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VA's malpractice tab: $845M in 10 years

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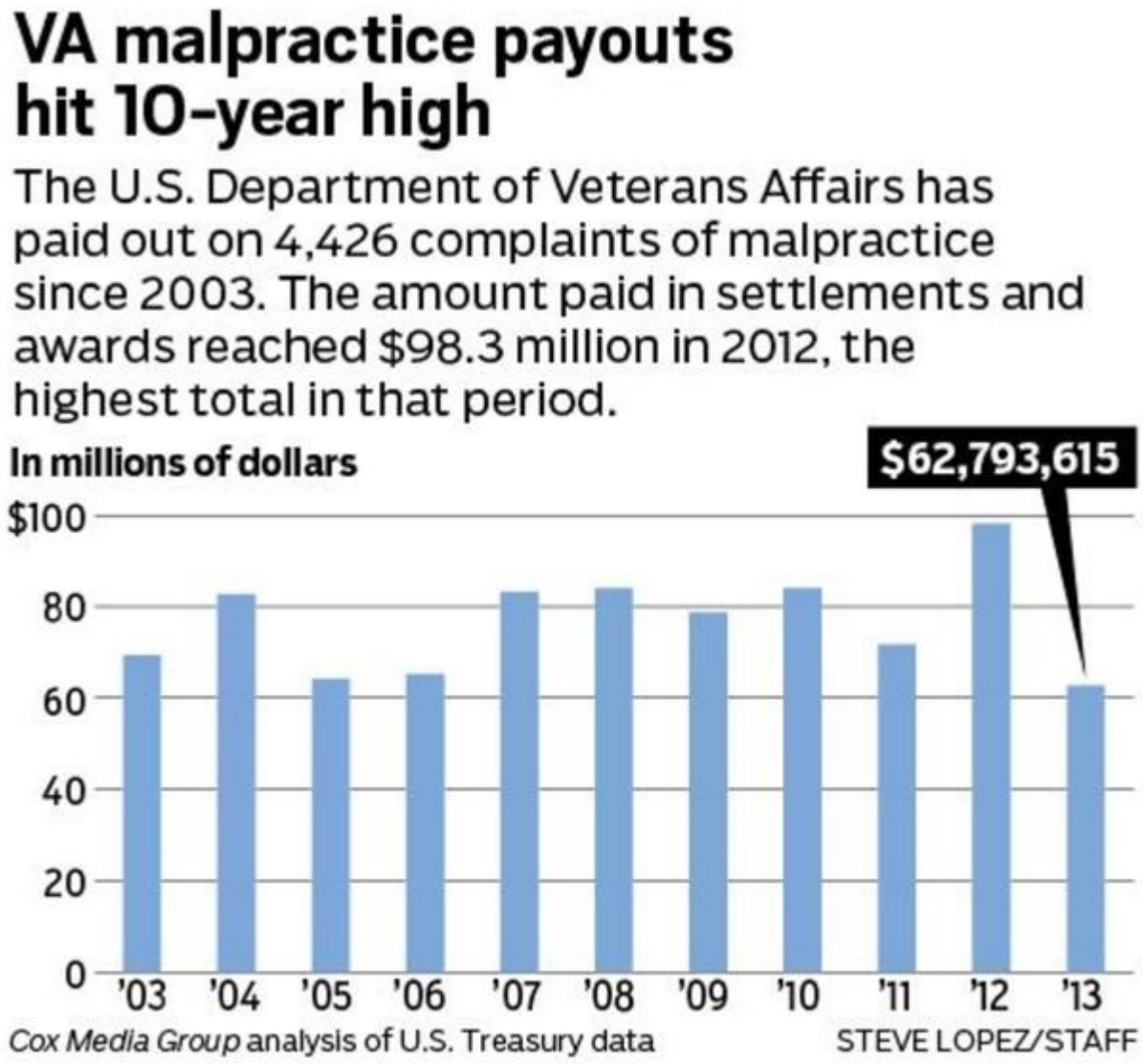

The U.S. Department of Veterans Affairs paid out roughly $845 million in malpractice cases during the past 10 years — a period that has seen the agency face scrutiny for giving bonuses to medical professionals who provided or oversaw substandard care.

The payouts reached a high point in 2012, a Cox Media Group nationwide investigation found, leaving government watchdogs and members of Congress wondering if the VA is learning from its mistakes.

“The VA likes to say they’re accountable. I don’ t believe the word even exists in the VA dictionary,” said Rep. Jeff Miller, R-Florida, chairman of the House Committee on Veterans Affairs.

Cox reporters analyzed federal treasury data that found taxpayers spent more than $800 million paying 4,426 veterans and their family members who brought malpractice claims against the VA medical system since 2003. In 2012, a total of 454 financial settlements and awards added up to $98.3 million.

“This is something that has been going on for close to a decade and yet we haven’t seen major reform happen at the Department of Veterans Affairs,” said Daniel Epstein, executive director of the Washington-based group Cause of Action.

Reporters went behind the numbers to talk to families who said all that money was not worth what led to the payouts: a flag-draped casket or a brave man or woman left broken.

Their stories were wrenching: a 20-year Marine Corps veteran who went in for a tooth extraction and is now paralyzed and unable to talk; the Vietnam War veteran who died from cancer after doctors failed to note evidence in multiple X-rays over three years; the Korean War veteran who went in for a routine biopsy and bled to death without being checked on for hours.

VA officials point out that they manage one of the nation’s largest medical networks, and say the number of malpractice claims are relatively low. In 2012, the VA treated more than 6.3 million veterans and had only 1,544 claims filed.

Dr. Anupam Jena, an assistant professor at Harvard University, noted that the VA pays out on about 25 percent of claims. Meanwhile, private sector health systems pay out for about 20 percent,

according to a study he participated in of 40,000 doctors published in The New England Journal of Medicine.
“Are VA doctors worse than other doctors?” he said. “No.”

But the 454 payments issued in 2012 are the second most in 10 years, eclipsed only by 462 payouts in 2008.

“It’s very apparent because of the spike in payouts that have been happening over a number of years that they’re woefully falling behind on a curve that they never should be behind in the first place,” Miller said.

‘Something should change’
The veterans’ stories often start the same.

“He trusted them all,” said Veronica Boritz. “Bill always felt that the Air Force had promised him care as he grew older, and that was where he should go, so he did.”

Bill was a retired Air Force captain who flew B-52s in Vietnam. He went to the VA medical center in nearby Atlanta with a heart arrhythmia, and underwent a laser surgery that accidently punctured his heart.

That was only the beginning. Bill was treated and released, but repeatedly went to the emergency room because of dizziness. He was placed on several medications. During his final ER visit it was discovered that his organs were failing and his heart was still bleeding. Doctors told Veronica they would do emergency surgery.

“Shortly after that I was out in the hallway and the alarms went off. And I kept telling myself it wasn’t Bill,” she said.

But it was.

“He wasn’t just somebody I knew who died. He was my whole life,” she said.

She asked for an autopsy and the hospital did an internal investigation that found he died from neglect, she said. After years of legal wrangling with the VA, she accepted a $300,000 settlment.

It doesn't feel like justice, Boritz said. The doctor who she said made the fatal mistake was never held liable. Unlike in private practice, federal rules say she could only bring a malpractice suit against the VA, not the doctor.
"I think that seems an intrinsic right. The person who did the damage should suffer something," she said. "Something should change. Someone should be held accountable."

Poor performance rewarded

While being protected from malpractice lawsuits, VA doctors, nurses and administrators routinely receive pay raises and transfers the same year they are found to have provided substandard care. A U.S. Government Accountability Office report in July found that in 2011 the VA gave performance bonuses and awards totaling $160 million to medical providers without adequately linking that extra pay to their performance.

The performance bonuses averaging $8,049 went to 18,500 medical providers – or about 80 percent of the total of eligible providers. Performance awards averaging $2,587 went to about 20 percent. Federal auditors looked at records from VA centers in Georgia, Maine, Texas and Washington and found several examples of providers who made mistakes still getting bonuses. They included:

- A radiologist who failed to read mammograms competently, but received a bonus of $8,216.
- A surgeon who received $11,819 after he was suspended without pay for two weeks for leaving a surgery early.
- A physician who refused to see emergency room patients in the order they were given to him, leaving some waiting more than 6 hours, but he got a $7,500 bonus.
- A physician who practiced with an expired license for three months but received a $7,663 bonus.

Bonuses also went to VA hospital administrators who oversaw massive failures at their medical centers. They included:

- The man who oversaw the Pittsburgh VA during a legionnaires outbreak that led to five veterans dying and 21 becoming ill, received a $62,895 service award shortly after the outbreak was revealed.
- An Atlanta VA Medical Center director pocketed a $13,000 bonus in 2011 and another $17,000 worth of salary bonuses in 2010 while an audit found management problems contributed to two veterans committing suicide.
- The director of the Dayton VA Medical Center received an $11,874 bonus in 2010 and was transferred to a headquarters job in 2011 following revelations that a dentist there failed to change gloves and sterilize equipment between procedures for more than a decade, putting possibly thousands of veterans at risk.

Not only are these doctors and administrators not named in malpractice suits, but the money to pay malpractice claims doesn't even come out of the VA budget. It comes out of a federal treasury fund set aside to pay legal settlements against the government.

"They use bonuses like handing out candy at the VA," said Rep. Miller. "You usually discipline somebody by removing them from the position that they're in, and that's not the VA's modus operandi. They move them to another hospital somewhere.

"I don't know if removing the immunity is the way to go, but certainly having them feel the pain of these settlements or these awards being given out, I think is probably the only step that's going to make a difference."

Tooth extraction leaves veteran paralyzed

The largest malpractice payout in 10 years was for $17.5 million. It was awarded in 2012 to a Philadelphia Marine Corps veteran left permanently paralyzed by a routine tooth extraction. Christopher Ellison, who had served in the military for 20 years, went to the Philadelphia VA in 2007 to have several teeth removed. His blood pressure was dangerously low, but physicians went ahead with the procedure. He had a catastrophic stroke on his drive home and crashed his car two-tenths of a mile from the VA.

Home video supplied by Ellison's family shows the extent of his brain damage. He struggles to walk, communicate, or even peel a banana on his own. He requires around-the-clock care.

"I've never had a client where he wouldn't have traded the money he received to for the injury," said Ellison's attorney, **Shanin Specter**. "The injury is always worse than the benefit of the financial compensation."

Another large payout went to J.R. Howell, who was rushed to the Memphis VA emergency room in 2006 with abdominal pain, then sent home without a proper diagnosis. A neighbor stopped by to check on him at home and found him unresponsive.

"She said, 'Honestly I thought you were dead,' " he said.

He was rushed to the hospital again and ended up in a coma. When he awoke he was partially paralyzed. He was awarded $5.7 million last year.

Howell was drafted during the Vietnam War.
“We’ve seen battle. We’ve seen combat. And why do we have to come back home and fight when we come back home just to get proper medical care?” he said.

When Army veteran Thaddeus Raysor had an X-ray done at the North Florida/South Georgia Veterans Health System in August 2006, his widow said the staff failed to diagnose a 1-centimeter lesion on his left lung. They missed it again in 2007. By November 2008, it had grown to 8 centimeters, and the radiologist referred it for further evaluation.

But the studies weren’t ordered, and Raysor wasn’t told, according to his family.

By August 2009, a final X-ray showed the mass had grown to 9.5 centimeters and spread through both lungs. Raysor died Nov. 14, 2009, more than three years after his initial X-ray.

His family was awarded $875,000 last year.

VA responds
Department of Veterans Affairs officials declined to be interviewed for this story. Instead the agency issued a statement that read in part:
“VA takes this issue very seriously and Veterans Health Administration (VHA) personnel remain committed to maintaining a high level of quality care, transparency and accountability.”

Agency analyses of patient mortality and safety have found that VA medical centers outperform top health systems across the country, according to agency officials.

Unlike private sector hospitals, the VA system has a built-in process for making malpractice claims. It starts with an administrative claim that must be filed within two years of when the mistake took place. The VA has six months to offer a settlement before the claimant can take the issue to court. U.S. Rep. Phil Gingrey, a licensed OB-GYN, expressed concern that VA doctors are largely held unaccountable because incidents are not even reported to state medical boards.

“They’re not worried about losing their medical license, or worried about their hospital privileges being suspended, or their contract to work in that facility not being renewed, which is all applicable in

the private sector," said the Georgia Republican.

The VA embraces a disclosure policy that informs patients when the hospital becomes aware of an accident, negligence or even a near miss.
Attorneys interviewed for this story said the VA's disclosure policy likely cuts down on claims, as does the law limiting attorney fees to 20 percent of settlements or 25 percent of awards — which keeps some attorneys from taking cases. This is in addition to limits in some states on malpractice awards.

"(This) ends up hurting patients who are badly injured as a result of real malpractice," said Niley Dorit, who represents malpractice claims in California, which also limits total malpractice awards at $250,000.

Dorit represented John Lee Mackey, an Army veteran who died in 2009 after he went into the hospital with dehydration and doctors accidentally ran a catheter into his heart.

Bleeding to death
Veterans' family members interviewed for this story said they had to be their own advocate in asking for medical records and investigations.

"I found out by reading the reports, which were thick as a book, on the things that they didn't do," said Virginia Pennington, who said the Dayton VA, where her husband Charles died, did not fess up. Charles went into the hospital because he wasn't feeling well, and a blood test led to a liver biopsy. It seemed a routine procedure, so Virginia went home. When her phone rang the next morning, she assumed it was her husband letting her know how it went. Instead it was the hospital informing her he was dead.

"And so I didn't get to talk to him," she said. "Maybe if I would have been there I would have known they weren't taking care of him, and it could be corrected at that time."

The blood thinner the Air Force veteran was on led him to bleed to death in a hospital room where he wasn't checked on for hours after his surgery, she said.

"The records said he was supposed to be checked every half hour," she said, "and the records said, when we received them, that they hadn't checked on him at all."

Pennington settled for a $150,000 payout.

Ohio attorney Stephen O'Keefe, who specializes in VA malpractice claims, said he expects the dollar amount to rise as the VA handles a younger population returning from Afghanistan and Iraq. More money is awarded if the affected veteran is younger.

"I think you will continue to see an uptick in payouts," O'Keefe said. "In an ideal world, I would like to see my job go away, where people don't need an attorney to assist them when they have been injured by a physician or a nurse. But the reality is that's never going to happen.

"When there are humans in the system there are going to be errors."

The questions become, according to Cause of Action's Epstein: Why are the payouts increasing, and what is the VA doing to solve the problem?

"If it's the case that it isn't waste, fraud and abuse of our federal dollars, it's the (VA's) responsibly to disclose that, and explain why."

Reporter Craig Schneider contributed to this report.