UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-202636

APRIL 16, 1981

The Honorable John Leboutillier
House of Representatives

355

Dear Mr. Leboutillier:

Subject: Alleged Irregularities at the Veterans Administration Medical Center, Manhattan, New York (HRD-81-70)

Your predecessor requested that we review the Veterans Administration's (VA's) investigation of alleged irregularities involving the surgical service at the Manhattan VA Medical Center. As arranged with his office, our review focused on (1) the adequacy of the investigation conducted by VA's Office of Inspector General (OIG) and (2) whether the Manhattan VA Medical Center has corrected the problems identified by the OIG.

The allegations involved were anonymously reported to VA's OIG in April 1979, and included charges that

--surgical, therapeutic, or diagnostic procedures were being performed without informed patient consent and

--surgical procedures were being performed on weekends by medical school residents without an attending physician present, which resulted in amputations, loss of life, and lack of documentation of the events.

Additional allegations concerning questionable activities of the surgical service at the Manhattan Center were made in a series of news articles published in the New York Post.

VA'S INVESTIGATION

VA's OIG investigation was conducted at the Manhattan Center from April 10 through August 17, 1979. In addition to interviewing numerous center officials, employees, and former patients, the OIG selected 60 medical records for review from the center's surgical log and decedent affairs log for January 1978 to May 1979. Also, medical records of three patients specifically identified by the anonymous caller were selected for review.

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The OIG investigation did not address allegations involving quality of patient care and other medical determination issues. These issues were addressed by physicians from VA's Department of Medicine and Surgery who reviewed the medical records of 26 individuals selected by the OIG.

In addition, as suggested by the VA Administrator, an independent panel of three non-Federal surgeons reviewed the activities of the center's surgical service in November 1979.

The allegations concerning (1) informed patient consent, (2) inadequate supervision of medical school residents (the effect of inadequate supervision on quality of care was not evaluated by the OIG), and (3) poor medical record documentation were substantiated by the OIG's investigation.

The review of the 26 medical records by VA's Department of Medicine and Surgery found that patient care was appropriate, well planned, and properly executed. The Department concluded that there was no evidence of unnecessary surgery and no loss of life or limb as a result of inappropriate care.

The Department's conclusions were supported by the review of the three non-Federal physicians, who found no evidence of inadequate or substandard patient care. These physicians noted that the quality of care at the Manhattan Center was comparable with that furnished in other university centers.

GAO'S REVIEW

We reviewed the OIG's September 1979 report summary and its supporting documentation and, on a sample basis, verified the reported data. In addition, our chief medical advisor reviewed the medical records of the 63 patients that the OIG examined. Also, we conducted appropriate interviews and randomly selected and examined the documentation contained in the medical records for 30 of the 372 surgical procedures performed at the Manhattan Center in May 1980.

We believe that the OIG's investigation was adequate, and the center has taken steps to correct the problems identified.

Our review of the 30 surgical procedures performed in May 1980 showed that:

--No consent forms were altered, and written consents were obtained in every instance by resident physicians who were members of either the operating team or the same surgical service or clinical unit as the operating team.

--The medical records indicated that supervision of surgical residents in the operating room met, and sometimes exceeded, the standards of the Manhattan VA Medical Center. Also, the appropriate attending and consulting physicians were present in the hospital when surgery was performed.

--The frequency of progress notes written by attending physicians met accepted hospital standards.

The Manhattan Center director and his chief of staff agreed with our findings.

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As arranged with your predecessor's office, we did not obtain written comments from VA on matters discussed in this report. Copies of this report are being sent to the Chairmen of the House Committees on Appropriations, Government Operations, and Veterans' Affairs; the Chairmen of the Senate Committees on Appropriations, Governmental Affairs, and Veterans' Affairs; the Director, Office of Management and Budget; the Acting Administrator of Veterans Affairs; and the Honorable Lester L. Wolff.

Sincerely yours,

Gregory J. Ahart
Director