Fact Sheet

Pathology: List of Events & Background

A Veterans Health Care System of the Ozarks (VHSO) pathologist was found to be impaired on March 22, 2016. The pathologist was immediately removed from clinical care. Prior to this incident, this Veteran employee had no previous disciplinary actions, and was deemed an excellent candidate for the Impaired Physician Program. Following successful completion of the program and implementation of a monitoring program, the pathologist was placed back into clinical care on October 12, 2016.

On October 13, 2017, VHSO leadership received reports of possible impairment of the pathologist. An Employee Health Assessment was conducted, and the pathologist was deemed unsafe to work; was immediately removed from clinical care, and has since been terminated. Internal reviews of cases completed by this pathologist revealed errors and misdiagnoses in some cases. VHSO is in the process of notifying the affected patients.

As a result, the Department of Veterans Affairs has made the decision to conduct a thorough review of all cases read by the pathologist by an external review team. While the rate of errors was not large, the VA is having ALL cases reviewed to meet our commitment of providing safe care every time. These independent reviews are being done to ensure the safety of all patients who may be impacted. Letters will be sent to all patients who had a case read by this pathologist to inform them about this process. Follow-up will also be provided by phone or letter once the secondary review has been completed.

This independent review team is also charged with developing clear procedures for addressing this matter, including establishing a methodology for tracking second reviews of tests and protocols to notify affected patients. If errors are found that affect a patient's current treatment plan, the VA will reach out immediately to the affected patient.

Going forward, the VA has already strengthened internal controls to ensure any errors are more quickly identified and addressed. The VA is focused on conducting the reviews and notifying all affected patients. Patient safety is the top priority. In addition, accountability will be addressed as the investigation into this matter continues.

This process will take several months to complete. Veterans Health Care System of the Ozarks has set up a call center for patients who may have any questions or concerns about this process. That number is 866-388-5428. The local number to call is 479-582-7995. Both numbers will be operational at 10:00 a.m. on Monday, June 18.

VA

U.S. Department of Veterans Affairs

Veterans Health Administration
Veterans Health Care System of the Ozarks
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