



DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

In Reply Refer To: 10A2

JAN 3 1 2005

Scott Bloch
U. S. Office of Special Counsel
1730 M Street, N. W.
Suite 300
Washington, D. C. 20036-4505

Dear Mr. Bloch:

This letter and the enclosures are submitted as an addition to Secretary Principi's letter dated October 25, 2004 regarding allegations made by employees at the VA Medical Center in Canandaigua, New York (Office of Special Counsel File Numbers DI-03-0620 and 0621; DI-04-1862 and 1960).

Mr. Principi indicated in his earlier letter to you that the Network Director had instructed the VA Medical Center in Canandaigua to arrange for a review of Dr. Sharza's clinical practice. The medical center decided to conduct the review in such a way as to protect only the identity of the individual patients but not to protect the actual results of the review. That review of thirty randomly selected records of care that Dr. Sharza provided and thirty records of care provided by other primary care physicians in her work unit was recently completed. The results indicate that the care that she provided was "on par with her peers or slightly better" and that the care provided was well within community standards. I enclosed a report from Charles Norton, the Medical Care Line Manager in Canandaigua, summarizing the results of the review. As previously reported to you, the Administrative Board of Investigation (ABI) identified two cases of substandard care among the eleven cases cited in allegations made to your office. Dr. Robert Babcock, the Chief of Staff, counseled Dr. Sharza regarding those cases on November 2, 2004.

I also enclosed a copy of the full report submitted to the Network Director and the VHA Deputy Under Secretary for Health for Operations and Management (Deputy Under Secretary) by the ABI. The report more fully addresses your concerns related to Dr. Babcock's shredding of duplicate reports of contact that he received from two of the employees who made allegations to your office. In addition, I attached a copy of an action plan jointly signed by the Network Director and the Deputy Under Secretary. That plan is indicative of VHA's commitment to address the issues that arose during this review. The Network Director and the Network Chief Medical Officer have been personally involved in overseeing compliance with the plan.

RECEIVED - SPECIAL COUNSEL
GENERAL OFFICE
U.S. DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

As you know from the prior report, Dr. Sharza received a letter of admonishment on July 23, 2004. She filed a grievance under the negotiated grievance procedure in the AFGE Master Agreement. After considering all of the available evidence as well as Dr. Sharza's oral response, Dr. Babcock reduced the letter of admonishment to a written counseling. A complete copy of the grievance file is also enclosed.

The Network scheduled Dr. Sharza to attend Bayer training, a customer relations training course specifically designed for health care providers. The session that she was to attend was cancelled and she has been rescheduled to attend another session in February 2005.

In addition, I want to inform you of a number of personnel changes at the Canandaigua VA Medical Center. W. David Smith, the Medical Center Director, retired on January 3, 2005. Robert Ratcliff, a SES employee from outside of the Network, was detailed to serve as the Acting Director until the position is filled.

On January 10, 2005, Pamela Chester and the Network signed a settlement agreement regarding an EEO complaint over her reassignment from the position as Care Line Manager that was effective on October 31, 2003. She accepted a position as a Network Education Specialist. Her assignment to that position was effective on January 16, 2005.

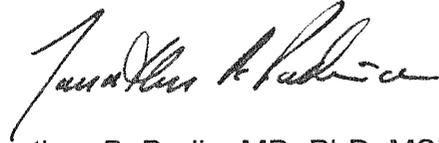
On October 3, 2004, Dr. Babcock, reassigned Dr. Sharma from the position as the Primary Care Lead Physician to the position as Lead Physician in Administrative Medicine. A copy of Dr. Babcock's letter informing Dr. Sharma of the reassignment and outlining her new responsibilities is also enclosed. The organizational issues that led to Ms. Chester's reassignment in October 2003 continued throughout the spring and summer of 2004. Dr. Babcock came to the conclusion that he should reassign Dr. Sharma to a different position.

On July 25, 2004, Charles G. Norton was selected as the permanent Medical VA Care Line Manager (MVAC) at the Canandaigua VA Medical Center. Mr. Norton now supervises Dr. Sharma.

And finally, I want to inform you about the status of an EEO complaint that Dr. Sharma filed a number of months ago. Dr. Sharma filed an EEO complaint alleging that the Medical Center failed to accommodate her physical condition that limits her ability to travel to areas where she was required to see patients. EEOC conducted a hearing on her complaint during the week of January 6, 2005. We have not received a report from that hearing as yet.

Should you have any questions, please contact Dan Kowalski, HR Consultant in the VHA HRM Group, 973 395-7245 or Jane C. Joyner in the VA Office of General Counsel, 202 273-6372.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan B. Perlin". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Acting Under Secretary for Health

Enclosures

LISTING OF ENCLOSURES

Prepared by Dan Kowalski, HR Consultant VHA HRM Group

1. Summary Report of the administrative review of patient care provided by Susan Sharza, MD, prepared by Charles Norton, Manager of the Medical VA Care Line at the Canandaigua VAMC.

This document includes two appendices that briefly describe the review process and contain a blank scoring sheet. Physicians from other VA Medical Centers in the Upstate New York Healthcare Network reviewed thirty patient records that documented care provided by Dr. Sharza and thirty patient records that documented the care provided by other primary care physicians from the Canandaigua VA Medical Center. The results of the review indicate that the quality of care Dr. Sharza provides is equal to or slightly better than the care provided by other primary care physicians in Canandaigua.

2. The full report prepared by the Administrative Board of Investigation (ABI) appointed by the VHA Deputy Under Secretary for Health for Management and Operations.

The Board submitted the report to the Deputy Under Secretary and the Network Director. The report discusses Dr. Babcock's shredding of duplicate reports of contact on pages 13 and 14. The report also discusses a number of contextual issues that are relevant to the allegations made by employees to OSC.

3. Action Plan dated October 6, 2004 signed by the Network Director and the Deputy Under Secretary for Health for Management and Operations.

This action plan addresses the recommendations of the ABI.

4. Written notification from Robert Babcock, MD, Chief of Staff at the Canandaigua VAMC, to Krishna Sharma, MD, regarding her reassignment from the position of Lead Physician in Primary Care to the position of Lead Physician in Administrative Medicine. The reassignment was effective on October 3, 2004.

Both positions are organizationally in the Medical VA Care Line at the Canandaigua VAMC. In addition, this enclosure contains an e-mail from Dr. Babcock indicating that he was beginning to think about redesigning the organizational structure of MVAC in May 2004. This enclosure also contains a undelivered letter dated July 15, 2004 that would have reassigned Dr. Sharma to the position of Lead Physician in Administrative Medicine in July 2004. The decision to reassign her was delayed pending the results of a VA Office of Inspector General visit in June 2004 and the results of the ABI in July 2004.

5. Grievance File of Susan Sharza, MD. Dr. Sharza filed a grievance under the negotiated grievance procedure contained in the Master Agreement between the VA and AFGE. After considering the documentation as well as Dr. Sharza's oral response, he decided to reduce the admonishment to a written counseling.

As the Chief of Staff, Dr. Babcock was the deciding official in Step 1 of the grievance procedure. His decision was within the scope of his responsibility. This enclosure contains Dr. Babcock's written analysis of the documentary evidence and his rationale for reducing the admonishment to a written counseling.

**Department of
Veterans Affairs**

Memorandum

Date: January 7, 2005

From: Medical VA Care Line Manager

Subj: Follow-up from ABI Review of Susan Sharza

To: Network Director (10N2)
Through Medical Center Director
Through Chief of Staff

1. A follow-up medical record review of Dr. Susan Sharza's patients was conducted per the request of the Network Director. The process to conduct the review, approved by the network CMO and QMO, was adapted from VHA's peer review directive (see attached Management Review Process) and followed recommendations from the ABI.
2. The closed record reviews were completed by primary care providers at the other sites in VISN 2 and returned to Charles Norton for collection and analysis. The reviewing providers were instructed to assign levels of care to nine elements of care as follows:

"As appropriate to each case, please consider the following elements assessing the decision made by the provider in primary care during FY04 and rate them a level one through three. The levels are:

Level 1) Most experienced, competent practitioners would have managed the case similarly;
Level 2) Most experienced, competent practitioners might have managed the case similarly;
Level 3) Most experienced, competent practitioners would have managed the case differently.

N/A – Not Applicable

Please include any pertinent comments for each element and associated provider. If a finding is a level 2 or 3, comments/clarification is required."

Elements reviewed and scored include:

- 1) Choice of diagnostic tests and timely ordering of diagnostic tests.
- 2) Performance of a procedure and/or treatment.
- 3) Addressing abnormal results of diagnostic tests.
- 4) Timeliness of diagnosis and appropriateness of diagnosis.
- 5) Timing of treatment initiation and appropriateness of treatment.
- 6) Adequacy of technique during procedure.
- 7) Recognition and communication of critical clues to patient's condition during period of clinical deterioration.
- 8) Timely initiation of appropriate actions during periods of clinical deterioration.
- 9) Other relevant aspects of care.

Thirty evaluable responses were returned related to care provided by Dr. Susan Sharza. Thirty additional reviews were performed related to the co-management of renal transplant patients by the remaining primary care providers.

- The reviews covering Dr. Sharza's patients had the following results. 25 of the 30 review forms returned a score of "Level 1". The remaining five cases are as follows:

Case 1) Was scored blank for overall care and a level 3 for elements one, three, four, and seven. This case had been seen only once by Dr. Sharza in September FY04 and therefore was included in the sample. However, the care reviewed and questioned was provided by a mid-level provider under the supervision of another primary care physician. Issues of weakness focused on providing care to patients co-managed with private sector providers.

Case 2) Scored a level 2 in elements one, three and nine. Findings relate to presence of documentation and results to support clinical action for treatment of co-managed patient.

Case 3) Scored a level 2 in elements three and six. Findings relate to presence of documentation and results to support clinical action for treatment of co-managed patient.

Case 4) Scored a level 2 in elements one, three, four, seven, and nine.

Case 5) Scored a level 2 in elements one, nine, and a level 3 for elements three, four, and five.

Cases 4 and 5 were reviewed by one Syracuse VAMC provider who also evaluated three cases of other primary care providers as discussed in paragraph 4. She summarized all five cases she reviewed with the comment, "All patients are primarily followed outside VA for primary care. I do not think that this was a good representation of patient care by your docs, as they are just filling scripts".

- The reviews completed for the rest of primary care had the following results. 20 of the 30 reviews returned a score of "Level 1," five reviews were identified with a score of "Level 2," three had a score of "Level 3" and in two records, the overall score was omitted by the reviewer. In one of the two without an overall score, elements for appropriateness and timeliness scored as Level "3". In the other, the reviewer commented the patient was "Managed Outside VA." In those records with one or more elements scoring "Level 3", it was clearly noted by the reviewer that documentation was lacking to support the management of the medications.

- The following table compares Dr. Sharza's results with her peers at the Canandaigua VAMC Primary Care Outpatient Clinic and the Rochester Primary Care Outpatient Clinic.

Element Number	1	2	3	4	5	6	7	8	9
Primary Care Providers	1.4	1.2	1.5	1.2	1.2	1.0	1.0	1.2	1.4
Dr. Sharza	1.2	1.0	1.2	1.1	1.3	1.2	1.0	1.0	1.1
Variance	0.2	0.2	0.3	0.1	-0.1	-0.2	0.0	0.2	0.3

As demonstrated in the above table, Dr. Sharza's record review results were on par with her peers or slightly better. Comments provided by the physicians performing the management record reviews consistently highlighted that these were co-managed care cases. The general comment associated with negative scores was the lack of documentation in the medical record from non-VA specialty providers or the lack of diagnostic test results associated with tests performed outside the VA. Therefore, the only issues identified with Dr. Sharza's care relate to patients co-managed with private sector providers. This issue was also raised in the reviews of the other primary care providers.

6. Based on the results from this management record review, all transplant patients who had been seen in primary care as a co-managed care individual for the purpose of receiving anti-rejection medications are in the process of being referred through Fee Basis for non-VA specialty care with prescriptive authority. Proper procedure for supporting co-managed care has been communicated to all primary care providers by the Chief of Staff. In addition, providers have been encouraged to utilize the availability of Fee Basis for the management of complex patients who are outside of the scope of usual primary care providers.
7. If you have any questions please do not hesitate to call me at (585) 393-7264.

Respectfully Submitted,

Charles G. Norton, RN, MS, CPHQ
Medical VA Care Line Manager



U. S. Department of Veterans Affairs
VA Medical Center
135 East 38th Street
Erie, PA 16504

September 14, 2004

Laura Miller
Deputy Under Secretary for Health for Operations and Management (10N)
U. S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

William F. Feeley
Director
U. S. Department of Veterans Affairs
VISN 2
113 Holland Avenue
Albany, NY 12208

SUBJECT: Administrative Board of Investigation, Canandaigua NY

I enclosed the report of the Administrative Board of Investigation that you both appointed to examine a number of issues at the VA Medical Center in Canandaigua NY.

James Palmer
Director and ABI Chair

**ADMINISTRATION ABI OF INVESTIGATION REPORT
CANANDAIGUA VAMC**

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ISSUE AND AUTHORITY

In the spring of 2004, the VA Office of the Medical Inspector (MI) received a complaint concerning Dr. Sharza, a physician at the VAMC in Canandaigua NY. The allegations included accusations that Dr. Sharza provided substandard care, refused to see some patients, was inappropriate in her behavior towards patients and other employees, including her supervisor, and that the facility leadership failed to adequately address those issues. The employees who filed the complaint included photocopies of portions of medical records in addition to reports of contact from other employees. The medical records contained patient identifying information including names and social security numbers. The MI reviewed the electronic medical records in the cases cited in the documentation and spoke to the Office of the Deputy Under Secretary for Health for Operations and Management (VHA) about the allegations. Both offices agreed that VHA would appoint an Administration ABI of Investigation (ABI) to visit the VAMC to examine the allegations and to recommend whether the MI should conduct a more thorough review of medical care provided at the facility. On June 16, 2004, William F. Feeley, the Director of the VA Healthcare Network Upstate New York, appointed the members of the ABI: James Palmer, the Director of the VAMC in Erie, PA; Mohamed Al-Ibrahim MD, the Chief of Staff of the Maryland Healthcare System; and Dan Kowalski, HR Consultant in the VHA HRM Group¹. The ABI made plans to visit Canandaigua on July 7 and 8, 2004.

Unknown to the VA, the same employees had already sent the same complaint and medical documentation to the Office of the Special Counsel (OSC) claiming Whistle Blower status. On June 21, 2004, OSC asked the Secretary of the Department of Veterans Affairs to investigate the allegations and report to OSC². On June 25, 2004, the Deputy Under Secretary for Health for Operations and Management appointed the ABI to examine the issues and respond to OSC³.

CONDUCT OF THE INVESTIGATION

The ABI visited Canandaigua on July 7 and 8, 2004. Prior to the ABI's arrival in Canandaigua, each witness received an e-mail that included a scheduled interview time, a brief description of the nature of the ABI charges, a Notice of Rights and Responsibilities, and a designation of Representative, if the witness intended to be represented. The ABI interviewed fourteen employees under oath. A court reporter transcribed the testimony and the witnesses were given the opportunity to review the transcripts. Copies of the transcripts that the employees reviewed are enclosed with the report that was sent to the Network. The transcripts are cited throughout the report as (Employee name) p. #. The ABI also collected documents during the testimony. Those documents are marked as Exhibits 1 – 22 and are enclosed in a binder labeled Exhibits. In

¹ See ABI Tab A for the appointment letter.

² See ABI Tab B for a copy of the OSC letter to the Secretary. The ABI has requested an opinion from the VA Office of General Counsel as to whether sending medical records that contain patient identifying information is a protected activity within the context of OSC's jurisdiction or whether the release of medical records outside of the VA violated the requirements to protect confidential patient information established by HIPAA. None of the patients consented to the release.

³ See ABI Tab C for the appointment letter and the delegation from the Secretary to the Deputy Under Secretary for Health for Operations and Management.

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addition, the ABI collected documents before, during and after its visit. Those documents are cited throughout the report as ABI Tabs and are enclosed in a binder labeled ABI Documents.

The members of the ABI discussed the evidence and jointly wrote this report with the exception of the section reviewing the standard of care provided by Dr. Sharza. Dr. Al-Ibrahim, the only physician on the ABI, wrote that section.

**ADMINISTRATION ABI OF INVESTIGATION REPORT
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OUR REVIEW OF THE MEDICAL RECORDS FOR THE PATIENTS CITED IN THE COMPLAINTS TO THE MI AND OSC REVEAL TWO CASES OF SUBSTANDARD CARE BY DR. SHARZA

The ABI reviewed all documents submitted prior to the visit as well as those collected during the visit, and identified two instances of care rendered by Dr. Sharza that did not meet the community standard. :

On December 30, 2003, patient 9255 (the last four digits of the patient's Social Security Number) complained of chest pain to the nurses on the inpatient unit where the patient was receiving care. When informed about the patient by the nursing staff, the Dr. Sharza evaluated the patient by phone. This type of "distant" evaluation was inappropriate for a hospitalized inpatient with this complaint. Evaluation of the patient was further delayed in order for the patient to eat a "skipped meal" and to go to the bathroom⁴. The patient was subsequently evaluated and transferred to a community hospital where he was found to have an acute myocardial infarction. the ABI concluded that most reviewers would have assigned a Level 2 to this encounter, indicating that most competent providers might have treated the case differently. With the subsequent adoption in January 2004 of VHA's current acute coronary syndrome guidelines, peer review would now assign a Level 3 to the management of this patient indicating that the care was not equivalent to the care provided in the community. Although the internal Patient Safety/Performance Improvement Staff determined that the care in this case was usual, customary and reasonable, the overall patient management system probably needs improvement. Symptoms, such as chest pain, seem to call for a more timely examination. This could reflect overall medical center policy for patient management for these symptoms. Dr Babcock informed Dr. Sharma that there were no findings and he would have managed the case the same way. The MVAC leadership found this finding "unbelievable" and felt Dr. Sharza was being "protected."

On April 30, 2004, patient 3923 appeared in the outpatient clinics complaining of pain in a surgical site having had a procedure a few days earlier. Dr. Sharza prescribed opiates without examination of the surgical area⁵. This case was referred to peer review and was determined to be a Level 2 case. The Dr. Sharma was aware that the case was reviewed at Level 2. Another reviewer could have easily assigned a Level 3 to this case since the surgical area in question was not examined.

While these two cases represent less than an acceptable level of care, they represent two of the eleven cases cited in the allegations and an extremely small percentage of the total number of patients that Dr. Sharza treated during the past two years.

Yet there seems to be some system issues. A facility SOP should guide the staff in dealing with urgent medical problems since Canandaigua does not have an emergency room but relies on the

⁴ Sharza pp. 25 – 27 and Sharma pp. 44 -46

⁵ Sharza pp. 27 - 29

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local community hospital. Dr Sharza should have told the staff to call 911 if she could not evaluate a case of chest pain in a timely manner.

The case was referred to ROPC for Peer Review, returned Level 2, which calls for a Peer Review. The case was "re-reviewed" by a physician on staff at CVAMC, referred to Peer Review Committee, which "overturned" the initial peer reviewer, and decided that Peer Review was NOT necessary.

- Based on the documentation submitted to the OIG, the case was sent to ROPC, reviewed on 5-28-04 and returned with a finding of Level 2.
- Reviewed by Patient Safety/Performance Improvement and referred to the Peer Review Committee in July 2004.
- Level 2 was not substantiated and therefore, NO Peer Review was done.

Considering the events of the past year involving allegations of poor quality of care, it would seem managerially prudent and clinically indicated to have a Peer Review conducted to have an objective analysis of the case on official record.

Considering the number of issues raised involving Dr. Sharza, the ABI does not believe that the Chief of Staff and Director placed the appropriate and necessary attention to the issues raised by other employees.

**ADMINISTRATION ABI OF INVESTIGATION REPORT
CANADAIGUA VAMC**

THE LEVEL OF SUPERVISION THAT DR. SHARZA PROVIDES TO ROBERT SMITH, A PHYSICIAN ASSISTANT, IS BARELY ADEQUATE

Dr. Sharza supervises Robert Smith, a Physician Assistant (PA) who provides much of the evaluative and routine medical care to the patient in the Domiciliary. Both Robert Smith and Dr. Sharza testified that they interact with each other between two and six hours per week⁶. Mr. Smith did testify that Dr. Sharza is very responsive to his infrequent pages⁷. Robert Smith described their interaction as consultative.

Q. Could you give us an idea of the time Dr. Sharza spends working with you and interviewing specific patients, physical examinations?

A. There is no direct involvement or supervision in as such. If I have a particular concern that I don't feel comfortable with or how to handle I will reach her by pager or phone if I happen to know where she is. It's strictly more of a consulting situation that I use her for if there is a particular patient problem that I need her expertise⁸.

In addition, there does not appear to be any systematic case review of Robert Smith's documentation outside of the Sharza-Smith supervisory relationship⁹.

Although Robert Smith functions under a scope of practice and although Dr. Sharza has confidence in his capability, she rarely sees the patients with or after Robert Smith. He does call her if he has any questions or is unsure of the proper course of action but those contacts are unusual. We believe that the level of supervision is barely adequate given the fact that a PA is not a licensed independent practitioner. It should be added there is presently a concern on the part of Mr. Robert Smith as to the amount of time that Dr. Sharza is available to him for consultation, assistance and back up.

⁶ Robert Smith p. 5 and Sharza p. 10 - 11

⁷ Robert Smith p. 4

⁸ Robert Smith p. 4

⁹ Sharma p. 40 - 41

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CANADAIGUA VAMC**

DR. SHARMA, DR. BABCOCK, AND W. DAVID SMITH DID NOT FORCEFULLY CONFRONT DR. SHARZA'S INAPPROPRIATE BEHAVIOR. MR. OLSZEWSKI WAS TOO PASSIVE IN HIS SUPPORT OF THIS PROCESS.

The documentary evidence available to the ABI and the testimony of a few witnesses describe a number of instances of inappropriate behavior by Dr. Sharza. The most egregious example occurred on June 20, 2003. Late that afternoon, Dr. Sharza refused to see a patient. When confronted by Dr. Sharma, her supervisor, Dr. Sharza gave her VA identification badge to Dr. Sharma and stated that she was resigning. Dr. Sharza then abruptly left her duty station with patients waiting. Although another provider saw the patients that afternoon, this behavior was clearly a serious breach of professional responsibility. On the following Monday, Dr. Sharza called Dr. Babcock to acknowledge the inappropriateness of her behavior and to request that she be allowed to return to work. Dr. Babcock consulted Joseph Olszewski, the Human Resources Manager who advised the Chief of Staff that the facility could not consider the Dr. Sharza's actions to constitute a resignation. Mr. Olszewski and Dr. Babcock met with Dr. Sharma and Ms. Chester to discuss what had transpired. Dr. Sharza returned to work and was charged leave without pay for the absence. It is important to note that, according to testimony, Dr. Babcock acted in accordance with advice from the HR Manager. The decision was clearly within the scope of his authority and did not represent an abuse of that authority. It is also clear that Dr. Sharma and Ms. Chester disagreed with the decision¹⁰.

Although the HR Manager was correct in his assessment that Dr. Sharza's actions did not constitute a valid resignation, Dr. Sharma and HR could have sent Dr. Sharza a written notice acknowledging her resignation. Same day (Friday) or overnight delivery (Saturday or Sunday) would have changed the facts and possibly the outcome. In addition, Dr. Sharza requested and was granted LWOP for her absence on Friday. AWOL would have been more appropriate. And finally, she should have been given a disciplinary for her behavior. Dr. Sharma, Dr. Babcock, W. David Smith and Mr. Olszewski should have acted more forcefully.

There are a number of reports of contact by medical and mental health staff that document or suggest a non-cooperative or unfriendly working style on the part of Dr. Sharza. These include rude encounters where unprofessional language was used, unanswered pages and lack of cooperation in developing a clinic appointment schedule. Dr. Sharma has acted on two of those instances. Dr. Sharza received a written counseling in November 2003; she also received an admonishment more recently for refusing to see a patient¹¹. But the HR Manager testified that prior to the preparation of the admonishment, Dr. Sharma did not approach HR for assistance with any specific documentation on which to base any formal action. Mr. Olszewski was aware of rumors but lacked specific facts to support any formal action¹². In her own testimony, Dr. Sharma discussed her rather passive approach towards addressing her concerns. She would talk to HR without any follow up, talk to Dr. Babcock, and not take action on his instructions that she

¹⁰ Babcock pp. 5 – 6 and 12 – 14; Sharma pp. 19 – 25 and 42; Sharza pp. 12 – 16; Chester pp. 9 – 12; and Lind pp. 3

- 8

¹¹ Sharma pp. 3 – 4 and 6 - 7

¹² Olszewski pp. 3 – 7, 14, and 25 – 26; and Sharma p. 5

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CANADAIGUA VAMC**

needed to address her concerns as Dr. Sharza's immediate supervisor¹³. Ms. Lind and Dr. Babcock are aware of Dr. Sharma's lack of follow up¹⁴.

The ABI believes that Dr. Sharma, Dr. Babcock, W. David Smith and Mr. Olszewski should have acted more forcefully. Dr. Sharma did not heed Dr. Babcock's advice to rely on HR for assistance after Dr. Sharza returned to work in June 2003¹⁵. And her reluctance to act coupled with the written notes that she forwarded to Dr. Babcock should have caused Dr. Babcock and W. David Smith to intervene more forcefully. On those occasions when Dr. Sharma did not follow up on providing HR with the documentation it needed to assist her in addressing her concerns, HR should have been more proactive in contacting her or involving Dr. Babcock.

But Ms. Lind discussed a specific incident in which nursing staff complained about Sr. Sharza's expectations related to the documentation of blood pressure. Ms. Lind thought that Dr. Sharza's expectations were proper and in accordance with policy. Ms. Lind asked nursing education to review the policy with staff. Yet even, in this instance, Ms. Lind thought that Dr. Sharza's communicating style was poor¹⁶.

Ms. Lind also recalled Dr. Sharza suggesting a number of other changes to existing care delivery practices. Her recollection is that the staff was often upset about the suggestions for change¹⁷. We will next discuss Dr. Sharza's suggestions and the reaction of staff to her suggestions.

¹³ Sharma pp. 15 - 18

¹⁴ Lind pp. 31 -32 and Babcock pp. 36 - 37

¹⁵ Babcock pp. 14 - 15 and 36 - 37

¹⁶ Lind p. 9

¹⁷ Lind pp. 9 -12

**ADMINISTRATION ABI OF INVESTIGATION REPORT
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**THE TRANSITION FROM A NETWORK WIDE CARE LINE TO A MORE
HIERARCHICAL ORGANIZATIONAL STRUCTURE HAS CREATED TENSIONS AND
COMMUNICATIONS PROBLEMS THAT PERSIST**

For a number of years under the former Network Director, the VA Healthcare Network Upstate New York operated under a complex, matrix care line structure that differed dramatically from the structure of VHA's twenty-one other Networks.

The Networks organizational structure included patient care service delivery organizations that managed the resources across all the VA Medical Centers and Outpatient Clinics in the Network. These organizations were structured along major medical specializations (e.g. Medicine, Mental Health, etc.) and had line authority over the employees who worked in those specializations at each site. In addition, the care lines had budgetary control over the resources including salaries.

There were a number of services that were not under the care line structure (e.g. Human Resources Management). Committees that included representatives from each Medical Center in the Network coordinated the work across the Network. But in these cases, line and budgetary authority remained at the local level.

The VA Medical Center Directors often served as the chair of coordinating structures that crossed the Network. But in this matrix, their control of resources was significantly diminished compared to the past and compared to the situation in other Networks. Sharlene Sacco, the Behavioral Health Care Line Manager in Canandaigua, and Sally Martin, the Line Manager of Geriatrics and Extended Care in Canandaigua, implied in their testimony that senior leadership at Canandaigua was uncomfortable with this structure¹⁸.

In March 2003, William F. Feeley, the recently appointed Network Director, began a planned realignment of the Care Lines across the Network. In the realignment, the Care Lines lost budget control and reported to the individual facility director's rather than the Care Line Manager in the Network Office.

Shortly after this change, Dr. Babcock and Ms. Lind began meeting with Dr. Sharma and Ms. Chester about changes that they wished to see in the delivery of services provided by the Medical Care Line (MVAC). The issues were varied: the distribution of work among practitioners, rearrangements in the physical work space to facilitate a number of related changes in service delivery, and most relevant to the allegations, the integration of medical care provided to the Domiciliary patients into the primary care clinics¹⁹.

The transition to providing medical care to the Domiciliary patients within the primary care clinics seems to be the most contentious issue. A number of witnesses testified about the benefits in changing this process as an important step in the Domiciliary's rehabilitation program. Dr. Babcock and Ms. Lind clearly pushed this issue²⁰. Ms. Sacco supported this

¹⁸ Martin p.p. 11 – 12 and Sacco p. 24

¹⁹ Babcock pp. 4 – 8, 30 - 39

²⁰ Babcock p. 16 and Lind p. 12

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CANADAIGUA VAMC**

change, as did Dr. Sharza²¹. Yet the transition was not smooth. Ms. Sacco testified about some transition problems, the appointment of a process action team to address those issues in the spring of 2004, and efforts by her employees to assist the MVAC employees in understanding the needs of those patients²². Ms. Lind testified about the resistance of Dr. Sharma and Ms. Chester to this plan, as did Dr. Babcock and Mr. Olszewski²³. The slow pace of change as perceived by Dr. Babcock was an important element in his decision to lower Dr. Sharma's proficiency rating for administrative duties when compared to prior years²⁴.

We believe that many of the issues raised in the complaints sent to the MI and OSC are rooted in tensions inherent in this organizational change, disputes over role ambiguity arising out of the transition from a complex matrix structure to a more hierarchical structure in which budgetary and line authority changed dramatically, and communications problems during this change management process.

W. David Smith, the Director, testified about a number of concerns: the relationship between Dr. Sharma and Dr. Sharza; the now resolved ambiguity over Dr. Sharma's supervisory direction over Dr. Sharza; the transition from a Network directed care line to a locally controlled care line that generated resistance especially from MVAC; and the integration of the Domiciliary patients into the primary care clinics²⁵. Although his enumeration of the issues is complete, the tenor of his testimony seems detached and relatively uninvolved. For example, in discussing the relationship between Dr. Sharma and Dr. Sharza, he states that:

I met personally with Dr. Sharma on three occasions to discuss what was going on and to try and seek a resolution but in my opinion you have two individuals who are hardened in their opinion. You have an individual Dr. Sharza who I would say is probably not the best at following directions for what reason I could not tell you and then you have her supervisor Dr. Sharma who may not be the absolute best at giving directions and making sure that there is clarity of those directions. And that to me is where the conflict stems from right there, to get a meeting of a mind between the two of those I don't know if it is possible or not²⁶.

He stated that he coached Dr. Sharma to be more directive and clear in her instructions to Dr. Sharza.

We've all been caught in this he said, she said, type of disagreement where everyone is finger pointing and I said the way to handle that if you are in that situation is to say just a moment Dr. Sharza, I will get somebody else in the room, put on the speaker phone and say, "Go take care of this discharge of this patient, do you understand that", she didn't do that but I think she would do that the next time. Lesson learned I think, leadership and

²¹ Sacco pp. 4 – 6, and 20 and Sharza pp. 36 – 39 and 41 - 43.

²² Sacco pp. 6, 9 – 11, 14, 18 and 20 and Sharza pp. 46 - 49

²³ Lind pp. 13 – 19; Babcock pp. 16 – 18 and 22; and Olszewski pp. 8 - 14

²⁴ Babcock pp. 24 – 26

²⁵ W. Davis Smith pp. 5 - 13

²⁶ W. David Smith p. 5

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supervision are things that you learn over the years after you have things fly back in your face²⁷.

In regards to the transition from the Network care line to the locally controlled care line, W. David Smith's assessment seems to focus on personal causes of resistance rather than seeing the resistance as stemming from the historical relationship.

(Y)ou could assess it from this perspective that you had a group of employees that essentially they didn't have much control over and their boss was sitting over in Albany and maybe you saw them once a month or whatever, and suddenly they were placed back under a much closer scrutiny and they said you know we are not really where we need to be and there was a pressure created that we needed to see more than 8 patients a day in primary care. That is unacceptable and that created or got the pot boiling without a question²⁸.

And he sees the problems related to the integration of the Domiciliary patients into the primary care clinics as resolved.

Anyway the initial transition was a little bumpy, there was some patients that were multiple bookings and some things like that occurred, but they got that cleared up right away, at least as far as I know²⁹.

The ABI believes that W. David Smith and Dr. Babcock were too passive in resolving this festering issue. Although we will discuss the communications problems that occurred with Ms. Chester in detail later in this report, the lack of clarity was felt by at least one other leader. Ms. Martin also testified about her unease over the lack of a clear direction over goals³⁰.

The ABI, however, sees the transition as an organizational and personal conflict between two coalitions:

1. Dr. Sharma and Ms. Chester who lost power, control and influence in the transition; and
 2. Dr. Babcock, Ms. Lind and W. David Smith who gained power, control and influence.
- Through her suggestions to change processes, through her involvement in the Medical Records Committee (she became Chair after her first year of employment) that gave her easy access to Dr. Babcock³¹, and as a result of her communication style, Dr. Sharza was perceived as part of the senior leadership collation.

Dr. Sharma's testimony on this point is particularly relevant. She discussed a change in Dr. Sharza's behavior after her first year of satisfactory employment.

²⁷ W. David Smith p. 6

²⁸ W. David Smith pp. 7 - 8

²⁹ W. David Smith p. 10

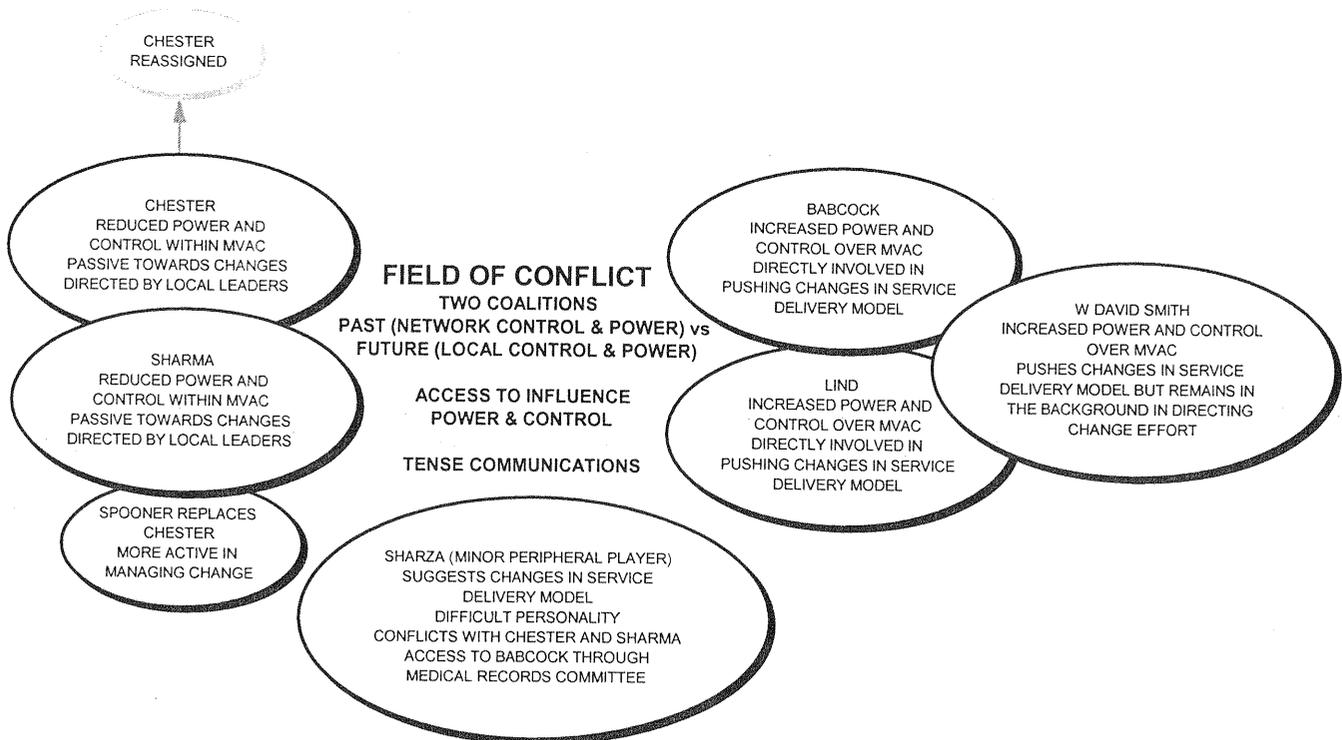
³⁰ Martin pp. 15 - 17

³¹ Babcock p. 20

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- Q. What do you think happened after that year to cause a person (Dr. Sharza) to change?*
- A. I think what happened initially she really thought about things and the way she was supposed to work but since Dr. Babcock told her, no, Mr. Smith will have all the power and I won't be the Lead Physician anyway, and she saw I did come back in October that I came back, my Lead Physician was taken away. She thought that one day I would be gone.*
- Q. But if the problem started in October 2002, how is that caused by the organizational change that occurred when Mr. Filley(sic Feeley) took over in the spring of 2003?*
- A. See, because they were looking for a Director.*
- Q. But Mr. Filley (sic Feeley) didn't take over until the Spring of 2003 and that's when the decision was made to change the organizational structure?*
- A. Yes.*
- Q. But her problems started in late 2002?*
- A. Yes, that is what I am trying to say at that time, they were looking for a director before Mr. Filley (sic Feeley) came and Dr. Babcock told her because Mr. Smith was one of the applicants for the Network MVAC position, and Dr. Babcock said, "he is going to get it". And when he gets it Dr. Babcock will have more power and he will make sure that something happens to me³².*

The ABI, however, sees her as a bystander. We depicted the field of conflict that we see.



³² Sharma pp. 25 - 26

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It is evident from the often angry tone in the testimony of Dr. Babcock, Ms. Chester and Dr. Sharma that this conflict continues. Although some alternate dispute resolution method has been attempted recently, it obviously has not been successful.

The transition remains incomplete and a source of discord.

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W. DAVID SMITH AND DR. BABCOCK REASSIGNED PAMELA CHESTER BASED ON LEGITIMATE PATIENT CARE AND BUSINESS RELATED PERFORMANCE ISSUES. WE DO NOT BELIEVE THAT THE ACTION WAS A REPRISAL.

Following the realignment of the care line from the Network to the facility, Ms. Chester's responsibilities changed in that she was no longer responsible for the Rochester Clinic. This change occurred in May 2003. Ms. Chester stated she was not given clear reasons, but W. David Smith testified that the Network office assigned a staff person to the Rochester Clinic making it necessary to move Pam Chester back to the VAMC.

On October 31, 2003, Dr. Babcock and W. David Smith reassign Ms. Chester from her role as the MVAC Manager to an Education position without any reduction in grade or salary.

Ms. Lind and Dr. Babcock's description as to the reasons for the reassignment are consistent. They recount a number of meetings with Ms. Lind and Dr. Sharma, resistance to a number of suggestions and rather passive implementation that they both found unacceptable³³. Although Dr. Babcock and Ms. Lind provided a number of documents that they claim indicates that Ms. Chester received clear feedback on her performance deficiencies as the MVAC Manager, Ms. Chester and the ABI view the documentation somewhat differently³⁴.

- E-mail dated May 30, 2003 (from Ms. Lind to Ms. Chester) contains general items for Action Plan but does not mention seeing the Domiciliary patients in Primary Care
- E-Mail dated June 13, 2003, (between Ms. Lind and Ms. Chester) did not include relocating the Domiciliary patients. A later reply does ask specifically for "date for moving S Sharza to MVAC downstairs." Ms. Chester responded that was Pat Spooner working with Dr Sharma to implement transition to Ambulatory Care in approximately two weeks.
- MVAC Strategic Planning, June 2003 mentions that "develop process" should be completed in two months
- MVAC Strategic Plan, June 17, 2003 mentions that meeting will be held bi-monthly to develop process and relocate Dr. Sharza in 2 weeks, on June 25, 2003.
- MVAC Strategic Plan, August 5, 2003 mentions that Dr. Sharza was relocated to Ambulatory Care on July 21, 2003
- MVAC Strategic Plan, September 2, 2003 mentions that the screening criteria for Behavioral Health patients was submitted to ECMS on August 29, 2003
- MVAC Strategic Plan, October 16, 2003 mentions that meetings were held with BVAC on September 12 and October 10, 2003 to discuss the admission and sick call of Domiciliary patients
- Memo dated April 26, 2004 from COS/Associate Director for Patient Care Services to Dr. Sharma and Ms. Spooner states that, among other items, the relocation of primary care services to Domiciliary and PR RTP residents has not yet been fully

³³ Lind pp. 19 – 22 and 27 – 28; and Babcock pp. 4, 6 – 9

³⁴ ABI Tab D for documents submitted by Ms. Lind after the ABI visit and for Dr. Babcock's written submission to the ABI before our visit.

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implemented, that an Action Plan is due April 30, 2004, and a response to plan by May 3, 2003.

- FY2005 Strategic Planning Objectives for MVAC includes one initiative to “incorporate the DOM and PR RTP patients into the primary care clinic.”

The documents list topics that were discussed, indicate the need for follow-up on some items, and list some deadlines. But the documents do not clearly specify the expectations that Ms. Chester was not meeting. Moreover, there is no document specifying what Ms. Chester needed to do to be successful or to resolve the perceived lacking attributes, skills, or knowledge. And, Ms. Chester was not placed on a Performance Improvement Plan.

But the documents do collectively indicate a passive approach towards implementing change. While we accept as probably accurate the assertion by Dr. Babcock, Ms. Lind and W. David Smith that Ms. Chester was resistant to some of the changes they wanted to see in the MVAC, we believe that the facility’s senior leadership could have managed this situation differently. The reasons that they gave for the reassignment include:

Not Following Directives: On May 6, 2003, Pam Chester was instructed to relocate DOM sick call to PC Am Care. From May through July 2003, numerous meetings were held regarding plans to make this happen. Relocation occurred on July 21, 2003.

Ineffective Relationship with Affiliate: Action Plans to improve/provide access to specialty care developed by Pam Chester resulted in “strained” relationship with University of Rochester.

Inability to Develop Business Plans: “Her inability to develop business cases for specialty care limited access to care, caused difficulty with our University affiliate, and had the potential to use VA resources inappropriately.”

A more direct and candid approach with Ms Chester, with clearly stated expectations and a more systematic way to measure progress would have made their perceptions more evident to Ms. Chester and this ABI. However, we do not believe that this action was taken as reprisal for raising issues about Dr. Sharza’s performance nor do we believe that it represents gross mismanagement or an abuse of authority.

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THE OVERALL LEVEL OF EMPLOYEE SATISFACTION AS MEASURED IN THE RECENT VHA ALL EMPLOYEE SURVEY IS HIGH. HOWEVER, THE CARES DECISION TO MODIFY CANANDAIGUA'S MISSION MAY HAVE IMPACTED THE RESULTS IN UNPREDICTABLE WAYS.

In the spring of 2004, VHA conducted a survey of the perceptions of its employees. The ABI had access to the data before its visit to Canandaigua. Two hundred and ninety-six employees at the Canandaigua VAMC responded to the survey. This response rate of 37.3 % was the lowest in the Network but is statistically sufficient to have faith in the data.

The survey measured employee satisfaction at three levels:

- Individual satisfaction through the Job Satisfaction Index
- Group interaction and interpersonal relations through the Organization Assessment Index
- Organizational Culture

At the individual level, the employees in Canandaigua are generally more satisfied than other employees across the Network. The scores in bold represent the highest scores in the Network.

Job Satisfaction Index

	Work Type	Work Amount	Pay Satisfaction	Coworker	Supervision	Senior Management	Promotion Opportunity	Work Condition	Customer Satisfaction	Praise	Work Quality	Satisfaction	Satisfaction 2yrs
VISN 2	4.09	3.63	3.26	4	3.64	3.11	2.61	3.55	4.08	3.19	4.49	3.82	3.16
Albany	4.02	3.66	3.22	3.98	3.63	3.12	2.7	3.51	4	3.19	4.47	3.74	3.12
Bath	4.11	3.75	3.41	3.97	3.76	3.26	2.72	3.77	4.18	3.2	4.47	3.91	3.43
Canandaigua	4.26	3.82	3.39	4.15	3.81	3.09	2.68	3.78	4.27	3.37	4.59	3.97	3.19
Syracuse	4.03	3.56	3.19	3.91	3.52	2.95	2.46	3.44	4.01	3.1	4.46	3.74	3.06
Western New York HCS	4.11	3.54	3.24	4.03	3.61	3.15	2.55	3.49	4.08	3.16	4.5	3.84	3.15

The perceptions on the Organization Assessment Index are much the same. Again, the best scores are in bold.

**ADMINISTRATION ABI OF INVESTIGATION REPORT
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Organization Assessment Index

	Cooperation	Conflict Resolution	Diversity Acceptance	Coworker Support	Supervisory Support	Customer Service	Innovation	Resources	Safety Climate
	3.59	3.35	3.78	3.7	3.66	3.73	3.52	3.84	3.83
Albany	3.6	3.39	3.8	3.74	3.62	3.67	3.52	3.81	3.79
Bath	3.53	3.34	3.81	3.68	3.73	3.82	3.61	3.99	3.94
Canandaigua	3.8	3.51	3.89	3.87	3.89	3.83	3.6	3.92	3.94
Syracuse	3.47	3.24	3.67	3.58	3.58	3.61	3.37	3.76	3.73
Western New York HCS	3.59	3.31	3.76	3.68	3.64	3.77	3.55	3.82	3.85

	Leadership	Rewards	Employee Development	Work Family Balance	Planning Evaluation	Job Control	Demands	Retention
	3.53	3.35	3.4	3.8	3.67	3.15	3.5	3.51
Albany	3.55	3.38	3.38	3.86	3.64	3.16	3.52	3.36
Bath	3.67	3.38	3.44	3.9	3.73	3.33	3.45	3.71
Canandaigua	3.66	3.51	3.54	3.98	3.81	3.21	3.35	3.7
Syracuse	3.32	3.2	3.28	3.53	3.54	3.02	3.42	3.4
Western New York HCS	3.55	3.34	3.41	3.8	3.69	3.13	3.61	3.56

At the level of organizational culture, the employees in Canandaigua perceive the situation in a similar manner when compared to other employees across the Network. The scores in bold are the best scores in the Network.

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CANANDAIGUA VAMC**

Culture

	Group	Entrepreneurial	Bureaucratic	Rational
VISN 2	2.97	2.98	3.4	3.39
Albany	2.87	2.89	3.41	3.35
Bath	3.13	3.12	3.4	3.49
Canandaigua	3.08	3	3.41	3.44
Syracuse	2.85	2.9	3.3	3.27
Western New York HCS	3.02	3.03	3.45	3.42

The data from the JSI and OAI seem to indicate that the employees at Canandaigua are slightly more satisfied than other employees across the Network. Making sense of the data is particularly difficult for outsiders who are unfamiliar with the local context. Since the ABI was in Canandaigua for only two days and spent the vast majority of that time isolated in a conference room, the difficult in sense making is a greater challenge. But we posed a number of questions:

- Given the CARES announcement that the facility will undergo a significant mission change that will have a yet unknown impact on employees, what contextual factors, organizational processes and procedures, underlie the employees' perceptions?
- Did the CARES announcement create solidarity among the employees that created a "halo" effect? If so, what actions fostered this effect?
- The ABI suspects that the family oriented community spills over into the facility and creates a high level social bond that fosters solidarity, and high levels of perceived satisfaction?
- Would the scores have been higher absent the CARES announcement?

**ADMINISTRATION ABI OF INVESTIGATION REPORT
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RECOMMENDATIONS

1. W. David Smith must hold every supervisor accountable to quickly address each individual instance of unprofessional behavior by any employee. Specifically, Dr. Sharma and Dr. Babcock must be held accountable to address each individual instance of unprofessional behavior by Dr. Sharza. Dr. Babcock must hold Dr. Sharma accountable for her lack of follow up. If she fails to act, he must do so.
2. W. David Smith and Dr. Babcock must clearly define and communicate their expectations related to the care of Domiciliary patients within the Ambulatory Care setting. In addition, they must proactively support their expectations with resources including but not limited to FTE and space. And they must put in place appropriate monitoring systems to gauge outcomes. Their involvement has been too passive.
3. W. David Smith and Dr. Babcock must resolve the issues related to the transition from a Network Care Line to one controlled locally. Their involvement has been too passive. The transition began in early 2003. Many issues are yet unresolved.
4. We do not recommend a separate review by the VHA Office of the Medical Inspector.

James Palmer
Chair

Mohamed Al-Ibrahim, MD
Member

Dan Kowalski
Member

**Department of
Veterans Affairs**

Memorandum

Date: October 6, 2004

From: Deputy Under Secretary for Health for Operations and Management (10N)
Network Director (10N2)

Subj: Recommendation Items for Administrative Board of Investigation Completed
July 7 and 8, 2004

To: Mr. David Smith, Medical Center Director (00)
VAMC Canandaigua, NY

The following actions with time frames will require a written response back to Ms. Laura Miller and myself by December 1, 2004.

FINDING:

Our review of the Medical Records for the Patients cited in the complaints to the Medical Inspector and Office of Special Counsel reveal two cases of substandard care.

ACTIONS REQUIRED:

1. Develop a facility wide Standard Operating Procedure to guide staff in dealing with urgent medical problems by *November 30, 2004*. (Page 5)
2. Due to the limited number of M.D. providers at the facility, utilize a Peer Review process that includes physicians from other Network 2 Medical Centers. Greater objectivity will be assured. Please perform a more complete assessment of the provider's practice to address the possibility of additional cases of sub-standard care and coordinate with Network CMO and QMO on this issue. *Complete by January 2, 2005*.
3. Although the sample size of the care review for Dr. Sharza was small, the two (2) errors identified were serious and were failures to respond in a professional manner. The two cases of failure to examine a patient with chest pain and provision of Narcotics for pain without direct examination are more egregious than technical errors. Please show evidence of proper counseling with Dr. Sharza by *November 30, 2004*.
4. Additionally, Dr. Sharza is to attend BAYER Training to assist with improved understanding of the importance of interacting in a professional manner. A class is scheduled in Buffalo for December 9, 2004, please ensure Dr. Sharza's attendance.

FINDING:

The level of supervision that Dr. Sharza provides to Robert Smith, a Physician Assistant, is barely adequate. (Page 7)

ACTIONS REQUIRED:

5. David Smith - A structural supervisory process is to be initiated with reporting of same to Dr. Sharza direct report. *Initiate by November 30, 2004.*

FINDING:

Dr. Sharma, Dr. Babcock, and David Smith did not forcefully confront Dr. Sharza's inappropriate behavior. Mr. Olszewski was too passive in his support advice role. (Page 8)

ACTIONS REQUIRED:

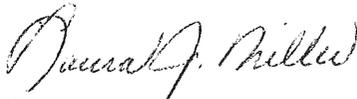
6. The above parties need to meet and recognize that personal ownership and accountability is required to prevent a situation from going from problematic to worse. Senior Management Officials will be held accountable for failure to act especially when issues directly impact on clinical care. Precise accountability and direction must exist in the supervisory process. *On-going.*

FINDING:

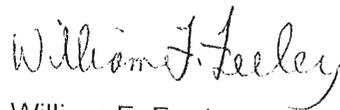
The transition from a Network wide Care Line to a more hierarchical organizational structure has created tensions and communication problems that persist. (Page 10)

ACTIONS REQUIRED:

7. This issue clearly rests in the proactive management of change area. Senior Management Officials – Mr. Smith, Dr. Babcock, and Ms. Lind will facilitate a session with all supervisory people in the organization at both the Canandaigua and Rochester Outpatient Clinic locations and facilitate a discussion surfacing concerns about the transition within Network 2. *Complete by January 2, 2005.*



Laura J. Miller



William F. Feeley

Leading Health Care In The 21st Century



DEPARTMENT OF VETERANS AFFAIRS
Canandaigua VA Medical Center
400 Fort Hill Avenue, Canandaigua, NY 14424

June 29, 2004

Susan Sharza, M.D.
Medical VA Care Line (200)
VA Medical Center
Canandaigua, NY 14424

SUBJECT: Proposed Admonishment

1. It is proposed to admonish you based on the following reason:

CHARGE I: You are charged with failure to follow the instructions of your supervisor.

Specification: On April 15, 2004 at approximately 11:00 a.m. you were instructed by me to provide medical clearance for patient M.H. who was going to be discharged that morning. Part of this medical clearance included looking at the EKG that you had ordered the day before. In response you told me, "I have to complete my yesterday's notes and I don't want to argue anymore! I told you that I would not do anything on 36B" (or words to that effect). I asked you if you were refusing to see patients and you told me, "Yes" and hung up the telephone. You refused to see the patient. You are charged with failure to follow my instructions as your supervisor when you were told to see a patient to medically clear him for discharge.

2. You have the right to reply to this notice orally, or in writing, or both orally and in writing, and to submit affidavits and other documentary evidence in support of your reply, showing why the charges are unfounded and any other reasons why you should not be admonished. You will be given until the close of business on July 16, 2004 to reply to this reason orally or in writing, or both orally and in writing, and to submit any affidavits or other documentary evidence. Your oral and written replies should be submitted to me.

3. The evidence on which this notice of proposed action is based will be available for your review in the Human Resources office in Building 7. You will be allowed 8 hours of official duty time for reviewing the evidence relied on to support the reason in this notice, preparing a written reply, securing affidavits, and for making a personal reply.

Leading Health Care In The 21st Century



DEPARTMENT OF VETERANS AFFAIRS
Canandaigua VA Medical Center
400 Fort Hill Avenue, Canandaigua, NY 14424

Arrangements for the use of official time or requests for additional time should be made with me.

4. You may be represented by an attorney or other representative of your choice at all stages of this matter. Any representative must be designated in writing.

5. The final decision to effect the action proposed has not been made. I will make the final decision and will give full and impartial consideration to your replies, if submitted.

6. You will be given a written decision within 21 days of the receipt of your replies or, the close of business on July 23, 2004, if you do not reply.

7. You will be retained in an active duty status during the advance notice period.

8. If you have any questions about the reason why this action is proposed, contact me or Cheryl Wisnieski ext. 37766 in the Human Resources office.

Sincerely,

KRISHNA SHARMA, M.D.
Lead Physician, Medical VA Care Line

I have received the original of this letter.

Signature

Date

Leading Health Care In The 21st Century



DEPARTMENT OF VETERANS AFFAIRS
Canandaigua VA Medical Center
400 Fort Hill Avenue, Canandaigua, NY 14424

MVAC Lead Physician

I have received the original of this document with attachment.

Roger C. Lynon for

Susan Sharza, M.D. Date: 7/23/04

*Received by Roger C. Lynon Ph.D.,
AFCE Steward, at the request
of Susan Sharza MD*

DPF



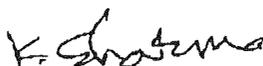
DEPARTMENT OF VETERANS AFFAIRS
Canandaigua VA Medical Center
400 Fort Hill Avenue, Canandaigua, NY 14424

July 23, 2004

Susan Sharza, M.D.
Medical VA Care Line (200)
VA Medical Center
Canandaigua, NY 14424

SUBJ: Admonishment

1. In conjunction with the letter dated June 30, 2004 in which you were given advanced notice of your proposed admonishment; a decision has been made to admonish you. Charge 1(You are charged with failure to follow the instructions of your supervisor) as stated in paragraph one of the proposed admonishment is sustained.
2. In reaching this decision I have carefully considered all the evidence developed including your written reply.
3. A copy of this admonishment will be placed in your Official Personnel Folder. You may, if you wish, make a written reply in explanation of your conduct. If you do, it will also be placed in your Official Personnel Folder.
4. This admonishment may remain in your folder for two years or it may be withdrawn and destroyed after six months, depending on your future behavior and attitude.
5. The sustained charge does not involve a question of professional conduct or competence. Therefore, if you believe this admonishment is unjustified, you may appeal the action under the grievance procedure in part IV, chapter 3 of VA Handbook 5021 (attached) or under the AFGE negotiated grievance procedure, but not both. The timely filing of a grievance under either procedure shall constitute an irrevocable election. Grievances filed under the negotiated grievance procedure must be filed within 30 calendar days of the date that you receive this letter.
6. If further information about the grievance procedure is required please contact Cheryl Wisnieski ext. 37766 in Human Resources.


Krishna Sharma, M.D.

American Federation of Government Employees
Local 3306

VAMC Canandaigua, Fort Hill Ave., Canandaigua, NY 14424

Phone (585) 394-1717 FAX (585) 393-8339

Colleen Combs, President

Joi Washburn, Exec. V.P.

TO: Dr. Robert Babcock, Chief of Staff
FROM: Colleen M. Combs, AFGE President
SUBJ: AFGE 2nd Step Grievance Response / Dr. Susan Sharza, MD
DATE: September 7, 2004

Second step grievance filed on behalf of Dr. Sharza on August 18, 2004.
Grievance meeting held

AFGE Local 3306 submits the following response on behalf of Dr. Sharza, as the disciplinary action violates the AFGE Master Agreement and the AFGE Local 33006 Supplemental Agreement as follows:

1). Article 37 Section 2 (a): In the evidence file provided to AFGE, there is no documented evidence of any negative patient outcomes in relation to the alleged incident of April 15, 2004. There is also no specific documented evidence of substance that would warrant this disciplinary action.

Section 5: The decision of the disciplinary action shows managements lack of responsibility to correct alleged inappropriate behavior between the employee and the supervisor. The obvious intention is to be strictly punitive, while offering no further corrective actions to assist the employee.

Section 6: The decision of the disciplinary action is related to an incident allegedly occurring on April 15, 2004. The initial notification of proposed discipline first occurred on June 30, 2004, which is more than 60 days after the alleged incident. This demonstrates managements untimeliness and the disciplinary action is strictly punitive.

2). Article 13 Section 6: AFGE reinforces the disciplinary action is strictly punitive and demonstrates harassment. The alleged incident that has led to disciplinary action lacks sufficient documentation of specific circumstances, that would deem this case as complex.

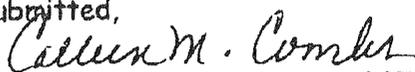
AFGE will again emphasize the decision of the disciplinary action of admonishment is untimely, inappropriate and unreasonable as it relates to the alleged incident occurring on April 15, 2004.

AFGE Local 3306 offers the following as resolution to this grievance regardless of outcome:

- 1). The disciplinary action of admonishment of Dr. Sharza be rescinded and removed her record, without any further repercussions to the employee. This incident will not be considered should any future incidents occur.
- 2). Employee receive a copy of job description / functional statement. *
- 3). Employee receives in writing, clear communication of additional duties / responsibilities and managements provisions to ensure employee meets those responsibilities. *

In addition, AFGE Local 3306 offers the following if the outcome is in the employee's favor:

- 4). Restoration of 13 days of Sick Leave used caused from initial mockery and humiliation of proposed discipline.
- 5). Employee reserves the right to submit resignation at any time in the next 90 - 120 days without repayment to the Department of Veterans' Affairs any additional monies/benefits earned: special pay; education; loan repayment.

Submitted,

Colleen M. Combs, President AFGE 3306

A review of the evidence file reveals:

1. The provider normally covering acute psychiatry, PA Smith, (36-B), was absent on AL 4/15/04.
2. The intermittent provider assigned to temporarily replace PA Smith was "pulled" by management to cover primary care on 4/15/04 due to the unexpected absence of a second MVAC provider.
3. The nurse manager of 36-B and Dr. Sharza were not notified of the new coverage arrangements. It appears MVAC leadership "assumed" Dr. Sharza would cover the void.
4. There is a discrepancy in the recollections of a phone conversation between Dr. Sharma and Dr. Sharza that took place at approximately 10:40 am on 4/15/04. Dr. Sharma recalls Dr. Sharza responding in the affirmative when Dr. Sharma asked, "Are you refusing to see patients?" Dr. Sharza recalls informing Dr. Sharma she "was currently involved with (her) own assigned patients, including seeing (a) patient with injury..." and, "could go and see (the 36-B patient) and take care of other needs when done with what I am currently doing..." According to Dr. Sharza, the phone conversation ended with Dr. Sharua stating, "Okay, Dr. Sharza, never mind. I will just have to find someone else to take care of this." Dr. Sharza, replied, "very well then."
5. Shortly after the phone conversation Dr. Sharma asked PA Talone to take care of the immediate problem on 36-B.
6. Pat Spooner states she paged Dr. Sharza who remarked she "was too busy" to attend patients on 36-B. Ms. Spooner notes the location of the phone (on caller-ID) was *Rec Cnter*, commenting that a plant and baked goods sale was being held there that day. Dr. Sharza asserts she was examining patients on LT Psychiatry at the time. IT staff confirm the office used by Dr. Sharza was formerly occupied by the Recreation Therapist assigned to the unit. The caller-ID lists the location as "Rec Therapy."

The review casts doubt on whether the actions of Dr. Sharza rose to the level of willful "failure to follow the instructions of (her) supervisor." Further, there is evidence that *mvac* management failed to timely communicate their revised staffing plan to appropriate stakeholders and may have over-reacted to Dr. Sharza's pushback, erroneously reaching the conclusion she was at the plant sale. On the other hand, Dr. Sharza, in debating a supervisor's request, (as unreasonable as it may have seemed,) is deserving of a reminder that when the supervisor provides the employee with an assignment or an order, the employee must do what is assigned and file an objection to it after the fact.

In an attempt to resolve this grievance, the admonishment is rescinded and replaced with written counselling related to the "work now, grieve later" rule. In furtherance of the additional relief requested by Dr. Sharza related to written staffing assignments, I have directed the MVAC Care Line Manager, Chuck Norton, to develop and distribute to all providers a plan for covering staffing exigencies created by unexplained provider absences in primary care and in the medical coverage of behavioral health patients. Mr. Norton has also been asked to provide Dr. Sharza with a written explanation of her

"position description." I do not find merit in the remaining relief requested by Dr. Sharza through her AFGE representative related to restoration of sick leave and the waiver of repayment of special pay and education loan benefits in the event of Dr. Sharza's resignation. Moreover, the request exceeds the authority of the grievance examiner to adjudicate.

**Department of
Veterans Affairs**

Memorandum

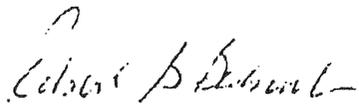
Date: September 15, 2004

From: Chief of Staff (11)

Subj: AFGE Grievance/Dr. Susan Sharza

To: AFGE Local 3306 / Dr. Susan Sharza

1. In response to your grievance relating to the admonishment given to Susan Sharza, M.D., I have made the decision to cancel the admonishment. Instead, Dr. Sharza will be given a written counseling for resisting her supervisor's request that she accept additional patient care assignments. I feel this is necessary, as it will serve as a reminder to Dr. Sharza that when a supervisor provides an employee with an assignment, the employee must do what is assigned and file an objection to it after the fact. This is based on the "work now, grieve later" rule. I have directed the MVAC Care Line Manager, Chuck Norton, to develop and distribute to all providers a plan for covering staffing exigencies created by unexpected provider absences in primary care and in the medical coverage of behavioral health patients. Mr. Norton has also been asked to provide Dr. Sharza with a written explanation of her "position description."
2. I do not find merit in the remaining relief requested by Dr. Sharza in this grievance related to restoration of sick leave and the waiver of repayment of special pay and education loan benefits in the event of Dr. Sharza's resignation.
3. I trust that this will resolve this grievance.



ROBERT B. BABCOCK, M.D.

**Department of
Veterans Affairs**

Memorandum

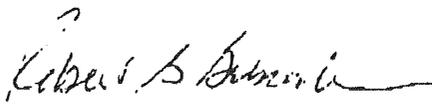
Date: September 15, 2004

From: Chief of Staff (11)

Subj: Written Counseling

To: Susan Sharza, M.D.

1. The purpose of this memorandum is to document my concerns regarding your response to the request of your supervisor, Dr. Krishna Sharma, to accept additional patient care responsibilities. On April 15, 2004 at approximately 11:00 a.m. you were asked to provide medical clearance for patient M.H. who was to be discharged that morning. Part of this medical clearance included reading the EKG that you had ordered the day before. Because of your resistance to your supervisor's request, the patient had to be evaluated by another provider in order to avoid delaying the discharge.
2. In the future, you are expected to complete your assignments as directed by your supervisor and file any objection to the assignment after the fact. A recurrence of this type of behavior may result in disciplinary action.



ROBERT B. BABCOCK, M.D.

Department of
Veterans Affairs

Memorandum

Date: September 30, 2004
From: Robert Babcock, M.D., Chief of Staff (11)
Subj: Change of Duty Assignment
To: Krishna Sharma, M.D., Lead Physician, MVAC

1. Please be advised that in consultation with Mr. Charles Norton, Medical VA Care Line (MVAC) Manager, I have decided to realign the MVAC functions. Effective October 3, 2004 MVAC will be organized into three sections under the MVAC Care Line manager. There will be a primary care section with clinical leadership provided by a lead physician. The second section will be called *Administrative Medicine* and will comprise several functions. They include environmental medicine, research, education, MOD management, employee health, compensation and pension exams and the provision of hospital-based medical services to behavioral health patients. The clinical leadership of this section will be provided by a lead physician who will report to Mr. Norton for supervisory, clinical and performance issues. The third section will be comprised of specialty care and will be under the direct supervision of Mr. Norton. (See Attached New Organizational Chart).

2. Effective October 3, 2004 you will be assigned to the Administrative Medicine Section as the Lead Physician. You will no longer be assigned a primary care panel and you are to make plans with Mr. Norton to transition your current panel to other providers with a completion date of not later than November 15, 2004. This should give you ample time to make the transition with minimal disruption to your current patients.

3. Mr. Norton will develop your 2005 performance standards reflecting your new assignment. You will experience no change in your pay and your performance standards will stay in the current ECF format.

4. Please feel free to contact me if you have any questions pertaining to your new assignment and related issues.

5. Your cooperation on these changes will be appreciated.



Robert Babcock, M.D.

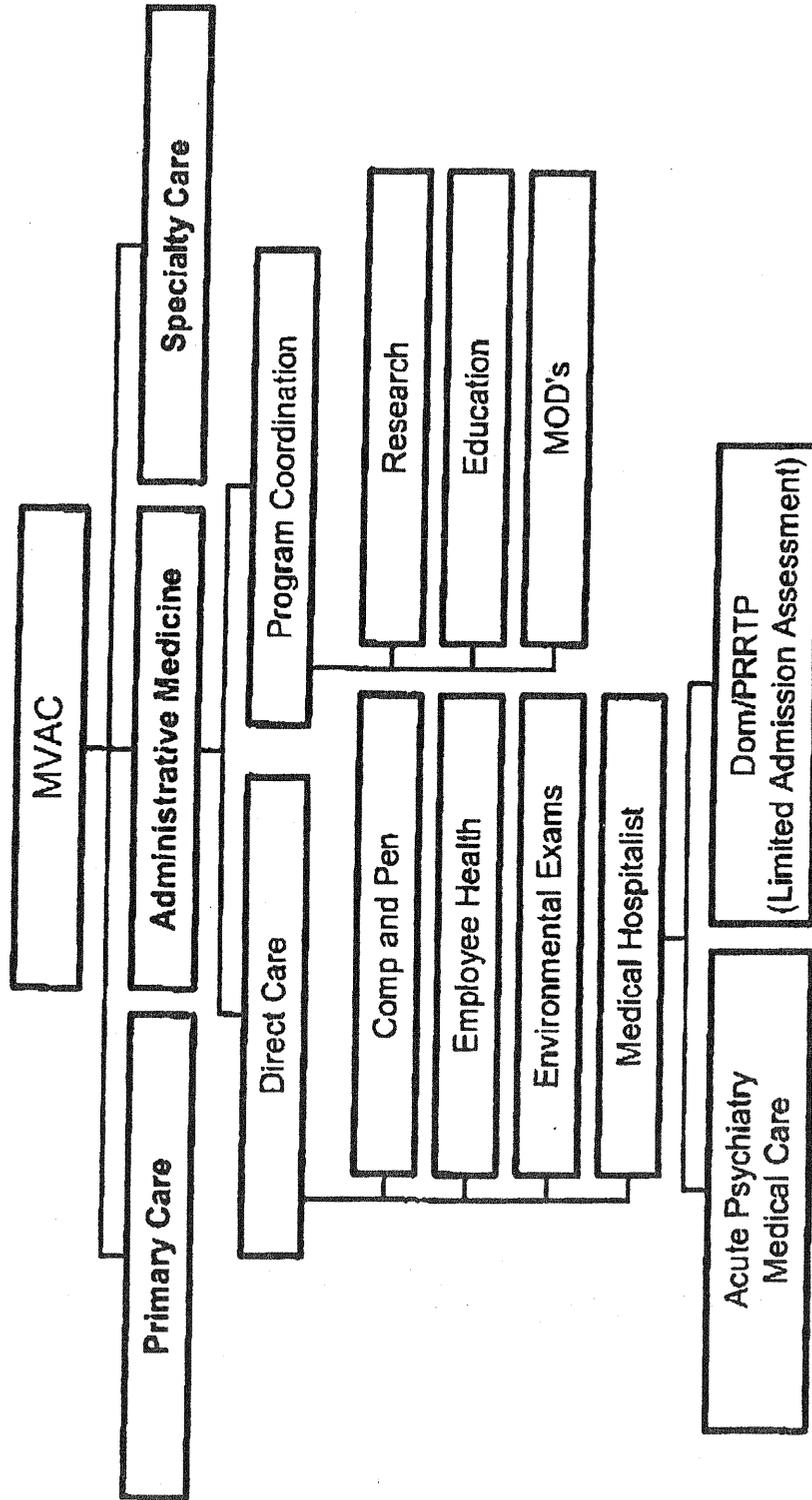
Attachment

I have received the original of this memo.

K. Sharma
Signature

11/30/04
Date

Medical VA Care Line



8

Babcock, Robert B.

From: Babcock, Robert B.
Sent: Sunday, May 02, 2004 10:44 AM
To: Lind, Patricia; Piazza, Kenneth P; Smith, W.David
Subject: Organizational Structure

Attached is a draft of a proposed core of a PowerPoint presentation that is designed to meet two needs: (1) the Senior Leadership presentation later this month related to the role of the ADPNS, and (2) local staff discussions explaining the care line re-organization to be implemented post-OIG visit.

Clearly both purposes require further work, at a minimum:

1. The interface of the care line managers, COS and ADPNS in ROPC
2. For local use, further details on proposed staffing of integrated BVAC-MVAC and Administrative Medicine, and
3. The selection process for the manager of *Behavioral and Medical VA Care*
4. For Senior Leadership more details on how the COS and ADPNS share the co-management functions, and
5. How is management effectiveness evaluated? What are the outcomes? How does the Director hold the COS-ADPNS jointly accountable?

Please start adding to and editing the list above and provide feedback on the attached presentation.

PS: Isn't there a better name than "Behavioral & Medical VA Care Line"?

11/23/2004

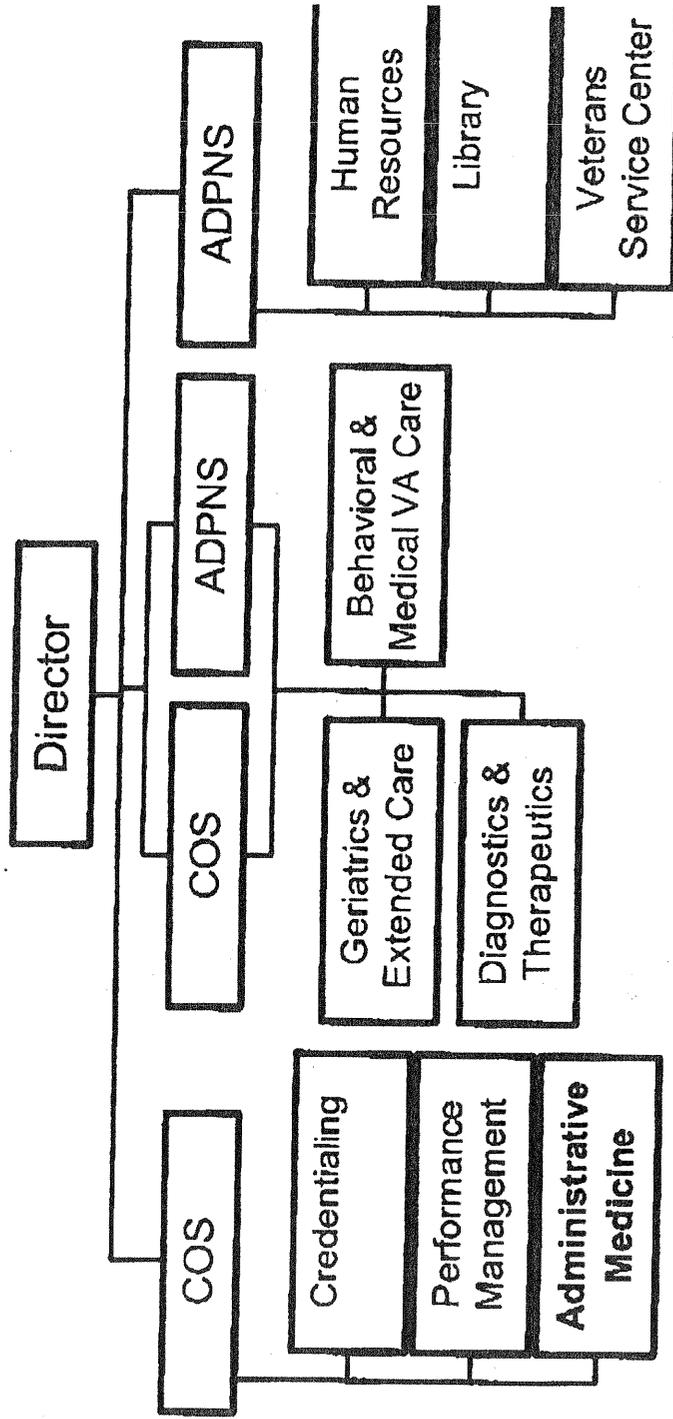
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Nov-23-2004 11:50am From-Canada/Rua VA Human Resources

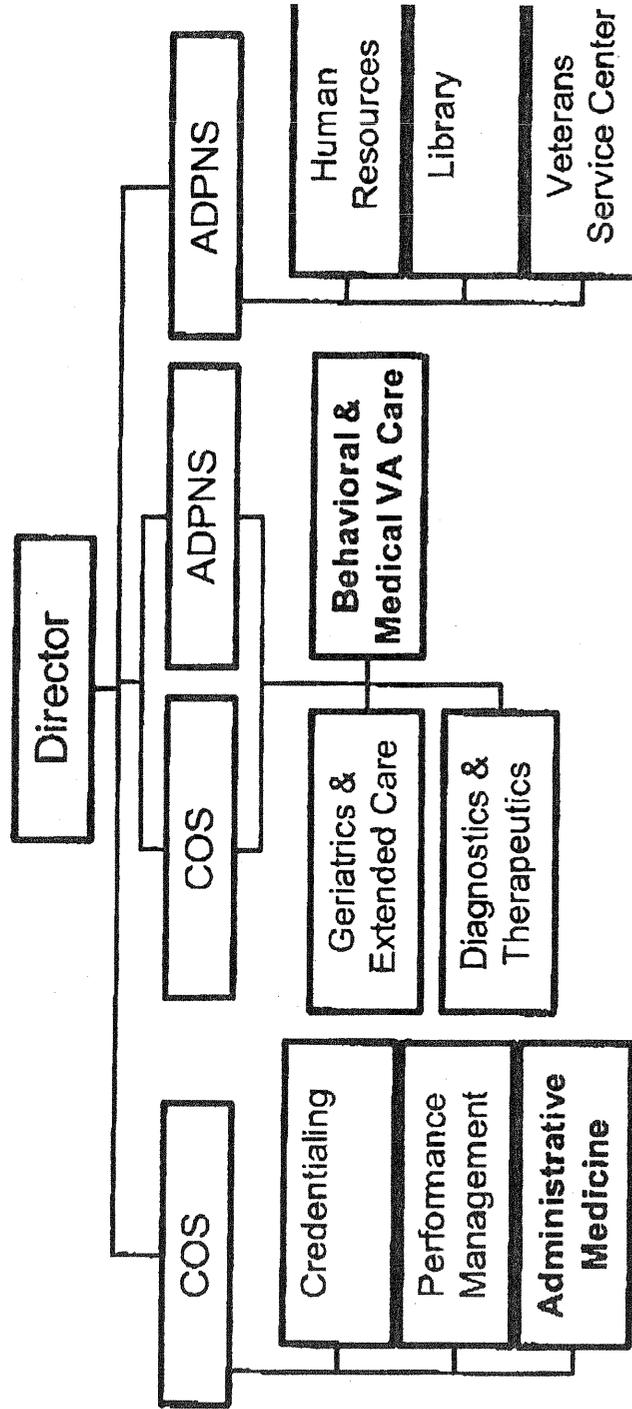
Clinical Services Org Chart: New

The Role of Administrative Medicine...

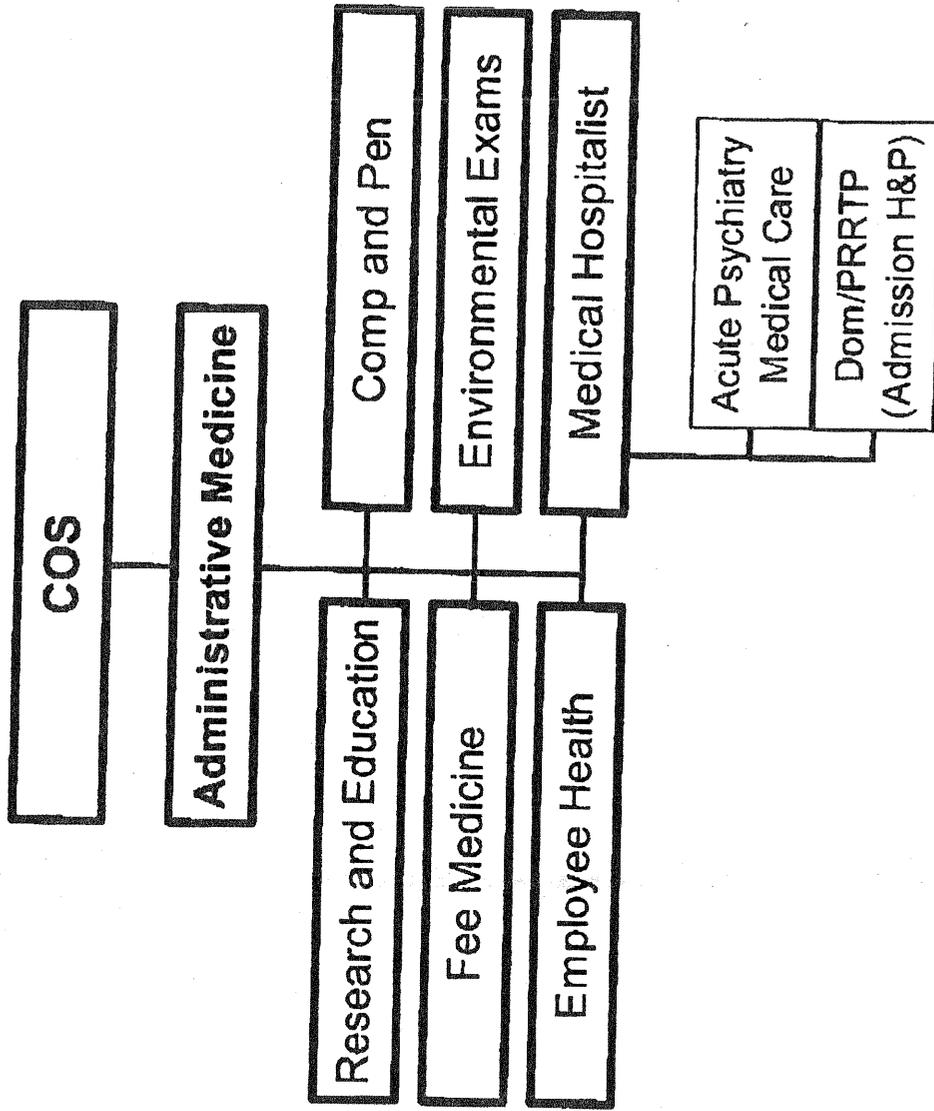


Clinical Services Org Chart: New

1. Integration of BVAC and MVAC
2. Creation of Administrative Medicine



The Role of Administrative Medicine



**Department of
Veterans Affairs**

Memorandum

Date: July 15, 2004

From: Robert Babcock, M.D., Chief of Staff

Subj: Change of Duty Assignment

To: Krishna Sharma, M.D., Lead Physician, MVAC

1. Please be advised that with the selection of Mr. Charles Norton as the new Medical VA Care Line (MVAC) manager, I have decided to realign the MVAC functions. Effective July 25, 2004 MVAC will be organized into three sections under the MVAC Care Line manager. There will be a primary care section with leadership provided by a lead physician. The lead physician will report directly to me for supervisory, clinical and performance issues. The second section will be called administrative medicine and will be made up of a number of functions. They include environmental medicine, research, education, MOD management, employee health, compensation and pension exams and the provision of hospital-based medical services to behavioral health patients. The leadership of this section will also be provided by a lead physician that will report to me directly for supervisory, clinical and performance issues. Subordinate staff will include at least one physician assistant. The third section will be comprised of specialty care and will be under the direct supervision of the MVAC Care Line manager (See Attached New Organizational Chart).

2. To facilitate Mr. Norton's transition, I plan to move his office to the basement of Building 1 so he is closer to the center of MVAC operations. The lead physician of primary care will also be housed in the basement of Building 1. The lead physician of the administrative medicine section will be housed on the 3rd floor of Building 1.

3. Effective July 25, 2004 you will be assigned to the Administrative Medicine Section as the Lead Physician. Please contact the current Acting Care Line Manager, Ms. Pat Spooner, to make plans for moving your current office furniture, etc. to your new space on the third floor so it will be in place by July 25, 2004. I will make the appropriate changes to your performance standards currently in place to accommodate your new assignment areas. You will experience no change in your pay and your performance standards will stay in the current ECF format. You will no longer be assigned a primary care panel and you are to make plans with Mr. Norton to transition your current panel to other providers with a completion date of not later than August 31, 2004. This should give you ample time to make the transition with minimal disruption to your current patients.

4. Please feel free to contact me if you have any questions related to your new assignment and related issues.

5. Your cooperation on these changes will be appreciated.

Robert Babcock, M.D.

6



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

October 25, 2004

CENTRAL OFFICE
WASH. D.C.
U.S. OFFICE OF
SPECIAL COUNSEL

2004 OCT 26 AM 7:50

Scott J. Bloch
U.S. Office of Special Counsel
1730 M Street, N.W.
Suite 300
Washington, DC 20036-4505

Dear Mr. Bloch:

Enclosed is the Department of Veterans Affairs' (VA) report in response to your request of June 21, 2004, to investigate allegations made by employees at the VA Medical Center in Canandaigua, New York (Office of Special Counsel File Numbers DI-03-0620 and DI-03-0621; DI-04-1862 and DI-04-1960.)

A VA Administrative Board of Investigation did not find gross mismanagement arising out of the actions of the staff physician or Chief of Staff, but made a number of recommendations for dealing with allegations involving the staff physician. Veterans Health Administration (VHA) management is addressing the recommendations for dealing with the allegations of substandard care through the peer review process, as well as human resources and performance management issues involving the lead physician and staff physician. The VHA Network Director will also address the finding that the local facility needs to clarify the protocol for dealing with a patient who presents in an outpatient clinic with a complaint of chest pain. The Network Director has also directed the Medical Center to send a number of medical records for patients treated by the staff physician to a peer reviewer at a VA Medical Center within the Network.

If you have any questions about the contents of the report, please have a member of your staff contact Dan Kowalski, Human Resources Consultant in the Veterans Health Administration Human Resources Management Group, at 973-395-7245 or Jane C. Joyner in the VA Office of General Counsel, at 202-273-6372.

Sincerely yours,

Anthony J. Principi

Enclosure

REPORT TO OFFICE OF SPECIAL COUNSEL

Prepared by: James Palmer, Mohamed Al-Ibrahim, MD, and Dan Kowalski

Department of Veterans Affairs



**Department of
Veterans Affairs**

Report Date: October 25, 2004

OSC File Numbers
DI-03-0620; DI-03-0621; DI-04-1862; DI-04-1960

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OSC File Numbers
DI-03-0620; DI-03-0621; DI-04-1862; DI-04-1960

EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA), Veterans Health Administration (VHA) was asked to review allegations of gross mismanagement made by federal employees to the Office of Special Counsel (OSC). The information disclosed by the VA employees alleges that a VA staff physician has neglected and abused patients at the medical center in Canandaigua, New York, and that the Chief of Staff has refused to address the physician's misconduct. Based on this information, VHA convened an Administrative Board of Investigation (Board) to examine these issues. The Board concluded:

- The complaint cites eleven cases of alleged substandard patient care. The Board identified two cases of less than an acceptable level of care by the staff physician. Based on these findings, the Board has recommended a more thorough review of the staff physician's practice be conducted by the facility through the peer review process.
- While there is anecdotal evidence that the staff physician often exhibits poor interpersonal skills, there has been little if any adverse impact on patient care.
- The lead physician, the immediate supervisor of the staff physician, has not pursued all of the human resources and performance management methods available to correct the behavior and conduct that she finds unacceptable.
- The Chief of Staff has not abused his authority in addressing the allegations contained in the employees' complaint to OSC.
- In March 2003, the recently appointed Network Director began a planned realignment of the Medical Services Care Line across the Network. The Service Lines under the previous Network Director had line and budgetary authority over the care line employees in each facility in the Network, including Canandaigua. In the realignment, the Care Lines lost budget control and now report to the individual facility directors rather than the Care Line Manager in the Network Office. The Board believes that many of the issues raised in the complaints sent to the VA Office of the Medical Inspector (MI) and OSC are rooted in tensions inherent in this organizational change, disputes over role ambiguity arising out of the transition, and communication problems during this process.

SUMMARY OF COMPLAINANTS' ALLEGATIONS

The Secretary of Veterans Affairs was asked by the Office of Special Counsel (OSC) to investigate allegations of patient abuse and neglect by a VA staff physician. It is also alleged that the Chief of Staff has failed to address the misconduct of the staff physician. A lead physician of the unit in which the staff physician worked and the co-manager of the medical unit made the allegations. Two additional anonymous employees also provided information to OSC. The lead physician is the immediate supervisor of the staff physician.

The lead physician and co-manager allege that over the past two years, they have witnessed numerous instances of patient neglect and mistreatment of veterans by the staff physician. They allege that the staff physician has repeatedly refused to see and treat patients, and that she has falsified medical charts by stating that she has examined patients when no examination took place. They also allege that she has repeatedly failed to respond to her pager, has refused to see patients for scheduled appointments, and has refused to speak to other VA medical personnel regarding patients. They cite numerous instances when some of these actions took place. One anonymous employee alleged that the staff physician routinely ignores triage recommendations of the nursing staff and has refused to see patients presented for medical evaluation and treatment, which has placed an undue burden on other providers who must see additional patients.

The lead physician and co-manager further allege that they have brought these issues to the attention of the Chief of Staff through numerous reports of contact. They allege that the Chief of Staff has shredded these Reports of Contact, and has failed to take any action to resolve the ongoing problems concerning the staff physician. The lead physician alleges that although she has been prohibited from taking any action regarding complaints received from other staff members concerning the staff physician, she has also been instructed to advise complaining staff members that she will address the problems.

The employees assert that the information presented represents serious allegations of patient neglect and mistreatment that put sick patients at an increased risk. They assert that the staff physician's behavior has placed an undue burden on the on-call physicians and other medical staff, and that the staff physician's actions, and the failure of the Chief of Staff to address the problems, adversely affect VA's ability to care for veterans.

OSC determined that this information, if true, established a substantial likelihood of gross mismanagement arising out of the actions of the staff physician and the Chief of Staff.

METHODS FOR CONDUCTING THE INVESTIGATION

In the Spring of 2004, the VA Office of the Medical Inspector (MI) received a complaint of substandard medical care by a staff physician at the VAMC in Canandaigua, NY. The allegations included accusations that the physician provided substandard care, refused to see some patients, was inappropriate in her behavior towards patients and other employees including her supervisor, and that the facility leadership failed to adequately address those issues. The employees who filed the complaint included photocopies of portions of medical records in addition to reports of contact from other employees. The medical records contained patient identifying information, including names and social security numbers. The MI reviewed the documentation and the electronic medical records in the cases cited in the documentation and spoke to the Office of the Deputy Under Secretary for Health for Operations and Management in VHA about the allegations. Both offices agreed that VHA would appoint an Administrative Board of Investigation (Board) to visit the VAMC to examine the allegations and to recommend whether the MI should conduct a more thorough review of medical care provided at the facility. On June 16, 2004, the Director of the VA Healthcare Network Upstate New York, appointed the members of the Board: James Palmer, the Director of the VAMC in Erie, PA; Mohamed Al-Ibrahim, MD, the Chief of Staff of the Maryland Healthcare System; and Dan Kowalski, Human Resources Consultant in the VHA Human Resources Management Group. The Board made plans to visit Canandaigua in early July.

Four VA employees sent the same complaint and medical documentation to the OSC. On June 21, 2004, OSC asked the Secretary of the Department of Veterans Affairs to investigate the allegations. On June 25, 2004, the Deputy Under Secretary for Health for Operations and Management appointed the same Board to examine the issues raised by OSC and to prepare a report to OSC.

The Board visited Canandaigua on July 7 and 8, 2004. Prior to the Board's arrival in Canandaigua, each witness received an e-mail that included a scheduled interview time, a brief description of the nature of the charges, a Notice of Rights and Responsibilities, and a designation of Representative, if the witness intended to be represented. The Board interviewed fourteen employees under oath. A court reporter transcribed the testimony and each witness was given the opportunity to review his or her transcript. The members of the Board discussed the evidence and jointly wrote this report.

The Network Director's initial charge to the Board (regarding complaints made to the Medical Inspector) was broader than that of the Deputy Under Secretary for Health for Operations and Management to investigate the matters referred by OSC. Specifically, the Network Director also charged the board to assess the overall level of employee satisfaction. Therefore, the Board prepared and submitted a separate report to the Network Director.

SUMMARY OF THE EVIDENCE

The staff physician is the main provider of medical care for the veteran patients in the Domiciliary that is located in one building on the sprawling multi-building campus. The staff physician supervises a Physician Assistant who provides much of the evaluation work and routine care for the patients admitted to the unit. Other physicians provide mental health care. In addition, the staff physician sees outpatients in the ambulatory care clinics that are located in a different building from the Domiciliary. The staff physician also sees patients on a mental health inpatient unit that is located in yet another building. The lead physician, her immediate supervisor, is therefore generally unaware of the staff physician's exact location at any time and is not immediately aware of her activities.

I. The lead physician and co-manager allege that over the past two years, they have witnessed numerous instances of patient neglect and mistreatment of veterans by the staff physician. Evidence relevant to this allegation includes the copies of patients' medical records that accompanied the OSC letter. Complainants' allegations in this regard suggest that the staff physician provided substandard care in these situations.

A. Documentary Evidence

The Board reviewed eleven cases cited in the documentation sent to the MI and OSC. The review included a review of the electronic medical records.

B. Testimony

The Board had reviewed the medical records in the case cited in the complaint to OSC prior to the appearance of the staff physician. The staff physician testified about the two cases discussed below and confirmed the sequence of events as the Board describes.

C. Findings

The Board identified two instances of care rendered by the staff physician that did not meet the community standard.

On December 30, 2003, patient 9255 (the last four digits of the patient's Social Security Number) complained of chest pain to the nurses on the inpatient unit where the patient was receiving care. When informed about the patient by the nursing staff, the staff physician evaluated the patient by phone. This type of distant evaluation was inappropriate for a hospitalized inpatient. After a delay for the patient to eat a "skipped meal" and to go to the bathroom, the patient received further evaluation. The patient was subsequently transferred to a community hospital where he was found to have an acute myocardial infarction. Prior to January 2004, the Board

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concluded that a peer review (a process where another physician reviews the medical record to determine if the care provided was equivalent to the standard of care provided in the community) would have assigned a Level 2 to this encounter, indicating that although the care provided was within the acceptable standards of care, some other providers may have treated the case differently. With the subsequent adoption of VHA's current acute coronary syndrome guidelines, peer review would now assign a Level 3 to the management of this patient indicating that most practitioners would have managed the case differently.

On April 30, 2004, patient 3923 appeared in the outpatient clinics complaining of pain in a surgical site having had a procedure a few days earlier. The staff physician prescribed opiates without examination of the surgical area. This case was referred to peer review and was determined to be a Level 2 case. The lead physician was aware that the case was reviewed at Level 2. Another reviewer could have easily assigned a Level 3 to this case since the surgical area was not examined.

The Board reviewed the other cases and concluded that the care provided was within acceptable standards. For example, patient 7504 was not given an opiate refill but instead was referred back to his primary care provider; patient 2362 was given medications and a follow-up appointment; patient 3552 was triaged and scheduled for a routine appointment; patient 8348 had a known cardiac arrhythmia, was examined and had stable vital signs; the consult for patient 8099 was delayed but the delay did not affect the patient's health outcome; and patient 1946 was referred to a gastroenterologist who was following the problem instead of being seen the same day.

It is significant to note that one of the nine additional cases cited by the lead physician and the co-manager in their complaint to OSC was evaluated by the Medical Center's Peer Review process and found to be acceptable. The lead physician was aware of the Peer Review findings prior to submitting the complaint to OSC.

The number of cases cited represents a small fraction of the number of patients the staff physician treated during the past two years.

D. Recommendations

The facility should initiate a peer review process to perform a more comprehensive review of the staff physician's overall clinical practice to ensure that the two cases cited are indeed isolated incidents. Appropriate administrative action should be initiated in response to any additional instances where sub-standard care is discovered.

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The facility has a policy for referring and reviewing cases for peer review. The lead physician is aware of the policy and should refer any future allegations regarding substandard care for peer review. In addition, the lead physician may initiate disciplinary action for cases where she believes that the physician violated VA's standards of conduct.

II. The lead physician and co-manager allege that the staff physician has repeatedly refused to see and treat patients, including patients scheduled for appointments. Another complainant made a similar allegation, asserting that the staff physician has refused to see patients presented for medical evaluation and treatment, which has put an undue burden on other providers who must see additional patients.

A. Documentary Evidence

The documents provided to OSC include reports of contacts from office support staff who interact with the staff physician during the course of the workday. The lead physician and co-manager solicited some but not all of the reports of contact. The documents discuss a few cases of poor interpersonal communications as well as a few situations when the staff physician refused to see patients.

B. Testimony

The staff physician testified that, on occasion, she refused to see unscheduled patients when she has a number of scheduled patients waiting. In those cases, other providers with open appointment slots did see the patients. Both the lead physician and the co-manager testified that patient care has never been compromised when the staff physician refused to see a patient. Both the lead physician and the staff physician testified that there have been a few cases when the staff physician was overbooked and thus was unable to see all the scheduled patients.

C. Findings

The Board verified two instances when the staff physician refused to see a patient.

The first occurred on June 20, 2003. Late that afternoon, the staff physician refused to see a patient. When confronted by the lead physician, her supervisor, the staff physician gave her VA identification badge to the lead physician and stated that she was resigning. The staff physician then abruptly left her duty station with two patients waiting. Although another provider saw the patients that afternoon, this behavior was clearly a serious breach of professional responsibility. On the following Monday, the staff physician called the Chief of Staff to acknowledge the inappropriateness of

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her behavior and to request that she be allowed to return to work. The Chief of Staff consulted the Human Resources Manager who advised the Chief of Staff that the facility could not consider the staff physician's actions to constitute a resignation. The HR Manager and the Chief of Staff met with the lead physician and the co-manager to discuss what had transpired. The staff physician returned to work and was charged leave without pay for the absence. Although the Board members might not have made the same decision as the Chief of Staff in allowing the staff physician to return to work, the decision was clearly within the scope of his authority and did not represent an abuse of that authority. It is important to note that the Chief of Staff acted in accordance with advice from the HR Manager. It is also clear that the lead physician and the co-manager disagreed with the Chief of Staff's decision.

The second instance occurred early in 2004. The lead physician issued a disciplinary action (a letter of admonishment) to the staff physician.

D. Recommendations

If similar conduct occurs in the future, the Board recommends that the lead physician quickly investigate the circumstances and initiate appropriate corrective action.

The facility should also review its scheduling practices to avoid overbooking time slots.

III. The lead physician and the co-manager allege that the staff physician falsified medical charts by stating that she has examined patients when no examination took place.

A. Documentary Evidence

The lead physician submitted a written document to OSC alleging that the staff physician was improperly documenting interactions with patients. Specifically, the lead physician indicated that the staff physician was documenting care that did not occur.

B. Testimony

The staff physician testified that she enters information in the electronic medical record based on conversations that she has with domiciliary patients in the corridors and in other sites away from the clinics. The lead physician testified that she disagrees with the staff physician's practice regarding documenting such conversations with patients.

C. Findings

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Although the lead physician testified that she disagrees with the staff physician's practice regarding documenting conversations with patients, this Board does not. The Board found no evidence of falsification of medical documentation.

IV. The lead physician and the co-manager allege that the staff physician has repeatedly failed to respond to her pager.

A. Documentary Evidence

The complaint to OSC included written documents indicating that the staff physician fails to respond to electronic pagers.

B. Testimony

The staff physician testified that on occasion, she does not receive a page until she goes to another building in the medical center and that long before the Board's visit the staff physician requested and received a replacement pager.

The Physician Assistant who works with the staff physician testified that he pagers her throughout the week and that she generally responds within 10 minutes.

The lead physician testified that she gave the staff physician a written counseling in November 2003, after the staff physician did not respond to a page.

C. Findings

The medical center consists of a number of buildings roughly arranged around two large circles. Thick walled brick tunnels, some partially below ground level where we suspect the strength of the pager signal fluctuates, connect the buildings. The paging system does not capture usage information that would allow the Board to examine computerized usage data to address this allegation. The Board was unable to definitively resolve the allegation that the staff physician repeatedly failed to respond to her pager.

D. Recommendations

If this alleged conduct occurs in the future, the Board recommends that the lead physician immediately investigate the circumstances and initiate appropriate action.

V. The lead physician and co-manager allege that the staff physician has refused to speak to and cooperate with other medical personnel regarding patients. Specific instances noted in the OSC letter include a refusal to speak with the Behavioral Health Care Line Manager and a refusal to consult with a psychiatrist. One complainant alleged that the staff physician routinely ignores triage recommendations of the nursing staff.

A. Documentary Evidence

The complainants to OSC included written documents alleging that the staff physician fails to discuss cases with Mental Health and other staff.

B. Testimony

The lead physician testified that a number of employees have complained to her about interpersonal communications issues with the staff physician and she herself has a confrontational relationship with the staff physician.

The Behavioral Health Care Line Manager testified that the staff physician does talk to mental health staff about patients.

The Nurse Executive testified about a specific incident in which nursing staff complained about the staff physician's expectations related to the documentation of blood pressure. The Nurse Executive thought that the staff physician's expectations were proper and in accordance with policy. The Nurse Executive asked nursing education to review the policy with staff. Yet even in this instance, the Nurse Executive thought that the staff physician's communication style was poor.

The Physician Assistant, the employee who has the most interaction with the staff physician, testified that their interactions are professional and appropriate.

C. Findings

Documentation from a small number of other employees indicates that the staff physician can be rude and is often demanding. Yet her interactions with the Physician Assistant whom she supervises contradicts the perceptions recounted in the documentation.

D. Recommendations

If this conduct occurs in the future, the Board recommends that the lead physician investigate the allegations and initiate appropriate corrective action.

VI. The lead physician and co-manager allege that they have brought these issues to the attention of the Chief of Staff through numerous Reports of Contact. They allege that the Chief of Staff has shredded these Reports of Contact, and has failed to take any action to resolve the ongoing problems concerning the staff physician. The lead physician alleges that although she has been prohibited from taking any action regarding complaints received from other staff members concerning the staff physician, she has also been instructed to advise complaining staff members that she will address the problems. Complainants allege that the failure of the Chief of Staff to address these problems has adversely affected VA's ability to care for veterans.

A. Documentary Evidence

Prior to the Board's visit to the medical center, the Chief of Staff submitted a lengthy written statement to the Board that referenced a large number of notes and documents that he kept related to the interpersonal conflict between the staff physician and the lead physician and the transition from the network directed care line to a locally controlled care line (See Important Contextual Information below). He received many of those documents from the lead physician and the co-manager.

B. Testimony

The Chief of Staff testified that he recalls a single instance when he shredded documents that he received from the lead physician and co-manager. He had asked the lead physician and the co-manager to begin scheduling Domiciliary patients into the primary care clinics. The lead physician and co-manager resisted this change in the care delivery model. After a month of inaction, the lead physician and co-manager scheduled a meeting with the Chief of Staff, presented him with three reports of contact that the co-manager had solicited regarding the staff physician's poor communications with other staff, and a request to terminate the staff physician. The Chief of Staff testified that he was appalled at their request since it was based on solicited documentation related to poor interpersonal communications. He did investigate the allegations and ultimately met with the staff physician to counsel her about her communication style.

The Chief of Staff testified that he has encouraged the lead physician to initiate corrective action whenever the lead physician believes that such action is appropriate. But the HR Manager testified that prior to the preparation of the admonishment mentioned earlier, the lead physician did not approach HR for assistance with any specific documentation on which to base any formal action. In her own testimony, the lead physician discussed her rather passive approach towards initiating action. She would talk to HR without any follow up, talk to the Chief of Staff, and not take

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action on his instructions. It is significant to note that the lead physician has given the staff physician a written counseling and an admonishment.

C. Findings

The Board has concluded that there is no credible evidence that the Chief of Staff impeded the lead physician from acting. It is significant to note that the lead physician has not pursued all of the human resources and performance management options available to correct the behavior and conduct that she finds objectionable.

D. Recommendations

If in the future, the lead physician believes that the staff physician has acted in a manner that warrants corrective action, the lead physician should initiate appropriate corrective action.

IMPORTANT CONTEXTUAL INFORMATION

For a number of years under the former Network Director, the VA Healthcare Network Upstate New York operated under a complex care line structure that differed dramatically from the structure of VHA's other Networks. The Network's organizational structure included patient care service delivery organizations that managed the resources across all the VA Medical Centers and Outpatient Clinics in the Network. These organizations were structured along major medical specializations (e.g. Medicine, Mental Health, etc.) and had line authority over the employees who worked in those specializations at each site. In addition, the care lines had budgetary control over the resources including personnel services dollars.

There were a number of services that were not under the care line structure (e.g. Human Resources Management). Committees that included representatives from each Medical Center in the Network coordinated the work across the Network. But in these cases, line and budgetary authority remained at the local level.

The VA Medical Center Directors often served as the chair of coordinating structures that crossed the Network. But in this matrix, their control of resources was significantly diminished compared to the past and compared to the situation in other Networks.

In March 2003, the recently appointed Network Director initiated a realignment of the Medical Services Care Line (MVAC) across the Network. The Service Lines under the previous Network Director had line and budgetary authority over the care line employees in each facility in the Network, including Canandaigua. In the realignment, the Care Lines lost budget control and reported to the individual facility directors rather than the Care Line Manager in the Network Office.

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Shortly after this change, the local senior leadership at the Canandaigua facility began meeting with the lead physician and the co-manager about changes that they wished to see in the delivery of services provided by the care line. The issues were varied: the distribution of work among practitioners, rearrangements in the physical work space to facilitate a number of related changes in service delivery, and most relevant to the allegations, the integration of medical care provided to the domiciliary patients into the primary care clinics.

The transition to providing medical care to the Domiciliary patients within the primary care clinics seems to be the most contentious issue. A number of witnesses testified about the benefits in changing this process as an important step in the Domiciliary rehabilitation program. The Director, the Chief of Staff, the Nurse Executive, the Manager of the Behavioral Health Care Line, and the staff physician supported this redesign. A number of witnesses testified that the lead physician and co-manager resisted this change and slowed its implementation. A process action team was appointed in the Spring of 2004 to complete the implementation. The slow pace of change as perceived by the Chief of Staff was an important element in his decision to lower the lead physician's proficiency rating for administrative duties when compared to prior years.

We believe that many of the issues raised in the complaints sent to the MI and OSC are rooted in tensions inherent in this significant organizational change, disputes over role ambiguity arising out of the transition from a complex matrix structure to a more hierarchical structure in which budgetary and line authority changed dramatically, as well as communications problems during this change management process. These tensions clearly affected the working environment and contributed to stress among staff. However, it is doubtful if these had a direct effect on patient care.

VIOLATIONS OR APPARENT VIOLATIONS OF LAW, RULE OR REGULATIONS

Although the Board found no violations of law, rule or regulation, the Board found confusion over a local policy. The facility warns patients entering the grounds that it does not have an emergency room and that if they need such assistance, they should go to the community hospital. But the Board found that some witnesses were confused over the proper protocol to be followed when a patient appears in an outpatient clinic with a complaint of chest pain. The Network Office in Albany will ensure the facility will clarify its protocol and ensure that all staff are aware of the policy.

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CONCLUSIONS

Two of the cases reviewed by this Board represented less than an acceptable level of care by the staff physician and are therefore significant lapses in professional judgment and performance. But since the two cases represent a small percentage of the total number of patients seen by the staff physician, the Board does not believe that they establish gross mismanagement.

Having concluded this, this Board is cognizant that these significant lapses in professional judgment are serious and should have caused the lead physician to initiate more formal corrective action. The Board has recommended a more thorough review of the staff physician's practice be conducted by the facility through the peer review process.

In addition, any future allegations regarding substandard care by this physician should be reported and reviewed through the peer review process or immediately lead to corrective action by the staff physician's supervisor.

With regard to the staff physician's conduct, the Board concludes that the lead physician has not pursued all of the human resources and performance management methods available to correct the behavior and conduct that she finds unacceptable. The Board recommends that the lead physician and the HR Manager confer to discuss human resources and performance management methods available to correct unacceptable behavior and conduct.

The lead physician, one of the complainants, is the immediate supervisor of the staff physician. The lead physician has initiated administrative action against the staff physician on two separate occasions by issuing a written counseling and an admonishment.

The Board found no credible evidence that the Chief of Staff has impeded the lead physician's ability to act.

The Board did not find credible evidence of abuse of authority or gross mismanagement by the Chief of Staff.