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The Special Counsel

April 13, 2000

The President  
The White House  
Washington, D.C. 20500

Re: OSC File No. DI-99-0748

Dear Mr. President:

In accordance with 5 U.S.C. § 1213(e)(3), I am transmitting a report from the Honorable Togo D. West, Jr., Secretary, Department of Veterans Affairs (VA), sent to me pursuant to 5 U.S.C. §§ 1213(c) and (d). The report sets forth the findings and conclusions of the Secretary's review of disclosures of information allegedly evidencing a substantial and specific danger to public health and safety within the Department of Veterans Affairs, Carl T. Hayden Veterans Affairs Medical Center (VAMC), Phoenix, Arizona.

The whistleblower, Winston Liao, M.D., provided comments on the agency report to this office pursuant to 5 U.S.C. § 1213(e)(1), which I am also transmitting.

We have carefully examined the original disclosures and reviewed the agency's response and Dr. Liao's comments. Pursuant to 5 U.S.C. § 1213(e)(2), I have determined that the findings in the agency's report contain all of the information required by statute. I have also determined that the findings appear reasonable except to the extent that the VA has not committed to take specific disciplinary or other appropriate action against individuals found to have provided substandard care to patients.

Dr. Liao, who consented to the release of his name, was a physician anesthesiologist in the Department of Anesthesiology at the VAMC for 12 years, until his reassignment to the Employee Health Unit, Ambulatory Care Center, in September 1999. He alleged that he observed an extremely high incidence of complications occurring in patients under the care of a particular Nurse Anesthetist at the VAMC. He alleged that this individual falsified medical records by pre-recording patients' vital signs and that he left patients unattended during procedures. Dr. Liao claimed that the Nurse Anesthetist's allegedly negligent behavior caused at least four patient deaths, and has resulted in the collapse of at least eight patients after surgery. According to Dr. Liao, some patients required re-intubation, and most were admitted to the surgical intensive care unit from the recovery room after collapse. Dr. Liao stated that he had personal knowledge of at least these twelve patients. Dr. Liao alleged that it is his opinion that these complications resulted from the Nurse Anesthetist's inattention to patient monitoring during and/or after the administration of anesthesia. He asserted that this

individual has been involved in at least 198 cases of serious injury or death due to his incompetence.

The VA report partially substantiated Dr. Liao's allegations. It found that the subject Nurse Anesthetist provided substandard anesthesia care in six of 14 cases over a period extending from 1993 to 1999. The report confirmed that the subject Nurse Anesthetist had incidents in the post-anesthesia care unit in numbers greater than the other five Nurse Anesthetists did. In six patients, according to the report, premature endotracheal extubation at the end of anesthesia appeared to be the primary problem. The report also confirmed that the subject Nurse Anesthetist had behavioral issues, and was at times brusque, intimidating, moody, bullying and volatile. According to the report, the subject Nurse Anesthetist was heard to speak about some veteran patients in a deprecating, insulting manner.

Of the 14 patients studied, three died. The report stated, however, that based on the review of medical records, interviews with clinical and management staff, and the review of personnel folders and quality improvement documents, there was no evidence that the Nurse Anesthetist's behavior caused the three patient deaths. In addition, the report found that the Nurse Anesthetist was not solely responsible for the substandard care provided in any of the six instances.

On a broader scale, the report found that the VAMC lacked a plan and a process to measure and assess data regarding anesthesia quality issues during the period from 1993 to 1999. Reviews were performed only on a case-by-case basis, and, prior to March 1999, there were no Anesthesia Mortality & Morbidity conferences. The report also found that senior VAMC officials, including the former Chief of Surgery, the Acting Chief of Surgery, and the former Chief of Anesthesia, did not communicate serious concerns related to anesthesia and surgery upwards. Surgical Mortality & Morbidity Conferences, where anesthesia and surgical complications and deaths were discussed, were closed to Nurse Anesthetists and other involved staff. The report found numerous weaknesses in the infrastructure supporting the surgical and anesthesia programs.

Finally, the report stated that officials at the VAMC violated the law by failing to provide a proficiency rating for the subject Nurse Anesthetist since January 1997. Because the VAMC failed to rate the employee, he was presumed to be fully satisfactory.

The agency has recommended that the VAMC provide continued close supervision and monitoring of the Nurse Anesthetist. According to the report, the Veterans Health Administration will instruct the VAMC, through Veterans Integrated Service Network 18, to assure that "appropriate" action is taken with respect to both the Nurse Anesthetist's performance and his interpersonal behavior. The VAMC accepted the resignation of the former Chief of Anesthesia in February 1999, and a contract for anesthesia services was established immediately. The new Acting Chief of Anesthesia began in March 1999.

In addition, the VAMC has indicated that it has taken or will take the following management initiatives related to this investigation: (1) regular Anesthesia Mortality &

Morbidity Conferences began in March 1999, which include reviews of anesthesia quality of care issues with recommendations and actions; (2) effective supervision and monitoring of the subject Nurse Anesthetist by the new Acting Chief of the Anesthesia Section began in March 1999 and is continuing; (3) criteria for endotracheal extubation were being developed by Anesthesia staff members at the Medical Center in September 1999; and (4) data collection was begun in June 1999, regarding specific anesthesia care performance measures (indicators) on a systematized schedule. The report notes that there were significant reductions in anesthesia-related incidents in the six-month period from March to September 1999.

Finally, the report stated that the Office of the Medical Inspector (OMI) is evaluating the need to recommend that standardized extubation guidelines at the termination of anesthesia be applied throughout Veterans Health Administration facilities. The Acting Under Secretary for Health will assure that appropriate guidelines are in place at the facility and that the OMI and VA's Office of Patient Care Services expeditiously provide recommendations regarding national guidelines.

#### Whistleblower's Comments

Dr. Liao has provided comments on the report. Dr. Liao expressed his view that the investigation performed by the agency was inadequate. He stated that the investigative team assigned to review his allegations reviewed only 14 cases, out of nearly 300 that he presented to VA officials concerning the Nurse Anesthetist.<sup>1</sup> In addition, Dr. Liao stated that he was barred from accessing medical charts in order to respond to the agency's inquiries, and was barred from assisting in the investigation in any significant manner. Dr. Liao takes issue with the agency's decision not to take disciplinary action against the Nurse Anesthetist despite the findings of substandard care.

Dr. Liao pointed out that the report states that Anesthesia Mortality & Morbidity Conferences began in March 1999, but that all fourteen cases reviewed by the agency occurred prior to March 1999. Although the Chief of Staff reported having no knowledge of the problems until March 1999, Dr. Liao has written documentation, including correspondence from the Chief of Staff, showing that he and another physician anesthesiologist discussed these issues with the Chief of Staff as early as February 1999. Dr. Liao also alleged that the investigative team reviewed only one case with him in a meeting lasting less than one hour. Finally, Dr. Liao alleged that although the report substantiated his allegations that anesthesia records had been removed, the agency made no effort to ascertain who removed the records.

Dr. Liao noted in his comments that the agency has taken relatively little action in response to its findings of substandard care, despite identifying systemic weaknesses in the

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<sup>1</sup> The allegations that the OSC transmitted to the Secretary for investigation and report referred to twelve specific patients, and included Dr. Liao's allegation that patients suffered complications as a result of the Nurse Anesthetist's incompetence in at least 198 cases. The agency chose to limit its review to the medical records of only 14 patients.

Department of Anesthesia at the VAMC. The management initiatives identified in the report parrot representations made to Senator John McCain, in a letter dated April 7, 1999 (prior to this office's transmittal to the Secretary), from James E. McManus, M.D., VA Medical Inspector. In that correspondence, the VA acknowledged many of the same problems identified in the agency's report to this office, as well as additional weaknesses in the Department of Anesthesia.

#### Agency's Supplemental Report

In a supplemental response received from James E. McManus, M.D., VA Medical Inspector, on March 16, 2000, the agency advised this office that the VAMC has taken the following actions since issuing its report to OSC:

- 1) Standardized extubation guidelines are in place, and no further system-wide action is required;
- 2) The subject Nurse Anesthetist remains under "appropriate" supervision and performance monitoring by the Acting Chief, Anesthesia Section. The subject received a proficiency rating of highly satisfactory in January 2000;
- 3) A supervising Certified Registered Nurse Anesthetist has been appointed to assist in monitoring and to address learning needs of the group. No problems have been identified;
- 4) Anesthesia staff members have completed an Airway Study, focusing on reintubation in the immediate post-operative period;
- 5) Criteria for endotracheal extubation were developed and implemented by anesthesia staff at the Medical Center in September 1999;
- 6) Systematic data collection on performance measures in anesthesia began in June 1999 and continues.

#### Special Counsel's Comments and Recommendation

It is of particular concern that, in the face of the report's findings and conclusions, the agency has not taken any measures to discipline the Nurse Anesthetist and/or the other employees involved in administering substandard care to patients. While the OSC is not in a position to evaluate the medical evidence reviewed by VA officials, it seems that it is a matter of common sense that the VA should consider removing the patient care responsibilities of a staff member whose actions have been found in more than a few isolated instances to be associated with a high rate of patient mortality who is found to have provided inadequate patient care. Pursuant to the authority given me in Section 1213(e)(3), I am including the above comments in correspondence to you and the appropriate congressional oversight

committees, together with a recommendation that the VA be encouraged to reexamine any policy or procedures that would permit or force the retention of such employees.<sup>2</sup>

Based on the representations made in the report and as stated above, I have determined, pursuant to section 1213(e)(2), that, except as noted above, the findings in the agency's report appear reasonable and contain all of the information required by statute.

As required by section 1213(e)(3), I have sent a copy of the report, the supplemental response, and Dr. Liao's comments, together with my comments and recommendation, to the Chairmen of the House and Senate Committees on Veterans' Affairs. We have also filed copies of the report, the supplemental response, and Dr. Liao's comments in our public file and closed the matter.

Respectfully,



Elaine Kaplan

Enclosures

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<sup>2</sup> The report contains a case-by-case discussion of the fourteen patient records reviewed. Although OSC lacks the medical expertise to conclusively address the issue, in two cases the report's conclusion that the substandard anesthesia care did not result in the patients' deaths appears inconsistent with the findings noted in the case discussions. In case number eight, the findings were that:

Extubation was premature and unnecessary because the patient was going to the SICU. Blood gases were not documented nor were other parameters that could support the decision to extubate the patient. The patient was not adequately resuscitated following his respiratory arrest in the SICU. The autopsy report concluded there was no morphological explanation for the patient's sudden death. All members of the review team assigned a Level 3 (most practitioners would have given anesthesia care differently) to the subject Nurse Anesthetist's management of this case.

In case number 12, the patient went into cardiac arrest prior to surgery, was successfully resuscitated, but was noted to be in a vegetative state with irreversible anoxic brain damage. The patient was found to have had end-stage cardiac disease. The review team found that there was an unsatisfactory cardiac work-up prior to the procedure, and questioned the accuracy of the documentation recorded during administration of anesthesia.