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Report to Sen. William Proxmire, Chairman, Senate Committee on Appropriations: HUD-Independent Agencies Subcommittee; by Elmer B. Staats, Comptroller General.

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An investigation by the Veterans Administration (VA) of allegations against the North Chicago VA Hospital was monitored. The employees' union of the hospital made the allegations which included charges of: mismanagement by hospital officials, reprisals and threats against high-level hospital officials and rank and file employees who question hospital policies and recommend changes, and related internal problems that have apparently led to a decline in the quality of medical care for North Chicago veterans. Additional allegations concerning certain questionable hospital activities were also made during VA's onsite investigation. The VA appeared to investigate adequately the allegations of irregularities at the hospital and has taken steps to correct the hospital's internal problems. The majority of the allegations against North Chicago VA hospital and the University of Health Sciences/The Chicago Medical School were not substantiated during the investigation. VA investigators documented the problems and made recommendations for corrective actions by the VA's central office. Actions have been taken under the direction of the Chief Medical Director. The investigation addressed all but three of the allegations contained in a statement prepared by VA hospital employees. (SW)

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133044

JAN 31 1978

The Honorable William Proxmire
Chairman, Subcommittee on HUD-
Independent Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

In your letter of April 29, 1976, you asked us to monitor the Veterans Administration (VA) investigation of allegations against the North Chicago VA Hospital and make a final report to you. The North Chicago VA Hospital's employees union made the allegations, which included charges of

--mismanagement by hospital officials;

--reprisals and threats against high-level hospital officials, and rank and file employees who question hospital policies and recommend changes; and

--related internal problems that have apparently led to a decline in the quality of medical care for North Chicago veterans.

Also, additional allegations concerning certain questionable hospital activities were made during VA's onsite investigation.

VA's investigation was conducted from April 26 through June 11, 1976. Based on our examination of the investigative report summary, dated November 5, 1976, and its supporting documentation, we believe that VA has adequately investigated the allegations of irregularities at North Chicago and has taken steps to correct the hospital's internal problems.

The majority of the allegations against the North Chicago VA Hospital and the University of Health Sciences/ The Chicago Medical School were not substantiated during

the investigation. Concerning the allegations that were substantiated, the VA investigators documented the problems and made recommendations for corrective actions by VA's central office. Under the direction of the Chief Medical Director, such actions have been taken.

The investigation addressed all but three of the allegations contained in a statement prepared by VA hospital employees. Two allegations, identified as "1(d)" and "3(b)" in the statement, were omitted from the investigation because both directly concerned the activities of the university and only indirectly pertained to VA.

Allegation 1(d) stated that university physicians promised the Illinois Lake County Medical Society that they would not enter private practice in the North Chicago area but, nevertheless, have attempted to reserve beds at private hospitals in the area for their private patients. Allegation 3(b) stated that the university had so offended the commander of the Great Lakes Naval Hospital that the Navy announced it would not accept residents from the school.

The VA investigation did not address the third allegation concerning the proposed transfer of an 87-acre tract of North Chicago VA Hospital land to the university. According to VA officials, this matter was reviewed by VA's Department of Medicine and Surgery. In our report 1/ to you, we concluded that VA's actions to transfer the land to the university did not strictly comply with Federal regulations.

Our comments in enclosure I to this letter address the allegations (whether sustained or unsustained), which in our opinion warrant further discussion. The investigation report summary designated that allegations were unsustained when they were insufficiently corroborated by the evidence found. We designated that allegations were sustained when they were confirmed or corroborated in part or in full by the testimony of witnesses and/or documentation. For your information, we have listed in the enclosure each of the allegations (except those omitted from our review), noting which allegations were sustained during the investigation and which were not.

1/"Veterans Administration Land Transfers to Medical Schools: Propriety and Impact" (HRD-77-105, June 3, 1977).

As directed by your office, we have not obtained written agency comments on the matters discussed in the report. However, we have discussed these matters with agency officials and have considered their comments in the report.

As arranged with your office, we are sending copies of this report to the Administrator of Veterans Affairs.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

Enclosure

ENCLOSURE I

GAO EVALUATION OF VA'S INVESTIGATION OF EMPLOYEE ALLEGATIONS AT THE NORTH CHICAGO VA HOSPITAL AND OF THE CORRECTIVE ACTIONS TAKEN

BACKGROUND

Since October 1973, the University of Health Sciences/ The Chicago Medical School (university) has sought to relocate from Chicago's West Side Medical Center and begin construction of new medical educational facilities on an 87-acre tract at the North Chicago VA Hospital. As of January 1978, the medical school had not executed its planned relocation; however, it has maintained an affiliation with the VA hospital since July 1974. During this time, VA has commenced converting its North Chicago hospital from a neuropsychiatric to a general medical and surgical facility.

Prior to and during the implementation of the affiliation, conflicts arose in several hospital services among physicians and staff over decisions regarding the management of hospital activities. Also, interpersonal difficulties developed between the North Chicago hospital director and the hospital's chief of staff over the mission of the hospital and specifically, how the hospital's mission would relate to the affiliation. When it became apparent to VA's Chief Medical Director that these two top hospital officials could not resolve their differences, and that their conflict was polarizing the hospital staff, both were reassigned in order to prevent any adverse effect on the quality of patient care. In early April 1976, the hospital director was transferred to the Boise, Idaho, VA hospital as director. The hospital's chief of staff remained at the hospital but was demoted to associate chief of staff for education.

On April 12, 1976, after the hospital director's transfer was announced, a group of North Chicago VA Hospital employees traveled to Washington, D.C., to present a "statement of concerns" to the staffs of (1) the House Committee on Veterans' Affairs, (2) the Senate Appropriations Subcommittee on HUD-Independent Agencies, and (3) VA's Chief Medical Director. In the statement, the employees alleged irregularities on the part of the chief of staff and other hospital staff members, expressed admiration for the efforts of the former hospital director, and protested his reassignment.

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VA's Chief Medical Director responded to the allegations by requesting VA's Investigation and Security Service to investigate the situation. Also, VA's Internal Audit Service, and the Department of Medicine and Surgery initiated efforts to evaluate certain allegations relating to hospital management and the quality of care.

In addition to the allegations in the statement of concerns, VA's investigative team addressed other allegations brought to its attention during the onsite investigation. Shortly after the VA investigators completed their work at the North Chicago hospital, VA's Internal Audit Service conducted a management audit of the hospital from August 6 through September 21, 1976, to assess its overall operations. In October 1977, VA's Internal Audit Service conducted a followup audit to evaluate the effectiveness of the hospital's efforts to correct deficiencies noted in the prior audit.

Our review and monitoring of VA's efforts focused on the investigation and subsequent VA actions taken in addressing the veracity of the employee allegations. Because the VA investigation occurred after the transfer and demotion of the hospital director and the chief of staff, respectively, the report did not address what actions, if any, would have been appropriate in the case of these officials.

THE INITIAL ALLEGATIONS

The North Chicago VA Hospital employees made a number of allegations against (1) certain university physicians who were placed in positions at the VA hospital and (2) the university itself. Some of these allegations appeared in the statement of concerns; others were made during the course of the investigation. The allegations reviewed by us in this report and contained in the statement are summarized on the following page: 1/

1/As used here, the number/letter symbols relate to those used in the statement of concerns.

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	Sustained by VA	Not sustained by VA
University Physicians		
1(a). A number of university physicians with VA appointments rarely, if ever, treated patients at the North Chicago VA Hospital--two surgeons; one staff physician in infectious diseases, medicine service; one opthalmologist; one cardiologist; and one pathologist.	X (Sustained for one opthalmologist and one staff physician in infectious diseases, medicine service)	
1(b). A number of university physicians used VA secretaries mostly on university rather than VA hospital business.		X (The activities of two secretaries did indicate, however, that medicine service was overstaffed.)
1(c). VA research funds allocated to a university physician for infectious disease research were illegally expended.		X
A chemist hired with clinical funds was coerced into resigning to prevent being fired.	X	
Hospital chief of staff		
2(a). The chief of staff hired two residents in medicine at the hospital for whom residency positions had not been authorized by VA's central office.	X	
2(b). The chief of staff and acting chief of psychiatry wrongfully informed the Lake County, Illinois Health Department that the VA hospital would provide it with the services of VA-salaried psychiatry residents for a 6- to 9-month period at no cost.		X
2(c). While the hospital director was out of town, the chief of staff transferred, without the director's approval, a radiation therapist from the Lakeside, Illinois VA hospital to the North Chicago hospital, although the latter hospital was not equipped for radiation therapy.	X	
Patients were then transferred to the North Chicago hospital for radiation therapy.		X
Because of the hospital's lack of equipment, patients requiring radiation therapy had to be sent to the Great Lakes, Illinois Naval Regional Medical Center at a cost of $3,000 to the North Chicago hospital.	X (At a cost of $3,952 to VA for therapy treatments)	
2(d). The chief of staff was responsible for the resignation or transfer of four psychiatrists and one physician in rehabilitation medicine.	X (Sustained in part for four of the five physicians)	
The chief of staff participated with a university physician in the attempted removal of a part-time VA physician who was to be replaced by a friend of the chief of surgery. (note a)		X
The chief of staff harassed the research-in-aging laboratory staff and attempted its removal.		X
2(e). The chief of staff asked members of the Lake County Medical Society's Executive Board to pressure VA to remove the North Chicago hospital director.		X
University control of the North Chicago VA hospital		
3(a)(1). The university procrastinated for months before appointing a chief of psychiatry because the school was not interested in treating psychiatric patients.		X
3(a)(2). Funds desperately needed by the hospital to treat 800 chronic psychiatric patients were channeled to surgery service.		X
The funds were being used to establish a $200,000 surgical unit desired by the university.		X
3(a)(3). Since the hospital's affiliation with the university, the number of patients receiving foot care has dropped by one-third.	X (Amount of reduction not addressed in report summary).	

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University control of the North Chicago VA hospital	Sustained by VA	Not sustained by VA
3(a)(4). Because the hospital was critically underfunded, it had to close an entire hospital ward.		X
Although the hospital was underfunded, patient care funds were used to pay for $8,000 worth of artificial heart valves ordered by university physicians. The valves could not be used because the hospital could not fund an open heart surgical unit.		X (No evidence that hospital could not afford the valves. Also, $3,400 spent on these items.)
OTHER ALLEGATIONS		
The following additional allegations were identified at the hospital during VA's investigation: (note b)		
General		
A. A biological technician was retained on the VA payroll after he had ceased to work at the hospital.	X	
B. The wife of a university physician was illegally employed as a consultant to VA.	X (The consultant received no financial compensation for this employment)	
C. Two patients, who died at the hospital, received questionable treatment.	X (Sustained for one patient)	
D. Surgical records of deceased patients had been destroyed to cover up the circumstances of their deaths.		X
E. One of the staff physicians in surgery should not have been employed by VA since he performed very few surgical procedures.	X	
F. The former chief of social work was coerced by the former hospital director into misusing funds.		X
G. The chairman of the Department of Anatomy, Northwestern University Medical School, knew of misused research funds.		X
H. Usable chemicals of the research-in-aging laboratory were destroyed.		X
I. The VA associate chief of staff for research improperly used research funds.	X	
J. The chief of neurology service was conducting an investigational drug study using incompetent patients without obtaining the consent of their conservators.		X
K. The chief of surgery service, while conducting research with an investigational drug, was not always obtaining properly completed consent forms.	X	
Hospital chief of staff		
L. The chief of staff approved the improper use of the VA hospital's laboratory to conduct tests for a clinic run by the university.	X	
M. The chief of staff improperly reviewed employee files.		X
N. The chief of staff established a "mental competency review board."		X
O. The chief of staff's employment by the medical school was in conflict with the best interests of the VA hospital.		X

a/The VA investigation the physician cited above has since been dismissed. According to a VA central office official, no cause was given for her dismissal because VA regulations do not require that cause be given in the dismissal of a part-time physician.

b/We have lettered these allegations to distinguish them from those in the statement of concerns.

ANALYSIS OF THE ALLEGATIONS

The investigative report specifically addressed the previous allegations, while the VA internal audit report provided a general background on the hospital's operations. Because the information contained in those reports are too voluminous for inclusion in the report, we are only presenting (1) the results of VA's investigation, including the recommendations relating to those findings which VA concluded deserved further attention, and subsequent VA actions in response to the recommendations and (2) our comments and conclusions on the results of those VA investigative efforts which we believe warrant further discussion.

INVESTIGATIVE REPORT RECOMMENDATIONS

The investigative report recommended that the Chief Medical Director consider:

Allegation	Recommendation
1(a).	Determining the need for a second opthalmologist in the opthalmology section of the surgical service.
1(b).	Assuring that appropriate reassignments of two secretaries in medicine service are accomplished to alleviate an overstaffing situation.
1(c).	Admonishing or counseling a physician in the infectious diseases section who hired an assistant through use of an illegal position description.
A.	Reprimanding or admonishing an administrative assistant who kept a biological technician on the payroll after his term of employment, to compensate the technician for time he had spent working for VA but for which he had not been paid (and recovering a salary overpayment to the biological technician).
B.	Terminating the employment of a physician who was hired as a research advisor in violation of VA regulations.
C.	Determining whether the specific actions of the physicians involved in the postoperative treatment of a VA patient constituted negligence and, if so, what action should be taken.
E.	Determining the need for the services of the staff surgeon who was performing very little surgery.
I.	Counseling the associate chief of staff for research regarding improper use of funds.
K.	Counseling the chief of surgery service regarding the proper use of patient consent forms involving the use of an investigational drug as part of his research project.

In addition, the allegations relating to university control of the North Chicago VA Hospital (3(a)) was investigated by the acting Director of Medical Service, VA. He concluded that a clear redefinition of the mission of the North Chicago VA Hospital, the role of the medical school in the affiliation, and the importance of providing high-caliber leadership at the hospital was needed in light of his findings.

The VA Investigation Report did not recommend actions against the former chief of staff--although certain allegations against him were sustained--because disciplinary action had previously been taken by VA's central office.

VA ACTIONS ON THE RECOMMENDATIONS

According to VA's Chief Medical Director, the agency has addressed all of the above recommendations through the following actions:

Allegation	VA action
1(a).	At the time of the VA investigation, two part-time opthalmologists were on duty, equating to 1.6 full-time physicians. Subsequently, a third part-time opthalmologist was employed on September 1, 1976, which increased the full-time equivalent employment to 2.1. However, one opthalmologist (the former VA chief of opthalmology) was terminated December 17, 1976, thereby reducing the full-time equivalent figure to 1.2. This was the situation as of April 1977, and the hospital director was satisfied with the arrangement.
1(b).	The VA Investigation Report concluded that medicine service was overstaffed by two secretarial positions. The hospital, in response to the investigation, conducted a staff utilization study of the service, which resulted in the deletion of one secretarial position. Both of the secretaries cited in the VA Investigation Report have since resigned.
1(c).	The physician in the infectious diseases section was admonished on January 21, 1977, for hiring an assistant by using a deceptive position scription.

3(a). In the third quarter of fiscal year 1977, all VA hospitals were requested by VA's central office to redefine their missions. VA's central office has reaffirmed its support of the North Chicago VA Hospital/Chicago Medical School affiliation, recognizing that it will require constant monitoring by the central office.

A. The hospital administrative assistant was reprimanded on January 22, 1977, for maintaining a biological technician on the hospital payroll beyond his term of employment. A "Bill for Collection" was presented to the overpaid biological technician, who subsequently requested a waiver from VA's central office. The request for waiver was forwarded by VA's Office of the Controller to the Comptroller General of the United States on March 10, 1977. As of November 1977, action on the waiver was still pending.

B. The illegally employed research advisor was terminated on November 11, 1976.

C. Subsequent to VA's investigation, VA central office's surgical service noted that there was

> "* * * an error in diagnostic judgment, the magnitude of which is difficult to assess. Classical clinical signs and symptoms of intra-abdominal or retraperitoneal hemorrhage were not present and although a hematocrit determination or red blood cell count would have been appropriate, they would not have been diagnostic unless hemodilution had taken place. We, therefore, do not feel that any negligence was involved nor is any further action necessary."

E. The current North Chicago VA Hospital director has determined that the services of the staff surgeon, who allegedly performed very few surgical procedures, are required and that he is performing surgery.

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I./K. The asscciate chief of staff for research and the chief of surgery were counseled on January 31, 1977, and February 1, 1977, respectively.

OUR COMMENTS AND CONCLUSIONS

Having reviewed and evaluated the VA investigative report's findings and conclusions, and the working papers supporting the report, we offer the following comments and conclusions:

Allegation	Our comments and conclusions
1(b).	This allegation charged that two VA secretaries of certain university-affiliated physicians were spending most of their time on university rather than VA business. The information collected on this matter by VA investigators did not sustain the allegation although this conclusion was not specified in the investigative report. This notwithstanding, we are satisfied that the allegation has been investigated sufficiently.
2(d)(1).	The VA investigators did not sustain the allegation that the chief of staff was instrumental in the separation of a staff psychiatrist because that psychiatrist was not available for comment. In commenting on our report to the Congress, "Controls on Use of Psychotherapeutic Drugs and Improved Psychiatrist Staffing Are Needed in the Veterans Administration Hospitals" (MWD-75-47, Apr. 18, 1975), the acting hospital director told us that this particular psychiatrist had resigned after a peer review had found that her prescribing practices for psychotherapeutic drugs were too routinized. When we contacted the hospital's former chief of staff (who was the acting hospital director cited above) on this matter, he indicated that he was not a member of the peer review team in this case and that he never suggested to the psychiatrist that she leave the hospital staff. He also said that to his knowledge, no one else made such a suggestion either, but that the psychiatrist was distressed at the conclusion of the peer review team and left of her own accord.

We concur in VA's conclusion that the veracity of this allegation has not yet been determined. Its veracity cannot be determined until the the psychiatrist is questioned about this matter; however, neither we nor the VA investigative team could locate the former VA psychiatrist for an interview. Presently, we do not believe further investigative effort is warranted.

2(c). Documentation supporting the VA investigative report indicates that the action of North Chicago hospital management (not the chief of staff exclusively) regarding the research-in-aging laboratory staff could reasonably have been construed as harassment. The investigative report concluded not to sustain this allegation because documentation also existed which indicated that members of the research-in-aging laboratory staff had behaved in an uncooperative manner towards hospital management. Other VA reports supported both sides of this controversy.

On the basis of our evaluation of available information and documentation, we believe it would be fair to say that both the employees and management had conducted themselves inappropriately. Also, VA documentation supports the allegation that management had been attempting to remove research-in-aging laboratory staff members. Special personnel deficiency reports were drafted concerning two senior research-in-aging staff members, as tensions between the staff and hospital management were growing. Memoranda attached to the reports and sent to the two researchers stated

> "You will be given until March 30, 1974 to demonstrate an acceptable level of performance. Failure to achieve this level of acceptable performance will result in action being initiated to remove you or other appropriate action."

Earlier, in a letter written to the Regional Director of Field Operations at VA's central office, the hospital director had recommended

that the research-in-aging staff be moved to another hospital or phased out. Although we believe the allegation regarding the attempted removal of the research-in-aging staff has been sustained, we do not believe it would be appropriate to comment on whether such an action could have been justified. That decision properly rests with VA.

3(a)(2)/(4). The VA investigative report did not sustain the allegations that the North Chicago VA hospital was critically underfunded and funds were being "channeled" from the psychiatry service to other service as a result of medical school pressure. However, the VA investigators did verify that the surgical service was being expanded without corresponding progress in the psychiatry service, and the neglect evident on the psychiatric wards was "tragic." This issue was further reviewed by VA's Internal Audit Service in August 1976. At that time, the VA auditors recommended that the North Chicago hospital give increased attention to insure that the needs of long-term patients be met rather than concentrating exclusively on acute care areas. During a followup audit conducted in October 1977, VA's Internal Audit Service determined that the hospital has made a concerted effort to correct the deficiencies in its psychiatry service, noting that physician staffing in this service has significantly increased.

A. The action of the hospital's administrative assistant, who kept a biological technician on the VA hospital payroll beyond his term of employment to compensate the technician for time during which he had worked but had not been paid, was considered by VA to warrant a reprimand. However, the willful fabrication of a false position description and the hiring of an assistant under that position description by a staff physician in the infectious diseases section (allegation 1(c)) was considered by VA as warranting only an admonishment. The VA personnel manual containing the agency's policy for issuing admonishments and reprimands indicates that the types of actions performed by both the assistant administrator and the staff physician at least warran eprimand.

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The corrective actions taken by VA, therefore, do not appear to be equitable, particularly since the supporting documentation indicates that the administrative assistant was apparently attempting, in good faith, to insure the equitable compensation of another employee.

On the other hand, the staff physician was attempting to finance the salary of an unauthorized research assistant for himself through the misuse of clinical funds. Although we have no recommendation to make on this matter, we note it for VA's consideration in future personnel actions.

I. It should be noted that at the time of the VA investigation, the investigators were unable to perform a financial audit of research funds because of deficiencies in record keeping at the hospital. Information developed during the subsequent VA internal audits shows that as of fiscal year 1975, these records have improved to capture financial information more accurately.

K. The VA investigative report stated that there was insufficient monitoring of patients' consent forms for the use of an investigational drug--sodium cefoxitin--for the chief of surgery's research project. In December 1977, VA officials told us that hospital policy at North Chicago hospital concerning the use of investigational drugs now requires that a signed copy of patient consent be sent to the pharmacy service prior to dispensing the drug. The VA Internal Audit performed in October 1977 verified the hospital's compliance with the policy.

A similar allegation against the chief of neurology service (allegation J) was not sustained by VA, and we support their conclusion.

L. The university-affiliated health clinic, for which the North Chicago VA Hospital provided laboratory tests, has not reimbursed VA for those tests. VA investigators determined that the hospital's provision of the free tests to the clinic was illegal because the clinic was

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not officially affiliated with the hospital. However, VA's Chief Medical Director has advised us that VA's total charges to the clinic for the tests--estimated by VA's central office at $300 to $400--would be too small to initiate collection procedures. He also stated that because the clinic is being operated for indigent patients, VA prefers to consider the free provision of services as a contribution to the community.

An official in VA's Department of Medicine and Surgery advised us that as of May 12, 1976, shortly after the cited tests were performed, VA ceased providing these services to the clinic.

We agree with VA's investigators that the provision of free services to this clinic was inappropriate. We also agree that it would not be worth the effort that might be required to collect the cost of the tests as estimated by VA. However, we believe that VA is required to initiate normal claims collection procedures for recovery of the amount due before concluding that the amount involved is not worth the effort.