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White Paper Regarding Hotline Inspection
VA Medical Center, Alvin C. York Campus, Murfreesboro, TN
2009-00068-HI-0005
HL-0026

I. BACKGROUND

In a recent confidential complaint to OIG, allegations were made that [redacted] received poor care during a visit to the emergency department and weekend inpatient stay at the Alvin C. York VA Medical Center.

The medical record was reviewed and interviews were conducted with individuals involved in the care of this veteran including his primary care provider, attending physician for acute care, gastroenterologist who completed the flexible sigmoidoscopy, surgeon who performed the diverting colostomy, as well as nurses and other selected staff.

Our review examined the entire spectrum of this patient's care and we found concerns related to [redacted]

- [redacted] told us that she was close friends with [redacted] for 15 years. They did church missionary work together and she considered them "family."
- According to [redacted]'s report, [redacted] had not had health care since serving in Vietnam. [redacted]. The same day, [redacted] enrolled at the Alvin C. York VA Medical Center and subsequently had a [redacted] outpatient clinic visit with [redacted]
- From our review of records, we found that his presenting symptoms were serious and warranted an aggressive approach. [redacted] failed to do so during the initial appointment with [redacted]. For example, she did not: 1) complete a rectal exam; 2) expedite a colonoscopy appointment by provider-to-provider phone call or identify the consult as urgent; 3) order further diagnostic studies to address his enlarged liver with elevated liver enzymes; nor 4) schedule him for follow up sooner than 3 months. Further, she ordered an anti-anxiety medication, which is contraindicated in liver disease, without documenting symptoms or justification.
- [redacted] told us that [redacted] brought a letter from [redacted] which she read and returned to the patient. She claimed this letter reflected [redacted]'s concerns about possible colon cancer. She admitted that she did not reference, keep, or photocopy the letter for VA records.
- [redacted] came to the Alvin C. York VA Medical Center Emergency Department with worsened symptoms. That afternoon, he was admitted to ward 1A with [redacted] as the attending physician.

- [redacted] told us that she went, as a friend, to visit him after work that day and found no treatments in progress. Therefore, she went to the nursing station, used CPRS to review his medical record, and made phone calls regarding his care. According to [redacted] these phone inquiries were met with an AOD report that radiology staff left for the day and an MOD who was not concerned.
- Upset with the perceived lack of medical attention for [redacted] stated that she left the medical center and drove 120 miles on her motocycle to visit her parents. [redacted] said that she returned to check on [redacted] on Sunday and spoke with [redacted] regarding his mental status changes, order for restraints, and being forced to have Colyte after vomiting.
- During her interview, [redacted] stated that she was approached in the hallway by an angry woman with wildly mussed hair, big boots, unusual clothes, and a non-professional appearance. [redacted] asked her who she was and [redacted] said she was related to [redacted]. According to [redacted] was inappropriately confrontational, loud, and critical while standing in the hallway and within earshot of other people. Concerned for patient privacy, [redacted] led [redacted] to [redacted] room and gained permission from him to discuss his care with her. In the presence of [redacted], [redacted] was again rude, critical of the care given, and threatened to go to higher authorities.
- [redacted], a flexible sigmoidoscopy was performed and [redacted] was found to have advanced rectal cancer with liver metastasis. Within hours, he was transferred to Nashville VA Medical Center where he underwent emergency surgery the next day. The patient improved sufficiently to be discharged home [redacted] with instructions to return to the Surgical Clinic in one week.
- [redacted] inappropriately used a CPRS electronic consult to outline her concerns about the inpatient care delivered to [redacted]
- [redacted] returned weekly for specialty outpatient appointments, but deteriorated rapidly from progression of the disease. He was re-admitted to Nashville VA Medical Center on (b)(6), and ultimately discharged, at the wife's request, with home hospice care [redacted]. [redacted], he died at home [redacted].
- [redacted] stated that she gets into trouble when reporting concerns within the VA. Instead, she reported her concerns regarding this care episode to a community physician, thereby violating privacy rules. She told us that she has not had a good relationship with [redacted] since her initial job interview when he was verbally and behaviorally hostile towards her.

We found several additional points of concern in this inspection:

- We found that principles of ethics and professionalism were compromised by [redacted]s arrangement to treat a close friend, her actions to intervene

with his Inpatient care, and inclination to report internal problems to non-VA sources.

- Compared to the reports of other clinical staff and documentation within CPRS, [redacted] gave exaggerated descriptions of the patient's colonoscopy preparation, reaction to medications, and length of ventilator support. Further, her reports regarding availability of weekend services were not substantiated by other providers.
- Others describe interactions with her as emotionally driven and stressful.
- [redacted]s presentation during our interview was professional but very rigid and with forced effort to suppress emotion. She was the only interviewee who was accompanied by a union representative.
- [redacted] blamed others for her personal struggles and poor working relationships.
- [redacted] stated that she was an advocate for veterans. However, some of the steps she had taken towards that goal have been reactive.

II. CURRENT STATUS

Preliminary findings appear to not substantiate allegations of poor emergency and inpatient care during June. However, problems with conduct by [redacted] and outpatient care provided by her [redacted] were identified.

III. CONCLUSIONS

Inspection findings raise concern that [redacted] may be emotionally volatile and her clinical skills need to be evaluated. It seems appropriate for the system to take action to further investigate this matter and take actions, as indicated.

IV. FOLLOW UP

[redacted]