GAO

United States
General Accounting Office
Washington, D.C. 20548

Office of Special Investigations

B-282124

March 19, 1999

The Honorable Harry Reid
United States Senate

Subject: Department of Veterans Affairs: Alleged Improper Personnel Practices at the Ambulatory Care Center in Las Vegas, Nevada

Dear Senator Reid:

This letter responds to your December 1, 1998, request that we investigate alleged improper personnel practices by the Department of Veterans Affairs (VA) at the Addeliar D. Guy III VA Ambulatory Care Center in Las Vegas, Nevada. Specifically, your office received information from several Las Vegas veterans organizations alleging that the ambulatory center's Chief of Staff, Dr. Anthony Salem, maintains a "hit list" for the purpose of disciplining or terminating ambulatory center employees who are known to be strong advocates of health care for veterans.

In summary, we found insufficient evidence to substantiate the allegation of a hit list. However, a number of the individuals we interviewed during the course of our investigation raised concerns about the quality of health care at the center, which we describe in this letter. These concerns have been referred to the VA Office of Inspector General.

Background

The Addeliar D. Guy III VA Ambulatory Care Center opened in August 1997 as a state-of-the-art facility that includes a nuclear radiology capability, an ambulatory surgery suite, and a women's center. It is one of five components of the Las Vegas VA Medical Center, which serves nearly 200,000 veterans. The other components are the Michael O'Callaghan Federal Hospital, which provides intensive, medical-surgical, and psychiatric care; a day treatment center; an outreach center; and a readjustment counseling service.

Insufficient Evidence of a "Hit List"

Representatives of several veterans organizations alleged in a November 1998 letter to your office that nine employees of the Addeliar D. Guy III VA Ambulatory Care Center had been

threatened with termination or discipline by the ambulatory center's Chief of Staff for being strong advocates of veterans.

Six employees named in the letter told us that the Chief of Staff had not threatened them with disciplinary action or job removal. Indeed, three of these employees were unaware that they had been named in the letter as targets of the Chief of Staff. Furthermore, the Chief of Staff had high praise for the performance of several of these employees.

The remaining three employees told us that the Chief of Staff had threatened them with dismissal or reassignment based on poor performance; but they asserted that the real reason for the Chief of Staff's actions was their outspoken support of health care for veterans. The Chief of Staff told us that he had removed one of these employees as the acting Chief of Radiology and reassigned her to a staff radiologist position because of ineffective management. He confirmed that he had threatened to fire another doctor because he had received numerous patient complaints concerning the employee's job performance. He also confirmed that he had put a third employee on notice that if his performance did not improve, he would take the necessary steps to remove him. This employee told us that the Chief of Staff had assigned him additional duties, which he refused to do. He stated that he had filed an Equal Employment Opportunity complaint against the Chief of Staff for harassment, which was resolved through the Alternative Dispute Resolution process. The ambulatory center Director told us he supported the Chief of Staff's decision to make changes in the radiology department and confirmed that his office had received many complaints about the second employee discussed above. The ambulatory center Director did not express a view about the third employee.

Although none of the persons we interviewed could provide sufficient support for the allegation that the Chief of Staff had a hit list, many of the people we interviewed believed that such a list exists. The Chief of Staff's management style, described by center employees as confrontational, and low employee morale contributed to this opinion. In addition, the Chief of Staff's criticism of several center employees for sending e-mail messages that complained about the lack of proper health care for veterans or advised patients to contact their congressional representatives helped to foster this view. Although the Chief of Staff denied the existence of a hit list, he stated that he understood how his statements and management style could have contributed to the belief that such a list exists.

Health Care Issues Raised During the Investigation

During the course of our investigation, ambulatory center employees and representatives of veterans organizations raised concerns about the quality of care administered at the ambulatory center and other components of the Las Vegas VA Medical Center. Among other things, they noted the following:

- lack of specialty care in such areas as cardiology and urology,
- lack of MRI (magnetic resonance imaging) or mammogram service at the ambulatory center,

- nonuse of an electroencephalograph machine in the neurology department,
- excessive waits by patients having medical appointments,
- failure to fix airflow in surgical suites,
- difficulty in recruiting doctors and nurses, and
- excessive reimbursement to the U.S. Air Force for services performed by the Michael O'Callaghan Federal Hospital.

We did not independently investigate any of the health care concerns raised during our investigation. However, ambulatory center management acknowledged their existence and agreed to take actions regarding them. The ambulatory center Director told us that, among other things, he would review specialty care, reimbursement, and other arrangements between the Las Vegas VA ambulatory center and the Michael O'Callaghan Federal Hospital. He stated that VA expects to correct the airflow problem in the ambulatory center's surgical suites by July 1999. The Director also stated that to improve dissemination of information and reduce "rumors" about a hit list, he would work with veterans organizations and hold town hall-type meetings with ambulatory center staff. The Chief of Staff outlined his goals, including expanded specialty care sessions, improved overall clinic operation, and increased resident doctor training.

Scope and Methodology

We conducted our investigation from December 1998 to February 1999 at the Addeliar D. Guy III VA Ambulatory Care Center in Las Vegas. During our visits to the ambulatory center, we interviewed the nine employees identified in your December 1, 1998, letter; the ambulatory center's Chief of Staff; other center managers; cognizant medical staff; and several members of advocacy groups for veterans.

We will provide copies of this letter to the Department of Veterans Affairs and will make copies available to others upon request. If you have any questions or need additional information, please contact Assistant Director Stephen Iannucci at (202) 512-6722.

Sincerely yours,

Robert H. Hast
Acting Assistant Comptroller
General for Special Investigations

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