

Valerie Taylor
Michael E. DeBakey VA Medical Center
Houston Texas 77030
June 1, 2007

U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

Dear Ms. Myers:

I have received the report from Michael J. Kussman, Acting Under Secretary for Health, Department of Veteran Affairs, in response to my allegations of a substantial and specific danger to public health and safety arising out of actions by employees at the Department of Veteran Affairs (VA), Michael E. DeBakey VA Medical center (VAMC), Houston, Texas.

First let me preface my response with my gratitude and thanks to the U.S. OFFICE OF SPECIAL COUNSEL for investigating my complaints. However I do not agree with the findings from the OMI, and find that they are vague and the investigation poorly conducted at best. To the best of my ability, I will respond to all of their findings in the order that they are listed.

Findings:

I was indeed interviewed by the OMI team. They reviewed the two patient incidents that I reported, one in October 2005 and one in December 2005. They found that both incidents occurred within the month prior to the implementation of the new Nursing AOD policy, they also report informing me about the mistiming of the events.

What they failed to report is that I informed them that the memo (there wasn't a policy then and there isn't one now) about the AOD reorganization came out in January 2006, however the AOD positions had been dissolved in September 2005. If they had investigated that information they would have found that there were no incident reports from the AOD's regarding the two off tour incidents, because they had already been relieved of that duty. All they had to do was ask. The only policy that was in place was the AOD policy dated 2003, and they wouldn't of received that one if I had not given it to them. (Apparently the facility administrators didn't see fit to give it to them).

As far as the resident physicians, the OMI reports that there were no incidents reported regarding a compromise of patient safety and the lack of resident knowledge about policy and procedure of the VAMC.

Again, the VAMC is not going to politely hand over any incriminating evidence; you have to ask for it. If the OMI team had simply reviewed incident reports during the appropriate time frames they would probably have found many.

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The report states that a multidisciplinary committee provided guidance and received feedback on the policy prior to its implementation. It goes on to say that a ten question survey was given to the staff nurses and nurse managers which turned out a low response rate with only three nurse managers responding and an inconclusive finding. Although the Clinical Practice Office reported overall positive responses for nursing satisfaction on the 2006 all employee survey, a collated roll-up of the data for generalization to all nurses in the Medical Center was not provided (no surprise here).

We provided much feedback to administration about this policy and simply stated, "WE WERE IGNORED!" That being said, is it any wonder why only three nurse managers responded to the satisfaction survey? Enough said, I think the OMI's findings in that area speaks for itself.

The OMI reported an interview with the five Care Line Nurse Executives, with the Associate Chief Nurse also in attendance. As reported by the OMI they all concurred with the value of the previous AOD role, and little response was given when asked whether the new policy was working. (I wonder what that meant). They went on to tell the team about all of the adaptations that they had made to compensate for the gaps on the off tours, such as; and I quote,

- "Some have hired Care Line bed control/ flow coordinators."

Yes, some have hired bed control/flow coordinators; others have not.

- "Some have shifted their RN staffing to enhance off-tours."

Yes, some have shifted their RN staffing to enhance off-tours; what they didn't tell you is that they were turning the lives of their employees upside down.

- "The Extended Care Unit provided their nurse managers with cellular phones to replace pagers."

Yes, they did, now the nurse manager can be reached immediately with just the touch of a speed dial button at anytime of the day or night. Why didn't they just implant a tracking chip in them; it would probably be more cost efficient.

- The OMI reported, " There were some issues with the Code Green (psychiatric) emergencies and Code Blue (medical) emergencies as the nursing AOD had attended all codes. " A Code Green requires the attendance of a mental health RN and a Code Blue requires a critical care RN." "These episodes have the POTENTIAL to critically reduce staff in the Mental Health unit and ICU's as both have a greater population of patients requiring one-to-one care. Previously, the AOD would have solved issues with the movement of staff from one unit to another to accommodate temporary staffing losses. "However, no specific adverse

incidents were identified when we queried the Care Line Nurse Executives, nor was there specific data provided to the OMI those outcomes had been affected.”

It stands to reason that if the staffing level is critically reduced in a critical care area, then patient care activity will also be reduced to a critical level. This presents a substantial and specific danger to public health and safety, especially in Intensive Care Units.

The AOD's would respond to such emergencies, leaving the staff nurse to take care of patients or stand in for nurses who responded to such emergencies.

It was reported by the OMI that the Care Line Nurse Executives said that the role of the Nurse Manager was a 24 hours per day, seven day a week job. The OMI could not find documentation to support this finding in the Criteria Based Functional Statement, Nurse Manager and/or the VA handbook, thus requesting confirmatory information regarding this role requirement. They were given the functional statement for the Nurse Manager (which they had already reviewed) and told under leadership #1 for nurse level 2 and 3 states; “Demonstrates knowledge of scope of practice and RN accountability in assignment, delegation and supervision of staff.” The OMI reports the facility states “This implies 24hr. accountability.”

I am at a loss for words as to why the Medical Inspectors would accept such nonsense as valid. That statement is very direct, it says accountability; not accessibility. There seems to be some misunderstanding as to the definition of the two, so I will give the Miriam Webster' dictionary definition of each:

Accountability – 1.) The quality or state of being accountable; or an obligation or willingness to accept responsibility; or to account for one's action.

Accessibility – 1.) Providing access; or capable of being reached; also being within reach.

Everyone in an administrative/leadership position is accountable for what occurs in their respective areas whether they are there or not. It does not mean that you have to be there/ or be accessible 24 hours a day. Also this was not “implicated” when I began my management position at the VAMC 5 years ago, so why now? Also there was no pay for the on-call status of nurse managers. Physicians rotate call duties at the most every 6 months, they are paid and they have residents in-house, so they basically are never called. Social workers rotate call duty, they are paid on-call pay, and they rarely if ever get called. The OMI did a survey of the VA's and found only one small VA where the nurse managers were on-call, and guess what; they are getting on-call pay. What's going here at the Houston VA, what's different about the nurse managers here. It seems that the administration is picking and choosing whom they want to pay on-call pay to, and it appears that they are engaging in Unfair Labor Practices and Abuse of Authority. However, no one feels the need to do anything about it, even though it's against the law.

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As managers we work 8 long, hard hours. When we leave we get calls on the way home, when we get home, during dinner, while helping the kids with their homework, when preparing for bed, and while we are sleeping. I ask anyone reading this; "Would you do it, or better yet, could you do it?" I definitely feel that some sort of back pay or retribution is in order.

The OMI stated they interviewed 22 Nurse Managers.

There is nothing else to be said here. What they heard from the Nurse Managers speaks for itself.

The OMI interviewed six nurses who previously occupied the AOD role. The AOD's informed them that they were not consulted about the proposal, but were instead simply informed.

So much for all staff input.

The OMI interviewed 30 charge nurses.

Again, nothing else to be said, the results speak for themselves.

The OMI met with four Care Line Executives.

Again, the results of that interview speak for itself. Also The OMI reports from the Care Line Executives, and I quote states, "The Clinical Executive Board had little input opportunity prior to approval of the policy." Again, so much for all staff input; makes you wonder who exactly was on that multidisciplinary committee team that gave input into this new policy, that the facility said it employed.

The OMI interviewed 11 residents.

These residents were not here during the times in question.

The OMI reports consulting with two consultants from the Texas BNE. They go on to give the definition of a Professional Nurse. They also report that these consultants concurred that there was no threat to a Nurse Manager's licensure when providing

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supervisory advice over the phone to staff nurses within her unit if this process remains within the scope of nursing activities (described under the nursing standards for the nurse's state of licensure).

That is in total contradiction to what I was told by BNE consultants. Either way it doesn't matter, because thankfully I can read and I have read the Nurse Practice Act. The Board of Nurse Examiners exists for the safety of patients, not the welfare of nurses. So when the BNE reported to the OMI that it was okay for a Nurse Managers to give advice over the phone, what they didn't say was "As long as you give the correct advice." If you give the wrong advice, even if no harm comes to the patient, you can best believe that your license is at risk at that point. I can certainly see that happening in the middle of the night when your mind is of foggy.

In Conclusion:

The method for conducting the investigation was poorly executed and took on a lackadaisical approach. Information that should have been requested was not. On page 3 of the report, The OMI gives a list of documents they reviewed for the investigation. They failed to review the most important documents relevant to the situation; that would be incident reports obtained from the Risk Management Department and all Joint Commission mandated self reported sentinel events that occurred during the months of October 2005 to April 2007. Theses reports would have given them all they needed, in terms of veteran harm. Instead they just reported they weren't given anything that caused them to believe that the veterans were at risk of harm.

In the words of the Medical Inspector, I am appalled that the OMI came here and although repeatedly said that they were appalled at the situation, left leaving only a vague and meaningless recommendation. I now understand why the folks at Walter Reed Hospital did not report the deplorable conditions there; because they knew nothing would be done.

Although I have since become a staff nurse, I feel as though I was forced out of my management position because I could not physically or mentally work 24 hours per day, seven days per week. I have had to take a decrease in pay, was denied promotion again, even though I have received an Outstanding rating every performance review for the last 5 years, (although I was recently informed by our Human Resources Department that my file does not contain any of my performance reviews or board actions from 2004 to the present), and had to endure harassment from my Nurse Executive shortly after the OMI

**Department of
Veterans Affairs**

Memorandum

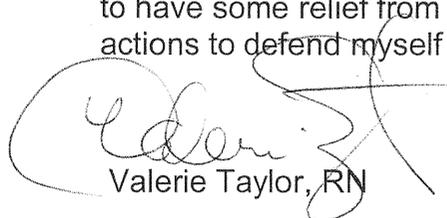
Date: 1-23-07
From: Valerie Taylor RN, Nurse Manager, NU6F
Sub: Mental Health Care Line Nurse Executive
To: Mr. Edgar Tucker, Director
Mrs. Thelma Gray- Becknell, Chief Nurse Executive

First, let me preface this letter by saying that I recognize that this is an unusual approach to resolve an issue but I feel that this is the only feasible means available to address my concerns. I am writing the two of you out of respect with the hopes that someone will listen to me and address my concerns. Please note that I do not take using this approach lightly. Prayerfully, I will not do it again.

The Mental health Care Line has been a very hostile and abusive place to work for the past couple of years, but I've managed to hang in there for the sake of the Veterans. Ms. Jennan Swafford is the most abusive, brash, defensive, and untruthful supervisor I have ever had the pleasure to work for. Recently, within the past two weeks it has gotten severely worse for me. She has been screaming at me, talking to my staff about me in a negative way, accusing me of not safely staffing my unit (even when there is evidence to the contrary), and harassing and abusing me.

This morning she began talking loud to me in a disrespectful and nasty tone in front of members of the treatment team and another nurse manager falsely accusing me of not properly staffing the unit. Her disposition was so hostile and threatening that I had to try to defend myself.

I have recently applied for a staff nurse position in an attempt to remove myself diplomatically from the situation, but at this point I can no longer take it. It is becoming very difficult for me to concentrate on my duties and fend her off on a daily basis. I need to have some relief from this situation because I am at my wits end and I fear that my actions to defend myself could be misinterpreted as insubordinate.



Valerie Taylor, RN

Valerie Taylor
Michael E. DeBakey VA Medical Center
Houston Texas 77030
October 26, 2007

U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

Dear Ms. Myers:

I have received a copy of the supplemental report from Michael J. Kussman, Under Secretary for Health, Department of Veteran Affairs, to The Honorable Scott J. Bloch regarding the planned follow-up actions in response to the one recommendation in VA's report submitted in connection with Office of Special Counsel File Number DI-06-2205, in response to my allegations of a substantial and specific danger to public health and safety arising out of actions by employees at the Department of Veteran Affairs (VA), Michael E. DeBakey VA Medical center (VAMC), Houston, Texas.

First let me preface my response with my gratitude and thanks to the U.S. OFFICE OF SPECIAL COUNSEL for investigating my complaints.

The Michael E. DeBakey Medical Center has gotten progressively worse since the OMI's departure. It comes as no surprise to me that the Medical Center gave a vague and inadequate response, as these responses are common and usually go unchallenged. However I will give a basic account of how things have unraveled since the investigation, and subsequent recommendation, and then I will respond to the letter.

Post OMI recommendation to the Michael E. Debakey Medical Center, to "take a critical and formal approach to reviewing the policy to abolish the AOD role considering its impact on patient safety and employee satisfaction":

Mr. Kussman begins his report by saying that "The Office of Medical Inspector did not identify clinical, safety issues or adverse events resulting from the policy change."

This is true, as the OMI team interviewed the Management team they asked us to give them specific events that resulted in safety issues, or poor outcomes for the veterans as it related to the removal of the AOD's . The Management team at this time informed the OMI team that there had been no adverse events because we as managers had preempted them by any and all means necessary, i.e.; hours of phone calls at all times of the night between management and staff, also coming in to work at all times of the day and night, to include after work hours, weekends and Holidays to handle issues. We went on to tell them that as we were doing our best to keep things under control (which was not very good), we were way overstretched, and that we would not be able to function at that

capacity much longer. We did however give them many tales of near misses which they obviously chose to ignore.

Mr. Kussman went on to say, " VHA identified administrative concerns related to staffing which have arisen due to the current policy, e.g., seriously low morale among affected nursing staff." He also says that he recognizes that these issues have the potential to lead to negative outcomes; thus the facility was required to re-evaluate whether the administrative concerns caused by implementation of the policy(as identified by the Medical Inspector) will create any risk to patient safety or adversely affect or compromise the quality of care provided to patients.

The medical Inspector did manage to get one thing right and that was his ability to recognize the potential for negative outcomes. The thing that he got wrong was that he believed that the Administration of the Michael E. DeBakey Medical Center would re-evaluate the implementation of the policy based on his recommendation.

Since the Medical Inspector's departure and subsequent findings and ruling, these are just a few of the negative outcomes that he recognized as potential:

Six Nurse Managers step out of their roles as leaders in the following areas;

- Acute and Geriatric Psychiatry
- Acute Adult Psychiatry.
- Surgical Intensive care Unit.
- Medical and Surgical Step down Unit.
- Nursing Home and Transitional care
- Medicine.

I cannot go into the circus that is still going on trying to replace all of the Manager's that stepped down, but I can assure you that it is not a pretty picture.

Mental Health- After my departure as Nurse Manager of the Acute and Geriatric Unit and the Nurse Manager of the Acute Adult Unit, the morale was so low, and the turnover rate was so high that the Administration had to implement a 10% base pay incentive increase to retain the nursing staff. To date they are still unhappy.

The nursing staff signed a petition expressing their disgust with the Mental Health Administration for allowing things to get so out of control.

The Chief of Mental Health was ordered by the Chief of staff to do rounds on the nursing units twice per day without fail to ensure support and feedback.

The Nurse Manager position for the acute unit was filled 3 months later and to date my position has still not been filled.

The Nurse executive was finally removed for her incompetence as an executive and a leader, and for harassing me after the Medical Inspector left.

The Mental Health care Line remains in turmoil.

Surgical Intensive care Unit (SICU) - After the departure of the SICU Nurse Manager, the morale was so low and the turnover rate so high that they had to hire contract nurses to fill the openings. It is said that over 10 seasoned nurses left and went to other areas of the facility. They have still not recuperated.

Within the last 3 weeks four SICU beds had to be shut down by the Chief of Staff after he made a surprise after hours visit to the unit, only to find that there were not nearly enough nurses to take care of these critically ill patients. (This is a prime example of what happens when you don't have an AOD or nursing supervisor to intervene on behalf of the veterans or staff). The Nurse Executive and Nurse Manager had to be called at home to fix the problem. What would have happened had the Chief of Staff not come in and taken a tour?

On 10/12/07 the Nurse Executive was removed from her position as Nurse Executive of the Operative Care Line for incompetence and placed in quality management after only 10 months in the job. I'm not sure but it may have had something to do with her having no clinical background in Operative Care, only Mental Health.

The Liver transplant program slated to begin in July of 07' in conjunction with another major medical facility is still on hold, because the only person that had transplant experience was the Nurse Manager who stepped down.

These are just a few things that have happened since the OMI ruling. It can be said that it is not related to the removal of the AOD's, however the removal of the AOD's have caused a trickle down effect as follows;

- The AOD's were removed.
- A complaint was filed with OSC.
- Office of The Medical Inspector investigates.

- Office of Medical Inspector rules in favor of the Hospital.
- Nurse Managers step out of their roles.
- Staff Morale extremely low, Turnover rate extremely high.
- Sub standard and poor care for our veterans.
- Poor patient outcomes.

Bed closure for any unit has a negative effect on patient care, however when it is a critical unit such as SICU the effects are even more damaging because these are your most critically ill patients. It also means that surgeries may have to be delayed and/or rescheduled and it takes months sometimes years for the veterans to be scheduled for surgery. It was also told to me by one of the medicine unit manager's that it was requested that they take some surgical patients since surgery had to close beds in their areas. This is just the beginning, it has and it is going to get worse.

Mr. Kussman also says," although the AOD was not providing nursing services and was administrative in function, we will determine whether the lack of AOD involvement interferes with the furnishing of needed nursing care.

I'm not sure why Mr. Kussman states that the AOD's were not providing nursing services, when it is clear in the policy that I gave them that they were (see attached). I'm also not sure if Mr. Kussman understands the role of an administrative nurse because he says that the AOD's were administrative in function; that's true, that is the role of an AOD, nursing supervisor, nurse executive, associate chief nurse executive and chief nurse executive, they function as administrative nurses, guiding and overseeing the care delivered by clinical nurses, ensuring safe, appropriate and timely care to patients. I am totally confused by his lack of understanding.

Mr. Kussman assured the Honorable Scott J. Bloch that the VHA uses a stringent performance management program evaluating hundreds of clinical measures on an ongoing basis to ensure maintenance of the highest quality of care. "Issues that could result in any denigration of care are taken very serious and addressed quickly."

That statement is not even a good book answer. I'm afraid Mr. Kussman has been snowed.

"To date, the facility has submitted a request to the Organization Excellence Board (OEB) for re-evaluation of the nursing AOD role redesign."

This thing has taken on a metamorphosis. Now it's the AOD role re-design. There is no role re-design. Those AOD's lost their positions and had to apply and compete for positions elsewhere, if it were a true AOD role re-design then it stands to reason that AOD's would be in those re-designed positions.

Also who is the Organizational Executive Board? If they are going to sit in their offices and read anything that the Michael E. DeBakey sends them and then plan to make an informed decision based on what's written, then rest assured we will remain in our dysfunctional state.

"The Associate Director for Patient/Nursing Services met with the Performance Improvement Coordinator who is organizing a group of multidisciplinary team members to interview doctors, nurses, administrative officers and stakeholders as an initial step in the re-evaluation process."

This sounds like the same phantom group of multidisciplinary team members that the administration claimed they interviewed before implementing the change in the beginning.

Also in the first managers meeting after the departure of the OMI, the manager group was told by the Associate Director for Patient/Nursing Services (the above mentioned individual), "You all need to stop beating a dead horse, the AOD's are gone and they are never coming back." This tidbit of information was given to the management team without provocation, and as soon as I stepped out to go to the restroom.

It was stated, " The work of this team will be monitored by the office of the Clinical-Quality Liaison for the Office of the Deputy Under Secretary for Health Operations and Management at the Veteran's Health Administration Central Office."

All of the above listed titles may sound impressive to someone who doesn't know any better; however the proof is in the pudding not in the title. Whoever is monitoring this issue needs to really find out what's going on and not get buried in a myriad of paper work sent to them for review by the Michael E. DeBakey Medical Center.

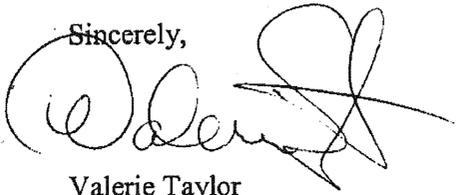
And last but not least, Mr. Kussman states, "Please be assured that we take any potential threat to delivery of high quality care to veterans very seriously and we will take necessary corrective action recommended by the review."

If this were the case then the OMI should have taken corrective action when they came to the Michael E. DeBakey medical Center, because the potential threat that he referred to was already there.

In conclusion, the Medical Inspector's Office needs to put it's money where it's mouth is and get back down here to Houston and find out first hand what has really transpired since their departure and not rely on the reports from the Medical Center.

I stepped down from my position as Nurse Manager in February of 2006 and have been moved around like a chess piece ever since. Despite this I am still very much dedicated to the care given to our veterans, and will fight every chance that I get to ensure that it happens.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Valerie Taylor', with a large, stylized flourish at the end.

Valerie Taylor

**U.S. OFFICE OF SPECIAL COUNSEL**

1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

October 10, 2007

Ms. Valerie Taylor
6701 Sandspoint #129
Houston, TX 77074

Re: OSC File No. DI-06-2205

Dear Ms. Taylor:

Enclosed is a copy of a supplemental report from Michael J. Kussman, Under Secretary for Health, Department of Veterans Affairs, in response to your allegations of a substantial and specific danger to public health and safety arising out of actions by employees at the Department of Veterans Affairs (VA), Michael E. Debakey VA Medical Center (VAMC), Houston, Texas.

Pursuant to 5 U.S.C. § 1213(e)(1), you may comment on the supplemental report if you wish. Your comments will be sent to the agency head, the President, and the appropriate congressional oversight committees in accordance with 5 U.S.C. § 1213(e)(3). With your consent, your comments will also become part of a public file maintained by OSC. We have enclosed a consent form for your signature, which we ask that you sign and return with your comments.

Please respond within 15 days from the date that you receive this letter. If you cannot complete your comments within this time, please call me at (800) 572-2249 or (202) 254-3625, so that we may arrange a short extension of the response date.

Sincerely,

A handwritten signature in cursive script that reads "Malia S. Myers".

Malia S. Myers
Attorney
Disclosure Unit

MSM/msm
Enclosures



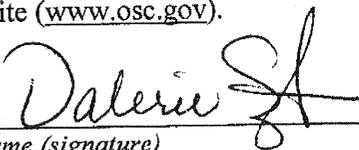
U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505
202-254-3600

CONSENT TO PUBLIC RELEASE
OF WRITTEN COMMENTS ON AGENCY REPORT

(OSC File No. DI-06-2205)

I consent to public release by the U.S. Office of Special Counsel (OSC) of my written comments on the agency report required by OSC in response to my disclosure in the file identified above. My consent includes placement of my written comments in the public file maintained by OSC pursuant to 5 U.S.C. § 1219(a)(1).*

I understand that my consent means that OSC may release my written comments in response to an outside party's request for access to the public file; as part of any press release issued by OSC about the agency report; or in other circumstances deemed appropriate by OSC. I also understand that my consent means that that my written comments may be included in public file or press release documents posted from time to time on OSC's web site (www.osc.gov).



Name (signature)

VALERIE TAYLOR

Name (printed)

10/26/07

Date

* 5 U.S.C. § 1219 ("Public information") reads, in relevant part: "The Special Counsel shall maintain and make available to the public—... a list of ... matters referred to heads of agencies under [5 U.S.C. § 1213(c)], together with reports from heads of agencies under [§ 1213(c)(1)(B) about] such matters."

MICHAEL E. DeBAKEY VETERANS AFFAIRS MEDICAL CENTER
Houston, Texas

MEDICAL CENTER POLICY
MEMORANDUM NO. 118CPO-002

July 5, 2005

ADMINISTRATIVE OFFICER OF THE DAY

I. PURPOSE

This policy delineates the role and scope of the nursing supervisor functioning as the Administrative Officer of the Day (AOD) at the Michael E. DeBakey VA Medical Center (MEDVAMC).

II. PROCEDURES

The AOD serves in the absence of the Medical Center Director and Chief Nurse Executive, providing administrative and clinical direction outside of normal business hours (during the evening, night, weekends and holiday tours of duty). The AOD has authority to make decisions, serving as the highest administrative level on site after regular business hours.

III. RESPONSIBILITIES

A. The AOD provides leadership to care line and service line staff to ensure the delivery of quality care and improve outcomes at the program or care line level.

B. The AOD utilizes MEDVAMC policies as well as professional standards of care and practice to make sound decisions, proposals and recommendations to executive staff.

C. The AOD submits a daily report to the Chief Nurse Executive/Clinical Practice Office (CPO) Director, reporting activities which have impacted patient care delivery in the previous 24 hours.

D. The AOD confers with the Medical Administrative Assistant (MAA) on unusual matters regarding patient care issues to achieve positive outcomes.

E. The AOD acts as a patient advocate in matters regarding patient rights and ethical issues. In the case of significant adverse events to a patient or the facility, the AOD will contact senior management in a timely fashion to apprise them of these events.

F. The AOD provides assistance to Care Line Nurse Executives in their absence concerning staffing to support patient safety.

MEDICAL CENTER POLICY
MEMORANDUM NO. 118CPO-002

July 5, 2005

IV. REFERENCE

M-1, Part I, paragraph 1.57, *Administrative Officer of the Day*.

V. RESCISSION

Medical Center Policy Memorandum Number 118-002, *Administrative Officer of the Day*, dated April 23, 2002.

/elt/

EDGAR L. TUCKER
Medical Center Director