USA TODAY TMI

'I no longer trust them to fix me when I'm broken'

VETERANS STILL SUFFERING FROM POOR VA CARE DESPITE FIXES TOUTED IN WASHINGTON

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OKLAHOMA CITY — Sometimes an affliction that's right there, plain to see, is overlooked, despite the best intentions.

So it was for Charles Hand and George Washington Purifoy, two men who served their country but whose country failed them.

Both sought care at Veterans' Affairs medical facilities in Oklahoma. And in their cases and others, medical professionals missed or misdiagnosed their conditions resulting in life-altering consequences.

Hand and Purifoy are two of an untold number of veterans still suffering from shortfalls in care at the VA. Their stories suggest that the government's attempted fixes have not yet translated into better health care for veterans at facilities across the country.

The VA has struggled to meet unprecedented demand as new waves of veterans with complex needs return from the wars in Iraq and Afghanistan at the same time Vietnam veterans are aging and requiring more care. Its failures have played out in crisis after crisis in recent years, from the benefit-claims backlog that reached more than a half million applications in 2013 to the revelation last year that patient wait-time records were manipulated while veterans died waiting for care.

George Purifoy, a 65-year-old Vietnam veteran has been missing the majority of his nose since 2013.
(Photo: Shane Bevel for USA TODAY)

“I’m not going to roll over and die just because the VA’s not taking care of me and other veterans.”

Former VA secretary Eric Shinseki stepped down, President Obama installed a new secretary, and Congress passed legislation trying to fix the agency. But on the front lines, it can be hard to tell the difference.

The Oklahoma City VA Medical Center has had five directors in three years and is awaiting the appointment of a sixth. By the VA’s own statistics, the facility has consistently ranked among the lowest performing in the country — one out of five stars. Measures of patient safety — the rates of in-hospital complications and adverse events following surgeries and procedures — are among the highest of VA facilities across the country, as are mortality rates for patients suffering from pneumonia or congestive heart failure. The Oklahoma City VA also has among the highest turnover rates for registered nurses.

When Purifoy, 65, originally complained of severe pain after radiation therapy damaged the bone under his nose, VA clinicians in Muskogee and Tulsa, Okla., thought it was a dental problem and sent him for root canals and other procedures. Now, he has no nose, no front teeth, and he’s still in debilitating pain.

The Oklahoma City Veterans' Affairs Medical Center treats 60,000 veterans annually.
(Photo: Donovan Slack, USA TODAY)

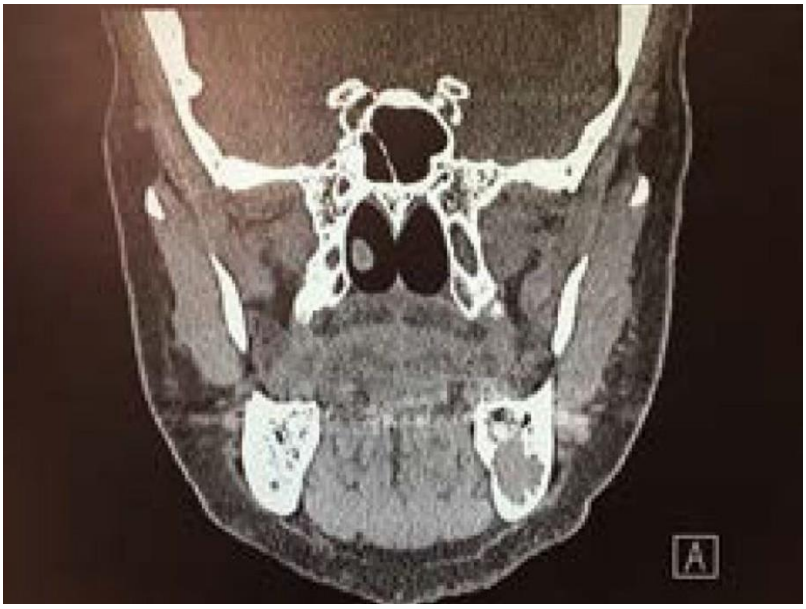
Last year, Congress passed the Choice Act designed to allow veterans to seek care in the private sector if their local VA could not meet their needs. Yet the Oklahoma City VA is forcing Purifoy to travel for treatment to a VA facility in Shreveport, La. — a six-hour drive from his home — even though a non-VA hospital is literally across the street.

“I really can’t tell you how I do it,” Purifoy said. “I ignore the pain. I just know I’ve got to live one way or the other. I mean, I’m not going to roll over and die just because the VA’s not taking care of me and other veterans.”

The VA says it has hired more than 1,500 doctors in the past year to increase access to care. Yet the agency says there still is no VA surgeon in the state of Oklahoma who can treat him.

When Hand, 90, went to the emergency room at the Oklahoma City VA in September 2014 after a fall, a mass in his jaw was clearly visible on a CT scan taken at the time. But he was told everything was fine — there were no fractures. It was actually cancer. It has now spread to his liver and lungs.

When his primary care doctor finally decided something might be wrong with his jaw — five months after the tumor was missed on the scan — it took another four months for the VA to diagnose the cancer.



A CT scan of Charles Hand's jaw in September 2014 shows a tumor in his left, front jaw.
(Photo: Courtesy Charles Hand)

“Now my wife and my son will tell you that I’m a sweet, lovable, pliable, easy-to-get-along-with fellow, but there’s some things that bug me,” Hand said. “And that bugged me extremely.”

VA officials say that since Secretary Bob McDonald took over in July 2014, they have initiated supervisor training to protect whistleblowers trying to report problems. But after a doctor — who was inspired to join the VA after the wait-time scandal last year -- repeatedly tried to report lapses in Hand’s, Purifoy’s and other patients’ care, Oklahoma City VA officials turned around and launched an investigation of the doctor.

An independent specialist who reviewed five cases, including Hand’s and Purifoy’s, at the request of USA TODAY found that their care was “tragic” and “unbelievable.”

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“I don’t know if there are others — there probably are, but it just seems like there’s a lot of miscommunication among the departments, a lot of lost time where patients come for appointments and the doctors they’re supposed to see are not there, a lot of people managing things but missing the big

picture," said Dr. Marci Levine, an oral and maxillofacial surgeon and professor at New York University's College of Dentistry. "And then the patients are obviously suffering at the end."

The failures she identified are not unique to the Oklahoma City VA, according an independent assessment by consultants at McKinsey & Co. "(M)ost areas of the organization show a highly risk-averse culture; lack of role clarity; fragmentation and organizational silos; and breakdowns in communication, accountability, and key processes that impair the organization's ability to deliver the mission," they wrote in a report issued in September.

In a statement issued by VA spokeswoman Walinda West, agency officials said they initiated reviews of the five patient cases in response to USA TODAY inquiries. They said problems in Oklahoma were not reflective of the system as a whole and pointed to a recent survey by one advocacy group that found 80 percent of veterans were satisfied with VA care. "Do we have room to improve at VA? Yes, we do, and VA continues to evolve as an integrative health care system, modernizing processes and capabilities to put the needs of veterans first," the statement said. "Our job is to understand what led to the improper care and make corrections."

Chapter 1

HEEDING THE CALL

McDonald, in an interview outlining his plans to turn around the VA on "60 Minutes" in November 2014, inspired a surgeon in private practice in Boulder, Colo., to help. Within two months, Eve Bluestein had moved to Oklahoma City to start work at the VA. She had no idea, though, what a tough mission she had signed up for.

Within days, Bluestein began encountering problems. The operating room wasn't equipped with necessary instruments, there was a paucity of staff trained well enough to assist her, and she said patients did not receive follow-up appointments after surgery but rather were told to call if they had

problems. Bluestein regularly dashed off increasingly urgent memos to her bosses. “I AM DISCOVERING THAT I DO NOT HAVE THE TIME OR RESOURCES TO PERFORM MY JOB PROPERLY,” read one she wrote in late February for a meeting with her supervisor, Dr. Shakiba Nasser.

Bluestein said each week, it seemed another patient who had been neglected, misdiagnosed or mistreated in some other way by the VA arrived in her office.

Dr. Eve Bluestein was inspired to close her private practice after 14 years and go to work at the VA after watching Secretary Bob McDonald on "60 Minutes" last fall.
(Photo: Shane Bevel for USA TODAY)

There was Purifoy, who was so desperate for care that clinicians at one point called in a suicide-prevention team to ensure he didn’t take his own life. In public, he wears a mask that covers the gaping hole in the middle of his face, but people still recoil when they see him. “Little kids, I see them tug their moms and dads,” he said.

And there was Hand. He had contacted the Oklahoma City VA twice in the months after providers overlooked his tumor on the CT scan, once because he was having trouble swallowing and the second time because his jaw had gone numb. Doctors prescribed throat lozenges and medication for a possible nerve condition. He eventually saw a neurologist, an ear, nose and throat specialist and then Bluestein, who was the first to review the earlier scan and conclude it was likely metastatic cancer. That was in May – eight months after the CT scan was taken in the emergency room.

George Purifoy served in Vietnam. He had his nose removed in 2013 after a bout with nasal cancer.
(Photo: Courtesy George Purifoy)

“I was very upset that it had been on there and nobody had said anything earlier,” Hand’s son Mike said. “And of course my thought was, well, OK, if we’d have known about this back in September, and started on treatment, would the tumor be, would it be gone?”

Chapter 2

MISSION CRITICAL

Kevin Davis, 51, who helped install runway lights in Baghdad during the Gulf War, fell on hard times after leaving the service and found himself homeless in 2012. Davis took advantage of a special VA program that year to have all his teeth extracted and dentures made. But he developed a persistent infection that went undiagnosed for three years, despite being visible on an X-ray taken at the Oklahoma City VA four months after the extractions.

In December last year, he returned with a swollen face but was denied care. He was told the homeless program only covered his initial extractions. “(As) I was in the process of relaying this information to the patient, he interrupted me and said this was our fault and he would get to the bottom of this himself and hung up on me,” a dental assistant wrote in his chart.

When he finally made it in to see Bluestein two months later, the infection had progressed so far that she had to remove a large portion of his right lower jaw and replace it with a plate.

“I no longer trust them to fix me when I’m broken. And, you know, a 70-year old man get(s) broken.”

Stanley Christian Jr. piloted helicopter gunships in Vietnam and proudly recounts his unit’s strafing of enemies during the Tet Offensive, one of the largest campaigns of the war. But he breaks down in tears when he talks about the Oklahoma City VA. “I no longer trust them to fix me when I’m broken,” he said. “And, you know, a 70-year old man get(s) broken.”

Christian had complained to the VA in 2010 that he felt there was something wrong with his upper right jaw, like he had a broken tooth and was getting food caught up there. An X-ray at the time showed no bone behind his back upper right tooth, but he was told he had chronic gum disease and should brush and floss better.

Four years later, the VA finally discovered the likely cause, thanks to a scan performed in the private sector. He had had an aggressive cyst that had grown to encompass large areas of bone by that time. Surgeries to remove it created a hole between his sinus and mouth that he is still suffering from. Every time he drinks, the liquid comes out his nose, and he is in danger of contracting an infection that could spread to his brain.

Bluestein says she continued trying to register complaints about the cases with her direct boss, the center's chief of staff and director. She became so frustrated by May, she alerted the House Committee

on Veterans' Affairs. Still, the VA didn't investigate the cases. On June 9, hours after she emailed her supervisors to say she planned to pull case files herself for investigation, Oklahoma City VA officials placed her on administrative leave, escorted her out of the building and barred her from returning without a police escort.

She resigned a few weeks later and returned to private practice in Colorado. VA officials in Oklahoma City now are alleging she provided inadequate care, a charge she is fighting with the help of the Office of Special Counsel.

Chapter 3

'THE THING WITH THE VA'

Levine, the surgeon who reviewed the cases at the request of USA TODAY, concluded the VA missed Hand's tumor, Davis's infection, and Purifoy's bone ailment. She said VA clinicians should have done more to investigate Christian's cyst and done a better job trying to repair the hole between his mouth and sinus.

"I think the overwhelming theme among the cases is that the patients had a lot of complications …that may not have been so extreme had they been able to receive care in a much more efficient manner," she said. "It's really unfortunate."

The VA declined to comment on Bluestein without her written permission, something she did not provide on the advice of counsel.

In the statement issued by West, the VA spokeswoman, officials said preliminary reviews confirmed clinicians missed Hand's tumor. They did not address the 2012 X-ray of Davis, whose infected right jaw went undiagnosed for the next three years, but they confirmed it was present on a 2013 scan, a "missed diagnosis on the part of radiology." In Christian's case, they said a review found "most experienced, competent practitioners might have handled the case differently." With Purifoy, they said Oklahoma City VA officials were unaware of any misdiagnoses. They said much of his care was provided by VA facilities in Tulsa and Muskogee, Okla.

VA officials declined to respond to follow-up questions, saying the cases still are under review. The agency said it also would send the cases to a third-party investigator to determine if VA care fell short.

VA officials launched investigations of five patient cases in response to inquiries from USA TODAY.
(Photo: Donovan Slack, USA TODAY)

VA officials said in the statement issued by West that the Oklahoma City Medical Center is trying to recruit more doctors and says it has a plan to improve its ranking within the VA system on patient care. When asked why the center had cycled through so many directors in recent years, they said “employees choose to leave for various reasons, but our goal remains steadfast.”

“Medical staff at the Oklahoma City VA Healthcare System are dedicated to providing the best care possible as they ensure veterans are getting the care they need,” the statement said. ”Our mission is to take care of veterans and we remain focused on providing them the best care possible.”

As the medical center undertakes its plan for improvement, some of its patients still are struggling. William Benthin, a 76-year-old Vietnam veteran, has been in excruciating pain for months. His left jaw is dying, a side effect from medication, and when he opens his mouth, the decaying bone, still covered with nerves, is exposed and visible.

The Oklahoma City VA for months has denied him surgery that could ease his pain. If he wanted a second opinion, VA providers told him he could go to the facility six hours away in Shreveport. After receiving inquiries from USA TODAY, they told him he could see someone else. At the non-VA hospital across the street.

“The thing with the VA, they’re supposed to take care of me medically for the rest of my life,” Benthin said. “They promised me health care, and I figured they would take care of me, but so far they haven’t.”