



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

AUG 31 2004

In Reply Refer To: 53E/cl

Ms. Catherine A. McMullen
Chief, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036-4505

Dear Ms. McMullen:

Secretary Principi delegated authority to the Office of Inspector General (OIG) to respond to the allegations raised in your letter dated May 7, 2004, regarding U.S. Office of Special Counsel (OSC) File Numbers DI-04-0685 and DI-04-0765. The allegations by Drs. Dennis Beshara and Jane Holtzclaw against Dr. Anup Sidhu, an employee of the U.S. Department of Veterans Affairs Medical Center (VAMC), Sheridan, Wyoming, fall into two distinct groups. The first concerned patient care issues pertaining to the alleged misdiagnoses of veterans. Questions include whether veterans were misdiagnosed; whether they were prescribed inappropriate medications; and whether other medications were improperly discontinued and/or discontinued in an improper manner (i.e., too abruptly). The other issues involve an allegation that an underlying, improper financial relationship between the pharmaceutical company and the physician may have been the impetus for the alleged misdiagnoses and improper treatment. We received and investigated allegations involving the same parties in 2002. We did not substantiate the allegations then and do not substantiate the current allegations against Dr. Sidhu.

In January 2002, we received and investigated allegations by Drs. Beshara and Holtzclaw against Dr. Sidhu and another physician under OIG Case Number 2002 HL-0366. Our criminal investigators conducted interviews with Drs. Beshara, Holtzclaw, Sidhu, the Sheridan VAMC Director, and several other parties. We closed the case because the OIG investigation did not substantiate the allegations. In response to an OSC request, we provided your office with our Hotline case file on February 3, 2004.

In response to the current allegations on patient care, the Veterans Health Administration (VHA) immediately responded by convening a review of the quality of patient care allegations under the authority of the Network Director, VA Rocky Mountain Network Office, Glendale, Colorado. The Network Director exercises

Ms. Catherine A. McMullen
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direct program management authority over VAMCs in that region, including the VAMC Sheridan, Wyoming. To ensure objectivity, the Network Director secured the services of the Chief of Mental Health Services and the Director of Outpatient Mental Health Services, employees of the VAMC Denver, Colorado. They conducted the review on May 12 -13, 2004. The review team did not substantiate the allegations of patient abuse, but did find significant interpersonal issues among the parties. They recommended immediately returning Dr. Sidhu to work. VHA management is addressing the poor interpersonal relationships among Drs. Beshara, Holtzclaw and Sidhu. We are enclosing a copy of their findings for your review.

On the allegation that an underlying, improper financial relationship existed between the pharmaceutical company and the physician, we opened OIG case number 2004 HL-0747 to revisit this matter. On June 3, 2004, OIG criminal investigators issued a subpoena for case-related files from Astra Zeneca Pharmaceutical. Astra Zeneca fully cooperated with OIG criminal investigators, providing the subpoenaed files through their legal counsel on June 17 and July 20, 2004. OIG criminal investigators completed their review of these files on August 3, 2004, and found nothing that would suggest an underlying, improper relationship exists between Astra Zeneca and Dr. Anup Sidhu. Our criminal investigators found no evidence of a violation of law, or evidence of any research relationship involving VA. The documents Astra Zeneca provided under the subpoena were consistent with our understanding of the matter from our prior investigation.

In view of the above findings, we have closed OIG Case 2004 HL-0747 as unsubstantiated and plan no further action on this matter. If I can be of further assistance, please contact me at (202) 565-8633.

Sincerely,

Christina A. Lavine
CHRISTINA A. LAVINE
Director, Hotline Division

Enclosure

Report of Investigation
Sheridan VAMC

I. Charge:

As requested by VISN 19 Leadership, on May 12th and 13th, 2004, Dr. Herbert Nagamoto and I visited the Sheridan VAMC to investigate allegations presented to the Office of Special Counsel that a Sheridan Psychiatrist, Dr. Sidhu, intentionally misdiagnosed numerous VA Mental Health patients and over-prescribed certain medications creating a substantial and specific danger to public health. We focused the investigation on clinical care, in particular, the allegations made against Dr. Sidhu by Dr. Bashara. We attempted to answer the following questions:

1. Were there any objective data to suggest that there were deviant prescribing practices by Dr. Sidhu that adversely affected patient care?
2. How did the clinical care provided by the psychiatrists compare to each other?
3. Did the conflicts among the psychiatrists, specifically Drs. Bashara and Sidhu, adversely affect the milieu on the inpatient psychiatric units? Were the nurses able to provide adequate clinical care and were the patients satisfied with the care they received from the nurses and their physicians?
4. Did these issues among the physicians adversely impact their professional relationships among the group resulting in:
 - a. Changing medications on each other's patients without consulting with each other?
 - b. Decreased ability to cooperate and collaborate in a way that made the whole greater than the sum of its parts. That is, could they learn from each other? Could they cooperate in appropriate chart audits, standard of care assessments, and in examining adverse outcomes, for example, suicide data?

II. How we made our assessments:

1. We interviewed Maureen Humphreys, the Hospital Director.
2. We interviewed Dr. Trehan, the Chief of Staff.
3. We interviewed all the psychiatrists, including Dr. Sidhu, Dr. Beshara, Dr. Holtzclaw, Dr. Olson, and Dr. Schultz, the Chief of Psychiatry.
4. We interviewed all four of Dr. Sidhu's inpatients and did a detailed chart review for each.
5. We interviewed four additional patients divided between Dr. Beshara and Dr. Holtzclaw. Detailed chart reviews were done for each patient.
6. Duration of interviews ranged from twenty-five minutes to one hour per patient. Patients on the acute ward and the SNU were interviewed. All patients were offered the opportunity to refuse to talk with us. Only one patient, suffering from severe paranoia, refused.
7. Drs. Adler and Nagamoto completed charts and patients interviews together. One interviewed the patient. The other asked any remaining questions at the conclusion of the interview. A DSM-IV consensual diagnosis was made and treatment and charting issues reviewed.

8. An additional patient was briefly interviewed and chart discussed, but time did not permit a twenty-minute interview and this interview data was not included. The chart was reviewed in detail.

9. Eight of the twenty-six notes by Dr. Sidhu that Dr. Beshara believed represented inappropriate prescribing or poor patient care were reviewed. We are in the process of reviewing the others as well.

10. We interviewed nursing staff on the evening shift on the acute care ward and observed their admitting procedures (May 12) until 8 PM. On May 13, we interviewed nursing staff on the SNU.

11. A verbal report was made in a conference call with Dr. Maffet and Mr. Biro. Maureen Humphreys and Dr. Trehan were in the room with us.

III. Findings:

1. There is no evidence that Dr. Sidhu is prescribing deviantly or endangering patients. By objective outcome criteria, especially suicides and length of stay, he has the best results.

2. The wards were quiet, well-organized, patients looked relaxed, all described the hospital as a haven. Nursing staff felt that they were not adversely affected by putative physician disagreements, although for reasons of confidentiality, the specific allegations by Dr. Beshara were not discussed with nursing personnel or specific physicians named.

3. All the physicians agreed that they do not change medications on each other's patients without consultation.

4. They all believed that overall, they gave excellent care.

5. The two physicians (Drs. Schultz and Olsen) not part of the conflict felt that Drs. Sidhu and Beshara represented differing viewpoints within psychiatry, recapitulating the history and conflicts in the field, but that the department would operate better if they could find a middle ground.

Briefly, Dr. Sidhu believes the data support diagnosing more patients in the bipolar spectrum and treating them accordingly, as well as making hospital stays as brief as is necessary for treatment.

Dr. Beshara is more conservative in his viewpoints and argues that many patients need more time in the hospital.

There is objective evidence in the research literature for both viewpoints. Treatment needs to be individualized for each patient.

6. Dr. Holtzclaw and Dr. Beshara insisted on being interviewed together and having a union representative present. Dr. Holtzclaw would only say that she was in complete agreement with Dr. Beshara.

7. Thus, patient care did not appear to be adversely affected and the milieu on each ward functioned well.

8. However, the ability of the psychiatrists to cooperate and learn from each other was made more difficult and indeed was adversely affected by the accusations. Cooperation on several critical issues, including evaluation of completed suicides and developing a system-wide solution was impossible.

9. Of particular concern in the process, was that Dr. Beshara, in contrast to all the other psychiatrists, insisted on additional time, spending an hour describing his allegations about Dr. Sidhu and made other allegations that were presumptive, had no data for them, and appeared to be delusional.

It was not in our purview to do a clinical interview of Dr. Beshara, however, we strongly recommend that an independent in-depth clinical evaluation of Dr. Beshara be completed, as well as projective testing. In spite of our concerns, we were relieved from our chart reviews that Dr. Beshara's treatments did not seem to be affected by his issues with Dr. Sidhu. Dr. Nagamoto and I made detailed notes.

10. We also did not do specific investigations that would interfere with the OIG. We did not investigate allegations of financial remuneration from drug companies, previous scientific studies by Dr. Sidhu, etc. We kept the focus on patient care. We did review the patients and the charts for any evidence of illicit studies conducted on the ward or any scientific study of patients without their consent and could find no evidence of this. The only time that medications were changed were when one psychiatrist was on extended vacation and another was covering.

11. Most of Dr. Sidhu's patients did say that he spent too brief a time with them, usually only five minutes. Several of Dr. Beshara's patients said that they had too little clinician time on the ward.

IV. Final Recommendations:

1. Dr. Sidhu should be returned to work immediately.
2. Dr. Beshara's vehemence and apparently delusional nature of his concerns require a clinical evaluation of Dr. Beshara, with the focus on ability to work with colleagues.
3. It is up to the VISN and the OIG to decide whether an IG investigation of Dr. Beshara's charges is warranted. We could not find objective data to substantiate his claims.
4. Incidental findings from chart reviews and recommendations concerning patient care were reviewed with Dr. Trehan.
5. Overall the hospital runs well. The nursing staff morale is good, the patients seem adequately cared for, and the hospital is spotless.
6. Of the three physicians whose charts were reviewed, Dr. Holtzclaw had the most complete documentation.
7. Psychiatrist time could be restructured so that they could spend a half-hour/week with each inpatient in addition to the brief round time.

Respectfully Submitted,

Lawrence E. Adler, M.D.

Chief, MHS, DVAMC

Professor of Psychiatry, University of Colorado Health Sciences Center.

CAPT, MC, USNR(IRR)

and

Herbert T. Nagamoto, M.D.

Director of Outpatient MHS for DVAMC

Associate Professor of Psychiatry, University of Colorado Health Sciences Center.



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Ms. Catherine A. McMullen
Chief, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036-4505

Dear Ms. McMullen:

This is a follow-up response to our telephone conference of October 14, 2004, regarding U.S. Office of Special Counsel (OSC) File Numbers DI-04-0685 and DI-04-0765, involving the Department of Veterans Affairs Medical Center (VAMC), Sheridan, Wyoming.

As a result of that telephone conference, we agreed to provide you a status report on the implementation of three final recommendations (#1, #2 and #7) made in the Veterans Health Administration (VHA) review of May 12 – 13, 2004. The Director of the Sheridan VAMC has provided us her response, which is enclosed for your convenience. We also requested a status on VHA's review of the remaining medical records in question. Their findings are also enclosed with this packet.

Your request for clarification of certain conversations between Dr. Beshara and Mr. Lawrence Biro, VA Rocky Mountain Network Director, revealed these communications pertained to administrative and operational matters. Additionally, Mr. Biro informed Dr. Beshara that any said discussions should not discourage or prevent him from discussing whatever issues he wished with any regulatory or oversight body to include, but not limited to Office of Special Counsel, Office of the Inspector General, Office of Resolution Management, or the chain of command within the Department of Veterans Affairs.

Our office considers this matter closed. If I can be of further assistance, please contact me at (202) 565-8633.

Sincerely,

A handwritten signature in cursive script that reads "Christina A. Lavine".

CHRISTINA A. LAVINE
Director, Hotline Division

Enclosure

Lavine, Christina

From: Lee, Mary (DEN-V19)
Sent: Wednesday, November 17, 2004 10:54 AM
To: Lavine, Christina
Cc: Sharp, Barry
Subject: RE: RE: VAMC Sheridan, WY

Christina,

I have attached a memo in response to the follow-up questions regarding the Sheridan VAMC. VISN 19 concurs with the memo.

Thank you,
Mary Lee

-----Original Message-----

From: Lavine, Christina
Sent: Thursday, October 14, 2004 11:49 AM
To: Lee, Mary (DEN-V19)
Subject: RE: VAMC Sheridan, WY

Good Afternoon Mary. Thank you for speaking with me today. As a follow-up to our conversation, please advise us the status of implementation of the below recommendations made by Drs. Adler and Nagamoto in the Report of Investigation on the VAMC Sheridan issues:

1. Dr. Sidhu should be returned to work immediately.
2. A clinical evaluation of Dr. Beshara, with the focus on ability to work with colleagues.
3. Psychiatrist time could be restructured so that they could spend a half-hour/week with each inpatient in addition to the brief round time.

Additionally, the report mentions a further review of the remaining 18 medical records in question. The review had already covered 8 medical records and found no evidence of improper care. Have the additional records been reviewed, and if so, what are the findings.

I understand the Director of the Sheridan VAMC is on travel this week, and that you will need some time to respond back to us. I will suspend the response due date until October 29, 2004. If more time is necessary, please let me know and please do not hesitate to call me if I can be of assistance. Thanks, Chris

*Christina A. Lavine
Director, Hotline Division
VA Office of Inspector General
(202) 565-8633 - office
(202) 565-7936 - fax*

Department of Veterans Affairs

Memorandum

Date: November 10, 2004

From: Director, Sheridan VAMC (666-00)

Subj: Adler Review Status Report

To: Director, VA Rocky Mountain Network (10N19)

1. Per your request, the following is the status of the implementation of Drs. Adler and Nagamoto's recommendations of May 17, 2004.

- a. Dr. Sidhu was returned to duty on May 14, 2004.
 - b. Ms. Clara Trapnell, HR Specialist (VACO), is currently in process of arranging the appointment for an evaluation of Dr. Beshara with Dr. Brad Felker, MD, Puget Sound Healthcare System. He was recommended by the Mental Health Strategic Healthcare Group in VACO. Ms. Trapnell will provide him with both reports authored by Drs. Adler and Nagamoto. Dr. Beshara will be advised in writing not later than November 19, 2004, to report for the evaluation. Sheridan VAMC will make travel arrangements.
 - c. Dr. Schultz, ACOS/Mental Health, has instructed all psychiatry staff that effective November 15, 2004, each inpatient psychiatry patient will be seen by the attending psychiatrist for a minimum of 30 minutes per week, in addition to time spent with the patient during treatment team meetings. This will be documented by placing a note in the newly created template "individual psychotherapy (Psychiatrist's) note". An on-going monitor will review compliance.
2. A further review of the remaining medical records in question was conducted by Drs. Adler and Nagamoto. A report of their findings dated September 26, 2004, is attached.
3. If there are further questions, please do not hesitate to contact me.

Maureen Humphrys

September 26, 2004

MEMORANDUM:

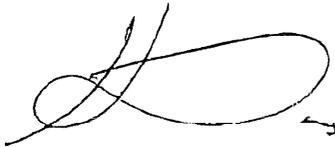
1. On September 24, 2004, Drs. Adler and Nagamoto completed a chart review of outpatients seen by Dr. Sidhu in December of 2003. This chart review was a follow up to our May 12 and 13, 2004 visit to the Sheridan VAMC. A total of 20 outpatient charts were reviewed with joint review of all charts. It was not felt necessary to review all 29 charts cited by Drs. Beshara and Hotzclaw in their communication with the U.S. Office of Special Counsel (OSC) as several clear patterns emerged that were consistent in the charts reviewed.
2. Our previous memo reviewed patients seen on the wards at Sheridan, active inpatient records, and included interviews with inpatients and staff. That will not be reiterated here.
3. Findings from the chart review:
 - a. We did not find any evidence of a substantial or specific danger to public health.
 - b. Dr. Sidhu may be using gabapentin as a primary mood stabilizer more than would be considered mainstream practice at this time, especially given the current evidence in the literature on this issue.
 - c. When making a diagnosis in the bipolar disorder range, Dr. Sidhu does support the diagnosis with specific symptoms consistent with depressive and manic symptoms.
 - d. Dr. Sidhu's routine follow-up notes appear to stress sleep, racing thoughts, and vivid dreams, and a somewhat frequent noting of "prognosis is poor" without clear discussion.
 - e. When re-diagnosing a patient seen previously by Dr. Sidhu, Dr. Beshara in a second opinion discussed the patient's history and complaints at great length, but in re-diagnosing them with depression NOS, he did not discuss specific symptoms or lack thereof or other factors such as family history when ruling out any bipolar component.
 - f. Both Dr. Sidhu and Dr. Beshara, in some cases, should be devoting more work and documentation on some patient's comorbid substance abuse problems. Overall, substance abuse follow-up and treatment did not seem to be seen as the critical issue it really is.
 - g. Again, while both Dr. Sidhu and Dr. Beshara's documentation in the charts reviewed raise some questions as noted above, there is no evidence of willful misdiagnosing or mistreatment of patients and no evidence of a substantial or specific danger to public health.
4. Recommendations:
 - a. As in any healthcare facility, effective ongoing peer review is needed to help identify specific clinical practice areas that would warrant improvement such as those noted above.
 - b. Comments made by several of the psychiatrists interviewed at the Sheridan VAMC on May 12 and 13 of this year would suggest that such effective peer review is not always occurring, particularly in the area of morbidity and mortality conferences as would normally be required for completed and attempted suicides. Steps should be taken to review, assess, and improve psychiatrist peer review as indicated. Any barriers to an effective peer review process should be clearly identified and effectively dealt with.
 - c. At this point, the emphasis should be on facilitating patient care in the department and not on personal accusations, which, as we noted before, have interfered with department morale and

made effective peer review difficult or impossible to achieve in such important areas as completed and attempted suicides of patients.

Respectfully submitted,



Lawrence E. Adler M.D.
Chief, MHS, Denver VAMC
Professor of Psychiatry, University of Colo. Health Sci. Ctr.
CAPT, MC, USNR (IRR)



Herbert T. Nagamoto, M.D.
Director, Outpatient MHS, Denver VAMC
Associate Professor of Psychiatry, University of Colo. Health Sci. Ctr.