Committee on Veterans' Affairs
U.S. House of Representatives
"Scheduling Manipulation and Veteran Deaths in Phoenix: Examination of the OIG's Final Report"
Wednesday, September 17, 2014, at 12:00 P.M.
334 Cannon House Office Building

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Statement for the Record

This statement is submitted in response to a request from the House Committee on Veterans' Affairs. The request arose from statements reported in an article in the Arizona Republic published on September 10, 2014.[1] In the article two forensic pathologists stated that death certificates would record the proximate cause of death, that is, the medical condition or injury that initiated the chain of events ending in death. Review of death certificates alone would be a poor means of screening for evidence that delay in receiving medical evaluation led to an adverse outcome. This is true in part because death certificates only report on deaths, and death is not the only possible adverse outcome. This is also true because the phrase "delay in medical evaluation or treatment" would not constitute the underlying cause of death. A disease or injury would necessarily have led to seeking medical evaluation, and that disease or injury would be the underlying, or proximate, cause of death.

On August 26, 2014 the Office of the Inspector General of the Department of Veterans' Affairs issued its report "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System."[2] The Executive Summary of this report describes the information which the Office of Audits and Evaluations reviewed to assess whether a delay in care contributed to deaths that occurred in patients in question. The information reviewed was each patient's electronic health record, supplemented, when available, with information from "sources that included Medicare, non-VA health records, death certificates, media reports, and interviews with VA staff."[2] This is the appropriate sort of information necessary when attempting to determine what role, if any, a delay in care may have played in a subsequent death. On pages 2-27 the report provides succinct reviews of the medical history on 45 patients, including 6 patients who died. The information provided in these reviews is the sort necessary to assess the role that delay of care may have played in a death, and these case histories show how complicated medical cases can be. The process of reviewing medical records and related ancillary information that the Office of Audits and Evaluations followed is the same sort of process that forensic pathologists follow to determine the cause of death in a case.

In summary, death certificates alone are unlikely to reveal the effect of any delay in care that a decedent received. A comprehensive review of medical records, as conducted by the Office of the Inspector General, is the appropriate means to try to determine what role, if any, a delay in receiving medical care played in causing or hastening a death.

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[1] http://www.azcentral.com/story/news/politics/investigations/2014/09/10/report-phoenix-va-deaths-raises-questions/15375005/
[2] http://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf