PREFACE

This book details a series of mysterious poisonings suffered by patients at the Ann Arbor Veterans Administration Hospital, an affiliated hospital of the University of Michigan Health System, during the summer of 1975. Every effort has been made to report these events as they occurred and without bias or conjecture. The book is based on personal interviews and the recollections of participants, as well as newspaper accounts and court records. For the sake of anonymity, the names of patients involved in these events have been altered. The identities of all others in this story remain unchanged in the text.

Paralyzing Summer: The True Story of the Ann Arbor V.A. Hospital Poisonings and Deaths
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PART 1

THE INVESTIGATION

CHAPTER 1

The Veterans Administration Hospital

ANN ARBOR, MICHIGAN

1975

It was a Saturday afternoon late in July. In the Veterans Administration Hospital (VA) aides on the wards were collecting lunch trays. A few patients in wrinkled cotton robes were shuffling slowly in the halls. It seemed that the hospital was settling in for a quiet afternoon when suddenly red emergency lights began flashing high on corridor walls throughout the building. Doctors' pagers began to shrill, announcing the need for immediate help. In the Intensive Care Unit (ICU) on the hospital's third floor a patient had suddenly stopped breathing.

Moments earlier a male nurse, glancing across the eight beds in the unit's open ward, had seen that a patient by the name of Leonard Meadows was in distress. The man lay thrashing, shaking, gasping for air. His face was an ashen gray. The nurse started toward him. The man collapsed. Before the nurse could reach his bed, the man had stopped breathing.

If the nurse had had time to wonder, he might have questioned why a patient who had seemed in stable condition a half hour earlier should suddenly be in such distress, but there was no time to wonder. Shouting an alert, he rushed to do what he could.

Feeling for any obstruction in the man's throat, and finding none, the nurse thrust back the man's jaw, clamped a plastic mask over his nose and mouth, and began to pump air manually into his lungs, using a device known medically as an ambu-bag. Working like a bellows, the bag expressed air as the nurse compressed it. Steadily, repeatedly, he compressed it, knowing that ambu-bagging was, at best, a stopgap measure, a way to supply vital oxygen until a doctor arrived to begin an intubation. Anxiously the nurse glanced toward the unit's doorway. With relief he saw that help was already rushing in.

A Code 7 alert is a call to all available medical personnel anywhere in the hospital to respond without delay. The speed of the response is

impressive. Within minutes of the summons interns and residents, medical students and nurses were racing toward the ICU. Minutes later they were crowding into the narrow space around the patient's bed. A nurses' aide came dodging between them, pushing a cart stocked with equipment that would be needed for an intubation. A respiratory therapist hurried into the room and, moving the patient's intravenous (IV) rack to one side, trundled a mechanical ventilator into place beside the bed.

Jon Benner, a resident from the surgical service, went to work at once. Bending over the motionless patient, he began the necessary procedure. Into the man's throat he inserted a laryngoscope. This battery-lighted, metal-bladed instrument would serve to make way for the thin, plastic endotracheal tube that he intended to slip between the man's vocal cords and then into his windpipe. Once in place and connected to the ventilator, the tube would carry oxygen directly into the man's lungs for as many hours as this was needed.

Quickly, with the help of the lighted scope, Benner eased the tube into place. The therapist reached for the free end of the tube and attached it to the ventilator. The ventilator wheezed into action. The man's chest began to rise and fall.

Within two or three minutes it was evident to those standing around the bed that the resuscitation was having an effect. Although the man lay limp and unmoving, it was clear that the ventilator was forcing air into his lungs. His normal color was returning.

This was a quick response and one that surprised Benner. It was not typical of most of the breathing arrests he had witnessed. Ordinarily eight or ten minutes might elapse before a patient undergoing an arrest began to respond to resuscitation if, in fact, he or she responded at all. Patients suffering breathing arrests were almost always very ill. Often in these cases resuscitation failed, the illness engendering the arrest having overwhelmed all efforts to reverse the process. To Benner, Meadows's swift response seemed a curious exception.

Meadows was a sixty-one-year-old retired farmer who had undergone surgery the day before to remove a malignant tumor from his right lung. The surgeons felt that the procedure had been successful. Postoperatively Meadows had been recovering satisfactorily. On the morning following the surgery, Dr. Kalia Sadasivan, a surgical resident who had assisted at the procedure, spent fifteen or twenty minutes talking with Meadows and reported that he seemed to be in good condition.

Sadasivan remembered starting home that afternoon, sure that Mead-

ows was doing well, but when he arrived his telephone was ringing, the hospital calling to tell him Meadows was in arrest. "I didn't believe it," Sadasivan said. "I said, 'Please check to make sure it is Mr. Meadows and not someone else.' I'd spoken to the man hardly ten minutes prior to the phone call." When he returned to the hospital, he found Meadows already intubated.

The next day Dr. Anne Hill, the head of anesthesiology at the hospital, was astonished to learn of Meadows's arrest. "I couldn't believe it when they told me," she said. "He was in great shape after surgery. I could see no reason for the arrest."

Hill, a small, red-haired, Irish-born woman, was known in the hospital as a doctor who showed unusual concern for the patients she had anesthetized for surgery, paying close attention to their condition and recovery for days after the surgery was completed. Meadows was one of these patients, and his arrest troubled her a good deal.

There were none of the underlying problems that might cause such an event to occur, she explained later. The surgery itself could cause shortness of breath but not a complete cessation of breathing. There was no evidence of a heart problem to explain the episode. Meadows's pulse was reported strong throughout the resuscitation, and an electrocardiogram showed nothing unusual. Subsequent scans revealed no blood clot or other unexpected abnormality in his lungs; there had been no obstruction in his throat and no problem inserting the laryngoscope. In fact that had been easy, Benner reported. He had encountered no resistance to the instrument, no spasm or gagging as would be expected. It was almost as though the muscles in Meadows's throat were paralyzed, which was puzzling in itself. "And why did he recover so quickly?," Hill wondered. None of this was typical of a breathing arrest caused by underlying illness. There appeared to be no obvious explanation for any part of the event.

On Sunday morning, the twenty-seventh, the doctors removed Meadows's breathing tube. His seeming paralysis had disappeared, and he had no trouble breathing on his own. He ate normally and was able to leave his bed and walk a little in the unit later that day. Apparently he was suffering no serious aftereffects from the arrest the day before. All seemed to have been resolved and was going well for him until shortly after five o'clock, when he stopped breathing for a second time.

Hillary Stitt, whose husband Gordon was lying in a nearby bed, was the first to see that Meadows was in trouble. As she recalled later, "He was throwing his arms and legs around and kind of short of breath like

a person that had been running. . . . His wife had just left, and I thought, my goodness, I hope there isn't anything really wrong with him because when she left she thought he was getting along fine. But he was heaving like he couldn't breathe. So I said, 'Oh my God, I'd better get somebody.'" She ran to find a nurse.

Dr. Sadasivan was on the ninth floor when his pager sounded, signaling another crisis in the ICU. He started for the unit at once, running down the flights of stairs to the third floor, where he joined others rushing into the room. As Mrs. Stitt recalled later, "it was like people were coming out of the woodwork."

Feeling for a pulse in the carotid artery in Meadows's neck and finding one, Sadasivan determined that this was no heart problem and began an intubation. But again there seemed to be no obvious reason for the arrest and nothing to explain its sudden onset. That Meadows had arrested twice in just over twenty-four hours and for no apparent reason either time was more than troubling. But his was only the beginning of the mysterious arrests that day. A few hours later Gordon Stitt stopped breathing.

Mrs. Stitt, leaving the hospital earlier that evening, had thought her husband was doing fine, just as Mrs. Meadows had. She was astonished when, sometime after ten o'clock, the hospital called to tell her that he had stopped breathing. Returning to the ICU, she found her husband intubated and unable to speak because of the apparatus in his mouth and throat connecting him to a ventilator. "And the doctors couldn't tell me why it had happened," she said. The doctors didn't know.

Stitt had undergone surgery a few days earlier to repair an aneurysm, an abnormal enlargement of the aorta, in his abdomen. This had been a significant procedure but not one that would be expected to give rise to a breathing arrest. The doctors agreed on that. Stitt's arrest was baffling.

At 9:45 the following evening Stitt arrested again. Fifteen minutes later Homer Mercer, an elderly patient in a nearby bed, was found blue and struggling to breathe.

This was five arrests in three days. In the next three days there were six more, three in the ICU and three on other floors. None could be satisfactorily explained.

Prior to the summer of 1975, hospital statistics show that the number of arrests occurring anywhere in the hospital in the space of a month was approximately eight, or two per week. In the last six days of July 1975 there were eleven.

So began the nightmare that was to engulf the hospital that summer, a

nightmare that would lead eventually to media coverage coast to coast, to a hospital in turmoil, to a community in uproar, and ultimately to a trial for multiple murders.

CHAPTER 2

From its beginnings in 1953 the Ann Arbor VA, as it is usually called, has maintained a close relationship with the University of Michigan Medical Center, located a mile or two away across the Huron River. Medical students, interns, and resident physicians in training at the university spend several months' rotation at the VA as part of that training in surgery, internal medicine, and related subspecialties. The hospital's senior staff, responsible for the supervision and instruction of these young doctors, is comprised of physicians from the University of Michigan Medical School faculty. They head the hospital's various departments, or services as they are called.

The hospital is proud of its university affiliation. The patients benefit, it is believed, from the large number of young doctors available to attend them. And it is these doctors-in-training, or house staff members as they are called, who undertake the day-to-day patient care.

For these young doctors the day begins early. Often before patients' breakfast trays have arrived on the floors, they are making their rounds, visiting the patients in their care. In groups organized by specialty, they snake through the wards in their white coats, stopping to gather at patients' bedsides. Students, who have yet to earn their MD degrees, and interns, who have only recently been awarded theirs, stand listening and learning as the residents speak to patients. It is the residents, many of them in their fourth and fifth years of postgraduate training, who make decisions about the patients' care and treatment in consultation with members of the senior staff.

By seven-thirty on weekday mornings, rounds finished, the residents on the surgical service will be scrubbed and ready to enter the operating rooms. Residents on the internal medicine service head for the clinics to evaluate the problems and complaints of the many outpatients scheduled to be seen that day. Toward evening the groups will assemble again to make another tour of their patients, stopping to speak with families to answer questions and explain treatments. It is a long day.