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**Analysis of Disclosures, Agency Investigation and Report, Whistleblower Comments, and  
Comments of the Special Counsel**

**Summary of  
OSC File Nos. DI-03-0620, DI-03-0621, DI-04-1862 and DI-04-1960**

The whistleblowers are health care professionals employed at the U.S. Department of Veterans Affairs (VA), VA Canandaigua Medical Center, Canandaigua, New York. The VA is charged with caring for veterans throughout their lives in recognition for the service to our nation. Allegations that the VA has failed in this critically important mission are particularly troubling. In this case, the whistleblowers alleged that Dr. Susan Sharza, a VA physician, repeatedly refused to see patients, falsified medical records, repeatedly failed to respond to her pager in emergency situations, and failed to communicate important medical information regarding patients to specialists at the facility. In addition, they alleged that VA Medical Center management officials, in particular Chief of Staff Dr. Robert Babcock, failed to address these issues and impeded the efforts of one of the whistleblowers to take appropriate steps to correct the problems. The whistleblowers alleged that this gross mismanagement and abuse of authority resulted in neglect and mistreatment of veterans.

At the request of the VA Secretary, the VA Veterans Health Administration (VHA) investigated. The allegations were partially substantiated with the investigation confirming two instances of substandard care involving Dr. Sharza and two instances when she refused to see patients. The investigation concluded that she did not falsify medical records and was unable to determine whether or not she intentionally failed to respond to her pager. Even though the investigation uncovered instances of substandard care and poor conduct, the agency ultimately concluded that these incidents were insufficient evidence to support a finding of gross mismanagement. The agency also found no evidence that Dr. Babcock abused his authority.

**The Whistleblowers' Disclosures**

The information was disclosed by 4 whistleblowers—Dr. Krishna Sharma, Lead Physician, Medical VA Care Line; Ms. Pamela Chester, former manager, Medical VA Care Line; and two additional health care professionals who remained anonymous. The whistleblowers allege that over the past two years they witnessed a number of instances of patient neglect and mistreatment of veterans by Dr. Sharza. They alleged that Dr. Sharza repeatedly refused to see and treat patients. In addition, they stated that she falsified medical charts by noting that she had examined patients when she had not. For example, they described instances when she walked by a patient's room and observed the patient briefly. She did not go into the room nor examine the patient, yet she noted in the patient's medical chart that she had done an examination.

The whistleblowers also alleged that Dr. Sharza regularly ignored her pager, including emergency messages. In addition, Dr. Sharza, on occasion, reportedly refused to see patients who had scheduled appointments and refused to speak with other physicians, often specialists calling to consult about a patient's condition or treatment. Similarly, the whistleblowers reported that Dr. Sharza routinely ignored the triage recommendations of the nursing staff and refused to see patients for medical evaluation and treatment. As a result, the patients had to be assigned to other providers placing an undue burden on other VA physicians.

Dr. Sharma and Ms. Chester stated that they attempted to resolve issues surrounding Dr. Sharza's conduct on numerous occasions. Specifically, they reported that in May 2003, they provided numerous Reports of Contact (ROCs) describing her conduct to Dr. Babcock. In response, he reportedly shredded the ROCs. Indeed, Dr. Sharma reported that Dr. Babcock instructed her to advise medical staff who complained about Dr. Sharza that she would resolve the problem, while at the same time he directed her not to take action against Dr. Sharza.

### **The Report of the Department of Veterans Affairs**

The VA Office of the Medical Inspector (Medical Inspector) also received a separate complaint regarding Dr. Sharza's treatment of patients and substandard work. The Medical Inspector and the Under Secretary for Health and Management agreed that VHA would appoint an Administrative Board of Investigation (the Board) to review both complaints. The VA provided OSC with a report prepared specifically for OSC (OSC report). Subsequently, in response to additional inquiry from OSC regarding the scope of the investigation and the findings, the VA provided the following additional information: a summary of the administrative review of Dr. Sharza's patient care, the full report of the Board (the Board report), the Action Plan for the facility, and documentation regarding the reassignment of Dr. Sharma and the disciplinary action taken against Dr. Sharza. A brief summary of the information provided follows.

The Board visited Canandaigua in July 2004 and interviewed 14 employees under oath and reviewed documentation. The investigation revealed two instances of substandard care, one involving a violation of VHA's acute coronary syndrome guidelines, and two instances where Dr. Sharza refused to see patients. The Board concluded, however, that these incidents did not support a finding of gross mismanagement. Similarly, the Board concluded that Dr. Babcock did not abuse his authority or impede Dr. Sharma's ability to take action against Dr. Sharza when necessary. Finally, the Board concluded that Dr. Sharma did not pursue all option available to correct Dr. Sharza's conduct.

Despite these findings, the Board goes on to state that the substandard medical care reflected significant lapses in medical judgment and performance. The Board recommended a more thorough peer review of Dr. Sharza's practice at the facility. In addition, the Board recommended that any future allegations of substandard medical care involving Dr. Sharza be reported and peer reviewed immediately and accompanied by the necessary corrective action. To that end, the report recommended that Dr. Sharma consult with Human Resources Management regarding methods available for addressing the problems as they arise.

The OSC report explains that as a staff physician at VA Canandaigua, Dr. Sharza is the main provider of medical care for veterans in the domiciliary program. She is also responsible for seeing patients in the outpatient clinic which is located in another building, and in the mental health inpatient unit located in a third building. She supervises a physician's assistant who is responsible for much of the evaluation and routine care. According to the OSC report, due to Dr. Sharza's responsibilities in various buildings, Dr. Sharma, her immediate supervisor, is often unaware of her location and activities at any time.

The Board reviewed the medical records of the eleven cases cited in the complaints to the Medical Inspector and OSC and concluded that there were two instances of substandard care rendered by Dr. Sharza. The investigation found that Dr. Sharza failed to provide proper care to a patient complaining of chest pain under the VHA acute coronary syndrome guidelines. Specifically, her evaluation of the patient by telephone was inappropriate as was the delay in medical evaluation so the patient could eat and use the bathroom. In the second case of substandard care, Dr. Sharza simply renewed the opiate prescription for a patient complaining of post-operative surgical pain without examining the surgical area.

The care provided by Dr. Sharza in the remaining 9 cases was found to be within acceptable standards. The OSC report noted that Dr. Sharma may initiate disciplinary action in cases where she believes the VA's standards of conduct have been violated.

The Board also found that there were two instances where Dr. Sharza refused to see patients. The first incident occurred on June 20, 2003. When Dr. Sharma confronted her for refusal to see a patient, Dr. Sharza became hostile, turned in her pager, announced her resignation, and left the facility. She left other patients waiting to be seen. The report states that those patients were seen by other providers, but finds that Dr. Sharza's conduct constituted a serious breach of professional responsibility. The second instance occurred in early 2004. The report notes that Dr. Sharma issued a letter of admonishment to Dr. Sharza regarding this incident.

With respect to the allegation that Dr. Sharza was falsifying medical records, the investigation revealed that Dr. Sharza entered information into the electronic medical records based on conversations she had with domiciliary patients in the corridors and other sites. The Board did not find fault with the practice and found no evidence that medical information or medical records had been falsified. The OSC report notes that Dr. Sharma and other health care professionals disagreed with Dr. Sharza's practice and the Board's conclusion.

The Board was unable to determine whether or not Dr. Sharza intentionally failed to respond to her pager. The report notes that VAMC Canandaigua has a number of buildings and thick-walled brick tunnels partially below ground level. Given the type of paging system used, there was no technical analysis that could be done to see if and when all the messages had been received. The Board recommended that Dr. Sharma investigate and take appropriate action if she believes Dr. Sharza intentionally fails to respond again.

According to the OSC report, during the investigation into the allegation that Dr. Sharza refused to speak with and cooperate with other health care professionals, Dr. Sharma,

Ms. Chester, and Ms. Pat Lind, Nurse Executive, all testified that Dr. Sharza had significant communications problems which affected patient care. A physician's assistant, Mr. Robert Smith, supervised by Dr. Sharza, testified that his interactions with her were professional. The report acknowledges that there is information that Dr. Sharza's behavior is often rude and demanding, but notes the neutral comments from Mr. Smith stating that he has the most interaction with her. The OSC report does not articulate a specific conclusion but appears to give deference to Mr. Smith. The Board report states, however, that Dr. Sharza's supervision of the physician's assistant is barely adequate. It notes that there was no systematic case review of his documentation. In addition, he expressed concern about the amount of time Dr. Sharza was available to him for consultation.

The investigation also included an inquiry into Dr. Babcock's conduct and the allegation that Dr. Babcock shredded ROCs provided by both Dr. Sharma and Ms. Chester. The Board also considered Dr. Sharma's allegation that he prohibited her from taking any action against Dr. Sharza but instructed her to advise staff members that she would deal with the problems.

Dr. Babcock provided the Board with a written statement addressing the conflict between Dr. Sharma and Dr. Sharza. He acknowledged that on one occasion he shredded ROCs from Dr. Sharma and Ms. Chester. He explained that the ROCs had been solicited and he objected to the production of ROCs in this manner. He reports that he investigated the underlying allegations presented in the ROCs and counseled Dr. Sharza. According to the OSC report, he also stated that he encouraged Dr. Sharma to take whatever action she deemed necessary with respect to Dr. Sharza.

The Board concluded, however, that there was no credible evidence that Dr. Babcock impeded Dr. Sharma's disciplinary efforts. The OSC report notes that Dr. Sharma gave Dr. Sharza a written counseling and an admonishment but finds it significant that she did not pursue all the human resource options available to correct Dr. Sharza's behavior. The Board report is more critical of Dr. Babcock. Specifically, it states that Dr. Babcock, and Mr. W. David Smith, Medical Center Director (Director Smith), in addition to Dr. Sharma, did not confront Dr. Sharza's inappropriate behavior. In view of the number of issues raised regarding Dr. Sharza by other employees, neither Dr. Babcock nor Director Smith gave the issues the attention needed to resolve the problems. The Board report also states that Mr. Joseph Olszewski, Chief of Human Resources, was too passive in his advisory role.

#### Reorganization at VA Medical Center Canandaigua

The OSC report also includes a summary of additional information relevant to the investigation. It explains that the VA Healthcare Network Upstate New York operated under a Care Line structure that was different from other networks. Under this structure, the patient care service delivery organizations were organized along medical specializations, such as Medicine or Mental Health. Those organizations had authority over the personnel working in those departments, control over the budget including the allocation of personnel service dollars, and reported to the Care Line Manager.

In March 2003, the facility underwent a realignment which fundamentally changed the structure of operations. Under this realignment, the Care Lines lost budgetary control and reported to the facility director instead of the Care Line Manager. This change raised a number of issues including: the distribution of work, rearrangements of the physical work space, and the integration of medical care provided to the domiciliary patients into the primary care clinics. According to the reports, Dr. Babcock and Dr. Sharza supported the realignment, while Dr. Sharma and Ms. Chester, did not. Thus, the Board concludes, this professional disagreement significantly contributed to tensions and communications problems among the staff.

The investigation also included an analysis of the care Dr. Sharza provided to 30 other patients described in the Board report. That analysis concluded that the medical care she provided was equal to or slightly better than the care provided by other primary care physicians. Based on this conclusion, there was no recommendation for an additional peer review.

#### Actions Taken By the Agency in Response to the Investigation

The Board report describes recommendations issued by the Board in response to its findings. The Board stated that Director Smith must hold supervisors accountable for addressing inappropriate behavior by employees. In this case, Drs. Babcock and Sharma must address any inappropriate conduct by Dr. Sharza. In addition, if Dr. Sharma fails to act, Dr. Babcock must hold Dr. Sharma accountable for this and take the necessary action himself. The Board report identifies this as a matter to be addressed on a continuing basis and suggests the parties meet to prevent the situation among senior management from worsening. This includes discussions with supervisors regarding the issues presented by the realignment.

The Board also states that Dr. Babcock and Director Smith must define their expectations regarding the care of domiciliary patients and support those expectations with full time equivalents and space. The Board report notes that to date, their involvement has been too passive. The Board report notes that Dr. Babcock and Director Smith must resolve the issues regarding the realignment. Again, the Board found that their involvement had been too passive.

Additional recommendations included developing a standard operating procedure for managing urgent medical problems, utilizing a Peer Review process which includes physicians from other Network 2 Medical Centers to ensure greater objectivity, implement a structural supervisory process with Dr. Sharza's physician's assistant, counsel Dr. Sharza regarding the two serious incidents of substandard care, and require Dr. Sharza to attend training to improve her understanding of the importance of professional conduct and interactions.

Finally, Acting Under Secretary for Health Jonathan B. Perline advised OSC of a number of personnel changes which had taken place at the Canandigua VA Medical Center. Director Smith retired as Medical Center Director on January 3, 2005, Mr. Robert Ratcliff, a Senior Executive Service employee, was detailed as Acting Director pending the hiring of a new director. Ms. Chester has accepted a position as a Network Education Specialist as of January 2005, and Dr. Sharma was reassigned from the position in the Medical VA Care Line to Lead Physician in Administrative Medicine. In addition, he states that the action plan provided demonstrates VHA's commitment to addressing the issues that arose during the investigation.

He emphasizes that the Network Director and the Network Chief Medical Officer have been involved in the oversight of the plan.

### **The Whistleblowers' Comments**

A summary of Dr. Sharma's comments is presented below. Ms. Chester and the anonymous whistleblowers did not comment on the report.

#### **Krishna Sharma, M.D.**

Dr. Sharma provided detailed comments which included a compelling critique of the report with supporting documentation. She takes exception to the VA's conclusions that she did not do enough to address Dr. Sharza's performance problems and denies that she was too passive. She points out that beginning in March 2003, she verbally counseled Dr. Sharza more than once and in November 2003, gave her a written counseling.

Dr. Sharma takes issue with the report's statements that she did not follow proper procedure after Dr. Sharza abruptly resigned in June 2003. She recounts that she advised Dr. Babcock, and Ms. Chester advised Mr. Olszewski of Dr. Sharza's resignation and abandonment of her patients. At that time, no one informed her that it was necessary to send a Federal Express letter to Dr. Sharza and secure her resignation in writing. On the contrary, Ms. Chester was informed that Dr. Sharza could be fired because she was in a probationary status. Only later did Mr. Olszewski tell Dr. Sharma that he believed it would be nearly impossible to fire Dr. Sharza. Additionally, Dr. Sharma informed Dr. Babcock and Director Smith verbally and in writing that she opposed Dr. Sharza's return after her resignation.

Dr. Sharma also stated that the finding that she did not charge Dr. Sharza Absent Without Leave for her abrupt departure is incorrect. Moreover, in September 2003, when Dr. Sharma renewed Dr. Sharza's privileges in the VA's computerized Vet Pro program she noted that she was being forced by management to do so.

Throughout her comments Dr. Sharma chronicles her communications with Dr. Babcock and other officials, including Human Resources staff, in which she asked for assistance. Particularly troubling is Dr. Sharma's repeated assertion that Dr. Babcock directed her not to take any action against Dr. Sharza and further, that he told her to tell other staff members that she would take action against Dr. Sharza when Dr. Babcock had specifically forbidden her to do so.

Dr. Sharma contends that despite her requests for assistance in writing and in person, Mr. Olszewski refused to provide any assistance and guidance on how to handle Dr. Sharza. Dr. Sharma also contacted Mr. Douglas Nathar, Chief of Performance Management, about Dr. Sharza's inappropriate behavior. Although he met with Dr. Sharma, he ultimately refused to undertake a time study review of Dr. Sharza's work as Dr. Sharma had requested, and provided no explanation for this decision.

In addition, Dr. Sharma describes Dr. Babcock's repeated interference in her attempts to discipline Dr. Sharza and questions Dr. Babcock's management of the matter. For instance,

Dr. Sharma proposed admonishing Dr. Sharza for insubordination and refusing to see a patient on April 15, 2004. She contacted Mr. Olszewski and provided him written documentation regarding the insubordination. He responded that he would let her know whether she could take disciplinary action. A few days later, she asked him again about disciplining Dr. Sharza, and his reply was the same. After a meeting on April 23, 2004, attended by Dr. Sharma, Ms. Lind, Ms. Pat Spooner, Acting VA Medical Care Line Manager, and Dr. Babcock, they followed up with Mr. Olszewski who eventually replied that he would draft a letter of admonishment. Subsequently, he informed Ms. Lind and Dr. Sharma that Dr. Babcock had determined that Dr. Sharza should not be admonished.

Dr. Sharma pursued the admonishment in spite of considerable hostility to her efforts. She was told by Mr. Smith not to give the admonishment and that she should "trust him" on the issue. Despite her requests, no one provided her an explanation in writing as to why she should not admonish Dr. Sharza, instead, Mr. Smith later denied he had asked Dr. Sharma not to issue the admonishment. In July 2004, Dr. Sharma formally admonished Dr. Sharza only to have Dr. Babcock rescind the admonishment in September.

Finally, Dr. Sharma notes her disagreement with the Board's decision not to recommend a separate review of Dr. Sharza's record by the VHA Medical Inspector. She also responded to the report's assertion that the realignment is responsible for the tensions in the department. Dr. Sharma believes that Dr. Babcock created many of the problems through his abuse of authority and failure to address the issues and problems caused by Dr. Sharza. She reports that because no action was taken against Dr. Babcock, personnel at the facility are more hesitant about coming forward to report problems and fear reprisal.

### Conclusion

Based on the representations made in the agency report and as stated above, I have determined that the agency report contains all of the information required by statute and that its findings appear to be reasonable. OSC has also learned that Dr. Sharza resigned her position on February 25, 2005. Dr. Sharza's resignation eliminates any remaining concerns regarding the quality of medical care she provided to veterans.

While I have determined that this report meets the statutory requirements, I note with concern the agency's conclusions in the OSC report regarding Dr. Babcock's conduct. While the Board report is more critical of Dr. Babcock, Dr. Sharma's repeated assertions and descriptions of the ways in which Dr. Babcock hindered her efforts to take disciplinary action against Dr. Sharza are troubling. The agency appears to have ascribed much of the conflict between these two professionals to disagreement over the reorganization. Moreover, the VA seems to have disregarded Dr. Sharma's actions and her outreach efforts to other personnel at VA Canandaigua for assistance in addressing Dr. Sharza's conduct. Given the information Dr. Sharma provided, the agency may wish to review Dr. Babcock's actions with closer scrutiny should similar allegations arise in the future.