



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Clinical and Administrative Issues Alexandria VA Medical Center Pineville, Louisiana

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding quality of care, altered medical records, intimidation, and management responsiveness at the Alexandria VA Medical Center in Pineville, Louisiana.

We did not substantiate the allegations made by any of the seven complainants. We found no evidence that the treatment provided by an intensive care unit physician (Physician X) was improper or harmful. We also found that patients received treatment for post-traumatic stress disorder in accordance with guidelines, and that patients were prescribed and received medications suitable to their conditions. We found no evidence that a patient's medical record was altered, and we determined that VA Police & Security Service acted properly to protect the patients and staff in the medical center. Managers were aware of patient and family complaints about Physician X and took acceptable actions to remedy the concerns. We made no recommendations.



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

TO: Director, South Central VA Health Care Network (10N16)

SUBJECT: Healthcare Inspection – Alleged Clinical and Administrative Issues, Alexandria VA Medical Center, Pineville, LA

Purpose

On June 6, 2010, the VA Office of Inspector General (OIG) received a referral from the Assistant United States Attorney (AUSA) for the Western District of Louisiana regarding patient care and administrative issues at the Alexandria VA Medical Center (the medical center) in Pineville, LA. The AUSA had received written statements from multiple complainants and referred the quality issues to the OIG. The Office of Healthcare Inspections reviewed the allegations to determine whether they had merit.

Background

The medical center has 225 inpatient beds and provides acute and intermediate mental health (MH), medicine, surgery, physical rehabilitation, neurology, oncology, dentistry, and geriatric services. Primary and specialized outpatient services are provided at the medical center and two community based outpatient clinics in Lafayette and Jennings, LA. The medical center is part of Veterans Integrated Service Network (VISN) 16, also known as the South Central VA Health Care Network.

In September 2007, a complainant made allegations to the Federal Bureau of Investigation (FBI), who referred the case to the VA OIG. The complainant alleged that his father received questionable medical treatment from a certain physician (Physician X) at the medical center. He further alleged that Physician X provided questionable care to several other patients, presumably with the intention to harm them or cause their deaths. Our investigation revealed no evidence that the complainant's father, nor any of the other patients, were harmed by Physician X. Details of that investigation are outlined in our report, *Questionable Medical Treatment and Suspicious Deaths, VA Medical Center, Alexandria, Louisiana*, OIG report number 07-03382-76, February 14, 2008.

In April 2010, nine complainants submitted written statements to the AUSA regarding quality of care, altered medical records, intimidation, and management responsiveness at the medical center. Four of the nine complainants had also complained in 2007. Two of those complaints were fully reviewed and addressed in our previous report and were not re-evaluated during this inspection. The two other complainants (from 2007) made new allegations in their statements to the AUSA. In case #1, the complainant alleged that our conclusions about the proximate timing of travel funds and a do not resuscitate (DNR) order were erroneous. She also newly alleged that Physician X promised not to remove her husband from a ventilator until family could visit, but did so anyway. In case #2, a complainant raised concerns about a change in the route by which antibiotics were administered. In this report, we followed up on those concerns, and addressed the allegations made by the five new complainants.

Scope and Methodology

We interviewed the complainants we were able to contact. We also reviewed patient medical records; staff training records; relevant policies and procedures; incident reports; performance improvement (PI) data; patient satisfaction reports; patient advocate reports; Physician X's credentialing and privileging folder; an external review report; VA Police and Security Service (VA P&SS) Uniform Offense Reports (UORs); and quality assurance documents.

This review was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Quality of Care Issues

Case 1 : DNR, Travel Funds, and Removal from Ventilator Support*

Allegation 1(a): Physician X lied to the OIG when she said that she had a DNR order 9 days before she sent the \$50.00 [for transportation to the hospital].

We did not substantiate the allegation that Physician X lied to us, or that our previous conclusion regarding the timing of a DNR order and the issuance of travel funds was erroneous. In 2007, the complainant alleged that Physician X sent her a \$50.00 money order in April 2006, so that she would have enough funds to travel to the hospital and sign a DNR request. The signed DNR would allow Physician X to remove ventilator support, and the patient would die.

* We also reviewed aspects of these cases in 2007.

However, a progress note dated April 2006, showed that the wife wanted providers to withdraw life-sustaining support and provide comfort care¹ only. The progress note reflected that the wife asked the physician to wait until all family members could be contacted before removing the patient from the ventilator. For more than a week, the patient remained on the ventilator with comfort care only. Documentation indicated that providers were waiting for the family to decide when to withdraw the patient from the ventilator.

Physician X confirmed that she sent a \$50.00 money order so that the wife, who did not have adequate transportation resources, could see her dying husband one more time before he either died naturally or was removed from life support. The wife came alone to see her husband. The next morning, the physician removed the breathing tube, placed the patient on nasal cannula oxygen, and ordered 5 milligrams of morphine for pain. The patient expired 3 hours later.

As Physician X sent the \$50.00 money order to the wife 9 days after she had already agreed to withdraw life-sustaining treatment, we concluded that the funds were only intended to offset the wife's transportation costs.

Allegation 1(b): Physician X promised not to “pull the plug” until the patient's daughter got to the hospital to see her father before he died.

While it appears that the patient may have been removed from ventilator support before his daughter saw him at the hospital, we did not substantiate that this action was improper. A progress note, written on the day before the patient was extubated, reflected that the patient was non-responsive and had developed multi-system organ failure, and that providers were waiting for family to decide when to withdraw ventilator support. A nurse documented that evening that the wife was at the hospital and wished to remove life support, although she did not want to be present. Physician X was notified. The next morning at 9:10 a.m., Physician X documented, “Wife had come last night. OK with withdrawing off vent [ventilator]... Pt [patient] withdrawn this AM... Daughter is coming from Texas.” The patient died at about 11:00 a.m.

Contrary to the allegation, we found no documented evidence that the daughter called the hospital to report that she was on her way, only to be told that ventilator support had already been discontinued. The patient was placed in a DNR status in mid-April and was removed from ventilator support, with his wife's knowledge and approval, 10 days later.

¹ Relieving pain and suffering, controlling debilitating symptoms, while not preventing the patient from dying.

Case 2*: *Antibiotic Treatment and Amputation*

Allegation 2: Physician X improperly ordered oral (PO) rather than IV antibiotics, which were not powerful enough to treat a patient’s foot infection and methicillin-resistant staphylococcus aureus (MRSA).² Improper use of PO antibiotics contributed to the patient’s right above-the-knee amputation (AKA).

We confirmed that providers periodically changed from IV to PO antibiotics; however, we did not substantiate that these changes had any effect on the patient’s progressive lower leg amputations.

The complainant is a male with a history of stroke, uncontrolled diabetes mellitus (DM), hypertension (HTN), tobacco use, high cholesterol, vascular disease related to DM, and multiple vascular surgeries on both legs. The medical record further documents the patient’s history of non-compliance with his medical regimen.

In June 2005, the patient was admitted for amputation of his right great toe and community acquired MRSA. After the procedure, the podiatrist suggested consulting vascular surgery at the Houston VA Medical Center; however, the patient declined, stating that the Houston surgeons had already told him that they “had done all they could with bypasses and that amputation was next.”

In mid-June 2007, the patient was admitted for uncontrolled diabetes and a severe left foot infection with osteomyelitis.³ On hospital day (HD) 2, surgeons removed the first metatarsal of the left foot. His left foot wound culture was positive for MRSA. On HD 9, the podiatrist wrote “Partial foot amputation possible depending on issue with residual bone infection...” On HD 11, the podiatrist documented that the patient and his wife wished to attempt to salvage the remainder of the foot.

Between 2005 and 2009, the patient underwent progressive amputations of his right and left toes and right foot. Each time he received an alternating combination of IV and PO antibiotics, usually clindamycin, linezolid, gentamicin, and/or ciprofloxacin. His foot wounds routinely tested positive for MRSA.

In January 2009, the patient was hospitalized with a gangrenous right foot. The foot tested positive for MRSA and the provider ordered PO linezolid. The following day, the patient developed a fever and the provider switched to IV linezolid and PO ciprofloxacin. Two days later, the patient underwent surgery for right AKA and he was transferred to the ICU. The next day, the patient transferred to a medical unit and continued on IV antibiotics for 2 more days. The provider then switched to PO antibiotics and discharged the patient on HD 16. During a nursing follow-up call 2 days later, the patient praised the care he received while he was hospitalized.

² MRSA is a bacterium that is resistant to multiple antibiotics, causes serious disease, and is often difficult to treat.

³ Acute or chronic bone marrow infection.

We confirmed that providers changed the route of antibiotic administration from IV to PO several times. However, we determined that these changes were appropriate. When possible, providers try to convert from IV to PO therapy as soon as a patient is able to tolerate oral medications. This change improves the patient's mobility and allows for a more timely discharge home. While MRSA is a serious infection that is resistant to some antibiotic treatments, it is receptive to others. In this case, laboratory test results showed that the patient's MRSA was susceptible to (could be treated by) the antibiotics prescribed.

A combination of multiple health problems including DM, neuropathy, high cholesterol, smoking, and a history of non-compliance contributed to the loss of the limb. Research has shown that, "Patient noncompliance with routine preventative care appears to be associated with a significantly higher prevalence of ulceration and amputation."⁴

Case 3: Medication, Treatment, and Hospital Discharge Issues

Allegation 3(a), 3(b) and 3(c): Physician X discontinued a patient's aspirin therapy during his hospitalization, resulting in pulmonary emboli (PE);⁵ did not timely treat his cancer; and improperly discharged him from the hospital.

We did not substantiate that the discontinuation of aspirin therapy resulted in a PE. Documentation reflects that the patient experienced a PE in February 2008 due to plasmacytoma.⁶ In 2001, the patient was diagnosed with a blood clot in his heart for which he was prescribed blood thinners. The medical record showed that in 2007 he stopped taking the blood thinners and switched himself to aspirin due to side effects (breast tenderness). The anticoagulation clinic pharmacist advised against this action.

The patient was admitted to the medical center in mid-January 2008, for evaluation of middle to lower abdominal pain. On HD 4, a computed tomography (CT) of the patient's thoracic and lumbar spine showed a lytic lesion⁷. A bone survey taken on HD 6 showed bone destruction of the 8th vertebral body of the thoracic spine, but other lytic lesions were not apparent. The patient was scheduled to undergo a CT-guided procedure (kyphoplasty)⁸ to relieve a compression fracture in his thoracic spine on HD 11. Per protocol, Physician X had written an order to hold all blood thinners (aspirin in this case) for 5 days prior to the procedure. However, the kyphoplasty was cancelled and rescheduled several times while providers completed additional work-up. The patient underwent a biopsy of the thoracic lesion on HD 12 and was discharged later that day. He was ambulatory and his pain was controlled at the time of discharge. The patient was

⁴ Armstrong DG, Karkless LB. Outcomes of preventative care in a diabetic foot specialty clinic. J Foot Ankle Surg. 37:460-6.

⁵ Blood clots in the lungs.

⁶ Discrete solitary mass of neoplastic monoclonal plasma cells in either bone or soft tissue.

⁷ Destructive, usually cancerous lesion.

⁸ Procedure to expand collapsed vertebra.

scheduled for a bone marrow biopsy 12 days post-discharge and rescheduled for the kyphoplasty 17 days post-discharge. As such, Physician X did not reorder the aspirin therapy at the time of discharge.

During the first week in February, the patient presented to a private-sector emergency department (ED) with complaints of shortness of breath and back pain. The admitting diagnosis was rule out PE, mass in the lower thoracic region, and probable cancer or plasmacytoma. The plasmacytoma was confirmed on HD 6, and the patient underwent radiation therapy in a private-sector outpatient setting.

We determined that providers were conducting an appropriate work-up of the patient's presumed cancerous lesion. Unfortunately, the patient was admitted to a private-sector hospital before the work-up was completed and treatment initiated. Further, we found that the patient's discharge from the medical center in January was appropriate as the patient was ambulatory, pain free, had follow-up appointments, and met discharge criteria.

Case 4: Medication, Treatment, and Hospital Transfer Issues

Allegation 4(a) and 4(b): Physician X provided "lethal doses" of morphine to a patient, lied about her kidney disease, and did not transfer her to the Houston VA Medical Center for dialysis in a timely manner.

The patient was a female with a primary diagnosis of chronic liver disease, hyponatremia⁹ elevated blood sugar, renal failure with anuria,¹⁰ and hepatorenal syndrome.¹¹

She was admitted to the medical center in mid-August 2007, after 3 days of left lower leg weakness, difficulty walking, and jaundice.¹² On HD 3, Physician X ordered IV morphine sulfate (2mg/1ml) every 6 hours as needed for pain. Over the next 4 days the patient received three doses at the prescribed dosage to relieve pain. After each infusion, the patient's pain level improved and the medical record reflected that she was alert and oriented, resting quietly, or in no apparent distress. According to the Physicians' Desk Reference, the recommended dosage for IV morphine sulfate is 4 to 15 mg every 3 to 4 hours as needed.

We did not substantiate that providers ordered lethal doses of morphine for the patient. We determined that the patient received morphine dosages that did not exceed guidelines and that the treatment appeared to provide effective pain control without adverse effects.

⁹ Hyponatremia is the abnormally low concentration of sodium in the blood.

¹⁰ Anuria is the absence of urine formation.

¹¹ Hepatorenal syndrome refers to the development of renal failure in patients with advanced liver disease.

¹² Yellowing of the skin, usually resulting from liver disease.

An HD 4 progress note reflected that Physician X explained to the patient's daughter that dialysis was for kidney failure and that it would not improve her mother's liver failure. The provider initiated a consult for transfer to the Houston VA Medical Center as requested by the patient's daughter and the patient was transferred on HD 6.

We found no evidence that Physician X lied about the patient's kidney disease. Physician X explained the purpose of dialysis and its relationship to the primary liver failure. We also determined that 2 days to affect the patient's transfer to the Houston VA Medical Center was reasonable and timely.

Case 5: PTSD Treatment

Allegation 5: Medical center staff do not know how to manage veterans with PTSD.

We could not fully evaluate this allegation because it lacked specificity. As the complaint did not include examples of poor patient care or programmatic deficiencies, we evaluated the complainant's care in an effort to understand his concerns.

The patient is a male with chronic PTSD who attended MH appointments at the medical center approximately every 60–90 days between 2002 and 2006. Providers evaluated medication effectiveness at each visit and made medication adjustments according to VA guidelines.¹³

During a dental appointment at the medical center in April 2007, the patient got into a verbal altercation with staff about VA refusing to provide him with dentures. The patient believed his tooth loss was associated with medications prescribed by the VA. In mid-April, the Chief of Mental Health contacted the patient about the dental visit altercation, and at that time, reminded him of the services available in MH. The patient continued to see his primary care provider (PCP); however, he did not return for MH services.

The PCP provider documented in a January 2009 note that it was difficult for the patient to travel to the medical center for MH treatment and he was trying to find a provider near his home. In May 2009, the VA pharmacy filled prescriptions from the patient's private-sector MH provider. The patient continued to be followed by his medical center PCP.

We found that while the patient was actively enrolled in the MH clinic, he received care in accordance with VA guidelines. He received his prescribed medications in a timely manner, and he actively discussed and agreed to medication adjustments. We found no evidence that the patient complained about his MH or PTSD care, and that his decision to seek MH services in the community was a matter of convenience, not dissatisfaction.

¹³ Department of Veterans Affairs /Department of Defense, "Clinical Practice Guideline for the Management of Post-Traumatic Stress" Version 1.0, January 2004.

During a November 16, 2010, interview, the patient told us that the medical center was a “wonderful” place, and that he was pleased with his current care arrangements.

Case 6: Medication and Documentation Issues

Allegation 6 (a): Physician X deprived the patient of his clonidine¹⁴ therapy.

We did not substantiate the allegation. The patient has a history of PTSD, DM and HTN.

The patient had an active medication order for clonidine from August 2006 to April 2010 and was incurring a pharmacy co-payment because the medical record reflected that it was prescribed for “blood pressure to target chronic initial phase insomnia”¹⁵ rather than for his service-connected condition. During the second week in April 2010, the provider cancelled and reordered the clonidine on the same day to reflect that it was “for PTSD, nightmares, and related anxiety.” An early July MH progress note reflects the patient told his provider that his “mood is better now that I don’t have to pay for that medicine clonidine due to it now being linked to my service-connected condition.” As the patient has continuously received clonidine therapy from August 2006 to the present, the allegation has no merit.

Allegation 6(b): A physician that performed a compensation and pension (C&P) examination told the patient he had peripheral neuropathy¹⁶ but the medical report stated the he did not.

While we could not confirm or refute what the patient was told, we found that at least three notes, including a 2008 C&P introduction note, contained reference to the patient’s peripheral neuropathy diagnosis.

During an April 2010, C&P examination the patient reported periodic numbness and tingling in his feet, which was becoming painful. Nerve conduction, and magnetic resonance imaging (MRI) lumbar spine studies, revealed mild to moderate degenerative disc and spine changes. The note states, “No peripheral neuropathy was found on exam, veteran had brisk deep tendon reflexes in the ankle and knee and normal motor, sensory exam to extremities.” A May C&P exam note reflected, “electromyography (EMG) unremarkable per Neurology provider’s note.” Previous exams showed normal ankle reflexes, normal neurological and sensory exams, and recent onset of well-controlled DM. While we found some discrepancies in the patient’s medical record, they did not change the course of treatment or negatively impact his care.

¹⁴ An antihypertensive medication that is also sometimes prescribed for psychiatric conditions including anxiety associated with PTSD.

¹⁵ Clonidine reduces blood pressure, and is sometimes used as a sleep aid.

¹⁶ Disease affecting the functioning of the nerves outside the spinal cord. Symptoms may include numbness, weakness, and pain. There are many causes of peripheral neuropathy, including diabetes, certain drugs, kidney failure, and vitamin deficiency.

Case 7: Medication Dispute

Allegation 7(a): VA P&SS staff removed a patient from the MH clinic after a dispute over the medication lorazepam.¹⁷

We confirmed that there was a disagreement between the psychiatrist and the patient regarding lorazepam that resulted in the patient's removal from the MH Clinic. However, we did not substantiate that this action was improper.

The complainant is a male with a history of PTSD, anxiety, and depression, who has been taking lorazepam off and on since at least 1998. VA clinical practice guidelines do not recommend the use of benzodiazepines for the long-term management of PTSD symptoms but do acknowledge their use in the treatment of anxiety symptoms. Throughout the years, the patient's PCP and MH provider have periodically attempted to wean him from the lorazepam and introduce different medications that were less likely to cause dependence. In general, the patient was not satisfied with the changes and always requested to be placed back on lorazepam.

In late May 2006, the patient's lorazepam was discontinued and he was placed on diazepam (also a benzodiazepine). However, he still had four lorazepam refills available and continued to take this medication.

In late January 2007, the patient saw a new MH provider. At the time, the patient was prescribed diazepam (for restless leg syndrome) and citalopram (for depression), but was also taking lorazepam on his own. The patient requested a new prescription, to which the provider documented, "Patient will be referred to another clinician since his request cannot be fulfilled by current provider."

Five days later, the patient saw a second MH provider who had not treated the patient before. The MH staff, apparently anticipating a possible confrontation about the patient's lorazepam, arranged for another psychiatrist to also be present. The patient told the MH provider that he had been taking increased doses of lorazepam and other benzodiazepines due to the escalation of his anger toward his neighbor.

At the time of this visit, the MH provider documented the plan, as follows:

"1) When patient has discontinued/runs out of his current supply of benzos (he recently got refills of valium) plan to taper and discontinue use of all benzos with use of an [lorazepam] taper. Informed patient concerning the contraindications of benzo in treatment of PTSD. Benzos cause problems with disinhibition and can result in escalation of anger/flashbacks with amnesic episodes. Benzos also known to make depression worse. 2) In

¹⁷ Lorazepam is a medication that acts as a tranquilizer, used for short-term relief of anxiety.

future, patient may consider other meds/atypical antipsychotics to help patient control his rage. 3) Patient also offered anger management, which he refused. 4) Patient may request followup as needed.”

When the MH provider discussed the plan to wean him off lorazepam, the patient became hostile and refused the recommendation. The MH provider documented, “Patient was asked to leave provider’s office due to fear of further escalation of patient’s anger/hostility.” When the patient refused to leave the office, the MH provider contacted the VA P&SS in order to maintain safety of the staff. The VA P&SS Uniform Offense Report reflected that the patient was hostile. He [the patient] was advised to take his complaint to the patient advocate; however, we found no patient advocate reports related to this event.

In mid-February, the patient saw a MH clinic social worker to discuss his concern about the plan to discontinue the lorazepam that he had been taking off and on for 18 years. Six days later, arrangements were made for the cardiovascular disease/internal medicine physician, who was familiar with this patient’s care, to participate in a team meeting with MH providers and the PCP. The team agreed to restart the patient on lorazepam due to anxiety, and noted that the lorazepam would be prescribed by the PCP. They also agreed that he would continue to see his MH provider for his PTSD.

In late-May, the cardiovascular disease/internal medicine physician saw the patient and documented that they were working with the MH team to reduce and taper the lorazepam. On August 9, a MH provider wrote that the patient was receiving his medication management from his PCP, and “pt. desires to continue with this plan...” The MH provider further documented that they discussed this decision, and if he [the patient] wished to continue his medication management with the PCP, then there was no need for him to continue medication management with MH. The provider then documented that the patient could return to the MH clinic as needed.

In early August, the MH provider documented that the patient was currently being managed by PC, and “patient desires to continue with this plan.” VHA policy¹⁸ states that evaluations and treatment for MH conditions can be provided through MH, primary care, or by arrangements with non-VA community services.

We determined that the decision to have VA P&SS remove the patient from the MH provider’s office when his behavior became hostile and threatening was appropriate.

¹⁸ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, June 11, 2008.

Allegation 7(b): Medications were all discontinued and MH services denied.

We did not substantiate the allegation that the patient's medications were all discontinued and MH services denied. He received services in primary care and MH about every 90 to 120 days from October 2001 through August 2007.

We found no evidence that the MH clinic refused to provide services; rather, it appears that the patient agreed to have his PCP manage his medication and mental health conditions after August 2007.

Issue 2: Altered Medical Record

We did not substantiate the allegation that a patient's medical record was altered to hide Physician X's refusal to provide appropriate care. The patient's clinical course is outlined in Case 3, above.

During a phone interview, the patient reported that in or around April of 2008, he secured a copy of his medical record from his most recent medical center admission (January 2008). He reported that the record did not include information about white blood cell (WBC) counts, magnetic resonance imaging (MRI) studies, or CT scans. He told us that he misplaced the first medical record so he secured a second copy. The patient alleged that in the second copy, the medical center had incorporated the test results from the private-sector hospital into his VA medical record. He believed that the VA medical center was trying to take credit for work that the private-sector facility performed.

The patient's VA medical record reflects that in January 2008, he underwent CT scans of the thorax and pelvis with contrast, a CT of the thoracic and lumbar spine without contrast, and a bone survey¹⁹ at the medical center. While the VA medical record did not contain evidence of a WBC count being completed during his hospitalization, we did not find that to be problematic. The patient was not exhibiting signs of infection; thus, a WBC was not necessarily indicated.

We confirmed that the private-sector hospital's clinical notes were incorporated into the patient's VA medical record. The medical center's Utilization Management (UM)²⁰ department secured clinical information from the private-sector hospital in accordance with policy.²¹ This data was scanned into the patient's medical record so that it would be available to clinical providers for continuity of care. The UM staff also entered five notes related to the patient's admission to the private-sector hospital. The UM department is

¹⁹ A bone survey is a series of x-rays to check the health and status of a person's bones. It is an important tool for diagnosing the presence of multiple myeloma lesions in bone.

²⁰ Utilization management is the evaluation of the appropriateness, medical need, and efficiency of health care services, procedures, and facilities according to established criteria and under the provisions of an applicable health benefits plan.

²¹ Medical center memorandum 04-15, *Interfacility/Community Transfers*, September 7, 2007.

required to follow up with private-sector hospitals daily when VA has approved, and is paying for, a patient's care.

We found no evidence that the patient's medical record was altered; thus, we determined that there was not an effort to hide Physician X's refusal to provide care via this method. As indicated in our case review, we found the patient received appropriate care.

Issue 3: Intimidation

We did not substantiate the allegations that VA P&SS personnel were used to intimidate patients. Intimidation is a matter of perception that is difficult to validate. However, we found no evidence that any of the patients complained to the patient advocate or other officials at the time of the alleged events about intimidation or fear of reprisal. We confirmed that a MH provider contacted VA P&SS regarding a patient who had left the facility against medical advice.²² The MH provider felt that the patient may have been at risk for harm to himself or others. Ultimately, the MH provider determined that the patient was not an immediate risk and cancelled VA P&SS intervention. We found that the MH provider's actions were reasonable and appropriate to ensure the patient's safety.

We also confirmed that MH providers contacted VA P&SS when a patient refused to leave the MH outpatient clinic after a disagreement regarding an anti-anxiety medication (case 7 above). We determined that the MH provider and the VA police acted to maintain the safety of the patient and the MH staff in accordance with the medical center's policy on managing disruptive behavior.

A third complainant alleged that it was intimidating to know that providers *could* call VA police. We found this to be a speculative statement.

Issue 4: Management Responsiveness

We did not substantiate the allegations that management did not respond to patients' complaints about Physician X. We confirmed that management was aware of the concerns voiced by several patients and their family members. An external review agency evaluated the allegations and did not find any quality of care issues. However, they recommended that Physician X receive training. After completion of the training, staff noted improvements in Physician X's interpersonal skills.

We could not confirm or refute that senior managers did not respond to a patient's complaint about his treatment in the MH outpatient clinic. The medical center had no documentation on adverse events or patient advocate reports related to this case and two senior managers who may have had knowledge of the case had retired and were unavailable for interview.

²² The event involved the patient outlined in case #6.

Conclusions

We determined that the treatment provided to all the patients included in this review was appropriate. We found no evidence that the treatment provided by Physician X was improper or harmful. We found that VA P&SS acted properly to protect the patients and staff in the medical center, and that management took acceptable actions to address patient and family concerns related to Physician X.

Comments

The VISN and medical center Directors agreed with our findings. We made no recommendations.

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 10, 2010
From: Network Director, South Central VA Health Care Network (10N16)
Subj: OIG Report – Alexandria, LA VAMC
To: Director, Atlanta Office of Healthcare Inspections
VA Office of Inspector General

1. Thank you for the opportunity to review this draft report. I concur with the report and have no comments.
2. Should you need additional information, please contact Mary Jones, HSS, at 601-206-6974.

(original signed by:)

George H. Gray, Jr.

Medical Center Director Comments

Department of
Veterans Affairs

Memorandum

Date: December 7, 2010
From: Medical Center Director (502/00), VAMC, Alexandria, LA
Subj: Action Item: 16-10-12-20 – OIG Report - Alexandria VAMC
To: Network Director (10N16), South Central VA Health Care Network
Attn: Mary Jones

1. Thank you for the opportunity to review this draft report. Alexandria VAMC **concurs** with the content as stated in this draft. The findings will help to confirm to Physician X that she practiced evidenced-based medicine that was patient-centered.

2. Should you need additional information, please contact Chandra Harris, RN, BSN, MSA, Risk Manager, at (318) 466-2390.

(original signed by:)

Gracie Specks, MS, MBA

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates, Director Atlanta Office of Healthcare Inspections
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Acknowledgments	Jerome Herbers, MD Alice Morales-Rullan Karen Sutton
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