



U.S. OFFICE OF SPECIAL COUNSEL

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The Special Counsel

November 29, 2005

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

Re: OSC File Nos. DI-03-0620, DI-03-0621, DI-04-1862 and DI-04-1960

Dear Mr. President:

I received disclosures from Dr. Krishna Sharma, Ms. Pamela Chester and two anonymous whistleblowers who 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 in recognition for their service to our nation. Allegations that the VA has failed in its critically important mission and as a result, veterans are not receiving adequate care are particularly troubling and must be thoroughly investigated.

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 the patients to specialists at the facility. They also alleged that VA Medical Center management officials, in particular Chief of Staff Dr. Robert Babcock, failed to address the problems caused by Dr. Sharza and impeded Dr. Sharma's efforts to discipline her and correct her behavior. The whistleblowers alleged that this gross mismanagement and abuse of authority resulted in neglect and mistreatment of veterans.

I required the Secretary of Veterans Affairs to conduct an investigation into these disclosures pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary tasked the VA Veterans Health Administration with conducting the investigation and writing the report. As discussed further in the attached reports, the investigation partially substantiated the allegations confirming two cases where Dr. Sharza rendered substandard care and two instances where 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 to support a finding of gross mismanagement. The agency also concluded that Dr. Babcock did not abuse his authority.

The President

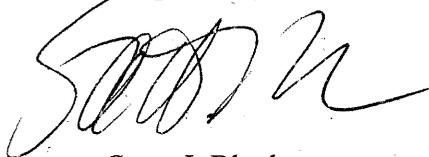
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Dr. Sharma provided detailed comments on the reports. Ms. Chester and the anonymous whistleblowers declined to comment. As required by law, 5 U.S.C. § 1213(e)(3), I am now transmitting the report and comments to you.

I have reviewed the original disclosures and the VA's reports. Based on that review, I have determined that the agency's reports contain all of the information required by statute and that the findings appear to be reasonable. However, given the information Dr. Sharma provided regarding Dr. Babcock's conduct, the agency may wish to review Dr. Babcock's actions with closer scrutiny should similar allegations arise in the future.

As required by law, 5 U.S.C. § 1213(e)(3), I have sent a copy of the report to the Chairman of the Senate Committee on Veterans' Affairs and to the Chairman of the House Committee on Veterans' Affairs. I have also filed a copy of the agency report and Dr. Sharma's comments in our public file and closed the matter.

Respectfully,

A handwritten signature in black ink, appearing to read 'S. Bloch', written in a cursive style.

Scott J. Bloch

Enclosures