Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Delay in Cancer Diagnosis and Treatment at a Southern Arizona VA Health Care System Community Based Outpatient Clinic

Report No. 11-03545-40

December 5, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

At the request of Senator Jon Kyl, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of delayed cancer diagnosis and treatment at a Southern Arizona VA Health Care System Community Based Outpatient Clinic (CBOC). Specifically, the complainant alleged that:

- The CBOC primary care provider (PCP) did not address the patient's complaints of fatigue, chest pains, and shortness of breath.
- The patient, who was diagnosed with lung cancer in May 2011, had not received a chest x-ray since 2007.
- The PCP delayed the diagnosis of lung cancer and subsequent treatment and denied the patient the chance to fight for his life.

We did not substantiate the allegation that the PCP failed to address the patient's complaints of fatigue, chest pains, and shortness of breath. We determined that the patient was never documented to have complained of fatigue or chest pain to his PCP. The PCP did evaluate the patient's shortness of breath, but only for potential cardiac causes.

We substantiated the allegation that the patient did not receive a chest x-ray for a period between 2007 through his final PCP visit in February 2011.

We could not substantiate the allegation of delayed diagnosis of lung cancer because it is conjectural whether a chest x-ray would have revealed a lung cancer in May 2010. Nevertheless, we determined that the PCP did not fully evaluate the cause of the patient's shortness of breath after ruling out cardiac causes. Prior to May 2010, diagnostic tests were neither ordered nor warranted due to the absence of any chest-related complaints.

In lieu of the quality assurance measures already implemented by the facility to address the issues raised in this review, we made no recommendations.

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

TO: Director, VA Southwest Health Care Network (10N18)

SUBJECT: Healthcare Inspection – Delay in Cancer Diagnosis and Treatment, Southern Arizona VA Health Care System Community Based Outpatient Clinic

Purpose

At the request of Senator Jon Kyl, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of delayed cancer diagnosis and treatment at a Southern Arizona VA Health Care System Community Based Outpatient Clinic (CBOC).

Background

The CBOC is part of the Southern Arizona VA Health Care System (the facility) in Tucson, AZ. It provides outpatient primary care services to approximately 3,000 veterans.

The facility provides acute care inpatient and outpatient health care services. It is part of Veterans Integrated Service Network 18 and serves a patient population of about 173,000. The facility provides outpatient care at seven CBOCs located in Northwest Tucson, Southeast Tucson, Casa Grande, Green Valley, Safford, Sierra Vista, and Yuma, AZ.

In June 2011, the complainant contacted Senator Kyl's office alleging that a CBOC primary care provider (PCP) delayed the patient's cancer diagnosis and treatment. Specifically, the complainant alleged that:

- The PCP did not address the patient's complaints of fatigue, chest pains, and shortness of breath.
- The patient, who was diagnosed with lung cancer in May 2011, had not received a chest x-ray since 2007.
- The PCP delayed the diagnosis of lung cancer and subsequent treatment and denied the patient the chance to fight for his life.

Scope and Methodology

We reviewed the patient's medical record and conducted telephone interviews with the complainant and the PCP. In addition, we obtained relevant Quality Assurance documentation as generated by the facility. We also reviewed VHA policies governing primary care.

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

Case Summary

The patient was a man in his sixties with a clinical history that included tobacco use disorder, chronic pain with narcotic use (prescribed), and tooth abnormalities. In December 2006, he elected to transfer his primary care from the community to the CBOC. Until his death in June 2011, the patient visited the CBOC numerous times, most often for mental health care. In January 2007, he had a routine screening chest x-ray (interpreted as normal by the radiologist) as part of an Agent Orange Registry examination.[1]

Between December 2007 and June 2011, the patient saw his PCP at the CBOC on ten occasions. During a single visit, in May 2010, he complained to his PCP of shortness of breath. At that time, the patient's lungs were clear bilaterally, and the PCP ordered an electrocardiogram,[2] a stress test,[3] and an echocardiogram[4] to evaluate for a possible cardiac cause of the shortness of breath (all tests interpreted as normal). In the May 2010 clinic visit the PCP did not document a specific follow-up plan regarding further evaluation for shortness of breath. In subsequent clinic visits with the PCP the patient offered no chest-related complaints of any type. On all occasions the PCP noted the patient's lungs to be clear to auscultation bilaterally.

In May 2011, the patient presented to the facility's Emergency Department (ED) due to several weeks of general malaise, fatigue, and anorexia. A chest x-ray on that day, the first since January 2007, was highly suggestive of malignant disease. Clinical tests promptly confirmed the diagnosis of stage IV non-small cell lung cancer.

Following ED evaluation and admission to the facility, a ward physician's note describes the patient as a male presenting with back, shoulder, and chest discomfort that started 1½ weeks prior as well as shortness of breath and recent weight loss. The documentation also quotes the patient as stating he "has not felt like this before."

The patient's weight loss had actually been ongoing since 2009 and was annotated in the medical record on sequential visits. His weight in June 2009 was recorded as 214 pounds and in February 2011 (at the final PCP visit) was recorded as 181 pounds.

[1] Agent Orange was an herbicide used between 1962 and 1971 during the Vietnam War. The registry was established for Vietnam veterans concerned about possible long-term effects of exposure to Agent Orange.
[2] An electrocardiogram is a non-invasive procedure for recording electrical changes in the heart. It is a starting point for detecting many cardiac problems.
[3] A stress test examines heart disease. Physicians and/or trained technicians perform this test to determine the amount of stress that a heart can manage before developing abnormalities.
[4] An echocardiogram is a non-invasive procedure that uses sound waves to create a moving picture of the heart. It allows physicians to see the heart beating and to see the heart valves and other structures of the heart.

Due to the complications of widely metastatic lung cancer the patient died on June 8, 2011.

Inspection Results

Issue 1: Complaints Not Addressed

We did not substantiate that the PCP failed to address the patient's complaints. The PCP ordered diagnostic tests to evaluate for a cardiac cause of the patient's isolated complaint of shortness of breath in May 2010. All cardiac tests obtained were interpreted as normal. In fact, the issue of shortness of breath was never again raised by the patient to the PCP and neither did the PCP reference the topic in subsequent chart documentation (i.e., in October 2010 and February 2011). A comprehensive medical record review found no other complaints of shortness of breath prior to the May 2011 ED presentation with advanced lung cancer. Further, there were no complaints of fatigue or chest pain from June 2009 to February 2011.

Issue 2: No Chest X-Ray Since 2007

We substantiated that the patient did not receive a chest x-ray from 2007 (obtained then as part of a protocol screening) until presenting to the ED in May 2011. As a routine diagnostic measure, it would have been reasonable for the PCP to have ordered a chest x-ray in conjunction with other diagnostic tests when evaluating the patient's shortness of breath in May 2010. The use of a chest x-ray is a common and accepted practice when attempting to diagnose the cause(s) of shortness of breath. The PCP neither determined the basis for the patient's shortness of breath in May 2010 nor acknowledged the normal results of the patient's cardiac evaluation. Additionally, there is no evidence that the PCP ever questioned the patient as to whether he experienced any further episodes of shortness of breath or related symptoms.

Issue 3: Delay in Lung Cancer Diagnosis

We could not substantiate the allegation of delayed diagnosis of lung cancer because it is conjectural whether a chest x-ray would have revealed a lung cancer in May 2010. Nevertheless, we determined that the PCP did not fully evaluate the cause of the patient's shortness of breath after ruling out cardiac causes. Prior to May 2010, diagnostic tests were neither ordered nor warranted due to the absence of any chest-related complaints.

We also determined that the PCP failed to address the patient's ongoing weight loss. Medical record documentation showed that the patient experienced progressive weight loss between June 2009 (214 pounds) and his last regularly scheduled PCP visit in February 2011 (181 pounds). We found no documented evidence that the PCP ever addressed this steady weight loss over the 20-month period. When asked about any awareness of trending weight loss during the years the PCP provided primary care to the patient, the PCP acknowledged being aware of the weight loss and attributed it to the depression and chronic tooth pain the patient was documented to have. Of note, the complainant reported in our interview that the patient, who once weighed 300 pounds, had experienced significant emotional trauma during this period (with the untimely death of adult children and other family stressors). The complainant also reported that the patient had developed severe dental problems with marked tooth pain and that this affected his eating patterns. The complainant stated that "over the last several years the patient did not eat half of

what he usually did." The PCP never addressed the patient's steady weight loss in clinical notes. We could not determine whether the PCP regarded the weight loss as desirable, undesirable, or neither.

Conclusions

We did not substantiate the allegation that the PCP failed to address the patient's complaints of fatigue, chest pains, and shortness of breath. We determined that the patient was never documented to have complained of fatigue or chest pain to his PCP. The patient did note shortness of breath on a single occasion and the PCP's evaluation was limited to cardiac causes for the complaint.

We substantiated the allegation that the patient did not receive a chest x-ray from 2007 until presenting to the ED in May 2011.

We could not substantiate the allegation of delayed diagnosis of lung cancer. We determined that it would have been reasonable for the PCP to have ordered a chest x-ray during the May 2010 visit. However, in considering all clinical circumstances, it is speculative whether a chest x-ray in May 2010 would have revealed a lung cancer at that time.

We also concluded that the PCP did not directly address the patient's gradual weight loss though the PCP reported being aware of it, attributing it to depression and chronic tooth pain.

In lieu of quality assurance measures already implemented by the facility, we made no recommendations.

Comments

The VISN and Facility Directors agreed with our findings.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 17, 2011

From: Director, VA Southwest Health Care Network (10N18)

Subject: Healthcare Inspection – Delay in Cancer Diagnosis and Treatment, Southern Arizona VA Health Care System CBOC

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Thru: Director, VHA Management Review Service (10A4A4)

1. Thank you for the opportunity to review the draft report regarding the OIG Inspection at the Southern Arizona VA Health Care System.

2. I concur with the findings submitted by the Southern Arizona VA Health Care System. There were no recommendations.

(original signed by:)

Lori Highberger, MD, Interim Chief Medical Officer for

Susan Bowers

VISN 18 Director

Department of Veterans Affairs **Memorandum**

Date: November 17, 2011

From: Director, Southern Arizona VA Health Care System (678/00)

Subject: Healthcare Inspection – Delay in Cancer Diagnosis and Treatment, Southern Arizona VA Health Care System CBOC

To: Director, VA Southwest Health Care Network (10N18)

1. The Southern Arizona VA Health Care System concurs with the findings of the above healthcare inspection. The report acknowledges the facility already implemented quality assurance measures. There were no recommendations.

2. If you have any questions, please contact me at (520) 629-1815.

(original signed by:)

Linda K. Reynolds for

Jonathan H. Gardner, MPA, FACHE
Director, Southern Arizona VA Health Care System

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Daisy Arugay Douglas Henao Thomas Jamieson, MD Mary Toy

Appendix C

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