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November 27, 2002

The Special Counsel

The President  
The White House  
Washington, DC 20500

Re: OSC File No. DI-01-1111

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 Anthony J. Principi, Secretary of Veterans Affairs. The report sets forth the findings and conclusions of the Secretary upon investigation of disclosures of information allegedly evidencing a substantial and specific danger to public health and safety, arising out of actions by officials at the Department of Veterans Affairs, (VA) Pittsburgh Healthcare System (VAPHS), University Drive Division (University Drive), Pittsburgh, Pennsylvania.

The whistleblower, Helen M. Pollitt, Registered Respiratory Therapist, 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 Veterans Affairs for investigation on November 29, 2001. An investigation was conducted by the VA Office of the Medical Inspector, and Secretary Principi sent a report to this office on May 10, 2002.

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

**The Whistleblower's Disclosures**

Ms. Pollitt is a Registered Respiratory Therapist at the VAPHS, University Drive, Pittsburgh, Pennsylvania. She alleged that University Drive respiratory patients do not receive proper medical care and attention, resulting in a disproportionately high number of patient deaths due to respiratory illness.

Specifically, Ms. Pollitt alleged that University Drive does not have the training nor the equipment to properly care for respiratory patients. Unlike other VA medical centers in the

area, University Drive does not have a separate pulmonary unit. Consequently, according to Ms. Pollitt, respiratory patients are assigned to general medical floors where they do not receive the level of attention needed for patients in such unstable physical condition. Further, Ms. Pollitt has observed a number of respiratory patients left unattended, creating a dangerous situation. According to Ms. Pollitt, respiratory patients are transferred frequently between units because no unit is equipped or staffed to handle these types of patients. Indeed, according to documents made available to our office, from December 1999 through November 2000, 11 pulmonary patients were transferred more than 72 times between units. Out of those 11 pulmonary patients, 6 of the patients died due to either respiratory arrest or complications from their respiratory condition.

According to Ms. Pollitt, the VA's Interim and Interdisciplinary Care Plan (Care Plan) contains specific instructions for the care of respiratory patients. The Care Plan provides that acute respiratory patients should receive constant monitoring and a staff member should be assigned to the patient to ensure that an airway remains open. However, Ms. Pollitt alleged that University Drive does not assign staff to acute respiratory patients nor are respiratory patients under constant monitoring.

Lastly, Ms. Pollitt alleged that University Drive does not maintain proper supplies and equipment necessary to attend to respiratory patients. In particular, she noted that there is a shortage of regulators and resuscitator bags. Moreover, she stated that the crash carts do not contain suction equipment, which is needed in the event that a tracheotomy patient stops breathing due to a blocked airway. According to Ms. Pollitt, the constant shortage of equipment hinders the medical staff's ability to respond to respiratory patients in an emergency.

#### **The Department of Veterans Affairs Investigation and Report**

Ms. Pollitt's allegations were investigated by the VA Office of the Medical Inspector (OMI). The OMI's investigation consisted of (1) an interview with Ms. Pollitt, (2) a site visit to University Drive conducted by one physician who specializes in pulmonary disease and two registered nurses, (3) a clinical peer review of the 11 patient cases specifically cited by Ms. Pollitt, that was conducted by two physicians who specialize in pulmonary disease and two respiratory therapists, and (4) a review of all VAPHS policies and procedures concerning respiratory patients, also performed by the two physicians and respiratory therapists who conducted the peer review. The investigation failed to substantiate Ms. Pollitt's allegations. The agency report concluded that the level of respiratory care provided to patients at VAPHS meets acceptable standards and does not pose a threat to their health or safety.

Based on a clinical peer review of the 11 patient cases cited by Ms. Pollitt, the reviewing team concluded that all of these patients had received adequate medical attention. They reported that only four of the patients had a primary respiratory diagnosis; of the

remaining patients, four had terminal cancer and three suffered from other long-term debilitating diseases. Of the six patients who died, four died from cancer, another had requested a "do not resuscitate" order after being diagnosed with inoperable mesenteric ischemia, and the last patient died in the VAPHS nursing home. The reviewing physicians commented that these particular patients were elderly and quite sick, and only one of them died unexpectedly. In regard to patient transfers, they found most of them to be timely and appropriate. Although they determined that two of the patients may have been transferred from acute care to the nursing home prematurely, they also noted that these two patients had been subsequently transferred back to acute care and treated appropriately. Thus, the reviewing team did not find evidence that any of these patients died due to inadequate respiratory care.

The OMI team also examined relevant VAPHS documents, including VAPHS respiratory care policies, a report of an external review of post-operative respiratory occurrences, and a memorandum from the VAPHS Director. In addition, OSC provided the OMI with a copy of a document submitted by Ms. Pollitt entitled "Interim and Disciplinary Care Plan." According to the agency report, the investigators were unable to locate this document among VAPHS records, and VAPHS staff claimed that they had never seen nor used these documents, nor were they aware of any requirement to do so. The reviewing team concluded that VAPHS policies provided appropriate respiratory care guidance for respiratory therapists and registered nurses.

A site visit was conducted on March 20 and 21, 2002, by a physician specializing in pulmonary and intensive care medicine and two registered nurses. The visiting OMI team interviewed hospital staff, analyzed hospital records, observed the hospital's respiratory care facilities, and inspected the hospital's respiratory equipment and supplies. The visiting team concluded that the VAPHS maintained appropriate respiratory care staffing levels, conducted adequate respiratory training, and provided adequate respiratory equipment and supplies to meet the standard of care for respiratory patients.

First, the visiting team examined the efficacy of the VAPHS organizational structure. The agency report explained that VAPHS is divided into a Critical Care Center and several medical-surgical units. Respiratory patients who require the highest level of medical attention and observation are cared for in the Critical Care Center. For those respiratory patients in the medical-surgical division who require a heightened level of observation, four beds within one of the medical-surgical units have been designated "high observation" beds, specifically for the purpose of providing high-level observation for patients at highest risk of respiratory compromise. The nurses who oversee these beds are required to receive special training and to meet specific competencies in respiratory care. The visiting team concluded that, notwithstanding the fact that the VAPHS does not have a separate respiratory care unit, the hospital units at VAPHS were carefully designed to provide patients with appropriate levels of care based upon the "level of acuity of illness."

The OMI team also found the hospital's level of respiratory care staffing to be sufficient. According to the report, VAPHS employs 13 full-time respiratory therapists in the Critical Care Center and 6 full-time respiratory therapists in the medical-surgical units. In addition, a physician manager heads the hospital's Respiratory Care Service, and the hospital employs one respiratory therapist who provides respiratory therapy training to the entire VAPHS staff. At the time of the site visit, the Critical Care Center was fully staffed, and, although the "high observation" unit had one vacancy and the respiratory care service had two, approval had already been given to these units to fill the vacancies. In addition, the team found that all respiratory therapists on staff possessed current and unrestricted practitioner licenses. In the rare event that a respiratory therapist is not available to provide respiratory care, all VAPHS nurses are trained to provide the necessary treatment, as evidenced by the nurses' continuing education records. The nurses who were interviewed confirmed that they received proper training for administering respiratory treatments.

The OMI team also assessed the patient care peer review process in place at VAPHS. The agency report described in detail the many opportunities and channels for peer review in existence at the VAPHS. The team found that the hospital conducts peer reviews for all patient transfers to ensure that quality care concerns are adequately addressed. They concluded that the VAPHS peer review process satisfies the intent outlined in VHA policy. Nevertheless, at the OMI team's recommendation, the VAPHS decided to refine its peer review process "by flow-charting and integrating the roles of its various committees."

Next, the OMI site visit team inspected the equipment in several medical units and toured the equipment and supply section to determine the adequacy of respiratory equipment and supplies. The team inspected the equipment on several crash carts and found all of it to be "current and checked according to VAPHS policy." They also found that all equipment had been appropriately inspected and tagged by biomedical engineering staff for preventative maintenance and none of the dates on the tags had expired. They reviewed cardiopulmonary resuscitation (CPR) critique sheets for the previous 12 months and found no record of the failure or unavailability of equipment during the administration of CPR. The respiratory care staff members indicated that they were unable to recall a time when an equipment request had been denied. The team also noted that the respiratory care department is staffed with a technician responsible for equipment monitoring and cleaning, and it has a back-up system for renting additional equipment, such as ventilators, in the event of a shortage. Thus, the OMI team did not find any evidence that VAPHS respiratory equipment is poorly maintained or in short supply.

An OMI team member interviewed Ms. Pollitt on March 26, 2002. Ms. Pollitt stated that, in her opinion, the respiratory care service at University Drive had greatly improved over the past year. However, she expressed concern about the quality of respiratory care currently provided at another VAPHS center, namely the Heinz Division. According to the agency report, the Chief of Critical Care has already addressed the concerns raised by Ms. Pollitt about

respiratory care at the Heinz Division. Ms. Pollitt stated that she is satisfied that the issues she raised in her disclosure to OSC concerning inadequate respiratory care at University Drive have now been resolved.

The agency report concluded that, based on the OMI's findings, respiratory care provided by VAPHS currently meets acceptable standards. However, the report also noted that, as a result of the investigation initiated by OSC, the OMI team recommended that VAPHS refine its peer review process "by flow-charting and integrating the roles of its various committees." According to the agency report, it appears that VAPHS has successfully implemented these recommendations.

### The Whistleblower's Comments

Ms. Pollitt provided comments on the agency's report. Although she expressed satisfaction with the standard of respiratory care currently provided at University Drive, she did not concur with the agency's conclusion that respiratory care at University Drive met the standard of care at the time she filed her whistleblower disclosure with OSC. She contended that the agency's conclusion is belied by the many significant improvements in respiratory care recently undertaken by the VAPHS, including an increase in respiratory staff and the expansion of respiratory training to all three VAPHS locations.

Ms. Pollitt raised other concerns about the quality of medical care provided by VAPHS, unrelated to her original allegations which were limited to respiratory care. In her opinion, many of the positive changes recently implemented by the respiratory care service should be extended to other areas of practice within the VAPHS, which she contends are suffering from many of the same problems that formerly plagued the respiratory care staff. She complained that VAPHS management is hostile towards whistleblowers and surmised that staff members in other units may be hesitant to complain about adverse conditions due to fear of retaliation. She expressed concern that medical staff shortages at VAPHS often cause excessive delays in medical treatment for many veterans. Lastly, she criticized what she perceives to be a recent trend throughout the VA health care system whereby, as the number of medical staff providing patient care decreases, VA medical centers hire greater numbers of administrators and quality care specialists to create a false impression that the standard of patient care remains acceptable. She suggested that, rather than hiring more quality care specialists, VA medical centers should raise the quality of patient care by hiring more health care providers.

### Conclusion

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

The Special Counsel  
The President  
Page 6

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

Respectfully,



Elaine Kaplan

Enclosures