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VA whistleblower says mental health care lacking in St. Louis

Blythe Bernhard May 13, 2014

John Cochran VA Hospital in St. Louis....

The former chief of psychiatry for the St. Louis VA hospital system claims he was demoted after complaining about an “artificial backlog” of mental health care created by staff members who treated patients just a few hours a day.

Veterans can wait a month or longer for mental health treatment in St. Louis because of the lax scheduling, said Dr. Jose Mathews.

“No one is working even close to a reasonable day’s work,” Mathews said. “It seems like that’s the norm here, and everyone seems to be OK with it except the veterans.”

Mathews filed a federal whistleblower complaint last year and said he worked for nine months to change the system before he was moved into a basement office to evaluate veterans’ disability claims.

“It’s more like a conveyor belt here,” Mathews said. “I got complaints that I’m spending too much time with the veterans. It’s just bizarre.”

Marcena Gunter, a spokeswoman for the hospital, said the complaints are under investigation.

“We take these allegations seriously,” Gunter said in a statement. “The St. Louis VA Medical Center leadership is aware of and is addressing the alleged issues.”

The VA St. Louis Health Care System lists 20 psychiatrists and 54 other mental health professionals on its staff. In a 2012 review of the system’s John Cochran and Jefferson Barracks hospitals, federal inspectors found that staff did not always follow up as necessary with mental health patients, including those at high risk of suicide.

Missouri U.S. Sens. Roy Blunt and Claire McCaskill sent a letter Monday to Veterans Affairs Secretary Eric Shinseki asking for information on the hospital’s mental health staff, how many patients they see each day and the average wait time for veterans to be treated.

“If true, (Mathews’) claims would demonstrate an unacceptable lack of leadership at the VA in St. Louis that is putting the health and safety of veterans at risk,” the senators wrote.

The allegations from Mathews follow a growing number of claims nationwide that VA hospitals have lengthy wait lists that cause delays in care and preventable deaths of veterans. As many as 40 veterans have died awaiting medical care from the VA hospital in Phoenix, according to whistleblower claims. Shinseki, the VA secretary, has ordered audits of all VA clinics in the country in the next several weeks to check for problems with access to care.

With 21 health care recruiters nationwide, the VA has gone on a hiring spree to provide medical services to an aging veteran population and veterans returning from Iraq and Afghanistan with brain injuries and post-traumatic stress disorder. The department has added nearly 2,000 mental health staff members in recent years. Doctors at the VA receive generous benefit packages with more than 50 paid days off each year, according to job postings.

Mathews, who is also on the faculty at Washington University, took over as chief of psychiatry for the St. Louis VA system in November 2012. He said he was astonished to learn of the limited workload of psychiatrists — typically about six patients per day in 30-minute appointments each. He said they should be seeing at least twice that many.

Mathews said he implemented several changes aimed at providing more timely treatment, but his efforts were met with opposition by staff. He was able to increase the average number of patients per psychiatrist to around nine per day by July. But in September, he was reassigned to a compensation and pension evaluation team.

Mathews raised other concerns in his whistleblower complaint and in a letter to McCaskill last month. He cited “misleading” data produced by the local VA that inaccurately boosted the patient numbers, denial of his request for an

investigation into two veterans' deaths, whether failure to report a suicide attempt that occurred during a visit by inspectors last year was intentional and payment of bonuses to most staff no matter their productivity.

Staffing shortages and other problems at the St. Louis VA have been the focus of several federal investigations and lawsuits in recent years. An Army veteran who lost his leg and suffered severe brain damage after a routine operation implanting a cardiac stent at John Cochran was awarded $8.3 million in federal court last year. In 2010, a nurse in Cochran's intensive care unit was disciplined after injecting a patient with a potentially lethal dose of painkillers. Also that year, more than 1,800 veterans were told they might have been exposed to HIV or other viruses in the dental clinic because of inadequate sterilization. The hospital temporarily shut down its operating rooms in February 2011 after rust stains were found on surgical equipment.

Mathews said he has received appreciative comments from some colleagues since speaking out about the problems at the VA. "It's incredibly sad to see how some of the veterans here are treated," Mathews said. "These are the most vulnerable veterans, and who is going to stand up for them? I'm going to stand up for them, come what may."

The Associated Press and Chuck Raasch of the Post-Dispatch contributed to this report.