ISSUES AT THE HARRY S. TRUMAN VA MEDICAL CENTER IN COLUMBIA, MO

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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ISSUES AT THE HARRY S. TRUMAN VA MEDICAL CENTER IN COLUMBIA, MO

WEDNESDAY, OCTOBER 25, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Y. Tim Hutchinson (chairman of the subcommittee) presiding.

Present: Representatives Hutchinson, Smith, Bilirakis, Quinn, Edwards, Kennedy, and Bishop.

Also present: Representative Volkmer.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. Good morning. I call this hearing of the subcommittee to order.

The subject of this morning's oversight hearing encompasses the tragic events at the Harry S. Truman VA Medical Center, Columbia, MO. The issues to be covered will include the work of the VA Office of Inspector General during its 3-year investigation into unexplained deaths and subsequent allegations of a cover-up of those deaths. We will include management and administrative issues raised in the Inspector General's report.

It is my understanding that the VA IG was called in to work on this case in October of 1992, when a statistical analysis led to grave concerns about an increased number of deaths on a particular ward of the hospital.

The VA IG issued two reports on Columbia, the first on September 28, 1994. This report concluded that although the IG could not comment on the causation of increased deaths on the particular ward at the hospital, a statistically significant relationship between a nurse, who is identified only as Nurse H, and the deaths on a particular nursing unit, could be concluded on the basis of statistical analysis.

In the report, the IG stated that the probability of this situation occurring by chance was less than 1 in 1 million.

In front of you this morning is a chart from the first IG report which graphically depicts the death rate for Ward 4 East. This is the unit on which Nurse H worked the night shift and the site of the increased and yet to be explained patient deaths.

In response to continued problems at the medical center brought on by charges of an alleged cover-up of patient deaths during 1991

and 1992, the IG continued their investigation at Columbia and released a second report less than one month ago.

As chairman of this subcommittee, I can say only that it was unsettling. It was very troubling. It was shocking to read this report.

The report identified a dysfunctional top management team in place during the 3-year period of the IG investigation. This team served only to exacerbate the seriousness of the unexplained increase in deaths at the medical center.

Although the team was ill equipped to handle the situation, the IG could not or did not substantiate the allegations of obstruction of justice or criminal misconduct by the team in place at the time.

The purpose of this hearing is to provide the subcommittee with a better understanding of the issues raised by this grave situation and to determine the degree to which the VA is able to identify, correct, and ensure the proper functioning of its top hospital managers.

I want to remind my colleagues—many of whom are in Democratic caucuses and Republican caucuses this morning, but I think they have a written memo on their desk when they arrive—that this is a hearing, not a trial.

The criminal part of this investigation has been in the hands of the FBI since 1992. Since that time, they have exhumed 13 bodies and have been conducting sophisticated toxicological tests on fluid and tissue samples taken from the exhumed remains.

I have personally reiterated my deep concern for a speedy resolution to the forensic part of this investigation, to Louis Freeh, the Director of the FBI. The highest concern of this subcommittee is to ensure that VA patient care is delivered in environments that are safe and free of harm.

It is my expectation, and one which is shared by my colleagues, that those who care for our Nation's veterans are the highest quality managers and health care practitioners and are committed to saving lives. These practitioners should also be able to exercise their best medical judgment in an environment that they perceive as safe without fear of personal or professional retribution.

Now, to reasonably accommodate all the witnesses this morning, I ask that each of you summarize your remarks in 5 minutes or less. Your complete written statements will be entered into the record.

I now recognize Chet Edwards, the ranking member, for his opening remarks.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS. Thank you, Mr. Chairman.

Normally I just submit my written statement, but because of the importance and nature of this hearing, I would like to read these comments into the record.

This hearing does raise a very disturbing subject. It goes to the most profound of VA's obligations, which is safeguarding the lives of its patients.

While there is generally agreement regarding some of the events that occurred at the Columbia, MO, VA Medical Center in 1992, there are sharp differences as to exactly what happened.

We will hear testimony to the effect that certain VA officials at the Columbia VA Medical Center in 1992 failed to fully meet critical obligations to safeguard VA patients. However, we will also hear conflicting testimony on this and other points; one view from the VA's Inspector General's Office and another from a member of the medical center staff. It is not clear that a single hearing, without sworn testimony from the many other medical center staff, regional office officials, and others involved, can fully resolve these factual conflicts.

Is this a case of mismanagement or, as one witness will allege, a cover-up, or is it neither? That is an important question, and I don't have the answer to that question, and that is why I appreciate your having this hearing, Mr. Chairman. Until we can answer that key question regarding Columbia to our satisfaction, I do think it is important to be careful in prescribing changes for the entire VA system.

I certainly have reached no judgment as to whether or not we will find a need to make systematic changes in the VA system, but if changes are indicated, I don't think we want to create a VA health care system that is administered mechanically in accordance with a Washington written policy cookbook. No set of rules or policies can replace good management. What I think we want is a VA system in which hospital administrators combine a dedication to patient care with the capacity and willingness to exercise sound judgment.

In that regard, I hope the very significant reorganization and cultural change under way in the Veterans Health Administration will foster a climate of patient-centered decision-making and local accountability.

Mr. Chairman, I commend you for holding this hearing. It raises very important issues, which I know we will address deliberately, forthrightly. I know this committee will not duck from hard questions. At the same time, I urge us not to leap to conclusions that we must do something before we get all the facts.

Once we have those facts, if we find cases of serious mismanagement, if we find cases of system breakdowns, then I will work with you and all other members of this committee to see that we make the changes necessary to prevent any unnecessary deaths in our VA medical centers.

Thank you very much, Mr. Chairman.

Mr. HUTCHINSON. Thank you.

Mr. Kennedy, do you have an opening statement?

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY, II

Mr. KENNEDY. Just very brief comments.

I want to first of all thank you, Mr. Chairman, for holding this hearing. I want to thank our witnesses for coming.

Obviously, the notion that this sort of a Dr. Kervorkian-type situation is roosting in the halls of a VA hospital, going on without any checks at all in terms of the kinds of activities that this individual was potentially involved with, is something that obviously needs to be addressed, and I think that you are to be commended for hosting a hearing and trying to get at the bottom of what is actually taking place at this facility. I appreciate that.

I am looking forward to hearing what the testimony is, and I believe these are very, very serious allegations that are being made, and I think it is important that this committee is willing to delve into controversial, difficult, and obviously very serious charges that are being made.

So I want to thank you, Mr. Chairman. I look forward to hearing from our witnesses.

Mr. HUTCHINSON. Thank you.

The chair now recognizes our first witness, Dr. Gordon D. Christensen, M.D., Associate Chief of Staff for Research and Development at the Harry S. Truman VA Medical Center in Columbia, MO.

Dr. Christensen conducted the statistical analysis which first led to the identification of the significant statistical relationship between a particular nurse and the deaths on the unit on which this individual worked.

Dr. Christensen, if you would be seated, we do thank you for traveling to be with us today. We welcome you.

Dr. Christensen, you are recognized.

STATEMENT OF GORDON D. CHRISTENSEN, M.D., ASSOCIATE CHIEF OF STAFF FOR RESEARCH AND DEVELOPMENT, HARRY S. TRUMAN VA MEDICAL CENTER, COLUMBIA, MO

Dr. CHRISTENSEN. Mr. Chairman and members of the committee, I am here to testify that the OIG report is wrong and dangerous. The report is wrong because it is an incomplete, dishonest, biased, flawed, and distorted presentation of the events that took place in Columbia. The report is dangerous because acceptance of this report promotes the cover-up of this mess and endorses the VA's policy of intimidation of whistle blowers. If you want to prevent a tragedy like this one from happening again, you must take immediate strong action.

I make these claims because I am the physician who led the internal investigation into the deaths at the Harry S. Truman Memorial Veterans Hospital. I am also a physician whose public charges initiated the Inspector General's investigation. I personally witnessed and documented a major portion of the events under our review today. When I tell you the OIG report is wrong, I know what I am talking about.

I led an internal investigation into the unexplained deaths in Ward 4 East. We found that at least 11, and probably more than 40, veterans died under circumstances that suggested they were killed. These deaths were overwhelmingly associated with a single nurse. On one in every three shifts worked by the nurse, a patient died. After 3 years' denial, the VA now reluctantly agrees with me that there was reason to suspect murder and that this matter was mishandled.

Unfortunately, there is not enough time for me to cover all the incomplete, dishonest, and biased, flawed, and distorted portions of the OIG report. Even my written testimony is incomplete. Instead, here are just a few glaring items:

Item: The OIG proposes to take administrative actions against the former acting Associate Director for Nursing and the former Chief of Staff because they did not act on rumor and they did not

adhere to a nonexistent policy to quickly address the unexpected deaths.

At the same time, the OIG informs us that the former Hospital Director, the former Regional Chief of Staff, and the current Regional Director actively opposed this same nonexistent policy.

How can we possibly hold a subordinate responsible for actions, decisions, and nonexistent policies that are actively opposed by top management?

Item: The OIG states there was no obstruction, but on page 38 they state—and I quote—"The director's action can be viewed as an effort to impede an official investigation by intimidating employees," unquote.

Item: The OIG tells you that these problems were due to a dysfunctional relationship between the Hospital Director and the Chief of Staff. What the OIG didn't tell you was that the Hospital Director had a long history of autocratic intransigent behavior, that he was unable to get along with any of his many Chiefs of Staff, and that his behavior was well documented, well known to the VA. In 1985 it almost resulted in the medical school breaking the affiliation.

Item: The OIG report declared it was appropriate for the Dean of the medical school to ignore the 40 unexpected deaths on a teaching ward and the charges by a house officer that nurses were killing patients because this was, I quote, "an internal matter."

Is this attitude consistent with the spirit of affiliation?

Item: In the entire 66-page document, the OIG neglected to tell you that on September 2, 1992, when I was the second in command of the hospital, I analyzed the data, called an emergency meeting, and told the Hospital Director, Mr. Kurzejeski, point blank that there were objective reasons to think that Nurse H was killing patients and the FBI must be immediately informed. Mr. Kurzejeski refused to call the FBI and repeatedly refused to call the FBI over the following months.

When I responded by stating I would report the nurse, the Chief of Staff of the region appointed a team of professionals to go to Columbia, review the data, and make the decision to report the nurse. But what the OIG didn't tell you is that the team did not intend to review my data, that I was kept off their agenda.

When I discovered this, I again stated I would go to the FBI. In response, the Chief of Staff, Dr. Dick, prevailed upon the team to allow me to present the data. After this presentation, the data could no longer be hidden. After this presentation, Mr. Kurzejeski told Dr. Dick—and this is what he told me—"You can expect to take a hit for this and probably Christensen too."

The conclusion that the OIG helped cover up this mess is inescapable. I personally briefed the Assistant Inspector for Health Care Inspections, Dr. Connell, on these problems in October of 1992. I then repeated these charges in writing to the Inspector General, Mr. Trodden, in February of 1993 and again in May of 1994. The conclusion that the OIG simply mislaid or forgot that high officials had been charged with obstructing the investigation into the deaths of 40 veterans is simply preposterous.

The voluntary departure of many of the charged officials over the 2 years the investigation languished only confirms the cover-up. In

the words of the editor of the Columbia Daily Tribune, "I call it a cover-up, big time."

This was a biased investigation. The investigation was conducted by the two agents who were blamed by the Inspector General for mishandling the allegations in the first place. After 9 months of investigation, the Inspector General released their report in a combined news conference with the hospital, a conference to which I was not even invited, although I did attend.

After reviewing the report, one of the very few things I learned was that there was a discussion between the Assistant Inspector General and the Chief of Staff of the hospital about taking actions against me for violating confidentiality regulations. This is the same Chief of Staff that had already promised to "get me" and who had threatened me if I dared to publicly report the possible murders of these veterans. I maintain that a watchdog agency cannot indulge in adversarial relationships with its informants and expect to provide impartial and rigorous oversight of management.

In a letter to the Columbia Daily Tribune published on Saturday, the correspondent clearly stated the issues before us: "Would the public really be happy with Richard Nixon appointing his staff to investigate Watergate or Bill Clinton appointing his staff to investigate Whitewater? Basically, all this cover-up thing is the VA investigating itself. How legitimate is that? There is a cover up. It's as plain as day. Deal with it and investigate to get these people out of the system."

The Inspector General's report is dangerous because it takes no steps to protect whistle blowers like myself and my colleagues. The only reason why I have been able to push this issue this far is because I have a professional standing independent of the VA. If I was not a tenured faculty member, if I was not a respected physician and scientist, I would have no hope of bringing this matter to your attention.

If the VA cannot respond to a quality of care problem as basic as this one and as well documented as this one, then there is no hope that the VA will ever respond to any problems that would be considered embarrassing to the VA.

In conclusion, I ask you, in the strongest possible terms, to reject the Inspector General's report and convene a truly impartial and rigorous investigation into the administrative response to deaths in Columbia. I ask you to take strong and quick action to protect whistle blowers like myself and my colleagues. If you do not do this, I can guarantee you that nosocomial murder as well as a whole host of less dramatic but equally dangerous patient care problems will happen over and over and over again.

Thank you.

[The prepared statement of Dr. Christensen appears at p. 106.]

Mr. HUTCHINSON. Could you explain to the subcommittee when and under what circumstances you were asked to perform the statistical analysis of mortality data at the Veteran's Center?

Dr. CHRISTENSEN. Sure. On August 27 of 1992, the quality assurance manager—the QA manager—came down and told me that there was a problem and that Dr. Adelstein, who was the acting Chief of Staff at the time, had asked me to be involved with it.

Basically, the problem was that there was a nurse who seemed to be associated with a series of deaths on the ward, and the association was that the deaths seemed to be taking place at night, and this was the time the nurse worked. The question was: Could this association, just be a matter of chance because the nurse was unlucky, or was there a real relationship?

Mr. HUTCHINSON. And how long did it take you to conduct the review, or the statistical analysis?

Dr. CHRISTENSEN. Well, we started on August 27, and we concluded the initial analysis on September 2. We worked around the clock, through the night, and so forth.

Mr. HUTCHINSON. And what did you find in your review?

Dr. CHRISTENSEN. I found that there was an overwhelming association of one nurse. I didn't know which nurse, because they purposely didn't tell me any names. I asked the QA manager not to tell me any names, so she coded all the names.

I knew that there was an overwhelming association of one nurse with codes and with deaths, basically, at least a tenfold increase. The probability of it occurring by accident was so infinitely small that I couldn't calculate the number. It was highly significant, and that was sufficient for me.

Then I gave her the results. This is when Nurse H got the designation, because that was the code letter assigned to that particular nurse. She revealed that that was the nurse upon which the suspicions had focused.

Mr. HUTCHINSON. What were the statistical probabilities this could have happened by chance?

Dr. CHRISTENSEN. It was a probability of less than one in a million. My original calculation was less than one in a thousand, because from a statistical point of view, that was all that was important.

My statistical abilities did not allow me to calculate a number smaller than one in a thousand because these numbers don't appear in the normal manuals. The normal statistical tables only report the probabilities of less—1 in 10, or 1 in 20, or 1 in 1,000. They don't go to one in a million, because it is so highly significant.

Mr. HUTCHINSON. Dr. Christensen, after you completed your analysis, what did you do with it, and what was the reaction of those to whom you reported?

Dr. CHRISTENSEN. I called the emergency meeting, and we convened a group of the hospital leaders. I was the acting Chief of Staff on that particular day. The meeting included Mr. Kurzejeski, the QA manager, and a series of other people, and we presented the data, that this was a big association.

At that particular meeting, it was revealed to Mr. Kurzejeski that there was a lot of talk on the ward and that an intern had accused the nurse of killing a patient. As it worked out, that was the last patient who died in the series. I gave them the data and I said it looked like there was very real reason to think there was murder and we should call the FBI or the police or the coroner today. They had to be contacted today because they needed an opportunity to conduct an investigation while the nurse still didn't know that he was under investigation, so that they could gather

evidence, perhaps survey the individual, perhaps observe the individual, or do something in order to figure out what was going on.

Mr. HUTCHINSON. And the reaction?

Dr. CHRISTENSEN. He (Mr. Kurzejeski) said that we should not report it, that that was his decision to make. He said that he would think about it and that perhaps he would call the OIG.

So what I did was, I continued the analysis, rechecked my calculations, and reapproached him the next morning right after the morning report.

I was no longer the acting Chief of Staff. Dr. Adelstein had taken over at that point as the acting Chief of Staff, and I reiterated my request and told him that the reanalysis and recalculation and recheck of the figures, all confirmed what I had earlier told him, that we needed to call somebody right away.

Mr. HUTCHINSON. In your own notes, you state that patients appear to have died natural, spontaneous deaths and there was no overt evidence of murder.

Dr. CHRISTENSEN. That is correct.

Mr. HUTCHINSON. Yet in your testimony you allege that, in fact, there was a murder and a subsequent cover-up.

Is there an apparent contradiction, or am I misreading, or how do you explain it?

Dr. CHRISTENSEN. No, you are not misreading at all. You have to recognize, I am talking from a medical standpoint and an epidemiological standpoint. The evidence, or the appearance of murder, is only present in the aggregate and is not present in any individual situation.

We know that in aggregate, looking at all the deaths on the wards, that there were far too many that could be explained. But looking at any one particular individual, just looking at the person there was no overt evidence of death, although there were a number of very funny situations where patients died unexpectedly.

The QA reviewers, who are trained in this did notice that the patient's progression toward death just wasn't normal. Some people were dying simply when they shouldn't be dying, and there were too many of these unexpected or unanticipated deaths. But if you really looked at any individual person, just in and of themselves, you would be hard pressed to say that there was anything particularly unusual.

Mr. HUTCHINSON. With your statistical data, where you were citing one in a million, I think that was later confirmed by another biostatistician?

Dr. CHRISTENSEN. Yes, that is correct.

Mr. HUTCHINSON. Is there any explanation for that spike in deaths apart from, you know, some kind of a homicide or something like that?

Dr. CHRISTENSEN. Yes. First, you have to realize that we didn't believe it either. Those of us who work in hospitals don't usually think of people killing people in hospitals. You don't work in hospitals to kill people. You work in hospitals to save people. So we actually worked from a bias that it couldn't possibly be.

There were two major concerns. One was that it was just an unlucky association, and two was that there was a shift in the popu-

lation in the hospital from one ward to another; that there was a realignment of patients.

Now, we did not have a whole lot of data on the realignment, because the possibility the nurse was associated with the deaths emerged so quickly and was, of course, very pertinent to the care in the hospital.

The OHI looked at the realignment issue and was able to detect three different trends. One trend indicated that there was an increase in deaths on the ward which occurred before the nurse started working there and which they thought could be explained by a change in the hospitalization patterns of patients in the hospital.

They also noted a much stronger association of deaths when the nurse went on the ward, a similar and very strong association of the deaths stopping when the nurse went off the ward, and a prolonged low rate of deaths on the ward which they ascribed to the Hawthorn effect. The Hawthorn effect is when the increased attention to the ward made everyone more careful, this is often seen in situations like this.

Mr. HUTCHINSON. Now you felt so strongly that something illegal had gone on——

Dr. CHRISTENSEN. Yes.

Mr. HUTCHINSON (continuing). That this was not explainable, other than foul play, that you eventually wrote a letter to the FBI. Is that correct?

Dr. CHRISTENSEN. I did contact the FBI later in November of 1993, I wanted to tell them it seemed to me that the investigation was stalled and they needed to do something, either declare the nurse was innocent or declare the nurse was guilty, or something.

I went and approached them about this and also offer my services if they needed some medical input into this situation. I was very concerned because a year had passed by and no decision was made, and of course you can't have a registered nurse forever on nonpatient care activities. We had to make a decision one way or the other, and they were to figure that out.

Mr. HUTCHINSON. When you raised concerns about the lack of whistle blower protection and breaches in confidentiality and that the system had really failed, and implied that there had been retribution or recriminations against you, can you expand on that? Exactly what communications did you give to law enforcement, and what kind of recriminations, if any, were brought against you?

Dr. CHRISTENSEN. Okay. My contacts were with the OHI in October of 1992, and then repeated contacts by mail with the Inspector General's Office in February of 1993 and again in May of 1994. My only other contact with the FBI is as I have already described. Over that period of time it seemed like nothing was being done.

Mr. HUTCHINSON. Can I stop you? When was your first communication? Because you gave several dates there.

Dr. CHRISTENSEN. My first communication with the Inspector General was with Dr. Connell in Kansas City in October of 1992.

Mr. HUTCHINSON. October of 1992?

Dr. CHRISTENSEN. Yes.

Mr. HUTCHINSON. Then go ahead. I am sorry.

Dr. CHRISTENSEN. Then I wrote letters to Mr. Trodden in February of 1993 and again in May of 1994, specifying problems and

specifically what I anticipated or expected was the obstruction of the process.

Also, at that time (May of 1994), my boss, Dr. Dick, who was Chief of Staff, was being demoted. From my perception this demotion was in direct response to Dr. Dick taking a step which I interpreted to be a violation of his superiors' directives. This violation was to have me speak to the regional site team and deliver the quality assurance.

This presentation was important because, the data that I had developed with QA was protected as confidential by the hospital as quality assurance data, and this was the damning data.

Even at that late date, the official position of the hospital was that this data was protected as confidential information and not to be revealed to anybody, including the FBI.

Mr. HUTCHINSON. Maybe I missed it. Do you feel that there has been retribution or you have been punished in any way because of your dogged pursuit of this whole case?

Dr. CHRISTENSEN. I feel like I labor under a tremendous atmosphere of problems. There are a series of situations where I thought I was being threatened.

The most threatening or intimidating to me was when I had proposed to communicate to the State Board of Nursing that the nurse had been associated with these deaths. I felt a moral dilemma. I thought there was murder and I thought the nurse was a danger to other patients and I was not able to communicate this danger to the people who needed the information to deal with it.

When I proposed to inform the State Board of Nursing and Mr. Kurzejeski received my proposal, Dr. Dick came downstairs to my office. Dr. Dick was literally ashen and trembling and said that Mr. Kurzejeski intended to destroy me, not only my career in the VA but my professional career as a physician, if I proceeded with my proposal to contact the State Board.

I felt further intimidation several days later when I received a letter from Mr. Kurzejeski indicating that not only was the VA upset about this but the FBI was upset about this and the Inspector General was upset about this, that I had proposed to make this particular communication. It seemed, from my perspective, the whole world was coming down on me.

In the fall of 1992, the hospital recruited a new Chief of Medicine (Dr. Bauer). Out of the blue one day; in the spring of 1993, he stated that he was going to "get me" for reasons I never fully understood. And then later on, (after he became the Chief of Staff) about a year and a half later (December 1994), I proposed to present the investigation into the deaths on 4 East at a professional meeting because it seemed to me that the VA refused to deal with this problem on an honest basis and I wanted the problem to be addressed. At the time the new Chief of Staff called me into his office and proceeded to tell me that if I made this presentation, it would be taken very badly for me.

Subsequently, for the first time in my professional career, my conduct as an investigator, scientist, and as an administrator was called into question. Never before had I received such questions. Of course, that was after I had already gone public with my complaint of obstruction.

Mr. HUTCHINSON. I have before me a memorandum from the former director of the medical center to you. I want to quote from that and get your response to it. It is to you through the chief of staff.

"I have been informed that a signed copy of the letter that you said you would not send was, in fact, sent to the Federal Bureau of Investigation, who faxed it to the Inspector General's Office, who faxed it to the region, et cetera, et cetera. Needless to say, I am very disappointed. The memorandum you sent to me was marked 'confidential.' Any confidentiality intended was certainly breached when copies were sent by you to others inside and outside this hospital," and then quoting at the conclusion of the memorandum, "You should, therefore, refrain from further contacts with the FBI and IG about this case. If you are contacted directly by either the FBI or IG, you should inform me of the content of your discussion."

Do you recall that?

Dr. CHRISTENSEN. Very well so. I was devastated by it. For one thing, that doesn't—what it doesn't clarify is that the FBI requested the letter.

What happened was I spoke with Dr. Adelstein, who was the Chief of Pathology Service and also the Deputy Medical Examiner for Boone County, and he said, "Well, if you do this, you might be interfering with the FBI investigation into the place where this nurse had subsequently gone to. You better let them know what was going on."

I called the FBI and explained what I was doing, and I explained that I had written this letter. I said, "Would you like to see it?" And he said, "Oh, we want very much to see it." I said, "Well, I have got the fax machine here. Would you like me to fax it?"

Now, I did it thinking that if the FBI was conducting an investigation of a murder in the hospital, there really wouldn't be anything confidential from the hospital that the FBI shouldn't have. Why keep information from one from the other? The FBI was doing a murder investigation for the hospital. There shouldn't be any difference in confidentiality between these two constitutions.

So I gave the FBI the letter so they would have an opportunity to know if I was doing something wrong.

Then when I received that letter back, it seemed to me that the entire Federal bureaucracy was down on top of me and I had to shut up. I did shut up. It thoroughly intimidated me.

I will let you know, too, that this is a very difficult situation for me to deal with, because there is reason to think that subsequent injury might have occurred and perhaps it might have been prevented if I had gone ahead and contacted the State Board of Nursing. There is now some interest in the fact that there are additional deaths at another health care facility, and perhaps it was because this information wasn't communicated.

Mr. HUTCHINSON. Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Dr. Christensen, I will not have enough knowledge today of the facts to know whether someone committed a crime or not.

I am not sure if I can agree that you can go from statistical analysis to an assumption that somebody is guilty. The statistics of any of us being alive in this room today are one in trillions, if you want

to work out the calculations. The statistical analysis of my being elected a Member of Congress is probably about 1 in 300,000. There are that many adults in my district. Yet I am here.

Having said that, I have great admiration for what you have done, because while statistical analysis, in my mind, doesn't convince me of someone's guilt, it certainly raises a question and a red flag, and had I been in your shoes, I hope I would have had the courage to do exactly what you did to raise that flag.

Dr. CHRISTENSEN. Thank you.

Mr. EDWARDS. And despite my frustration at not having enough knowledge to determine at the end of the day what exactly happened, if the FBI can't figure that out in 2 or 3 years, I am not sure I can do it in 2 or 3 hours of hearings.

Despite that, I would say that we need more Federal employees that have the courage that you have had to come forward and put up with all the problems you have had to face.

Not knowing whether there was guilt or innocence in this case on behalf of the nurse that we have talked about, I guess I would just say one of my greatest concerns systematically is that of whistle blower protections. I would like to ask if, as a follow-up to this hearing, if you want to put in writing any additional specific suggestions of how we could do a better job protecting individuals such as yourself who do have the courage to come forward.

Whether your ultimate conclusion is right or wrong isn't important to me today. It is the fact that if there is a red flag out there, if there is a question mark, employees ought to be encouraged to come forward, not discouraged.

And I hope we could also get from you more information about the specific threats that have been made against you, and I hope this committee would pursue those specific threats.

But you are going to have to be very specific to us. We can't indict somebody in the VA system because you generally felt they were out to get you. If there were specific statements made to you or someone else, I would like to know about that, and I would like this committee to pursue that.

In addition to my concern about seeing that we have stronger whistle blower protections, I have some questions about the IG's actions in this case. Why did they delay this so long? And secondly, was their conclusion warranted that there was no effort to cover up?

It appears that at least there is some evidence to suggest that the VA personnel leaders involved did not pursue this as aggressively as they should have.

So those are just some points I wanted to make.

I guess I would like to ask you a question.

You are not suggesting that we ought to presume someone is guilty of a crime based on statistical analysis. Is that correct?

Dr. CHRISTENSEN. No, no, not at all.

Mr. EDWARDS. I want to be clear on that.

Dr. CHRISTENSEN. My concern is that VA employees at all levels, and not just mine but lower, should feel like they can properly approach a legal official, police, FBI, without fear of recrimination if they believe there has been patient abuse, specifically murder. That is all it is.

We do not know that there was specifically, absolutely murder committed in a criminal sense. I think from a medical, epidemiologic sense there is no question about it, but from a legal sense that is entirely different.

But the question really before us is whether or not hospital care workers should have the freedom to inform police authorities when they believe, in good conscience, in good faith, that patients are at risk.

Mr. EDWARDS. And I absolutely agree with you on that, and if there are some weaknesses in our whistle blower protection laws, I would like to be part of changing and strengthening those.

I was involved in drafting the legislation in Texas. We have had the same problem there. Somebody that did his duty was an honest whistle blower, and, in fact, his allegations turned out to be true. He was awarded by the court millions of dollars, and the State legislature in Texas has refused to pay him. That has put a cold chill upon anybody else who is out there wanting to do what they think is the right thing to do.

The next question: Do you have confidence that the FBI investigation of this matter is proceeding objectively and thoroughly?

Dr. CHRISTENSEN. I have high faith in the Federal Bureau of Investigation. It has a tremendous reputation, and my dealings with them have been very nice. They have been extremely polite to me and very nice.

I have heard some things which suggested that the things didn't go right for them, but it is only things passed on to me. I have no firm, objective evidence that there was any problem.

Mr. EDWARDS. Okay.

Dr. CHRISTENSEN. It would be difficult to prove in the circumstances that it came up.

Mr. EDWARDS. My time is up. Thank you, Jim.

Mr. HUTCHINSON. Mr. Volkmer is not a member of the committee but he represents Columbia, MO, and the Medical Center there and we would welcome you to the panel today. And, Harold, you are certainly invited to participate. You are recognized if you have questions.

OPENING STATEMENT OF HON. HAROLD L. VOLKMER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. VOLKMER. Thank you very much, Mr. Chairman.

I wish to first commend you for holding these hearings. I am sorry I was not able to be here at the beginning. As you may or may not know, my wife is very seriously ill, even though she is home at the time, and I am not probably going to be able to stay. It depends on how long this lasts whether I stay through the full hearing or not. But she didn't have a good night last night. So I was a little delayed getting in.

I also want to welcome Dr. Christensen for being here.

I would like to ask a few questions because I can go back in my mind as how I saw this develop basically, mostly in the media, when it was first brought to my attention, et cetera.

When did you first bring this to the attention of Dr. Kurzejeski?

Dr. CHRISTENSEN. On September 2, 1992.

Mr. VOLKMER. And at that time, what was his immediate response? Well, first of all, who was present? Was Dr. Dick present at the time?

Dr. CHRISTENSEN. No. Dr. Dick was on annual leave. I don't offhand know all the people who were present. There is an acting Associate Director Nurse who is not the one who is in the report but a substitute for that one. I believe Neva Berkey is her name. Dr. Simpson, who——

Mr. VOLKMER. Well, Dr. Kurzejeski is the important one anyway. So go ahead.

Dr. CHRISTENSEN. Right.

Mr. VOLKMER. Tell me exactly what his reaction was.

Dr. CHRISTENSEN. He was very cool. He didn't react one way or the other. He took it under advisement and told us to keep it quiet, that he would be the one to make the decision about reporting and he had to think about it. It surprised me because I would have thought that somebody would be extremely angry at even the prospect that someone would come in and murder patients in a hospital. My response would have been anger but he wasn't. He was very cool and collected.

Mr. VOLKMER. Now, I don't want to jump around too much. I am trying to keep this in the time frame. Later on, there was a question as to your statistical analysis; is that correct or incorrect?

Dr. CHRISTENSEN. The work was sent off to Health Services Research and Development in Ann Arbor. It was sent off on the 24th. Then on the 29th a memorandum was generated saying that there were a series of problems with the material.

Two things disturbed me. One was that they said, send us everything you've got now. I literally picked up everything I had and sent it to them. It was not a research report. It was not anything. It was just a series of documents and charts and tables with no explanatory material.

Mr. VOLKMER. No explanation from you at all?

Dr. CHRISTENSEN. Right. It was criticized as if it was the final product. What bothered me was that no one called me to ask, "can you explain what you did here." "Why did you do this?" "Did you notice you did this?" "What does this mean?" There was nothing like that. Instead, there was a white paper put out the next day, actually technically the day before, stating that the work was flawed and that was all.

Mr. VOLKMER. Didn't you—wasn't there another team or group that came to the hospital?

Dr. CHRISTENSEN. Yes. That was the regional site team and they came down just a couple of days later to provide an official review. That was the group that I was specifically told was coming down to review the information and make the decision to report the nurse. That was the reason they were coming down. I was told that very, very specifically.

But when they came down, I was told I was not on their agenda. They would not review the quality assurance information, and that was it. I told Dr. Dick, "look, you can't do this; if you do this, I am going to go across the street and I am going to tell the police and the FBI; you can't this." So he went back and prevailed upon the committee to have me present.

Mr. VOLKMER. Let me interrupt for just a minute, then. So there really was not another review of all the statistical data?

Dr. CHRISTENSEN. No.

Mr. VOLKMER. As far as you know there has never been one?

Dr. CHRISTENSEN. Well, the OHI began a review in October of 1992. It took them 2 years. What I was told was that they kept relooking at it because the numbers wouldn't go away. But they confirmed the basic substance of what I did.

Now, I have also sent the material off for publication. I have recently just gotten a review back, and they accepted it. There is no problem with that. They want me to rewrite the manuscript in a different way, but the basic premise and so forth seems to be accepted.

Mr. VOLKMER. Now, were there—I know the deaths in, what was it, Ward 4E——

Dr. CHRISTENSEN. Right, 4 East.

Mr. VOLKMER (continuing). Were unusual numbers to begin with?

Dr. CHRISTENSEN. Yes, yes. Large numbers. And also it was patients coming in, like I think there was one woman who came into the emergency room for a tube to be changed. They couldn't change it that day so they put her in the hospital overnight and she died suddenly and unexpectedly. There was no real reason. It was a series of deaths like that.

Mr. VOLKMER. Right. It is not like somebody is expected to die——

Dr. CHRISTENSEN. Right.

Mr. VOLKMER (continuing). When those things were occurring?

Dr. CHRISTENSEN. Right.

Mr. VOLKMER. Now, during the same time frame, did the total deaths in the hospital drop?

Dr. CHRISTENSEN. No, no, they did not. The total deaths remained the same. That was an area of concern and confusion. It was not fully explained why that was.

Mr. VOLKMER. So your—let me put it this way: At this time, do you feel that, perhaps correctly so, if I may interject, that Dr. Kurzejeski and Dr. Dick were not at all helpful but in fact tried to stymie the full investigation?

Dr. CHRISTENSEN. I think Mr. Kurzejeski did. Dr. Dick, like everybody else, when he first heard this, was incredulous. He had to work through this himself. He would suggest studies and so forth. One day he actually came down and helped analyze the data. He was amazed. I mean, it was all there, and he believed at that point. And when you see the people believe and understand that there really is a reason to suspect murder, their entire attitude changes.

Then he—what he did was he knew what he was doing as far as his career. If he crossed Mr. Kurzejeski because Mr. Kurzejeski had a terrible history and Dr. Dick worked with him. Nevertheless, Dr. Dick chose patients over his own career, and that is really kind of the crux of the whole situation, is that he chose to do the right thing at the right time.

Mr. VOLKMER. Did you ever get a feeling that Mr.—Dr. K, as I always call him, was worried about his own career, something like this happening on his watch?

Dr. CHRISTENSEN. I didn't have that relationship with him. I can't say.

Mr. VOLKMER. You don't know?

Dr. CHRISTENSEN. I don't know. I can't even speculate.

Mr. VOLKMER. All right. Now, as I understand, and you may or may not know—I don't know—is this still under FBI investigation?

Dr. CHRISTENSEN. That is what I understand, correct.

Mr. VOLKMER. Right. That is what they tell me anyway, they are still investigating.

Dr. CHRISTENSEN. Correct.

Mr. VOLKMER. Do you know whether or not—the information that I have is that all 13 of the bodies were exhumed. Is that correct?

Dr. CHRISTENSEN. That is correct. They exhumed 13 bodies, correct.

Mr. VOLKMER. Autopsies were performed?

Dr. CHRISTENSEN. Yes.

Mr. VOLKMER. You don't know what the results were?

Dr. CHRISTENSEN. I don't know anything about it. I haven't seen anything.

Mr. VOLKMER. You don't know what they were?

Dr. CHRISTENSEN. Right.

Mr. VOLKMER. How do you feel at the present time about your status at the VA hospital?

Dr. CHRISTENSEN. Well, I don't think I likely have much longer there, particularly some people would prefer. It—that—it is a personal bother but I am more concerned about how I think about myself, to be quite honest. I would rather be a failed employee—besides I can always go out and take care of patients and go some place else—if I feel like I have my own integrity.

What I feel bad about is being forced or compromised in a situation where I feel like I am part of a crime or a cover-up of a crime and that is a concern about the possibility of further deaths elsewhere. I just—that just is very hard for me to accept.

Mr. VOLKMER. As a physician, the duties that you were performing at the hospital in September of 1992——

Dr. CHRISTENSEN. Yes.

Mr. VOLKMER (continuing). Have those changed to the present time?

Dr. CHRISTENSEN. No, they have not changed. I was in—in September of 1992 I took care of patients on 4 East. I take care of patients on 4 East still. I was Associate Chief of Staff. I am Associate of Chief of Staff now.

Now, my being Associate Chief of Staff for Research has been called for review. It began this past winter after I became public. It is now requested and set up for a review team to come down to Columbia and review my performance as Associate Chief of Staff for Research.

Mr. VOLKMER. All right. But at one time, you were told, who was it, by Dr. K, that the data that formed the basis for your analysis was confidential?

Dr. CHRISTENSEN. Yes.

Mr. VOLKMER. Was not to be reported to the FBI?

Dr. CHRISTENSEN. That is correct. It was protected as quality assurance information. I didn't know who the confidentiality was for. Obviously, the patients wouldn't be—I think the families would like to know.

Mr. VOLKMER. They are dead.

Dr. CHRISTENSEN. Yes. The nurse has already admitted to the newspapers that he was the subject of the allegations, and that was confirmed by the hospital director in a press conference so there wasn't anything confidential there. It seemed to me that the only thing that was confidential was the fact that it could present a problem for the VA, and I don't think that is the purpose of confidentiality of the quality assurance rules.

Mr. VOLKMER. You mentioned one other thing that concerns me. This is getting a little far afield, I know, of the purposes of your hearing but we have got something back home, as we say, that concerns a lot of people. The nurse's identity has now been established; is that correct?

Dr. CHRISTENSEN. I try to avoid it.

Mr. VOLKMER. I am not asking for names. I want that to be very clear.

Dr. CHRISTENSEN. Yes.

Mr. VOLKMER. I know that. But I mean the public now knows it, basically?

Dr. CHRISTENSEN. Yes.

Mr. VOLKMER. And you mentioned something that some deaths had since occurred?

Dr. CHRISTENSEN. In a nursing home subsequent where the nurse worked, in the first 12 months where the nurse worked, apparently 30 patients died. In the subsequent 10 months after the nurse left, only 6 patients died.

Now, that begins to get into the same pattern we saw in the VA. We get a whole series of deaths when the nurse is there. The nurse goes away, the deaths stop. He goes to another facility and we get a whole series of more deaths. He goes away and the deaths stop. Now, that is just the beginning of the investigation and that is all the information I know, but that obviously is a concern back home.

Mr. VOLKMER. Yes. It will be a concern, yes, it is.

Thank you very much, Mr. Chairman. My time has long expired. I appreciate your permitting me to ask questions.

Mr. HUTCHINSON. We appreciate you being here.

Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. My apologies for being late. As you know, there is a joint conference over on the House Floor and we substituted for you, Mr. Chairman.

Mr. HUTCHINSON. Thank you.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. I have an opening statement that I might ask unanimous consent be made a part of the record?

Mr. HUTCHINSON. Without objection.

Mr. BILIRAKIS. Dr. Christensen, I wasn't here for your testimony, and I have already apologized for that so I won't go into any of the details. But maybe from a more generic sense, over the years—and I am one of those people who feels that our veterans' hospitals are

pretty darn good. They are not perfect but I haven't seen a perfect hospital yet, whether it be government or private or charitable or whatever the case may be.

But there are problems. There are problems regarding our hospitals and there are problems with other—and this is a health care hearing—but with other veterans' type services, if you will. I think much of those problems, from what we have heard from testimony over the years here, is more of an attitude type of thing on the part of staffs and employees and staffs of those hospitals or those other veterans' facilities.

For instance, we have had testimony that a lot of the employees treat veterans like they are on welfare. They have used those terms every once in awhile, things of that nature, which are pretty darn horrible, but it just happens. And even when they don't communicate that type of language, that is the thinking that many of them have.

I guess I am just wondering generically, this would apply to nurses and I think it should apply, frankly, to physicians and all the way down the line, do we—what sort of a process do we go through, the VA, regarding the making of the decision whether to hire someone? Because every job, in my opinion, is just as important as every other job, all the way down to that lowest level because they deal with veterans and, you know, they can turn off an awful lot of veterans if they go about it the wrong way and be almost as wrong really as this nurse, whatever his or her conduct may be.

[The prepared statement of Congressman Bilirakis appears at p. 103.]

Dr. CHRISTENSEN. I don't have a whole lot of information on that because that is not my role. I believe there is something like a vetting process for nurses, although it is not as tight for people who get in as contract nurses as opposed to staff nurses but I am not an expert on that.

But if I could back up to what you said earlier, the Harry S. Truman VA Hospital is a wonderful facility and the people there—and I know because I work there—are very caring people. We regularly, and this is literally true, we regularly have patients come specifically to our facility because we are a caring institution. And by far and away, the staff they really do care about what they do. We may not do it perfectly and we may do it slow sometimes and we may not be able to do everything we can, but the attitude of the people is very caring, and people purposely choose to work in the VA because it is probably one of the few places you can really go into altruistic medicine. You don't have to worry as much about, you know, the billing and all those types of things. You can really just take care of people. I would say 99 percent of the people there are superb people and I would not hesitate to be cared for myself in that facility. This is a separate issue but it is a very high issue. It is a management issue. And it does impact upon what we do in particular cases.

My particular concern is not so much that this did happen as that it will happen again. Our inability to recognize the problems that led to this mean that we can't correct them in the future. That actually has been the whole genesis of my approach: Let's fix it. I

am not really so worried about that it happened but let's understand why it happened and let's fix it.

Mr. BILIRAKIS. This is why I went to my questioning, if we could call it that, because I think that is really where the problem lies. I suppose a person can be a mental case and, as history has proven over the years, go on some sort of a rampage after patients or whatever. But the point is, I will worry about attitudes, and I have heard said that many veterans are in the hospital because they are ill because of overdrinking and things of that nature. I mean, it is not my opinion but my point is you do hear these things. And the people who say those things have the wrong idea. They have the wrong attitude in general——

Dr. CHRISTENSEN. Yes, yes, that is correct.

Mr. BILIRAKIS (continuing). About the role of the veteran and what the veteran has gone through over the years and that sort of thing.

Dr. CHRISTENSEN. That is correct.

Mr. BILIRAKIS. It leads them up to this particular point. So I am not sure really what your role is because I did not hear the first part of your testimony. But, it seems to me that all of us should be greatly concerned that the proper psychological testing, Mr. Chairman, or whatever it takes to keep these things from happening, because as the doctor said, this has happened and it is important, of course, that an investigation is taking place. And somebody else is going to decide whether there is any criminal conduct or whatever the case may be, but our role is to make sure that this sort of thing, along with the other littler things, treatment of veterans and conduct and attitude towards veterans, doesn't continue to happen. And that is why I asked you these questions.

If you have any opinions in that regard, and maybe feel that you don't think you want to make them public and would like to submit anything like that to us here, I would welcome it.

Dr. CHRISTENSEN. I have some comments at the end of the written testimony about what we could do to make watchdog agencies work and they would address that. I think that would be a big help.

Mr. BILIRAKIS. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Bilirakis. I assure you that all of your written comments will be included in the record and your suggestions will be taken very seriously.

Let me just go back to the statistical study. Your review and your data in which you came up with the statistical probabilities of this happening by chance, those deaths occurring, that spike in deaths occurring on the shift of one particular nurse. The OHI, when they investigated and reviewed this, did they confirm your results?

Dr. CHRISTENSEN. Yes.

Mr. HUTCHINSON. So this was not just your statistical study? This has been confirmed?

Dr. CHRISTENSEN. Right, right. They confirmed it and then they sent to an external biostatistician at Penn State and the external biostatistician rechecked everything and he too confirmed it.

I think the actual numbers of the OHI were virtually identical to mine. The biostatistician used a slightly different variation on the statistical tests and basically came up with the same set of numbers.

Mr. HUTCHINSON. As I understand it, basically, you did this study, you did this review and you came up with this what to you was an overwhelming statistical case that something bad was going on.

Dr. CHRISTENSEN. Right.

Mr. HUTCHINSON. You felt morally compelled to get law enforcement involved in this.

Dr. CHRISTENSEN. That is right.

Mr. HUTCHINSON. You were specifically told by the director, don't talk to the FBI?

Dr. CHRISTENSEN. That is correct. That is correct, absolutely correct.

You see, part of the problem is that I am a scientist. I am an epidemiologist. These are very real numbers. They are numbers by which all physicians practice medicine. In the some 20 years I have been in science and medicine, I have never seen data this abnormal, this striking. This is the most bizarre situation I have ever seen.

Mr. HUTCHINSON. This was an issue of morals and ethics?

Dr. CHRISTENSEN. Yes, very much so. Where I got guidance for it was, when the director was refusing to report, I went to my minister. We sat down and I talked to him. He was one of the few people that I actually revealed this situation to. We discussed it. He said, "Well, this is horrible; you have to take a stand." I feel like I now have to take a stand and that gave me a lot of strength.

Mr. HUTCHINSON. Now, you are a tenured professor at the medical school; is that correct?

Dr. CHRISTENSEN. Yes, that is correct.

Mr. HUTCHINSON. As I read the OIG report and the various reviews that were done, I see very little about the role of the medical school in all of this. Were they passive? What was their attitude toward what you had discovered?

Dr. CHRISTENSEN. In October, I understand Dr. Dick has told me he briefed the Dean in detail on this. Later on that winter, I briefed the Dean of the medical school in detail on this. Well, not in detail. I briefed him on it and described the problems.

Now, I assumed that he knew what was going on; that he was involved; that he was taking steps. I wasn't going to go and tell him. I assumed that everything was fine.

To my surprise, we didn't discuss it in the hospital. We didn't discuss it in the university or the VA. There was no staff meetings, no faculty meetings. Nothing was said about it even though a graduate student, in essence, a house officer, had been brought up before this board and charged with making a false allegation or a flippant allegation.

Later on, when this was brought up in the meeting, looking at the confirmation of the new Chief of Staff, I brought up the fact that this had not been addressed. I passed out the OHI report and said we really need to take a look at this. The Dean at that point passed over it. The minutes of that contact were not communicated

in the minutes of the Dean's committee meeting. The fact that this occurred just doesn't appear. There is a sense of no involvement of the university in this at all, which to me is wrong. I mean, the university is critically involved with the conduct of that hospital.

Mr. HUTCHINSON. Do you have any feeling as to why they were less concerned, or at least your impression was there wasn't a lot of concern there?

Dr. CHRISTENSEN. Well, I have no real data. I have a guess, sure, but some people would say I am a conspiracy theorist or something. I have no real data.

Mr. HUTCHINSON. Now, on the staff, was this commonly talked about? I mean, I read in the report that the nurse was called the "crash cart kid."

Dr. CHRISTENSEN. Right. The report doesn't provide all the information because there is a lot of controversy about this gentleman. Like in many other situations, he was very skilled. He was talented. There are a lot of people who thought he was really good. There was a lot of controversy. Some people felt very strongly that he was involved. Some people felt very strongly that he was being fingered unnecessarily. So there was a lot of discussion both ways on the ward at this time.

Subsequently, there has been a lot of discussion and whispering in the hospital. What you see before you is not just one person but what you see before you is a large number of people hoping, through me, to express our concern. The hospital itself is very concerned about it. The hospital staff is very concerned about it.

Mr. HUTCHINSON. Let me return to the issue that Harold raised concerning the autopsies. There had been autopsies after the exhumations by the FBI. But were there any autopsies performed at the time of death prior to that?

Dr. CHRISTENSEN. I understand there was some. I don't know how many. I understand also some materials were preserved and sent off. I don't have any particular facts about that because I was never involved in that aspect of it, but I understand that something was done.

Dr. Adelstein, who is the Chief of Pathology Service, did come with me here so if there is some questions about that I am sure he would be delighted to answer them.

Mr. HUTCHINSON. Okay. Well, the FBI has been now involved since 1992, it is better than 2½ years. I know the FBI and their labs have been stressed with the bombing in New York City, the Oklahoma City bombing, the incidents in the West on the train wreck, and so forth. But I have expressed my concern to the Director that this receive a high priority and that the conclusion of those toxicological tests and the forensic tests, that we see that very soon or that they complete their role in it.

Now, Dr. Christensen, do you reject the idea or the conclusion, I should say, of the OIG report that basically there was no cover-up, that there were a lot of mistakes made but it could all be explained by dysfunctional management? Do you reject that and believe that there was more going on?

Dr. CHRISTENSEN. Yes. Yes.

Mr. HUTCHINSON. Can you kind of just expand on why you reached that conclusion?

Dr. CHRISTENSEN. Why there was a cover-up?

Mr. HUTCHINSON. Why you concluded that it cannot be explained by dysfunctional management; that there was a conscious, deliberate, I guess for lack of a better word, a cover-up or at least an effort to obstruct the investigation.

Dr. CHRISTENSEN. Yeah. Just a second. Let me—this is probably the best way to set it up.

This is in December of 1994. I approached the Chief of Staff about presenting this information in public so that we could publicly discuss how to handle these problems and develop policies and procedures because this had never been done. And this is what the Chief of Staff told me and I documented it in a memorandum.

The conclusion of the Department of Veterans Affairs regarding this affair, the deaths on 4 East, is that there is no conclusion. No comment can be made with the available data and therefore no action can take place. The position of the Department of Veterans Affairs is that nothing worthwhile can be accomplished by publicly presenting this material. Since nothing can be gained by presenting this information, the Department of Veterans Affairs does not want this issue publicized because it will only cause unnecessary damage to the public image of the department. Therefore, the department will not authorize a presentation of this material by an employee of the department. Violations of this directive could be cause for reprimand and possibly further action.

And then verbally, not communicated in the memorandum, because I didn't think he would sign his name to it, he also warned me that if I nevertheless went ahead and presented the data, if I took it upon myself as an individual, as a private individual, my VA superiors would look very harshly upon this action.

I consider that a cover-up and I consider it a very dangerous because, one, it doesn't let the families know. It deprives information from them. And, two, it means we can't do anything about it. And there is no—as far as I could tell, no change in policies, procedures, anything, either locally or system-wide, that would address this type of issue, which was a concern because this appears to be the fourth time this has happened in the VA hospital.

Mr. HUTCHINSON. What were you quoting from, Dr. Christensen?

Dr. CHRISTENSEN. That was a memorandum that I wrote up describing my meeting with the Chief of Staff. I wrote it up after he came and counseled me. That is what he told me. So I wrote it down and I gave it back to him. He signed off that that was what he told me.

Mr. HUTCHINSON. That is your memory of the meeting and he signed off on that?

Dr. CHRISTENSEN. That is correct. What happened was he called me up to his office. He told me that. I went down to my office, wrote it all out and brought it back up to him. He and the current Hospital Director both signed off saying this is correct instructions that they had given, although they wanted to emphasize that it was not the Department of Veterans Affairs' opinion. It was their own opinion, the Chief of Staff and the Hospital Director.

Mr. HUTCHINSON. Thank you. Mr. Bishop, do you have questions?

Mr. BISHOP. Not at this time, Mr. Hutchinson.

Mr. HUTCHINSON. Do any other members of the panel have other questions for Dr. Christensen?

Well, let me say, before we dismiss you because I have not complimented you, I want to associate my remarks with Mr. Edwards. I think you are to be commended for your dogged pursuit of this, and I know it could not have been easy and that you have certainly faced a lot of criticism for the actions you have taken, and in my estimation, whether I agree with everything you have alleged or not, or whether I have yet concluded on all of those allegations, that you are a hero and that, had you not been so determined and resolved in bringing this to light we might not have law enforcement involved in this today on this investigation. So I certainly commend you for that, and thank you for your testimony today. And I also would remind you——

Mr. VOLKMER. Mr. Chairman.

Mr. HUTCHINSON. Yes. I will recognize you in just a moment, Harold.

Mr. VOLKMER. All right.

Mr. HUTCHINSON. I also would just like to say that should there be—or should you feel that there are any reprisals or punitive actions taken because of your testimony today, that you should notify the committee. We would like to be aware of that.

Dr. CHRISTENSEN. Thank you, sir.

Mr. HUTCHINSON. Mr. Volkmer.

Mr. VOLKMER. Yes. Where does the Director of Nursing, at the time, back in 1992, fit into all of this?

Dr. CHRISTENSEN. Well, she shouldn't and that was a concern about the OIG report. Until the OIG report released their report, it never even crossed my mind that she would be a part of this. The woman is a very nice woman. She was only in an acting position. Now, something happened to her after all of this and she was reduced in her position. She filed an EEO complaint. The EEO came and interviewed me about this because I had written a letter in support of her saying that I thought she had done a very good job and I didn't see any problems with her performance at all. I thought she had a very good performance.

Because of my letter, he came and interviewed me. He said at the end of it, what do you know about how she was responsible for the poor medical care in 4 East? I said, "4 East? Are you talking about the deaths on 4 East? She had absolutely nothing to do with it." And she didn't. I thought she handled it as well as she could. She is not a trained epidemiologist. She was just in an acting position and I thought she actually did a very exemplary job of handling it. I was shocked when I saw what the OIG wrote.

I must say for physicians, nurses, our stock is our reputation. That is all we have. And although it may not seem like much to you, but to have publicly said that you have done terrible things or you have contributed to the abuse of patients, that is horrible. I mean, that just destroys you.

The former Chief of Staff (Dr. Dick) is totally demoralized. This particular woman is totally demoralized. This is just a terrible thing to come out. And at the same time, knowing that the higher officials were not criticized at all when they are the ones who were

imposing these things, this is just very bad and that is where a lot of the—where a lot of retribution comes in, I think.

Mr. VOLKMER. Could I ask one additional question?

Mr. HUTCHINSON. Without objection.

Mr. VOLKMER. I may be going back over old stuff, but at the present time what is your relationship with the new Director and Chief of Staff?

Dr. CHRISTENSEN. I have a very poor relationship with the Chief of Staff. It is always cordial but extremely poor, essentially a nonfunctional relationship. My relationship with the Director is that he is a very nice person, and I—I work very well with him. Unfortunately, the times in the past when this has come up, he has failed to take action.

Specifically, when the OHI draft report was released in September, he asked me to come up and to advise as far as a response to that, and I came up, and I said, look, now that it has come out, it seems like this confirms. Why don't you go—we need to tell this to the families what happened. We need to go ahead and do some policies and procedures to prevent this from happening again, and you need to take a look at what happened to people, particularly this young intern who was called up before this board and read a letter of counseling or whatever when actually he really did the right thing. He saw something terrible and reported it. He didn't do it perhaps in the right way but he noticed there was at least some problem. You need to address this and make sure at the VA if this ever becomes public that we did the right thing and we responded to it. And there was no response from the Director.

Mr. VOLKMER. And so right now, that is why you say you don't know how much longer you are going to be in your present position, et cetera?

Dr. CHRISTENSEN. Yes, true.

Mr. VOLKMER. That is what leads you to that?

Dr. CHRISTENSEN. Yes.

Mr. VOLKMER. What is your feeling about—if you look at the total VA hierarchy and the strata, the regional office, headquarters up here, how do you feel?

Dr. CHRISTENSEN. It is very autocratic. I think it creates a lot of buffers between me and you, basically. I mean, yesterday I was making rounds on 4 East. Now I am here. Between me and you is all of these layers of bureaucracy and they kind of, I think, twist the meaning of things and buffer you from me, is what I think. I think it is very difficult for them to admit that a mistake was made, particularly a mistake of this magnitude.

Mr. VOLKMER. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you. Do any other members of the committee have questions before we dismiss Dr. Christensen?

If not, thank you, Dr. Christensen. We appreciate your testimony.

The chair now recognizes our second panel of witnesses.

Our first panelist is Mr. William T. Merriman, Deputy Inspector General of the Department of Veterans Affairs, accompanied by Mr. Jack Kroll, Assistant Inspector General for Departmental Reviews and Management Support.

Thank you, gentlemen, for coming. It is my understanding that Mr. Merriman is going to testify. You are recognized.

STATEMENT OF WILLIAM T. MERRIMAN, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JACK H. KROLL, ASSISTANT INSPECTOR GENERAL FOR DEPARTMENTAL REVIEWS AND MANAGEMENT SUPPORT, DEPARTMENT OF VETERANS AFFAIRS

Mr. MERRIMAN. Mr. Chairman, I would like to thank the subcommittee for the opportunity to discuss my office's work related to the unexpected deaths at the VA Medical Center, Columbia, MO.

During the past 3 years, my office has expended over 6,500 staff hours reviewing various events related to the unexpected deaths. For example, my Office of Investigations is involved in an FBI-led case to determine if these patients were harmed and, if so, by whom. The investigation is ongoing.

In response to a request from VHA's Central Region, my Office of Health Care Inspections conducted an analysis that confirmed a statistical relationship between the deaths and a particular nurse. The statistical analysis determined that there was less than a one-in-a-million probability that association between the presence of the nurse and the deaths was caused by chance.

My office also reviewed allegations that VA officials failed to respond adequately to information concerning the deaths and tried to cover up the matter. While the initial allegations targeted the former director of the medical center and the VHA Central Region chief of staff, others, including the current medical center management team and my office became subjects of the allegations.

While our review of these allegations concluded that medical center and Central Region management did not intentionally suppress information in an attempt to cover up the deaths, we did determine that the management team in place at the medical center when the deaths occurred was "dysfunctional" and unable to work together to respond effectively to an "out of the norm" situation.

Even though we found no evidence of criminal misconduct, judgmental errors made by management in responding to the unexpected deaths were significant. For example, in our opinion the nurse should have been relieved of patient care duties at least 2 months earlier, and medical center top management should have reported the suspicions about the nurse's possible involvement in harming patients to law enforcement authorities.

In our view, the three top medical center managers share the responsibility for not relieving the nurse in question of patient care duties in a timely manner. These three managers plus the VHA Central Region chief of staff must share the responsibility for their decision not to report the incident to law enforcement authorities.

Because the director and the VHA Central Region chief of staff are no longer employed by the VA, we recommended appropriate administrative action and training for the two remaining employees for their role in not responding to the unexpected deaths in an appropriate and expeditious manner. We also made a systemic recommendation to refine VA policy guidance to better guide managers in handling and reporting incidents like this should they occur at another VA medical center.

I would like to address two other issues concerning this matter. First, there remains the question of whether or not the nurse should be reported to the State Licensing Board. Even though the nurse no longer works for VA, the current medical center director is coordinating this issue with appropriate VA legal staff to determine if anything can or needs to be done at this time.

The other issue deals with allegations concerning the conduct of OIG staff with respect to overseeing the various aspects of the unexpected deaths during the past 3 years. Of particular concern to me is the allegation that the OIG failed to protect the identity of Dr. Christensen. I can assure this subcommittee that we take the confidentiality of our complainants seriously. We have carefully reviewed the allegations made by Dr. Christensen and the applicable law relating to the confidentiality of employees who bring complaints or information to the IG. Although there were two instances where a contact by Dr. Christensen was brought to the attention of VA, neither involved a situation where Dr. Christensen had brought a complaint or information to the IG. Our internal review found that there was no disclosure by the OIG of Dr. Christensen's identity with respect to the allegation of a cover-up.

I am aware of Dr. Christensen's dissatisfaction with our report. It is not uncommon for a complainant to be less than satisfied with the results of an OIG review, especially when the allegations are not fully substantiated. I regret that Dr. Christensen feels this way, but I can assure you that our report represents a comprehensive and objective undertaking designed to fully understand the entire sequence of events surrounding the unexpected deaths. This was an extensive review in which a total of 75 interviews were conducted of over 50 individuals. Many of the interviews were tape recorded under oath. We drew what we believe to be the most balanced set of conclusions from often conflicting testimony.

In closing, I would like to express my opinion that the top management team that is currently responsible for the Columbia VA Medical Center seems to work well together and should be able to respond effectively to serious incidents should they occur in the future.

This concludes my statement. I will attempt to answer any question you may have. Accompanying me today is Jack Kroll, my Assistant Inspector General for Departmental Reviews and Management Support. I have asked Jack to assist me in responding to your questions because he was directly responsible for overseeing completion of our review of the allegations.

Mr. HUTCHINSON. Thank you, Mr. Merriman. I will ask the questions and then I will let you decide whether you—who wants to give the response.

Mr. MERRIMAN. Yes.

[The prepared statement of Mr. Merriman appears on p. 130.]

Mr. HUTCHINSON. In October 1992, officials at the Veterans Health Administration Central Region asked the Office of Health Care Inspections to review concerns about a possible excessive death rate on one ward, expressed by managers at the Harry S. Truman Memorial Veterans Hospital in Columbia.

How long did it take your office to initiate this review or how long did it take the OHI to initiate that review and how long did it take to complete it once it was initiated?

Mr. MERRIMAN. It took 2 years to complete it.

Mr. KROLL. Mr. Chairman, the review was initiated almost immediately. Dr. Connell went out to Kansas City and met with the individuals involved in mid-October and then his biostatistician, Margaret Young, became involved in the review. It did take, as Mr. Merriman explained, 2 years to complete.

Mr. HUTCHINSON. How long did it take to complete, 2 years?

Mr. KROLL. Two years. We issued our report on September 28, 1994, and we started the review in October of 1992.

Mr. HUTCHINSON. So you are saying that the allegations, that there were several months in which the—the request was not taken seriously, that that is not true; that you immediately responded by sending somebody to the hospital to begin the investigation?

Mr. KROLL. Oh, yes. Dr. Connell was out there in October of 1992 and met with Dr. Christensen, Dr. Dick, and he also met with the FBI. Our criminal investigative staff was also on-site in October, early October 1992.

Mr. HUTCHINSON. All right. This was the initial investigation regarding the statistical studies, right?

Mr. KROLL. It was.

Mr. HUTCHINSON. And does it normally take, did you say 2 years, before the report was issued?

Mr. KROLL. Yes, sir.

Mr. HUTCHINSON. So we have a case in which there were serious allegations of management shortcomings involving multiple patient deaths and it took us 2 years to get a statistical confirmation and verification of what Dr. Christensen had done?

Mr. MERRIMAN. The statistical work did take 2 years. At that time, the FBI was already investigating the circumstances at the medical center. Dr. Connell was asked to validate some of Dr. Christensen's work. Dr. Christensen's initial analysis resulted in the nurse being taken off of the ward. That is of great credit to him. He made that happen.

There was some question in the mind of the Central Region as to the validity of the statistics. They had a Central Region statistician take a look at it, and then Dr. Connell made a more comprehensive review. He looked at what Dr. Christensen did, what the Central Region did and then he extended the analysis to look at death rates beyond the time in question. Once he derived his results, he confirmed them with a statistician from Penn State University.

Part of the problem was Dr. Connell took a different approach. There are many people who have looked at this in different ways statistically. Peg Young, on his staff, used a statistical technique called "time series analysis" which is generally used in the commercial world. All in all, it took us much longer than we would have liked but there were some reasons for this.

Mr. HUTCHINSON. Okay. The impression that you are giving me is that you just jumped right on this thing. But in—this is the second report?—yes, in the most recent OIG report, you state, on July

21, 1994, the hotline and special inquiries division formally referred the complainant's letter to OHI for action.

Now, that would be several months—that would be many, many months after.

Mr. KROLL. Mr. Chairman, I would like to clarify that. We are talking about apples and oranges. What we were initially talking about was Dr. Connell's review, the blue covered OIG report. That review was triggered by Dr. Falcon, the regional chief of staff, asking us to validate Dr. Christensen's statistical data.

Later on, in February of 1993, Dr. Christensen sent the IG, Mr. Trodden, a letter alleging a cover-up. This was the first time that we were aware of the cover-up allegations. The alleged cover-up is the issue that is addressed in my report, my September 28, 1995, report.

Mr. HUTCHINSON. Okay. It did take 2 years to complete this?

Mr. KROLL. It did take 2 years for us to respond to Dr. Christensen's February 1993 letter, which is longer than it should have.

Mr. HUTCHINSON. You stated in your investigation that there were 75 interviews that were conducted. I think in Dr. Christensen's testimony, he says that the OIG report does not refer to the following statement reportedly made by the chief of staff for the Central Region to the former hospital director when informed of the suspicions of murder on September 3, 1992. And I quote, "the last time I was called about a problem like this we fired the director and the chief of staff. Are you sure you want to continue this discussion?"

Did you, in your investigation, attempt to verify that statement? Was that included among those reviews, those interviews?

Mr. KROLL. Yes, we did.

Mr. HUTCHINSON. So you found no evidence that the statement was made?

Mr. KROLL. Differing opinions. We found what we thought was a neutral third party who was there during the conversation, and she did not remember those words being said.

Mr. HUTCHINSON. And for that reason none of that was included in the report?

Mr. KROLL. No. Because of the conflicting testimony, we did not include that issue in our report. We did include that statement in our review.

Mr. HUTCHINSON. The autopsy issue, some of the deceased patients have been exhumed. How many were exhumed, is it 13?

Mr. KROLL. 13 is the number.

Mr. HUTCHINSON. Those were all from deaths on Ward 4E; is that correct?

Mr. KROLL. Yes, during that period of time, March to August of 1992.

Mr. HUTCHINSON. How many autopsies were performed on patients who died on 4E prior to the FBI getting involved in the exhumations? At the time of their deaths, how many autopsies were performed; do you know?

Mr. KROLL. My understanding is that there were 14.

Mr. HUTCHINSON. And did the VA preserve samples obtained from results of those autopsies?

Mr. KROLL. My understanding is they did not.

Mr. HUTCHINSON. And so the FBI was not given any—obviously no samples, but any of the information of the results of those autopsies?

Mr. KROLL. That is what we were told.

Mr. HUTCHINSON. That they do have that, or they do not? Was that information conveyed to the FBI?

Mr. KROLL. The——

Mr. HUTCHINSON. The results of those autopsies.

Mr. KROLL. I am not sure.

Mr. HUTCHINSON. Okay.

Mr. KROLL. I am just not sure.

Mr. HUTCHINSON. If you could provide the committee that information, we would be appreciative.

Mr. KROLL. We will do it.

[The information follows:]

Responsible Medical Center officials have informed the OIG that the autopsy results are filed in the patient's medical record. The FBI obtained the original medical records for all the patients who died on Ward 4 East during the period of time in question. Therefore, the FBI has the autopsy results for the patients who died on Ward 4 East in mid-1992 and were subjected to an autopsy.

Mr. HUTCHINSON. At pages 20 and 21 of the IG's report, on page 20, we are told, January 28, 1993, the former medical center director wrote a letter to the special agent in charge of the FBI investigation stating his intention to return Nurse H to a direct patient care assignment by February 15, 1993, unless the FBI had any additional information which would negatively affect this decision. A day later, January 29, a representative of the under secretary for health instructed the former medical center director that he was not to return Nurse H to patient care duties without the approval of the under secretary's office. And from that, Nurse H never returned to patient care duties while employed at the medical center.

Should these events involving Nurse H trigger the reporting requirement to the State Licensing Board under 38 CFR section 47.2, which states that the VA has a mandate to conduct a program to report to the State Licensing Board any separated licensed health care professional who was fired or who resigned after serious concerns about such individual's clinical competence had been raised but not resolved.

You touched upon that in your opening.

Mr. MERRIMAN. That is correct, Mr. Chairman.

They had an obligation to conduct a review, to make a determination whether or not to report to the State Licensing Board. The medical center did not do that. The director should have conducted a review that would have included sworn testimony and a determination as to the reportability to the State Licensing Board. That, I believe, is the requirement.

That wasn't done. We think that review should have been done. I believe that is what is required under the law and regulation.

Mr. KROLL. As you know, we had requested a formal opinion from our Office of General Counsel on that very issue because we wanted, if anything, to err on the side of patient safety vis-á-vis just meeting some reporting requirement, and they have provided an extensive opinion on that issue.

Mr. HUTCHINSON. The counsel's opinion—basically, I am paraphrasing, but they basically said they were under no requirement to report to the State Licensing Board. Is that correct?

Mr. MERRIMAN. They needed to make a determination as to where there was a significant increase in deaths.

Mr. KROLL. It is my understanding that the director had a duty to do more than he did before the decision was made not to report to the State Licensing Board. We have held discussions with the general counsel since we have issued our report, and with the IG legal officials on that issue, and I am sure the OGC is going to be talking more about it during panel session, but I think there are some changes at least in under consideration.

Mr. HUTCHINSON. I have other questions but I don't want to dominate this so let me recognize Mr. Edwards for questions.

Mr. EDWARDS. Thank you, Mr. Chairman.

I would like to ask you, on the timing of Dr. Christensen's report to the IG's office about his concern about a cover-up, he claims that he, I believe, talked to Dr. Connell in October of 1992. Is that not correct?

Mr. MERRIMAN. He talked to Dr. Connell in October of 1992 in conjunction with the Central Region asking us to look at the statistical analysis.

Dr. Connell went out and talked to Dr. Christensen and others to get their statistical data to begin his review. I don't believe that the allegations of cover-up were included in that conversation. Dr. Connell's recollection was that there was some conversation about protection from retaliation, should there be any retaliation down the line, or words to this effect.

His recollection was that they did not get into the cover-up allegations during that conversation. That was discussed in a letter we received directly from Dr. Christensen, where he laid the allegations. That is what started the cover-up investigation.

Mr. EDWARDS. Okay. Let me ask you also, in your many, many hours of investigation on this issue, have you spent much time looking at the question of intimidation and threats against Dr. Christensen? And, if so, is there tentatively some wrongdoing there that we need to pursue?

Mr. MERRIMAN. I don't believe Dr. Christensen has claimed retaliation. He has had a number of conversations with the director, one-on-one. He perceives that he is not welcome, things like that. But we have not had claims of retaliation by him.

Obviously he is uncomfortable with our office. Were he to come in with claims of retaliation, I would probably get OSC involved at this point in time.

Mr. EDWARDS. So one option for him if he feels either someone has retaliated against him or tried to intimidate him because of this, he could report that information to you and you would be willing to look into that?

Mr. MERRIMAN. Well, certainly.

Mr. KROLL. We would be willing, or as Mr. Merriman mentioned, the Office of Special Counsel could get interested in this and he could have his choice. Since he has expressed some displeasure with our other reviews, he may choose the Office of Special Counsel.

Mr. MERRIMAN. He did report to us two cases of retaliation of his coworkers which we did look into.

Mr. EDWARDS. In your statement a moment ago, you said that you did not find reasonably that there was any criminal action on behalf of the management of the VA Medical Center but clear evidence of poor management in judgment. Could you tell me, what is the difference?

I think you said they should have reported some of these concerns 2 months earlier. What is the difference, in your judgment, or what is the difference legally between a criminal cover-up and a manager's lack of action when there is at least indications that there could be a serious problem?

Mr. MERRIMAN. We looked at the Federal and the Missouri State statutes on criminal obstruction of justice. They are fairly specific. You are talking about physical intimidation, changing records, tampering with juries, things along these lines. So we did not see the criminal obstruction of justice aspect to this case.

When you shift from that to cover-up, then you get into what were the perceptions of management that were going on at that time?

Dr. Christensen clearly believes, based upon his statistics, that there was murder. The medical center and other managers do not take this position. They see only the statistical relationship. They understand the significance of it. However, we felt the suspicions of foul play should have been reported to criminal investigators.

On statistics alone, they could have reported their suspicions to criminal investigators. How do you determine there is a murder without getting the people who are professionally qualified to make this determination involved? So we fault the director on that basis. We think that the director refused to accept the possibility that this nurse was actually injuring people. He hoped that he would identify some statistical relationship, something that went on in that ward, some different mix of patients, something that would explain what was happening other than the actual killing of patients. Very early on they should have gotten some criminal investigators involved.

We fault the chief nurse. Dr. Christensen is amazed that we criticized the chief of nursing. We have sworn testimony that 2 months before they finally got Nurse H off the ward, coworkers had come to the chief of nursing, complained that they thought there was a relationship between this individual and the deaths that were going on. Nurse H himself approached supervisory nurses and complained that people were making these allegations about him and asked for some relief, a change to another position. No action was taken. It was within the power of the chief nurse to have taken some action, she didn't have to make a judgment as to whether it was murder. You don't have to make a clinical judgment. You have a problem with your staff. They are pointing fingers at each other. No action was taken.

Mr. EDWARDS. It seems to me one of the systemic problems we have to deal with—the military, I am sure, has the same problem—is maybe someone's own personal career path, this will open up potential problems in his or her own backyard and yet they clearly should have the legal and moral obligation to bring forward these

kind of things, possible problems or crimes, very expeditiously and very aggressively and somehow we need to deal with that.

One final quick question, if I could, Mr. Chairman. Do you see something wrong with the VA evaluation system that gives the VA Medical Center director in this particular case, I believe, an $8,000 bonus during the time period that serious questions are being raised about the competence and the handling of this case?

Mr. MERRIMAN. I see problems with that evaluation, not necessarily the system.

Mr. EDWARDS. Thank you.

Mr. BILIRAKIS. You mentioned the word "systemic," and I think that is very apropos from the bottom all the way up through the system.

Is there a VA-wide clearinghouse for all health care workers, do you know, Mr. Merriman?

Mr. MERRIMAN. I really don't. I would defer that to the next panel.

Mr. BILIRAKIS. Well, I don't know. I am referring to this, and you probably haven't seen the recommendation, but one of the recommendations made by Dr. Christensen is to create a VA-wide clearinghouse for all VA workers, require all health care workers, including temporary employees, to have clearance before starting their employment. Now, I am not sure exactly what he means by that, whether he is talking about a clearinghouse.

Mr. MERRIMAN. Well, there is a credentialing and privileging system for physicians. At the nurse level, I am just not sure what they have.

Mr. BILIRAKIS. For physicians?

Mr. MERRIMAN. Yes.

Mr. BILIRAKIS. I would say the problem lies with more than just physicians.

Mr. MERRIMAN. Well, I would agree.

Mr. BILIRAKIS. I don't know. This is really quite a story. You used the word "dysfunctional." I imagine probably a stronger word than that is more appropriate.

The nurse was on duty for 45 of the 55 deaths that occurred on Ward 4 East between March 8 and August 22 and then when that person was reassigned the person was reassigned to ICU. Unbelievable.

Do we have any history of any deaths or a death that may have occurred in ICU during the 2 days that that nurse was assigned there?

Mr. MERRIMAN. I don't believe any are claimed.

Mr. BILIRAKIS. In terms of how they relate to ordinarily expected. Of course, ICU, I guess, is a more expected death rate, obviously.

Mr. MERRIMAN. Yes.

Mr. KROLL. It was such a short period of time, there wasn't any spikes in the death rate. It was only a matter of a few days until the medical center was finally able to relieve that nurse from all patient care duties.

Mr. BILIRAKIS. Well, the Chairman, and he is very nice and he, without really even saying so, I think, expressed some consternation at the amount of time of the investigation. He kept referring to 2 years, 2 years. And Mr. Merriman, you said that the investiga-

tion is ongoing, if I might use your exact words, and we are talking about 2½ years' worth of ongoing. I realize sometimes these investigations take some time.

Now, you know, I guess it is a twofold thing. One is ongoing from the standpoint of determining whether there is any criminal conduct here and that sort of thing, and punishing the individuals involved if there was any, but the other would be ongoing in terms of trying to determine what is wrong and maybe trying to fix it so that these things don't happen again.

Is your ongoing investigation addressing that second area also?

Mr. MERRIMAN. The ongoing investigation that we would refer to is the FBI investigation.

Mr. BILIRAKIS. Just the FBI?

Mr. MERRIMAN. Our recommendation to the department is in connection with reporting criminal activity to law enforcement authorities—to clarifying VA's policies on reporting of criminal activity on the mere suspicion that it exists so that we can get professional law enforcement authorities involved in making a determination as to what is going on.

We have an initiative ourselves where we are working with the department on a new quality program review process, whereby we will go out to the medical centers and we will have a series of questionnaires where we talk to a random sample of the patients, patient advocates, staff, and the top three administrators of the hospital center. We administer a questionnaire to the director, associate director, chief of staff. We have hopes that this will give us some fix on the relative health of the hospital in terms of staff morale and what is going on in that hospital. We have prototyped it now at three facilities. We hope to do eight facilities next year with our health care inspection people.

Mr. BILIRAKIS. With the hope that it might spread throughout the entire system ultimately?

Mr. MERRIMAN. Yes, sir. We are also continuing to work with Penn State University on this statistical process control. We have hopes that it can be used at an individual hospital and it envisions getting a real-time fix on statistical abnormalities rather than waiting for a batch process.

Mr. BILIRAKIS. Well, I am not trying to belittle your overall job. I am sure you are very busy people. But I would suggest that time is certainly of the essence. This is a terrible story. I am sure we all agree. There is no excuse for it.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Bilirakis.

Mr. Volkmer, you are recognized.

Mr. VOLKMER. I am sorry. I didn't get all the testimony and all the questions. If you have already covered it, just say so. I can check with the staff later on for the answers.

When you or your office began this investigation, did you discuss or interview Dr. Christensen?

Mr. KROLL. Oh, yes. When we began our review this past January, Dr. Christensen was the first person that we talked to.

Mr. VOLKMER. All right. Did you discuss with him the problems he was having as far as comments being made to him; that some-

body was going to get him; he had problems with reporting this to the FBI, him being told not to do it, those kind of things?

Mr. KROLL. Yes. When we first contacted him, his allegations were against the former director and the former chief of staff, but as time went on over the next 4 or 5 months, from January to May of this year, Dr. Christensen provided us either in writing or verbally voluminous information of problems at the hospital. We had some 40 pages of material from him.

Mr. VOLKMER. In other words, his allegations were based on what I would characterize as basically, shut up and leave it alone?

Mr. KROLL. He discussed allegations of intimidation with us, yes.

Mr. VOLKMER. Did you all investigate those?

Mr. KROLL. Yes, we have looked at those and talked with the people involved.

Mr. VOLKMER. And what answers do you come up with? Do I find that in your report?

Mr. KROLL. Not directly.

Mr. VOLKMER. No, you don't.

Mr. KROLL. No.

Mr. VOLKMER. That is why I am curious. Why isn't there something about this in the report?

Mr. KROLL. It was one of these cases where we have two sides to the story. As best we can tell there has been nothing official in terms of a personnel action that has happened to Dr. Christensen. He still has the same position.

Mr. VOLKMER. Well, I agree with that. But are you saying—did the persons that you talked to, that supposedly made the allegations or made the statements to him, did they deny those?

Mr. KROLL. We talked to the chief of staff, for instance, and there is, as Dr. Christensen explained, not a good relationship between the chief of staff and Dr. Christensen. I think they see the world through two different sets of eyes. What Dr. Christensen perceives as intimidation, Dr. Bauer would see it as an aggressive management style for what is needed in that hospital. That hospital had suffered for a long time for a lack of aggressive management style on the part of the chief of staff. The new chief of staff comes in and establishes an aggressive style. Dr. Christensen doesn't like that.

Mr. VOLKMER. Now, what do you mean by "aggressive management style"? Tell me what that is.

Mr. KROLL. That is a good question. It is a manager who sets a very clear path to follow.

Mr. VOLKMER. You used the phrase. I would like to know what it is.

Mr. KROLL. It is a very clear path of what needs to be done, what should be done, and what is expected of the physicians. One of the issues that came up was the development of job standards. I was amazed Dr. Christensen didn't have job standards. The new chief of staff wanted to develop job standards for Dr. Christensen. Dr. Christensen felt that intimidated him. That is a standard thing in the government, to establish job standards, and Dr. Bauer is trying to get things back on track, in our opinion.

Mr. VOLKMER. Have you ever talked to Dr.—excuse me—Mr. Kurzejeski or Dr. Dick in regard to any statements that they may have made back in 1992, to Dr. Christensen?

Mr. KROLL. Well, first of all, Dr. Dick and Dr. Christensen are compatriots in this.

Mr. VOLKMER. Right.

Mr. KROLL. So there isn't any disagreement between those two. There certainly is a long history of disagreements between Dr. Christensen and Mr. Kurzejeski. We interviewed Mr. Kurzejeski once as a part of this review. Again, they see things totally different, from two different sets of eyes.

Mr. VOLKMER. As a result of your investigation, even though it is not in the report, do you have an opinion as to whether or not Dr. Christensen was intimidated in any way during this time frame?

Mr. KROLL. I have——

Mr. MERRIMAN. He doesn't seem to be a person that is easily intimidated.

Mr. VOLKMER. Pardon?

Mr. KROLL. I have not noticed any attempt to intimidate him. Earlier on, there was a letter read into the record where the director told him not to contact the IG. After that happened, he sent us volumes of information. So the bottom line was, there was no adverse effect.

Mr. VOLKMER. I am not saying there was adverse effects. What bothers me is that people within the bureaucracy there at the hospital may have, and I don't know, I wasn't there, may have attempted to stymie something that should have been looked at; in my opinion, should have been looked at.

Mr. KROLL. We agree.

Mr. VOLKMER. When you look at the statistical data as to what occurred, I am not saying anybody was deliberately murdered, killed or anything else, but, hey, there is something funny going on here. Do you agree with that?

Mr. KROLL. We agree. We agree there was a certain amount, if you will, of what is called damage control going on there at the hospital.

Mr. VOLKMER. Right. You called it dysfunctional management.

Mr. KROLL. We called it dysfunctional management—bad judgment.

Mr. VOLKMER. Couldn't it just have been that somebody was trying to take care of their own reputation? Couldn't it have been that Mr. Kurzejeski really didn't want anybody to know about it because it may affect his ability to continue as director or his ability to continue within VA?

Mr. MERRIMAN. That is a possibility.

Mr. VOLKMER. I say could.

Mr. MERRIMAN. That is a possibility. Another possibility is, if you look at it in an extremely positive light, that maybe he is protecting the reputation of the hospital and the patients that are going there. Maybe he is concerned that there is going to be a label of murder placed on the hospital, which he doesn't believe to be the case, and this negative publicity is going effect the view of the hospital.

Mr. VOLKMER. The image of the hospital?

Mr. MERRIMAN. Yes, right. He could have looked at it that way, too. There are many possibilities you can draw from this depending on how you look at it and what your insight is.

Mr. VOLKMER. Okay. Thank you very much, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Harold.

You are being very kind to this former director. I mean, the fact was that after the FBI began the investigation, after the statistical studies had come out, he writes a letter to the FBI and asks that the man be put back in patient care. Is that correct?

Mr. KROLL. That is correct.

Mr. MERRIMAN. That is correct, yes.

Mr. KROLL. We point out that was a mistake.

Mr. HUTCHINSON. Let me go back to this issue of the time on the reports because I am still confused on it. Jack, if I heard you correctly, a moment ago you said, in response to Harold, that when we began our review this past January. Did I hear you correctly?

Mr. KROLL. You heard me correctly, Mr. Chairman.

Mr. HUTCHINSON. Well, according to the time line that we have, February 16, 1993—1993—the complainant by letter asked the OIG to review management's administrative response to the increased deaths on Ward 4E. That is why I am confused. If the complainant wrote the letter on February 16, 1993, and you said that you began the review this past January and yet you said there was an immediate response, I am confused.

Mr. MERRIMAN. Dr. Christensen wrote a letter of complaint in February 1993 of allegations of cover-up and mismanagement at the hospital. That did take us to January 1995 to start on.

Mr. HUTCHINSON. Well, that was the point I was trying to make earlier.

Mr. MERRIMAN. I am sorry. We also received a request from the Central Region to look at the statistical review. That started immediately.

Mr. HUTCHINSON. I know. That was done and completed and you made no recommendations. But here, we have a letter of request, a complaint on February 16, 1993, concerning multiple deaths under suspicious circumstances that you only began a review on this past January. Have I got my sequence correct?

Mr. MERRIMAN. The sequence is correct, but what is missing from the sequence is the fact that the FBI was in there investigating at the time we received the letter from Dr. Christensen. They had already received the allegations of foul play. They had taken over the review. They had medical experts assisting them in taking a look at it. We screwed up by not starting quicker on the administrative aspect of it. The time sensitivity probably wasn't there with the staff because the FBI was in there already investigating.

There is no good reason why our system broke down and we didn't start earlier. We should have. But that doesn't mean during that time period nothing was going on. The FBI was conducting its investigation.

Mr. HUTCHINSON. I guess the phrase could be "dysfunctional management."

So you did not pursue this aggressively because the FBI was involved?

Mr. MERRIMAN. That is correct.

Mr. HUTCHINSON. Maybe somebody else can speak up on that.

Mr. VOLKMER. Wait a minute.

Mr. KROLL. Can I make one comment?

Mr. HUTCHINSON. Yes.

Mr. KROLL. There was a series of administrative errors in handling the February 1993 allegations that came in from Dr. Christensen, but the allegations did go immediately to our Kansas City Criminal Investigative Office, and they did contact Dr. Christensen.

He was told we had this ongoing FBI investigation, we are not going to look at these charges right away, and we are going to put them on hold. What happened is, the allegations were put on hold and were forgotten until they were brought back up by Dr. Christensen later on, a year later.

The second time the OIG took a look at the allegations we still didn't do everything we should have done. Finally the allegations came to my office's attention in January of 1995 and to Mr. Trodden's attention. He ordered an immediate investigation.

Yes, we are 2 years late, and we point that out quite clearly in our report.

Mr. HUTCHINSON. Thank goodness for his doggedness. I mean, here you have a case; even if you are only looking at the administrative and even if the criminal is all in the hands of the FBI, you have got a case in which a dysfunctional management exacerbated a situation in which there were multiple deaths. I mean, I would think that that ought to be a very high priority with the Office of the Inspector General.

Let me move to this issue of the whistle blower—the whistle blower issue. What is the IG's policy regarding confidentiality of disclosures made by VA employees to the IG?

Mr. MERRIMAN. That they are to remain confidential unless they give us permission to otherwise disclose their name, or unless the Inspector General makes the determination that disclosure is necessary to pursue an investigation. That has never been actually done.

Mr. HUTCHINSON. Did Dr. Christensen grant permission for his expressed concerns to the IG to be made public?

Mr. MERRIMAN. No, he did not.

Mr. KROLL. No, he did not.

Mr. HUTCHINSON. Were his rights to confidentiality honored?

Mr. MERRIMAN. His rights to confidentiality in terms of allegations he made in general about the medical center were honored to the point where our report that we issued recently talks about the complainant and Dr. Christensen separately.

We get into this issue on two instances. In one case Dr. Christensen sent material to the FBI that was intended, I guess, to go to the State Licensing Board. The FBI sent it to our Investigative Office, who looked at it, and they thought that there was a potential libel suit here. Dr. Christensen must have been accusing the nurse of murder or whatever, and there was also a potential breach of quality assurance information by Dr. Christensen.

The OIG investigators asked for advice from their supervisors in Washington, who said to give it to the district counsel for a judgment as to the nature of the quality assurance information in-

volved. District counsel sent it to the Central Region. The Central Region sent it to the hospital director.

We should have discussed it with Dr. Christensen before giving it to district counsel, but what we were trying to do was, A, to head off a potential libel suit and, B, to prevent Dr. Christensen from violating the quality assurance statutes, which are criminal statutes.

Mr. HUTCHINSON. So his letter to the FBI went to—or his communication to the FBI was faxed to your—to the Inspector General's Office, which in turn sent it to the regional director, which in turn sent it to the hospital director?

Mr. MERRIMAN. Which in turn—it came to our local Investigative Office, who provided it to district counsel, the attorneys in the district counsel's office.

Mr. HUTCHINSON. And from the district counsel, it went to the hospital director?

Mr. MERRIMAN. It went to the Central Region and then to the hospital director.

Mr. HUTCHINSON. At which point, Dr. Christensen was called on the carpet and told not to communicate anymore with the FBI?

Mr. KROLL. Yes, sir.

Mr. HUTCHINSON. And this is—is that little sequence of events that the—the reason that in your report you acknowledge not only did the administrative inquiry into the complainant's allegations that you took too long but you should have been more careful to protect the confidentiality of the complainant—it is in regard to that?

Well, what should other whistle blowers conclude from this experience? I mean, this breakdown in confidentiality, I would think, would be a disincentive for people to report these kind of things in the future to your office.

Mr. MERRIMAN. I can't think of another case where we have been charged with a breach of confidentiality.

In this particular case, I don't think Dr. Christensen would allege that we breached the confidentiality of his disclosures to us of the problems with management.

What happened was, during the course of this investigation, these early stages when they are exhuming bodies, a lot of things are happening. He sends the material to the FBI. I don't even know why they sent it to our people. They didn't seem to know what to do with it. It comes to our guys. They look at it and say, "Gee, this is a potential breach of the QA standards. It is a potential libel issue. We need to get an opinion on it."

It probably should have come to our own attorneys. If that had happened, we would perhaps have been more sensitive to it. But it goes to the district counsel, who are the ones that make determinations with respect to QA material.

We should have handled it differently. It would have been easy, as soon as we got it, just to call Dr. Christensen and say, "Hey, we have some concerns about this. Did you check with counsel? Do you know what you are doing?"

He had already sent it to the director. The director had the same material. But we had an obligation to talk to him before we did anything further with it, and we fell down on that.

Mr. KROLL. Mr. Chairman, I might also add that Dr. Christensen implies that this somehow put a chill maybe on future whistle blowers after what happened in this particular case.

My office has the hotline operations for the IG, and we have over 20,000 complaints each year. It is the most active complaint center in the entire IG community. My special inquiry staff, which did this review, has a list of reviews the length of my arm backed up, just for lack of staff, that we can't do.

So people are very willing and open to come to the IG with complaints, and, as Mr. Merriman mentioned, these are the only two times I can ever remember where there was a disclosure.

Mr. HUTCHINSON. I am sure it was something of a shock to Dr. Christensen when he had communicated with the FBI and found that back in the hands of the hospital director.

Did the meeting of the hospital director with Dr. Christensen at that point in which he instructed Dr. Christensen to have no further communications with the FBI or your office—did you consider that reprisal? Did you consider that recrimination?

I mean, I think you have basically said that there weren't any reprisals against Dr. Christensen. Dr. Christensen has testified that he was intimidated, as well as shocked, at this meeting.

Mr. MERRIMAN. The director did not have the authority to tell Dr. Christensen he could not talk to us or the FBI. That was clearly wrong.

Reprisal—in regards to the letter he sent, I wouldn't call it reprisal. I think of reprisal in terms of taking a personnel action or something with his job. He was having this conversation with Dr. Christensen, trying to limit his access to us and the FBI inappropriately because he received the letter. I don't know that I would call it reprisal.

Mr. HUTCHINSON. If a superior instructs a subordinate to have no communications with a Federal agency, isn't there an implied threat involved?

Mr. MERRIMAN. Well, there certainly would be. He is giving him an order. Any order, if violated, has some potential consequences. He was giving him an illegal order at that point. He shouldn't have. No manager in the department has the authority to preclude an individual from going to law enforcement authorities or to the IG. It was illegal.

Mr. HUTCHINSON. That was an illegal order?

Mr. MERRIMAN. I am sorry. Wrong terminology. It was inappropriate. I don't know that it breaks any statutes necessarily, but there is free and open dialogue required with the Inspector General. The director did not have the authority to do what he did.

Mr. HUTCHINSON. Okay. In the first IG report, the September 28, 1994, statistical review, the report contains no recommendations. How frequently does your office provide reports making no recommendations? And under what circumstances do you issue reports without recommendations?

Mr. MERRIMAN. It wouldn't be that common. In this particular case, it is sort of a unique report. What you have is basically an analysis performed for the Central Region to confirm some data.

In other words, the Central Region is coming to us and they are asking for us to validate the statistical information that they have

from Dr. Christensen and that their statistician had already looked at. We are concluding that there is validity to the statistical information, and we have come up with the 1 in 1 million probability.

So Dr. Connell wasn't making a recommendation. He was providing an analysis. It is sort of an unusual report.

Mr. HUTCHINSON. He thought it spoke for itself?

Mr. MERRIMAN. Yes, that is correct. It is an unusual way to do our reports.

Mr. HUTCHINSON. Let me just state before we dismiss this panel, Harold, do you have other questions? Let me recognize you at this point.

Mr. VOLKMER. I just have a brief one.

Just to turn it around and perhaps put yourself in Dr. Christensen's shoes for a minute. Now, you have previously sent this memo out to the FBI, and then you are called in to the director's office, and the director knows about it because he has a copy of it. Now, how would you feel?

Mr. MERRIMAN. Well——

Mr. VOLKMER. What would you think?

Mr. MERRIMAN. We agree that it was inappropriate.

Mr. VOLKMER. Not just inappropriate. What would you think? Wouldn't you think perhaps that the agencies were working together to try and cover this whole thing up?

Mr. MERRIMAN. I don't have——

Mr. KROLL. I don't know if I would go that far, because Dr. Christensen also gave the director a copy of this letter. We are talking about a letter that made a circuitous route. He gave a copy of this letter to the director, so it wasn't any secret.

Mr. VOLKMER. I know that, but now all of a sudden your letter that you sent to the FBI has found its way back to the director's office. Gee whiz, come on. You mean you wouldn't have some suspicion, if that had happened to you, that there was something going on out there among this bureaucracy?

Mr. KROLL. I don't know if I would take it to the step that the whole FBI, the IG, the VHA, and everybody else was in some kind of conspiracy. I don't think I would take it that far.

Mr. VOLKMER. You wouldn't take it that far?

Mr. MERRIMAN. I wouldn't take it that far, particularly on that issue.

Mr. VOLKMER. You would immediately think that somebody just goofed up the line?

Mr. MERRIMAN. That is one reasonable explanation. In this case, that is what happened.

Mr. VOLKMER. Thank you.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Harold.

Let me go back. I want to pick up on what Mr. Volkmer was questioning concerning the whole issue of a cover-up, and that—you know, it has been pointed out that maybe you were very narrow in your report, in which you rejected the idea of a cover-up or any kind of obstruction or anything like that, and you concluded by saying, quote, "The evidence points to bad management rather than a well-conceived management plan to deliberately cover up or suppress the information about the increase in deaths."

I want to just kind of cite from your report, what you say, on page 21, the former director ignored the district counsel's advice to inform the FBI. The former regional chief of staff ignored the district counsel's advice and recommended not to inform the FBI. The former director and former chief of staff, quote, "withheld statistical analysis from the board members conducting the administrative board of investigation."

The former director denied the request for assistance from the University of Missouri School of Medicine's biostatistician who could have confirmed Dr. Christensen's studies. You concluded that this request should have been granted but it wasn't.

You conclude on page 32 that the former chief of staff, quote, "delayed investigation of the problem by law enforcement authorities," end quote.

The former director refused to report Nurse H to the Missouri State Board of Nursing. If it had been a private hospital in the State of Missouri, such reporting would have been required by Missouri State law.

And you conclude on page 38 that the former director improperly limited communications with the OIG and the FBI in March of 1994, and I quote: "The director's action can be viewed as an effort to impede an official investigation by intimidating employees and is clearly improper."

Those are your words from your report that he intimidated, that he impeded an official investigation.

Yet on page 32 you say, quote, "We found no conclusive proof of an intentional cover-up by the medical center and central and regional officials."

So my question is: What exactly would have constituted conclusive proof?

Mr. MERRIMAN. I honestly believe that these individuals—the director, the regional chief of staff—did not want to take action unless they had clinical proof that something was wrong.

They initiated a number of actions they thought would give them an answer. You can look at that as some sort of cover-up. I just don't think that was what was going on in this particular case.

Clearly, they should have gone to law enforcement authorities. They should have gone to where they could have gotten the expertise to make something happen. They just rejected the possibility that there was a mass killer loose out there.

I am sure that they were trying to contain this within the system until they found an answer that would explain it and relieve them of the publicity that they had such a condition in the medical center. That is what I think was going on.

I don't think they got together and tried to figure ways to cover up what they believed to be a crime.

Mr. HUTCHINSON. Would they have to get together for there to be a cover-up?

Mr. MERRIMAN. No, they wouldn't have to get together, but they would have to believe that there was a crime committed and try to cover it up. I don't think they did.

Mr. HUTCHINSON. Well, then your conclusion was, they impeded an official investigation. That is page 38.

Mr. KROLL. It can be viewed as an effort to impede, and certainly some people can view it that way.

Mr. HUTCHINSON. That was not your view? It was not the view of—now, I think I read, "The director's action can be viewed as an effort to impede an official investigation by intimidating employees and is clearly improper."

Mr. KROLL. Yes. Then I said from a practical standpoint, to the best of our knowledge, it didn't limit the OIG or FBI in obtaining appropriate information.

After all, put it in context just a bit. It is bad, and we admit he should not have done this. I am not defending him, but it wasn't done in October of 1992 when this whole investigation was started, it was done in February of 1994, long after the FBI had been on-site and done all their interviews. The basic criminal investigation was over, for all practical purposes, as far as on-site work. We tried to look at the issue with a certain amount of it practically.

Also, all those quotes from our report are very accurate, but we also got together with our legal people and we asked do all of those things add up to a crime? They looked through all the Federal statutes, all the Missouri statutes, in terms of obstruction of justice and did not get a match.

So that is why we are calling it a series of bad judgments. We describe how bad the management was at that hospital and from the people we have talked to, serious misjudgments were made, and we have got them documented throughout our report, and you accurately pulled them out.

Mr. HUTCHINSON. Well, I mean I guess we don't want to debate this, but impeding an official investigation, I don't think—that is not technically a violation of law, to impede an official investigation by law enforcement authorities? Because, I mean, you conclude it is clearly improper. What you don't conclude is that it was illegal.

Mr. KROLL. It didn't really impede it. I guess that is what we would say.

Mr. HUTCHINSON. They were ineffectual in their efforts.

Mr. KROLL. The FBI was already off site by then. That is how I would put it. I am not a lawyer, but that is the twist I would put on it. This is legal language in our report.

Mr. HUTCHINSON. Yes. The rules permit counsel to make inquiries, and so I would recognize the Minority counsel at this time.

Mr. IBSON. Might I just clarify? The complainant made allegations of a "cover-up." Have you not taken the narrowest possible approach to that by going to the Missouri Code, and invoking criminal statutes, when, in the eyes of a layman, as you said yourself, this was "damage control," this was "containment," a "cover-up," precisely the term any layman would apply in this instance, regardless of what the criminal code might provide?

Mr. MERRIMAN. I am sorry. We didn't go to the Missouri State Code and the Federal Code to determine whether there was a cover-up or not. Criminal obstruction of justice is what we were trying to determine. This was the allegation. We couldn't find a violation of the Code.

Cover-up, a layman might say that. Obviously certain people in the medical center have concluded there is a cover-up. Others would see it as a series of management actions, trying to avoid neg-

ative publicity over an event that they weren't convinced happened, the actual killing of individuals at the medical center.

We didn't see the collusion of individuals trying to suppress a known crime. We just weren't willing to call it a cover-up.

Mr. IBSON. Thank you.

Mr. HUTCHINSON. We thank you for your testimony, and you are excused.

The chair now recognizes Dr. Garthwaite, Deputy Under Secretary for Health, accompanied by Mr. John Carson, FACHE, director of Harry S. Truman VA Medical Center since 1994, and Mr. Robert E. Coy, deputy general counsel.

I understand Dr. Garthwaite will be presenting testimony, and you are recognized at this time.

STATEMENT OF THOMAS L. GARTHWAITE, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS' HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: JOHN T. CARSON, FACHE, DIRECTOR, HARRY S. TRUMAN VAMC, COLUMBIA, MO; AND ROBERT E. COY, DEPUTY GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. GARTHWAITE. Thank you, Mr. Chairman.

In the interest of time, I have abbreviated some of the testimony.

I appreciate the opportunity to discuss issues related to the recently released Inspector General report entitled, "Alleged cover-up of an Increase in Deaths at the Harry S. Truman VA Medical Center in Columbia, Missouri."

At the outset, let me state that the VA is very concerned about the unexplained pattern of deaths at the Columbia facility. We determined that there was an apparent increase in the number of deaths on Ward 4E through our extensive quality improvement assurance processes, processes that are in place in our facilities throughout the United States and which are designed to alert management when potential problems exist.

In this case, it is also important to note, as has already been noted, that the Federal Bureau of Investigation has not provided us with any conclusive evidence yet of criminal activity. The under secretary for health requested the results of the FBI investigation in a letter to the director a week ago.

I agree with the findings of the OIG special inquiry report that there is no evidence of a cover-up by management. Some actions by VAMC management officials were, in retrospect, errors in human judgment.

In retrospect, for example, the acting associate director for nursing should have notified top management of nursing concerns about the apparent increase in deaths on Ward 4E sooner. Once notified, the director and chief of staff, among others, should have been more aggressive in seeking clinical corroboration of patient-related problems relating to the deaths.

The issue of not notifying the FBI is also complex. On September 2, 1992, a meeting was held with the director, associate director, acting associate director for nursing, the clinical nurse reviewers, and the associate chief of staff for research and development, and his research assistant. The results of Dr. Christensen's preliminary

data were reviewed, and a decision to remove the nurse from patient care was made.

The issue of whether the medical inspector, the FBI, or forensic pathologists should be involved was also discussed. Without clinical substantiation of the statistical analysis, the regional office advised that there was no justification for contacting law enforcement authorities. Management followed their guidance.

To assist management in determining when an incident should be reported to the appropriate law enforcement authorities, I will ensure that additional guidance is provided so that there is a mechanism in place to make sure that incidents such as the unexplained pattern of deaths at VA Medical Center in Columbia are in place.

Our current philosophy is one of decentralization of authority and empowerment of our field management officials. We have always expected them to make the best decisions with the information available to them.

With respect to Columbia, it is easy to retrospectively second guess decisions but somewhat more difficult to judge the quality of those decisions when you are not there at the time.

The issue of whether management should have reported the nurse to the State Licensing Board is an important and difficult one. My written testimony and the opinion of the VA general counsel address those issues and their complexity, and we would be happy to take questions regarding those.

Mr. Chairman, let me address your concerns about ensuring a properly functioning top management team. The VA Medical Center in Columbia, MO, has a new management team in place that, from all indications, works well together. The present director was recently selected to become a network director. I will ensure that a fully capable management official is selected to replace him.

In addition, the Veterans Health Administration is undergoing a major reorganization in headquarters and in the field. In March we proposed a reorganization of VA and last month were authorized by Congress to proceed to change the span of control over our facility management teams. Previously, each of VA's four regional offices had a span of responsibility of about 44 facilities.

With implementation of the Veterans Integrated Service Networks, or VISNs, the network directors will be responsible for about 10 facilities. This narrowed span of control will allow for more direct supervision and guidance of management at those facilities.

We believe that we have carefully selected the best qualified candidates as network directors to lead VA as we sit at the threshold of the transformation in VA health care which we are undertaking.

I will note, for Mr. Bilirakis' input, that we took so seriously the selection of those VISN directors that Drs. Kizer, Moravec, Story, and myself interviewed all 52 top-rated candidates personally for at least an hour and probed and attempted to find out what kind of decision-making parameters they might use to make management decisions in the future.

I would also note, for Dr. Christensen, that the number of layers between the under secretary of health and the facility director has been streamlined in our reorganization from five to three.

In closing, let me reiterate that VA discovered the abnormal patterns of death through its quality improvement program. We recognize that we have an obligation to our patients and to society to work with licensing boards to assure the quality of health care professionals. We are also sensitive to the rights that our employees and all citizens have to due process, and we look forward to working with you in applying these important principles, which may at some times seem to conflict.

This concludes my statement. We will be pleased to answer any questions.

[The prepared statement of Dr. Garthwaite appears at p. 136.]

Mr. HUTCHINSON. Thank you, Dr. Garthwaite.

In your statement, on page 2, you stated that management followed the guidance of the regional office in not contacting law enforcement officials. Was that consistent with legal advice received from the VA District Counsel's Office?

Dr. GARTHWAITE. I think there was in the very early portion of this a little disagreement and then some clarification.

Maybe Mr. Coy would like to comment on that since he was involved. I was not here at the time.

Mr. COY. On the 25th of August, a telephone call was received by our district counsel from an individual in Quality Assurance indicating that there was some statistical information that caused some concern with respect to increased deaths on the ward, and seeking some advice as to what the district counsel thought should take place at that point in time. There were discussions between several individuals at one point.

Finally, the district counsel did call the director and make some recommendations with respect to removing the nurse from patient care activities. He also made a recommendation to proceed immediately with further investigation and suggested strongly that consideration should be given to calling in law enforcement individuals.

Over the next couple of days the Region did get involved. There was an attorney outstationed in the region office at Ann Arbor who, based upon information received from the region to the extent that this was an aberration that can be explained, associated with some referral patterns, raised some question as to whether it was appropriate yet to call in law enforcement individuals.

There were, therefore, a number of discussions over a 2-day or 3-day period between our attorneys in the field and our office, and we reiterated the recommendation of the district counsel.

There was obviously some disagreement in the medical community as to the validity of the statistics, and all we had to go on was the concern that was expressed by the individual from the quality assurance office. So we did give advice, and that advice was apparently not followed, based upon additional evidence that the director apparently considered to be relevant.

Mr. HUTCHINSON. Where was the dispute concerning the statistical data? I mean, I haven't heard any testimony to indicate that anybody disputed what Dr. Christensen claimed—while there was a desire to verify that with an overview, there wasn't any—I mean, am I wrong? Where was the——

Dr. GARTHWAITE. I think what may have happened, trying to reconstruct this from a large amount of material, is that when this was reported to the region, they said, "We better make sure. This is a very serious accusation."

I don't think anyone wanted to believe that a health care provider was guilty of accelerating the deaths of a large number of our patients. So they gave some of the statistical data to the head of the Health Services Research and Development Office, which happened to, coincidentally, be located in Ann Arbor, and they issued—that individual issued a report which raised some questions. I don't think it totally invalidated the statistics but simply raised some questions.

Any time you get a group of statisticians together, there will be questions. And there were questions raised, and I think that added some doubt in the minds of both the region and the director as to whether or not they had enough basis to accuse—essentially accuse someone of mass murder.

Mr. HUTCHINSON. Well, let me say that I understand the concerns about due process, and I share them. But I do not think it is a very complex issue, when you have evidence of multiple deaths under suspicious circumstances and allegations of foul play, that you ought to opt always on the side of patient safety and that communication with law enforcement would have been an easy call.

Dr. GARTHWAITE. I wholeheartedly concur with you, and I have always felt, in my own professional practice, that if there is an issue, there is one standard that cannot be lowered, and that is the patient first, and if there is any question, we need to protect the patient's safety, and then the rights of the health care provider are secondary to that.

Mr. HUTCHINSON. In your testimony, you gave us assurances that this issue is going to be addressed. Has it been? Have there been policy changes regarding when and under what circumstances law enforcement is notified of deaths under—unexplained deaths or deaths under suspicious circumstances?

Dr. GARTHWAITE. A significant portion, I think, of what happened here is not a lack of policy but it is, in fact, a lack of judgment.

We routinely reported anything suspicious to the medical examiner in Milwaukee when I was chief of staff there, simply because we felt that was our obligation and duty. At times they would do some follow-up, and at times they would not.

But in terms of statistical analysis identifying a death pattern and something to be alerted to, that is an issue that not only the VA but all health care providers in the United States have only recently become more sensitive to. It is not just a VA issue.

Mr. HUTCHINSON. Well, in your testimony you did say that there was going to be—you would ensure——

Dr. GARTHWAITE. Right. We will provide guidance concerning when, how and what kind of statistical suspicions should lead to reporting.

But if you read the general counsel opinion on that, it becomes a very difficult issue to decide when is the threshold to do that.

Had this individual decided to have a slower rate—let's assume that this is a nosocomial murder and that these individuals have had their deaths accelerated by this nurse. If this individual had

done this at a slower rate to escape statistical attention, this could be happening in a variety of medical centers throughout the United States today, and it is a frightening thought, but it is true.

Mr. HUTCHINSON. It is a frightening thought, but I think—well, the previous panel, in talking about the order that the former director issued to Dr. Christensen that he was not to contact the FBI, said that it was an illegal order, and then they backed off of that and said that it was an improper order, was it an illegal—was it illegal for the director to tell an employee not to communicate with the FBI or the OIG?

Mr. COY. Probably not a crime or a misdemeanor. But it definitely violated clear instructions that have been given by the Secretary of Veterans Affairs and disseminated to all employees, indicating that employees should be free to contact the IG on any matter. They have a hotline number to call which provides for confidential input to the IG.

So without a doubt, it violates the directions, and clear directions that have been given by the Secretary.

Dr. GARTHWAITE. I would agree, and we are against that.

Mr. HUTCHINSON. On the issue of the State Licensing Board, that we have talked some about, reporting a separated health care provider to the appropriate State licensing board, the VA has a clear mandate to conduct a program to report to State licensing boards any separated licensed health care professional who was fired or who resigned after having had such individual's clinical privileges restricted or revoked.

Should those health care providers who do not have clinical privileges—and I understand that that is the distinction here, as to why not reporting to the boards of State licensing that the decision was that that was proper not to do that report.

But should health care providers who do not have clinical privileges, such as registered nurses, but who do have a significant amount of unsupervised direct patient care duties, be subject to a similar objective reporting requirement?

I mean, in fact, RN's probably have more direct patient contact than those who do have clinical privileges. So is there a problem in the current policy?

Dr. GARTHWAITE. We will re-examine the policy from all we have learned from this particular situation. All policy directives are subject to learning from future occurrences.

My suspicion is that, given the nature of how long these investigations take, there is a long period of time between suspicion of a problem and the ability to conclude anything, and that it will behoove all State governments and all health care organizations to try to fill in that gap and protect the public during that time. We take that obligation extremely seriously and work with the interpretation of the laws as they exist to try and make that happen.

Mr. HUTCHINSON. Okay. If I understand, the position of the VHA was that this particular nurse did not need to be reported to the State Licensing Board because he didn't have clinical privileges and you weren't subject to State law.

Dr. GARTHWAITE. Right.

I think one way to interpret why the director made a decision not to go forward is, under the law as we read it, the third provision—

someone terminated while under suspicion would require a significant evidence file, which was basically at the time in the hands of the FBI, so that what the individual failed to do was to ask the FBI for that evidence file so they could report.

Had we asked the FBI for evidence to make a report, we could have put together an evidence file, which then has to be given to the individual being reported, according to the statute, if I am not mistaken.

Mr. HUTCHINSON. But the fact that this nurse for 16 months has not been allowed direct patient contact, doesn't that indicate that there was a huge cloud of suspicion? And under the current mandate, a person with clinical privileges, if those privileges have been restricted or revoked, you have to report.

Dr. GARTHWAITE. But technically these are not privileges.

Mr. HUTCHINSON. I know technically they are not. That is what I am asking. This RN, who has more patient contact than do most doctors, shouldn't that mandate apply to them?

Dr. GARTHWAITE. Yes, I agree, and I am sorry if I wasn't clear. I think it should—I think it should. But does it or did it at the time, was the question.

Mr. HUTCHINSON. I thought what you said was, we will reevaluate, we will look at it.

Dr. GARTHWAITE. Right. We will make sure that we have the legal basis to do that, and, if we don't, we will request that we get that legal basis.

Mr. COY. I think the law will not be an impediment. I think there is a way we can work through the process.

I believe the current policy was premised upon situations that we normally deal with, which would have been an isolated incident. Medical misadventure they call it, or a personal problem. And they usually had thought that if the individual was on board, you could work with them, you could retrain them, you could help them deal with their problems thru counseling.

We were not dealing with, nor had we had experience with, a multiple situation such as this. As a result, the policy has limited the reporting requirement to people who had left, not to people who were still on board.

I think there is probably a sound basis for taking a hard second look, because we now have clear examples of a situation where the current policy failed, and we probably do want to take another look.

I don't believe the law itself is a problem, although we may have to do some modifications of routine uses under the Privacy Act so that we can report individuals still employed. Our current Privacy Act routine use, with respect to releasing information to the licensing board, has some limitations based upon due process concerns that probably need to be balanced out against other requirements. But I think we can work our way through this under current legal requirements.

Mr. HUTCHINSON. All right.

Was the VA prohibited from reporting Nurse H to the State Nursing Board? I understand the determination that it wasn't required. But was there a prohibition from that—from that report being made?

Mr. COY. I can say that under current policy, and under our current routine use, we would have been prohibited from releasing merely statistics. What we have established was a procedure that would say that, once you have statistics that cause concern, you have further investigation and you get more information. That is the way our routine use for releasing information under the Privacy Act was developed. We could modify that routine use.

I would have to say that today, based upon our current routine use, which can be modified in 45 days, there would be a problem with respect to reporting this nurse based only on the statistics, without additional investigation.

Mr. HUTCHINSON. Of course, if it had been left to the VA, that clinical evidence would never have been obtained, because the law enforcement would never have been brought in. So we would have been left only with the statistical evidence.

Mr. COY. I don't want to try to defend everything that happened in the past. I believe, however, that at some point in time, as they worked through this process, that law enforcement people would have been brought in. I would have hoped that would have happened. But it certainly didn't happen soon enough.

Mr. HUTCHINSON. Well, it was reported in the press that Assistant Inspector General Jack Kroll stated in a press conference—and I quote—"It seems the director, who also acted on the advice of the chief of staff from the region, felt before you report to law enforcement you need a body lying there with a knife in its back."

It seemed to me that, from that statement, that Mr. Kroll didn't think it ever would have gone to law enforcement.

Mr. COY. Well, I don't know whether he is talking about law enforcement or whether he is talking about a licensure board. Hopefully, good judgment would have said that it should have been reported and would be reported to the law enforcement people. The licensure board issue is more complicated.

Mr. HUTCHINSON. If I understand, you said that, going back and forth as far as law enforcement and the licensing board, but on the licensing board you would have been prohibited from reporting.

If the State board had requested information about Nurse H, could that then have been communicated to them?

Mr. COY. If the State board had requested the statistics, which were quality assurance statistics, we could have, under the current law, released those statistics.

What the State board would have done, however, was to ask for an investigation, which is exactly what we said you should do before you report the nurse, per se.

So the answer is yes, with a proper request, we could release the statistics to the State board. I think they now probably have them. But the answer is yes, we could have responded to their request.

Mr. HUTCHINSON. Did Nurse H's subsequent employer make an inquiry to the VA regarding his past employment?

Dr. GARTHWAITE. We can find no evidence of that. We have looked.

Mr. HUTCHINSON. Could you, Dr. Garthwaite, respond to the issue that Mr. Edwards raised earlier concerning the awarding of an $8,000 bonus to the former director at the very time that these allegations of dysfunctional management, possible cover-up were

being publicized, and at the same time, the FBI had an open and ongoing investigation that he would have been awarded this bonus?

Dr. GARTHWAITE. I did not review that specific thing. I will say that during our reorganization, our plan is to tie high management bonuses with objective outcomes for patients, objective patient outcomes, measurable outcomes of patient care improvements in the system. Traditionally, most reward systems in many personnel systems both in and out of government have been determined by an immediate supervisor based on a relatively subjective review of that individual.

As we have tried to make that more objective, sometimes we generate a lot of paperwork, but whether it is substantially more objective or not, I am not always convinced. So if the immediate supervisor subjectively rated that individual, I think that certainly is subject to second-guessing based on what has been presented here today and other information. But I think the key is can we make that system better and can we reward the proper things within the organization and that is our attempt into the future.

Mr. HUTCHINSON. Well, are you aware of what kind of job evaluations and performance evaluations the former director had prior to the awarding of the bonus?

Dr. GARTHWAITE. I am not. We can find that out, supply it.

(Subsequently, the Department of Veterans Affairs provided the following information:)

SENIOR EXECUTIVE SERVICE PERFORMANCE APPRAISALS

Kurzejeski, Joseph L., retired on 6/3/94
Attached are copies of the following performance documents from Mr. Kurzejeski's Official Personnel Folder:

- VA Form 5-3482 - SES Performance Appraisal for the period 10/1/92 to 9/30/93
- VA Form 5-3486a - SES Performance Rating/Award Authorization for the period 10/1/92 to 9/30/93 (attached to above form)
- VA Form 5-3486a - SES Performance Rating/Award Authorization for the period 10/1/91 to 9/30/92
- VA Form 5-0205 - SES Recertification for the period 11/18/88 to 11/18/91
- VA Form 5-3486a - SES Performance Rating/Award Authorization for the period 10/1/90 to 9/30/91
- VA Form 5-3486a - SES Performance Rating/Award Authorization for the period 10/1/89 to 9/30/90
- VA Form 5-3486a - SES Performance Rating/Award Authorization for the period 10/1/88 to 9/30/89

When an executive retires, his Official Personnel Folder is sent to the Federal Records Center in St. Louis. Only the above-mentioned documents are sent with the OPF. Other performance documents (such as the full written plans and appraisals for the four years prior to his last appraisal) are removed from the folder and destroyed in accordance with records retention schedules.

Please keep in mind that employee performance documents are Privacy Act records and should be safeguarded from inappropriate disclosure.

Prepared by: Office of Human Resources Management (053)
Department of Veterans Affairs
September 12, 1995

Department of Veterans Affairs

SENIOR EXECUTIVE SERVICE
PERFORMANCE RATING/AWARD AUTHORIZATION

RATING PERIOD	
FROM	TO
October 1, 19 92	September 30, 19 93

1. NAME OF EXECUTIVE (Last, First, M.I.)	2. SOCIAL SECURITY NUMBER	3. PAY LEVEL AND PAYABLE SALARY
KURZEJESKI, JOSEPH L.	114-14-8158	ES-4 $107,300

4. TITLE AND LOCATION OF POSITION(S) UPON WHICH RATING IS BASED
Director
VAMC Columbia, MO

5. TITLE AND LOCATION OF CURRENT POSITION (If different from above)

6. STATION NUMBER	7. ORGANIZATIONAL COST CODE
543	

8. FINAL RATING AND AWARD

A. The performance rating for this Executive is Outstanding

B. A performance award is approved in the amount of $ 8,000

9. SIGNATURE OF AUTHORIZING OFFICIAL	10. DATE
Jesse Brown, Secretary	12/10/93

VA FORM AUG 1990 5-3486a

EXISTING STOCK OF VA FORM 5-3486a, SEP 1982, WILL BE USED.

1-EMPLOYEE PERFORMANCE FOLDER

Department of Veterans Affairs

Senior Executive Service Performance Appraisal System

MPORTANT: For additional information, see MP-5, Part 1, Chapter 920, Section F.

PERFORMANCE PLAN AND APPRAISAL OF

EMPLOYEE'S NAME (Last, First, Middle Initial) KURZEJESKI, JOSEPH L.	PAY LEVEL SALARY ES-670-4
POSITION TITLE AND NUMBER Medical Center Director	
DEPARTMENT OFFICE Department of Veterans Affairs	LOCATION Harry S Truman Memorial Veterans Hospital, Columbia, MO 65201
DATE ASSIGNED PRESENT POSITION July 31, 1997	PERIOD COVERED BY THIS APPRAISAL FROM October 1, 1992 TO September 30, 1993

SECTION A - PERFORMANCE PLAN

dentify the critical and non-critical elements and performance standards for the position to be rated. Critical lements (i.e., those elements which contribute towards accomplishing organizational goals and objectives and re of such importance that unacceptable performance of them would result in unacceptable performance in the osition) are to be identified with an asterisk. Each position must have at least one critical element. Performnce standards are statements of the individual and organizational expectations or requirements established by nanagement for each element. There are usually three to five performance standards for each element.

ELEMENTS/PERFORMANCE STANDARDS

See Attached

FORM 5-3482 (1989)

EXISTING STOCKS OF VA FORM 5-3482a, DEC 1988, WILL BE USED.

DIRECTORS' PERFORMANCE STANDARDS

FY 1993

CATEGORY A

1. ORGANIZATIONAL PRESENTATION

-Represent the organization, internally and externally, as a major health care facility head in such a manner to reflect positively on the facility, the Department and the mission.

-Ensure facility employees, higher level Departmental management, and other Department components are timely informed of program developments which affect them.

-Establish and maintain positive relations with patients, veterans' organizations, the media, and other interested groups demonstrating sensitivity and responsiveness to their needs and concerns.

2. PROGRAM MANAGEMENT

-Ensure facility programs reflect the mission and priorities of the Department.

-Demonstrate active involvement in the strategic planning process, including evidence of appropriate collaboration with other facilities internal and external to the VA in planning new or expanded services.

-Ensure proper planning and preparation for VA/DoD Contingency.

-Establish systems ensuring timely access to care for patients being transferred internally and externally.

-Establish an organizational structure and an operating system that ensures the effective, efficient and timely accomplishment of program goals and plans.

3. RESOURCE MANAGEMENT*

-Effectively allocate financial, space, equipment and human resources in a manner which demonstrates commitment to quality health care delivery, improved productivity, technological advances and cost effectiveness.

2. FY 1993 Director Performance Plan

3. RESOURCE MANAGEMENT* (cont'd)

-Develop a plan with clearly defined priorities to ensure that the facility is maintained in repair, meets program requirements and provides an aesthetically pleasing environment.

-Demonstrate creativity in resource management as evidenced by initiatives which shift resources from low priority to high priority areas.

-Ensure applicants and employees are selected, assigned and developed consistent with EEO principles and in a manner which maximizes the use of their skills in achieving organizational goals. Demonstrate commitment to achieving approved EEO objectives. Demonstrate leadership in resolving employee-management disputes.

-Operate an effective performance management system.

-Achieve year-end fiscal and personnel objectives and targets within limits set for the facility.

-Pursue sharing initiatives for the purpose of maximizing efficiency in service provided by VA, community and other governmental agencies.

-Ensure that fiscal integrity is maintained at the VAMC during the fiscal year.

4. ORGANIZATIONAL EFFECTIVENESS

-Establish and maintain a system to ensure complaints are appropriately received and resolved, sources of complaints of a recurring nature are investigated and corrective action initiated on time.

-Internal control systems consistent with OMB, GAO, and VA guidelines are in place and identified problems are corrected promptly.

-Avoid unnecessary duplication of services in concert with a national health care plan.

3. FY 1993 Director Performance Plan

5. QUALITY MANAGEMENT*

-Ensure an effective Quality Management Program consistent with VACO and regional quality management policy is established and maintained. This is demonstrated by the following:

a. Ensure deficiencies of external reviews (e.g., JCAHO, CAP) are corrected on time.

b. Ensure QA programs are identified and reviewed annually and timely corrective action is taken and documented.

c. Ensure, through an effective Risk Management Program, those factors which impact negatively on the facility are monitored, evaluated, and corrected, such as patient/employee incidents, tort claim outcomes, and other adverse patient occurrences.

d. Ensure the implementation of an effective Utilization Management Program.

e. Ensure appropriate medical record documentation monitoring mechanisms are maintained for record review and problem identification and resolution.

-Ensure facility is in full compliance with all applicable VACO policy memoranda and JCAHO standards regarding the credentialing and privileging processes and that proper documentation is available.

-Ensure the implementation of an effective mechanism to document appropriate granting of clinical privileges to appropriate staff and to monitor clinical performance for consideration in reprivileging.

6. CATEGORY B

Medical School Affiliation Management (if affiliated)

-Promote effective working relationship between the affiliate and the facility so adherence to the requirements of the affiliation agreement can be met by both parties. Establish systems to ensure positive medical school communication and effective problem resolution.

4. FY 1993 Director Performance Plan

Medical School Affiliation Management (if affiliated) (cont'd)

-Ensure the needs of the affiliation relationship are effectively integrated with patient care needs of the facility.

-Ensure the effective integration and documentation of appropriate supervision of medical students and residents within the health care delivery system.

Medical Research Management

-Develop an environment in which internally and externally funded research is encouraged and supported, and is conducted within a framework meeting scientific, ethical, and administrative standards.

Significant Construction

-Ensure appropriate and timely input into determining the proper scope of construction projects, incorporating facility goals, objectives, and long-range plans, as well as regional needs of veterans. This would include positive staff involvement and interaction with Region and VACO officials.

-Ensure that the full impact of construction projects on existing facilities is considered and planned; e.g., interruption of patient care services, utility shutdowns, impact on employee working conditions. Ensure appropriate measures are taken to mitigate any adverse impacts.

-Ensure a high level proactive involvement in the Facility Development Planning (FDP) process and evaluation.

7. CATEGORY C

-Ensure adequate resources are dedicated to the Medical Care Cost Recovery Program in order to maximize reimbursement from co-payment and third party billing programs.

-Ensure that fiscal integrity is not compromised at the VAMC during the fiscal year; e.g., that funding in restricted accounts is appropriately spent, and that realistic budget and workload plans are developed and implemented without violating VHA policies.

-Ensure that all requests for compensation and pension examinations are processed, scheduled and completed within the guidelines for timeliness.

5. FY 1993 Director Performance Plan

7. CATEGORY C (cont'd)

-Meet requirements of the Prosthetic Improvement Plan including timely processing of orders and appropriate obligation of funds.

-Direct and support the facility safety and health programs. Demonstrate evidence of management involvement with program goals and objectives. Motivate employees to work safely and to maintain a safe and healthful work environment.

-Reduce the facility's OWCP Table 2 employee lost time accident rate by at least 3 percent over the previous fiscal year's rate, or maintain an accident rate of 3.0 or lower.

-Ensure collateral assignment(s) are monitored on an ongoing basis and report significant issues and developments.

Pharmacy:
- Support and ensure that the Pharmacy Service will be proactive in implementation of pharmaceutical care programs. This will include support for clinical pharmacy primary care and consultation programs, pharmacy involvement in drug cost containment programs, clinical education programs, and technician training programs.

- Ensure that Pharmacy Service develop and implement a plan for taking responsibility for pharmaceutical care and for assurance of delivery of appropriate pharmaceutical care.

ADP:
-Ensure all mandated DHCP deadlines are met in full.

Planning:
-Demonstrate active involvement in the strategic planning process, including evidence of collaboration with other VA facilities in planning new or expanded services, particularly where the potential for duplication of services exists.

-Ensure that appropriate planning approvals are received prior to implementing or soliciting funding for new programs.

-Ensure proper planning for VA/DoD Contingency and conduct appropriate VA/DoD Contingency exercises at least annually.

-Demonstrate active participation in Network Council meetings and contributions to network activities.

-Demonstrate responsiveness to the network objectives and responsibilities outlined by VACO and the Region.

ADDENDUM TO: Columbia

6. CATEGORY B

Significant Construction:

-Ensure delegated construction program (NRM & Minor) award obligations are in agreement with target allowance spending plan and operating plan timeframes.

-Ensure continued progress on design and activation development phases of the Outpatient Clinical Addition.

7. CATEGORY C

-Address issues specified by the Regions regarding workload management and affiliation relationships.

-Address issues specified by the Region regarding interpersonal relationships among management and Service Chiefs.

Consumer/Public Affairs:

-Maintain positive relations with Congressional offices and local media with regard to ongoing FBI/OIG investigations.

Planning:

-Assure appropriate implementation of specially funded programs, including those funded through activations (e.g., substance abuse, PTSD, homeless, GEM, etc.)

-Ensure successful operation of hospice consultation teams.

-Ensure compliance with bed control policies and procedures including compliance with definition of staffed operating beds.

SECTION A, PERFORMANCE PLAN (Continued)

ELEMENTS/PERFORMANCE STANDARDS

PERFORMANCE PLAN COMMUNICATED

DATE COMMUNICATED	SIGNATURE OF RATER	SIGNATURE OF EMPLOYEE
2-24-92	for A. ZAMBERLAN REGIONAL DIRECTOR CENTRAL REGION	

MID YEAR SELF ASSESSMENT

JOSEPH L. KURZEJESKI
Harry S. Truman Memorial Veterans' Hospital
Columbia, Missouri 65201

In resource management we continue to emphasize cost containment as a means to achieve our planned workload. We have implemented a total funds management program (TFM) for both salary and all other dollars which decentralizes fund control to the service level. It is working fairly well.

The hospital's performance management program has also been decentralized with excellent results. Our efforts to maintain an Equal Employment Opportunity complaint free operation continues to pay dividends as does our close working relationship with local American Federation of Government Employees (AFGE) officials. Our EEO Specialist and Patient Representative serve as faculty in Region and RMEC educational programs and our Associate Director serves on the Regional Planning Board. Appropriate recognition programs are conducted for employees, volunteers and patient activities. Our Ambassador Program which informs community and state officials of our VA-wide activities is highly successful.

Definite referral patterns have been arranged with medical centers in and outside of our network for cardiology, cardio-thoracic, and neurosurgery cases. Referring facilities are extremely complimentary about our service and quality of patient care. We support some of the travel costs involved with each referral. The high number of referrals is causing part of our budgetary problems.

The Quality Assurance and Safety Management Programs continue to be emphasized and we are in compliance with applicable JCAHO, CAP and OSHA accreditation standards. The Regional Review Program requirements have been implemented and are monitored on a regular basis. We have begun the implementation of a Total Quality Improvement (TQI) Program through various educational activities.

Our credentialing and privileging process is well managed and meets or exceeds all standards. The Medical Care Cost Recovery (MCCR) Program is outstanding and continues to gain national recognition for our efforts.

Compensation and Pension (C&P) examination completion has been somewhat of a problem but recently they have been completed on a more timely basis.

We continue to meet or exceed time frames for construction projects, controlled correspondence and DHCP activities. We are well prepared to award a number of contracts if a "Jobs Bill" is passed and they are funded.

Although the hospital has been besieged by inappropriate publicity about the number of deaths occurring in the hospital, employee and

patient morale continues to be positive. We continue to expend a considerable amount of time on this issue in order to maintain a positive public image.

Monthly meetings with the Medical School Dean and several department chairs continue to keep mutual concerns addressed. However, our financial problems hinder us from supporting needed clinical staff. Several clinical service chiefs who are not committed to the goals of this facility and the Department of Veterans Affairs (and their practice of involving others at a higher organizational level) continue to cause management to devote a considerable amount of time to this unprofessional conduct.

Although much of our time during the past six months has been devoted to some of the issues mentioned above, the record of service to the veterans we treat is excellent and we continue to maintain this objective as our primary goal.

DIRECTOR'S PERFORMANCE (SELF ASSESSMENT)
October 1, 1992 - September 30, 1993

CATEGORY A

ORGANIZATIONAL REPRESENTATION

The hospital's proactive approach to community relations and public image has reflected well on the facility, the Department of Veterans Affairs (VA) and our mission. Established programs and activities such as the Patient Representative office, annual consumer affairs briefing, the Ambassador Program and a highly functional Public Affairs Program assure positive external representation. Again this year, the Ambassador Program featured several distinguished individuals including the Missouri Secretary of State.

During this past year of close scrutiny from nearly everyone as a result of the Federal Bureau of Investigation/Office of Inspector General investigation (FBI/OIG), considerable time and effort have been expended to assure positive relations with the many publics of the hospital.

I have continued to actively participate in the meetings and programs of all major veterans organizations in the area including Disabled American Veterans, Veterans of Foreign Wars, etc.

Our local "Golden Age Games" for veterans was a great success this year. Together with the national games, these programs ensure our senior veterans will hold a special sense of pride and accomplishment as a result of the total team effort put forth by hospital personnel.

PROGRAM MANAGEMENT

We have held strategic meetings with Department personnel from Department of Veterans Affairs Central Office (VACO), Central Region and private firms concerning the Outpatient Clinical Addition project. These planning meetings have served to keep our staff and Department components apprised of the recent developments affecting this important project and its associated program impact.

The hospital Strategic Planning Board meets on a monthly basis with a balanced clinical and administrative membership. This group has been particularly involved during the year with activities associated with the Outpatient Clinical Addition project. The planning board is also involved with program considerations and activities of the Missouri/Southern Illinois network.

The hospital has now implemented a joint cancer care initiative with the affiliate in which state-of-the-art equipment (radiation treatment simulator and linear accelerator) were jointly acquired through the high tech/high cost procurement program. This

represents appropriate collaboration with other institutions in planning and implementing new services while containing patient care costs.

The hospital Department of Veterans Affairs/Department of Defense (VA/DoD) contingency plan has been updated within this past year to conform with new format guidelines received from the Central Region. All involved services within the hospital have prepared individual service plans in support of the overall hospital plan. Call back lists and procedures for call back are reviewed and updated on a regular basis. Testing of call back procedures has been accomplished. We have successfully participated in the quarterly bed status update process as well as the annual VA/DoD contingency exercise. The hospital is in regular contact with the primary medical center for which we provide secondary support (Department of Veterans Affairs Medical Center [VAMC] St. Louis, MO) and information concerning referrals to be received from them is routinely incorporated during the quarterly bed availability reporting exercises.

As a referral center for cardiac patients this hospital is very cognizant of the need for excellent communications and expeditious transfer of patients and records. Detailed and comprehensive procedures are in place for the acceptance of transfer patients and their records. Copies of operative reports, procedure reports and hospital summaries are forwarded to referring medical centers as soon as they are completed. Records are expeditiously processed to ensure their availability in support of patient care once patients are returned to their home medical centers. We have received numerous compliments during the rating period from the medical centers who refer patients to this hospital for services.

An effective committee structure within the hospital and regular staff meetings at all organizational levels ensure the effective and timely accomplishment of program goals and plans. Committee structure is reviewed annually. The Strategic Planning Board is active, the hospital Quality Council and Total Quality Improvement (TQI) initiative has been successfully launched and the annual management briefing process continues to facilitate service level input to new program planning and implementation.

RESOURCE MANAGEMENT

The hospital "Total Funds Management" system has been enhanced to allow the service chiefs the flexibility and latitude to reallocate funds between personal services and all other accounts to improve productivity. This also serves to increase cost effectiveness while maintaining our commitment to quality health care delivery. Decentralization of financial resource management has resulted in

the facility achieving its fiscal and personnel objectives and, in many cases, exceeding established goals and expectations. Regarding financial management systems reporting, the creation of a special reports section has resulted in the availability of valuable cost and resource utilization information in a comprehensive and timely fashion.

The hospital's five-year facility plan defines priorities to effectively address all long term maintenance needs. Each service provides updated information concerning project and program requirements. There is a specific portion of the hospital budget which addresses station level projects. These projects ensure vital maintenance and repair requirements are met and provide for an aesthetically pleasing patient care environment. In addition, the station engineering service administers an effective and comprehensive preventive maintenance inspection program which ensures all critical components of utilities, equipment, biomedical elements and safety systems are maintained in repair.

The expanded availability of specific, current financial operating data facilitates the targeting of resources from lower to high priority areas. Concerted effort has been put forth to focus available resources on high priority areas such as cardiac surgery and cardiac catheterization. This effort has resulted in over 250 open heart procedures being performed and elevating the hospital to the forefront among VA facilities in terms of volume and cost efficiency in this and other categories.

As an equal opportunity employer, the hospital reinforces its commitment to Equal Employment Opportunity (EEO) principles including both internal and external components. Utilization of various EEO programs such as cooperative education and upward mobility are exemplified by our affiliation with Lincoln University, an historically black college, within the commuting area. Affirmative action goals are established and monitored to assure maximum accomplishment. The FY 1993 Annual Accomplishment Report for Minorities and Women met all established criteria. Our Persons with Disabilities Program received a "Satisfactory Plus" rating for the current year. All EEO complaints have been successfully resolved at the local level during informal processes as a result of "win-win" negotiation techniques between management and employees.

The hospital's performance management system strength continues to be recognized in improved employee morale through recognition of accomplishments and an effective employee awards program. Local performance appraisal distribution for the Performance Management

After the point of project approval a steering committee is established which is comprised of representatives of affected services. This committee ensures the project design and implementation meets the needs of the users and appropriately supports all aspects of the affected patient care environment.

Project phasing during the design process is consistently conducted in a way which minimizes disruption to user services. Work which may adversely affect the utility needs of patients or staff working conditions is scheduled for off-hours completion. During this rating period there were no instances in which patient care services were interrupted for reasons associated with construction work. Major renovation included replacement of four x-ray rooms and renovation of six elevators.

This hospital is now in the process of beginning its Facility Development Plan (FDP). Various aspects of the FDP are discussed during management committee meetings and the Strategic Planning Board monthly meeting. The Interactive Medical Facility Planning (IMFP) space plan has now been developed which involved the input of every service chief in the hospital. Meetings were held with services to validate data which has consistently been provided by the dates established by VACO.

Delegated construction program award obligations have always been in agreement with the total target allowance spending plan and the operating plan timeframes. Our one Minor project, "Correct Fire Safety Evaluation Survey (FSES) Deficiencies," is within budget and available for award in FY 1993. Our one Minor/Miscellaneous project, "Renovate Nursing Home Care Unit (East)," is also within budget and available for award to Purchase & Hire (P&H) in FY 1993. All FY 1993 nonrecurring maintenance (NRM) projects were available for award within total target allowance funding. The hospital was able to effectively use savings from some projects to offset higher bids on others.

Development of the Outpatient Clinical Addition project is progressing exceptionally well. This project is currently part of the Department of Veterans Affairs FY 1995 budget submittal to Congress. Submission of high quality application and design program packages were provided to Central Region construction management staff within established time frames.

CATEGORY C

FACILITY SPECIFIC PERFORMANCE STANDARDS

Medical Care Cost Recovery (MCCR)

The hospital's MCCR program was reviewed by the Fiscal Integrity staff this past spring. Results of that review were very favorable and indicated that resources assigned were adequate and that procedures in place were maximizing reimbursements. We will exceed our FY 1993 minimum and median goals despite the curtailment of pharmacy co-pay income related to the implementation of the income test software.

Fiscal Integrity

In FY 1993 this hospital was subject to a fiscal integrity audit and site visit conducted by Austin Data Processing Center staff. The results of this audit were most favorable. It underlines the fact that fiscal integrity is not compromised, funding in restricted accounts is appropriately spent and the hospital is in compliance with Veterans Health Administration policy in developing and implementing the budget and workload plans.

Compensation and Pension Exams

Late last year and during the beginning of this year, a combination of increased examination requests and loss of some examining physicians caused this hospital to exceed the timeliness standards. After significant effort to improve this situation we have met or exceeded the timeliness standard consistently since February, 1993. This pattern will continue into FY 1994.

Prosthetics Improvement Plan

This hospital has substantially met all Prosthetics Improvement Plan requirements during the rating period. In October, 1992, we experienced eight delayed orders, and in November, 1992, this figure dropped to one. There have been no other delayed orders since that point in time. All delayed order reports were submitted in a timely fashion as required. Contracting Officers Certification Program was implemented in July, 1991. The prosthetic Decentralized Hospital Computer Program Version 1.5 was implemented October 1, 1992. The hospital conducted a prosthetics patient satisfaction survey which was recently submitted as required. An additional 0.5 FTE was allocated to the Prosthetics and Sensory Aid Service to bring staffing level up to workload demands.

Safety and Health Program

Under my direction, the Hospital Safety and Health Programs have received appropriate support and visibility as evidenced by the following actions. Safety is now included as a component of each service's annual management briefing. The facility Safety Specialist is now a full member of the Administrative Executive Board. Staffing in the safety office has been restructured to meet recommended guidelines. Safety work practices are consistently promoted through activities such as routine facility safety tours and the identification of safety hazards in the workplace.

Office of Workers' Compensation Program and Accident Rates

Current data indicates the hospital has experienced a 35% reduction in lost-time claims (annualized rate between reporting periods) and a 16% reduction in overall accidents. These results demonstrate substantial improvement over last year and far exceed the required standard.

Pharmacy

I have demonstrated a commitment to improve timeliness and efficiency of the pharmacy program through allocation of resources for technologically advanced equipment and associated space requirements including the ATC-212 automatic dispensing system.

Appropriate planning and facility resources are ensured through the development of a computer based pharmaceutical budget management program which monitors workload, patient cost and pharmaceutical cost by practitioner. I have approved a clinical pharmacy position for drug utilization evaluation (DUE) and Pharmacy and Therapeutics (P&T) Committee activities. This position also supports the overall pharmaceutical care program and patient counseling requirements.

Automated Data Processing (ADP)

All mandated packages have been installed in the production account according to required schedules. Additionally, Information Resources Management Service (IRM) is currently running many non-mandated releases.

Planning

This facility now has an active and effective Strategic Planning Board which includes the Dean of the affiliate medical school as a member. This planning body is active in work involving network planning issues. In addition, we continue to collaborate with other VA facilities in our area to facilitate the efficient transfer and referral of patients to this hospital who need specialized care. During the rating period the number of referrals to cardiology and cardiothoracic surgery have increased due to these efforts.

All relevant planning approvals are secured in advance of any proposals which may require new program resources.

Testing of VA/DoD contingency plan call back procedures is routinely accomplished. We have successfully participated in the quarterly bed status update process as well as the annual VA/DoD contingency exercise.

Responsiveness to network objectives and contribution toward network activities is demonstrated through regular attendance at all face-to-face network council meetings as well as teleconferences. There is evidence of program planning cooperation and improvement in service delivery related to patient transfer and referral as a result of this improved responsiveness.

Substantial progress has been made in the area of fully integrating the needs of the affiliation with the patient care needs of this hospital. There has been significant improvement in lines of communication both within this facility and with our affiliate institution.

All specially funded programs are implemented appropriately and within specified time frames including those funded through activations.

This hospital has a fully functional hospice consultation team with appropriate membership.

During the rating period the hospital has been in full compliance with bed control policies currently in place. Current operating bed levels combined with our workload management efforts have combined to ensure that our occupancy rate for the medical center is consistently above 80%. During the past year we initiated one request for operating bed adjustment which has since been withdrawn after being deemed unnecessary for FY 1994. An annual bed inventory has been conducted and all beds accounted.

DIRECTOR'S NARRATIVE
Page 2

Other indicators of my performance include but are not limited to the following:

An outstanding Labor Management Relations Program is evident by no unfair labor practices and no grievances progressing beyond the operating service level.

An outstanding EEO Program as recognized by no formal EEO complaints being filed during the course of the recertification period.

Development and implementation of a highly successful guest relations/patient representative program as noted by our Ambassador Program, and Consumer Affairs and Consumer Outreach Program.

Our reporting of patient incident rates is one of the best in the country.

Ranked within the top 25% of all VAMCs in the nation for performance associated with third party billing and collection activities this hospital's percentage of collection activities exceeds 95%.

Action has been taken to ensure adequate support for the Compensation and Pension (C&P) examination program. Speciality and general medical physicians have bee recruited through the FEE Basis program to supplement staff resources assigned. Over the course of the recertification period C&P examinations have been processed in a timely manner with an average processing time of 25 days or less.

Reduced inflated performance ratings.

Was instrumental in establishing a radiation therapy contract (re: 1.5 million savings) the first multi-year sharing contract in the VA.

Provided the necessary leadership and direction towards expanding cardiac surgery programs.

Planned workload over the course of the recertification period was either meet and/or exceeded.

The record for Columbia (since my appointment as director) is one of excellence. I have created a climate within the hospital directed at problem solving; whereby, there is a direct commitment towards the achievement of facility and agency goals. In retrospect, I have been successful in meeting mission objectives during a period where the availability of resource support was highly limited.

Department of Veterans Affairs

SENIOR EXECUTIVE SERVICE PERFORMANCE RATING/AWARD AUTHORIZATION

RATING PERIOD
FROM October 1, 19 90 TO September 30, 19 91

1. NAME OF EXECUTIVE (Last, First, M.I.)	2. SOCIAL SECURITY NUMBER	3. PAY LEVEL AND PAYABLE SALARY
KURZEJESKI, Joseph L.	114-14-8158	ES-4

4. TITLE AND LOCATION OF POSITION(S) UPON WHICH RATING IS BASED

Director, VA Medical Center, Columbia, MO

5. TITLE AND LOCATION OF CURRENT POSITION (If different from above)

6. STATION NUMBER	7. ORGANIZATIONAL COST CODE
543	

8. FINAL RATING AND AWARD

A. The performance rating for this Executive is Excellent.

B. A performance award is approved in the amount of $ None.

9. SIGNATURE OF AUTHORIZING OFFICIAL	10. DATE
Edward J. Derwinski, Secretary	12/13/91

VA FORM AUG 1990 5-3486a

EXISTING STOCK OF VA FORM 5-3486a, SEP 1982, WILL BE USED.

1 EMPLOYEE PERFORMANCE FOLDER

Department of Veterans Affairs

SENIOR EXECUTIVE SERVICE
PERFORMANCE RATING/AWARD AUTHORIZATION

RATING PERIOD	
FROM	TO
October 1, 19 89	September 30, 1990

1. NAME OF EXECUTIVE (Last, First, M.I.)	2. SOCIAL SECURITY NUMBER	3. PAY LEVEL AND PAYABLE SALARY
Kurzejeski, Joseph L	114-14-8158	ES-4

4. TITLE AND LOCATION OF POSITION(S) UPON WHICH RATING IS BASED

MC Director, Columbia, MO

5. TITLE AND LOCATION OF CURRENT POSITION (If different from above)

6. STATION NUMBER	7. ORGANIZATIONAL COST CODE
543	401

8. FINAL RATING AND AWARD

A. The performance rating for this Executive is Excellent

B. A performance award is approved in the amount of $ None

9. SIGNATURE OF AUTHORIZING OFFICIAL	10. DATE
Edward J. Derwinski, Secretary	12/13/90

VA FORM AUG 1980 5-3486a

EXISTING STOCK OF VA FORM 5-3486a, SEP 1982, WILL BE USED.

1 - EMPLOYEE PERFORMANCE FOLDER

Veterans Administration

SENIOR EXECUTIVE SERVICE
PERFORMANCE RATING/AWARD AUTHORIZATION

RATING PERIOD
October 1, 19 88 to
September 30, 19 89

1. NAME OF EXECUTIVE (Last, First, M.I.)	2. SOCIAL SECURITY NUMBER	3. PAY LEVEL AND PAYABLE SALARY
KURZEJESKI, JOSEPH L	114-14-8158	ES-4 $76,400

4. TITLE AND LOCATION OF POSITION(S) UPON WHICH RATING IS BASED
Director (00)
VAMC
Columbia, MO

5. TITLE AND LOCATION OF CURRENT POSITION (If different from above)

6. STATION NUMBER	7. ORGANIZATIONAL COST CODE
543	

8. FINAL RATING AND AWARD

A. The performance rating for this Executive is Excellent.

B. A performance award is approved in the amount of $ None.

9. SIGNATURE OF AUTHORIZING OFFICIAL	10. DATE
Edward J. Derwinski, Secretary	12/15/89

VA FORM SEP 1982 5-3486a

SUPERSEDES VA FORM 5-3486a (Test), APR 1980, WHICH WILL NOT BE USED

1 EMPLOYEE PERFORMANCE FOLDER

Consumer/Public Affairs

Considerable effort has been put forth on the part of the entire staff and the Hospital Director in maintaining positive relations with Congressional offices and local media during the ongoing FBI/OIG investigation. The hospital public affairs program has been responsive in all dealings with the local media and any other sources of inquiry concerning this issue.

MEETINGS/CONFERENCES ATTENDED BY DIRECTOR
10/1/92 - 9/30/93

11/8 - 11/10/92	Senior Management Conference - New Orleans Funded by St. Louis CEC
2/7 - 2/12/93	VA Information Technology Conference Austin, TX Funded by local facility travel budget
2/23/93	Travel to St. Louis to meet with Regional Director Funded by local facility travel budget
5/13/93	Site visit to St. Louis VAMC Funded by local facility travel budget
6/21 - 6/22/93	Innovative Approaches to Quality Regional Education Conference - Oak Brook, Chicago RMEC funding
8/1 - 8/4/93	Budget Hearings in Ann Arbor Region Funding

CHANGES TO PERFORMANCE PLAN (Changes may be recorded anytime during the rating period)

ELEMENT

STANDARD(S)

ELEMENT

STANDARD(S)

ELEMENT

STANDARD(S)

DATE COMMUNICATED	SIGNATURE OF RATER	SIGNATURE OF EMPLOYEE

SECTION B - PROGRESS REVIEW

At least one progress review is required during the appraisal year. Employee must be informed of his/her level of performance as measured against the performance plan.

A performance review was conducted and discussed, and the employee's performance as of this date:

☐ Is considered Fully Successful or better.

☒ Needs improvement to be Fully Successful or better.

SIGNATURE OF RATER	DATE
A. ZAMBERLAN REGIONAL DIRECTOR, CENTRAL REGION	4-8-93

SECTION C-1 - ACTUAL ACHIEVEMENT

Indicate the single, overall level of achievement that best describes the employee's performance for each ELEMENT shown in Section A. Do not indicate achievement for each individual standard. Specific achievement must be provided in Section C-2 for each element where a level of achievement other than Fully Successful has been assigned.

ELEMENTS (Use the same key word description for each element as in Section A)	LEVELS OF ACHIEVEMENT: EXCEPTIONAL	FULLY SUCCESSFUL	LESS THAN FULLY SUCCESSFUL
Organizational Presentation	✓		
Program Management	✓		
Resource Management*	✓		
Organizational Effectiveness	✓		
Quality Management*	✓		
Category B	✓		
Category C	✓		

SECTION C-2 - SPECIFIC ACHIEVEMENT

Describe specific achievement(s) for each element where a level of achievement other than Fully Successful has been assigned in Section C-1.

ELEMENTS/ACHIEVEMENT(S)

See attached.

Central Region Director's Performance Appraisal

Name: Joseph Kurzejeski **Rating:** Outstanding
VAH: Columbia, MO

CATEGORY A

Organizational Representation: Mr. Kurzejeski represented the organization, both internally and externally, in a manner that reflected positively on the facility and the Department and its mission. Through a number of means, employees were informed of program developments affecting them in a timely manner.

The VAH was in the top quarter of all Central Region facilities in distribution of news releases. The VAH provided copies of more than 100 news clippings to the Region, placing it in the top 20% of all Region facilities.

Program Management: Mr. Kurzejeski's participation in network meetings has been good. The Associate Director serves on the Regional Planning Board.

The Director demonstrated acceptable and appropriate administrative oversight of clinical issues.

***Resource Management:** Planned FTE will be met. Planned patients treated will be exceeded (+4%/+41.8). Outpatient visits will be met.

MCCR - Through August, Columbia has collected $2,966,462. They are projected to collect 110% of their minimum goal through FY93, surpassing their median goal. Comparing FY93 with FY92, collections have decreased by 6%. Columbia has developed a house staff orientation program to educate physicians concerning the MCCR program in an effort to increase awareness.

Mr. Kurzejeski supported the EEO Tecnical Advisor assisting with the AEP for 1 week in Ann Arbor. He also supports this person assisting the Region with the National Traning Program for Supervisors and Managers as a facilitiator. He in addition supported her participation in a week long meeting to revise the National Training manual. Mr.Kurzejeski implemented a mentoring program for career advancement during this performance period. He also supported his Associate Director's participation on an AIB at another facility regarding EEO issues.

Organizational Effectiveness: On average, draft responses to controlled correspondence were received more than three days in advance of assigned deadlines, placing the VAH in the top 16% region-wide.

Internal control systems are in place and identified problems are corrected in a timely manner. The medical center has an effective system that ensures that complaints are appropriately received and resolved. Complaints of a recurring nature are investigated and corrective actions initiated in a timely manner. The medical center works well with others in the network to avoid duplication of services.

***Quality Management:** The hospital is in full compliance with JCAHO accreditation, submission of A-123 reports, Credentialing and Privileging (all QA criteria), tort claim reporting, and reporting of adverse occurrences.

2. Joseph Kurzejeski

CATEGORY B (Affiliation & Construction)

The Columbia VAMC is a "Dean's Committee" affiliated teaching hospital with an approved medical school affiliation with the University of Missouri-Columbia, which provides 87 residents. Educational affiliations with several other institutions of higher learning exist for several allied health occupations, primarily nursing.

An extensive research program which includes more than 20 VACO funded and several other externally funded projects totaling nearly $2 million is conducted at the facility. This medical research program offers the opportunity for clinical investigators to study problems of importance to the veteran population and the nation as a whole. This opportunity enhances the institution's recruitment and retention of high quality health care providers. Major research areas include molecular biology, rheumatology/immunology, nuclear medicine, cardiovascular disorders, endocrinology, infectious disease and nephrology.

In the area of construction, the scope of the proposed major project was developed and the project advanced to an earlier budget year. Development activities continue to improve.

CATEGORY C

ADP: The VAMC supports and has implemented the mandatory DHCP packages.

The facility Compensation and Pension examination average processing time exceeded the 35 day requirement for the first 3 months of the fiscal year. This was attributed to increased workload. Additional staff was hired and the problem resolved.

The hospital's scores on the Electronic Annual Workplace Evaluation were 92.74 in Safety and Fire Protection and 79.38 in Industrial Hygiene. The overall facility score was 84.90. Columbia received the lowest IH score in the Region. Scores above 80 are considered to be good.

Through June 1993 the Table 2 Lost Time Claims Rate was 3.99. For the same three quarter period in FY92 the rate was 5.75. The goal of maintaining the rate below 3.0 and/or reducing the rate by 3% has been met.

A hospice consultation team was established.

NARRATIVE: This past year, Mr. Kurzejeski performed all of his organizational functions in a outstanding manner. Mr. Kurzejeski has been a healthcare provider for approximately 45 years. Through his leadership he literally runs the leanest and meanest medical center in the Central Region. This past year he has confronted a very serious situation regarding alleged inappropriate deaths. The Quality Management program under his direction is in full compliance with JCAHO accreditation and all the external reviews. It is his intent to retire during the next calendar year and I know that he will make the same contributions with anything to which he aspires.

SECTION D - SUMMARY RATING LEVEL

Using achievement levels assigned in Section C-1 and the criteria described below, check the rating which describes the employee's performance during the covered period.

PERFORMANCE RATING

- [x] OUTSTANDING - Achievement levels for all elements are designated as Exceptional.
- [ ] HIGHLY SUCCESSFUL - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for non-critical elements are designated as at least Fully Successful. Some, but not all, non-critical elements may be designated as Exceptional.
- [ ] FULLY SUCCESSFUL - The achievement level for at least one critical element is designated as Fully Successful. Achievement levels for other critical and non-critical elements are designated as at least Fully Successful or higher.
- [ ] MINIMALLY SATISFACTORY - Achievement levels for all critical elements are designated as at least Fully Successful. However, the achievement level(s) for one (or more) non-cirtical elements is (are) designated as Less Than Fully Successful.
- [ ] UNSATISFACTORY - The achievement level(s) for one (or more) critical element(s) is (are) designated as Less Than Fully Successful.

- [x] Check here if multiple summary ratings are not applicable and the above rating represents the initial rating to be forwarded to the Performance Review Board

SIGNATURE AND TITLE OF RATER	DATE
A. Lamberlan A. LAMBERLAN, FACHE, Regional Director	10/15/93

SECTION E - NARRATIVE SUMMARY

If multiple summary ratings or other special circumstances affected the assignment of the initial rating, briefly describe the basis for deriving the initial rating. This section may also be used to describe significant accomplishments not otherwise described in the appraisal, to comment on the executive's potential for higher level positions, and/or to document Executive Development Plans.

SUMMARY

SECTION F - INITIAL RATING

State the rating to be referred to the Performance Review Board if based on consideration of multiple summary ratings or if the rater who supervised an executive for less than 90 days endorses the summary rating level proposed by the previous supervisor.

RATING	SIGNATURE OF RATER	DATE

SECTION G - EXECUTIVE REVIEW

ACTION

☐ I do ☑ I do not request higher level review.

☐ I do ☑ I do not wish to provide a written response. The executive should attach the written response to this form.

SIGNATURE OF EXECUTIVE | DATE 10/29/93

SECTION H - HIGHER LEVEL REVIEW (OPTIONAL)

ACTION

☑ Concur with rating.

☐ Do not concur with rating - Recommend rating of _____

BASIS FOR RATING CHANGE

SIGNATURE AND TITLE OF REVIEWER | DATE 11/4/93

SECTION I - PERFORMANCE REVIEW BOARD RECOMMENDATIONS

DEPARTMENT PERFORMANCE REVIEW BOARD RECOMMENDATION ▶ RATING Outstanding

OPTIONAL COMMENTS

SIGNATURE OF CHAIRPERSON | DATE 11/23/93

AGENCY PERFORMANCE REVIEW BOARD RECOMMENDATION ▶ RATING Outstanding

OPTIONAL COMMENTS

SIGNATURE OF CHAIRPERSON | DATE 12/3/93

Carol Kummer for Ronald Cowles

SECTION J - FINAL RATING

RATING	SIGNATURE OF APPROVAL OFFICIAL	DATE

S. GOVERNMENT PRINTING OFFICE 1989 0-440-333

Department of Veterans Affairs

SENIOR EXECUTIVE SERVICE
PERFORMANCE RATING/AWARD AUTHORIZATION

RATING PERIOD
FROM October 1, 19 91 TO September 30, 19 92

1. NAME OF EXECUTIVE (Last, First, M.I.)	2. SOCIAL SECURITY NUMBER	3. PAY LEVEL AND PAYABLE SALARY
KURZEJESKI, JOSEPH L.	114-14-8158	ES-4 $104,000

4. TITLE AND LOCATION OF POSITION(S) UPON WHICH RATING IS BASED
Director, VAMC Columbia, MO

5. TITLE AND LOCATION OF CURRENT POSITION (If different from above)

6. STATION NUMBER	7. ORGANIZATIONAL COST CODE
543	

8. FINAL RATING AND AWARD

A. The performance rating for this Executive is Excellent.

B. A performance award is approved in the amount of $ _____.

9. SIGNATURE OF AUTHORIZING OFFICIAL	10. DATE
Anthony J. Principi, Acting Secretary	12/8/92

VA FORM AUG 1990 5-3486a

EXISTING STOCK OF VA FORM 5-3486a, SEP 1982 WILL BE USED

1 - EMPLOYEE PERFORMANCE FOLDER

Department of Veterans Affairs

SENIOR EXECUTIVE SERVICE RECERTIFICATION

NAME OF EXECUTIVE	POSITION TITLE AND ORGANIZATION
Joseph L. Kurzejeski	Medical Center Director (Office of Director)

CURRENT PAY RATE	RECERTIFICATION PERIOD FROM	TO
ES-670-4 $100,500.00	November 18, 1988	November 18, 1991

STANDARD FOR RECERTIFICATION

1. The career appointee must perform at the level of excellence expected of a senior executive. Excellence means that the executive has demonstrated over the recertification period that he or she has achieved excellence in:
   a. Planning for, substantially advancing, and attaining Presidential, agency, or organizational goals and objectives that required a sustained superior effort.
   b. Taking specific initiatives that advanced a major policy and/or significantly improved delivery of services.
   c. Taking the necessary actions to ensure the achievement of a quality product in a timely manner.
   d. Making significant technical, scientific, or professional contributions.
2. Also, if applicable to the responsibilities of the senior executive, excellence is demonstrated by:
   a. Achieving substantial savings in the execution of programs under his or her direction.
   b. Maintaining the high quality and effectiveness of programs under his or her direction with reduced resources.
   c. Providing strong leadership to enhance the development, utilization and achievements of subordinate personnel, including achievement of equal employment opportunity goals.

PART I - DOCUMENTATION OF RECERTIFICATION FACTORS

NOTE: Part 1 to be completed by executive or supervisory official.

ANNUAL SES PERFORMANCE RATINGS

YEAR	PERFORMANCE RATING LEVEL	YEAR	PERFORMANCE RATING LEVEL	YEAR	PERFORMANCE RATING LEVEL
1989	VAF 5-3486A Excellent	1990	VAF 5-3486A Excellent	1991	Excellent

AWARDS AND OTHER RECOGNITION

SEE ATTACHED NARRATIVE

DEVELOPMENTAL ACTIVITIES

SEE ATTACHED NARRATIVE

ACCOMPLISHMENTS ON BOARDS OR TASK FORCES

SEE ATTACHED NARRATIVE

REPUTATION IN FIELD OF EXPERTISE

SEE ATTACHED NARRATIVE

EFFORTS TO PROMOTE COOPERATION BETWEEN VA AND PUBLIC/PRIVATE SECTOR

SEE ATTACHED NARRATIVE

VA FORM 5-0205

Kurzejski

SENIOR EXECUTIVE SERVICE RECERTIFICATION

AWARDS AND OTHER RECOGNITION

I received a certificate of Recognition for Support of EEO Programs presented by the Columbia Chapter of the National Association for the Advancement of Colored People (NAACP) April 9, 1989. In addition, I was nominated for the Secretary's Annual EEO Award. I have also received recognition from the Nurses Organization of Veterans Affairs (NOVA) for my support and involvement in establishing the position of Associate Director for Nursing at this facility.

DEVELOPMENTAL ACTIVITIES

Community service membership and involvement in professional associations include but are not limited to:

Member:	Columbia Chamber of Commerce;
Participant:	All major veterans, organizations including but not limited to VFW, DAV, American Legion, etc.;
Preceptor:	University of Missouri-Columbia, School of Health Management Sciences; and
Preceptor:	Washington University School of Medicine, Graduate Program in Health Care Administration.

Meetings/Conventions/Conferences/Outside Training

1990:

- Directors Conference, September 17-20, Denver, CO
- VAccess Customer Conference, July 17-20, Austin, TX
- Central Region Directors Conference, July 8-9, Ann Arbor, MI
- Senior Management Conference, October 23-25, San Francisco, CA
- Association of American Colleges, October 26-27, San Francisco, CA
- AHA Annual Convention "The Federal Connection" , July 30-August 1, Washington, DC
- Challenges for Public Health Managers, May 15, Jefferson City, MO

SENIOR EXECUTIVE SERVICE RECERTIFICATION
Page 2

1991:

- Regional Director Meetings, July 8-9, Ann Arbor, MI
- National Association of State Veterans Homes, August 11-12, (Missouri Veterans Commission) St. Louis, MO
- VFW Annual Convention, July 13-14, Kansas City, MO
- ACMC/Cath Meeting, May 8-10, Charleston, SC

ACCOMPLISHMENTS ON BOARDS OR TASK FORCES

Over the course of the recertification period I have not been appointed by either the Regional Director, Chief Medical Director or Secretary, Department of Veterans Affairs to serve on boards or task groups. I indicated my willingness to the Regional Director to perform collateral duties in support of the region. However, no collateral assignments were delegated.

REPUTATION IN FIELD OF EXPERTISE

In collaboration with the Chief, Nursing Service, a proposal was submitted to VA Central Office requesting a change in our hospital's top management organization structure elevating the Chief, Nurse to an Associate Director level. I provided support and direction for this project during the evaluation process. In addition, I was the primary author of an article on this subject, published in the VA Practitioner, September, 1990 issue.

EFFORTS TO PROMOTE COOPERATION BETWEEN VA AND PUBLIC/PRIVATE SECTOR

In 1989 I initiated a program entitled the "Ambassador Program". The intent of this program was 1) to improve the image of the Department of Veterans Affairs and the federal employees, and 2) to help counteract any adverse publicity about the VA that appears periodically in the national media. Two of our volunteers who are very active in community programs serve as our "ambassadors". These ambassadors invite distinguished guests, individually, to our hospital for a program which is provided by the top management team. The program provides an overview of the VA and our facility through a slide presentation and discussion followed by a tour of the hospital. Thus far, the program has been presented to over 50 community leaders including U.S. Senators and Congressmen, state officials and local community leaders. Feedback from the program has been most positive. We have seen a heightened awareness of the VA by members of our business community as well as state and national leaders. This proactive approach provides the opportunity for us to present the VA story in a positive fashion, thereby enhancing the VA's public image.

Other programs noteworthy of mention include our Annual Consumer Affairs Conference, and Consumer Outreach Program both of which promote cooperation between the VA and the public/private sector.

DIRECTOR'S NARRATIVE

Over the course of the recertification period substantial compliance was achieved in the accomplishment of agency goals and proposed initiatives. For example, action was taken to create a smoke-free environment within the hospital. This agency directive was fully implemented with minimal adverse reaction from patients, visitors, hospital staff and union representatives.

In accordance with the Secretary's goal to convert additional beds to extended care, action was taken by this facility to activate thirty additional Nursing Home Care Unit beds. This activation project was accomplished within 90 days from initial notification by the Regional Director's office.

A principle responsibility of a hospital director is to make decisions and implement actions which are in the best interest of the hospital and the clientele served. Facing a budget short fall, I evaluated the situation and decided to impose workload restrictions. My primary concern centered around ensuring that service connected veterans continued to receive the full range of entitled benefits. The action taken ensured that continuity of care was provided for the patients we treat, reduction of our potential deficit, and ensured uninterrupted service through the remainder of the fiscal year.

During the recertification period full implementation was achieved with respect to integrating the Chief, Nursing Service into the position of Associate Director for Nursing. The success of this program did not go unnoticed. Birch and Davis, efficiency reviewers for VA Nursing Services, visited our facility in April 1991, noting that the reorganization had "had many favorable results" at our hospital. The reviewers recommended retention of the position and further recommended that VACO consider the applicability of this designation (Associate Director for Nursing) at other VAMCs.

The hospital's quality assurance program continues to function at a highly successful level. This is reflected in the survey findings of JCAHO during their November 1989, visit to this facility.

With respect to financial management, I have managed the hospital budget in a manner noteworthy of recognition. Over the last three years I have closed out the fiscal year without external assistance and achieved assigned workload within budgeted levels.

and Recognition System (PMRS) and Performance Management System (PM)S periods ending in FY 1993 was consistent with Central Region and Department guidelines.

During the rating period this hospital entered into a new VA/DoD sharing agreement with Ft. Leonard Wood. Also, as previously stated, effective October 1, 1993, we began a new sharing agreement with the Ellis Fischel Cancer Center for state-of-the-art cancer care and treatment.

Maintaining the financial integrity of this hospital is an ongoing program and an intrinsic element of my management and TQI philosophy. Accomplishment of this goal is reflected by the absence of any cited deficiencies during the recent audit by the Austin Financial Integrity team.

ORGANIZATIONAL EFFECTIVENESS

Complaint resolution at the lowest possible level continues to be one of the strengths of this hospital. I have made a concerted effort to facilitate solutions to problems and complaints identified to the Patient Services Assistant office. These various activities and any resultant corrective actions are reviewed by top management on a daily basis.

The A-123 program has been effectively integrated into the overall quality management program of this hospital. While this program continues to evolve, we continue to be proactive in addressing issues identified as either material weaknesses or Inspector General/Government Accounting Office (IG/GAO) issues. The hospital Quality Improvement Manager served as a member of the A-123 Task Force demonstrating a commitment on the part of the hospital toward improvement of the overall process.

This hospital continues to identify opportunities for health care sharing initiatives and the development of cooperative ventures both within and outside VA in concert with a national health care plan. Examples of these initiatives have been described above and include recently instituted sharing agreements with DoD and our affiliate.

QUALITY MANAGEMENT

During the last Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey, this hospital received a Hospital Accreditation Program (HAP) score of 94, a long term care grid score of 93 and a home care grid score of 91. These scores are all above system and national averages for these accreditation components. Both Type I recommendations previously identified have been resolved and removed. We anticipate early resolution of the

one ancillary testing program recommendation issues during the College of American Pathologists (CAP) survey this year.

An annual Quality Improvement Evaluation is performed in October of each year and findings are reported to the Director through the Clinical Executive Board, the Administrative Executive Board and the Nursing Executive Board.

This hospital is in full compliance with directives and requirements of the Patient Incident Reporting Program as evidenced by a satisfactory evaluation from the June, 1993, Central Region site visit. A Peer Review Board has been established and is operating effectively in monitoring and recommending corrective action on patient/employee incidents, tort claims and other adverse occurrences. A mechanism is in place that assures the service chief is aware of all tort claims filed and decision rendered by District Counsel.

A Utilization Review program is in place and working effectively. This program has been successfully integrated with Medical Care Cost Recovery (MCCR) activities. Staff have received appropriate training regarding implementation of this directive.

Under my direction, the facility is in full compliance with JCAHO standards regarding medical record documentation. Opportunities for improvement have been identified and implemented with positive results. Clinical pertinence review is performed monthly to include quality of documentation review and resident supervision. Our approach to medical record documentation monitoring was shared in a national teleconference sponsored jointly by the Central Region and the Cleveland Regional Medical Education Center (RMEC).

This hospital is in full compliance with all established credentialing and privileging guidelines, directives and policies. A full-time Credentials Coordinator position has been established. In June 1993, the mechanism for documenting and monitoring clinical performance was reviewed during a Central Region site visit and found to be in full compliance with established guidelines and directives.

An Executive Assistant for TQI position has been established in the Office of the Director. The hospital TQI program is progressing according to plan with the establishment of the Quality Council, vision statement, quality improvement goals and several ongoing TQI work groups conducting projects spanning several different disciplines.

CATEGORY B

MEDICAL SCHOOL AFFILIATION MANAGEMENT

Significant time and effort have been expended by the Director, Chief of Staff and the Dean of the School of Medicine to promote a more effective working relationship between the affiliate and this facility. This effort is producing beneficial results. Regular meetings have served to enhance communication and problem resolution. Substantial progress has been made in the area of fully integrating the needs of the affiliation with the patient care needs of this hospital. Revised policies concerning supervision of residents have been implemented locally and are being effectively monitored. Supervision requirements continue to be reinforced by the Director and Chief of Staff.

There is also further progress in enhancing the overall effectiveness of the Dean's Committee in its role as an advisory body and oversight committee for affiliation matters. Strategic issues as well as discussion on patient care needs in relation to the affiliation are consistently addressed by the Dean's Committee.

MEDICAL RESEARCH MANAGEMENT

Under my direction, the hospital continues to foster an atmosphere of learning through research, that challenges the best scientific investigators on the staff to solve the medical problems of our veteran patients.

I attend the Research and Development Committee meetings regularly and participate in the review of research protocols. All clinical research proposals are subject to an administrative review of their impact on hospital operations to prevent implementation delays and to limit the fiscal impact of such research on the medical care appropriation.

All research activities at this hospital are conducted under strict ethical standards and are routinely monitored and reviewed for compliance with these standards.

SIGNIFICANT CONSTRUCTION

Initial scope of construction projects is determined during development of the facility Five Year Plan. Facility goals and objectives, the regional needs of veterans, long-range plans, input from affected staff and any interactions with Region and VACO officials are incorporated into the scope of each project.

Mr. HUTCHINSON. If I understand it, is it your position that this $8,000 bonus was a subjective decision that was kind of a fluke and really isn't reflective of what goes on systemwide?

Dr. GARTHWAITE. Each medical center director I think at the time was required to submit an extensive evaluation of the medical center and its performance. In part the evaluation was an evaluation of the performance of the medical center as a whole and to some extent the director gets some credit and I assume some blame for the overall performance of the medical center.

Mr. HUTCHINSON. You have to admit that it is pretty bizarre to get an $8,000 bonus when the OIG is declaring that there is dysfunctional management.

Dr. GARTHWAITE. Yes, although the OIG reports were well beyond when the bonus was awarded, I believe.

Mr. HUTCHINSON. Well, the report was issued well beyond but the investigation was ongoing, was it not, at that time? I mean that is what they were basing it on is what was going on at that time in the hospital.

Dr. GARTHWAITE. I would agree.

Mr. HUTCHINSON. So has the VHA taken any steps to address how, number one, we could have a top management team at a major medical center declared dysfunctional that in fact instead of helping solve a problem exacerbated the problem, according to the OIG, and awarding bonuses to—to that very management? Have you done anything yet to address these—how this could happen?

Dr. GARTHWAITE. We proposed a new method by which we propose bonuses. We removed that top management team, replaced it with a different one. I think those are two major actions. We have not, to my knowledge, gone back and reviewed every bonus.

Mr. HUTCHINSON. So the bonus process has been changed. How has it been changed, the awarding of bonuses?

Dr. GARTHWAITE. Right. As part of the reorganization, we have proposed a total revamping of executive pay and have proposed to award bonuses based on objective improvements and outcomes for patients and we have identified I think up to 200 objective criteria that we will be measuring, both for VISN directors and for people that report to them. So those may be waiting times for patients, mortality rates for surgery, medication errors, patient satisfaction with services provided, as opposed to the more subjective evaluation done by the immediate management superior.

Mr. HUTCHINSON. I have got a few more questions.

I will yield to Mr. Volkmer if he would like to—if he has questions at this time.

Mr. VOLKMER. I just have a few questions.

I am a little concerned, Dr. Garthwaite, with the comments you made in regard to the review by the team on statistical data when it was done up in, I guess it was Detroit, and the finding that there were some things wrong with it. And that kind of made it look like maybe Dr. Christensen's findings weren't—I am characterizing what you said, but basically I get the thought that they weren't quite accurate, et cetera.

Dr. GARTHWAITE. We can provide a copy of the report from the HSR&D people. I this that is what probably prompted the region to then ask for the OIG to review the statistics and the OIG felt

it was also important for them to ask an outside statistician to review the statistics.

Mr. VOLKMER. Well, you heard the testimony of Dr. Christensen, and correct me if I am wrong about this, as I remember, Dr. Christensen said he was never contacted about the team when they did that review of the statistical data. And when they find some things that they thought weren't done properly, they never called him up and said why did you do this or why did you do that?

Dr. GARTHWAITE. My understanding was that the team rightly or wrongly was asked to come in and review an allegation by a resident that this nurse was killing his patients and they focused largely on that. It may have been expanded somewhat to look at some other pieces of data, and as Dr. Christensen pointed out with Dr. Dick's intervention that he was allowed to present to the team. So I think that perhaps got expanded beyond its original scope.

Mr. VOLKMER. Well, maybe I am making a mountain out of a mole hill, but it appears to me that some of the problems when I first reviewed it, if what Dr. Christensen says is true, they came back and said there were some flaws or whatever. I would hope that in the future if something like this ever occurred, and I hope it doesn't occur, but in the event that it would and there was a review that at the time that they would at least contact the person that made the original determination if they think there is something wrong with the way he has done it, to contact that person and say now, why did you do it that way, rather than just take it upon himself to say well, it wasn't any good. Understand what I am saying?

Dr. GARTHWAITE. Yes, I totally agree and I sincerely believe that most, if not all, the managers might have followed a different course.

Mr. VOLKMER. What is going on within the VA now that we know all that has happened and it is all open, everybody can look at it, what policy changes are being made so that we don't have to have it happen again somewhere?

I am not saying—I heard you say it could be happening and everything else. I am not saying you can prevent it altogether. As far as in the event that somebody, I don't care whether it is a worker or whether it is a—I mean, a nurse, or whether it is an intern or whether it is a doctor or whoever it is, somebody in the future says hey, here it is, it is happening in Denver or it is happening in Seattle, are we going to go through this 4 years after that again to say now because the local director and the local chief of staff maybe, or at least the director, I don't want to hurt the image of my hospital?

You understand?

Dr. GARTHWAITE. Yes, I understand perfectly.

Mr. VOLKMER. What policy are we making so that if a person does make that allegation he is not being told now we don't want you reporting that to the FBI?

Dr. GARTHWAITE. I think we have many rules that would guide us to do the right things. Unfortunately, placed in certain situations, human beings sometimes disappoint us.

It is my hope that as we select individuals and as we reward certain types of behavior and discourage others that as an institution

the VA can be consistent in what we reward and discourage. I think we have begun what I would consider a cultural and a massive transformation of the system.

I think decisions are made differently. I think that the fact that Dr. Christensen is here with unedited testimony is important, and frankly, I think he has done a wonderful job at bringing that forward.

I think he is to be commended for his honesty and his persistence in trying to see through what he believes to be the right thing. And so other than to publicly behave in a way that encourages people to follow the rules that are already there and to discourage those people as strongly as we can who fail to meet those expectations, I am not sure what exactly we can do.

There are some other things we do that will try to detect and find those things, but when you talk about a management response, I think my first answer is important. The other things we do is we have more and more statistical evidence as we computerize more and we do better with information as we enhance our quality improvement systems I think we are better at detecting it. We noted this increase that may not have been noted in every hospital in the United States and it may not have led to this investigation.

In addition, we have an enormous database with surgery patients now over 100,000 strong where we are trying to understand what are the risks for going into surgery and how do we improve and correct that process. We have surveyed 100,000 veterans for their satisfaction with their care and we can get that down to the ward level so that we know whether or not—whether we are making a difference, whether they feel good about their care.

We are asking them the questions that they believe are important about their care. So we are doing whatever we can to aggressively pursue the right thing to make people assure people get the best quality care.

When it gets down to the bottom line of people following decisions and being honest and upright, I think that probably the best we can do is to encourage them to model that behavior and to come down hard on people who don't meet our expectations.

Mr. VOLKMER. Mr. Carson.

Mr. CARSON. Yes, sir.

Mr. VOLKMER. What is the morale at the Columbia VA Hospital, at the present time, viewing this situation?

Mr. CARSON. I think Dr. Christensen correctly portrayed that when he mentioned his views of the Columbia VA Hospital, I certainly share them. I think it is an excellent VA medical center.

A number of patients come there specifically because of its reputation when they could choose other VA medical centers. Obvious—excuse me, I have a cold. Obviously, one of the difficulties at the medical center has been the impact of this particular concern that is ongoing.

We would all like to see it resolved, hopefully soon, by a report from the Federal Bureau of Investigation. But I believe very strongly in spite of that we have excellent morale at the medical center. It is not good everywhere, as you would expect. There are always some concerns. But it is best voiced I believe very strongly

by the fact that many patients come to our medical center very specifically, as I mentioned, when they could choose other VA's and by and large the patients that we deal with and their families, in contacts we have with them, are very pleased with the services they receive.

So I think it gives very, very good care and it has a very committed staff who are dedicated to doing that and this is one of the particular incidents that we would all like to see put behind us. It, in fact, unfortunately, is facing us, but I don't think it has impaired the staff at all in their providing quality patient care.

Mr. VOLKMER. Just to put a plug in, you need a little outpatient center, don't you?

Mr. CARSON. Yes, sir. We would hope that no one derails our ambulatory care center.

Thank you, Congressman Volkmer.

Mr. VOLKMER. Just had to put the plug in.

Mr. HUTCHINSON. You never miss an opportunity.

Mr. VOLKMER. Thank you, Mr. Chairman.

Mr. HUTCHINSON. The chair would recognize Minority counsel for a question.

Mr. IBSON. Mr. Coy, I would just like to ask one question, if I might.

Dr. Christensen has raised a substantial question regarding the Inspector General's ability to have conducted an independent impartial objective investigation in this case. I would like to ask you for the future, remote as this scenario might be, whether in a case like this where the integrity of the IG's ability to conduct an investigation is called into question, whether there are alternative mechanisms by which such an investigation could be mounted, whether, for example, arrangements could be entered into with another agency's inspector general to investigate a matter within the Department of Veterans Affairs.

Mr. COY. Well, we try to work closely with law enforcement agencies. State law enforcement agencies, licenser boards, medical examiners.

Could we get involved in a situation you have suggested? Sure, we have had joint investigations before. Usually it has been in situations which involved two departments. But I am sure that that type of a shared activity is permissible under the Economy Act.

Whether it is necessary, is another question. But there are options that can be available. I think by and large most people would say that the IG is not impeded from proceeding without, you know, fear of any problem areas with respect to their independence or objectivity.

But to answer your question specifically, there probably are other investigative approaches that can be utilized if we wanted to, but we try to work together to accomplish a good result.

Mr. IBSON. Thank you very much.

Mr. HUTCHINSON. Before we dismiss the panel, we appreciate your patience and sticking around so long this morning. I have just a few concluding questions.

I understand there have been a number of tort claims filed against the VA on the basis of what happened in Columbia. How

many wrongful death claims have been filed to date against the VA?

Mr. COY. There have been six administrative tort claims filed relating to deaths that occurred on that ward over the period of time that we are talking about.

Mr. HUTCHINSON. And what is the status of those claims?

Mr. COY. Based on our investigation and the lack of specific information with respect to negligence, wrongful death or anything of that nature, four of those claims were denied. One claim is pending. And one claim was settled because there was specific evidence of improper care that we could clearly define.

I believe the patient choked, but there was a clearly defined incident, and that case was settled. So one of the six was settled, one of them is pending and one of them has proceeded to a litigated status, as opposed to an administrative tort claim.

Mr. HUTCHINSON. The VHA, Dr. Garthwaite, in response to the OIG's recommendation has promised policy guidance changes to cover situations like at the VAMC in Columbia. This is to occur in the upcoming revisions to M–2, Part 1, Chapter 35, Integrated Risk Management program. Can you give us kind of a goal on when we can expect those policy changes to be implemented and what those changes might be?

Dr. GARTHWAITE. I think we will do that with all due haste. We will move expeditiously to get that done within the next couple of months.

I think the goal is to provide as specific and helpful guidance and guidelines as possible, taking into account some of the complexities that we have already talked about. And I think that the hardest part will be to look at when you have a suspicion, how much data does one need and how much suspicion does one need to contact legal authorities. And I think that we want to make sure that the guidance suggests it is better to err on the side of contacting rather than to err on the side of not contacting. And I think that to the extent that there are a lot of rules and regulations that every VA manager and employee is subject to, we have to make sure that we not only make those rules but then articulate them well and educate our work force to carry them out. So that is where I would aim.

Mr. HUTCHINSON. Okay.

On the quality assurance teams, does the VA require the inclusion of a biostatistician on those teams?

Dr. GARTHWAITE. No.

Mr. HUTCHINSON. No.

Who do the teams look to for validating statistical analysis?

Dr. GARTHWAITE. Well, typically people with the most expertise, and obviously in this case to—to Dr. Christensen. The medical center that I was at previously, we had a physician who was the sort of the main liaison with that group and he had a biostatistical background as well.

You raise an important issue. It is one I think we ought to look at and see if we can provide that kind of expertise. Certainly at a VISN level we should be able to identify someone with expertise in each of our 22 visions who cannot only be there to answer questions but hopefully to provoke some good questions.

Mr. HUTCHINSON. Mr. Carson, describe the Quality Assurance program at the Med Center now. Is it essentially the same that was in place in Columbia in 1991 and 1992, or have changes been made?

Mr. CARSON. In terms of the number of people doing that task, it is basically the same. In terms of some of the significant changes that have occurred, I think one of the major changes that is particularly important in this case has to do with now we identify number of deaths by ward, where before we tended to do it by service.

We also have gotten more heavily involved in terms of identifying activities by the provider, which I think is the second piece and very important piece for any Quality Assurance program. There had been a tendency in the past to do it more in terms of services provided as opposed to providers providing that service. So that right now we have better trending of where deaths occur so that hopefully we would pick up any unusual occurrence faster. We also are looking more specifically at providers as we use the QA data for their privileging activities.

It is important for us to have information by provider. I think that that has strengthened significantly over the last 3 or 4 years, not only at the VA in Columbia, but I think in the VA system in general.

Mr. HUTCHINSON. Do you concur with that, Dr. Garthwaite; is that what kind of changes have been made systemwide?

Dr. GARTHWAITE. Yes. And we always will be able to ask good questions for which we will have not have collected the data. But as we continue to enhance our data systems, that is a significant part of our objective.

Mr. HUTCHINSON. Mr. Carson, it is my understanding that several of the individuals who contributed to the Dysfunctional Management Environment Report of the OIG report have been placed in different positions. What tools do you have as manager to ensure that your management team is functioning as it should?

Mr. CARSON. I think that Dr. Garthwaite touched very effectively on that. And one of the most exciting things I believe about the VISN structure has to be the fact that we are developing for everyone our performance requirements, performance expectations, or performance contract, whatever the terminology might be, so that we are actively developing objective criteria with which to measure everybody.

Unfortunately, that is not totally in place even at our Medical Center, and I believe Mr. Kroll mentioned that some of that activity is presently taking place.

We presently have for most employees their performance requirements, but as Dr. Garthwaite mentioned, over the years, unfortunately, many of those are very subjective and they don't lead to objective measures to determine the effectiveness. But right now we have performance requirements in place. They are being improved so that they will be more like performance contracts.

We are modifying them where they contain subjective measures so that we can utilize objective measures and they all are being aimed at being very patient-centered and patient-specific.

Mr. HUTCHINSON. Now, if the performance levels are not achieved, do the current Civil Service in Title 38 authorities allow you to effectively reprimand or terminate employees who may not measure up?

Mr. CARSON. They certainly allow us to do that. I guess we could debate whether or not we could use the word "effectively" do it. But there is no question if someone fails in their performance that appropriate actions can be taken, sometimes it takes a little longer than we would like. The system over the years has been streamlined but the basic answer to your question is yes, there are measures in place to allow us to take appropriate action.

Dr. GARTHWAITE. I would say that the effort required often in those situations is extreme and requires a lot of expertise and expert individuals to be involved early in the process. That has impeded some of our attempts at removal in the past.

I mean, it is a laborious process to say the very least. Whether or not it functions well, it functions I think well to remove individuals who would not on a scale—on a grade scale like you get in college, who would receive an F, there is going to be little doubt.

The question may come—I have always had doubt in the system in whether someone who gets a D or D-minus, whether you have—whether that is easily done or not and it is—it often becomes a matter of judgment. It is very difficult and very time-consuming.

Mr. HUTCHINSON. I want to thank the panel. And I want to express my gratitude to all of the witnesses today for their contribution to this hearing.

And let me echo what Mr. Bilirakis said earlier, I don't think this should undermine confidence in the VA system and that what occurred at Columbia is the rarest of exceptions to the general pattern of good, quality care for our veterans. And I would—I would regret greatly that if what came out of this hearing was in any way undermining the VA mission or the confidence in the VA health care system. We have a good system and we have lots of people who are very committed to the care of our veterans and to providing them the best health care possible.

I do believe that in our oversight responsibilities and fulfilling them that there have been today raised very grave and very serious issues that need to be not glibly addressed but very seriously addressed and very expeditiously addressed, and I will just commit that this subcommittee will continue to monitor the changes in response to the tragedy at VA Columbia.

Thank you for your participation.

And the hearing is adjourned.

[Whereupon, at 12:28 p.m., the subcommittee was adjourned.]

APPENDIX

SUMMARY OF THE IG FINDINGS OF THE ALLEGED COVER-UP OF AN UNEXPLAINED INCREASE IN DEATHS AT THE COLUMBIA VA MEDICAL CENTER OCTOBER 25, 1995

BACKGROUND

In late August 1992 the quality assurance team at the Columbia, Missouri VA Medical Center identified a trend in death rates on a particular nursing unit. Of 23 patient deaths between October 1991 and August 1992 one particular nurse was on duty, and this nurse was the only nursing professional on duty for 13 of the deaths. The nurse was removed from patient care duties and later left VA employment. Dr. Gordon Christensen, the assistant chief of staff for research, uncovered the suspicious pattern of deaths. He later accused hospital management of trying to cover up the deaths.

A statistical link between the death rate on the nursing unit and the nurse, identified as nurse H, was confirmed by outside researchers and 13 bodies were exhumed in an attempt to ascertain the causes of death of these patients. The FBI has conducted an ongoing investigation and the VA IG's office has issued two reports -- the first on September 24, 1994 and the second on September 28, 1995.

The first report was a statistical analysis of the alleged excessive deaths. The IG concluded that there was a statistically significant relationship between nurse H and the deaths on a particular nursing unit. It also stated that the probability of this occurring by chance was less than 1 in 1 million.

The second IG report addresses the allegations of a possible management cover-up of the suspected patient deaths at the medical center. The IG concluded that there was no intentional cover-up; however, the top management was described as dysfunctional and incapable of working together as a team. The IG also found no obstruction of justice, nor was there evidence of criminal misconduct by the managers. All members of the top management team to include the director, the chief of staff, and the acting director of nursing have all been replaced, retired or moved to less responsible positions.

IG's Conclusion

The IG admits that it took too long in dealing with Dr. Christensen's complaints and the beginning of the administrative inquiry into the allegations. They also recommended policy changes to address the failure of management to take timely and appropriate action in such cases.

PATIENT DEATHS INVESTIGATION CHRONOLOGY
Harry S. Truman Memorial Veterans' Hospital
Columbia, Missouri

9/25/92: The hospital Public Affairs Officer responded to the initial media contact concerning "strange" events surrounding deaths on ward 4E. A Report of Contact documenting the initial telephone call was generated and telefaxed to the Regional Director and to VACO Field Support.

9/28/92: There was frequent contact with the Regional Office of Public Affairs (OPA) office (Denver) and the Regional Director's office (Ann Arbor) concerning a public statement for the media. The statement was read by the PAO late that afternoon and copies of the Region's media statement were released. The latter reference the fact that a Regional Site Team would visit the hospital beginning 10/1/92.

9/29/92: The Boone County Medical Examiner met with hospital management officials and was assured that there was not sufficient suspicion to report anything to the medical examiner system.

9/30/92: The Hospital Director conducted a press conference with a focus on the contents of a "Talking Paper." The press conference was decided upon and called after numerous conversations with the Regional Director and his staff. Cogent points highlighted included Regional HSR&D's analysis that local statistical analyses were flawed and that further statistical analyses were necessary. It was understood that the additional statistical analyses would be performed by VACO.

10/1/92: The Regional Site Team arrived and began their review of medical records and interviews with staff members.

10/2/92: The Regional Site Team completed the review and left the hospital. Later that day, based upon preliminary information provided by the Team and the Regional Director's office, the PAO provided a brief summary of the team's findings to the news media. The Regional Chief of Staff formally requested further review by the VA Medical Inspector General to help resolve questions about the statistical analysis of the deaths as well as assessing any impact on the mortality rate which may have resulted from changes in the types of patients treated on the unit.

That same day, the FBI made initial contact with the Hospital Director. It was a very general conversation and did not create an impression that the FBI was involved.

The PAO was advised by the Tribune reporter that the OIG had already decided to investigate. The reporter questioned whether hospital officials or the Region had requested the OIG's involvement before the OIG had decided to enter the investigation.

10/5/92: The hospital became aware that formal requests for investigation of two mortality cases on ward 4E had been received by the Medical Examiner's office. The Medical examiner formally requested the opportunity to review two medical records.

The PAO was telephoned by the FBI spokesman for the Kansas City office and was advised that the FBI was going to enter the investigation to determine any potential criminal actions. A meeting was scheduled on 10/6/92 in Jefferson City with representatives of the FBI and OIG present.

10/6/92: OIG staff arrived at the hospital to begin their investigation. That afternoon, the Hospital Director met with FBI and OIG officials concerning the joint investigation to be conducted.

Reporter from KOMU-TV (NBC affiliate) delivered FOIA request to PAO. The request, which was delivered to the Hospital Director, was for "any and all information" concerning deaths on ward 4E.

10/7/92: A full entourage of FBI agents and OIG staff were present at the hospital.

"Nurse H"

[redacted]., was advised by the Hospital Director that it would be preferable for [redacted] to remain out of direct patient care activities until after the OIG/FBI reviews were concluded.

10/9/92: The U.S. Attorney's office issued a press release concerning the joint investigation by the U.S. Attorney, FBI and OIG. Hospital management was advised that all media inquiries were to be referred to FBI, OIG or VACO spokespersons.

10/13/92: The Chief of Staff and two other physicians met with Dr. Connell in Kansas City.

A response to the 10/6/92 FOIA request was mailed to the KOMU-TV reporter. A redacted copy of the formal Board of Investigation report sans conclusions and recommendations was released.

Reporter from KBIA Radio (PBS affiliate) delivered three FOIA requests to PAO. The requests included the investigation report, patient incident report forms and mortality review records.

Nurse H

10/15/92: [redacted], was interviewed by KOMU-TV (NBC affiliate) reporter concerning the formal Board of Investigation report which had been released to the reporter under FOIA provisions. The interview was conducted without any clearance from the PAO who had declined to comment on the report when asked by the reporter. The filmed interview was broadcast on 10/16/92. (The PAO has a videotape of the story.)

10/16/92: A FOIA request for patient medical records from ward 4E for the period of 4/1/92 to 8/31/92 was received from the same KOMU-TV reporter.

10/22/92: A response to the FOIA requests from the KBIA Radio reporter was mailed. Material released included a redacted copy of the formal Board of Investigation report sans conclusions and recommendations as well as a copy of a blank patient incident report form.

A response to the 10/16/92 FOIA request from the KOMU-TV reporter was also mailed. No additional information was released and the response letter indicated that a photocopying fee of approximately $4,239 would be required before any patient medical records were photocopied and redacted.

A story in the Columbia Daily Tribune reported that the FBI had established an 800 hotline for information concerning the deaths on ward 4E. FBI officials did not communicate this action with any hospital officials.

10/30/92: Dr. Connell was at the hospital and met with the Hospital Director.

11/9/92: Two VA forensic physicians were at the hospital to review information.

11/10-12/92: Staff members from Dr. Connell's office were at the hospital reviewing information and requesting additional information.

11/15/92: A news story about the investigation appeared in the Columbia Missourian. [redacted], Nurse H had obviously been interviewed again, but no prior notice or coordination with the PAO had occurred.

If there are questions concerning the above information, please contact L. Stephen Gaither, Administrative Assistant to the Chief of Staff and Public Affairs Officer. His FTS number is 700-276-6012.

THE HONORABLE MICHAEL BILIRAKIS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

HEARING ON THE HARRY S. TRUMAN MEDICAL CENTER
IN COLUMBIA, MISSOURI AND RELATED MANAGEMENT ISSUES

OCTOBER 25, 1995

THANK YOU, MR. CHAIRMAN.

FIRST, LET ME COMMEND YOU FOR SCHEDULING THIS MORNING'S OVERSIGHT HEARING ON THE COLUMBIA MISSOURI MEDICAL CENTER AND MANAGEMENT ISSUES. THIS IS AN IMPORTANT ISSUE WHICH DESERVES OUR ATTENTION.

LIKE THE OTHER MEMBERS OF THE SUBCOMMITTEE, I AM ALWAYS CONCERNED ABOUT THE QUALITY OF HEALTH CARE THE NATION'S VETERANS RECEIVE AT VA MEDICAL FACILITIES. CONSEQUENTLY, I WAS GREATLY DISTURBED BY THE REPORTS OF AN UNEXPLAINED INCREASE IN DEATHS THAT OCCURRED IN 1992 AT THE HARRY S. TRUMAN VA MEDICAL CENTER.

FROM MARCH TO MAY 1992, THE DEATH RATE ON ONE OF THE MEDICAL CENTER'S NURSING UNITS NEARLY TRIPLED AND CONTINUED TO REMAIN HIGH THROUGHOUT THE SUMMER. APPARENTLY, THIS HIGH DEATH RATE IS ATTRIBUTABLE TO ONE PARTICULAR NURSE. ONCE THIS NURSE WAS FINALLY REASSIGNED, THE DEATH RATE ON THIS UNIT RETURNED TO NORMAL.

ALTHOUGH THE VA DISCOVERED THE ABNORMAL PATTERN OF DEATHS THROUGH ITS QUALITY IMPROVEMENT PROGRAM, IT IS TROUBLING TO LEARN THAT THE MEDICAL CENTER'S MANAGEMENT FAILED TO TAKE APPROPRIATE ACTIONS TO DEAL WITH THE SITUATION. THE INSPECTOR GENERAL'S OFFICE HAS DESCRIBED THE COLUMBIA CENTER'S TOP MANAGEMENT AS "DYSFUNCTIONAL" AND UNABLE TO WORK TOGETHER AS A TEAM.

CLEARLY, OUR VETERANS DESERVE THE BEST TREATMENT AVAILABLE, AND WHENEVER A SERIOUS PROBLEM LIKE THE ONE AT THE COLUMBIA MEDICAL CENTER ARISES, THE VA MUST TAKE SWIFT ACTION TO CORRECT THE SITUATION.

AS MEMBERS OF CONGRESS WITH OVERSIGHT RESPONSIBILITIES OVER VETERANS HEALTH CARE, IT IS INCUMBENT UPON US TO FULLY INVESTIGATE THIS MATTER. WE MUST ENSURE THAT THIS PROBLEM IS NEVER REPEATED ELSEWHERE IN THE VA HEALTH CARE SYSTEM.

I AM ANXIOUS TO HEAR ANY RECOMMENDATIONS OUR WITNESSES MAY HAVE ON WAYS WE CAN STRENGTHEN AND IMPROVE THE VA'S QUALITY ASSURANCE PROCESS. OUR VETERANS DESERVE THE BEST HEALTH CARE AND THE BEST HEALTH CARE PROFESSIONALS.

MR. CHAIRMAN, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THE COMMITTEE ON ANY SUGGESTIONS THE WITNESSES MAY HAVE ON THE ISSUES BEFORE US TODAY.

THANK YOU.

Statement of Rep. Michael P. Flanagan of Illinois

October 25, 1995

Mr. Chairman, thank you for holding this hearing today. I look forward to hearing the testimony regarding the alleged cover-up of an unexplained increase in the rate of deaths at the Columbia VA Medical Center.

The issues raised at this hearing are vitally important to fully understand the events surrounding Columbia VA Center and what steps need to be taken to correct any wrongdoings. It is absolutely imperative that any investigation conducted with regard to any objectionable activities within a Veterans' hospital are conducted in a timely, efficient manner, with great attention paid to details. We owe it to our Veterans to fully and properly investigate any questionable activities and occurrences. I look forward to hearing what our panelists have to say on this issue.

Mr. Chairman, in the interest of time I request that I be able to submit my full statement for the record.

TESTIMONY OF GORDON D. CHRISTENSEN, M.D.
BEFORE THE UNITED STATES CONGRESS
HOUSE SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS

October 25, 1995

MR CHAIRMAN AND MEMBERS OF THE COMMITTEE.

I am here to testify that the recently released report by the Office of the Inspector General (OIG), No. 5PR-A19-115, is wrong and dangerous. The report is wrong because it is an incomplete, dishonest, biased, flawed, and distorted presentation of the events that took place in Columbia. The report is dangerous because acceptance of this report promotes the cover-up of this mess and endorses the VA's policy of intimidation of whistleblowers. If you want to prevent a tragedy like this one from happening again, you must take immediate strong action.

In presenting this written testimony, I will follow this outline:

1. Background
2. Critique of the Report by the Inspector General
   a. incomplete sections
   b. flawed sections
   c. distorted sections
   d. dishonest sections
   e. bias
3. Cover-Up
4. How this report is dangerous
5. Recommendations
6. References
7. Appendix: Chronology

I will also use the following conventions:

When referring to pages in the report, I will simply state the page number. When referring to other documents, the boxed [] number will refer to the list of documents at the end of this testimony.

1. BACKGROUND

I am the physician who led the internal investigation into the deaths at the Harry S. Truman Memorial Veterans' Hospital. My qualifications are the following:

- board certified in the specialty of Internal Medicine
- board certified in the subspecialty of Infectious Diseases
- licensed by the State of Missouri
- tenured Professor, University of Missouri- Columbia
- established scientist and epidemiologist
- Missouri State Representative, Society for Healthcare Epidemiology of America

I am also the physician whose public charges initiated the Inspector General's investigation. I personally witnessed and documented a major portion of the events under our review today. The following paragraphs describe the chronology of this investigation. A detailed chronology of the investigation and response is appended to the end of the testimony.

In August and September of 1992, I led an internal investigation into the unexplained deaths and cardiorespiratory arrests ("codes") on ward 4 East. The investigation was conducted by the Hospital's Quality Improvement (QI) program under my direction. I was responsible for designing, analyzing, and presenting the QI data.

In the course of this QI investigation, we found that at least eleven and probably more than forty veterans died under circumstances that suggested they were killed.

These circumstances were:

- the patient's deaths were unexpected
- the death's occurred in May, June, July, and August of 1992
- too often the deaths occurred between 1 and 3 am
- too often the deaths occurred in private rooms

These deaths were overwhelmingly associated with a single nurse, later identified as "Nurse H."

These associations included:

- the unexpected deaths began when the nurse began working as an R.N.
- when the nurse was assigned a chaperon, the unexpected deaths only took place when the chaperon was sick and unavailable
- when the nurse was taken off the ward the deaths stopped
- during fiscal year (FY) 1992, the chances of dying while Nurse H was staffing 4 East were ten times higher then when other nurses staffed 4 East
- on the average, one in three shifts staffed by Nurse H experienced a death, while on the average, only one in thirty shifts staffed by all other nurses experienced a death
- the probability that the association of Nurse H with these deaths was accidental were vanishingly small, less than one in a million

The chronology of the recognition, evaluation, and administrative response to this situation is well documented. I have included a recitation of these events in Appendix A.

2. CRITIQUE OF THE REPORT BY THE INSPECTOR GENERAL

Time and space do not allow me to cover all the incomplete, dishonest, biased, flawed, and distorted portions of the OIG report. The following are only a few of the problems.

A. Incomplete Sections. I have used the term incomplete to refer to unanswered questions and missing sections. These items would include, but are not limited to:

- The OIG discussed the controversy regarding the reporting of the nurse to the State Board of Nursing. The OIG did not, however, address whether or not any hospital official can ever use intimidation to keep an employee who is acting in good conscience from reporting suspected murder to the police.
- Were the "all-employee meetings" on October 7, 1992 in which employees were warned, under penalty of heavy fines, to not reveal quality assurance information consistent with the law?
- The OIG claimed there was no obstruction, but on page 38 they state: "The Director's action can be viewed as an effort to impede an official investigation by intimidating employees..." Why is this not obstruction?

- Did authorities familiar with criminal law review all aspects of this affair, or was the issue of whether or not a law had been broken left entirely to the discretion of the OIG?
- What action did the OIG take in regards to the report of possible drug overdoses on 9/17/92 [page 2]? Was the action timely? Was information uncovered? Was this charge passed on to the FBI? And when was the charge passed to the FBI?
- Did the OIG perform a document inventory? It was my impression that original documents were destroyed. After making this charge I discovered that the former Chief of Staff had retained the documents I thought were destroyed. The OIG referred to a variety of documents generated before September 2, 1992. What was the fate of these documents? Since the OIG concluded that employees didn't respond appropriately to the deaths, can the OIG defend that conclusion with early documents indicating who knew what when?
- If the deaths were documented in the cardiopulmonary resuscitation committee, why didn't Hospital officials who reviewed those documents recognize the problem [page 7]?
- On page 7, the OIG revealed that someone reported the deaths and suspicions in Morning Report in May or June of 1992. When I have attended morning report it always included the Hospital Director, the Associate Director for Nurses, the Chief of Staff, and the QI Manager amongst others. Who attended this session and what did they do about the information? If the suspicions were brought forward at that time, is it credible that they were forgotten?

B. Flawed Sections. I have used the term flawed to refer to sections in which important information was omitted from the OIG report. These items would include, but are not limited to:

- The OIG discussed the relationship between the former Hospital Director and the Chief of Staff. The OIG concluded that this relationship was dysfunctional and the source of the management problems. The OIG did not report that the former Hospital Director had a long history of autocratic intransigent behavior, that he was unable to get along with any of his many Chiefs of Staff, and that his behavior was well documented and well known to the VA. In 1985 it almost resulted in the Medical School breaking the affiliation. Documents supporting these statements were submitted to the OIG by the former Chief of Staff. Instead of considering these documents, the OIG dismissed them as "voluminous."
- The commentary on page 49 suggested that the local search committee endorsed the promotion of the Acting Chief of Staff. This was not so.
- The OIG report does not refer to the following statement, reportedly made by the Chief of Staff for the Central Region to the former Hospital Director when informed of the suspicions of murder on September 3, 1992. "The last time I was called about a problem like this we fired the Director and the Chief of Staff, are you sure you want to continue this discussion?"

This comment was witnessed by the Chief of Pathology Service and was considered by him to be coercive.

- There is a major discrepancy between the OIG report and the timeline of the QI Manager [1]. On page 19, the OIG indicated that District Counsel correctly advised the former Hospital Director to report the deaths. This statement is not supported by paragraph 14 of the QI Manager's timeline. Furthermore, this suspicion is not consistent with the report of contact dated October 5, 1992 [2], in which Assistant District Counsel advised the Hospital that the FBI should not be given access to quality assurance information without an appropriate court order. The quality assurance information was the information that suggested that there was murder.
- The OIG declared it was appropriate for the Dean of the Medical School to ignore the 40 unexpected deaths on a teaching ward and the charges by a houseofficer that nurses were killing patients because this was "an internal matter." This attitude does not appear to me to be consistent with the spirit or intent of affiliation as described in the VA manual.

C. Distorted Sections. I have used the term distorted to refer to sections in which important information was twisted in meaning. These items would include, but are not limited to:

- The discussion of the responsibilities of Hospital management to report and act on the suspicion of murder is incomplete and misleading. Here are some of the many problems:
  - » The VA does not and did not have a clear policy on when to act and when to report suspected murder.
  - » A policy of reporting when there are only rumors of murder was opposed by the former Hospital Director [page 17], the former Chief of Staff for the Region [page 22], and the current Regional Director [page 59].
  - » The discussion ignored the fact that many people in the Medical Center supported the nurse and did not support the allegations, that there was confusion regarding the significance of the Hospital statistics, and that there was virtually no data upon which to make a decision.
  - » The discussion criticized the decisions made by the former Chief of Staff and the Acting Associate Director for Nursing before September 2, 1992. This discussion overlooked the decisions made by the Regional Site Visit Team many months later; recommendations which were nearly identical - but not as strong - as the actions taken by the former Chief of Staff and the Acting Associate Director for Nursing.

  How can we possibly hold a subordinate responsible for actions, decisions, and nonexistent policies that are actively opposed by top management?

- On page 33 a recommendation was made to take administrative action against the former Chief of Staff for not generating data quickly enough. This recommendation was not credible, considering:
  - » He was first informed of an increase in deaths and codes on August 4. The suspicion of murder was not introduced until August 17. The nurse was off the ward by August 24.
  - » He did direct QI to obtain better data on both August 4 and on August 18.
  - » When data was not forthcoming on August 17, he recognized the deficiency and initiated a pathology investigation on August 24 and an epidemiology investigation on August 27.
  - » A study was performed and it got a preliminary answer by September 2 and a full answer by October 1. Furthermore, the answers were the correct answers. This performance was not equaled by the Office of Healthcare Inspections which took two years to issue a report or the OIG which took eight months to issue a report.

- In the discussion of the responsibilities of the former Hospital Director in this matter, there is no mention of the September 2 meeting. On that date when I was the second in command of the Hospital, I analyzed the QI data, called an emergency meeting, and told the former Hospital Director that there were objective reasons to think that Nurse II was killing patients and that the FBI must be immediately informed. The former Hospital Director refused to call the FBI and repeatedly refused to call the FBI over the following month.

- The discussion of the regional site visit team does not mention:
  - » That the presentation of the QI data was kept off the original meeting agenda.
  - » That when I discovered this absence, I stated I would go to the FBI.
  - » That in response, the Chief of Staff, Dr. Dick, overrode the explicit instructions of the former Hospital Director and had me present the data to the team.
  - » That after this presentation the former Hospital Director told the former Chief of Staff "You can expect to take a hit for this and probably Christensen to."

D. Dishonest Sections. I have used the term dishonest to indicate sections which appeared to me to be deceptive. These items would include, but are not limited to:

- The OIG proposed we accept the appointment of the Chief of Staff and the appointment of the Chief of Human Resources as appropriate because the paper work was in order. If there were improprieties, is it credible

to expect the improprieties would have been documented? Substantial questions about these two appointments were not addressed.

- The OIG endorsed the conduct of the Administrative Board of Investigation (Board of Inquiry) which was appointed to investigate the allegation of murder by the houseofficer. For the following reasons, this endorsement was dishonest:
  - » The appointment letter for this Board authorized a wide ranging investigation, but in violation of this letter the former Hospital Director restricted the Board to deciding whether or not the House officer made this charge against the nurse.
  - » This was the only Board of Inquiry appointed by the Hospital, despite the multiple charges of murder by multiple independent sources, including myself.
  - » The event took place when the charged nurse was under a cloud of suspicion and increased supervision for suspected murder in earlier cases.

  Under these circumstances, limiting the Board to the single charge by the houseofficer was not credible. If it was appropriate to limit the charge, then there should have been other Boards for the other charges; if the Board included the other charges, it should have included the other testimony. Furthermore:
  - » The OIG ignored the explicit instructions to me from top management that the Board was intended to investigate my charge of murder for the purpose of informing the police.
  - » The OIG ignored the public use of the findings of this Board by the Hospital Director to exonerate the nurse.
  - » The OIG ignored the significance of the suspected perjury by Nurse II in testifying before a Board investigating a charge of murder.
  - » The OIG ignored the fact that the former Hospital Director withheld evidence - the quality assurance data - from the Board that was specifically requested by the Board.

- The OIG endorsed the conduct of the Peer Review Board which was appointed to investigate the last five deaths associated with Nurse II. For the following reasons, this endorsement was dishonest:
  - » The members of the Peer Review Board were not told that they were examining charts of patients suspected to have been murdered. The claim by the OIG that not informing the members was appropriate in order to keep the review objective is simply wrong. You can not test a hypothesis without being informed of the hypothesis.
  - » The charge letter for this Board asked the members to examine the quality of medical and nursing care, documentation, and level of supervision by

attending physicians. By implication, the members could reasonably guess that management suspected a problem in one of these areas. Most people would not equate a problem in medical and nursing care with murder.

» From the standpoint of a murder investigation, the charge to the Board was not credible. Are we to expect the physicians to find murder documented in the medical record? Will they find such documentation when it was missed by a prior review of the record by the QI reviewers?

» The OIG ignored the public use of this board by the former Hospital Director to justify the claim that no patient abuse was found.

- The OIG declared the criticism of the QI investigation by the Director of the Great Lakes Health Services Research Development Office was appropriate. For the following reasons, this claim was not credible:
  - » The work was judged as a "research report." The submitted work was actually a collection of documents pertaining to an ongoing murder investigation which were requested by Central Region. It was not intended or presented as a finished product.
  - » There was a rush to judgement. There was no attempt to question me on any problems regarding the work. The work was sent to the Region on September 24; an official statement was released by the Central Region on September 29, 1992 which declared the QI investigation to be flawed.
  - » The OIG ignored the use of this criticism by Hospital Officials [3] to discredit the QI study.

E. Bias. I have used the term bias to refer to sections in which I believe the OIG revealed a prejudiced approach to this investigation. These items would include, but are not limited to:

- The OIG claimed Hospital Officials did not act quickly enough in response to the rumors of murder on 4 East. These charges were directed primarily against the Acting Associate Director for Nurses, the Chief of Staff, and to a lesser extent the Hospital Director. These charges ignored the obligations of the QI Manager and the Hospital Police who also had the authority and the ability to take action on this matter. The OIG report also failed to criticize the large numbers of Hospital employees who were aware of the suspicions of murder long before documents indicated top management was informed. Since all Federal employees are charged with bringing possible crimes to their supervisor's attention or to the OIG's attention, by the OIG's criteria these individuals were also derelict.

- This was a biased investigation. The investigation was conducted by the two agents who were blamed by the Inspector General for mishandling the allegations in the first place.
- The Inspector General released their report in a combined news conference with the Hospital, a conference to which I was not invited - although I did attend.
- After reviewing the report, one of the very few things I learned was that there was a discussion between the Assistant Inspector General and the Chief of Staff of the Hospital about taking actions against me for violating confidentiality regulations. This was the same Chief of Staff who had already promised to "get me" and who had threatened me if I dared to publicly report the possible murders of the Veterans. It appears to me that a watchdog agency can not indulge in adversarial relationships with its informants and expect to provide impartial and rigorous oversight of management.

3. COVER-UP.

According to Dr. Peck [4] "The failure to report a crime is itself a crime." "This crime is called a 'cover-up.'" Dr Peck explains the importance of the cover-up in the following passage: "One of the tests for criminal responsibility is the question of whether the defendant knows the difference between right and wrong. If a criminal in any way, shape, or form attempts to conceal his crime, it is assumed he knew his action to be a crime - that is, to be wrong."

It appears obvious to me that multiple VA officials attempted to conceal both the prospect that murder might have been committed as well as their own actions to conceal the prospect of murder. It appears to me that the conclusion that there might have been murder was not difficult for the VA to accept - instead it was all to easy for the VA to accept. The real question for the VA was not "Is there a reason to suspect murder?" The real question was "What do we do about it?" The answer was: "Hide it."

The existence of a cover-up is obvious to the community. In a communication to the Columbia Daily Tribune [5], the correspondent clearly stated the issues: "...would the public really be happy with a Richard Nixon appointing his staff to investigate Watergate or Bill Clinton appointing his staff to investigate Whitewater? Basically, all this cover-up thing is the VA investigating itself. How legitimate is that?" "There is a cover-up. It's as plain as day. Deal with it and investigate to get these people out of the system."

The conclusion that the OIG helped to cover-up this affair is inescapable. I personally briefed the Assistant Inspector General for Healthcare Inspections on these problems in October of 1992, I then repeated these charges in writing to the Inspector General in February of 1993 and again in May of 1994. The OIG did not act on these charges, there was no investigation, or deposition, or visit by an agent. Instead the OIG explained that the complaint was mislaid, misdirected, and forgotten. The conclusion that the OIG simply mislaid or forgot that high officials had been charged with obstructing the investigation into the deaths of 40 Veterans is simply not credible. The voluntary departure without punishment of many of the charged officials over the two years the investigation languished only confirmed the cover-up.

In an editorial in the Columbia Daily Tribune [6] the editor stated:

> I have the distinct feeling the VA from top to bottom would have done nothing without being forced into it. Even now, the VA investigator's report explains nothing that we already did not know. It is itself a sort of cover-up, a mere ratification of unavoidable essential bare bones of information that already had been known.

Why is a cover-up bad? After all, the incident happened three years ago, no one can do anything about the dead patients, the suspected nurse apparently can't be prosecuted, bad press will just upset living patients, bad press could interfere with the stream of money, and besides, who can blame the VA for wanting to cover-up the prospect of forty deaths in their hospital?

A cover-up is bad because in order to succeed, the cover-up must be maintained indefinitely by suppressing all information at all times. The result is the following:

- A cover-up hides information from the families. Families have a legitimate right to know what happened to their relatives. This information does not belong to the VA, it belongs to the patient and the patient's survivors. If murder was committed, the families have the right to press for investigation and prosecution. If there was negligence, the families have the right to file for redress.
- A cover-up must be maintained by intimidation. This abuses the rights of employees, rewarding employees with poor ethical

standards and punishing those with high ethical standards. A general policy of cover-up and intimidation erodes the character of the institution.

- A cover-up hides pertinent information from public authorities with legitimate right to the information, such as the police, the coroner, and the licensing boards. Failure to transmit this information sets the stage for continued problems in a new setting. Repetitive cycles of murder have happened before in other situations and may have happened in this instance.
- A cover-up prevents the Hospital from taking steps to prevent the problem from arising again. Unable to acknowledge murder, the VA is powerless to enact policies and procedures to prevent or limit murder. This is of concern, since this appears to be at least the fourth time the VA has faced this situation. Prior episodes occurred in Ann Arbor, Cincinnati, and Northport, Long Island.

4. HOW THIS REPORT IS DANGEROUS.

The Inspector General's report is dangerous because it maintains the cover-up and it take no steps to protect whistleblowers like myself and my colleagues.

The only reason why I have been able to push this issue this far is because I have a professional standing independent of the VA. If I was not a tenured faculty member, if I was not a respected physician and scientist, I would have no hope of bringing this matter to your attention.

Unlike me, most hospital employees are heavily dependent upon the VA. The VA controls their pay and their employment record. It is devastating to face a cut in pay or criticism because you opposed your employer. It is thrilling to receive a bonus or praise for cooperating with your employer. Very few individuals have the scruples or the economic and professional freedom to criticize their employer as I have done. Perhaps partly for this reason, the best examples of nosocomial murder are in teaching hospitals.

The uneven balance of power between informant and management could be countered by a watchdog agency, if the agency was truly independent, maintained the confidentiality of informants, and operated first as an informant advocate. It appears to me that in this case the OIG failed to meet these three tests. As a consequence, it is unlikely that employees will approach the OIG with any substantive problem.

A saying in the VA is: "The best way to get an appointment with your boss is to make a complaint to the OIG."

If this situation is allowed to continue, if the VA is unable to respond to a quality of care problem as basic as the accusation of murder, if the VA is unable to respond to a problem that is as well documented as the deaths in Columbia, then there is no hope that the VA will ever respond to any problem that could be considered embarrassing to the VA.

5. RECOMMENDATIONS

I ask you to reject the Inspector General's report and convene a truly impartial and rigorous investigation into the administrative response to the deaths in Columbia. I ask that such an investigation include hospital epidemiologists, risk managers, and physicians. I know that such an investigation will confirm my testimony in full. I believe an independent investigation with strong recommendations is the only way to bring real change into the VA by holding administrators responsible for their administration.

I ask that you take strong and quick action to protect whistleblowers like myself and my colleagues. Only by fulfilling the promise made to me and my colleagues of full protection will the VA communicate to its employees that they should not hide murder and other crimes.

I ask that you mandate that as soon as possible someone should counsel the families of all of the patients that might have been murdered.

I ask that you reconsider the use and intent of the laws protecting the confidentiality of quality assurance information. It appears to me that all too often these laws are used, as they appear to have been in this case,

to protect the secrets of the VA rather than the privacy of employees and patients.

I ask that you mandate that the VA take immediate and dramatic steps to protect patients from this and similar problems in the future. The VA should consider doing some or all of the following:

- Establish training criteria for quality assurance personnel and ensure that a quality assurance operation is not supervised or subservient to a person who does not have a professional degree in patient care.
- Develop a rapid response team that will work system wide to advise field operations on how to handle crises like nosocomial murder.
- Develop and use training materials for the field on how to respond to patient abuse.
- Mandate training for all top management in how to handle charges of patient abuse and why you should not conduct a cover-up.
- Establish a clear unmistakable policy of when to report and when to act on the suspicion of murder.
- Establish a clear and unmistakable policy of requiring hospitals to report patient abuse or suspected abuse to licensing boards.
- Establish a clear and unmistakable policy of allowing employees to report suspected major crimes to police authorities without requiring the approval of the Hospital Director.
- Create a VA wide clearing house for all healthcare workers. Require all health care workers, including temporary employees, to have clearance before starting their employment.

Finally, I ask that you take steps to ensure there is rigorous and effective oversight of the VA. This could mean making the OIG a truly independent agency by removing it from the VA or establishing a system wide ombudsman to represent employees.

Thank you.

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7. APPENDIX: CHRONOLOGY

In constructing this chronology, I have used a variety of documents listed in the references and the following abbreviations:

HSTMVH	= Harry S. Truman Memorial Veterans' Hospital
VA	= Department of Veterans Affairs
QI	= Quality Improvement
GL-HSR&D	= Great Lakes Health Services Research and Development Office
CBE	= Center for Biostatistics and Epidemiology
OHI	= Office of Healthcare Inspections
HD	= Hospital Director
COS	= Chief of Staff
A-ADN	= Acting Associate Director for Nursing
CS/CR	= Chief of Staff for the Central Region
OIG	= Office of the Inspector General
AIG-HI	= Assistant Inspector General for Healthcare Inspections
CPS	= Chief of Pathology Service

1. Recognition of the Epidemic of Deaths and Codes on 4 East.

In mid-July of 1992, QI began a review of codes and deaths on ward 4 East [1,7]. The QI review was prompted by three independent sources of information. The Acting Associate Director for Nursing (A-ADN) had informed QI that the Nursing Service Cardio-Pulmonary Resuscitation Committee had reported in their June meeting a sharp increase in the number of codes on 4 East [1,7]. The QI clinical reviewers had also noted an unexplained increase in the number of deaths on 4 East [1,7]. And the ward clerks on 4 East had become concerned over an apparent increase in deaths and codes [1].

Hospital mortality statistics demonstrated no significant change [1]. Furthermore, nursing personnel believed that any apparent increase in deaths on 4 East could be due to a recent tendency to hospitalize the sickest medicine patients on 4 East [1,7]. QI began an investigation to resolve these issues.

The first audit of the patients who died on 4 East did not demonstrate any commonality [8]; the cause of death was attributed to underlying disease [8] and there were no findings to suggest otherwise in the autopsied cases [8]. Nevertheless, it was the impression of the QI reviewers that in many cases the deaths were unusual - the patients' decline was often rapid in onset and unexpected by the medical staff [8].

The excess codes and deaths continued over the following month. With increasing events, the QI section intensified their investigation, expanding the scope and increasing the number of clinical reviewers assigned to the task [1]. On August 4, 1992, the Hospital Director (HD) and the Chief of Staff (COS) were first informed of the problem [1]. In the meantime the hospital staff on 4 East became aware of the increase in codes and deaths and individual staff members began casually commenting on the apparent association of a particular nurse with these critical care events [1].

The possibility that a particular nurse was responsible for the critical care events first came to the QI Manager's attention on August 17, 1992, when a QI reviewer, an HSTMVH police officer, and (on August 19, 1992) the Chief of Respiratory Therapy independently approached the QI Manager with similar suspicions concerning the same nurse [1]. These suspicions were immediately passed

onto the HD and COS [1]. The suspected nurse would later be given the code name "Nurse H." This nurse started to work on 4 East as a Graduate Nurse Trainee in December of 1992 [1]. The nurse was licensed as an Registered Nurse in March, 1992, and shortly afterwards began staffing 4 East in that capacity [1].

The role of Nurse H in the critical care events on 4 East was confounded by the observation that the excess codes and deaths appeared to be occurring on the night shift and this was the same shift Nurse H often worked alone. Was the nurse causing the codes and deaths or simply unlucky to be the only registered nurse on duty when the patients died? This was discussed at a meeting of hospital officials on August 18, 1992, in which it was decided for the safety of the patients and staff to assign an additional nurse to 4 East at night to chaperon Nurse H [1].

Additional suspicious deaths occurred on August 20 and 22 when the chaperon was unavailable [8]. The unexpected death of patient at 2:08 AM on August 22 prompted the on-call intern to ask Nurse H: "Why are you killing my patients?" [8,9]. The intern did not know that Nurse H had already been identified by QI, the hospital police, and a respiratory therapist as possibly causing the excess codes and deaths or that Nurse H had been assigned a chaperon. Nurse H was disturbed by the intern's comment and complained to the nursing supervisor who filed an incident report on August 25, 1992 [9].

On August 24, 1992, the COS asked the Chief of Pathology Service (CPS) to assist in the investigation [1] and the COS and A-ADN decided to remove the suspected nurse from direct patient care at the HSTMVH [1]. The nurse did not return to patient care during the remainder of the nurse's employment at the HSTMVH.

On August 25, 1992, hospital officials informed the Central Region (which supervises the HSTMVH) via the QI Consultant for the Region. The District Counsel (which provides legal advice to the HSTMVH) was also informed via a staff attorney of these events [1] and concurred with the actions of hospital officials [1].

At the request of the CPS, on August 27, 1992, the QI Manager contacted me for guidance in conducting an epidemiologic investigation of the deaths [1]. My colleague, an experimental pathologist, was also brought into the investigation at that point.

2. Investigation of the Excess Deaths.

The QI manager presented an alarming problem but did not present any data. Although data existed, at the time it lacked denominators and comparison groups, rates had not been normalized, there was no statistical analysis, graphical displays, or tables. There was also no formal clinical analysis of the patient deaths - only summary impressions of the cases gained by the QI reviewers. The available data consisted of lists of employee and patient names and dates. Because of the sensitive nature of the problem and the need to protect employee identity, this information was not presented at the meeting and the QI Manager refrained from referring to specific employees by name. It was agreed that in order to minimize bias, QI would continue to avoid naming names, all data collection would be coded by QI before submission to the statistician for analysis, and code names would be substituted for employee names in any discussions or reports of the investigation.

Between August 27, 1992, and October 1, 1992, the QI staff collected information and passed it onto me for analysis. The results were assembled into a series of graphs, tables, and memoranda. These documents were used in a series of briefings with hospital officials which in turn led to additional studies. The evolving document paralleled the evolving investigation, culminating in a final report on October 1,

1992, [10] which was presented to a site visit team from the Central Region of the VA which had been appointed to investigate the deaths.

3. The Administrative Response.

The QI investigation did not come to the attention of the general public until September 25, 1992. The only hospital personnel fully apprised of the situation was the HD, all other employees operated on a need-to-know basis and very few were aware that ward 4 East had an excess in critical care events or that a particular nurse was suspected to be the cause of these deaths. In order to control the distribution of documents, excess copies were regularly shredded.

In a meeting on August 28, 1992, the QI staff expressed grave concerns regarding patient care under Nurse H [1] and misgivings that the situation would be hushed-up by hospital authorities. I asked for the QI reviewers cooperation to keep the investigation confidential and to perform the investigation in an unbiased manner. I also pledged that if the investigation confirmed the suspicions of the QI reviewers, the nurse would not be returned to patient care and the investigation would not be hushed-up.

On the morning of September 2, 1992, I calculated the "relative risk" of dying under the care of individual 4 East nurses [8]. When the QI Manager identified Nurse H as the suspected nurse, an emergency meeting was held with the HD [8]. As the Hospital Epidemiologist and Acting Chief of Staff, I declared that Nurse H was probably committing murder and asked that the police be immediately informed [8]. The HD took the request under advisement and instructed the staff to keep the matter confidential and continue the investigation [8]. The HD promised that if further investigation confirmed the suspicion of murder, then the Inspector General would be informed. At a follow-up meeting on September 3, I reiterated the request to inform the police and the HD promised to immediately inform the IG [8] but did not do so. On September 8, 1992, I repeated in writing the request to inform the police [8]. This request was ignored.

In a telephone conversation on September 3, 1992, the HD consulted the Chief of Staff for the Central Region (CS/CR) in Ann Arbor, Michigan, and asked for instructions. The CS/CR reportedly responded: "The last time I was called about a problem like this we fired the Director and the Chief of Staff, are you sure you want to continue this discussion?" After further discussion, it was decided that the HD should appoint two boards of investigation, a Peer Review Board and a Board of Inquiry.

On September 7, 1992, my request to consult University of Missouri biostatisticians for help in designing the statistical studies was turned down by the HD [8].

A Peer Review Board was appointed to examine the last five suspicious deaths. This Board, however, was not informed that a particular nurse was suspected of causing these deaths. The Board reported on September 14, 1992, that the patients received good medical care and died unexpectedly - but presumably of natural causes [11]. Nevertheless, the Board could not explain the death of one of the five patients and noted that all five patients died between 01:28 and 03:05 [11].

After repeated requests to notify the police authorities, I was informed by the COS that the HD had appointed a Board of Inquiry, that I should present the QI data to this Board, and the Board would then decide on the necessity of reporting the information to appropriate authorities.

The Board of Inquiry was a formal investigatory body empowered to take sworn testimony while investigating a charge of patient abuse. The appointment

letter for this Board specified the members were to conduct a wide ranging investigation into the intern's accusation against Nurse H - an inquiry which was supposed to include the QI Manager. When the Board of Inquiry was convened, however, the HD reportedly instructed the Board to limit the investigation to whether or not the intern made the accusation and to not involve the QI Manager. The Board was not informed of the existence of the QI data, or that the Hospital Epidemiologist, Hospital Police, Respiratory Therapy, and QI reviewers had independently identified Nurse H as a suspect in the deaths, or that Nurse H had been assigned a chaperon (who was unavailable on the night of the patient's death) to prevent further deaths. When the Board met on September 17, 1992, both the COS and I were specifically enjoined by the HD from addressing the Board.

The Board reported the following on September 21, 1992: The intern did indeed accuse Nurse H, but the accusation was made in jest and was not in itself indicative of patient abuse [9]. The Board also found [9] that there was "... a dramatic increase in the number of deaths occurring on ward 4 E." And that Nurse H "... has been involved in a disproportionate number of these deaths and in the corollary number of code blues on 4 E." The Board concluded [9] that Nurse H provided "inaccurate" sworn testimony and that the death of the patient was "unexpected" and "unexplained." The Board was also troubled by the observation that Nurse H often knew which patient would encounter problems before the rest of the nursing staff [9]. Unaware that such information already existed, the Board recommended that the increase in critical care events on ward 4 East and the involvement of Nurse H in these events be "rigorously" pursued [9]. In the meantime the Board recommended that Nurse H not be returned to direct patient care [9].

Once again I threatened to go directly to the police with the QI data, so the COS contacted the CS/CR and an agreement was made for the COS and I to fly to Ann Arbor - as soon as arrangements could be made - to present the data to Central Region officials. This agreement, however, was later changed by the Central Region who instead proposed to send a regional site team to the HSTMVH to conduct an investigation into the excess deaths. In the meantime, Central Region asked the hospital to forward a current copy of the QI report as well as the spreadsheets and data summaries to the Director of the Great Lakes Health Services Research and Development Office (GL-HSR&D) of the VA, which was also located in Ann Arbor. A copy of the September 24 report was sent.

On September 25, 1992, an anonymous caller alerted the local television stations and newspapers of the excess deaths on ward 4 East [12].

On September 27, 1992, the Boone County Medical Examiner publicly complained that he had not been informed of the excess deaths [13].

On September 28, 1992, the Central Region Office of the VA publicly commented [14,15] that "no clinical information has been identified at this time which would indicate less than optimal care in the specific cases reviewed." Nevertheless, it was announced that a regional site visit team would visit the facility to conduct an investigation [15]. In a 9/29/92 memorandum dated 9/30/92, [16] the Director of the GL-HSRD communicated to the CS/CR a detailed series of criticisms of the QI investigation. The Central Region summarized these criticisms in a White Paper dated September 29, 1992, [17] by stating: "... this review [by GL-HSRD] indicates that there are serious questions regarding the methodology utilized by Dr. Christensen, and that there are flaws in the statistical analyses performed." The White Paper also declared [17]: "The facility conducted peer review of the last 5 patients who expired on 4 East. Results of that peer review indicate that there are no quality of care concerns, and that the deaths were attributed to one or more of the patients underlying medical

problems." The Region then concluded [17]: "In summary, there is no empirical data which indicates that there is a problem in the quality of care provided at VAMC Columbia." I was not informed of the GL-HSRD critique or allowed to rebut or explain any problems.

Also on September 28, 1992, the HD publicly complained [18] "the recent publicity about the number of deaths occurring in this hospital over the past several months is an example of what occurs with anonymous information and aggressive reporting of incomplete information." The HD went on to comment [18] "There had been a statement made by a first year physician in training that indicated possible patient abuse. This has been formally investigated and no patient abuse was found. There was no need to inform the local Medical Examiner." The HD further elaborated in a September 29, 1992, in a hospital-wide memorandum [19]: "The facts are as follows: Contrary to media reports, at this time, no one has been accused of any wrong doing nor is anyone under investigation." In another memorandum also dated September 29, 1992 [20], the HD wrote Nurse H: "I am happy to inform you that the Board that investigated the allegation of possible patient abuse involving yourself found no evidence to support such an allegation."

On September 29, 1992, the Medical examiner was quoted [21] as saying: "According to them [hospital officials], there is absolutely no suspicion of any wrong doing or anything to report to the medical examiner system at this time."

In an October 1, 1992, press conference [22], the HD repeated that " [the investigation of the intern's accusation] showed no evidence of patient abuse. So the issue of patient abuse, from our point of view, is resolved." Concerning an increase in hospital deaths on ward 4 East: "In the five cases reviewed, in no case did we find anything that would indicate they died of any causes other than the causes, the problems they had with their medical condition."

Contrary to the explicit promise made to me, the agenda for the regional site visit team did not include a presentation of the QI investigation. After I again threatened to go to the police, the COS prevailed upon the site team and I was allowed to present the final QI report [10]. At a later date, the HD reportedly told the COS: "You can expect to take a hit for this and probably Christensen too."

My appearance before the regional site team (which included the Central Region QI Consultant who had been working with the Hospital on this problem) appeared to take them by surprise. Nevertheless, having received the report the regional site visit team concluded that further investigation was warranted. On October 2, 1992 the CS/CR contacted the Office of Healthcare Inspections (OHI) of the Office of the Inspector General (IG) to initiate an investigation [23]. An investigation was begun on October 6, 1992, and confidentially reported on September 28, 1994 [24].

After receiving anonymous complaints from hospital employees, a State Representative contacted the Federal Bureau of Investigation (FBI) [25]. In response to this request, on October 5, 1992, the FBI announced that they would open an investigation into the deaths [26]. Subsequently, I presented the QI report to a team of agents and the FBI impounded the medical records of 85 patients [26].

Because anonymous employees had contacted the State Representative, on October 7, 1992, the HD conducted hospital wide meetings and warned hospital employees that they would be prosecuted for disclosing confidential and privileged quality assurance information. The penalty for disclosure was a $5,000 fine for the first offense and a $20,000 fine for subsequent offenses [27].

In October I went with the CPS and the COS to Kansas City to discuss the problems in Columbia with the Assistant Inspector General for Healthcare Inspections (AIG-HI). That meeting included a presentation of the QI investigation

and a frank discussion of the handling of this matter by the HD and Central Region. The AIG-HI informed myself, the CPS, and the COS that we were protected as whistleblowers.

On October 21, 1992, the HD filed a memorandum [28] with the Acting Chief of Medicine which was reportedly read to the intern in the HD office. The memorandum stated: " [The HD] requests that [the intern] be informed of the seriousness of this situation and cautioned to be more professional in the future. Please advise [the intern] that remarks like he made and/or similar to them are inappropriate and raise doubts about the quality of care provided by individual(s) and this hospital. Additionally, he should be made aware that an allegation of patient abuse is taken very seriously and by its nature always requires investigation by a board. Investigations are costly both in time spent away from regular duties and in the emotional impact these investigation have on staff and board members."

The Dean of the University of Missouri-Columbia, School of Medicine was separately briefed by the COS and myself regarding these events but he did not take any action.

On January 28, 1993, the HD contacted the FBI and proposed to return Nurse H to direct patient care on February 15, 1993 [29]. On 1/29/93 the HD was instructed by officials from the Washington office of the Department of Veterans Affairs to not return Nurse H to patient care "without the approval of the Secretary's Office [29]."

On February 16, 1993, I contacted the IG by letter specifying that VA officials had obstructed the police investigation and covered-up the deaths [30]. The IG did not conduct an investigation and took no action.

In March, 1993, the local newspaper announced that the FBI had exhumed 13 patients for forensic analysis [31]. In September, 1993, the local newspaper announced that the FBI investigation was stalled [32]. The only official comment on the investigation came in January 1995, when in response to charges of cover-up, the IG stated that the case remained open and the FBI was continuing to perform forensic analysis [33].

At the end of 1993, Nurse H left the employment of the HSTMVH to work at another patient care facility. Hospital and Regional officials refused to inform the Missouri State Nursing Board that Nurse H had left the facility while under investigation and at a time when the nurse had been removed from patient care responsibilities. {Such reports are, I believe, required by Missouri State law [34].} In a memorandum dated 3/1/94 [35], the HD prohibited me from informing [36] the State Nursing Board of the results of the QI investigation. According to the HD, this information was "quality assurance information and protected by law [35]." {My interpretation of VA policy [37] was that Nurse H's identity was protected but not the statistical information. Since a nurse had publicly admitted that he was the subject of the Board of Investigation and this had been confirmed by the HD in a press conference, I did not believe the privacy of the nurse was a major issue.} The HD then concluded [35]: "Sharing with the Missouri State Nursing Board information or knowledge gained by your involvement in this investigation is a violation of law and the penalties of that violation can be severe. If I am made aware that a violation did occur, I would have to take appropriate action." In a follow-up memorandum [38], the HD informed me: "You should, therefore, refrain from further contacts with the FBI and the IG about this case. If you are contacted directly by either the FBI or the IG, you should inform me of the content of your discussion."

In May 1994, the HD demoted the COS. I believe the demotion was for allowing me to address the regional site visit team. The COS filed a complaint to this effect with the IG on May 11, 1995 [39] and again the IG failed to respond.

In late August of 1994, a draft copy of the OHI report was circulated to the HSTMVH for comment. I was shown a copy of this report by the QI Manager (now retitled the Total Quality Improvement Coordinator) and asked to submit comments. I informed the new Director by word and memorandum that it appeared to me the OHI had confirmed the results of the QI investigation and that the Hospital should act on this confirmation by: informing the families of the dead Veterans of the results of the investigations, redressing any personnel actions which would appear to be inappropriate, and developing policies and procedures to stop this from happening again. The new Director took no apparent action.

Following internal release of the OHI report in October, 1994, I requested permission from the new Hospital Director to report the statistical analysis at the 5th Annual Meeting of the Society for Healthcare Epidemiology. The new Director responded that I should not disclose the identity of the institution or that the end points were mortality data [40]. The new Director also stated [40]: "The conclusion from three different statisticians [which included myself as well as the OHI, & CBE] is that there was a statistically significant relationship between an individual and the risk of an event. 'Statistical analysis cannot comment on causation.' No recommendation was made with respect to a specific individual. No other conclusions can be derived from the data."

Since these conclusions were not my conclusions I appealed. In response the new Acting Chief of Staff provided the following instructions [41]:

> a. The conclusion of the Department of Veterans Affairs regarding this affair [the deaths on 4 East] is that there is no conclusion, no comment on causality can be made from the available data and therefore no action can take place.
> b. The position of the Department of Veterans Affairs is that nothing worth while can be accomplished by publicly presenting this material.
> c. Since nothing can be gained by presenting this information, the Department of Veterans Affairs does not want this issue publicized because it will only cause unnecessary damage to the public image of the Department.
> d. Therefore the Department will not authorize the presentation of this material by an employee of the Department. Violation of this directive would be cause for a reprimand and possibly further action.

Not included in this memorandum was an additional verbal statement by the Acting Chief of Staff that if I did take it upon myself to publish this information as a private citizen, my VA superiors would look very harshly upon this action.

The abstract was sent anyway.

In a Dean's Committee meeting on 1/5/95, which was considering the suitability of promoting the Acting Chief of Staff to Chief of Staff, I brought up this issue. I stated that in my opinion the Acting Chief of Staff should not be promoted because he continued the old policy of covering-up this issue. I also distributed copies of the OHI report. This report and these issues had not previously been brought to the attention of the Committee. The Committee took no action and these events were not included in the minutes of the meeting. A January 8, 1995 newspaper report stated [42]: " [The Dean] has been satisfied both at the time of the initial investigations and after reading the inspector general's report, that local VA officials dealt responsibly with the deaths." The Dean was also quoted as saying [41]:

'I don't have any information that shows me that anyone in the institution shares Dr. Christensen's misgivings."

On 1/10/95, I publicly charged the VA with obstructing the investigation and covering-up the deaths [43]. The IG initiated an investigation into these charges in January, 1995.

STATEMENT OF
MR. WILLIAM T. MERRIMAN
DEPUTY INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
OCTOBER 25, 1995

I would like to thank the Subcommittee for the opportunity to discuss my office's work related to the unexplained increase in deaths that occurred in mid-1992 on Ward 4 East of the Harry S. Truman VA Medical Center in Columbia, Missouri.

For the past 3 years, some element of the VA Office of Inspector General (OIG) staff has been involved in investigating, inspecting or reviewing events related to this unexplained increase in deaths. My office has spent over 6,500 staff hours on the various projects at VAMC Columbia.

OIG Work at VAMC Columbia

The first element of my office to become involved was the criminal investigators from our Office of Investigations, who have been working on this case with the FBI since October of 1992. The focus of the criminal investigation has been on trying to determine if these patients were harmed and, if so, by whom.

The FBI has the lead on the criminal investigation. The FBI has been assisted by expert medical consultants in reviewing the patients' medical and other related records. They are also conducting lab tests on tissue and other samples that were taken from the bodies of 13 veterans that were exhumed as a part of the criminal investigation. It is my understanding that the lab work is still on going and the FBI considers this an open investigation. At this time, the FBI has been unable to provide an estimated completion date for the investigation.

The second element of my office to become involved in reviewing the unexplained increase in deaths at VAMC Columbia was our Office of Healthcare Inspections. In response to an October 1992 request from Central Region Veterans Health Administration (VHA) officials, a biostatistician from our Healthcare Inspections staff conducted a statistical analysis that confirmed a statistical relationship existed between the large number of deaths on Ward 4 East in mid-1992 and the duty times of a particular nurse assigned to that Ward.

My Office of Healthcare Inspections released their statistical analysis report on September 28, 1994. That report confirmed there was a probability of less than 1 in 1 million that the relationship between the presence of this

nurse on Ward 4 East and the unexplained deaths on Ward 4 East in mid-1992 was caused by chance.

The third element of my office to become involved in issues related to the unexplained increase in deaths at VAMC Columbia was my Special Inquiries staff. Our special inquiry began in January of this year and ended with the publication of our 66 page report on September 28, 1995.

Allegations Received by the OIG

The special inquiry was triggered by allegations the OIG received from the primary complainant, Dr. Gordon Christensen, who is a physician and service chief at the Medical Center. Dr. Christensen accused officials of failing to notify law enforcement authorities; failing to protect patients by not relieving the nurse, who was allegedly involved in harming patients, of patient care duties; and attempting to suppress and cover-up information about the deaths.

Dr. Christensen's initial allegations targeted two senior VHA management officials - the former Director, Mr. Joseph Kurzejeski and the former VHA Central Region Chief of Staff, Dr. Spencer Falcon - as the officials responsible for the cover-up and who acted in an "unethical and irresponsible manner." However, as time went on, others were also seen by Dr. Christensen as participating to some extent in the cover-up and suppression of information. Others brought into the allegations were the current Medical Center management team, OIG staff, the VA District Counsel, and the Dean of the affiliated medical school.

In an attempt to get to the bottom of Dr. Christensen's allegations, my staff interviewed everyone they thought might be able to shed some light on the issues, including individuals suggested by Dr. Christensen. My staff interviewed more than 50 people, some of them more than once, so all together they conducted about 75 interviews. The interviews were supplemented with reviews of available records at the Medical Center in Columbia, the Regional Office in Ann Arbor, and VHA Central Office in Washington.

My staff also met with Dr. Christensen on a number of occasions to obtain and exchange information on the allegations. We also interviewed current and former VHA officials to obtain their views on the relevant issues.

OIG Findings

The primary conclusion in our September 28,1995 report was that we did not find evidence Medical Center and Central Region management officials intentionally covered-up the unexplained increase in deaths at VAMC Columbia. However, we found that a dysfunctional top management team was in place at the Medical Center in mid-1992. This team which consisted of the nursing service supervisor; the Chief of Staff, Dr. Earl Dick; and the Director, Mr. Joseph Kurzejeski were not able to work together to respond in an effective and timely manner to an "out of the norm" situation presented by the unexplained increase in deaths on

Ward 4 East in mid-1992 and the possible association of a Medical Center nurse with these deaths.

The management breakdowns were significant enough that we are not surprised some may view the managers' actions or, lack of action, as a conspiracy to cover-up the incident. We believe Dr. Christensen and some others view the actions, of at least Mr. Kurzejeski, as a criminal offense e.g. obstruction of justice. We disagree. Criminal investigators from the FBI and the OIG have been reviewing the issues surrounding the unexplained deaths at VAMC Columbia for the past 3 years and, to date, these investigators have not found evidence of criminal misconduct by the former Director or other members of top VHA management.

Furthermore, this Special Inquiry of the alleged cover-up failed to disclose any conduct by these top managers that warranted referral to law enforcement authorities. Based on everything we know at this time, we believe the response and/or lack of response by these managers to the unexplained increase in deaths was a management problem, bad judgment by these managers.

While we did not validate Dr. Christensen's criminal cover-up allegations, we did validate his administrative allegations that (i) the nurse should have been relieved of patient care duties earlier, and (ii) suspicions about the nurse's possible involvement in harming these patients should have been reported to law enforcement authorities by Medical Center top management.

Our report is replete with examples of judgmental errors by the management team in responding to this serious situation. Also, our report contains excerpts from VHA's management and other reports that highlights the management problems with Dr. Dick and Mr. Kurzejeski. In our view, the top three Medical Center managers, Mr. Kurzejeski, Dr. Dick, and the nursing service supervisor must share the responsibility for not relieving the nurse of patient care duties in a timely manner. Mr. Kurzejeski, Dr. Dick and Dr. Falcon must share the responsibility for not reporting the incident to law enforcement authorities.

Reassignment of Nurse to Non-Patient Care Duties

Management's failure to reassign the nurse to non-patient care duties in a timely manner is, in our view, a very serious problem. Patient safety has to be the top priority of management. We found the nurse started working as the lone Registered Nurse on the night shift on Ward 4 East in March 1992. By May 1992, the death rate on the Ward had nearly tripled and continued to remain high on the Ward throughout the summer until the nurse was reassigned from Ward 4 East on August 23, 1992 to the Surgical Intensive Care Unit (SICU). In all, this nurse was on duty for 45 of the 55 deaths that occurred on Ward 4 East between March 8 and August 22, 1992. The number of deaths on Ward 4 East returned to normal after the reassignment of the nurse.

The nurse was not actually reassigned to non-patient care duties until Dr. Christensen and others went to the Director on September 2, 1992, and recommended the nurse be relieved of patient care duties. The nurse never returned to patient care duties at the Medical Center after that date.

We believe the nursing service supervisor had knowledge of the unexplained increase in deaths and possible association of the nurse with these deaths more than 2 months before any action was taken to remove the nurse from Ward 4 East. Even when the reassignment was made, it was to a Ward where there were patients who were even more sick - the SICU. The nursing service supervisor had authority to reassign the nurse to non-patient care duties, but did not. The nursing service supervisor let the top management team down in this case through her inaction.

The Medical Center Chief of Staff, Dr. Dick, had overall responsibility for the quality of medical care at the Medical Center. His slow and generally ineffective medical response to try to determine a cause for the unexplained increase in deaths as well as his concurrence of Nursing Services' poorly designed and ill-advised plans to monitor the nurse on Ward 4 East and then to reassign the nurse to the SICU helped make a bad situation worse.

Finally, the Director as "Captain of the ship" was too complacent in recognizing and reacting to the situation and, in particular, assuring that his immediate subordinates were taking actions that were in the best interests of the patients. The unexplained increase in deaths was an "out of the norm" situation requiring tough, aggressive leadership by the Director rather than a "sit back and wait for things to develop" approach.

Reporting the Incident to Law Enforcement Authorities

The reporting of the issue to law enforcement authorities was also not handled well. In fact, VAMC Columbia and Central Region officials never did report the matter to law enforcement authorities. It was reported to the FBI by a Missouri State legislator based on an anonymous complaint to him. Once notified, the FBI began its investigation almost immediately.

Mr. Kurzejeski essentially believed that, unless he could establish the patients had been harmed, he did not want to notify law enforcement authorities. Following Mr. Kurzejeski's logic, the unexplained increase in deaths would not have been reported to this day since no one yet has proven the nurse harmed the patients. We even found Mr. Kurzejeski attempted unsuccessfully to return the nurse to patient care duties while the FBI and the OIG were in the midst of the criminal investigation to determine if that nurse had harmed patients.

Dr. Falcon essentially supported Mr. Kurzejeski's rationale that there was no justification for contacting law enforcement authorities without clinical evidence that someone had harmed the patients. Dr. Dick let both Mr. Kurzejeski and Dr. Falcon down by failing to initiate peer

reviews and other analyses to determine if there was clinical evidence of patient harm. Since Dr. Dick did not initiate this clinical work, Mr. Kurzejeski and Dr. Falcon believed they did not have a basis to report the nurse to law enforcement authorities.

We also explored the written VA policy guidance that was available to the managers for reporting this type of incident to law enforcement authorities. We believe 38 CFR Chapter 1, Section 17.155 would permit a Director to notify law enforcement authorities based on mere suspicion of an employee's involvement in a patient's death regardless of whether that suspicion is based on statistical association or otherwise. Admittedly, this is a relatively obscure provision of the CFR and not a mandatory requirement.

The primary VHA policy guidance that relates to this issue is MP-2, Part I, Chapter 35 "Integrated Risk Management Program." This policy requires the Director to immediately report "murders" but does not address the issue of reporting to law enforcement authorities the suspicion of serious harm to patients caused by a medical center employee.

OIG Recommendations

Since Mr. Kurzejeski has retired and Dr. Falcon has left the VA, no recommendations were made regarding their role in responding to the unexplained increase in deaths at VAMC Columbia. The nursing service supervisor and Dr. Dick are still employees of the Medical Center, but no longer hold key top management positions. We are recommending appropriate administrative action and training for those two individuals for their role in responding to the unexplained increase in deaths.

We also made a systemic recommendation to refine the policy guidance in MP-2, Part I, Chapter 35 to better guide managers in reporting incidents like this should they occur at another VA medical facility.

The Undersecretary for Health's reply to our recommendations was responsive and is included in the report.

Other Related Allegations

Dr. Christensen made a number of allegations about events that happened after the FBI and OIG criminal investigation began. These are addressed in detail in Sections B, C, and D of our September 28, 1995, report. However, I would like to highlight a few of the more important issues from these sections of the report.

Dr. Christensen alleged in December 1993, when the nurse resigned from VA, that the law required the former Director to report the nurse to the Missouri state licensing board because the nurse resigned while he was under an active FBI/OIG investigation for harming patients and Dr. Christensen's statistical analysis linked the nurse with the deaths. Based on advice he received from the VHA Central Region quality assurance and legal staff, Mr. Kurzejeski decided not to report the nurse to the board. Since the nurse went on to work in a private nursing home and could

have, at least in theory, also have been reemployed at some future date in the VA system; we were concerned VA may have made the wrong decision not to report the nurse to the state licensing board. To us, this is a safety issue for future patients of the nurse.

We referred the issue to the VA Office of General Counsel for a legal opinion. The General Counsel held that Dr. Christensen's statistical evidence, alone, showing an association between the nurse and the patient deaths does not constitute sufficient evidence to report the nurse to the state licensing board. However, the General Counsel also held that Mr. Kurzejeski had a duty to investigate further before the decision was made to not report the nurse to the state licensing board. The current Medical Center Director is coordinating on this issue with appropriate VA legal staff to determine what, if anything at this time, needs to be done on this reporting issue.

An entire section in our report (Section C) responds to Dr. Christensen' complaints on the OIG staff's actions on this case. Of particular concern to me was the OIG staff's shortcomings in our protection of Dr. Christensen's identity as a complainant. We take the confidentiality of our complainants seriously and the Inspector General has issued a written apology to Dr. Christensen for any problems this may have caused him. Also, appropriate OIG staff have been counseled by me on this matter.

Because of the Committee staff's interest in the nepotism issue involving the hiring of a service chief at VAMC Columbia, we reviewed this area in depth. The allegation was that the hiring action was some kind of "pay-off" to entice the former Director to retire. We found no evidence of such a "deal." The hiring action was done in accordance with VA personnel rules and was carried out by individuals who owed no allegiance to the former Director.

Assessment of Current Top Management Team

In closing, I want to assure the Subcommittee that the picture I have painted of top medical center management in mid-1992 does not apply to the top management team that currently is responsible for VAMC Columbia. My staff has a very favorable impression of the new top management team at VAMC Columbia - Tom Carson, the Director, Dr. John Bauer, the Chief of Staff, and Mary Loomis, the Associate Director of Nursing. They seem to work well together as a team and we believe they would be able to capably respond effectively to serious incidents should they occur in the future at VAMC Columbia.

This concludes my statement. Thank you for your attention and the opportunity to appear here today. I would be happy to answer any questions you may have.

STATEMENT OF
THOMAS L. GARTHWAITE, M.D.
DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE
SUBCOMMITTEE ON HOSPITALS
AND HEALTH CARE
HOUSE COMMITTEE ON VETERANS' AFFAIRS

October 25, 1995

Mr. Chairman and Members of the Subcommittee,

I appreciate the opportunity to discuss issues related to the recently released Inspector General report entitled Alleged Cover-up of an Increase in Deaths at the Harry S. Truman VA Medical Center in Columbia, Missouri.

At the outset, let me state that VA is very concerned about the unexplained pattern of deaths at the Columbia facility. VA determined that there was an apparent increase in the number of deaths on Ward 4E through our extensive quality assurance (QA) process. This QA process is in place at all our facilities and alerts management when a potential problem exists.

In this case, it is also important to note that to this date, the Federal Bureau of Investigation has not provided us with any conclusive evidence of criminal activity. The Under Secretary for Health requested the results of the FBI's investigation in a letter to the Director dated October 18, 1995. The FBI, at this time, is unable to release any findings.

I agree with the finding in the OIG Special Inquiry Report that there is no evidence of a cover-up by management. Some actions by VAMC management officials were, in retrospect, errors in human judgment. For example, the Acting Associate Director for Nursing should have notified top management of nursing's concerns about the apparent increase in deaths

on Ward 4E sooner. Once notified, the Director and Chief of Staff should have been more aggressive in seeking clinical corroboration of patient care problems related to the deaths.

The issue of not notifying the FBI is also complex. On September 2, 1992, a meeting was held with the director, associate director, acting associate director for nursing, the clinical nurse reviewers, the Associate Chief of Staff for Research and Development, and his research assistant. The results of the ACOS for Research and Development's preliminary data were reviewed and a decision to remove the nurse from patient care was made. The issue of whether the Medical Inspector, the FBI, or a forensic pathologist should be involved was also discussed. Without clinical substantiation of the statistical analysis, the Regional Office advised that there was no justification for contacting law enforcement authorities. Management followed this guidance.

To assist management in determining when an incident should be reported to the appropriate law enforcement authorities, I will ensure that additional guidance is provided so that there is a mechanism in place to report incidents such as the unexplained pattern of deaths at VA Medical Center Columbia.

Our current philosophy is one of decentralization of authority and empowerment of our field management officials. We have always expected them to make the best decisions with the information available to them. With respect to Columbia, it is easy to retrospectively second guess decisions but more difficult to judge the quality of those decisions made within a specific context.

3.

The issue of whether management should have reported the nurse to the state licensing board is an important and a difficult one. VA's authority to report any separated health care professional to State licensing boards, at least in part, is derived from the Health Care Amendments Act of 1985, Public Law 99-166, Section 204 (b). This law authorizes VA to report a licensed professional who is fired or who resigns following completion of a disciplinary action relating to clinical competence. In this instance, there was never any specific decision or action which was observed and would have brought the individual's clinical competence into question. VA is also allowed to report professionals who resign after having had clinical privileges restricted or revoked. Again, this does not apply because the nurse in question was a staff nurse without privileges. Clinical privileges are only granted to members of the nursing staff who function in an extended role, such as nurse practitioners. This does not apply to general nursing staff.

VA is allowed to report professionals who resign after serious concerns about their clinical competence were raised but not resolved. This situation applies to the nurse in question. Under the circumstances in this case, there was a duty for the director to investigate sufficiently to provide a reasonable basis for deciding whether reporting is indicated. Generally, an investigation would create an evidence file which should include a list of the charges with supporting facts such as patient records, incident reports, witness statements, and a rationale for reporting on each of the charges. Once the evidence file is developed, a notice letter of the intent to report the practitioner to the State licensing board is sent to the individual. The entire file is then submitted to the General Counsel for final determination regarding whether the requirements of information disclosure laws have been met. The evidentiary standard implied by the law is that there must be substantial evidence of significant wrong doing.

As indicated at the beginning of my statement, the Under Secretary for Health has requested the results of the FBI investigation. If and when we receive information that supports our reporting the nurse in question to the State licensing authorities, we will do so.

Mr. Chairman, let me address your concerns about ensuring a properly functioning top management team. The VA medical center in Columbia, MO, has a new management team in place that works well together. The present director was recently selected to become a Network Director. I will ensure that a fully capable management official is selected to replace him. In addition, VHA is also undergoing a major reorganization in Headquarters and in the field. In March, we proposed a reorganization of VA, and last month, we were authorized by Congress to proceed to change the span of control over our facility management teams. Previously, each of VHA's four Regional Offices had a span of responsibility of approximately 44 facilities. With implementation of the Veterans Integrated Service Networks, the Network Directors will be responsible for about 10 facilities. This narrowed span of control will allow for more direct supervision and guidance of management at these facilities. We believe that we have selected the best qualified candidates as Network Directors to lead VA as we sit at the threshold of the transformation in veterans' healthcare.

In closing, let me reiterate that VA discovered the abnormal pattern of deaths through its quality improvement program. We recognize that we have an obligation to our patients and to society to work with licensing boards to assure the quality of health care professionals. We also are sensitive to the right our employees have to due process. We look forward to working with you in applying these important principles which may seem to conflict at times. Mr. Chairman, this concludes my statement. I will be pleased to answer any questions you or members of the Subcommittee may have.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

POST-HEARING QUESTIONS
CONCERNING THE OCTOBER 25, 1995
HEARING ON ISSUES AT THE HARRY S. TRUMAN VA MEDICAL CENTER
COLUMBIA, MISSOURI

FOR THE DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL (OIG)

SUBMITTED BY REPRESENTATIVE TIM HUTCHINSON
CHAIRMAN OF THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE

Question 1: According to the Office of Inspector General's Inquiry, *Alleged Cover-Up of an Unexplained Increase in Deaths, Harry S. Truman VA Medical Center, Columbia, Missouri*, September 28, 1995, (OIG Report), the timeline states that on September 17, 1992, "an informant alerts OIG of possible 'drug overdoses'". This event is listed with other significant events in the OIG's timeline, but not substantively discussed in the body of the report. (OIG Report, p. 2.)

a. Please explain this event in more detail and its correlation to the inquiry regarding the alleged cover-up of an unexplained increase in deaths at Columbia VAMC.

Response: On September 16, 1992, an OIG employee was on-site at VAMC Columbia on an unrelated matter. During a conversation with a hospital employee, the OIG employee was advised that an internal administrative investigation was ongoing concerning the deaths of a number of patients on Ward 4 East, all of the deaths occurring since January 1, 1992. The hospital employee identified another hospital employee who had additional information. The second employee stated that there had been 78 deaths on the fourth floor with over half occurring on Ward 4 East. The two hospital employees were not officially involved in the internal administrative investigation being conducted by the hospital and, therefore, did not have first hand knowledge of the facts , other than (1) there were a large number of deaths; and (2) there was an internal investigation underway. It is not clear if the reference to "possible drug overdoses" was a personal speculation of one of these employees or was among many of the rumors emanating from the internal investigation.

The OIG employee notified his supervisor in Kansas City who, on September 17, 1992, notified the Director of the OIG's Hotline and Special Inquiries staff in Washington, D.C. An OIG Hotline case was established on September 18, 1992 and because the matter was reported as "possible drug overdoses" the case was referred to the OIG's Healthcare Inspection staff for review. Shortly thereafter, the Assistant Inspector General for Healthcare Inspections was contacted for assistance with the VAMC Columbia issues by the VHA Central Region Chief of Staff. In response to this request, the Assistant Inspector General and some members of his staff made a field visit in early October 1992.

In summary, the informant's information did not trigger the subsequent OIG reviews of the issues at VAMC Columbia. We included the information about the informant on the report's timeline to show the first time the OIG heard about the deaths at VAMC Columbia.

b. Is this a possible criminal event that should have been reported to law enforcement authorities?

Response: At the time the OIG employee first heard rumors about the deaths (September 16, 1992), the OIG did not have enough information to report the matter to the FBI. Within a few days, the matter was reported to the FBI by a Missouri state legislator. The OIG went on record in the report that medical center officials should have reported the deaths to law enforcement officials in a more timely manner.

Question 2: The OIG's Report contains very little information regarding the role taken by the VA police force at the Columbia VAMC. Please explain in detail the role of the VA police in the matter of the unexplained increase in deaths and assess whether the VA police were effective in this case.

Response: Our discussions with the VA police chief disclosed that the Medical Center Director had not asked the VA police to participate in any investigation of the deaths. Therefore, the VA police did not conduct an investigation into the deaths on Ward 4 East.

The function of the VA police is to provide security of the grounds and buildings and ensure the safety of patients and employees. It would have been difficult for the VA police to effectively participate in a major criminal investigation of this type. VA police officers are not trained criminal investigators and certainly did not have experience in such a complex case. Furthermore, the VA police manual limits VA police personnel to the investigation of minor offenses. In summary, we do not fault the VA police for their actions, or lack of action, in this case.

Question 3: In Mr. Merriman's opening statement before the Subcommittee on October 25, 1995, he referred to a systemic recommendation to refine VA policy guidance to better guide managers in handling and reporting similar incidents, should they occur at another VA medical center. Please provide a copy of this recommendation, or if unavailable, describe it in detail.

Response: The systemic recommendation referred to in Mr. Merriman's opening statement is Recommendation 4 on page 33 of the OIG's September 28, 1995 report. We recommended that "the Under Secretary for Health revise MP-2, Part I, Chapter 35 on reporting serious incidents at medical centers to provide clarifying guidance that facility directors could use to determine if and when to report an incident such as the Columbia Medical Center's unexplained deaths to law enforcement authorities. In our view, the guidance in those cases, where we have strong suspicions a serious crime may have been committed, should emphasize both aggressive internal investigations to determine possible clinical causes as well as simultaneous reporting to law enforcement officials."

As a follow-up to the OIG report on VAMC Columbia, the Inspector General provided the attached letter to the Under Secretary for Health on November 29, 1995. This letter contains additional suggestions for the Under Secretary's consideration should similar situations to Columbia develop in the future.

Question 4: Please provide all pertinent information obtained as a result of autopsies performed on former patients of Ward 4 East who died during the time in question.

Response: The FBI contracted with a forensic pathologist who conducted the autopsies on former patients of Ward 4 East. The pathologist's report was furnished to the FBI. We would suggest you contact the FBI for a copy of the pathologist's report.

Department of Veterans Affairs

Memorandum

Date: NOV 29 1995

From: Inspector General (50)

Subj: Columbia VAMC

To: Under Secretary for Health (10)

1. This past Monday, I discussed the events at the Columbia VAMC with the Secretary in the context of a request by Inside Edition for an interview. During the course of our conversation, I indicated that the producer of Inside Edition expressed a great deal of interest in lessons learned and improvements which might be made to deal with similar situations should they develop in the future.

2. I pointed out to the Secretary that our report had one recommendation dealing with earlier reporting to law enforcement officials on which the Department had agreed to take action. I also indicated that the following additional initiatives could have merit:

o Reporting to or discussing with state licensing boards any situation where there is a strong correlation between the presence of a caregiver and harm to patients even without clinical evidence of wrongdoing when the caregiver plans to transfer to a non-VA facility (I recognize the General Counsel did not go this far in their opinion but I believe they were addressing what current regulations required not what was possible).

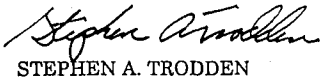
o Considering automatic administrative leave for one caregiver accused of harming patients by another caregiver (I would see this as automatic and short-term to a degree that no stigma is attached to the action. This would be similar to the approach law enforcement takes when a shooting occurs).

o Statistical charting of deaths by ward in addition to service (I understand that different approaches are taken at different hospitals).

2.

Under Secretary for Health (10)

3. The Secretary thought the above ideas might have merit and asked that I pass them on to you. One final thought, it would also seem appropriate that physical evidence be collected and analyzed for any subsequent deaths associated with a caregiver upon whom suspicion has been cast. I do not believe this was the case at Columbia.



STEPHEN A. TRODDEN

POST-HEARING QUESTIONS
CONCERNING THE OCTOBER 25, 1995
HEARING ON ISSUES AT THE HARRY S. TRUMAN VA MEDICAL CENTER
COLUMBIA, MISSOURI

FOR THE DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF THE GENERAL COUNSEL

SUBMITTED BY REPRESENTATIVE TIM HUTCHINSON
CHAIRMAN OF THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE

Question One

Question number one begins with the following statement:

> ***The former Medical Center Director, by memorandum, notified Dr. Christensen that his responsibilities had been carried out in the investigation, and any further action was solely the responsibility of the Director. He further advised that "You should, therefore, refrain from further contacts with FBI and OIG about this case." The OIG report concluded that the former Medical Center Director 'improperly" attempted to limit Dr. Christensen's communications with the FBI and OIG (OIG Report, p. 38.)***

The following specific questions are then asked.

Question 1.a and 1.b

Is this an illegal action on the part of the former Medical Center Director? If not, what is the difference between an illegal action and an improper action? Please provide an explanation with citations to law and regulation regarding the illegality or impropriety of such action.

Response:

Your first question is whether the actions on the part of the Director were "illegal." We defer to the conclusions of the Inspector General (IG) with regard to this matter. Specifically, we presume that the conclusion of the IG that the Director acted "improperly" rather than illegally was based on a determination that the Director did not violate any law. Given the facts developed and presented by the IG in his report, we are unable to conclude differently.

Next, you ask for an explanation of the difference between an illegal action and an improper action, and request that our explanation include citations to law and regulation. Examining the definitions of these two words can help clarify the differences. One source defines the word illegal as "[a]gainst or not authorized by law." Black's Law Dictionary 747 (6th ed. 1990). Another defines illegal as "[u]nlawful; contrary to law; illicit." Ballentine's Law Dictionary 579 (3d ed. 1969). In contrast, the word improper is defined as "[n]ot suitable; unfit; not suited to the character, time, and place [citation omitted]. Not in accordance with fact, truth, or right procedure and not in accord with propriety, modesty, good taste, or good manners." Black's Law Dictionary 751 (6th ed. 1990); *see*

also Ballentine's Law Dictionary 593 (3d ed. 1969) ("That which is not suitable; unfit; not suited to the character, time and place.) The distinguishing feature is that an *illegal* action involves taking an action (or failing to take an action) that is in some way contrary to a statute or the law. In contrast, an *improper* action suggests behavior that is based on bad judgment or an improper application of a procedure or policy. Thus in the instant case, if the IG and the FBI ultimately conclude that the Director demonstrated bad judgment in his interpretation or application of VA policy, but violated no criminal or other laws or statutes, his actions would be "improper" rather than "illegal," and would be subject to administrative remedies.

An illegal action includes violations of criminal laws and other laws. Criminal laws generally require a specific intent to commit a prohibited act. For example, if further development of the facts revealed that the Director's actions were not based on bad judgment, but rather were taken with the intent to conceal or impede the investigation of a crime, then a number of criminal statutes would potentially be applicable. These include statutes prohibiting the obstruction of justice and tampering with informants.

One such criminal statute specifically refers to attempting to influence witnesses. This statute states:

> Whoever knowingly . . . threatens, or corruptly persuades another person, or attempts to do so, or engages in misleading conduct toward another person, with intent to . . . hinder, delay, or prevent the communication to a law enforcement officer . . . of information relating to the commission or possible commission of a Federal offense . . . shall be fined under this title or imprisoned not more than ten years, or both.

18 U.S.C. §1512(b)(3). Another section of this statute states:

> Whoever intentionally harasses another person and thereby hinders, delays, prevents, or dissuades any person from . . . reporting to a law enforcement office . . . the commission or possible commission of a Federal offense . . . or attempts to do so, shall be fined under this title or imprisoned not more than one year, or both.

18 U.S.C. § 1512(c)(2); *see also* 18 U.S.C. §§ 1111-1113 (Murder, manslaughter or an attempt to commit murder or manslaughter are federal offenses within the territorial jurisdiction of the United States.) Thus, an allegation that the Director attempted, by threats or harassment, to prevent the reporting of information regarding murder or manslaughter could potentially be actionable under these sections of title 18.

Another criminal statute pertains to the obstruction of proceedings before departments, agencies and committees. This statute states:

> Whoever corruptly, or by threats or force, or by any threatening letter or communication influences, obstructs, or impedes or endeavors to influence, obstruct, or impede the due and proper administration

> of the law under which any pending proceeding is being had before any department or agency of the United States, . . . [s]hall be fined under this title or imprisoned not more than five years, or both.

18 U.S.C. § 1505. An allegation that the Director attempted to impede the investigation of the Federal Bureau of Investigation (FBI) or the IG could potentially be actionable under this statute.

An "illegal" action could also involve a violation of certain non-criminal federal statutes. We know of no evidence that the Director took any personnel action against Dr. Christensen. However, if the facts ultimately show that the Director took a *prohibited personnel action* against Dr. Christensen because of his disclosures to the FBI or the IG, certain additional laws may be implicated. For example, the Inspector General Act of 1978 states that "[a]ny employee who has authority to take, direct others to take, recommend, or approve any personnel action, shall not, with respect to such authority, take or threaten to take any action against any employee as a reprisal for making a complaint or disclosing information to an Inspector General, unless the complaint was made or the information disclosed with the knowledge that it was false or with willful disregard for its truth." 5 U.S.C. Appendix 3, § 7(c); *see also* Whistleblower Protection Act of 1989, Pub.L. 101-12, 103 Stat 16 (April 10, 1989); 5 U.S.C. § 2302(b)(8)(A) (An employee with authority to take personnel action is prohibited from taking or failing to take a personnel action as a reprisal for "a disclosure of information by [an employee] which [the employee] reasonably believes evidences . . . a violation of any law, rule, or regulation.") The Office of Special Counsel has authority to receive and investigate allegations of prohibited personnel practices and to pursue corrective actions. 5 U.S.C. §§ 1214, 1215.

Question 1.c

Dr. Christensen testified that, "I think from a medical, epidemiologic sense there is no question about it [that murder was committed], but from a legal sense that is entirely different." If a VA health care provider has a belief similar to Dr. Christensen's and possesses what he in good faith believes to be medical or epidemiological evidence of patient abuse constituting a crime, is such an employee free to inform local or federal law enforcement authorities of that belief and submit such evidence?

Response:

VA has a policy to guide the actions of medical centers and employees in the event of suspected patient abuse or other incidents involving patients. The policy involves monitoring, reporting, investigating and responding to such events. VHA Manual M-2, Part I Chapter 35, "Integrated Risk Management Program." Under this policy, if an employee believes that there has been an incident of patient abuse (or any one of a number of other mandatory reporting incidents, including suicide, attempted suicide, a missing patient, a homicide, an assault, or certain unexplained deaths), he or she is to document and report the incident in accordance with this policy. VHA Manual M-2, part I, Chapter 35, paragraph 35.08. The employee's superiors are then responsible for following an internal mechanism for investigating and responding to the incident including, when necessary, notifying local law enforcement authorities and

the FBI. VHA Manual M-2, Part I, Chapter 35, paragraph 35.11.

This policy, when properly followed, allows medical centers to quickly respond to allegations of patient abuse and take steps to investigate such matters. VA employees are expected to follow such policies. However, if an employee believes that his or her supervisors have failed to respond to the report of a potential criminal matter, no VA policy or regulation prohibits the employee from generally reporting the information to the Office of the Inspector General or to other law enforcement authorities, subject to confidentiality laws.

You also ask whether the employee would be free to submit evidence of the alleged crime of abuse. That would depend, in part, on the type of evidence that the employee had collected. If the information of an alleged crime was contained in records protected by the Privacy Act and sections 5701, 5705, and 7332 of Title 38, there are certain limits associated with the disclosure of the information, and Federal law requires that certain procedures must be followed by the agency prior to releasing the information. Although these confidentiality laws impose a limit on such a disclosure, they would not bar a disclosure by the agency or an employee that would generally inform law enforcement authorities of suspected criminal activity. More detailed patient information would be available upon a proper follow-up request by law enforcement authorities. Furthermore, under certain circumstances, patient names as well as the names of suspected employees may be included with the initial contact to the law enforcement authorities.

Question 1.d

What type of guidance are VA health care providers being given relating to informing law enforcement authorities of patient abuse?

Response:

As noted above, VA policy on reporting and investigating patient abuse is set forth in VHA Manual M-2, Part I, Chapter 35. Under paragraph 35.08 of this policy, VA health care practitioners must report possible patient abuse to their superiors within the medical center. The policy states that medical center Directors are responsible to educate and train employees on such matters. VHA Manual M-2, Part I, Chapter 35, paragraph 35.12(a)(5) (The medical center Director must "[e]nsure that education and training are provided for all employees, with special attention to those who have frequent contact with patients who are self-destructive, assaultive or cognitively impaired . . . [s]ince some incidents of patient abuse may result from insufficient employee education or understanding of patient behavior, continuing education should assist in the prevention of patient abuse.") The policy does not address the circumstances under which a VA health care practitioners could independently inform law enforcement authorities of patient abuse. The various Regional Counsel offices, however, are available to provide guidance to the VA Medical Centers whenever such issues and questions develop.

Detailed guidance and instructions regarding the release of any information from VA records to law enforcement authorities and others is provided by VHA Manual

M-1, Part I, Chapter 9. This chapter details the policies for release of medical information including that information covered by the Freedom of Information Act, the Privacy Act, and sections of 5701, 5705 and 7332 of Title 38. Additionally, the Office of General Counsel provides periodic seminars and training sessions to VHA employees dealing with the release of information.

Question 2

Please submit a current status report on all legal claims filed against or with the VA in regard to patient deaths on Ward 4 East of the Columbia VAMC for the time in question.

Response:

There were six administrative tort claims filed with VA in relation to deaths on Ward 4 East of the Columbia VAMC for the time period in question. The total amount claimed was $5,000,020.

a. One claim was settled for $100,000.

b. Three claims were denied without subsequent litigation. The survivors in one of these claims still have time in which to institute suit.

c. Another claim was denied administratively and suit was filed. The litigation is pending.

d. Another claim is still pending administratively.

Question 3

What restrictions exist to the VA notifying state licensing boards and the National Practitioner's Data Bank of performance and misconduct problems of its current and former health care employees who are licensed?

Response:

The Health Care Quality Improvement Act of 1986 (the Act), 42 U.S.C. §§ 11101-11152) requires that entities file certain reports with the National Practitioner Data Bank. The Act requires mandatory reports of medical malpractice payments, licensure actions take by Boards of Medical Examiners, and certain adverse actions on clinical privileges of a physician or dentist for a period of longer than 30 days. 42 U.S.C. §§ 11131 - 11133.

Although the Health Care Act does not apply to federal health care entities or doctors, the statute directs the Secretary of HHS to "seek to enter into a memorandum of understanding with the . . . Administrator of Veterans' Affairs" to implement the reporting provisions. 42 U.S.C. § 11152. HHS and VA have entered into a Memorandum of Understanding which provides, in pertinent part:

> The VA will file a report with the National Practitioner Data Bank . . . regarding any payment for the benefit of a physician, dentist, or other licensed health care practitioner which was made as the result of a settlement of judgment of a claim of medical malpractice . . . . The VA will file a report in accordance with regulations at 45 CFR Part 60, Subpart B, as applicable, regarding any of the following

> actions: a. Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days; b. Acceptance or the surrender of clinical privileges or any restrictions of such privileges by a physician or dentist either while the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding.

See Memorandum of Understanding Between the Department of Health and Human Service and the Department of Veterans Affairs, effective October 1, 1990.

VA regulations pertinent to the NPDB are set forth at 38 C.F.R. §§ 46.3 and 46.4. Under these regulations, VA files reports regarding medical malpractice payments made on behalf of any licensed care practitioner to the NPDB. 38 C.F.R. § 46.3. The existing VA regulations do not contain any other provisions for *directly* reporting licensed health care practitioners to the NPDB. Professional review actions that adversely affect the clinical privileges of physicians and dentists for more than 30 days are reported to state licensing boards who, in turn, are required (pursuant to 45 C.F.R. § 60.9 (b)) to report this information to the NPDB. 38 C.F.R. § 46.4.

VA policy on reporting separated employees to state licensing boards is set forth in VA Manual M-2, Part I, Chapter 34, section II, "VA Initiated Reporting of Separated Health Care Professionals to State Licensing Boards." Under this policy, VA will initiate a report on each *separated* licensed health care practitioner whose clinical practice so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. Assuming conformance with Privacy Act procedures, there are essentially no restrictions which prevent the VA under these circumstances from notifying a state licensing board, so long as there is substantial evidence that such has occurred. *See also* 38 C.F.R. § 47.2.

VA also responds to inquiries from state licensing boards. Specifically, VA policy allows disclosure of information in response to an inquiry regarding a current or former employee from a state licensing board when the licensing board's request satisfies requirements of the Privacy Act. VA Manual M-2, Part I, Chapter 34, paragraph 34.20. While confidentially laws would affect such reporting, VA would be able to comply with those provisions and report nevertheless. VA is presently reviewing its policy regarding initiating reporting of currently employed licensed health care practitioners to state licensing boards.

VHA Question 3

On August 25, 1992, on behalf of the former Medical Center Director, the Total Quality Improvement (TQI) Coordinator contacted the St. Louis District Counsel's office and reported what seemed to be "an inordinate number of deaths that have occurred while one particular nurse was on duty." According to the testimony of District Counsel, the former Medical Center Director was advised to reassign Nurse H to non-patient care duties and that concurrent with conducting an administrative investigation, he should notify FBI and

OIG. The OIG concluded that District Counsel's advise, in this case, was appropriate, but not followed by the former Medical Center Director. (OIG Report, p. 21.) Please describe the VA's policy regarding the amount of discretion individual medical center directors have in the determination of a course of action to take after receiving legal guidance or opinions.

Response:

The Office of the General Counsel and the various District [now Regional] Counsel Offices provide both oral and written advice. These offices do not have operational control over the VHA and cannot dictate policy or other discretionary decisions through informal advice or compel VHA officials to follow the advice provided.

The exception is when the *General Counsel* has written a conclusive or precedential opinion involving certain veterans' benefits laws administered by VA. The regulation at 38 C.F.R. §14.507 states the following:

> (a) A written legal opinion of the General Counsel involving veterans' benefits under laws administered by [VA] shall be conclusive as to all Department officials and employees with respect to the matter at issue unless there is a change in controlling statute or regulation, a superseding written legal opinion by the General Counsel, or the designation on its face as "advisory only" by the General Counsel or the Deputy General Counsel acting as or for the General Counsel. . . . Advice, recommendation, or conclusions on matters of Government or Department policy, contained within a written legal opinion, shall not be binding on Department officials and employees merely because of their being contained within a written legal opinion. . . .
>
> (b) A written legal opinion of the General Counsel involving veterans' benefits under laws administered by [VA] which, in the judgment of the General Counsel of the Deputy General Counsel, necessitates regulatory change, interprets a statute or regulation as a matter of first impression, clarifies or modifies a prior opinion, or is otherwise of significance beyond the matter at issue, may be designated a "precedent opinion" for purposes of such benefits. . . .