

Department of Veterans Affairs

Report to the U.S. Office of Special Counsel
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Department of Veterans Affairs, Veterans Health Administration,
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Executive Summary

The New Mexico Veterans Affairs Health Care System responded to an inquiry from the U. S. Office of Special Counsel (OSC) to the Secretary of Veterans Affairs dated November 13, 2000, regarding allegations against the Veterans Affairs (VA), Veterans Community Based Outpatient Clinic (CBOC), [REDACTED] New Mexico, clinic physician from a former Nurse Clinic Director.

The OSC concluded that the information provided by the former Nurse Clinic Director provided information that "demonstrates a substantial likelihood that a substantial and specific danger to public health and safety exists" at the Clinic. The former Nurse Clinic Director alleged that the Clinic physician on at least four occasions between (February 1999 and June 1999, and January 18, 2000) was treating patients while under the influence of alcohol. She went on to further allege that in February 2000, the management of the New Mexico Veterans Affairs Health Care System (NMVAHCS) told her to not file any additional reports of contact regarding the Clinic physician; that VA officials believed the problems at the clinic are management related and not caused by the Clinic physician's drinking; and as a result of VA management's response to the allegations the staff was "chilled" from reporting additional incidents of drinking. The Nurse Clinic Director resigned her position in July 2000 (her last day of employment was August 14, 2000). Pursuant to 5 U.S.C. § 1213, OSC directed VA to conduct an investigation into the allegations of the former Nurse Clinic Director.

Methodology

Prior to the VA's receipt of the inquiry from the OSC, the former Nurse Clinic Director filed reports of contact with her supervisor and other management officials alleging that she smelled alcohol on the Clinic physician, and that he was treating patients while under the influence of alcohol. At the direction of the NMVAHCS Chief Executive Officer (CEO), an Administrative Board of Investigation (BOI) was initiated on October 5, 1999 and concluded on November 9, 1999. The BOI was based on the allegations from the Nurse Clinic Director.

With the receipt of the November 13, 2000 letter from the OSC, the Interim Chief Executive Officer of the NMVAHCS independently reviewed the entire BOI.

Additionally, the Chief, Performance Improvement Section at the NMVAHCS conducted a further investigation which included a review of numerous documents as well as interviewing a number of Clinic personnel.

A Primary Care physician, with extensive experience in the practice and management of CBOC medicine conducted a peer review. He reviewed the medical records of 80 veterans who received care from the Clinic physician. He also reviewed the credentialing and privileging folder for the Clinic physician,

Reports of Contact, Incident Reports, Quality Management Reports and Peer Reviews pertaining to the Clinic physician's practice.

A clinical investigator staff member of the VHA Office of the Medical Inspector provided assistance and advice to the Chief, Performance Improvement Section, interviewed the nurse complainant, and reviewed a number of the above documents.

Findings and Conclusions

The BOI could not substantiate that the Clinic physician at the [REDACTED] Clinic had ingested alcohol while on duty or that alcohol impaired his clinical judgment. After reviewing the BOI, the Interim Chief Executive Officer concluded that none of the allegations in the BOI were substantiated. The Clinic physician's performance and clinical judgment have been evaluated and continue to be monitored by his supervisor. The Clinic physician also participates in the peer review process that all the General Internal Medicine providers participate in on a monthly basis. The Clinic physician is performing well at the clinic, and the staff has filed no further reports of contact regarding his performance.

The Chief, Performance Improvement Section, upon the extensive review of relevant documents and interviews of the Clinic physician, staff, and NMVAHCS staff relating to the Nurse Clinic Director's complaints, has found no evidence to support the former Nurse Clinic Director's complaints.

The physician completing the peer review concluded that the Clinic physician's use of diagnostic testing, consultation requesting, and treatment patterns were consistent with established medical practices. However, he did find examples of questionable documentation practices by the Clinic physician that may indicate a pattern of recording patient examination information that was not based on actual physical examination at the time of the note. The reviewer also noted examples of narcotic analgesic prescribing that might be considered outside the usual acceptable clinical parameters by some physicians. These new issues brought to light during the peer review will be addressed by the NMVAHCS management.

The clinical investigator from staff of the OMI could not find evidence to substantiate the allegations that the Clinic physician provided care while impaired; that the veteran patient appointments were cancelled due to the Clinic physician's impairment; or that the patients of the Clinic did not receive care when needed due to the absence of the Clinic physician.

This report sets forth the finding of the U.S. Department of Veterans Affairs (VA) regarding information that was submitted to the Office of Special Counsel (OSC) by Ms. Elizabeth K. McDonald, R.N., the former Nurse Clinic Director of VA's Community-Based Outpatient Clinic in [REDACTED] New Mexico. The report has been investigated pursuant to the requirement of 5 U.S.C. § 1213. The report is divided into five sections: (1) a summary of the information with respect to which the investigation was initiated; (2) a description of the conduct of the investigation; (3) a summary of any evidence obtained from the investigation; (4) a listing of any violation or apparent violation of law, rule, or regulation; and (5) a description of any action taken or planned as a result of the investigation.

I. Summary of the information with respect to which the investigation was initiated:

On November 13, 2000, the U.S. Office of Special Counsel (OSC) directed the Acting Secretary, Hershel W. Gober, to conduct an investigation into "information that demonstrates a substantial likelihood that a substantial and specific danger to public health and safety exists" at VA's Community Based Outpatient Clinic (clinic) in [REDACTED] New Mexico. The authority for this investigation is found in 5 U.S.C. § 1213. The information that caused this investigation to be initiated is set forth in the letter VA received from OSC.

The letter details information that OSC received regarding the alleged use of alcohol by a Clinic physician, Dr. [REDACTED]. The information was received from the former Nurse Clinic Director of the Clinic, Ms. Elizabeth K. McDonald, R.N. The letter details the information provided by Ms. McDonald regarding the various Reports of Contact (ROC) that she had filed. The letter also notes that a Board of Investigation was convened in October 1999, to investigate the allegations against Dr. [REDACTED] that Dr. [REDACTED] returned to the Clinic in December 1999; and that Ms. McDonald was instructed as to the procedure to follow if she had a reasonable suspicion that the physician was under the influence of alcohol. Ms. McDonald asserts that on January 18, 2000, the staff reported to her that Dr. [REDACTED] smelled of alcohol. She agreed, and reported her suspicion to the social worker that was to escort Dr. [REDACTED] to the Rehobeth Medical Center for a blood alcohol test. Ms. McDonald asserts that she observed that Dr. [REDACTED] delayed his departure to the Rehobeth Medical Center for approximately 30-45 minutes and that he drank large quantities of water during the delay. The letter states that the blood alcohol test was "inconclusive." The letter from OSC further states that in February 2000, Ms. McDonald was told not to file additional reports regarding Dr. [REDACTED]. The letter notes that on occasion subsequent to the incident on January 18, 2000, she noted that the physician smelled of alcohol. However, she asserts that due to the negative response from her supervisors, she filed no ROC on this incident. Ms. McDonald asserts that she observed numerous incidents of absenteeism by Dr. [REDACTED]. She asserts that because of management's failure to respond to this issue and take action against Dr. [REDACTED] the Clinic staff is "chilled" from reporting additional incidents of drinking.

VA initiated this investigation based on the information provided by the OSC.

II. Description of the conduct of the investigation:

The investigation involved a review of VA's formal BOI convened in October 1999 to investigate the allegations against Dr. [REDACTED] (paragraph A) as well as an independent review of all of the allegations set forth in the information noted above (paragraph B).

A. With the receipt of the November 13, 2000 inquiry from the U.S. Office of Special Counsel, the Interim Chief Executive Officer of the NMVAHCS independently reviewed the complaint (enclosure 1) and the report of the Administrative Board of Investigation (BOI) (enclosure 2) that was initiated on October 5, 1999 and concluded on November 9, 1999. The charge to the BOI was to determine if:

1. The Clinic physician was working under the influence of alcohol and thus impairing clinical judgement and resulting in patient complaints.
2. The Clinic physician allegedly ingested alcohol while on duty.
3. The Clinic physician's secondary employment outside the VA was interfering with VA physician duties.
4. The Clinic physician paid a patient to have a physical examination done elsewhere.

B. The Chief, Performance Improvement Section at the NMVAHCS conducted a further investigation which included:

- Complaint (enclosure 1)
- Report of the Administrative Board of Investigation, Case No. 99-5 including affidavits and related documents. (enclosure 2)
- NMVAHCS Medical Center Memorandum 11-27, "Outside Professional Activities for Title 38 Employees", dated 6/8/99 (enclosure 3)
- MP-5 Part II, dated 10/30/98
- Updates to MP-5, Part II, dated 10/23/99 and 9/1/00 (enclosure 4)
- Clinic physician's time and leave for calendar year 1999 and 2000
- Clinic physician's work load reports 1999 and 2000
- Clinic No Show Rates for January 1, 2, 3, 6, 8 and 9, 1999; January and February 2000, and January 2001
- Patient Complaint Reports from Patient Advocate database from calendar year 1996 through 2000
- Cancelled clinic dates for calendar year 1999 and 2000
- Outside Staffing Agency data for the Clinic physician from Snelling, National Emergency Services (NES) and Presbyterian Healthcare System Professional Staffing

- Calendar year 1999 and 2000 Reports of Contact relating to Clinic MD Staffing, Security issues generated by Clinic and Supervisor staff. Police and Security Service Reviews conducted in 2nd quarter FY 00 by VA Headquarters Security and Law Enforcement Representative
- Report of a Response to Senator Udall regarding a patient complaint about the [REDACTED] NM Clinic
- Comparison of the Clinic physician's availability as related to cancelled clinic dates
- Patient Satisfaction Surveys - Clinic specific compared to overall scores for all clinics for January 13 - December 10, 1998; March 13 - December 17, 1998; August 31 - November 18, 1998; May 1 - June 24, 2000; and November 3 - December 22, 2000
- Clinic physician's credential and privilege file
- Incident Reports
- Clinic Physician's Employee Health Record
- Admission Discharge and Transfer (ADT) computerized Records for check-in & checkout times for patients
- Laboratory and diagnostic tests and consults on February 16, 1999; March 25, 1999; June 2, 1999; and January 18, 2000
- OIG Hotline Case # 2001 HL0268 VAMC ABS NM 501 (enclosure 5)
- Reports of Contact related to Police/Security Issues for CY 1999 and 2000
- Requested [REDACTED] Police Department to provide a log of Police Calls to the Clinic for CY 1999 and 2000. As of this report, [REDACTED] Police Logs have not been received.

In addition, the Chief of Performance Improvement interviewed the following personnel:

- 5 staff physicians
- Clinic Administrator - General Internal Medicine - NMVAHCS
- Clinic Supervisor - CBOC, NMVAHCS
- Administrator of CBOC NMVAHCS during 1999-2000
- Administrative Officer of Clinic
- LPN at Clinic
- Veteran's Transition Center Director (MSW), [REDACTED], NM
- Interim Chief Executive Officer - NMVAHCS
- Clinic physician
- Chief of Internal Medicine Service

Based on allegations that the Clinic physician working in the [REDACTED] CBOC might have been practicing medicine while impaired either by alcohol or the rigors of outside employment, a peer review was completed by a Primary Care physician, with extensive experience in the practice and management of CBOC medicine, from the Northern Arizona VA Health Care System. He reviewed the medical records of 80 veterans who received care from the Clinic physician. He also reviewed Reports of Contact, Incident Reports, Quality Management Reports,

Peer Reviews pertaining to the Clinic physician's practice, and the Clinic physician's credentialing and privileging file.

A clinical investigator from the staff of the VHA Office of the Medical Inspector provided assistance and advice to the Chief, Performance Improvement Section, interviewed the nurse complainant, and reviewed a number of the above documents.

III. Summary of any evidence obtained from the investigation:

This section contains findings from the investigations completed regarding the allegations.

A. The Board of Investigation findings are located in enclosure 2.

The Board of Investigation made eight recommendations with regard to their investigation of Dr. [REDACTED]. The following is a summary of the actions taken by the Medical Center based on the Board's Recommendations:

Recommendation # 1: The Clinic physician was informed by his direct supervisor that the Board of Investigation was requiring him to have an evaluation session with Employee Assistance Counselor. In response, he stated that he did not have a substance abuse problem, and therefore declined to have the evaluation session, see enclosure 6. This was reported to the Chief Medical Officer, who consulted a member of the Health Professions Wellness Committee of the New Mexico Board of Examiners on February 14, 2000, see enclosure 7. Their discussion concluded that there was not enough information to proceed with any kind of action with respect to the Clinic physician.

Recommendation # 2: This recommendation detailed circumstances when the Clinic physician would undergo a blood alcohol test. A blood alcohol test was done per protocol on the Clinic physician, at the request of the Nurse Clinic Director on January 18, 2000, at the [REDACTED] Hospital Emergency Room. This test was reported back as 0.00 mg/dl for Ethanol in his blood. This result was conclusive. The Physician's supervisor then requested the controls that were used in this test. The Nurse Clinic Director's supervisor stated she clearly communicated to the Nurse Clinic Director the criteria set by the Board of Investigation for requiring the Clinic physician to have blood alcohol tests, and she stands by her testimony. The Nurse Clinic Director's supervisor reports that she was present at the Clinic on June 2, 1999, the date of the fourth incident identified in the Nurse Clinic Director's complaint, and she did not witness what was alleged.

Recommendation # 3: It was recommended that if the Clinic physician was found to be impaired, he would be subject to disciplinary action. The Clinic physician

was only sent to the Emergency Room, once on January 18, 2000, and was not found to be impaired. As a result, no further action was taken by his supervisor for this incident.

Recommendation # 4: This recommendation required the Clinic physician's supervisor to counsel him regarding non-VA patients. The Clinic physician's immediate supervisor completed the requested counseling during the Clinic physician's four-week preceptorship in the NMVAHCS clinics. The counseling included: outside work activities, staff roles, compliance with requested blood testing, and timeliness to the work site. Since the counseling, the clinic staff has reported no further instances of problems with the Clinic physician's timeliness to work. The Clinic physician complied with a request for blood testing, and continues to agree to comply with any future requests. The Clinic physician has limited his outside work activities so they do not interfere with his clinic responsibilities. The Clinic physician has also worked closely with the Clinic staff, and they have reported improved working relations with him.

Recommendation # 5: The Clinic physician was required to come to NMVAHCS for a four-week preceptorship that ended December 17, 1999. The Clinic physician saw patients in the [REDACTED] Clinic during this time and he was required to present each patient he cared for to the attending physician in clinic, so they could assess his clinical skills and judgement. These evaluations were submitted to the Acting Section Chief. In addition, the NMVAHCS nursing staff submitted a written statement regarding their evaluation after working with the Clinic physician. A physician who covered for the Clinic physician during this time reported that from the patients and charts he followed for the Clinic physician, he did not identify any problems with the care provided. In summary, the Clinic physician's performance in the [REDACTED] clinic was judged to be excellent by the medical and nursing staff alike.

Recommendation # 6: This recommendation described the appropriate method for reporting future incidents. The Clinic physician's supervisor was identified as the person to continue to review all Reports of Contact that were given to him from the Clinic staff. In addition, the supervision requested, and the Clinic physician has complied that the physician send him e-mails regarding his daily work and interactions at the clinic.

Recommendation # 7: This recommendation involved the possible co-location of facilities. A market survey analysis was conducted in early FY 2000 to determine the feasibility of combining [REDACTED] clinics in [REDACTED]. After completion of the survey it was recommended that a build-to-suit lease with a local contractor be pursued. However, the size and scope of the project (9,500 sq. ft.) at an undetermined amount, with a 10 year lease required by the bidder, was a significant fiscal commitment, and therefore, not feasible at this time.

Recommendation # 8: The Board of Investigation set out a list of recommendations to promote "team building" at the [REDACTED] Clinic:

8.1: The first team building recommendation involved staff training in management of violent patients. The [REDACTED] VA Transition Center Director provided training and weekly sessions to the clinic staff in the management of aggressive patients, communication, conflict management, stress management, and boundary issues. The [REDACTED] VA Transition Center Director reported and discussed the outcome of these meetings with Chief, Psychology Service who provided recommendations and guidance.

8.2: The second of these recommendations suggested that when the Clinic physician returned, the Chief, Psychology Service should be involved with the reintegration process. The [REDACTED] VA Transition Center Director and Chief, Psychology Service through the above weekly meetings worked with the staff regarding the reintegration process.

8.3: The recommendations also identified a number of community-based actions to deal with patient aggression. The clinic staff met with veteran groups in the service area to discuss issues at the clinic and to ask for their assistance in communicating with their membership about appropriate conduct while visiting the clinic. The Chief, Psychology Service, asked the Nurse Clinic Director to provide flyers to patients and post information on clinic bulletin boards informing them of issues at the clinic that caused delays in appointments and backlogs. The Nurse Clinic Director did not follow through with this request due to numerous concerns expressed by her to NMVAHCS Management. NMVAHCS concurred and did not pursue this recommendation.

8.4: This recommendation suggested that the Chief, Psychology Service should monitor progress at the clinic. The Clinic physician met with Chief, Psychology Service during his four-week preceptorship in NMVAHCS to address issues brought up in the Board of Investigation. On January 5, 2000, representatives from Medicine, Psychology, and Quality Management Services went to the Clinic to hold meetings with the staff and to continue to help facilitate Clinic physician's return. They also met with representatives of area veterans groups that utilize the clinic. These representatives were complimentary of the Clinic physician and the staff. Their concern was maintaining this resource in their community and increasing the staff. The Chief, Psychology Service and the Nurse Clinic Director's Supervisor did a follow-up visit 4-6 weeks later. The Chief, Psychology Service reported that during this visit the Nurse Clinic Director was non-cooperative, at first refusing to meet with her because the Clinic physician had not been removed from the clinic. The Chief, Psychology Service and the Nurse Clinic Director's Supervisor met with the staff as a group and worked out staff problems with the process for asking for a drug screen. They strongly encouraged the staff at that visit to follow through with the process as necessary. The Chief, Psychology Service also met with Clinic physician and told him that he had to go for a blood alcohol test within 1/2 hour of being asked to provide a blood

sample. He was told that he could not delay his departure. The Clinic physician agreed to cooperate with the arrangement.

B. Summary and findings from the review of the BOI conducted by the Interim Chief Executive Officer are as follows:

The BOI conducted a comprehensive investigation into the allegations against the Clinic physician. None of the allegations were substantiated. The Clinic physician's performance and clinical judgement have been evaluated and continue to be monitored by his supervisor. The Clinic physician also participates in the peer review process that all the General Internal Medicine providers participate in on a monthly basis. The Clinic physician is performing well at the clinic, and the staff has filed no further reports of contact regarding his performance. A Locum Tenens, a contract physician, is currently working with the Clinic physician. He assists in patient workload, and does not monitor or supervise the Clinic physician. He reports that the Clinic physician is a pleasure to work with, and has taught him a great deal about providing health care in a rural setting.

C. Summary and findings from the review conducted by the Chief, Performance Improvement Section (PI):

The Chief of PI Section reviewed all of the documents listed in Section II of this report, and interviewed NMVAHCS and Clinic staff regarding the Nurse Clinic Director's complaints that were reflected in the OSC letter of November 13, 2000 and the OIG Hotline Case # 2001 HL0268 VAMC ABQ NM 501 (enclosure 5).

The Clinic physician's time and attendance records, clinic cancellations correlated to clinic availability records, and workload reports demonstrated no evidence to substantiate absenteeism or lack of availability of the physician to the Clinic patients. Annual leave and occasional sick leave showed no unusual patterns or abuse thereof by the Clinic physician.

The Administrative staff with responsibility over the Clinic confirmed that on numerous occasions, the former Nurse Clinic Director complained that the Clinic physician was tardy and/or left early. The Nurse Clinic Director was advised/reminded by the administrative staff that, pursuant to VA policy, the Clinic physician must take leave if his time worked is less than 3 hours. Conversely if his work is completed and the Clinic is covered, the Clinic physician has the latitude to occasionally leave early. In the written complaint reviewed, it was noted that the maximum time of tardiness was two hours. The documents that were reviewed showed very few instances of documented tardiness or of leaving early.

According to the Administrator of the Clinic and Nurse Clinic Supervisor at NMVAHCS they surmised that the Nurse Clinic Director "did not want to

hear/accept this information as a statement of fact/VA Regulation." Thus the Nurse Clinic Director sporadically continued to complain that the Clinic Physician was tardy or absent without leave.

A review of the clinic appointment records from January 18, 2000, indicates that on that date, no patient appointments were cancelled.

The former Nurse Clinic Director states that in February 2000, she was told to stop filing reports on Dr. [REDACTED]. With regard to this issue, the Administrator of the Clinic confirmed that she had instructed the Nurse Clinic Director to stop "shot gunning" (which she defined as sending the same (old) reports to multiple parties at NMVAHCS). The Administrator of the Clinic at NMVAHCS also related that she does not recall sending an official (written) memorandum to the Nurse Clinic Director. No memorandum on this issue was found in the files that were reviewed. She did "possibly" recall sending an e-mail to the Nurse Clinic Director in addition to verbal discussions; but no e-mail has been located.

The Supervisor, Information Resources Management (IRM) Customer Support Section was delegated by the Chief, IRM to retrieve Veterans Health Information Systems and Technology Architecture (VISTA) e-mails of the Administrator of the Clinic at NMVAHCS and Nurse Clinic Director. The Supervisor, IRM Customer Support Section responded that the VISTA System was purged in November 2000 and that the e-mails in questions are therefore not retrievable.

Clinic staff who were interviewed for this investigation denied smelling alcohol on the Clinic physician after the January 18, 2000 incident.

When the Clinic staff were interviewed regarding being "chilled" from filing reports of any concerns, they stated that they were reminded repeatedly by the Nurse Clinic Director that Albuquerque (NMVAHCS) management will "not do anything anyway" and "will not support them." The Clinic staff also advised the Chief, PI Section that they were coerced/badgered into writing reports on the Clinic physician by the Nurse Clinic Director and feared for their jobs if they did not write a Report of Contact or other reports regarding the Clinic physician.

The staff further advised the Chief, PI Section that if called into court today, they would now state they were coerced to write up the Clinic physician by the Nurse Clinic Director and in essence their previous Board of Investigation testimony was skewed towards supporting the Nurse Clinic Director's opinions of the Clinic physician.

A telephone interview was held with the Clinic physician on March 5, 2001. Present on the call was the Clinic physician's attorney, NMVAHCS Regional Counsel, Clinical Investigator from the OMI, and the Chief of Performance Improvement Section. The following issues were discussed:

- The Clinic physician's recollection of having a discussion with the former Nurse Clinic Director regarding instances when the Nurse Clinic Director asserted that she smelled alcohol on the Clinic physician's breath (i.e., February 16 and March 25, 1999).
- The Clinic physician's view of his working relationship with Clinic staff and the former Nurse Clinic Director prior to her arrival, during her tenure at the Clinic and after her resignation.
- Discussion regarding the finding of beer in the biohazard refrigerator on August 25, 1999, as well as liquor bottles found in the bathroom trash by the janitor.
- The Clinic physician's perception of a safe work environment for himself, staff and patients, as well as claims from the former Nurse Clinic Director that the police were called to the Clinic at least once a week.
- Discussion of current peer review processes as related to Medicine Service and Locum Tenens physicians assigned to the Clinic.

The Clinic physician related the following opinions/perceptions:

- The Clinic physician stated that these "charges are wrong, false."
- The Clinic physician was unaware of Reports of Contact dated February 16 and March 25, 1999 until the former Nurse Clinic Director discussed them with him on April 5, 1999. He told her at that time that he was willing to have a blood alcohol test drawn at any time. In addition, the Clinic physician recalls that in June 1999 (unable to recall exact date) his supervisor telephoned him at the Clinic to discuss the Nurse Clinic Director's allegations of "smelling alcohol" on his breath. Again the Clinic physician told his supervisor he was willing to have a blood alcohol test drawn at any time. There was no further communication on the allegations until September 29, 1999. On September 29, 1999, the Clinic physician's supervisor and Acting Chief of PRIME Medicine Clinic discussed the allegations of the former Nurse Clinic Director with the Clinic physician.
- The Clinic physician advised that he tried for the first 6 months of the former Nurse Clinic Director's tenure at the Clinic to work with her and give her time to adjust to the Clinic routine. However, after 6 months he brought to the attention of the Nurse Clinic Director's supervisor and the Administrator of the Clinic the fact that the Nurse Clinic Director was not conducting the Nurse Clinics (i.e. Cholesterol Education and follow-up, Coumadin). The Clinic physician advised that prior to the former Nurse Clinic Director's arrival, he had worked at the Clinic for 3 years and during that time these were established Nurse Clinics.
- The Clinic physician stated after his arrival at the Clinic from his [REDACTED] stay at the NMVAHCS [REDACTED] (1999) he was welcomed by the Clinic staff. The former Nurse Clinic Director, however, openly stated to staff that she was not happy the Clinic physician was back and did not directly communicate with the Clinic physician.

- On January 18, 2000, the Clinic physician's impression of why the blood alcohol test was requested was that it was a Monday and that probably the Nurse Clinic Director felt she could find something if he was drinking on the weekend. NOTE: This was a Tuesday after a federal holiday.
- The Clinic physician's opinion of why the former Nurse Clinic Director resigned was that the Administrative Officer of the Clinic filed an EEO complaint against the former Nurse Clinic Director. He states that she told him and other staff that she did not "want to go through it."
- The Clinic physician disagreed with the allegation that the Clinic environment was unsafe. He further stated that since the former Nurse Clinic Director started working at the Clinic, there was an escalation of incidents of patients exhibiting hostile/angry behavior. He felt that the former Nurse Director set a "military mood" in the Clinic and that her demeanor with patients caused the escalation of negative behavior. The former Nurse Clinic Director responded to patients' exhibited behavior by calling police or writing Reports of Contact. The Clinic physician did not personally feel he was in danger. He did relay that the former Nurse Clinic Director did raise awareness of Clinic staff as to "no tolerance" of hostile behavior and that bulletproof glass was installed at her request. He was not part of the decision regarding the installation of this glass.
- The Clinic physician advised that he participates in the Medicine Service Peer Review process. He is given a list of another Clinic physician's patients (4-5 patients) and picks one chart at random to review. He stated he does ten chart reviews per month.

In summary, upon the extensive review of relevant documents and interviews of the Clinic staff involved, the Chief, Performance Improvement Section could not find any evidence to support the Nurse Clinic Director's allegations.

D. Summary and findings from the physician peer review:

The physician who conducted the peer review concluded that the Clinic physician's use of diagnostic testing, consultation requesting and treatment patterns were consistent with established medical practices. However, he did find examples of questionable documentation practices by the Clinic physician that may indicate a pattern of recording patient examination information that was not based on actual physical examination at the time of the note. The reviewing physician suggested that the Clinic physician may be relying on the computerized pre-defaulted template, and he noted examples of narcotic analgesic prescribing that might be considered outside the usual acceptable clinical parameters by some physicians. These new issues brought to light during the peer review will be reviewed by NMVAHCS management.

E. Summary and findings from the interview conducted by the clinical investigator from the VHA Office of the Medical Inspector:

A clinical investigator from the VHA Office of the Medical Inspector conducted an extensive telephonic interview with the complainant, the former Nurse Clinic Director of the [REDACTED] NM, Clinic on February 16, 2001.

The complainant related the information as is reflected in the OSC letter of November 13, 2000. She felt that initially, in February 1999, her supervisor did not take her reported concerns seriously and therefore did not forward her concerns up the chain of command or to the Clinic physician's supervisor. She felt the Clinic physician's supervisor would have acted had he known of the allegations. Although she had no further documented concerns, other than the dates specified, over the Clinic physician's impairment due to alcohol, she saw quality of care concerns that she reported to her supervisor. She states that there was no action taken by management regarding her complaints. She acknowledged that in September 1999 she was trying to get his supervisor's attention. She felt that the "physicians were taking care of physicians" and refusing to see the weaknesses in his practice. She expressed concerns that she was responsible for the staff at the Clinic, except for the physician, and that this arrangement led to obstacles in communications and interfered with the Clinic working as a unit. She indicated that after the Clinic physician's return to the Clinic in December 1999, the atmosphere between them was tense, but cordial. The Clinic staff was working together in a cordial atmosphere. She was at a loss as to what to do the next time she encountered a concern, and her efforts to obtain a copy of the instructions for the procedure to be followed for obtaining the blood alcohol level was futile. She stated that no further concerns from the Clinic staff were verbalized until January 18, 2000. On this date, there was a significant delay between the first staff person smelling the alleged alcohol and the time it was reported to the Nurse Clinic Director. An additional delay occurred between her completing her patient care, evaluating the situation, getting the order for him to go to the community hospital, and contacting the VA's Transition Center Director to escort the Clinic physician to the community hospital.

With regard to this incident, the VA's Transition Center Director related that at the most, 15 minutes transpired between the time he was called and the time he arrived to escort the Clinic physician to the ER at the local hospital to get the blood test. The total amount of time from the first person allegedly smelling the alcohol until the actual testing was performed at 11:07 a.m. may have been a little over 1 hour. At that point the blood alcohol test was negative. An expert physician for the Alcohol and Substance Abuse Program at the NMVAHCS was contacted regarding the possibility of a person who is suspected of having ETOH in their system altering the blood alcohol test by drinking copious amounts of water for one hour plus prior to a blood alcohol test being drawn. The expert physician confirmed that alcohol will stay in the bloodstream from 3-6 hours

depending on age and tolerance of the individual in question and that drinking copious amounts of water prior to the drawing of the blood test would not alter the test results. The Clinic physician's supervisor requested and received the controls for the test. The control parameters indicated normal results. The former Nurse Clinic Director also indicated that Clinic appointments were cancelled because of this activity, but no evidence exists (either in the records of the patients scheduled for that day or in the VISTA computerized medical record system reflecting scheduled appointments) to substantiate this claim.

In February 2000, the complainant alleged that she had been told by her supervisor to stop filing reports on the Clinic physician. She indicated to the OMI investigator that this request was verbal and then followed by a written document. (Neither she nor the interim supervisor could produce the document when asked). She acknowledged that the reports that she was submitting were the same reports of alleged alcohol impairment set forth in previous reports. She could not recall if any Clinic staff were aware that she was told to stop filing reports, but that the entire Clinic staff subsequently began attending the team building sessions that followed the Clinic physician's return.

The former Nurse Clinic Director alleged that the Clinic physician was excessively absent from his Clinic duties. She was not able to provide specific dates for these allegations. A thorough review of time and attendance for the Clinic physician could not substantiate the allegations. Patient appointments were not affected by the Clinic physician's absence, and the hours he worked for the staffing service at non-VA health care locations were not the same hours when he was obligated to the VA Clinic.

After the above two dates (January and February 2000), the complainant stated that she again smelled alcohol on the Clinic physician. She could not provide specifics as to when this happened nor what the impact was on the provision of patient care. She stated she did nothing with the information due to the earlier reaction from her supervisor. In our interview, she could not recall any specific situations or patient names. She further stated that the entire Clinic staff thereafter kept their concerns to themselves. The staff in the Clinic are an Administrative Officer, LPN, Nurse Clinic Director and one contract Health Tech. The Clinic staff, when questioned by the Chief, Performance Improvement Section about the "chilled" atmosphere indicated that the former Nurse Clinic Director was on a "witch hunt" and intimidated them into reporting those instances in 1999.

She indicated she could no longer be a part of providing poor quality care to the veterans, of which she is one, and that she resigned her position in July 2000.

In summary, she did not provide any new information that was not already set forth in previous complaints, nor could she provide the OMI copies of documents supporting the alleged actions taken against her. This telephone interview did

prompt a review of additional reports that might help to validate her allegations (e.g. Clinic security reports, incident reports). Neither the OMI nor the Chief, Performance Improvement Section could find evidence to substantiate the allegations that patient appointments were cancelled or that patients did not receive care when needed due to the absence of the Clinic physician.

IV. Listing of any violation or apparent violation of law, rule or regulation:

The above investigations found no violation or apparent violation of law, rule or regulation.

V. Description of any action taken or planned as a result of the investigation:

Management will review MP-5, Part II Physician employment and VHA supplements by March 23, 2001.

Management will review the government regulations related to employment drug testing by March 23, 2001.

Management has revised the New Supervisor orientation to include the assignment of a mentor from a like position, and clarification of the role of the direct supervisor.

Management will begin a review and restructuring of the Peer Review system for ambulatory clinics (CBOCs). A peer review consultant is scheduled for April 11 and 12, 2001.

Management will review the use of overprinted templates in the medical record by April 30, 2001 for the [REDACTED] Clinic and by July 1, 2001 for all other programs and sites.

Management will complete a review of narcotic prescribing by practitioners by April 30, 2001 for the [REDACTED] Clinic and by July 1, 2001 for all other programs and sites.

Management has designed a plan to improve the facility's procedure in investigating allegations of public health and safety issues raised by facility staff. The plan includes:

- The Education Service will devise training for new and existing supervisors of the standard procedure for review of Reports of Contact.
- The Education Service will submit the training outline to the facility's Chief Executive Officer by the end of the 2nd Quarter FY 01.

- Training to be completed by the end of FY 01 for all supervisors and incorporated into new supervisor orientations.
- Provide staff several options for reporting any concerns regarding public health and safety issues observed at any NMVAHCS locations by either utilizing the supervisory chain of command OR contacting the Patient Safety Coordinator through a dedicated telephone number. The "option approach" is deemed necessary when the supervisor is perceived to be part of the issue.
- The "option approach" will be presented to the Service Chiefs and the AFGE President for input and/or modification. An "option approach" will be adopted NLT the end of the 2nd Quarter FY 01.
- During the 3rd Quarter FY 01, staff will be educated on the "option approach" through Employee Weekly Bulletin, Quality bi-monthly Newsletter, Patient Safety leaflet for distribution throughout the Medical Center and in the New Employee Opportunity Room. The "option approach" flow chart will be distributed to all employees and the new process will be reviewed at all staff meetings and Administrative and Clinical Service Chief meetings.
- By the end of the 4th Quarter FY 01, and ongoing quarterly thereafter, the Patient Safety Coordinator will report to management the number and categories of notifications of the "option approach" received through the dedicated telephone number as compared to the number of written Reports of Incidents of Beneficiary. In addition, the report will include corrective actions taken by the Patient Safety Coordinator and/or Service(s) to correct any public health and safety issues identified.

Management will review the organizational reporting structure of the CBOCs by April 30, 2001. The emphasis is to enhance collaboration and communication across the various reporting disciplines.

ENCLOSURE 1



U.S. OFFICE OF SPECIAL COUNSEL

1730 M Street, N.W., Suite 300
Washington, D.C. 20038-4505

The Special Counsel

November 13, 2000

The Honorable Hershel W. Gober
Acting Secretary
Department of Veterans Affairs
810 Vermont Avenue, N.W.,
Washington, D.C. 20420

Re: OSC File No. DI-00-0866

Dear Mr. Secretary:

I am transmitting the following information for your attention and investigation pursuant to 5 U.S.C. § 1213. The information demonstrates a substantial likelihood that a substantial and specific danger to public health and safety exists at the Department of Veterans Affairs (VA), Veteran's Community-Based Outpatient Clinic (Clinic), [REDACTED], New Mexico. We received this disclosure from the former Clinic Director, Ms. Elizabeth K. McDonald, R.N. Ms. McDonald has consented to the release of her name.

Ms. McDonald is a registered nurse, RN level 3, who began working as the Clinic Director in November 1998. She alleged that on at least four occasions the clinic physician, Dr. [REDACTED], treated patients while under the influence of alcohol. In July 2000, Ms. McDonald resigned from her position with the VA due to the allegations detailed specifically herein.

The Clinic is located in a small [REDACTED] community [REDACTED] and has a staff of approximately six employees. Dr. [REDACTED] is the [REDACTED] physician for the estimated 1400 patients that seek treatment there. Ms. McDonald supervised the Clinic operations and staff, with the exception of Dr. [REDACTED]. At the VA, Quality Management Services (QMS) supervises nurses and the Medical Services Department supervises physicians. Therefore, Ms. McDonald and Dr. [REDACTED] had separate supervisory chains of command.

In the beginning of April 1999, Ms. McDonald reported her concerns about Dr. [REDACTED] drinking to her QMS supervisor, Ms. [REDACTED]. Ms. [REDACTED] instructed her to file ROCs noting her concerns and any problems at the Clinic. According to Ms. McDonald, Ms. [REDACTED] notified her supervisor, Ms. [REDACTED]. In turn, Ms. [REDACTED] supervisor, [REDACTED], Acting Chief of QMS, was supposed to notify Dr. [REDACTED] supervisor, Dr. [REDACTED].

The Honorable Hershel W. Gober

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Following her supervisor's instruction, Ms. McDonald filed Reports of Contact (ROCs) with the VA documenting four incidents when Dr. [REDACTED] smelled of alcohol while on duty. On February 16, 1999, Clinic staff members reported to Ms. McDonald that Dr. [REDACTED] smelled of alcohol and on March 25, 1999, Ms. [REDACTED], Director of the Artesia Clinic, contacted her with the same allegation. Ms. McDonald discussed these incidents with Dr. [REDACTED] on April 5, 1999. She contends that during that conversation, Dr. [REDACTED] admitted that he had a problem with alcohol. According to Ms. McDonald, he said that he and his wife were working on the problem and that it would not happen again.

The fourth incident occurred on June 2, 1999, when Ms. McDonald smelled alcohol on Dr. [REDACTED] while he was treating patients. In addition to smelling of alcohol on those days, Dr. [REDACTED] seemed confused, suffered from memory loss, appeared unable to understand Ms. McDonald's statements regarding the patients, failed to note medications prescribed in patient charts, was uncoordinated, and had difficulty operating some of the equipment in the office including, but not limited to, the facsimile machine and the computer. He also stepped away from people when speaking to them.

Ms. McDonald stated that no action was taken from February to September 1999, despite her reports. Due to the VA's failure to respond, she believed it was necessary to go outside her chain of command to bring the matter to the attention of Dr. [REDACTED] supervisors. In September 1999, she contacted Ms. [REDACTED], the RN manager of the outpatient clinic at the [REDACTED] VA hospital, who reportedly contacted Dr. [REDACTED]. In October 1999 Ms. McDonald contacted Ms. [REDACTED] directly to discuss her concerns regarding Dr. [REDACTED] drinking.

An internal medical investigative committee reviewed the allegations regarding Dr. [REDACTED] drinking in October 1999. On November 2, 1999, he was interviewed under oath. During that interview he denied that he had a drinking problem and that he had ever made such an admission. Within days of Dr. [REDACTED] interview, Ms. McDonald and the other staff members were interviewed. Ms. McDonald confirmed her previous reports regarding Dr. [REDACTED] in that interview.

Dr. [REDACTED] returned to work at the Clinic during the last week of December 1999. At that time, Ms. McDonald was advised by Ms. [REDACTED] that if the staff had a "reasonable suspicion" that he was under the influence of alcohol she should notify, Mr. [REDACTED], a licensed clinical social worker. Mr. [REDACTED] would then take Dr. [REDACTED] to the [REDACTED] Medical Center [REDACTED] in [REDACTED] for a blood/alcohol test.

On January 18, 2000, at approximately 10:00 a.m. the staff reported to Ms. McDonald that Dr. [REDACTED] smelled of alcohol. Ms. McDonald also noticed that

The Honorable Hershel W. Gober

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Dr. [REDACTED] smelled of alcohol. Mr. Koerber was notified and arrived at approximately 11:30 a.m. to escort him to [REDACTED] for the blood/alcohol test. Ms. McDonald watched Dr. [REDACTED] delay going to the hospital for approximately 30-45 minutes while he drank large quantities of water. When Dr. [REDACTED] finally went to [REDACTED] the test was inconclusive.

In February 2000, Ms. McDonald was told by Ms. [REDACTED] not to file any additional ROCs on Dr. [REDACTED]. According to Ms. McDonald, VA officials believe the problems at the Clinic are management-related and not caused by Dr. [REDACTED] drinking. Since the January 18th incident, Ms. McDonald observed Dr. [REDACTED] at work on one other occasion smelling of alcohol. Due to the negative response from her supervisors and VA management, however, she did not file an ROC or report this incident. She also noted numerous incidents of absenteeism. Further, Ms. McDonald believes that as a result of the VA management's response to the Clinic staff and failure to take action against Dr. [REDACTED] the staff has been "chilled" from reporting additional incidents of drinking.

To date, the efforts undertaken by the VA to address the issue of Dr. [REDACTED] drinking have not resolved the situation. Overall, questions about his behavior persist raising concerns about the medical treatment being provided to the Clinic's patients as well as the danger posed by a potentially impaired physician working at the facility.

Ms. McDonald provided copies of ROCs documenting the allegations of Dr. [REDACTED] drinking. She also provided ROCs documenting that liquor bottles are regularly found in the Clinic trash and documenting an instance of erratic behavior by Dr. [REDACTED] reported to Ms. McDonald by Ms. [REDACTED], a licensed practical nurse at the Clinic. Copies of those documents are enclosed.

The Special Counsel is authorized by law to receive information about alleged violations of law, rule or regulation, gross mismanagement, gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety in federal agencies. 5 U.S.C. §§ 1213(a) and (b). If I find that the information demonstrates a substantial likelihood one of these conditions exists, I am then required to send that information to the appropriate agency head for investigation or report. 5 U.S.C. §§ 1213(c) and (g). Accordingly, I am referring this information to you for an investigation of the allegations described above and a report of your findings within 60 days of your receipt of this letter.

The report must be reviewed and signed by you personally. Should you decide to delegate authority to another official to review and sign the report, your delegation must be specifically stated. The requirements of the report are set forth at 5 U.S.C. § 1213(d), a summary of which is enclosed.

The Honorable Hershel W. Gober

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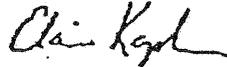
In the event it is not possible to report on the matter within the 60-day time limit, as the statute requires, you may request in writing an extension of time not to exceed 60 days. Please be advised that an extension of time will not be granted automatically, but only upon a showing of good cause. Accordingly, in the written request for an extension of time, please state specifically the reasons the additional time is needed.

After making the determinations required by 5 U.S.C. §1213(e)(2), copies of the report, along with any comments on the report from the person making the disclosure and any comments or recommendations by me will be sent to the President and the appropriate oversight committees in the Senate and House of Representatives.
5 U.S.C. § 1213(e)(3).

A copy of the report and any comments will be placed in a public file in accordance with 5 U.S.C. §1219(a).

Please refer to our file number in any correspondence on this matter. If you need further information, please contact Catherine A. McMullen, Chief, Disclosure Unit, at (202) 653-6005. I am also available to you for any questions you may have:

Sincerely,



Elaine Kaplan

Enclosures

Requirements of 5 U.S.C. § 1213(d)

Any report required under subsection (c) shall be reviewed and signed by the head of the agency and shall include:

- (1) a summary of the information with respect to which the investigation was initiated;
- (2) a description of the conduct of the investigation;
- (3) a summary of any evidence obtained from the investigation;
- (4) a listing of any violation or apparent violation of law, rule or regulation; and
- (5) a description of any action taken or planned as a result of the investigation, such as:
 - (A) changes in agency rules, regulations or practices
 - (B) the restoration of any aggrieved employee;
 - (C) disciplinary action against any employee; and
 - (D) referral to the Attorney General of any evidence of a criminal violation.

In addition, we are interested in learning of any dollar savings, or projected savings, and any management initiatives that may result from this review.

ENCLOSURE 2

Investigative Report and Recommendations in the Matter of Dr. [REDACTED]

NEW MEXICO VA HEALTH CARE SYSTEM)
ALBUQUERQUE, NM) Case No. 99-5
BOARD OF INVESTIGATION)

Board of Investigation:

Molly K. King, M.D., Chairperson (127)
Catherine Beesley, Chief Medical Office (11)
Rex Swanda, Ph.D., Psychology Service (116B)

As directed by a memorandum dated 10/5/99, the Board of Investigation convened on multiple occasions commencing on 10/6/99 and terminating on 11/8/99.

II. PURPOSE

The purpose of the Board of Investigation was to investigate the events surrounding Dr. [REDACTED] involving the [REDACTED] VA Clinic, as part of the New Mexico Health Care System, Albuquerque, NM while occurred on or about February 1999 through Sept 1999.

III. SCOPE

The scope of the investigation was limited to four allegations:

1. Dr. [REDACTED] is working under the influence of alcohol and thus impairing clinical judgement and resulting in patient complaints.
2. Dr. [REDACTED] allegedly ingested alcohol while on duty.
3. Dr. [REDACTED] secondary employment outside the VA is interfering with his VA physician duties.
4. Dr. [REDACTED] paid a patient to have a physical examination to be done elsewhere.

The board elected not to pursue events occurring subsequent (or prior to) those cited above.

IV. EXHIBITS

Materials reviewed by Board members included reports of contact, testimonies, clinical pertinence data on Dr. [REDACTED] external peer review data regarding the [REDACTED] Clinic, Dr. [REDACTED] proficiency report and his leave summary.

V. FINDINGS

1. Allegations #1 and 2 - Alcohol use while on duty as well as impairment of clinical judgement while under the influence of alcohol:

Four separate people testified that they smelled alcohol on Dr. [REDACTED] during working hours (E. McDonald, [REDACTED], [REDACTED] and [REDACTED]) during a period extending from February to June 1999. [REDACTED] testimony is in direct conflict with E. McDonald's statement that Dr. [REDACTED] smelled of alcohol on 6/2/99. Ms. [REDACTED] states she smelled cologne and not alcohol.

E. McDonald observes him drinking a liquid from small bottles kept in his brief case but she is not certain of the contents of the bottles. [REDACTED] states he keeps small bottles of mouthwash in his briefcase and Dr. [REDACTED] showed this bottle to the board members during his interview. Dr. [REDACTED] denies any ingestion of alcohol while on duty. E. McDonald states the janitor told her he finds small bottles of liquor in the men's room at the clinic on a regular basis. The janitor testifies he found a few half-pint bottles in the men's room some years ago but has not found small bottles.

None of the four stated he was impaired at any time. No one has ever directly observed him drinking alcohol while on duty.

E. McDonald testifies that Dr. [REDACTED] told her he "had a problem with alcohol" and that he and his wife were "working on it" (4/99). Dr. [REDACTED] states he never admitted a problem with alcohol and was instead talking about his other health problems.

Dr. [REDACTED] Proficiency Report from 3/98 through 3/99 is outstanding in the categories of clinical competence, administrative competence, personal qualities and overall rating.

External Peer Review and Clinical Pertinence data do not support any radical change in his performance over the last year.

2. Allegation #3 - Secondary employment outside the VA is interfering with his VA physician duties:

Dr. [REDACTED] was late to work on two occasions. One occurred during the spring daylight savings time clock change that made him 2 hours late. The second occurred while moonlighting in an emergency room. As he was leaving, a patient went into respiratory failure and required emergency intubation. Dr. [REDACTED] brought phone company documentation that he'd attempted to call the [REDACTED] clinic several times to let them know he would be late.

[REDACTED] testified that a non-VA patient that Dr. [REDACTED] had seen while moonlighting reported to the [REDACTED] clinic for follow up per Dr. [REDACTED] request. [REDACTED] testifies this was disruptive to the clinic. Dr. [REDACTED] denies he told the patient to come to the [REDACTED] clinic. The patient was not seen in the clinic.

██████████ testified that Dr. ██████████ told a VA patient he'd seen while moonlighting that weekend, to walk into the ██████████ clinic for a lab draw on Monday morning. This unscheduled walk-in was disruptive to the scheduled patients and other patients complained. Dr. ██████████ denies telling a patient to walk in for this lab draw.

██████████ testified that Dr. ██████████ told a VA patient that he would change the patient's dressings if the patient would report to the emergency rooms that Dr. ██████████ was working in over the weekend. Dr. ██████████ admits this occurred and recognizes that it meant lost workload for the VA.

██████████ clinic staff ██████████ and ██████████ testified that outside employers call the ██████████ clinic to either speak with or leave messages for Dr. ██████████ to set up his moonlighting schedule. Staff also report that patients comment how Dr. ██████████ is on the phone arranging his "other job." Dr. ██████████ states he has the contractors page him directly and he does not interrupt patient care to speak with them.

Dr. ██████████ rescheduled his interview with this investigation board for 11/1/99 to 11/2/99, as he did not feel he would be at his best, having moonlighted a 60-hour weekend prior to the meeting.

3. Allegation #4 - Dr. ██████████ paid a patient to have a physical examination performed elsewhere:

██████████ and ██████████ testified that a disruptive, violent patient requested Dr. ██████████ fill out a pre-employment physical so he could get a job driving a school bus. Dr. ██████████ uncomfortable with this as the patient is a known narcotic user, refused to fill out the paperwork. The patient is reported to have requested \$50 to get a physical exam performed by a local practitioner and Dr. ██████████ gave him the money. Dr. ██████████ states he did not give the patient any money as this is "against VA policy," which he confirmed by talking with the clinic Administrative Officer.

VI. CONCLUSIONS

1. Allegations #1 and 2:

The findings do not substantiate that Dr. ██████████ has ingested alcohol while on duty or that alcohol as impaired his clinical judgement.

While Dr. ██████████ supervisor Dr. ██████████ discussed the allegations of alcohol use in June 1999 he did not refer Dr. ██████████ to the Employee Assistance Program (EAP) as per policy.

The current climate of the ██████████ clinic is that personnel have united behind the idea that Dr. ██████████ has an alcohol problem. Potentially, the clinic may not be able to function as a unit given the polarization of beliefs.

2. Allegation #3:

Dr. [REDACTED] demonstrates poor judgement in seeing VA patients at a non-VA facility, thus losing workload. Seeing VA patients in a non-VA setting could be construed as "self-referral" practice. In addition, it is inappropriate for a non-VA patient to report to the [REDACTED] clinic.

While late for duty on two occasions, this does not appear to be unreasonable employee behavior. There is no documentation to support he leaves clinic early to get to his moonlighting activities. His use of sick/annual leave is not excessive and in fact, may be underutilized.

There is no peer assessment to support that Dr. [REDACTED] clinical skills are impaired by his moonlighting activities. However, there is no [REDACTED] located at the clinic to directly observe his clinical skills, as Dr. [REDACTED] is the [REDACTED] physician.

Dr. [REDACTED] discussion of the extensive hours he works outside the VA may be contributing to the clinic staff's perception he is not doing his "best" job for VA patients.

3. Allegation #4:

It is impossible to conclude whether Dr. [REDACTED] paid the patient \$50 for the physical examination to be done elsewhere. The Board recognizes that Dr. [REDACTED] is very generous and perhaps the miscommunication surrounding this allegation is due to a lack of acculturation within the VA system.

The clinic staff has concerns over their personal safety. The involved patient represents violence and intimidation and staff recently experienced aggressive acts toward the clinic (graffiti on the premises, threatening calls).

VII. RECOMMENDATIONS

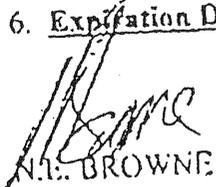
1. Dr. [REDACTED] is required to have an evaluation session with [REDACTED] Employee Assistance Counselor.
2. Dr. [REDACTED] has stated in writing he is willing to have a blood alcohol level test drawn at anytime [reference 9/29/99 Memorandum from Dr. [REDACTED] to [REDACTED], M.D., [REDACTED] M.D., and [REDACTED] M.D.]. In the event there is a reasonable suspicion of alcohol use or impairment during working hours, [REDACTED] VA Transition Center Director, or his designee, shall transport Dr. [REDACTED] to the [REDACTED] emergency room within 20 minutes of notification. A contract with said emergency room should be constructed in order to provide for a medical evaluation to be done on Dr. [REDACTED].
3. In the event Dr. [REDACTED] should be found impaired by the emergency room practitioner, he will be subject to appropriate disciplinary action as outlined by VHA Supplement, MP-5, Part II, Chapter 8, Appendix 8A, Table of Penalties.
4. Dr. [REDACTED] immediate supervisor will counsel him regarding boundaries regarding VA and non-VA patients.

5. Detailing Dr. [REDACTED] to work in the Internal Medicine Clinics at the Albuquerque VAMC for [REDACTED] weeks would allow for mentoring and acculturation. Directly supervised peer review would also occur at this time. His supervisor shall submit a report to the Chief Medical Officer, through Chief, Medicine Service, within one week of the end of the rotation. This report shall specifically address Dr. [REDACTED] clinical competence.
6. Any future reports of contact generated by [REDACTED] Clinic personnel related to Dr. [REDACTED] or patient care shall be forwarded to the Administrative Officer of the Community Based Outpatient Clinics who shall forward them to Dr. [REDACTED] supervisor.
7. Consider co-location of the [REDACTED] VA Clinic with the Veterans Transitional Center. Uniting the [REDACTED] could promote a feeling of security among staff, prevent duplication of services, and diffuse the feelings of isolation of the clinic. If co-location is not feasible, Engineering Service and Chief [REDACTED] should visit the clinic and develop a plan to improve safety at the clinic. Modifications might include the construction of an architectural barrier at the front desk, improved alarm notification systems and a meeting with the local police to discuss response problems.
8. To promote unity of the entire clinic staff a team-building project is to be established with the help of the Albuquerque Psychology Service.
 - 8.1. Staff should receive on-going training in management of aggressive patients. Weekly sessions with [REDACTED] MSW should be initiated and a focus should be the acquisition of such skills.
 - 8.2. Once Dr. [REDACTED] returns to the clinic, additional focus of clinical activity with staff should be on the development of a re-integration process that promotes respect and constructive feedback among all clinic members. Dr. [REDACTED] shall promote and monitor these goals.
 - 8.3. A committee of consumers in the [REDACTED] area should be convened and asked to assist with the development of a "zero tolerance policy" about aggressive and violent behavior. Perhaps a volunteer service in the [REDACTED] area could be the outcome of such a group. A public media campaign that includes posters, leaflets, and information should be circulated to clinic patrons.
 - 8.4. Dr. [REDACTED] shall monitor progress toward the above goals and shall visit the clinic two to three times over the next 6 months. Mr. [REDACTED] shall coordinate his activities with Dr. [REDACTED] to produce a coherent training plan that implements these goals. Dr. [REDACTED] shall inform CMO at the end of 6 months as to whether the clinic staff can function as a unit or whether alternatives should be explored.

ENCLOSURE 3

OUTSIDE PROFESSIONAL ACTIVITIES FOR TITLE 38 EMPLOYEES

1. Policy: It is the policy of the Medical Center that all Title 38 employees recognize their individual responsibility for meeting the full responsibilities and requirements of VA employment regardless of outside professional activities.
2. Responsibility: Service Chiefs will ensure that this policy is brought to the attention of all affected employees. Title 38 employees will comply with all aspects of this policy.
3. Procedure:
 - a. Full-time Title 38 employees may provide care for non-VA patients outside their tours of duty. No advance approval to perform outside professional activities will be required. However, due to call back provisions, employees are to provide management with information on how they can be reached outside their VA tour of duty.
 - b. Employees must ensure that any outside employment they accept will not conflict with their VA responsibilities. Employees who are unable to meet these responsibilities due to outside commitments, may be subject to disciplinary action.
 - c. Title 38 personnel will remain subject to the laws and regulations pertaining to conflict of interest, standards of ethical conduct and employee code of conduct. Therefore, each employee involved in an outside contractual relationship is responsible that no violation of these statutes and standards occurs.
 - d. When contractual relationships exist, employees should consult their supervisors and Human Resources Manager on matters such as patient care responsibilities, call back, call schedules, and tours of duty.
4. References: Pub. L. 104-262; VA Directive 5113 dated February 3, 1997; MP-5, Part II, Chapters 3, 7, and 13.
5. Rescission: Medical Center Memorandum 11-27, dated February 2, 1996, Outside Professional Activities for Title 38 Employees
6. Expiration Date: This Memoranda will expire June 8, 2002.


N.E. BROWNE
Medical Center Director

Distribution: "I"
"II"
All Nurse Practitioners
Nursing Service

ENCLOSURE 4

MP-5 Errata

Back to MP-5 Chapters

Since the original posting on the Intranet of MP-5 the following errors have been noted and corrected on the Intranet. Please assure these changes have been incorporated in your manual by re-printing the affected page off Intranet or by pen and ink notations. There are some "typos" regarding spacing which do not change meanings, procedures or laws and will not be changed, pending the conversion to Directives/Handbooks.

October 23, 2000

Added note regarding approval requirement in paragraph 4(f) of MP-5, Part II, Chapter 13, dated October 30, 1998, for Directors to participate in outside activities which is unenforceable, consistent with VHA Directive 5113, styled Outside Professional Activities - [Click here for details](#).

September 1, 2000

MP-5-, Part II, chapter 13, para 5g, has been deleted. Based on the intent of Congress in Public Law No. 104-262, the requirement in this paragraph for advance approval of outside professional activities was rendered unenforceable by operation of VHA Directive 5113 (February 3, 1997). The Directive deleted the advance approval requirement from the VHA Supplement to this manual.

May 18, 2000

To facilitate viewing of the large files, and for consistency, all VHA Supplements are listed separately in the table of contents and are available by direct links. This results in easier navigation as well as quicker access to the supplements.

May 9, 2000

MP-5, Part I, Chapter 300, Appendix B, para 2a(2). Corrected to add "Employees voluntarily separated without personal cause from qualifying positions described in a.) above may be appointed non competitively within 1 year of the separation."

MP-5, Part I, VHA Supplement 302, section 302B, para 302B.4a PAID code revised to "Y51" not V8.

MP-5, Part I, Chapter 575, section C rescinded by VA Directive and Handbook 5575.3/1.

MP-5, Part II, Chapter 3, Section E, para 8c 'Periodic Step Increases' revised to be consistent with VA Handbook 5103.9, Part I, para 12c.

September 15, 1999

MP-5, Part I, Chapter 712, para 7c. Corrected to read: "The activities will *not* be represented..."(emphasis added)

MP-5, Part II, Chapter 5, para 8e(4) Note revised to eliminate reference to key nursing personnel and nurse anesthetists

August 20, 1999

MP-5, Part I, VA Supplement 532-1, Section E. A link to VA Directive 5532.1 is provided for this rescinded supplement.

August 18, 1999

MP-5, Part I, Chapter 771, Appendix A, para 5 has been corrected to read "effected", rather than "rejected."

July 29, 1999

MP-5, Part II Chapter 3 and VHA supplement have been separated and new links established from Part II Table of Contents.. In addiiton, the individual "Table of Contents" for both sections have been linked to the paragraphs within the document

for improved navigation within one document.

July 21, 1999

MP-5, Part II, VHA Supplement, Chapter 7, Paragraph 7.11a(3) - corrects sentence to read that special pay "...is considered basic pay for the purpose of lump-sum leave payments."

July 19, 1999

MP-5, Part II, VHA Supplement, Chapter 2, Paragraph 2.19 - corrects wording on Oath, Affidavit, and Declaration for Federal Employment.

MP-5, Part II, VHA Supplement, Chapter 2, Paragraph 2.61 - corrects reference to read "For residents, see par 2.63."

MP-5, Part II, VHA Supplement, Chapter 2, Appendix 2-C, RCVL - Corrects page numbers to read 2C-1 and 2C-2.

May 11, 1999

MP-5, Part I, Chapter 300, Paragraph 4 c(2) - correctly cites 38 U.S.C. 513 as appropriate reference.

April 26, 1999

MP-5, Part I, Chapter 511, Appendix B, Exhibit 2, Paragraph 2 - corrects supervisory ratio to 1:15 (instead of 1:5)

March 15, 1999

MP-5, Part I, Chapter 302, Paragraph 9 b - corrects last sentence to cite reference regarding appeal rights for probationary period employees.:

MP-5, Part I, Chapter 315

Paragraph 8a & b - corrects for inclusion of physical/mental disability, reprisal

Paragraph 8c - corrects time limitations for filing MSPB appeals and EEO complaints

MP-5, Part I, Chapter 630, Paragraph 23 f (6) - Transfer of Annual Leave. Corrected to read that "Transferred annual leave may be substituted retroactively for periods of leave without pay.... Previous version incorrectly stated that annual leave may not be substituted..

MP-5, Part II, Chapter 2, VHA Supplement, Appendix 2J3 - Added "Selection Criteria for Chief, Pharmacy Service" which had been omitted from previous version.

February 10, 1999

MP-5, Part I, Chapter 300, Paragraph 15c(3) - Beginning with the last sentence the paragraph should read:

" For all actions involving centralized and noncentralized employees in Central Office, approval must be obtained from the appropriate Administration Head, Assistant Secretary, or other Key Official in advance. The authority to detail career and non-career SES and Schedule C employees is not delegated. These details must be approved by the Secretary. All requests must be routed through the Deputy Assistant Secretary for Human Resources Management."

MP-5, Part I, Chapter 302, Paragraph 1b - Insert "not" so that beginning of sentence reads " This chapter does not apply...".

VHA Supplement to MP-5, Part II, Chapter 2, Paragraph 2.05d - The word "successful" should be "unsuccessful."

VHA Supplement to MP-5, Part II, Chapter 2, Paragraph 2.63a - Citation in parentheses should be changed to "See MP-5, pt. II, Chapter 2, Section C."

VHA Supplement to MP-5, Part II, Chapter 8, Paragraph 8.34b(1)(c)2 - Change the Decision Official from "Deputy Under Secretary for Health" to "VISN Director."

MP-5, Part II, Chapter 3, Section A, Paragraph 7a - In the last sentence, replace the second notation of "Under Secretary for Health" to "appointing official."

MP-5, Part II, Chapter 3, Appendix F, Paragraph 3d - Change the first "Psychiatry" in the second column to "Physiatry."

MP-5, Part II, Chapter 5, Contents Page - Replaced in its entirety to reflect proper page numbers.

Back to MP-5 Chapters

Kenneth H. Quantock

Revised: February 08, 2001.

NOTE

What purports to be an advance approval requirement in paragraph 4(f) of MP-5, Part II, Chapter 13, dated October 30, 1998, for Directors to participate in outside activities is unenforceable, consistent with VHA Directive 5113, styled Outside Professional Activities. Any pre-approval requirement for an outside activity that purports to remain in the current MP-5, Part II, Chapter 13, is an administrative error and oversight. Formal rescission of MP-5, Part II, Chapter 13, dated October 30, 1998, will occur shortly.

Employees considering outside employment activities are urged to consult with ethics advisors in the Regional Counsel's or General Counsel's office.

[CLICK HERE TO CONTINUE TO MP-5, PART II, CHAPTER 13](#)

October 23, 2000

ENCLOSURE 5

Department of
Veterans Affairs

Memorandum

Date: JAN 31 2001

From: Director, Hotline Division (53E)

Subj: Hotline Case Number 2001 HL-0268, VAMC, Albuquerque, NM (501)

To: Director, VA Medical Center, Albuquerque, NM (501/00)

OFFICE OF INSPECTOR GENERAL REFERRAL

1. Response Due Date: **March 30, 2001**

2. The allegations described in the attachments were reported to the Office of Inspector General and are referred to your office for review in accordance with MP-1, Part I, Chapter 15.

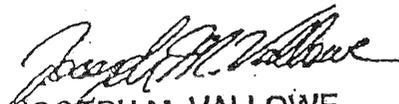
3. Please determine the merit of each complaint or allegation. When the review is complete, provide a report to:

VA OIG Hotline (53E)
P.O. Box 50410
Washington, DC 20091-0410
Attn: Ms. Dorcas Smith

You may also fax your report to 202-565-7936. The report should include the OIG control number above, describe how the allegations were reviewed, whether the allegations were substantiated, the corrective actions taken for any substantiated allegations, and the completion dates of the corrective actions. Please provide the documentation that supports your finding on each allegation. You should also include a point of contact and a telephone number or e-mail address in case we have follow-up questions. You should make every effort to protect the identity of the complainant during your review.

4. For your information, all or part of your report to the Inspector General may be available to the complainant under the Freedom of Information Act.

5. If you have any questions, please call Ms. Dorcas Smith at 202-565-8647.


JOSEPH M. VALLOWE

Attachment

cc: 105E

RECEIVED
JAN 31 2001
OFFICE OF THE DIRECTOR
VA MEDICAL CENTER
ALBUQUERQUE, NM

REPORT OF CONTACT

Date: JAN 31 2001

HOTLINE CASE NO.: 2001 HL-0268

ISSUES OR ALLEGATIONS TO BE ADDRESSED: VAMC, Albuquerque, NM (501)

SUBJECT(S) OF INVESTIGATION: (Mr. [REDACTED])

2. Alleged misuse of official time. Complainant alleges that Dr. [REDACTED] of the VA Medical Center, (Albuquerque, NM) has been working other jobs during his tour of duty at the VA clinic.

DETAILS OF ALLEGATIONS OR COMPLAINT:

See Attached.

Department of Veteran Affairs,
Office of the Inspector General
810 Vermont Ave., NW
Washington, DC 20420

excessive work hours the physician in question, Dr. [REDACTED] the
[REDACTED] worked at other jobs while working at the clinic.
There was a deposition in the packet [REDACTED] OSI,
where Dr. [REDACTED] states to his attorney that he would be
coming off a 60 hour shift at one of his second jobs- 60
hours on the weekend- so he did not want to do the
deposition on Monday as his attorney said he would be
'trashed' on Monday. (See page 88 of deposition)

Also see page 27-33 especially page 34 where he agrees
he is working, ...up to 140 (one hundred and forty) hours
a week.

On page 29 DR. [REDACTED] states he moonlights. "As much
as I can".... "I can work 60-70 hours straight".

Dr. [REDACTED] he was counseled by his supervisor
on this issue when it came to light.

he
would work Friday night through Sunday night, get off
Monday morning and come to the clinic. Many times he would
work nights through the week. 'The money is too good'.

he was filing [REDACTED]
and he should stop [REDACTED].
All three of the pieces the OSI said were second-hand
information ([REDACTED] and working extra
hours) are first hand, with one documented extensively in
the affidavit

ENCLOSURE 6

Date: September 29, 1999

From: [REDACTED] M.D.

Subject:

To: Joseph H. Sifers, M.D.
Robert B. Parsons, M.D. *RF*
Bruce L. Horowitz, M.D. *RF*

I denied the allegations that I work under the influence of alcohol. I have never been under the influence of alcohol in my clinic. I never admitted that I have an alcohol problem. When the Clinic Director, Beth wrote the ROC the first time I told Dr. Horowitz that I would be happy to give a blood sample if she or any other employee smells alcohol on me in the future. I am still prepared to do this in the future upon request. I can give a blood sample twice a week up to any amount of time upon request.

My performance at the job is perfect. I am calling my patients and writing them letters about their blood test results. My patients appreciate my services and me. I am always on time and leave my job on time.

I am sending only those people for consultations if they really need it. Please inquire to Beth in Hematology/Oncology about the patient named Mr. [REDACTED].

Mr. [REDACTED] requested his care to be transferred to the Albuquerque VAMC. But he did not see his MD and I was still responsible for his care. Mr. [REDACTED] urine sample was negative due to the fact that he was out of his medications. He came to the clinic for his medication refill at the time that the urine sample was taken.

I follow all of the VA Policies in my clinic. I never blamed anybody in the clinic. But, I did ask the Clinic Director Beth for smoking cessation classes, cholesterol education and to take all of the triage calls, which she was not doing. The previous RN, Cheryl was doing phlebotomies in the clinic and the RN Beth is not doing that either. She doesn't draw labs herself but makes the LPN or the Health Worker do it. I am not angry with anybody. I always follow whatever we discuss in our staff meetings and whatever the VA Directive is. She is not triaging the patients. Recently, a patient came in with chest pain (patient name [REDACTED]), and she sent him to the ER without checking his vital signs and without doing any EKG. These patients may have had MI? I would be more than happy to explain and/or discuss in detail any aspect of these allegations. Thank you.

Sincerely,

[REDACTED]
[REDACTED] M.D.

ENCLOSURE 7

December 5, 2000

On February 14, 2000, at 11 a.m., Dr. Barbara K. Chang, Chief Medical Officer, met with Dr. [REDACTED], Department of Anesthesiology, University of New Mexico School of Medicine. Dr. [REDACTED] is a member of the Health Professions Wellness Committee of the New Mexico Board of Medical Examiners. His committee is charged with looking into questions of impairment of health professionals as they arise and also primarily to assist, with a support network for health professionals and their families, for re-entry and rehabilitation into professional practice. In this instance, Dr. [REDACTED] had contacted Dr. Chang to follow-up on a report and allegations regarding Dr. [REDACTED] received from staff at the [REDACTED] VA Community-Based Clinic. Based upon the February 14th meeting and the information received, Dr. [REDACTED] did not feel that there was enough information to proceed with any kind of action with respect to Dr. [REDACTED]. However, Drs. Chang and [REDACTED] agreed to contact each other if any further information was received or if any assistance was needed. Dr. Chang contacted [REDACTED] again today and determined from him that no further information [REDACTED] had been received.


Barbara K. Chang, MD, MA

12/05/00
Date