11/9/09

Memorandum to the File-Administrative Closure

Allegation of a Physician Overmedicating Mental Health Patients
Malcolm Randall VAMC, NF/ SGVHS (Valdosta CBOC)
MCI: 2009-00313-HI-0018

On October 29, 2008, the Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections received an anonymous complaint that Malcolm Randall VAMC, Valdosta Community Based Outpatient Clinic (CBOC) psychiatrist has been overmedicating his (mostly female) patients, over the last year, but particularly within the last six months. The complainant alleges that as a result of overmedicating, several patients lost their jobs and some required hospitalization in non–VA facilities. The complainant also stated that a Greenleaf Center (non-VA facility) psychiatrist (no name provided) expressed concerns about the patients admitted to the facility because of the psychiatrist's overmedicating. The complainant provided the names for seven patients treated by the psychiatrist.

Methodology

We reviewed the medical records for six of the seven patients. We were unable to identify one of the patients due to erroneous identifying information. We reviewed an additional 15 randomly selected patients from the psychiatrist's clinic panel of 764 patients. We reviewed the VetPro files and patient advocate reports for the psychiatrist. We interviewed the psychiatrist, his supervisors and pertinent CBOC staff. For collateral review, we the psychiatrist's supervisor also reviewed the medical records of the six patients listed in the complaint.

Results

The psychiatrist was hired in 2007 as a staff psychiatrist for the Valdosta CBOC. We found that there were no peer reviews or patient advocate complaints against the psychiatrist. (b)(6); spoke on the condition of anonymity and expressed her concerns about the psychiatrist's prescribing practices and her observation that some patients got worse after starting his treatment regimen. She reported that the psychiatrist is more likely to prescribe multiple medications than therapy. (b)(6); (b)(6); She also stated that some patients had complained to the Patient Advocate and/or transferred to Lake City VA.[1] Management and other Valdosta CBOC staff did not report any problems regarding the psychiatrist's prescribing practices or patient care. The Associate Chief of Staff for remote clinics had recently named the psychiatrist as acting Chief Medical Officer for the Valdosta CBOC, describing him as the "most capable".
We found no evidence that overmedication caused any of the (identified or sampled) employed patients to lose their job. Due to the anonymous nature of the complaint and a lack of information, we could not contact the Greenleaf Center psychiatrist.

We found that the psychiatrist prescribed Tricyclics alone or with other sedating agents (benzodiazepines) with limited documentation regarding the rationale for the drug choice. We noted instances of Tricyclics

[1] We requested all patient advocate reports for the Valdosta CBOC. None of the seven complaints listed pertained to the psychiatrist.

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prescribed without the recommended electrocardiogram.[2] However, we found no evidence of inappropriate use of psychotropic agents or excessive dosages. The psychiatrist's psychotropic selections may not reflect the most up to date prescribing practice, but it does not rise to the level of reasonable concerns for the safety of the patients and did not fall outside the community reasonable standards of care. The psychiatrist's supervisor concurred with our findings and agreed to meet with the psychiatrist and submit a plan of action to the OHI.

The supervisor met with the psychiatrist on September 30, 2009 to discuss the results of the chart reviews and patient care in general. On October 15, the supervisor provided a statement indicating "The meeting was productive, cordial and mutually informative. We discussed his use of tricyclic antidepressant medications alone and in combinations with other potentially-sedating agents and in combinations themselves (Clomipramine in addition to Doxepin or Amitriptyline - the latter two as sleeping agents in appropriate doses or as adjuncts for treatment of chronic pain). The psychiatrist did agree that in the group of patients reviewed, there was opportunity for the patients to use medications in doses larger than recommended and in combinations not authorized, possibly resulting in undesired sedation. We discussed the advisability of routine laboratory evaluations and cardiograms for patients on tricyclic therapy and on the range ofpsychotropics he tended to use."

He stated that the psychiatrist provided a "broad, comprehensive understanding" of the medications and provided good care overall. He also stated (as an aside), that the newly appointed Chief of Psychiatry for the Gainesville Medical Center was impressed with the psychiatrist's clinical and psychopharmacological knowledge. They do not plan any Peer Review activities regarding the psychiatrist.

Conclusion

The supervisor stated that, unrelated to our investigation, the psychiatrist resigned to accept a position at a private facility in New Jesey effective October 30. Based on the above information and concurrence with OIG51, we are administratively closing this hotline.

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Office of Healthcare Inspections
October 15, 2009

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Office of Healthcare Inspections

[2]Tricyclics can cause cardiovascular effects in patients with preexisting heart disease. Electrocardiograms can identify abnormal cardiac rhythms.