 (3) 246–52. <https://www.ncbi.nlm.nih.gov/pubmed/22388585>. (The website was accessed on April 15, 2019.) Merriam-Webster Medical Dictionary. Atelectasis is the collapse of the expanded lung. <https://www.merriam-webster.com/dictionary/atelectasis#medicalDictionary>. (The website was accessed on April 15, 2019.)

tomography scan of the chest was ordered and showed near complete right lung collapse and right mainstem bronchus blockage with right lung empyema.<sup>37</sup>

The patient was tired, but alert and oriented at the time that the hospitalist, accompanied by a medical resident, explained the severity and terminal nature of the patient's condition (the patient had not tolerated chemotherapy and was not a surgical candidate). The hospitalist noted that the patient seemed surprised to learn that death would occur "in the next day, weeks or months at most." The hospitalist recommended a change in resuscitation status to DNR and move toward palliative care and home hospice.

The hospitalist documented the following in the EHR:

I told [the patient] that [cardiopulmonary resuscitation] would be of 'no help' since when [the patient] died of cancer [cardiopulmonary resuscitation] could only bring [the patient] back to die again. I told [the patient] I would write 'DNR order' unless [the patient] objected. [The patient] did not object...[family members] arrived near end of discussion and I repeated the above to them. I wrote DNR/DNI orders.

Later that day, nursing staff notified the Assistant Chief of Medicine that the patient and family was not in agreement with the DNR/DNI order and would like a change in code status to full code. The hospitalist was off-shift. The Assistant Chief of Medicine, along with three other specialists, met with the patient and family and outlined the current medical condition and poor prognosis, after which the patient and family chose to have the DNR order reversed. The Assistant Chief of Medicine documented that the four physicians were "all quite blunt" with the family and

gave a similar prognosis that [the hospitalist] had earlier. The pt [*sic*]/family was clearly wanting to be allowed the possibility of ventilation and even recussitation [*sic*]. Given the objection that they are now voicing (where they did not object earlier), I have canceled the DNR for now. Pt [*sic*] and family have been very slow to accept/comprehend the terminal nature of his condition. They want some more time to consider options and let this soak in.

At the hospitalist's request, the hospitalist was recused from the patient's care upon returning to work and learning of the reversal in the patient's DNR status. In an interview with the OIG, the

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<sup>37</sup> University of Rochester Medical Center. When breathing, "[a]ir enters the body through [the] nose or mouth[;] [a]ir then travels down the throat through the larynx and trachea[; and then] [a]ir goes into the lungs through tubes called main stem bronchi. One main-stem bronchus leads to the right lung and one to the left lung." <https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=85&ContentID=P01300>. (The website was accessed on April 15, 2019.) Merriam-Webster Medical Dictionary. Empyema is the presence of pus in a bodily cavity. <https://www.merriam-webster.com/dictionary/empyema>. (The website was accessed on April 15, 2019.)

hospitalist explained that ethics guidance from the American Medical Association states a physician is not required to provide care that the physician believes to be medically ineffective. The hospitalist added that as a trustee of the patient's care, the physician does what is best for the patient. The patient remained in the ICU for eight more days and was intubated and coded twice before dying.

### *Patient B*

The patient was in their mid-90s with a history of cardiomyopathy, chronic congestive heart failure, and aortic calcification.<sup>38</sup> The patient was admitted with shortness of breath (dyspnea) and pneumonia; a chest x-ray indicated bilateral pleural effusions with overlying atelectasis.<sup>39</sup> The admission note, written by a nurse practitioner, stated the patient wanted a full code status but not sustained life-saving measures. Two days later, a physician wrote within the text of an EHR note that the patient wanted to be full code. On hospital day 3, the patient had a syncopal episode and was transferred to the ICU.<sup>40</sup> The hospitalist had a discussion with the patient regarding resuscitation status and recommended palliative care, and DNR secondary to the congestive heart failure being not responsive to treatment. In doing so, the hospitalist acted in alignment with the facility policy in effect at the time that includes patients with end stage irreversible cardiopulmonary disease to be considered for DNR.<sup>41</sup> The hospitalist documented the DNR decision as follows:

Discussion of Advance Directives and patient's wishes was undertaken.

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<sup>38</sup> Merriam-Webster Medical Dictionary, *Cardiomyopathy*. Cardiomyopathy is any of several structural or functional diseases of heart muscle marked especially by enlargement and obstructive damage to the heart.

<https://www.merriam-webster.com/dictionary/cardiomyopathy>. (The website was accessed on April 15, 2019.)

"Mayo Clinic. Ejection fraction is a measurement of the percentage of blood leaving your heart each time it contracts." <https://www.mayoclinic.org/ejection-fraction/expert-answers/faq-20058286>. (The website was accessed on April 15, 2019.) Mayo Clinic. Congestive heart failure occurs when the heart muscle is too weak or too stiff to fill and pump blood efficiently. <https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142>. (The website was accessed on April 15, 2019.) Mayo Clinic. "Aortic valve calcification is a condition in which calcium deposits form on the aortic valve in the heart. These deposits can cause narrowing at the opening of the aortic valve...[and] can become severe enough to reduce blood flow through the aortic valve."

<https://www.mayoclinic.org/diseases-conditions/aortic-stenosis/expert-answers/aortic-valve-calcification/faq-20058525>. (The website was accessed on April 15, 2019.)

<sup>39</sup> Cleveland Clinic. "Pleural effusion, sometimes referred to as "water on the lungs," is the build-up of excess fluid between the layers of the pleura outside the lungs. The pleura are thin membranes that line the lungs and the inside of the chest cavity and act to lubricate and facilitate breathing."

<https://my.clevelandclinic.org/health/diseases/17373-pleural-effusion-causes-signs--treatment>. (The website was accessed on April 15, 2019.)

<sup>40</sup> American Heart Association. "Syncope is a temporary loss of consciousness usually related to insufficient blood flow to the brain." <https://www.heart.org/en/health-topics/arrhythmia/symptoms-diagnosis--monitoring-of-arrhythmia/syncope-fainting>. (The website was accessed on April 15, 2019.)

<sup>41</sup> Facility Policy 2016-11-074.

Diagnosis: Ischemic Cardiomyopathy, Chronic [congestive heart failure]recalcitrant to treamen [*sic*]

Prognosis: poor

Patient is oriented and understands the issues of Advance Directives.

The hospitalist also documented addressing the patient's cardiac status and recommending that the patient die in peace without machines or staff initiating chest compressions (DNR). When asked if this was consistent with the patient's wishes, the patient agreed.

Later that day, the palliative care practitioner conducted the initial palliative care consult, and the patient asked about having an internal cardiac defibrillator (an implantable device that monitors for rapid or chaotic heart beats and delivers a shock to restore heart rhythm to normal). The EHR showed that the palliative care practitioner explained that the patient was not an internal cardiac defibrillator candidate and included a concern that resuscitation would do more harm than good. However, the patient asked to "give it one shot," and the DNR order was rescinded.

Shortly after the rescission, the hospitalist documented disagreement with this decision and requested to be taken off the case due to ethical concerns. The palliative care practitioner spoke with a family member who reported being unsure of the patient's wishes and requested a goals of care meeting with the family member and patient. The palliative care provider agreed and suggested including other family members. The meeting was held the following day. The patient expressed a desire to get stronger and possibly go home but to not attempt resuscitation in the event of cardiopulmonary arrest. A DNR order was placed. Two weeks later the patient was discharged home with home hospice. The patient died at home approximately three weeks after discharge.

### *Patient C*

The patient was in their early 60s with a history of high blood pressure, morbid obesity, chronic respiratory failure, and obstructive sleep apnea (a decrease or stop in breathing during sleep). For the apnea, the patient was given a bilevel positive airway pressure ventilator (a noninvasive device that helps breathing) and oxygen at night. However, the patient was non-compliant with using the ventilator. The patient was positive for Influenza A and admitted to the observation unit.

The hospitalist's history and physical progress note indicated that the patient was not very talkative and did not answer questions unless asked several times. The hospitalist had a discussion with the patient about values, goals, and preferences. Documentation by the hospitalist included the patient's understanding of health issues that were chronic and wanting to have everything done to help but also agreeing to not having cardiopulmonary resuscitation in event of a cardiopulmonary arrest. A DNR order was placed. This order was automatically

discontinued when the patient transferred to another level of care, the ICU.<sup>42</sup> The night hospitalist covering the ICU documented that the patient wished to be DNR and wrote a DNR order in the early morning of the transfer. Later that morning, the patient refused the use of the ventilator, triggering a conversation with the day hospitalist about hypoxia, cardiac status, and code status. The day hospitalist documented that the patient decided to change the DNR to full code. The patient remained in the facility for another week with the full code status. As of late 2019, the patient continued to receive care at the facility.

## Summary

In late 2018, six weeks after Patient A's death and 11 days after Patient B's death, the facility held a medical education session during which time Patient A's case was presented to help physicians understand medical futility, discuss the ethical obligations of physicians, and recognize the patient's and family's perspectives.<sup>43</sup> The hospitalist was invited and attended the conference.

The OIG determined that the hospitalist held a strong belief based upon the ethical principles of beneficence and nonmaleficence to not provide cardiopulmonary resuscitation to patients who were terminal and had grim prognoses.<sup>44</sup> The hospitalist's documentation of the conversations held with these patients appears to be one of stark honesty regarding the current medical picture, the implication that cardiopulmonary resuscitation would not allow the patient to die in peace, and the futility of resuscitation measures. When interviewed by the OIG, the hospitalist clearly indicated no longer wishing to provide care that was medically ineffective, having done so in a past critical care practice. Such treatment conflicted with the hospitalist's ethical beliefs. Rather, the hospitalist would transfer patients to other physicians for care when necessary, which occurred in two of the three reviewed patients.

It was evident to the OIG team that the facility acted promptly to address patients' and families' requests to revisit their end-of-life decisions. In each case, the patient and family had a collaborative discussion about the patient's medical status and end-of-life wishes with physicians other than the hospitalist within 24 hours of the initial DNR discussion and order. The hospitalist

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<sup>42</sup> *VA Computerized Patient Record System (CPRS) V.1.0 Technical Manual*, November 2018. Auto-discontinuation of orders is an electronic process that involves the automatic discontinuation (cancellation) of orders for a patient once that patient is transferred from one location to another or from one level of care to another.

<sup>43</sup> University of Washington School of Medicine. "Medical futility refers to interventions that are unlikely to produce any significant benefit for the patient." Quantitative futility is "where the likelihood that an intervention will benefit the patient is exceedingly poor." <https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/medical-futility>. (The website was accessed on August 1, 2019.)

<sup>44</sup> FS, Kinsinger. "Beneficence and the professional's moral imperative." *Journal of Chiropractic Humanities*, (December 2009): 16(1);44–46. Beneficence is "an act of charity, mercy, and kindness with a strong connotation of doing good to others including moral obligation." Nonmaleficence is "the active avoidance of any act that would cause harm."

was able to be recused as the attending physician when ethical concerns with the patient's or family's decision to designate the patient as full code status arose. The OIG determined that the lack of a collaborative discussion with family involvement to include patients' preferences and quality of life, likely led to the requests for a reversal of the DNR orders. If the hospitalist had addressed these elements during the DNR discussion, facility staff may not have had concerns with the way the hospitalist presented the prognosis and end-of-life options to the patients and family members.

## **2. Alleged Failure to Evaluate, Plan, and Coordinate a Patient Discharge**

The OIG did not substantiate that the facility failed to evaluate, plan, and coordinate a patient discharge to meet the needs of the patient and family.

The allegation included complaints that the patient's discharge was rushed, without proper planning to address how the patient would receive medication, nutrition, and fluids at home. Specifically, concerns were shared related to the change in the estimated discharge date, the abrupt nature of the discharge, and the hospitalist's failure to place a nasogastric tube as the family requested prior to discharging the patient. In review of the facility response, the OIG remained concerned that facility staff had not provided the family with adequate information regarding whether home-hospice services could be provided to the ventilator-dependent patient.

The facility's discharge planning policy states "the [p]rovider determines when discharge is indicated, what aftercare is needed and the type of follow-up required."<sup>45</sup> The discharge plan is developed with the patient, family, and other treatment team members.<sup>46</sup>

### **Decision to Discharge**

The OIG team conducted interviews and reviewed the EHR to assess the patient's discharge process.

During the review of the patient's four-day admission (day 63–66), EHR documentation showed that, on the second day of admission, the facility staff started to evaluate the patient's discharge needs, which included consults with speech pathology, social work, and palliative care. The family stated that on the third day of admission, while the patient was in the ICU, the family and the hospitalist met, and the family asked why the patient could not go home "now." The family wanted to stop the delirium medication so the patient's mind would clear. The family reported that the hospitalist believed the patient's delirium would take one to two days to clear and

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<sup>45</sup> Facility Policy 2015-122-01, *Discharge Planning*, June 2, 2015.

<sup>46</sup> The treatment team includes a social worker, registered nurse, attending physician and clinical dietitian; other clinicians may also be included to address patient needs.

recommended transferring the patient to the HPU before a discharge home. The hospitalist adjusted one of the patient's delirium medications, and the patient was transferred to the HPU. The anticipated date of discharge was set for the sixth day after admission.

The following morning, the fourth day after admission, the hospitalist assessed the patient in HPU and documented in the EHR that the patient was able to make decisions. As noted above, with the family present, the hospitalist asked the patient about dying preferences (to be kept comfortable and whether to die in the hospital or at home). The patient nodded agreement to being kept comfortable and dying at home. The hospitalist then wrote discharge orders and arranged for transportation. Interviews with staff conveyed that although earlier than the anticipated discharge date, the patient did not have long to live, and by arranging early discharge, they were honoring the patient's wishes to die at home.

### **Home Medication, Nutrition, and Fluids**

EHR documentation supported that evaluation and planning occurred to address how the patient would receive medication, nutrition, and fluids at home.

Prior to this admission, the patient was identified as being at risk for aspiration. The speech pathology service was consulted on the day of admission. On the second day of admission, a speech pathologist attempted to assess the patient but noted the patient was not alert enough to complete a swallow evaluation and recommended continuing the puree diet, starting nectar thick liquids, and allowing ice chips.

On the third day of admission, a speech pathologist evaluated and documented the patient's swallowing ability, and stated that an ICU registered nurse reported a discussion with the patient about previously having a nasogastric tube and not wanting another. The speech pathologist documented placing a Passy-Muir valve over the tracheostomy to decrease the risk of aspiration.<sup>47</sup> The patient was able to swallow liquid medication without coughing, with one-to-one assistance and at a slow rate, allowing time to rest between each trial. Both the ICU registered nurse and family told the speech pathologist that at times the patient did okay on the current diet, with assistance and aspiration precautions in place; however, at times there was coughing.<sup>48</sup> Documentation included a discussion with the family and patient regarding the continued risk for aspiration, and the negative impact on the patient's swallowing ability if the

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<sup>47</sup> Johns Hopkins. A Passy-Muir Valve is a one-way valve that "attaches to the outside opening of the tracheostomy tube and allows air to pass into the tracheostomy." It is "commonly used to help patients speak more normally" and may reduce risk of aspiration. [https://www.hopkinsmedicine.org/tracheostomy/living/passey-muir\\_valve.html](https://www.hopkinsmedicine.org/tracheostomy/living/passey-muir_valve.html). (The website was accessed on April 26, 2019.) Passy-Muir website. [https://www.passy-muir.com/valves\\_page/](https://www.passy-muir.com/valves_page/). (The website was accessed on April 14, 2019).

<sup>48</sup> Aspiration precautions specific to the patient during oral intake included: "ensure adequate alertness, place [Passy-Muir valve] as tolerated, sit completely upright, slow rate, small [size bites], assist with self-feeding as able, discontinue with increased work of breathing or cough or decreased alertness, and oral care after meals."

patient wished to continue the pureed diet after having a nasogastric tube placed. The family and speech pathologist agreed to continue the current diet modifications and precautions with the addition of holding oral intake if the patient was not alert or could not tolerate the Passy-Muir valve. The facility dietitian also assessed the patient and noted the diet remained pureed, with nectar thick liquids.

Later that evening, an HPU registered nurse documented that the family was concerned about the patient's ability to swallow after receiving medication in pudding and then coughing pudding out of the tracheostomy. The nurse noted that "provider notified of concern...and will evaluate." The HPU registered nurse did not state which provider was notified, and there was no evidence of an evaluation that evening. Overnight, the patient was able to swallow medication but coughed when taking liquids. In the morning, the patient needed suctioning through the tracheostomy after taking oral medication.

According to the family, when they arrived at the HPU the morning the patient was discharged (the fourth day after admission), they witnessed the patient aspirating and were concerned that the tracheostomy suction cannister was filled with pudding and medication. The family verbalized concerns to the HPU registered nurse. The hospitalist addressed the family concerns later that morning. The EHR note stated that the family was upset and believed the patient's aspiration was caused by medication. The hospitalist informed the family that aspirating was part of the patient's dying process which could take weeks to months; while the family understood the discussion, they were not accepting of the patient's inevitable death. Honoring the patient's decision to die at home, the hospitalist entered discharge orders and instructions that included dietary restrictions as tolerated, "patient is aspirating." The nursing discharge note included that the speech pathologist's plan for managing difficulty with swallowing and aspiration precautions remained unchanged and included education.

The family reported requesting a nasogastric tube be placed prior to the patient going home, but the patient was discharged without the tube. The OIG team could not corroborate that this request occurred. EHR documentation indicated the family's first request for a nasogastric tube was less than four hours after discharge when they called the facility and spoke with an HPU registered nurse. The nurse offered to contact a hospitalist to make the request for the nasogastric tube; however, the family declined. EHR documentation noted the family contacted the facility the following day requesting a nasogastric tube for placement. A facility social worker and the HPU registered nurse both spoke with family members but were unable to assist in obtaining a nasogastric tube. The palliative care physician stated during an interview that placing a nasogastric tube at home is not usual and that an x-ray to check nasogastric tube placement is the normal procedure.

Two days after discharge the EHR noted the family received follow-up calls from both the palliative care physician and Assistant Chief of Medicine. The palliative care physician

documented that the patient had been admitted to home hospice the day after discharge and that the family reported that hospice staff had attempted to locate a nasogastric tube without success. The Assistant Chief of Medicine recommended the family bring the patient to the facility's Emergency Department for placement of the nasogastric tube. The family called 911 and asked that the patient be transported to the facility; however, the patient was transported to a non-VA hospital where a nasogastric tube was placed.

## Home-Hospice Services

The OIG determined that the hospitalist did not provide the patient and family with adequate information to make an informed decision regarding home-hospice services prior to discharge. However, home-hospice services with mechanical ventilation were subsequently provided to the patient.

During the review, the OIG team learned that being a ventilator-dependent patient may disqualify a patient from home hospice. On the HPU, a Palliative Care Consult Team is involved in patient care management and the coordination of discharges, including home-hospice consults.<sup>49</sup> When a home-hospice consult is placed, the hospice coordinator reviews the patient's EHR and makes a referral to the home-hospice agency. The patient care needs are discussed, and the hospice agency determines if care for the ventilator-dependent patient can be provided.

The day before the patient was discharged, the hospitalist documented that the family was "amenable" to hospice care at home and planned to place a consult for home hospice; but also noted that the patient may not qualify for home hospice due to a need for a ventilator. The following day, the hospitalist documented a discussion with family, "as to future course [*sic*]. Home hospice would take away ventilator [*sic*] and they do NOT want this." Therefore, a consult for home hospice was not placed and the patient was discharged to home.

Due to the shortened length of stay in HPU (less than 24 hours), discharge processes were truncated. While the hospitalist provided inaccurate information regarding ventilator dependence and home-hospice services to the family, key members (palliative care physician, advanced practice nurse, and social worker) of the Palliative Care Consult Team were not consulted and were therefore unable to educate the patient and family that home-hospice agencies may accept ventilator-dependent patients.

The EHR noted that the day after discharge, a non-VA hospice agency called the facility's Administrative Officer of the Day and explained that the family had contacted them requesting

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<sup>49</sup> Facility Policy 2017-111-05. The Palliative Care Consult Team includes staff physicians, palliative care advanced practice nurse, registered nurse, social worker, chaplain, psychologist; ad hoc members may include physical therapist, speech therapist, pharmacist, dietitian, and volunteer(s).

home-hospice care. A facility hospitalist was notified and placed a consult for outpatient hospice 26 minutes after the call.

## Summary

The OIG team concluded that the patient was discharged home earlier than estimated to honor the patient's wishes to die at home. A plan was in place at discharge to address the patient's medication, nutrition, and fluid needs that included dietary restrictions and aspiration precautions. The OIG could not confirm that the family requested the patient have a nasogastric tube placed prior to discharge, and EHR documentation did not include a plan for nasogastric tube placement prior to discharge. The family declined the services of home hospice based on the understanding that mechanical ventilation at home would not be supported. The shortened length of stay, inaccurate information shared by the hospitalist, and lack of Palliative Care Consult Team involvement may have contributed to the patient and family not receiving pertinent information regarding home hospice acceptance of ventilator-dependent patients. After discharge, the family requested and the patient received a nasogastric tube and home-hospice services.

## 3. Alleged Inappropriate and Unprofessional Behavior of a Hospitalist

The OIG was unable to determine whether the hospitalist demonstrated inappropriate and unprofessional behavior with the patient and family in HPU. Interviewees who were present at the bedside and the hospitalist's recollections differed regarding the discussion.

The complaint included that the hospitalist yelled callously and with malice at the patient and family members when informing the patient of being near death and inquiring about the patient's end-of-life wishes. Allegedly, the hospitalist's body language and tone conveyed the sense of being mean and mad.

The facility's Code of Conduct policy requires "[a]ll employees and volunteers to conduct themselves in a professional, respectful, and cooperative manner."<sup>50</sup> Disruptive/inappropriate behavior is defined in the facility's policy as "behavior that disturbs, interferes with, disrupts, or prevents the normal operations and functions of the [facility]." The American Medical Association defines disruptive behavior similarly also including "conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician."<sup>51</sup>

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<sup>50</sup> Facility Policy 16-11-119, *Code of Conduct*, September 29, 2016.

<sup>51</sup> American Medical Association. *Code of Medical Ethics Opinion 9.4.4*. Copyright © 2016.

The OIG interviewed the hospitalist and staff members identified in the complaint.<sup>52</sup> The hospitalist acknowledged having a discussion with the patient and family about the patient's health status and discharge. The hospitalist recalled that one of the family members was a nurse and the family asked questions to become educated about their father's condition. During the discussion of discharge, family requested that the hospitalist speak directly to the patient regarding a preference to die at home. None of the staff the OIG interviewed reported being present for the conversation or could recall overhearing the treatment planning discussion.

Following the patient's discharge to home, the family had multiple phone calls over the weekend with facility staff to request assistance getting a nasogastric tube for the patient. The complaint indicated that two days after discharge, the Assistant Chief of Medicine called the family to discuss the patient's condition and told the family they could bring the patient to the hospital Emergency Department for a nasogastric feeding tube placement. The family reported that during the conversation, the Assistant Chief of Medicine indicated that the hospitalist reported talking loudly to the patient, not yelling, so the patient could hear. The Assistant Chief of Medicine documented in the EHR a discussion with the family about many topics including the family's request for a nasogastric tube; however, there was no documentation about the hospitalist's behavior. During the OIG interview, the Assistant Chief of Medicine did not recollect discussing the hospitalist's behavior with the family.

Lacking written evidence or witness confirmation, the OIG was unable to determine if the hospitalist behaved in a manner that was inappropriate, unprofessional, or in violation of the facility's Code of Conduct during the treatment planning discussion.

## **Facility Oversight of Physician Behavior**

To further evaluate the hospitalist's behavior, the OIG reviewed the facility's oversight process regarding physicians' professional behavior. The facility had processes in place for staff to report concerns with quality of care and professional behavior and provided oversight of physician behavior.

The OIG asked staff about ways to report concerns in their workplace and learned that staff can (1) talk directly to their supervisor, (2) formally submit a Report of Contact, and (3) enter a

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<sup>52</sup> The complaint included the names of staff who likely overheard both the original interaction and a subsequent conversation recounting the initial occurrence.

patient incident report into the Joint Patient Safety Reporting System.<sup>53</sup> Patients and families can report concerns and complaints to the patient advocate.<sup>54</sup>

A supervisory registered nurse provided the OIG with details regarding three patients with DNR orders written by the hospitalist. In addition, the OIG learned of informal complaints from nurses related to the hospitalist's communication and responsiveness to patient care needs. The hospitalist's supervisor, the Assistant Chief of Medicine, was aware of staff's concerns that needed action, and reported that each had been addressed. The OIG reviewed patient incident reports and requested patient advocate events and found no complaints of unprofessional behavior specific to the hospitalist.<sup>55</sup>

The facility has a process to address ethics-related concerns. VHA policy requires that the facility has an Integrated Ethics policy and consultation service whose members respond to ethics questions and concerns.<sup>56</sup> The OIG team reviewed the Integrated Ethics program documentation and determined the facility has a policy and Ethics Consultation Service as required.<sup>57</sup> Seven cases were sent to the facility Ethics Consultation Service between late 2017 and spring 2019.<sup>58</sup> Four cases involved shared decision-making issues, and one case was related to end-of-life concerns. The remaining two cases were non-case consultations that were resolved by the consultation service completing the ethics consult in the EHR.<sup>59</sup>

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<sup>53</sup> VA National Center for Patient Safety, *Topics in Patient Safety*®, 17, no. 5 (April, May, June 2017). "The Joint Patient Safety Reporting (JPRS) system provides a standardized and simple way for a reporter to communicate safety-related incidents and issues to their patient safety professionals."  
[https://www.patientsafety.va.gov/docs/TIPS/2017\\_April\\_May\\_June\\_TIPS\\_Internet\\_FINAL.pdf](https://www.patientsafety.va.gov/docs/TIPS/2017_April_May_June_TIPS_Internet_FINAL.pdf). (The website was accessed on March 11, 2019.)

<sup>54</sup> "Patient representatives act as the agent of the Director and are specifically charged with dealing with concerns that cannot be resolved by working with [the] primary care team or front-line staff."  
[https://www.fayetteville.va.gov/services/patient\\_advocates.asp](https://www.fayetteville.va.gov/services/patient_advocates.asp). (The website was accessed on April 26, 2019.)

<sup>55</sup> The facility verified there were no complaints reported to the Patient Advocate regarding the hospitalist's behavior.

<sup>56</sup> VHA Directive 1004.06, *IntegratedEthics*®, October 24, 2018. VHA Handbook 1004.06, *IntegratedEthics*, June 16, 2009, rescinded August 29, 2013, contain the same or similar language related to integrated ethics policy and consultation services; The "Ethics Consultation Service is an organizational structure designated by VHA officials to be responsible for ethics consultation activities."

<sup>57</sup> Facility Policy 18-11-053, *IntegratedEthics*® (IE) Program, January 8, 2018

<sup>58</sup> The four cases outlined in this report were not referred for ethics review. While staff have a process in place to make referrals, they are not required to do so by VHA Handbook 1004.06.

<sup>59</sup> VHA Directive 1004.06. An Ethics Non-Case Consultation does not pertain to an active clinical case. "Non-[C]ase [C]onsultations include answering questions about ethics topics in health care, interpreting policy relat[ed] to ethics in health care, reviewing documents from a health care ethics perspective, providing ethical analysis of" and responding to organizational ethics questions.

VHA and facility policies require that the facility's Integrated Ethics Council establish annual performance and quality improvement goals for the Integrated Ethics program.<sup>60</sup> These goals are based on Integrated Ethics relevant data sources, the facility workbook, and the national objectives.<sup>61</sup> The OIG reviewed Integrated Ethics documentation from fiscal years 2018 and 2019. The facility had identified "Education/Marketing of Ethics Consultation Process [and] Improv[ing] the number of consults" as its fiscal year 2019 ethics issue and improvement goal. The facility did not complete relevant assessments in fiscal year 2018 to develop the performance and quality improvement goal; however, a fiscal year 2019 assessment was initiated in April 2019 with a facility-reported completion date of September 2019.

OIG team members reviewed the facility's requirements and processes for monitoring physician behavior. The Joint Commission requires that a facility's medical staff establish criteria and evaluate a practitioner's ability to provide patient care, treatment, and services within the scope of the physician's privileges.<sup>62</sup> Elements required to be monitored include interpersonal and communication skills, and professionalism. The OIG determined that the facility's medical staff bylaws included these required elements within the ongoing professional practice evaluation process. From summer 2017 through late 2018, the hospitalist's professional performance evaluation was completed without incidence of disruptive or unprofessional behavior. The hospitalist's interpersonal and communication skills were also assessed as part of ongoing monitoring as required.<sup>63</sup>

Medical residents are an additional source of input on physician behavior when they provide feedback about their experiences with supervising physicians. From fall 2017 through the OIG on-site visit in January 2019, there were no negative interactions reported between the medical residents and the hospitalist.

The OIG determined that the facility has mechanisms in place to provide oversight of physician behavior.

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<sup>60</sup> VHA Directive 1004.06; Facility Policy 18-11-053.

<sup>61</sup> The Facility Workbook is a tool used to help facility leaders assess the current ethics program, Department of Veterans Affairs, National Center for Ethics in Health Care Integrated Ethics® Facility Workbook 2015.

<sup>62</sup> The Joint Commission, Medical Staff Standard 06.01.05 Elements of Performance 2 and 8.

<sup>63</sup> Facility Bylaws and Rules of the Medical Staff, May 25, 2016

## Conclusion

The OIG was unable to determine whether the original patient had decision-making capacity to consent to a DNR status at the time the hospitalist discussed life-sustaining treatment with the patient. The hospitalist acted in accordance with VHA policy when determining and documenting that the patient had decision-making capacity to consent to the DNR status. However, documentation indicated the patient exhibited intermittent confusion and received medications that may have altered mental status. Regardless of the patient's decision-making capacity to consent to a DNR status, the OIG found that the presence of a DNR order did not impact the clinical outcome for this patient, since the need for resuscitation for cardiopulmonary arrest did not occur during the inpatient stay.

While evaluating the original patient's case, the OIG learned of three additional cases with concerns regarding end-of-life discussions and DNR orders that were placed and then reversed. The OIG determined that the hospitalist's interactions, as documented in the EHR, lacked evidence of a collaborative discussion pertaining to patients' preferences and quality of life. This likely led to the requests for the reversals of the patients' DNR orders. If the hospitalist had addressed these elements during the DNR discussions, facility staff may not have had concerns with the way the hospitalist presented the prognosis and end-of-life options to the patients and family members.

The OIG did not substantiate that the facility failed to evaluate, plan, and coordinate the patient's discharge to meet the needs of the patient and family. The EHR documentation indicated that a plan was in place at discharge to address the patient's medication, nutrition, and fluid needs that included dietary restrictions and aspiration precautions. The OIG was unable to confirm that the family requested the patient have a nasogastric tube placed prior to discharge, and EHR documentation did not include a plan for nasogastric tube placement prior to discharge. The family initially declined the services of home hospice based on inaccurate information that mechanical ventilation would not be supported at home. This information would likely have been corrected by the Palliative Care Consult Team; however, the shortened length of stay prevented this team from consulting with the patient and family prior to discharge. After discharge, the family requested a nasogastric tube and hospice, both of which the facility approved. The OIG concluded that the patient was discharged home earlier than estimated to honor the patient's wishes to die at home.

The OIG was unable to determine whether the hospitalist demonstrated inappropriate, and unprofessional behavior with the patient and family in HPU. The hospitalist's and the other interviewees' recollections differed regarding the discussion. Lacking conclusive evidence or witness confirmation, the OIG was unable to determine if the hospitalist behaved in a manner that was inappropriate, unprofessional, or in violation of the facility's Code of Conduct.

The OIG determined that the facility had processes to provide oversight of physician behavior.

The OIG made no recommendations.

## Appendix A: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: December 27, 2019

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Alleged Deficiencies in a Hospitalist's Interactions with a Patient at the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas

To: Director, Office of Healthcare Inspections (54HL05)  
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. The South Central VA Health Care Network (10N16) has reviewed and concurs with the draft report and conclusions for the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas.
2. If you have questions regarding the information submitted please contact VISN 16 Accreditation Specialist, at (601) 206-7022.

*(Original signed by:)*

Skye McDougall, PhD  
Network Director

## Appendix B: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: December 23, 2019

From: Director, Veterans Health Care System of the Ozarks (564/00)

Subj: Healthcare Inspection—Alleged Deficiencies in a Hospitalist's Interactions with a Patient at the  
Veterans Health Care System of the Ozarks, Fayetteville, Arkansas

To: Director, South Central VA Health Care Network (10N16)

1. I would like to express my appreciation to the Office of Inspector General (OIG) Healthcare Inspection Team for their professional and comprehensive review of Veterans Health Care System of the Ozarks.
2. I have reviewed the draft report for the Veterans Health Care System of the Ozarks and concur with the report and conclusions.
3. Please express my thanks to the team for their professionalism and assistance in our continuing efforts to improve the care we provide to our Veterans.

*(Original signed by:)*

Kevin L. Parks, MA  
Medical Center Director

## OIG Contact and Staff Acknowledgments

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Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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