Medical Xpress

'Significant delays' found in treatment of US veterans

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US military veterans were subjected to "significant delays" at a government clinic where up to 1,700 of them may have been kept off waitlists, said an inspector's report released Wednesday.

With a swirling scandal over treatment of wounded warriors growing into a political timebomb for President Barack Obama, the Veterans Administration launched a rapid response probe into allegations staff manipulated scheduling data and that veterans may have died waiting for treatment at a VA clinic in Phoenix, Arizona.

"While our work is not complete, we have substantiated that significant delays in access to care negatively impacted the quality of care at this medical facility," the preliminary report by the VA's Office of Inspector General (OIG) found.

Obama was briefed on the findings and the president considered them "extremely troubling," White House press secretary Jay Carney said.

The VA "should take immediate steps to reach out to veterans who are currently waiting to schedule appointments and make sure that they are getting better access to care now," he added.

Concern centered around accusations that many veterans were shunted onto "secret wait lists," with staff at VA facilities understating wait times for appointments.

The OIG identified some 1,400 veterans who were appropriately placed on the clinic's electronic wait list, or EWL.

"However, we identified an additional 1,700 veterans who were waiting for a primary care appointment but were not on the EWL," it said.

"Most importantly, these veterans were and continue to be at risk of being forgotten or lost in Phoenix Health Care System's convoluted scheduling process."

While an earlier national review of 226 veterans in Phoenix determined their average wait time was 24 days for primary appointments, the OIG found that the same 226 patients waited an average of 115 days for the appointments.

The IG also said that during its on-site work in Phoenix it received "numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility."

Secretary of Veterans Affairs General Eric Shinseki, the man at the heart of the scandal and on whom Republicans have called to resign, said he accepted the findings and found them "reprehensible."

"I am directing that the Phoenix VA Health Care System immediately triage each of the 1,700 veterans identified by the OIG to bring them timely care," Shinseki said.

But the breadth of the accusations and the report's findings drove the most prominent military veteran in Congress, Senator John McCain, to join the growing chorus of lawmakers calling for Shinseki's resignation.

"These are not just administrative problems, these are criminal

problems. We need the FBI and the Department of Justice to get involved," McCain, who represents Arizona, told reporters in Phoenix after the report's release.

"It's time for Secretary Shinseki to step down, and if Secretary Shinseki does not step down voluntarily, then I call on the president... to fire him."