Patient Deaths Blamed on Long Waits at the Phoenix VA

This morning the lead article in the Arizona Republic was a report blaming as many as 40 deaths at the Phoenix VA on long waits (1). Yesterday, Rep. Jeff Miller, the chairman of the House Committee on Veterans Affairs, held a hearing titled “A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths.” “It appears as though there could be as many as 40 veterans whose deaths could be related to delays in care,” Miller announced to a stunned audience. The committee has spent months investigating patient-care scandals and allegations at VA facilities in Pittsburgh, Atlanta, Miami and other cities. Miller said that dozens of VA hospital patients in Phoenix may have died while awaiting medical care. He went on to say that staff investigators have evidence that the Phoenix VA Health Care System keeps two sets of records to conceal prolonged waits that patients must endure for doctor appointments and treatment. Sharon Helman, director of Phoenix VA Health Care System, said in a written statement: “We take seriously any issue that occurs in our medical center and outpatient clinics. Therefore, we have asked for an external review by the VA Office of the Inspector General [OIG] ... If the OIG finds areas that need to be improved, we will swiftly address them as our goal is to provide the best care possible to our veterans.”

VA health system workers who asked not to be named because they fear retribution, said patient access data incorrectly show vets are able to see physicians within days when actual waits may be months. Dr. Sam Foote, who retired from the Phoenix VA in December, filed complaints with the VA inspector general seeking investigations of alleged medical care failures and administrative misconduct. In a Feb. 2 letter to the inspector general, Miller, Sen. John McCain and Rep. Ann Kirkpatrick, Foote said the Phoenix system is afflicted by “gross mismanagement of VA resources and criminal misconduct” that produced “systemic patient safety issues and possible wrongful deaths.” According to Foote, VA IG investigators came to Phoenix late last year and verified allegations he’d made in an October complaint, but no action was taken. In an interview, he said patients “were deliberately being held off the lists” to misrepresent the speed of health services for vets, but it remains unknown how many of the deaths may have been preventable. Foote went on to allege hostile working conditions that caused an exodus of quality doctors and nurses, producing backlogs in both primary care and specialty areas. One example was urology, where resignation of several of the staff urologists forced patients to be referred to out-of-state VA centers or private physicians for treatment. Foote described elaborate techniques that were used to mischaracterize system responsiveness, estimating that up to 30,000 patient charts have been altered. He said thousands of new patients must wait up to a year for assignment to primary-care physicians who are overbooked.

Allegations of falsifying wait times or retaliation against whistle-blowers are nothing new at the VA. A Senate hearing in 2011 found similar falsification of wait times (2). Review of the Office of Inspector General’s website revealed multiple instances of similar findings dating back to at least 2002 (3-6). In each instance, unreliable data regarding wait times was cited and no action was taken.

Fear of retaliation was cited by Foote as a reason for retirement and other employees asked that their names be withheld (1). These fears appear to be realistic. Recently, a VA employee was demoted after providing testimony about financial mismanagement at the Phoenix VA (7). In contrast, it appears that VA administrators have little to fear from whistle blowers, the OIG, or Congress. If recent history is any guide, it seems likely that the delays will be blamed on lazy providers and VA administrators will create another layer of bureaucracy ostensibly to solve the problem. However, the outcome will be further repression of any whistle blowers and depletion of already short patient care resources.

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