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The Special Counsel

September 17, 2013

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

Re: Ongoing Deficiencies at Jackson VAMC

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports based on disclosures from physicians at the Veterans Affairs Medical Center in Jackson, Mississippi (Jackson VAMC). Phyllis Hollenbeck, who is currently a physician at the Jackson Medical Center, disclosed numerous issues regarding patient safety, provision of services, and certification of medical providers. Charles Sherwood, who is retired but previously served as the Ophthalmology Section Chief at the Jackson Medical Center, alleged that a former Jackson radiologist failed to properly read thousands of radiology images, leading to missed diagnoses of serious conditions.

These whistleblower disclosures are the latest, and most severe, in a persistent drumbeat of concerns raised by seven Jackson VAMC employees to OSC in the last four years. Throughout this process, the Department of Veterans Affairs (VA) has consistently failed to take responsibility for identified problems. Even in cases of substantiated misconduct, including acknowledged violations of state and federal law, the VA routinely suggests that the problems do not affect patient care. A recent example is indicative: as the VA was investigating the two cases at issue, the director of the Jackson VAMC publicly stated in July that any issues at the facility were minor and "did not impact patient care." Such statements fail to grasp the significance of the concerns raised by Drs. Hollenbeck and Sherwood, and call into question the facility's commitment to implementing necessary reforms.

My specific findings are discussed in detail below. The two VA reports referenced in this letter substantiate some of Drs. Hollenbeck and Sherwood's claims and offer corrective action plans. Unfortunately, at this point it is not clear if the agency is implementing these actions. Given the apparent lack of progress in implementing the corrective actions, and the whistleblowers' ongoing concerns about patient safety, I find the VA's response unreasonable. I am requesting through this letter an update on proposed reforms within 60 days.

The whistleblowers' allegations were referred to the Honorable Eric K. Shinseki, Secretary, VA, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d).[1] The matters were then referred to the Under Secretary for Health, who tasked the Deputy Under Secretary for Health for Operations and Management to conduct the investigations. The Interim Chief of Staff submitted the agency's report on Dr. Hollenbeck's allegations to this office on July 15, 2013, and the report on Dr. Sherwood's allegations on July 29, 2013. Pursuant to 5 U.S.C. § 1213(e)(1), the whistleblowers were offered the opportunity to comment on the findings of the Secretary's office, and they both did so. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and whistleblowers' comments to you in OSC File Nos. DI-12-3816 and DI-13-1713.

I. OSC File No. DI-12-3816 (Dr. Hollenbeck's Allegations)

A. The Jackson VAMC Primary Care Unit is Chronically Understaffed

1. *The Allegations*

Dr. Hollenbeck was a physician in the Jackson VAMC's Primary Care Unit until September 2012, when she transferred to another clinic within the hospital. Dr. Hollenbeck alleged that prior to her transfer she was one of only three full-time Primary Care Unit physicians at the Jackson VAMC. She disclosed that many Primary Care Unit patients were seen by one of approximately 19 nurse practitioners (NPs) in the Primary Care Unit, rather than by a physician. Dr. Hollenbeck estimated that 85 percent of the Primary Care Unit patients received medical care from a NP without being assigned to or treated by a physician, and that patients were frequently unaware that they were not being seen by a doctor.

Dr. Hollenbeck further alleged that the Jackson VAMC overschedules patients for both physicians and NPs, resulting in an overworked, understaffed primary care clinic. The clinic policy, Dr. Hollenbeck explained, is that walk-in patients must be seen. These walk-ins are added to a schedule that is already overbooked. When a physician or NP left the

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[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c).

Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

Primary Care Unit, patient appointments scheduled months in advance were not cancelled or rescheduled. Patients were frequently scheduled in "ghost," or fictional clinics. According to Dr. Hollenbeck, patients scheduled in ghost clinics were shuffled to physicians or NPs in existing clinics as space and time allowed. In some cases, patients assigned to a ghost clinic would not be seen at all on the day they were scheduled, other than by the nurse who checked them in.

2. *The Agency's Findings and Recommendations*

The agency substantiated the allegation that the Jackson VAMC Primary Care Unit has a shortage of physicians. The report explained that pursuant to Veterans Health Administration (VHA) Directive 2009-055, *Staffing Plans* (November 2, 2009), facility directors must ensure that staffing is part of the facility's strategic and operational plans, and that the staffing plans receive annual reviews and revisions as necessary. The report stated that in primary care, staffing levels are partially based on patient panel sizes, which is defined as the number of patients assigned to a specific primary care provider. VHA Handbook 1101.2, *Primary Care Management Module* (April 21, 2009), describes specific program requirements for Primary Care Units, stating that staffing of Primary Care Units is a local decision and is affected by the amount of support staff, space, and administrative support available. VHA Handbook 1101.2 further indicates that for a site such as the Jackson VAMC, a typical panel would be 1,200 patients for a full-time primary care physician. VHA Handbook 1101.2 indicates that a NP is expected to carry a panel that is 75 percent the size of a full-time physician.

The report found that at the Jackson VAMC, 75 percent of the total Primary Care Unit staff consists of NPs, while the average VA-wide is 25 percent. Thus, the current ratio of NPs to physicians in Jackson is three to one, while comparable facilities typically have a ratio of one NP to every three physicians. The agency also reviewed the ratio of patient panel size to adjusted capacity.[2] The agency found that, while the Jackson VAMC's ratio for physicians was within agency guidelines, its ratio for NPs was above the agency's own suggested ratio.

Despite the finding that Jackson VAMC physicians were not generally over-scheduled or "over-paneled," witness accounts indicated that physicians frequently worked late to accommodate new patients and walk-in patients, who are not counted in panel sizes. The report noted with concern that Primary Care Unit physicians are often unable to review and address "View Alerts" -- daily electronic notifications about patients -- for two to three weeks.[3] View Alerts require immediate attention because of the possible serious nature of

[2] The ratio of patient panel size to adjusted capacity, as described above, "defines the number of patients assigned to a primary care provider in relation to that provider's capacity to see patients based upon the provider's time in the clinic, number of exam rooms, and support staff available." Agency Report, pg. 25.
[3] View Alerts include lab, imaging, and pathology results, consult recommendations, and other medical notes for co-signatures.

their content. Critical medical information is notated on these alerts, and facility policy requires communication of this information to providers. While the agency found no evidence of patient harm as a result of the delay in reviewing View Alerts, the report noted that the review team was unable to thoroughly assess the issue within the timeframe of OSC's referral, and recommended further review of the situation.

The report further explained that VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010), gives priority to veterans with a service-connected disability rated 50 percent or greater, while generally requiring that appointments are scheduled in a manner that meets patients' need without undue delay. However, priority scheduling should not interfere with the care of a previously scheduled patient or be prioritized above patients with acute health needs. The facility director is responsible for ensuring that a standardized scheduling system is in place and for defining standard work for clinic teams. This ensures efficient clinic operations, including check-in, provider visits, and check-out. The Directive includes practices to coordinate provider leave schedules to minimize patient cancellations. It also requires facility leadership to be vigilant in the identification of inappropriate scheduling activities. The policy does not set requirements for walk-in patients other than to require sufficient capacity for accommodation.

The report explained that Jackson VAMC practice is to see Primary Care Unit walk-ins the day they arrive. Often, multiple walk-ins are booked into a single appointment slot for one provider and wait hours to see a doctor. This double-booking also creates a delay in the wait time for regularly-scheduled patients. The report confirmed the existence of ghost clinics. For example, the facility created a "Vesting Clinic" for initial appointments of new Primary Care Unit patients. The report found that the Vesting Clinic was a unique practice by the Primary Care Unit and was created without an assigned dedicated provider. When a patient checks in for an appointment in the Vesting Clinic, he or she is scheduled on another provider's schedule as an overbooked or double-booked appointment. This practice places two patients into one 30-minute appointment time slot.

In addition, the agency stated that VHA practitioners are required to appropriately identify themselves to patients. The report noted that The Joint Commission Standard RI.01.04.01, #1 and #2 requires hospitals to respect a patient's right to receive information about the physician providing his or her care. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, para. 13.a.(8) and (9) requires practitioners give their name and title to the patient. Jackson VAMC NPs told investigators that they do identify themselves to patients as nurse practitioners, and the report found that all NPs wore their VA identification badges. The report noted, however, that due to patient privacy concerns, investigators were unable to conduct spot checks to observe staff first-hand.

The agency made a number of recommendations as a result of its findings. The agency stated that Jackson VAMC leadership should continue to work aggressively to hire

permanent, full-time physicians for the Primary Care Unit until a physician to NP ratio of 1:1 is reached. This includes consulting with the Office of Workforce Management and Consulting to ensure the use of all available resources for recruitment. When a sufficient number of physicians are hired, the Jackson VAMC should reduce panel sizes for NPs to be in line with VHA guidelines.

With regard to scheduling, the agency recommended that Jackson VAMC management eliminate ghost clinics and ensure that each clinic has an assigned provider. The facility should also eliminate the use of overbooked and double-booked appointments to the extent possible, and implement the principles of open access scheduling so that patients receive care when and where they want or need.

3. *The Whistleblower's Comments*

In her comments, Dr. Hollenbeck stated that, despite the report's findings, NPs do not wear the required red tags that identify them as nurse practitioners while working in the Primary Care Unit. Dr. Hollenbeck further explained that such identification is important because NPs and physicians do not provide equivalent care. She noted the various differences in study and practice between physicians and NPs, particularly that physicians complete over 15,000 more hours of study than NPs, and are subject to national standards for curriculum, examination, and licensing, unlike NPs.

Dr. Hollenbeck reiterated concerns regarding overscheduling within the Primary Care Unit. She noted that even when a patient is given an appointment time, if the appointment time is overbooked, the patient may not be able to wait to be seen. Many patients must wait months for a scheduled appointment, only to arrive and discover that the provider they were scheduled to see is no longer there. Dr. Hollenbeck illustrated this using her own experience. She was scheduled for extended medical leave in 2011 and met with Dr. James Lockyer, former Assistant Chief of Primary Care, to review a plan for covering her fully-booked December clinics. According to Dr. Hollenbeck, Dr. Lockyer and former Chief of Staff Dr. Kent Kirchner assured her that her clinics would be rescheduled appropriately. However, she learned upon her return that none of her appointments were rescheduled or reassigned. Rather, patients arrived, were checked in, and were told Dr. Hollenbeck was unavailable. The NPs would then attempt to have the patients seen by someone else, which was not always successful. She stated that tests were ordered but never followed up on, and notifications to patients were not sent.

Further, Dr. Hollenbeck emphasized that these problems persist. She stated that over the course of the year since her transfer from the Primary Care Unit, six physicians and one NP have rotated through her former position. As of August 2013, a plan is in place to bring in two temporary or "*locum tenens*" physicians to split the work in the Primary Care Unit. She explained that *locum tenens* physicians are once again necessary, because the permanent primary care physician hired in June 2013, has already left the Jackson VAMC. According

to Dr. Hollenbeck, the physician, who was an experienced doctor, was double-booked on his first day in the facility. She said he requested a decrease in his daily workload, but despite promises to that effect, saw no change. The physician resigned just a few months later.

Dr. Hollenbeck strongly emphasized the involvement of Dorothy White-Taylor, the former Associate Director of Patient Care, in the growth and staffing of the Primary Care Unit over a period of decades.[4] She noted that Ms. White-Taylor had significant influence over many of the decisions in the facility, in particular the number of NPs hired, resulting in the disproportionate NP-to-physician ratio observed in the agency's report. Dr. Hollenbeck stated Ms. White-Taylor fostered an environment in which NP status was elevated, and in which the failure to identify NP status to patients was tolerated. She noted that this was also the case for Ms. White-Taylor herself, who was always referred to as "Doctor," although she was neither a physician nor held a doctorate in a field of medical study.

B. Nurse Practitioners are not Properly Supervised or Licensed

1. *The Allegations*

Dr. Hollenbeck disclosed that the staffing shortage at the Jackson VAMC also led to inadequate supervision of NPs. She explained that under Mississippi law, a NP must enter into a collaborative agreement with a Mississippi licensed physician to perform quality reviews of the NP's provision of care. State of Mississippi Administrative Code, Part 2840, Chapter 2, Rule 2.3 sets requirements for the collaborative agreement, including quarterly face-to-face meetings between the NP and the collaborating physician and a monthly chart review process. Dr. Hollenbeck noted that not all NPs at the Jackson VAMC are licensed in Mississippi, but in its referral to Secretary Shinseki, OSC noted that many neighboring states, including Alabama and Louisiana, have similar requirements. Dr. Hollenbeck alleged that NPs at the Jackson VAMC were not following these requirements. She noted that because the Jackson VAMC has a physician shortage, there are not enough physicians to oversee the collaborative agreements, and NPs practice with little to no supervision.

Furthermore, Dr. Hollenbeck alleged that many of the Jackson VAMC NPs did not obtain the required licensure and certification to practice as nurse practitioners. VA Handbook 5005/27, *Staffing,* Part II, Appendix G6, Section B(a)(6) (March 17, 2009), states that any Registered Nurse (RN) moving into a nurse practitioner assignment must meet and maintain the following additional qualifications:

- "be licensed or otherwise recognized as a nurse practitioner in a State;"

[4] Dorothy "Dot" White-Taylor, Ph.D. was arrested in May 2012 and charged with prescription fraud in connection with her employment at the Jackson VAMC. The charges against Ms. White-Taylor were later dismissed. She remains employed by the VA in a non-clinical setting.

- "possess a master's degree from a program accredited by NLNAC or CCNE; and
- "maintain full and current certification as a nurse practitioner from the American Nurses Association ... in the specialty to which the individual is being appointed or selected."

Dr. Hollenbeck alleged that while some of the Primary Care Unit nurses obtained master's degrees, a number were not licensed or certified as NPs, but only as RNs.

2. *The Agency's Findings and Recommendations*

The report explained that pursuant to Article 8 of the Jackson VAMC's local bylaws, all NPs at the Jackson VAMC are considered Licensed Independent Practitioners (LIPs). Thus, the Jackson VAMC authorized its NPs to practice under clinical privileges. VHA policy, found in VHA Handbook 1100.198, *Credentialing and Privileging*, para. 2a, provides that all VHA health care professionals who are permitted by law to provide patient care services independently must be credentialed and privileged as defined in the Handbook. Paragraph 3h defines an independent practitioner as any individual permitted by law to provide patient care services independently, without supervision. Thus, NPs may not be considered LIPs unless they are permitted by their licensing states to practice independently.

The agency found that at the time of the investigation, only two Jackson VAMC Primary Care Unit NPs held state licenses permitting independent practice. The report stated that since 2010, a total of 42 NPs have worked in the Primary Care Unit, and currently 16 are employed in primary care.[5] Nineteen of the NPs are still employed by other units within the VAMC, while seven are employed elsewhere. Under VHA and local policy, NPs who are not licensed to practice independently must practice within a specialty area or in primary care in collaboration with a supervising physician and under written practice guidelines or "scope of practice." The report noted that states set the terms of individual collaborative agreements.

The agency found that the 42 NPs who worked in the Primary Care Unit since 2010 all had the required state licenses and certifications, except for three who were grandfathered as NPs under the agency's staffing policy, VHA Handbook 5005/27.[6] These three NPs hold

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[5] The Primary Care Unit employs 15 practicing NPs and one NP who serves as a supervisor and does not see patients.

[6] The report explained that prior to 2003, NPs were qualified based upon then-existing nurse qualification standards, which did not contain additional requirements for NPs. The nurse qualification standards were revised in 2003, requiring NPs to be licensed or otherwise recognized as a NP by a state and to be nationally certified. The revised standard exempted NPs from the additional requirements if they were VA employees before the standard was implemented and had no break in service. The nurse qualification standards were revised again in 2009, adding that NPs must be nationally certified in the specialty of assignment. NPs hired

Mississippi RN licenses. The report found that 8 of the 42 NPs at some point lacked a required collaborative agreement. Further, 13 of the 15 NPs currently in primary care are required by their state licensing bodies to have collaborative agreements, but only ten had such an agreement. Of the remaining three, one had an agreement as of April 29, 2013, but it had not yet been approved by the NP's licensing state. The report noted that this was the NP's first collaborative agreement, despite a VAMC tenure of several years. The two remaining NPs had agreements with a *locum tenens* physician, who resigned employment with the Jackson VAMC. As of the date of the report, these two NPs had not been assigned a new collaborator.

The report noted that the Jackson VAMC had no process in place to meet state monitoring requirements, leading to lapses in these requirements.[7] Further, the report indicated a lack of understanding within the Jackson VAMC leadership about NP practice and licensure requirements. Thus, the agency found that NPs in the Primary Care Unit, who were erroneously declared to be LIPs, practiced outside the scope of their licensure.

In its recommendations, the agency directed Jackson VAMC management to immediately correct the erroneous declaration that all NPs may practice as LIPs, and to amend facility bylaws to indicate that state licensure governs whether NPs may practice as LIPs. The report also recommended immediate implementation of scopes of practice in lieu of clinical privileges for NPs not permitted to practice as LIPs. Jackson VAMC management should also ensure more equitable distribution of collaborative agreements between physicians, with a limitation on the number of agreements any one physician may hold, including state-imposed limitations. Further, the report recommended elimination of the use of *locum tenens* physicians in the Primary Care Unit to the extent possible, and that *locum tenens* physicians not be assigned as physician collaborators due to the temporary nature of their employment. Finally, the report directed that facility leadership immediately implement a process to ensure that NPs are appropriately monitored and that such monitoring is documented as required by state licensure bodies.

3. *The Whistleblower's Comments*

In her comments, Dr. Hollenbeck emphasized that Jackson VAMC management was notified on many occasions prior to this investigation that there were ongoing problems with NP oversight in the Primary Care Unit. She stated that Ms. White-Taylor was responsible for grandfathering in certain NPs, and again emphasized that one of these NPs, who has been solely responsible for running the Women's Health Clinic since 1994, did not

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between 2003 and 2009 were thus exempted only from the requirement that they have a national specialty certification.

[7] The report also found, incidentally, that the Jackson VAMC had not yet transitioned from six-part paper credentialing and privileging folders to an electronic system. This transition was required by the VA Central Office to have been completed by July 1, 2012.

obtain a NP license until April 2013. She explained that the organizational chart in the Primary Care Unit, then under the management of Ms. White-Taylor, essentially operated as 20 to 24 solo private practices, with no uniform chain of command and constantly changing staff. As noted in the report, NPs far outnumbered physicians. As a result of this, physicians were subject to peer review but NPs were not. NPs never had their clinical work checked. Dr. Hollenbeck further stated physicians were ignored when they raised concerns about NPs practicing as LIPs because NPs and Ms. White-Taylor had significant power in the facility, such that physicians feared retaliation.

Dr. Hollenbeck stated that in December 2012, she attended a quarterly staff meeting, also attended by current facility Director Joe Battle and Veterans Integrated Service Network Director Dr. Greg Parker. At that meeting, Mr. Battle and Dr. Parker indicated that since all NPs licensed in Mississippi renew their licenses between October and December, and most Jackson VAMC NPs were licensed in Mississippi, leadership needed physicians to "do the right thing and help the Veterans" by signing the NPs collaborative agreements. According to Dr. Hollenbeck, Mr. Battle and Dr. Parker told the physicians that the agreements were "just a formality" because NPs did not need supervision. However, several physicians indicated that they had reached out to the Mississippi Board of Medical Licensing and understood that signing the agreements meant the physician was responsible for everything the NP did. The physicians questioned the ramifications for their own licenses if a NP's actions led to a malpractice lawsuit. In response, Mr. Battle told them they "couldn't get sued in the VA." Dr. Hollenbeck stated that when Mr. Battle was corrected on this point, and on whether individual physicians could be named as defendants, he told them, "Well, you can just write a letter saying you never really supervised that nurse practitioner." In addition, Dr. Hollenbeck stated that Mr. Battle and Dr. Parker informed the physicians that they planned to hold back 55 percent of a physician's performance pay unless they signed the collaborative agreements, and that any physician licensed in another state had to also get a Mississippi license so they could be available to sign a collaborative agreement.

Further, Dr. Hollenbeck stated that after Ms. White-Taylor's arrest, she told Mr. Battle during an in-person meeting that NPs were operating illegally. She stated that Mr. Battle insisted that the NPs were LIPs. In her comments, Dr. Hollenbeck noted that management failed to take any steps to institute appropriate monitoring of NPs, despite the obvious knowledge that NPs had licenses from states that required collaborative agreements. In fact, Dr. Hollenbeck stated that there is still no program in place at the facility to comply with oversight laws and regulations. Dr. Hollenbeck also noted that the report erroneously stated that of the five physician collaborators, three work in the Primary Care Unit. Dr. Hollenbeck asserted that only two of the physicians work in the Primary Care Unit. This is a violation of the law, which states that a collaborating physician must be in the same clinical discipline as the NP.

C. Medicare Home Health Certificates are Improperly Completed

1. *The Allegations*

Dr. Hollenbeck alleged that the Jackson VAMC failed to follow the statutory and regulatory requirements of the Medicare Home Health program. According to program requirements, before Medicare can pay for home health care services, a patient must receive a face-to-face evaluation and a physician must sign a patient's certification form. While NPs may participate in face-to-face patient evaluations and sign certifications, they may do so only when working in collaboration with a certifying physician in accordance with state law. Because the Jackson VAMC did not ensure that collaborative agreements were in place, Dr. Hollenbeck contended that Jackson VAMC NPs were ineligible to provide a face-to-face patient evaluation. Furthermore, the statute requires that the patient be under the care of the certifying physician during the time the home health services are provided. Dr. Hollenbeck alleged that, because approximately 85 percent of Jackson VAMC patients are never under the care of a physician, they cannot be eligible for this funding.

According to Dr. Hollenbeck, she was directed to sign Medicare Home Health Certification forms but refused to do so for patients she had not seen. She alleged that Dr. Kirchner and Dr. Lockyer commonly signed the forms as the certifying physician, even though providing patient care was never part of their duties. This permitted the funding requests to move forward without the necessary face-to-face evaluations by a qualified provider, in violation of federal laws and regulations.

2. *The Agency's Findings and Recommendations*

The agency's report acknowledged that Home Health Certifications require a physician's signature following a face-to-face patient encounter. The patient encounter may be carried out by the certifying physician, another physician who cared for the patient, or a NP or clinical nurse specialist working in accordance with state law and in collaboration with a physician who cared for the patient. The report determined that VA physicians must comply with these requirements, and that NPs may not certify the forms, but may conduct the face-to-face evaluations provided they are working in accordance with state law.

The report found that there was confusion within the Jackson VAMC as to who should complete the forms. For example, one physician reported that she received "stacks of forms to sign," while another indicated she stopped signing the forms altogether because she had no collaborative agreement with the NP conducting the face-to-face patient encounter. The report found that a chart review was not feasible in relation to this allegation because of the scope of the investigation and time constraints. The agency could not rule out the possibility that Home Health Certifications were improperly certified, and recommended that VHA task the appropriate offices to conduct a random check of Primary Care Unit patient charts. The report directed that the findings of this review be reported to the Under Secretary

for Health to determine if follow-up action is necessary. The agency also recommended that Jackson VAMC leadership consider creating a training module on completion of Home Health Certifications to ensure compliance.

3. *The Whistleblower's Comments*

Dr. Hollenbeck highlighted the report's statement that improper completion of Home Health Certifications could not be ruled out, but that the data to confirm this was not readily available. She stated her belief that there is a high likelihood of such wrongdoing, based upon the longstanding failure by the facility to oversee NPs properly. Dr. Hollenbeck noted that she provided the investigators with an e-mail memo from the Home Health Care Coordinator at the Jackson VAMC who directed NPs to have the physicians sign the Medicare forms. She reiterated that this direction called for physicians to sign forms of patients who had been seen only by a NP, which is illegal unless that NP is collaborating with a physician, and these NPs were not.

D. Improper Procedures for Issuing Narcotics Prescriptions

1. *The Allegations*

Dr. Hollenbeck disclosed that the Jackson VAMC improperly prescribed narcotics. Specifically, some NPs prescribed narcotics in violation of either state or federal law, and after investigating the facility, the DEA placed a moratorium on NPs writing narcotic prescriptions. According to Dr. Hollenbeck, this decision was made because the DEA discovered that NPs were improperly using a single "institutional" DEA identification number in violation of federal and state law.

Dr. Hollenbeck further alleged that she experienced pressure to sign prescriptions without the opportunity to see the patients in question. She stated that according to e-mails she received from Dr. Lockyer and Dr. Kirchner, as well as from Dr. Jesse Spencer, former Chief of Medicine, physicians were expected to order medication requested by the NPs. Dr. Hollenbeck noted that facility management directed NPs who held licenses to apply for individual DEA numbers, and that several *locum tenens* physicians were initially hired to run a "Controlled Substances" Clinic catering only to patients requiring narcotics prescriptions. This clinic was closed after a few months, but after the closure, *locum tenens* physicians were directed to add on any NP-assigned patients who called or walked in for narcotics prescription refills. Dr. Hollenbeck alleged that this practice is dangerous because patients seen by temporary doctors have no clear continuity of care or proper coordination of their extensive medical needs.

2. *The Agency's Findings and Recommendations*

The VA's report concluded that Jackson VAMC's policy of prescribing narcotics was inconsistent with federal law. In its report, the agency explained that pursuant to federal law, an individual practitioner authorized by a state license to prescribe controlled substances may do so using an institutional DEA number. Similarly, VA Handbook 5005 states that individual DEA certification is not necessary, but notes that if a practitioner's state of licensure requires individual DEA certification to prescribe controlled substances, the practitioner may not be granted authority to write prescriptions for controlled substances without an individual DEA certification. Thus, the report found that to the extent that Jackson VAMC local policy allowed NPs to prescribe narcotics using the facility's institutional DEA certification when a state license required individual certification, the policy was inconsistent with federal law.

The report further explained that controlled substance prescriptions must be for a legitimate medical purpose and issued by an individual practitioner in the usual course of practice. States regulate what constitutes a bona fide patient-provider relationship, which generally includes at least one in-person examination of the patient. However, the report noted that permissible exceptions to the in-person requirement might include a prescription by a "covering practitioner." In Mississippi, a prescription is considered valid when it is issued by a practitioner who has conducted at least one in-person medical evaluation of the patients, or a covering practitioner. Mississippi defines a practitioner as a "physician … or other person licensed, registered, or otherwise permitted to dispense … a controlled substance ..." A covering practitioner is defined as a practitioner who conducts an evaluation other than an in-person examination at the request of a practitioner who has conducted an in-person evaluation of the patient within the previous 24 months.

The agency explained that the Jackson VAMC's past practice was to authorize its Advanced Practice Registered Nurses[8] to prescribe controlled substances under the facility's institutional DEA number. Dr. Kirchner suspended this practice following a review, and NPs were instructed to ask physicians to sign the prescriptions. According to the report, in July 2012, Dr. Kirchner determined that there was no prohibition against covering physicians renewing controlled substances prescriptions after reviewing a patient's chart, but without seeing the patient. Thus, staff physicians were asked to work with NPs to review patient charts and renew the prescriptions accordingly. However, in August 2012, a DEA agent informed management that this practice was not allowed. Jackson VAMC then suspended the practice and created the Controlled Substances Clinic. According to the report, the Controlled Substances Clinic closed in November 2012 because many NPs had obtained individual DEA certifications.

[8] Advanced Practice Registered Nurses hold masters degrees and advanced clinical certifications. The term includes NPs, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists. It does not include RNs.

As a result, the agency recommended that all NPs receive individual DEA certifications and until then be disallowed from writing controlled substance prescriptions. The agency also recommended an update of the facility's NP functional statement, qualification standards, and dimensions of practice to be consistent with national policy. Finally, the agency directed the Jackson VAMC to conduct a clinical care review of a random sample of patient records for NPs prescribing controlled substances outside their authority. If clinical issues are identified as a result of this review, the review should be expanded.

3. *The Whistleblower's Comments*

Dr. Hollenbeck provided a detailed timeline of the events that occurred in relation to the improper prescribing of narcotics at the Jackson VAMC. She explained that she was on leave in May 2012 when the DEA first arrived at the Jackson VAMC to arrest Ms. White-Taylor. When she returned from leave in June 2012, she found that DEA agents had informed management that using an institutional DEA registration number for all practitioners was not permitted. On her first day back, Dr. Hollenbeck noted that a NP in her clinic said he was supposed to ask her to review a chart for a patient he had seen earlier in the day and after a discussion, have her sign for the patient's narcotics prescription. Dr. Hollenbeck reported that she told the NP that this request was illegal. He agreed but indicated that he was acting under instruction from Drs. Kirchner and Lockyer.

Dr. Hollenbeck explained that shortly thereafter, Dr. Lockyer sent an e-mail stating that the same prescription-writing process would be instituted for the other three Primary Care Unit physicians to "help" their "NP colleagues." While the e-mail did not order physicians to sign the prescriptions, Dr. Hollenbeck stated that the intent was clear: physicians who did not go along with the process were not team players and would be accused of hurting patients. In response, Dr. Hollenbeck called the DEA to inquire about the legality of such a process. She was informed it was not legal. A subsequent Jackson VAMC e-mail stated that physicians should continue signing narcotics prescriptions as previously directed.

Dr. Hollenbeck then informed Dr. Lockyer that she had proposed a solution via an e-mail to the physician and administrative leadership: The Jackson VAMC should hire *locum tenens* physicians to see NP's patients in need of narcotics prescriptions. In addition, Pain Clinic physicians, who already saw some of these patients, could take over the writing of those patients' narcotics prescriptions.

According to Dr. Hollenbeck, neither of these ideas was implemented at that time. Rather, physicians were notified that a nurse from each clinic should submit daily written requests to the primary care office, to be reviewed by Dr. Lockyer. Another e-mail stated that an administrative aide was bringing narcotics prescription requests the afternoon of the date of the e-mail, and asked Primary Care Unit staff not to "give [him] any grief."

However, Dr. Hollenbeck noted that because she had previously refused to write prescriptions for patients she did not see, she was not asked to review prescription requests. Dr. Hollenbeck explained that after this e-mail, the next direction (also via an e-mail from Dr. Spencer) was that written narcotics requests were to be taken to the Medicine Department office each afternoon for assigned physicians to review overnight. However, according to Dr. Hollenbeck, the assigned physicians turned out to be medical residents, whose evaluations were done by Dr. Spencer and Dr. Kirchner. Dr. Hollenbeck noted that this was a conflict of interest because these same doctors were asking the residents to break the law by reviewing prescription requests for patients they had not seen.

Dr. Hollenbeck noted that several *locum tenens* physicians in the Controlled Substances Clinic refused to write prescriptions for any patients they did not see. These "overflow" patients' prescription requests were addressed by Dr. Lockyer or Dr. Kirchner.

Dr. Hollenbeck explained that there was not a smooth transition from the Controlled Substances Clinic to NPs writing prescriptions again. Rather, she stated that the clinic ended in November 2012 because of ongoing concerns from the *locum tenens* physicians. The report noted that when the Controlled Substances Clinic ended, all NP-patient prescriptions were written by NPs who had obtained individual DEA registration numbers. But Dr. Hollenbeck emphasized that the agency's report contained an inherent contradiction: because none of the collaborative agreements were being enforced at that time, none of the NPs were legally licensed, and thus, they could not legally obtain individual DEA registration numbers.

II. OSC File No. DI-13-1713 (Dr. Sherwood's Allegations)

A. Failure to Properly Read Patient Images Directly Affected Patient Outcomes

1. *The Allegations*

Dr. Sherwood was the Chief of Ophthalmology at the Jackson VAMC. He retired in 2011 after 30 years of service. Prior to his retirement, Dr. Sherwood testified as a witness on behalf of several plaintiffs who were radiologists at the Jackson VAMC and who filed a discrimination lawsuit against the hospital.[9] Beginning in the late 1990s, the agency started correlating physician performance bonus awards to performance metrics. By 2004, the agency was basing radiologist pay on performance metrics. One of the metrics used is the Relative Value Unit (RVU), a system originally developed for Medicare. To quantify the relative difficulty of radiology readings, images are assigned a RVU that takes into account the number of images reviewed by the radiologist and the difficulty of the image. Images that are more difficult to read receive a higher RVU, and result in higher compensation for physicians and management.

[9] McIntire v. Peake, No. 3:08cv148-TSL-FKB (S.D. Miss. Aug. 10, 2010).

In 2004, former Chief of Radiology Dr. Vipin Patel instituted a computerized RVU tracking system at the Jackson VAMC. Under this system, radiologists receive performance evaluations and compensation based on the number of imaging studies they read and the RVUs of those studies. Imaging studies that are not yet read are listed in the RVU tracking system. Radiologists can assess the list and choose the images they intend to review by marking them in the computer system, thereby preventing other radiologists from reviewing the same images.

As a result of the Radiology Department's pay-for-performance system, several female radiologists filed a discrimination and retaliation lawsuit against the Jackson VAMC. In the lawsuit, the female radiologists alleged that Dr. Majid Khan, also a radiologist, regularly selected a high percentage of the available high RVU images to read, and then read the images at a rate that was far faster than could be expected to result in proper diagnoses. Dr. Khan also stated aloud during a peer review meeting that he did not read all of the images in each patient study he selected, and that if he tried to, the facility would need to hire more radiologists. Dr. Kahn maintained a high average read rate from November 2006 to June 2007, while spending half of his work day reading non-VA images as part of a collaborative relationship with the University of Mississippi.

The plaintiffs testified that they brought their concerns about Dr. Khan's actions to the attention of management on many occasions, including providing lists of patients who suffered serious adverse effects due to Dr. Khan's improper readings. The plaintiffs alleged that management, in particular Dr. Patel, took only superficial steps to correct these significant shortcomings, due in part to national origin discrimination by Dr. Patel in favor of Dr. Khan. However, the clinical concerns regarding Dr. Khan's actions and management's failure to act were not part of the plaintiff's case in chief, and thus, were not addressed by the jury.

According to the plaintiffs, Dr. Khan's failure to correctly read each image resulted in large numbers of missed diagnoses. The plaintiffs maintained a list of patients whose studies were misread by Dr. Khan. This included missed diagnoses of serious or fatal outcomes such as inoperable cancers and neck fractures. The plaintiffs also stated that Dr. Khan falsified his reports to cover up these missed diagnoses.

2. *The Agency's Findings and Recommendations*

The agency did not substantiate the allegation that Dr. Khan failed to fully or properly review radiology images. The agency relied on its review of several data sets related to Dr. Khan's productivity and found that the amount of time Dr. Khan spent on each image was not significantly shorter than his colleagues' times. Further, the agency found that Dr. Khan read an average number of lower value images in comparison to his colleagues. The agency further found that on a monthly basis Dr. Khan's monitor was open 26 hours longer than his colleagues, giving him additional time to read images. The agency concluded

that Dr. Khan was reading images of a similar type and with similar variety as those read by his colleagues. The agency found that Dr. Khan's comments regarding his failure to read every image were related to a specific instance in which he did not read an image for an abnormality that he had identified previously.

The agency found that Dr. Khan's actions did not affect patient outcomes. The agency referred to a prior review of 321 cases that was undertaken during Dr. Khan's tenure. Out of those 321 cases, the agency reported that 2 had major discrepancies, while 10 had minor discrepancies. Combined, the discrepancies represented 3.7 percent of the total cases reviewed. The agency found that this percentage fell within the accepted error rate of three to five percent. The agency noted that in another review of 30 cases undertaken while Dr. Khan was with the VA, no major findings or diagnoses were missed.

The agency contracted a third party company, Lumetra, to conduct an outside peer review of the 58 cases identified by the Jackson VAMC physicians in the underlying discrimination case. In its review, Lumetra found that 46 percent of the cases had no concerns, 21 percent were of possible concern, and 33 percent had verified findings of concern. Of the 31 cases described by Lumetra as having a high level of concern, 8 were identified as having moderate to high impact to patients. The agency explained, however, that because these cases do not represent a random sample of Dr. Khan's work, they may not provide a clear picture of Dr. Khan's actual error percentage. The report also determined that Dr. Khan did not intentionally alter his notes in order to conceal mistakes. Rather, the agency found that on two occasions, Dr. Khan misstated or deleted information in a report, but that the changes were not intentionally misleading.

The agency stated that no policy exists stating the appropriate number of images for random peer review on an annual basis. However, the report found that the peer review process in place during Dr. Khan's employment at the Jackson VAMC was not functional, and that competency monitoring for all providers was not effective. As a result, the agency recommended a review of the cases Lumetra identified as having a moderate to high impact on patient outcomes in order to determine the degree of harm. If appropriate, that information should then be disclosed to patients in accordance with agency policy. The agency also recommended that Dr. Charles Anderson, VHA Chief Consultant, Diagnostic Services, should identify an appropriate number of Dr. Khan's studies from between July 2003 and November 2007, in order to conduct an external peer review. Based upon that review and in conjunction with Dr. Anderson, the agency could take further action.

3. *The Whistleblower's Comments*

In his comments, Dr. Sherwood raised significant points of concern with the agency's findings. First, although Dr. Khan's relationship with the University of Mississippi (University) was raised in OSC's referral, the agency's report failed to address it. While the report included a variety of data reflecting Dr. Khan's work productivity, Dr. Sherwood

noted that the report ignores the fact that between 2006 and 2007, Dr. Khan was reading University of Mississippi studies for a significant portion of his tour of duty. Dr. Sherwood further pointed out that the reading monitor used for University studies was separate from the VAMC monitor, and was not connected to VistaRad, the VA's radiology data system. Thus, these studies are not included in the data produced by the agency, and the agency does not explain how Dr. Khan could maintain a high read rate of VA studies while also completing University work.

The agency also failed to address Dr. Anderson's statement from a memorandum dated September 20, 2007, that if Dr. Khan was reading such a high level of image studies while working fewer than 80 hours a week, it would raise concerns. Dr. Sherwood noted that data was submitted at trial reflecting Dr. Khan's RVU productivity workload, which according to the whistleblower is far more accurate than the data provided by the agency. The RVU productivity data measures the number of studies read or RVU, depending on the date the RVU was instituted. Dr. Sherwood contended that this data shows that Dr. Khan's read rates were significantly higher than those of his colleagues.

Dr. Sherwood also pointed out that the report's characterization of Dr. Khan's statements regarding his reading of every image does not align with sworn trial testimony about the statements. At trial, all of the witnesses interviewed testified that they heard Dr. Khan say that VA would have to hire more radiologists if he looked at every image. In its report, the agency insisted that Dr. Khan was referring to a single instance of a previously identified abnormality. However, Dr. Sherwood believes that Dr. Khan's statements and the witnesses' understanding of them clearly show that he was referring to reading images in general, and not to a particular image study.

With regard to the list of cases provided to Lumetra, Dr. Sherwood noted that the report does not indicate whether Lumetra received any documentation other than the image studies. Dr. Sherwood explained that an appropriate peer review would require access to prior studies and reports for comparison, and access to the Computerized Patient Record System for clinical data that should have been used by Dr. Khan. Dr. Sherwood pointed out that this data would also be necessary to address whether Dr. Khan falsified or improperly altered medical records.

B. Management Was Aware of Radiology Shortcomings but Took No Action

1. *The Allegations*

It was also alleged that, although the plaintiffs repeatedly told management in the underlying discrimination matter that Dr. Khan's work was sub-standard, Jackson VAMC took no definitive action to resolve the problem. In 2007, the Jackson VAMC conducted its own internal review of the flawed reports identified by the plaintiffs. In a November 21, 2007, memorandum, the former Chief of Radiology stated that he spent 10 hours reviewing

the reports and found no instances in which he would have altered the patients' care. It was alleged, however, that this report was flawed and the outcome could not be trusted because of underlying tensions within the department. In June 2007, the VA Office of the Inspector General (OIG) conducted an investigation into the plaintiffs' allegations. The OIG report, dated April 8, 2008, did not substantiate the plaintiffs' allegations, instead determining that the data provided to investigators was biased, and finding only one patient outcome affected by Dr. Khan. As a part of its investigation, the OIG sent the 30 cases discussed above to an outside peer reviewer. While the external peer review report did not find that Dr. Khan's error rate was higher than his colleagues' error rates, it did find that the Jackson VAMC's internal peer review process was flawed, and recommended that another VA Medical Center conduct the Radiology Department's peer reviews.

2. *The Agency's Findings and Recommendations*

In its report, the agency determined that management took a variety of steps to address complaints about the quality of Dr. Khan's work. The agency cited the review of 300 of Dr. Khan's cases following his two confirmed errors early on in his tenure. The agency also cited the review of 30 cases discussed above, and the former Chief of Radiology's review of the 58 cases referenced by the plaintiffs in the underlying matter. The report noted that after a partial review of these cases by an administrative board, it was found that Dr. Khan's work was not substandard, but that there was ongoing conflict within the Radiology Department and that an external review of 2,000 to 3,000 cases should be undertaken. However, according to the report, a Professional Standards Board (PSB) was convened to review this recommendation, and found that no further review was necessary. The report acknowledged that there was an appearance that the leader of the PSB was biased in the matter, based upon earlier support he had provided to Dr. Khan and previous statements he made regarding the plaintiffs. Notwithstanding the appearance of a conflict, the agency determined that these actions constituted sufficient action by Jackson VAMC management in response to repeated complaints regarding Dr. Khan.

3. *The Whistleblower's Comments*

In his comments, Dr. Sherwood reiterated that the VA's 2007 Administrative Investigation Board recommended a review of 3,000 studies for a statistically valid review of Dr. Khan's error rate, but that the subsequent PSB deemed it unnecessary. In addition, Dr. Khan's true error rate is still unknown, as a statistically valid review has never been conducted. Dr. Sherwood noted that at trial, Dr. Khan's supervisors and colleagues testified that no other radiologist at the Jackson VAMC had any similar major errors requiring an institutional disclosure during their employment.

Dr. Sherwood also noted that Dr. Patel was an active researcher and editor of a peer-reviewed medical journal. As such, he would have been aware that a sample size of 30 cases would not yield a statistically valid result. Dr. Sherwood contended that the small sample

size was intended for use in routine annual screening, and not for practitioner performance concerns of the type associated with Dr. Khan. Dr. Sherwood further noted that the report itself stated that a sample size of 30 has been deemed too small, even for routine evaluation.

Additionally, Dr. Sherwood explained that prior to the PSB, Dr. Patel circulated a false e-mail to the participating service chiefs regarding the list of 58 cases and the motivations behind it. Dr. Patel admitted during trial testimony that he lied in that e-mail. Dr. Sherwood contended that the purpose of the false e-mail was to discredit the claims against Dr. Khan and shield him from closer scrutiny, and that the e-mail served to influence the conclusions of the PSB. Dr. Sherwood noted that the report characterizes Dr. Patel as having retracted the claims of wrongdoing made in his e-mail. However, Dr. Sherwood stated that Dr. Patel was forced during trial to confess to making false claims in his e-mail.

C. The Agency Failed to Notify Potentially Affected Patients

1. *The Allegations*

VHA Directive 2008-002 (January 18, 2008), which was later updated but was in effect at the time of the discrimination trial, provides the steps that must be taken by the agency to inform patients when there is the possibility that an adverse event has occurred; Para. 5.a.(1) of the Directive states that adverse events are events that cause death or disability. Paragraph 5.b. further provides that when adverse events have the potential to affect or may have already affected multiple patients, the process for a large-scale disclosure must be followed. This process is described in Para. 9 of the Directive, which explains that decisions regarding the large-scale disclosure of adverse events are made by the Principal Deputy Under Secretary for Health following a multi-step VA Central Office process involving a Subject Matter Expert Review Panel and/or a Clinical Review Board, both of which are defined in Para. 3 of the Directive.

At trial, testimony indicated awareness by management of four instances in which Dr. Khan failed to properly read patient studies and the patients subsequently returned with serious illnesses, including cancer. In each of those instances, an Institutional Disclosure was conducted, which is also described in the Directive.[10] However, it was alleged that the agency appeared to have made no efforts to disclose to all the patients potentially affected by Dr. Khan's alleged malfeasance. It also did not appear that the agency conducted the required Clinical Review Board or Subject Matter Expert Review Panel.

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[10] As defined by VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients* (October 2, 2012), Institutional Disclosures are the formal process by which facility leaders, clinicians, and other appropriate individuals inform the patient that an adverse event has occurred during the patient's care that resulted in or could result in death or serious injury.

2. *The Agency's Findings and Recommendations*

The agency's report emphasized that not all of the cases identified by the plaintiffs necessarily represented malfeasance on the part of Dr. Khan. The report also noted that perceived differences of opinion between radiologists do not necessarily constitute errors, and that not all errors have clinical significance. Of the three disclosures that were made to patients, only one resulted in litigation. The report determined, on the basis of the litigation, that Dr. Khan likely should have been reported to the National Practitioner's Data Bank, but noted that there is no litigation pending against Dr. Khan. The report acknowledged that it is unclear whether a fourth matter regarding a gastrointestinal review by Dr. Khan was assessed by the facility to determine the need for institutional disclosures to affected patients, or whether the case was included in any external reviews. However, the agency recommended disclosures of the eight cases identified by Lumetra.

3. *The Whistleblower's Comments*

Dr. Sherwood stated in his comments that it was only after patients discovered harm on their own or as part of the litigation discovery process that the VA disclosed misconduct. He reiterated that the true number of affected patients is unknown and will remain so until a full review of Dr. Khan's work is undertaken.

III. The Special Counsel's Findings

I have reviewed the original disclosures, the agency's reports, and the whistleblowers' comments. In both cases I find the agency's reports deficient for the reasons outlined below.

A. OSC File No. DI-12-3816

The agency's report in this matter acknowledges violation of federal and state laws, as well as agency policies. I consider these breaches extremely serious because they relate to inadequate patient care. Dr. Hollenbeck's comments are particularly compelling and indicate that many members of management were aware of the ongoing understaffing, lack of required oversight of NPs, and improper narcotics prescription processes. However, the agency did not indicate that any actions were taken to hold accountable management officials who contributed to and approved of these chronic problems.

In addition, the report noted that on several occasions it was unclear whether patient care was compromised, and indicated that the agency has not determined whether Medicare Home Health Certification forms were improperly completed in violation of federal law. Further investigation is required to identify affected patients, and to obtain the data necessary to fully answer these questions. These are integral components of the referred allegations and the report is incomplete until answers to these outstanding questions are provided.

Further, to OSC's knowledge, the recommendations in the report are not yet fully implemented. According to Dr. Hollenbeck, only one new physician has been added to the Primary Care Unit. Despite the agency's recommendation that the use of *locum tenens* physicians be curtailed, it appears that two new *locum tenens* physicians will be added to the Primary Care Unit staff. Recently, I was notified that Mr. Battle, the facility Director, placed an opinion column in the Jackson Clarion-Ledger on July 4, 2013. In that piece, Mr. Battle stated that only one violation was identified following multiple outside reviews, including the investigation of these allegations. This statement is factually inaccurate and extremely troubling given that the agency's recommendations for corrective action have not been implemented. In a previous case concerning allegations about the Jackson VAMC, the VA failed to provide the Jackson VAMC with its findings or even a copy of its final report in the matter.[11] In light of this, both the VA and the Jackson VAMC must take significant steps to prevent these serious patient care problems.

B. OSC File No. DI-13-1713

I have many concerns regarding the outcome of the agency's investigation into Dr. Sherwood's allegations. The fact remains that the underlying litigation confirmed that there was discrimination occurring at the Jackson VAMC in favor of Dr. Khan. Armed with that information, and with trial transcripts in which Dr. Patel admits to making false statements, it becomes increasingly difficult to believe that the agency's past reviews of Dr. Khan's work were objective or sufficient. Furthermore, the agency admits in its report that it has not determined what number of cases constitutes a sufficient review to achieve a statistically viable error rate. The report also acknowledges that a sample of 30 is considered insufficient even for a routine evaluation. Thus, it is not reasonable to conclude that the agency's prior reviews of Dr. Khan's work ensure that no additional patients have been harmed or that management's responses have been sufficient.

Further, there are remaining questions about the review conducted by Lumetra, as Dr. Sherwood stated in his comments. It is unclear how much information and documentation the agency provided Lumetra, or what information other than the images Lumetra used to reach its conclusions. It is also troubling that the agency does not address Dr. Khan's rate of reading images in relation to the amount of time he spent working on non-VA image studies. This appears to be a crucial question, since many of the agency's conclusions rest on the finding that Dr. Khan's read rates were not abnormally high compared to colleagues. I find Dr. Sherwood's evidence of Dr. Khan's read rates compelling, and believe that these issues need to be addressed.

In addition, I note that the agency's report contains several recommendations still outstanding, including consultation with Dr. Anderson on preparing an external peer review. Without findings from a full peer review, I believe it is not possible to determine whether

[11] See OSC File No. DI-11-1625.

Dr. Khan's work was adequate or whether his actions affected patient outcomes. Based upon the foregoing, I find the agency's report insufficient and unreasonable, and recommend that further action be taken to ensure that patients have received appropriate care. I have requested an update on these outstanding items within 60 days, including information on the status of the agency's peer review and the impact of that review on patient outcomes.

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As required by 5 U.S.C. § 1213(e)(3), I have sent unredacted copies of the agency's reports and the whistleblowers' comments to the Chairs and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports and whistleblowers' comments in our public file, which is now available online at www.osc.gov. [12]

Respectfully,

Carolyn N. Lerner

Enclosures

[12] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted versions of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted versions as an accommodation.