VA hospital delays didn't cause deaths, investigators say

27 August 2014

But draft report still finds unacceptable scheduling problems, according to published report.

(HealthDay)—Investigators with the U.S. Veterans Affairs Department say there's no evidence that any deaths at a Phoenix VA hospital—the center of a nationwide scandal—were caused by delays in care.

A draft report from the VA's Office of Inspector General (OIG) doesn't dispute that there were serious scheduling problems. But the investigators couldn't determine that those lapses in care led to the deaths of scores of patients, which a retired VA doctor had alleged, according to the *Associated Press*.

"It is important to note that while OIG's case reviews in the report document substantial delays in care, and quality-of-care concerns, OIG was unable to conclusively assert that the absence of timely quality care caused the death of these veterans," VA Secretary Robert McDonald said in a memorandum about the report, the *AP* reported.

Last spring, Dr. Samuel Foote, a long-time VA doctor, told Congress that as many as 40 deaths were related to unacceptable scheduling problems that VA employees had concealed. Foote retired last December.

As a result of the allegations, former VA Secretary Eric Shinseki resigned. Subsequently, Congress allocated an extra $16 billion to help remedy some of the problems that had surfaced throughout the VA's national system.

According to the *AP*, Deputy VA Secretary Sloan Gibson confirmed the draft report findings and said delays in care are still commonplace. "They looked to see if there was any causal relationship associated with the delay in care and the death of these veterans and they were unable to find one. But from my perspective, that don't make it OK," Gibson said.

"Veterans were waiting too long for care and there were things being done, there were scheduling improprieties happening at Phoenix and frankly at other locations as well. Those are unacceptable," Gibson added.

Foote charged that VA employees had falsified data to make it appear that waiting times were reduced in the absence of any improvements.

When the Inspector General's office investigated the matter, it found 1,700 veterans waiting for primary care appointments at the Phoenix VA whose names weren't on the waiting list. Gibson said appointments have since been made for those 1,700 veterans. However, another 1,800 veterans in Phoenix who've sought appointments won't be seen for at least 90 days, he said, according to the *AP*.

Gibson said the VA is taking action to improve staffing and health care nationwide, sending more veterans to private doctors and firing personnel involved in administrative blunders and coverups.

For veterans who can't get in to see a doctor at VA hospitals, Congress has allocated $10 billion over three years for private medical care. Legislators also approved $5 billion to hire more VA health care providers and $1.3 billion to set up 27 new VA

clinics nationwide, the news report said.

More information: The U.S. National Library of Medicine has more on health issues faced by veterans.

APA citation: VA hospital delays didn't cause deaths, investigators say (2014, August 27) retrieved 28 January 2022 from https://medicalxpress.com/news/2014-08-va-hospital-didnt-deaths.html