UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

HUMAN RESOURCES DIVISION

B-161475

NOV 16 1977

The Honorable G. William Whitehurst
House of Representatives

Dear Mr. Whitehurst:

This letter is in response to your February 7, 1977, request to our Office to make certain inquiries on behalf of your constituent, Mrs. Emma Jean Hedrick, 968 Newell Avenue, Norfolk, Virginia 23518.

As you will recall, Mrs. Hedrick's son, Sergeant First Class (SFC) Stephen Lee Hedrick, suffered cardiac arrest and an upper gastrointestinal hemorrhage during surgery at the U.S. Army's 121st Evacuation Hospital, Seoul, Korea, on December 20, 1974. Neurological damage resulted and SFC Hedrick died on February 7, 1975. SFC Hedrick's surgery was being performed to correct problems resulting from a back injury incurred while he was stationed in Vietnam. In your letter, you requested that our Office determine whether corrective action had been taken by officials at the Army's 121st Evacuation Hospital as a result of their own investigation of this matter.

The subject of the implementation of any corrective action was of particular interest to you since the Office of the Army Surgeon General had informed you in a May 13, 1976, letter on this subject that corrective action had been taken to insure compliance with current policy and high quality of care. In the May 1976 letter, the Army's Director, Health Care Operations, told you that as a result of the Army's investigation of the matter, several factors were identified as contributing to SFC Hedrick's cardiac arrest and his subsequent death. Specifically cited were the less than thorough preoperative patient evaluation, the delay in recognition of the magnitude of bleeding, and the delay in administering resuscitation--because of the patient's prone position required for his back operation--which ultimately resulted in neurological damage. However, it was your understanding that despite such assurances, corrective efforts had not been initiated.

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A representative of our Washington, staff met with Mrs. Hedrick on March 31, 1977, in your Norfolk, Virginia, district office to further discuss the circumstances involved in this case. Mrs. Hedrick provided us with a thorough briefing on this matter. She also gave us copies of her son's medical treatment records for use in our inquiries. These records have been very helpful and will be returned to Mrs. Hedrick in the near future. All treatment records and other relevant medical data obtained during our inquiries were reviewed by our Office's medical advisor.

Based on his review, our medical advisor believes the dominant issue in this case was SFC Hedrick's past history of a peptic ulcer which, for unknown reasons, appeared not to be known to the admitting physician in the 121st Evacuation Hospital's orthopedic service. The medical history taken by the admitting physician did not include any indication that SFC Hedrick had provided information to the physician concerning his condition. If SFC Hedrick withheld information concerning his condition, his reluctance to provide this information may have contributed to his untimely death.

On the other hand, it is difficult to understand why the peptic ulcer condition was not evident to the admitting physician based upon SFC Hedrick's medical records. According to a January 1975 Army investigative report concerning the case, a review of the patient's health record revealed a known history of peptic ulcer disease initially noted and treated at the U.S. Army Hospital, Fort Meade, Maryland, in July 1973 with subsequent hospitalization for the condition in September 1973. Also, the patient's medical records show that he had experienced upper gastric pain on June 20, 1974, and was treated for the condition at the 121st Evacuation Hospital. We received conflicting information concerning whether these medical records were available to the physicians involved at the time of SFC Hedrick's surgery in December 1974. They may have relied on the medical history and examination performed by the admitting physician in lieu of reviewing the patient's past health record to satisfy themselves that the patient was ready for surgery.

Our staff visited the 121st Evacuation Hospital on March 29 and 30, 1977, to determine what corrective action had been taken in response to the recommendations contained in the Army's January 1975 report on the care provided SFC Hedrick. Each of the recommendations was discussed with the hospital officials whose activities were affected by these recommendations. These officials' responses, without exception, were

that the recommendations were nothing new and were, in fact, normal operating procedures that should always be observed. We were told that the Army investigative report's recommendations did not result in specific policy changes or establishment of additional controls to insure compliance with normal procedures.

On May 25, 1977, we brought this apparent absence of specific corrective action to the attention of the responsible officials in the Office of the Army Surgeon General in Washington, D.C., who in turn instructed the Commander, Medical Command, Korea, to address this issue. The Army's response to us was delayed due to several factors, one of which was the reassignment of a new Commander to the Medical Command, Korea. After evaluating the existing conditions relative to the recommendations made in the Army's investigative report of this matter and the possible need for any new controls or procedures, the new Commander, Medical Command, Korea, provided the following information to the Office of the Army Surgeon General.

In reference to the investigative report's recommendations, the Commander pointed out on September 2, 1977, that corrective actions have been initiated to insure compliance with current policy and to insure that the highest quality of medical care is provided in the Command. The following required procedures were mentioned as steps taken to specifically address the recommendations in the investigative report.

--A careful, complete history and physical examination, including a review of the individual's health record (DD Form 722) is to be performed by the attending surgeon for every patient admitted to the surgical services. Such an examination is within the professional standards taught in U.S. medical schools and residency training programs. The professional qualifications of the individual physicians at this hospital are reviewed periodically by the Department of the Army and by the Credentials Committee of the 121st Evacuation Hospital. The quality of inpatient health care, including such examinations, is reviewed monthly by a random analysis of inpatient records by the hospital's Medical Records Audit Committee.

--Each surgical patient is formally signed over from the surgical ward to surgery by a registered nurse.

--Each patient undergoing surgery is evaluated pre-operatively by an anesthesiologist or a nurse anesthetist. This evaluation includes a review of the patient's hospital record, an examination as appropriate, and a patient interview to include an anesthetic history and counselling for the proposed method of anesthesia. In the event that this evaluation is made by the "on call" anesthetist during non-duty hours, the anesthetist responsible for the case is informed of the evaluation and is responsible for reviewing the case and seeing the patient prior to surgery. In cases where local anesthesia is administered by the operating surgeon, an anesthetist is required to be available in the operating suite in case additional services or resuscitation are required.

--In keeping with established practices in civilian and military hospitals, the turnover of nursing and ancillary personnel in the operating room is being kept to a minimum. The surgical nurse scrubbing on a case may be relieved briefly by another qualified surgical nurse after 3 to 4 hours and will return to complete the case. The relief nurse is always briefed on the progress of the case, the operative set-up, and the anticipated requirements. The responsible scrub nurse may be relieved only with the knowledge and permission of the operating surgeon. In the event of an exceptionally long case, the scrub nurse may be permanently relieved by the scrub nurse of the following shift with the surgeon's permission. The same procedures are also to be followed by the circulating nurse and operating room technicians and relief personnel are always informed of the progress of the case and of any unusual or anticipated requirements.

--At the beginning of each surgical case, suction bottles are marked and, during surgery, are changed only with the knowledge of the operating surgeon and anesthesiologist or nurse anesthetist. Sponges are weighed and are not removed from view until approved by the anesthetist. Efforts are being made to obtain a system of disposable in-line suction traps which will further help to measure the amounts of blood lost during surgery.

--Any unusual occurrence noted during the conduct of an operation by any person in the room is immediately brought to the attention of both the anesthesiologist/nurse anesthetist and the operating surgeon.

--Any signs of hypoperfusion, hypoventilation, acidosis or arrhythmia are always of marked concern to the anesthesiologist/nurse anesthetist. As soon as any such difficulty is encountered, assistance from other anesthesiologists/nurse anesthetists is summoned, the responsible operating surgeon is notified of the problem, and professionally appropriate corrective or resusitative measures are taken. Electrocardiographic monitors are routinely employed in all major cases. Also, equipment capable of monitoring continuous arterial blood pressure will be available in November 1977.

In further reply to our inquiry concerning the medical care being provided in Korea, the Acting Director, Army Health Care Operations, informed us on October 7, 1977, that certain other actions have been or are being taken by the Commander, Medical Command, Korea, to insure that the highest quality of care is being maintained within thd Command.

In this regard, the Acting Director cited the following actions:

--Consultant support is being provided by the 121st Evacuation Hospital to outlying treatment facilities.

--A professional executive committee has been established to maintain open lines of communication between the Commander and his professional staff.

--A credentials committee, using the standards of professional care and hospital management set forth by the Health Services Command and Joint Commission on Accreditation of Hospitals, is being developed.

--A director of medical education has been appointed who monitors all educational projects within U.S. Army hospitals in the Command.

--A medical and surgical grand rounds program has been initiated.

--Morbidity and mortality conferences have been established in which the most important problem cases and all deaths are discussed.

--Weekly medical lectures have been initiated as part of the professional development program for the Second Infantry Division medical staff.

--A program has been instituted for the continuous upgrading of the operating rooms in the 121st Evacuation Hospital.

--A monthly professional staff meeting, which is attended by the physicians and dentists assigned to the 121st Evacuation Hospital and outlying dispensaries, has been implemented.

In our opinion, these actions, if continually emphasized by Army officials and effectively implemented at the Command's health care facilities, should prevent a reoccurrence of the factors which contributed to SFC Hedrick's death.

We trust that this letter satisfactorily responds to both you and your constituent's concern over the corrective actions taken by officials at the 121st Evacuation Hospital in Seoul, Korea.

Sincerely yours,

Gregor J. Ahart
Director