



U.S. OFFICE OF SPECIAL COUNSEL

1730 M Street, N.W., Suite 300

Washington, D.C. 20036-4505

The Special Counsel

August 29, 2001

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-00-0866

Dear Mr. President:

In accordance with 5 U.S.C. § 1213(e)(3), I am transmitting a report provided to me pursuant to 5 U.S.C. §§ 1213(c) and (d) by the Honorable Hershel W. Gober, former Acting Secretary of the Department of Veterans Affairs. The report sets forth the findings and conclusions of the former Acting Secretary upon investigation of disclosures of information allegedly evidencing a substantial and specific danger to public health and safety at the Department of Veterans Affairs (VA), Veterans Community-Based Outpatient Clinic (Clinic), Gallup, New Mexico.

The whistleblower, Elizabeth McDonald, the former Director of the Clinic, consented to the release of her name. She also provided comments on the agency report to this office pursuant to 5 U.S.C. § 1213(e)(1), which I am also transmitting.

These allegations were referred to the Secretary of the Veterans Affairs for investigation on November 13, 2000. The New Mexico Veterans Affairs Health Care System conducted an investigation and sent a report to this office on March 8, 2001. Upon further inquiries from my office, the VA conducted additional investigations and provided supplemental reports dated April 6, 2001 and June 21, 2001.

We have carefully examined the original disclosures and reviewed the agency's response and Ms. McDonald's comments. Pursuant to 5 U.S.C. § 1213(e)(2), I have determined that the findings in the agency's report appear reasonable and contain all of the information required by statute.

The Whistleblower's Disclosures

Ms. McDonald is a registered nurse who became the Clinic Director in November 1998. She alleged that on at least four occasions the Clinic physician treated patients while under the influence of alcohol.

The President
Page 2

The Clinic is located in a small rural community northwest of Albuquerque. It has approximately six employees. The Clinic physician is the only physician for the estimated 1400 Clinic patients. As Clinic Director, Ms. McDonald supervised the Clinic operations and staff, with the exception of the physician, who is supervised by a physician with VA Medical Services.

In the beginning of April 1999, Ms. McDonald reported her suspicions about the physician's drinking to her Quality Management Supervisor (QMS), Ms. Gail Guy. Ms. Guy instructed her to file Reports of Contact (ROCs) noting her concerns and any problems at the Clinic. According to Ms. McDonald, Ms. Guy notified her supervisor, Ms. Pamela Gustafson. In turn, Ms. Gustafson's supervisor, Ms. Cynthia Nuttall, Acting Chief of QMS, was to notify the physician's supervisor, Dr. Bruce Horowitz.

Ms. McDonald filed ROCs documenting four occasions when she believed that the physician smelled of alcohol while on duty. In addition, she noted that the physician appeared to exhibit other indicia of alcohol use. These included confusion, memory loss, inability to understand Ms. McDonald's statements regarding the patients, failure to note medications in patient charts, lack of coordination, and difficulty operating some office equipment such as the facsimile machine and the computer. She stated that he also stepped away from people when speaking to them.

On February 16, 1999, Clinic staff reported to Ms. McDonald that the physician smelled of alcohol. On March 25, 1999, Ms. Rebecca Muncy, Director of the Artesia Clinic, reported the same observation.

Ms. McDonald discussed these incidents with the physician on April 5, 1999. According to Ms. McDonald, the physician admitted that he had a problem with alcohol and stated that he and his wife were working on it. He also stated that it would not happen again. Subsequently, on June 2, 1999, Ms. McDonald smelled alcohol on the physician while he was treating patients.

Ms. McDonald stated that despite the filing of ROCs, VA officials took no action on the allegations from February to September 1999. Therefore, in September 1999, Ms. McDonald went outside her chain of command and contacted Ms. Barbara Jamarillo, the RN manager of the outpatient clinic at the Albuquerque VA hospital. Ms. Jamarillo reportedly contacted the physician's supervisor, Dr. Horowitz. In October 1999, Ms. McDonald contacted Ms. Nuttall, the Acting Chief of QMS directly to discuss her concerns.

The Clinic physician worked in another VA facility in Albuquerque for a period of approximately four months, September 1999 to December 1999. In October 1999, an internal Board of Inquiry (BOI) was convened to review the allegations that the

The President

Page 3

physician was under the influence of alcohol while treating patients and allegations of absenteeism. On November 2, 1999, during an interview under oath, the physician denied that he had a drinking problem and denied that he had ever made such an admission. Ms. McDonald and the other staff members were also interviewed and confirmed the previous reports regarding the physician smelling of alcohol.

When the physician returned to the Clinic during the last week of December 1999, Ms. McDonald was advised by her supervisor that if the staff had a "reasonable suspicion" that he was under the influence of alcohol she should notify Mr. Tim Koerber, a licensed clinical social worker and the VA Transitional Center Director. Mr. Koerber would then take the physician to the Rehobeth Medical Center (Rehobeth) in Gallup for a blood/alcohol test.

Ms. McDonald alleged that on January 18, 2000, at approximately 10:00 a.m., the staff reported that the physician smelled of alcohol. Ms. McDonald had also noticed the smell of alcohol. Mr. Koerber was notified and arrived at approximately 11:30 a.m. to escort him to Rehobeth for the blood/alcohol test. According to Ms. McDonald, the physician delayed going to the hospital for approximately 30-45 minutes while he drank large quantities of water. It was her understanding that the results of the test were inconclusive.

In February 2000, Ms. McDonald was told not to file additional ROCs on the physician because VA officials believed the Clinic's problems were management-related, not caused by the physician's drinking. After the January 18th incident, Ms. McDonald noted that the physician smelled of alcohol at work on one other occasion. Due to the negative response from VA management, however, she did not report this incident. She also noted numerous incidents of the physician's absenteeism and the alleged detrimental effect of his absenteeism on the Clinic's operations and patients. Finally, Ms. McDonald alleged that as a result of the VA management's poor response to the Clinic staff and failure to take corrective action against the physician, that the staff has been "chilled" from reporting other incidents of the physician smelling of alcohol.

The Department of Veterans Affairs Investigation and Reports

Upon receipt of OSC's referral under 5 U.S.C. § 1213(c), the Interim Chief Executive Officer of the New Mexico Veterans Administration Health Care Systems (NMVAHCS) reviewed the proceedings conducted by the Administrative Board of Inquiry (BOI) in November 1999. The Chief of the Performance Improvement Section at NMVAHCS conducted an additional investigation reviewing information from numerous sources including the BOI, the Clinic physician's time and leave for calendar years 1999 and 2000, the Clinic physician's work load reports for 1999 and 2000, and

The President
Page 4

Clinic no-show rates for dates in January 1999 and January and February 2000 and January 2001. The Chief also reviewed ROCs about the physician filed in calendar years 1999 and 2000, as well as police and security reviews conducted in 2nd quarter of FY 00, Patient Satisfaction Surveys, records of appointments cancelled, records of the physician's credential and privilege file, and his employee health record.

Another component of the investigation was a peer review conducted by a Primary Care Physician with significant experience in the practice and management of community-based clinics. He reviewed the medical records of 80 veterans as well as the credential and privilege folder for the physician, ROCs, Incident Reports, Quality Management Reports and relevant Peer Reviews. The investigation also included interviews with several personnel. In addition to the Clinic staff, five staff physicians, the Veteran's Transition Center Director, the Interim Chief Executive Officer and the Chief of the Internal Medicine Service were interviewed.

The VA report states that the BOI of November 1999 did not substantiate the allegations that the physician was treating patients while under the influence of alcohol or that his rate of absenteeism was excessive. Also provided was a summary of the BOI's recommendations.

Discussion of Allegations Regarding Alcohol Use and Absenteeism

The second investigation into these allegations, generated by OSC's November 2000, transmittal of the whistleblower's allegations, was also unable to substantiate the allegations that the clinic physician was treating patients while under the influence of alcohol or that he was otherwise impaired by alcohol while at the Clinic. In addition, no evidence was found to substantiate Ms. McDonald's allegations of absenteeism, inadequate patient care due to the physician's absenteeism, or violations of any laws, rules, or regulations. The investigation of the absenteeism allegation included reviews of the Clinic physician's time and attendance records, Clinic cancellations and workload reports.

The Clinic staff corroborated the instances of smelling of alcohol in 1999 and January 2000 as alleged by Ms. McDonald. They stated, however, that they were pressured by Ms. McDonald to file ROCs regarding the physician and feared for their jobs if they did not. During the investigative interviews, staff members stated that if asked to testify today they would say they were coerced by Ms. McDonald to write up the Clinic physician and that the testimony before the BOI was "skewed" toward supporting Ms. McDonald's opinion.

The report also states that the Clinic personnel denied smelling alcohol on the Clinic physician after the January 18, 2000 incident. When asked specifically whether

The President

Page 5

they had been "chilled" from reporting such incidents, they stated that Ms. McDonald told them that NMVAHCS management would not do anything, nor support them.

The report confirms that Ms. McDonald was told to stop filing ROCs on the physician by the Administrator of the Clinic at NMVAHCS. The Administrator reportedly issued this instruction because Ms. McDonald was resending the ROCs describing incidents that had already been investigated by the BOI.

The report also included summaries of the interview with the Clinic physician and Ms. McDonald. The physician denied all charges regarding the smell of alcohol. He also stated that he told his supervisor that he was willing to have a blood/alcohol test at any time. The report notes Ms. McDonald's concern that attempts to address the physician's problems were futile and that, in this instance, physicians were "taking care of physicians." The interview with Ms. McDonald prompted a review of Clinic security and incident reports, but did not provide information not already set forth in previous complaints.

The peer review findings of the Clinic physician's practice concluded that his use of diagnostic testing, consultation requesting, and treatment patterns were consistent with established medical practices. The review noted, however, that the physician's documentation practices were questionable, and indicated a pattern of recording information not based on actual examination. The reviewing physician suggested that the Clinic physician might be relying on a computerized pre-defaulted template. He also noted examples of narcotic prescribing that might be considered outside acceptable clinical parameters. The report stated that NMVAHCS would further review the issues identified by the peer review.

With respect to the blood alcohol test conducted on January 18, 2000, the investigator spoke with Mr. Tim Koerber, the VA Transition Center Director. He stated that 15 minutes passed between the time he was called and when he arrived to take the Clinic physician to Rehobeth. The test results were negative; the Clinic physician's supervisor reviewed the test controls and results, as did the VA investigator. The report states that the total amount of time that passed from when the smell of alcohol was noted to the time the test was done was a little over an hour. The VA also contacted a physician expert from the Alcohol and Substance Abuse Program at NMVAHCS for an opinion about the possibility of altering the result of a blood/alcohol test by drinking large amounts of water. According to the expert, alcohol stays in the bloodstream for 3-6 hours and is affected by such factors as age and tolerance for alcohol. In his expert opinion, however, drinking a large amount of water prior to a blood alcohol the test would not affect the outcome.

The President
Page 6

OSC submitted a number of questions to the VA in response to the agency's report. Specifically, OSC asked for clarification on the Patient Satisfaction Surveys reviewed, the Clinic staff members interviewed, and the response provided by the physician on the presence of beer in the refrigerator and liquor bottles found in the bathroom trash. In addition, OSC also asked for clarification on the VA's review of the use of computerized templates at the Clinic and the Clinic physician's narcotic prescribing practices.

In its first supplemental report dated April 6, 2001, the VA addressed these issues. The report states that the Patient Satisfaction Surveys from all relevant years, including 1999, were reviewed during the investigation. In addition, the report notes that all Clinic staff members were interviewed by the Chief of the Performance Improvement Section during the course of the investigation. The Clinic physician denied any knowledge of the beer and alcohol at the Clinic.

Discussion of Administrative and Management Actions

The VA's report includes a description of action taken or planned in response to the investigation initiated by the OSC. The report set forth several steps that management plans to undertake as follows: 1) management will review Manual of Personnel-5 (MP-5) on physician employment and VHA supplements by March 23, 2001; 2) management will review government regulations related to employment drug testing by March 23, 2001; 3) the New Supervisor Orientation has been revised to include a mentor and clarification of the role of the direct supervisor; 4) management will review and restructure the Peer Review system for ambulatory clinics, a peer review consultant is scheduled to participate in this review on April 11-12, 2001; 5) management will review the use of overprinted templates in the medical records of the Clinic by April 30, 2001; and by July 1, 2001, for other programs; 6) management will review the narcotic prescribing by practitioners for the Clinic by April 30, 2001; and by July 1, 2001 for other programs.

In addition, management has designed a plan to improve the facility's procedure for investigating public health and safety allegations raised by VA personnel. The plan includes training by the Education Service for new and existing supervisors on the procedure for reviewing ROCs. The Education Service will submit the training outline to the facility's CEO by the end of the second quarter of FY 01 and the training is to be completed by the end of FY 01. Staff members will be provided with options for reporting public health and safety concerns observed at NMVAHCS facilities. Staff will be able to report their concerns through their supervisory chain of command or contact the Patient Safety Coordinator through a dedicated telephone number. The NMVAHCS has determined that the option approach is necessary because there may be instances when the supervisor is part of the problem. The option approach will be

The President
Page 7

reviewed by the Service Chiefs and the American Federation of Government Employees and is expected to be implemented by the end of the 2nd quarter of FY 01.

During the 3rd quarter of FY 01, staff will receive training on the option approach. Information on the new program will be published in the Employee Weekly Bulletin, the Quality Bi-monthly Newsletter, and a Patient Safety pamphlet and will be distributed throughout the Medical Center. In addition, a flow chart describing the option approach will be distributed to all employees and the option approach will be reviewed at staff meetings and meetings of the Administrative and Clinical Service Chiefs. By the end of the 4th quarter of FY 01, and on a quarterly basis thereafter, the Patient Safety Coordinator will present a report to management comparing the number of allegations made under the new option approach with the previous reporting system. Information will also be provided on corrective actions taken by the Patient Safety Coordinator and or the medical services divisions. Finally, the report states that management will review the reporting structure of the CBOCs, such as the Clinic at issue in this case, by April 30, 2001 to enhance collaboration and communication across various reporting disciplines.

In the first supplemental report dated April 6, 2001, the VA noted that a review of narcotic prescribing practices for practitioners at outpatient clinics was underway. A pharmacist had been designated to undertake the review using information that complements the Joint Commission on Accreditation of Health Care Organizations Standards for Pain Management and the VA's 5th Vital Sign Pain Management Program. The results of the review will be given to the Medication Use Committee on a quarterly basis; the first report was submitted on April 4, 2001.

In the second supplemental report dated June 21, 2001, the VA concluded that when these allegations regarding the physician were made, the procedures for reporting and investigating allegations of alcohol use and or substandard patient care were inadequate. The procedures in place during 1999 hindered management's ability to promptly investigate and address the allegations. As described previously, management has implemented new procedures to correct the inadequacies. The new procedures will also provide for ongoing evaluation to ensure that performance problems in the New Mexico system will be reported and investigated in a timely manner.

With respect to the Clinic physician at issue in this case, management evaluated the Clinic physician's performance and the quality of care provided during the time period the alleged misconduct was taking place. As a result of that evaluation, the VA concluded that during the time period the physician was allegedly using alcohol patients at the clinic were receiving appropriate care and treatment.

The President
Page 8

The second supplemental report also provided an update on the actions taken by the VA as follows:

1. The Chief of Human Resources was asked to provide clinical and appropriate administrative service chiefs and supervisors with access to MP-5, Part II regulations on physician employment and VHA supplements. The Chief of Human Resources will confirm that the above-named individuals have reviewed the policy by September 30, 2001.

2. A review of government regulations related to employee drug testing was completed in March 2001. The Chief of Human Resources has advised that under VA Directive 5383, the VA may test for any drug identified in Schedule I or II of the Controlled Substances Act. However, this directive does not include blood alcohol testing. The Chief of Human Resources recommended that the Employee Assistance Program (EAP) review the issue of blood alcohol testing; the Chief, Performance Improvement Section also asked EAP to review this matter and provide VA management with recommendations by June 30, 2001.

3. VA management has revised the New Supervisor orientation to include assignment of a mentor from a like position. The role of the direct supervisor has also been clarified.

4. An outside consultant conducted a review of the Medical Center's peer review process for ambulatory clinics, also referred to as CBOCs. In response to the consultant's report, the Chief Medical Officer developed a plan addressing the issues in the consultant's report. The plan will be implemented by September 30, 2001.

5. A review of the Clinic's use of overprinted templates in the medical records was conducted. In addition to the 80 patients reviewed in the peer review process in February 2001, the records of 238 additional patients were reviewed. The analysis shows that the templated notes appear to be edited properly. Therefore, no further action will be taken on this matter at the Clinic. A review of other programs and sites is underway; completion of the review is expected by July 1, 2001.

6. Management reviewed the Clinic Physician's narcotic prescribing practices specifically examining whether the his prescribing pattern was within the normal prescribing protocol for the safe and effective use of controlled substances for chronic pain management. A random sample of prescriptions was selected for review; the review period was March 2000-March 2001. The report states that the analysis of the prescriptions showed that the Clinic physician was consistent with current facility-wide documentation practice. The report also noted that the Director of Pain Management

The President
Page 9

and the Pain Management Team of the NMVAHCS continue to monitor this matter as part of a facility-wide improvement plan.

A review of the narcotic prescribing practices of other programs and sites is also underway. These reviews will be done on a monthly basis with reports sent to the Medication Use Committee and Executive management as part of the facility-wide improvement plan.

7. Management has designed procedures for the investigation of public health and safety issues allegations raised by staff. An online computer training system has been developed that includes a requirement that all supervisors complete this training by September 30, 2001, as part of their annual mandatory training. Action has also been taken to revise the manner in which allegations are made and educate that staff about the new procedures. The Medical Center Memorandum published on March 30, 2001, and entitled "Patient Safety Improvement" has been revised to reflect the option approach employees may now use to report such allegations. This memorandum will be incorporated into the mandatory training for new employees, flyers were distributed to all employees on May 21, 2001, and a description of the option approach was published in the 2nd quarter Quality Newsletter that is distributed to all employees. The description will also be published in the 3rd quarter newsletter. The option approach was discussed at the Director's staff meeting. The first report from the Patient Safety Coordinator on employees' use of the option approach is due on September 30, 2001.

Management reviewed the organizational reporting structure of the CBOCs has been completed. The Service Director of the CBOCs has provided a reorganization proposal to the Chief Medical Officer. This proposal is scheduled for review and discussion with the new Chief Executive Officer in mid-July.

The Whistleblower's Comments

Ms. McDonald provided lengthy comments, summarized only briefly here, in which she disagreed with the investigation and its conclusions. In particular, she found it troubling that a physician could smell of alcohol while working at the Clinic and yet not be deemed impaired. She noted that she has considerable experience with substance abuse issues and questioned the lack of definition and guidelines used by the Albuquerque VA in reaching its determination. Ms. McDonald took exception to the statements given by staff members. She objected to the staff's characterization of her actions and to their assertion that their testimony at the BOI was skewed in response to her influence. She emphasized that staff members repeatedly brought their concerns regarding the physician smelling of alcohol and his conduct in the Clinic to her. She states that she was responding to their concerns and voicing her own.

The President
Page 10

In addition, Ms. McDonald noted that a Clinic staff member, Ms. Marion Bell, listed the physician's drinking and the workplace stress that it caused her as the underlying reason for her request for Worker's Compensation.¹ Further, Ms. McDonald noted that Ms. Rebecca Muncy, Director of the Artesia Clinic, who had commented on the physician smelling of alcohol, had not been interviewed.²

Ms. McDonald also expressed concern with the number of hours the physician was working at another facility and the level of absenteeism she observed. She felt the investigation did not accurately reflect the inconvenience experienced by the patients and noted that during the time she served as director of the Clinic many appointments had to be rescheduled. She also noted that ROCs were filed on a number of topics including, violence issues at the Clinic, the physician not wearing gloves, the physician not getting consent forms signed, and complaints from patients.

¹The VA investigated this issue in its second supplemental report dated June 21, 2001. The report notes that on May 31, 2001, the Chief, Performance Improvement and Clinical Program Manager and the Clinical Investigator of the VHA Office of Medical Inspection conducted a second interview with Ms. Bell regarding her OWCP claim. During that interview, Ms. Bell recanted statements made to the OWCP that the staff had been under extreme stress due to the physician's alcoholism and the unresponsiveness of the Quality Management Service. She stated that she filed the OWCP claim to draw attention to the Clinic's problems. She now contends that she could not handle Ms. McDonald's comments about the physician's alcoholism and the conditions of the Clinic. In March 2000, Ms. Bell sought professional help and through counseling identified the source of her stress as Ms. McDonald, not the physician. As a result, she did not follow through with her OWCP claim. Ms. Bell also confirmed four occasions when she smelled alcohol on the physician's breath; three of these occurrences were in 1999 prior to the BOI, the last was in January 2000. These were the same instances alleged by Ms. McDonald.

²The VA interviewed Ms. Muncy, the former Clinic Director of the Artesia Clinic on May 30, 2001 and discussed the interview in the second supplemental report. She visited the Clinic for a week to mentor Ms. McDonald in 1999 and smelled what she thought was alcohol on the physician's breath. However, she noted that he did not exhibit any signs of impairment or intoxication and that she was not in a position to evaluate the care he provided. She informed Ms. McDonald and her supervisor of her observations but was unaware of any action taken on the issue. Ms. Muncy also stated that she was aware that some communication problems existed among the staff but she was unaware of the allegations involving alcohol. While at the Clinic Ms. Muncy noted the stress among the staff and also heard various stories about the physician from the staff. She did not witness anything confirming those stories.

The President
Page 11

Finally, Ms. McDonald stated that her management of the Clinic and her actions reporting the physician were motivated by her concern for patient care and safety. When she felt that she could not manage the Clinic in a manner that provided the appropriate level of care for the veteran population, she resigned her position. Ms. McDonald stated that the staff was in many ways dysfunctional. She tried to be as responsive as she could to their concerns as well as their requests for leave. In addition, she nominated staff members for awards. In fact she reports that staff members told her many times that she was the most supportive supervisor they had had. For these reasons, it is unclear to her why the staff has so dramatically changed their opinions and statements regarding the problems at the Clinic, her actions, and the allegations involving the clinic physician.

Conclusion

This case involved serious allegations potentially affecting the VA patients seeking treatment at the Clinic. Given the seriousness of the allegations and the statements by the Clinic staff that the physician smelled of alcohol, this case is troubling. Nevertheless, due to the lack of evidence establishing the physician was impaired by, or under the influence of, + alcohol while on duty, I am not able to conclude that the agency's determination is unreasonable. In the one instance where a blood/alcohol test was performed in response to the Clinic staff and Ms. McDonald noting the smell of alcohol on the physician, the test result was negative.

Based on the representations made in the report and as stated above, I have determined, pursuant to section 1213(e)(2), that the findings in the agency's report appear reasonable and contain all of the information required by statute.

As required by section 1213(e)(3), I have sent a copy of the report and Ms. McDonald's comments to the Chairmen of the Senate and House Committees on Veterans' Affairs. We have also filed copies of the report and Ms. McDonald's comments in our public file and closed the matter.

Respectfully,



Elaine Kaplan

Enclosures