Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Misdiagnosis
Hudson Valley Health Care System
Castle Point, New York

Report No. 12-03041-32

November 13, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant involving staff at the Hudson Valley Health Care System (HVHCS) in Castle Point, NY. Specifically, a complainant alleged that a patient reported to her that HVHCS staff:

- Told him that he had pancreatic cancer (and, in distress, he relapsed into substance abuse).
- Contacted him several days later to report that he did not have pancreatic cancer after discovering that they mixed-up laboratory results.
- Told him that they did not know who the other patient was with the positive cancer result.

We did not substantiate that HVHCS staff initially told the patient he had pancreatic cancer and later recanted. The patient's electronic health records from four recently visited Veterans Health Administration facilities holds no mention of pancreatic cancer or reports of emotional distress related to such. We determined that the patient could have misunderstood discussions with staff regarding his mild pancreatitis diagnosed during a February 2012 HVHCS inpatient stay. However, we were unable to reach the patient to determine whether or not this was true.

We did not substantiate that HVHCS staff mixed-up laboratory results and failed to identify another patient with pancreatic cancer diagnosis. HVHCS had no new cases of pancreatic cancer diagnosed during the relevant timeframe, and we found no documentation suggestive of a missed or delayed pancreatic cancer diagnosis. Finally, in the absence of any mention of pancreatic cancer in the subject patient's electronic health record, it seems unlikely that a laboratory "mix-up" occurred. We made no recommendations.

The Veterans Integrated Service Network and Medical Center Directors concurred with the report. No further action is required.

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

TO: Director, VA New York/New Jersey Veterans Healthcare Network, (10N3)

SUBJECT: Healthcare Inspection – Alleged Misdiagnosis, Hudson Valley Health Care System, Castle Point, New York

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding the misdiagnosis of pancreatic cancer for a patient treated at the Hudson Valley Health Care System (HVHCS) in Castle Point, NY.

Background

Hudson Valley Health Care System

HVHCS provides inpatient and outpatient health care services at two campuses located in Montrose and Castle Point, NY. Outpatient care is also provided at seven community based outpatient clinics located in Goshen, New City, Port Jervis, Monticello, Poughkeepsie, Pine Plains, and Carmel, NY. HVHCS is part of Veterans Integrated Service Network (VISN) 3.

Allegations

In May 2012, the OIG Hotline Division received a complaint from a private-sector veteran advocate who stated that a patient called her in March to report that HVHCS staff:

- Told him that he had pancreatic cancer (and, in distress, he relapsed into substance abuse).
- Contacted him several days later to report that he did not have pancreatic cancer after discovering that they mixed-up laboratory results.
- Told him that they did not know who the other patient was with the positive cancer result.

Scope and Methodology

We conducted telephone interviews with the complainant and the HVHCS director. During our site visit from May 22 to May 24, 2012, we interviewed the Chief of Staff, Chief of Quality Management, and the Patient Advocate. We reviewed the patient's electronic health record (EHR) and other documents, including policies, incident reports, patient advocate reports, and adverse event disclosures. We requested a list of all patients newly diagnosed with pancreatic cancer from January 1 through May 18, 2012; however, there were none to report.

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

Inspection Results

Issue 1: Misdiagnosis

We did not substantiate that HVHCS staff initially told the patient he had pancreatic cancer and later told him he did not have the cancer. We reviewed the patient's EHRs from four VHA facilities where he recently received care and found no mention of pancreatic cancer or reports of emotional distress related to such. During a February 2012 inpatient stay, the HVHCS provider documented that the patient had a mild case of pancreatitis, which resolved within 2 weeks, and he was medically stable upon discharge. We found no evidence that anything more serious was either overlooked or reported to the patient.

It is plausible the patient misunderstood the conversation with staff regarding the mild pancreatitis diagnosis; however, we have been unable to reach him to confirm whether or not this is true. The patient advocate produced copies of complaints from the patient dated 2006 and 2007 indicating he knew how to communicate concerns; however, there has been no contact from the patient since then.

Issue 2: Missed Diagnosis

We did not substantiate that HVHCS staff failed to notify another patient about their pancreatic cancer diagnosis after the initial "mix-up." We requested the facility provide us with a list of all patients newly diagnosed with pancreatic cancer during the period from January through May 18, 2012; however, there were none to report. From our review of other documents, we found no relevant incident reports, disclosures, or other evidence of staff documentation of issues related to this or any other patient regarding missed or delayed pancreatic cancer diagnosis. Finally, in the absence of any evidence of pancreatic cancer in the subject patient's EHR, it seems unlikely that a laboratory "mix-up" occurred.

Conclusion

We did not substantiate that the HVHCS staff misdiagnosed, and later recanted, that the patient had pancreatic cancer. We determined that the patient knew how to utilize VHA's patient advocacy program, scheduling, and telephone care during the weeks surrounding this allegation. It is possible that the patient misunderstood a conversation with staff regarding his diagnosis of mild pancreatitis. In the event of such a serious misunderstanding, one would expect the patient to have discussions with VHA's treating staff and the patient advocate; however, there is no evidence of such. The HVHCS staff attempted to contact the patient during our site visit and as recently as June 20; however, the patient did not respond to telephone or letter communications.

We also did not substantiate that there was a laboratory mix-up and another patient was unaware of having pancreatic cancer. The HVHCS leadership described plans to continue to try to contact the patient to investigate the matter further. We made no recommendations.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the report. No further action is required.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 1, 2012

From: VA New York/New Jersey Veterans Healthcare Network, (10N3)

Subject: **Healthcare Inspection – Alleged Misdiagnosis, Hudson Valley Health Care System, Castle Point, NY**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Thru: Director, VHA Management Review Service (VHA10AR MRS)

I would like to thank the Office of Inspector General (OIG) Team who conducted a Healthcare Inspection review from May 22 to May 24, 2012.

I have reviewed the findings in the draft report for the VA Hudson Valley Health Care System and concur with the findings, which includes no recommendations.

Michael A. Sabo, FACHE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 19, 2012

From: Director, Hudson Valley Health Care System Director (620/00)

Subject: **Healthcare Inspection – Alleged Misdiagnosis, Hudson Valley Health Care System, Castle Point, NY**

To: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

I would like to thank the Office of Inspector General (OIG) Team who conducted a Healthcare Inspection review from May 22 to May 24, 2012.

I have reviewed the findings in the draft report for the VA Hudson Valley Health Care System and concur with the findings, which includes no recommendations.

Should you have any questions, please contact Patty Armstrong, Chief of Quality Management Service at extension 2205/5613.

Gerald F. Culliton, Director
VA Hudson Valley Health Care System

Appendix C

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	Nelson Miranda, LCSW Melanie Oppat, MEd, LDN Terri Julian, PhD Joanne Wasko, LCSW Cynthia Gallegos, Program Support Assistant

Appendix D

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