Administrative Closure
Primary Care Provider Concerns at the
Robert J. Dole VA Medical Center (589A7/000)
Wichita, Kansas
MCI# 2014-04437-HI-0588

On July 15, 2014, Congressman Tim Huelskamp sent a letter to the Acting VA Inspector General that included three allegations brought to the Representative's attention by anonymous Robert J. Dole VA Medical Center (Wichita VAMC), Wichita, Kansas, staff. Allegation 1 concerned schedule "gaming." Allegation 2 concerned access to care and the quality of care in the primary care clinic. Allegation 3 stated "several of the doctors (b)(6) at the Wichita VAMC refuse to touch patients during examinations."

On August 8, the Deputy Assistant Inspector General, Office of Healthcare Inspections, emailed the Director of the Kansas City Regional Office of Healthcare Inspections and requested that the office review Allegation 3 while on site during a planned Combined Assessment Program Review at the Wichita VAMC scheduled to commence August 11.

On August 11 and 12, we interviewed the Wichita VAMC Director, Chief of Staff, Associate Chief of Staff for Primary Care Operations, Quality Management Director, Quality Management Survey Coordinator, Patient Safety Director, Patient Advocate, and primary care nursing and physician staff. We also reviewed patient safety duty to report documents, patient advocate complaint data, and the results of two Wichita VAMC patient surveys conducted by VAMC staff in December 2010 and November 2011specifically to investigate similar allegations.

We learned (b)(6) physician had made this allegation to Wichita leadership through the duty to report system in 2010 and again in 2011. Specifically, the allegation concerned (b)(6). Both times, without advance notice to primary care providers, the Chief of Staff conducted patient surveys and asked, among other questions, whether or not the provider physically examined them. Each time, the allegation was not supported by actual patient reports. All primary care providers were also directly observed conducting physical examinations of patients, and the observations did not support the allegation. In addition, the Chief of Staff met with all primary care providers in person and/or through video conferencing to discuss the allegation, engage discussion, and emphasize the importance of physical examination.

The Associate Chief of Staff for Primary Care Operations, (b)(6) (b)(6), told us she expects all primary care providers, (b)(6) to touch their patients. She stated touching patients is an internal medicine expectation, and conducting a thorough examination without touching a patient is not acceptable. (b)(6) (b)(6) (b)(6) The patient advocate provided fiscal year 2014 patient complaint data, and there were no complaints concerning providers not touching patients.

(b)(6)

(b)(6). We learned the (b)(6) has a history of reviewing their medical record care and documentation extremely thoroughly and reporting items the physician determines is insufficient. A few peer reviews have resulted. In response, some primary care physicians began doing similar record reviews after their patients received ED care from the physician and reported care they determined was insufficient. Some of those resulted in peer reviews as well. (b)(6) (b)(6).

The Wichita Chief of Staff and Director and the VISN Director have discussed this and have also met individually with the involved staff to attempt reconciliation. (b)(6) (b)(6)

Because the facility initiated appropriate actions to investigate the allegation prior to our review, I am administratively closing this case.

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Assistant Inspector General for
Healthcare Inspections