



DEPARTMENT OF VETERANS AFFAIRS  
Washington DC 20420

July 29, 2013

The Honorable Carolyn N. Lerner  
Special Counsel  
U.S. Office of the Special Counsel  
1730 M Street, NW, Suite 300  
Washington, DC 20036

RE: OSC File No. DI-13-1713

Dear Ms. Lerner:

I am responding to your letter regarding allegations by (b) (6), M.D., a former ophthalmologist at the G.V. (Sonny) Montgomery Department of Veterans Affairs Medical Center (VAMC) in Jackson, Mississippi. The Secretary has delegated to me the authority to sign this report and take any actions deemed necessary under 5 United States Code (U.S.C.) § 1213(d)(5).

Dr. (b) (6) retired from VA in 2011. Dr. (b) (6) alleged that: (a) a former radiologist, (b) (6), M.D., at the facility regularly marked patients radiology images as "read" when, in fact, he failed to fully or properly review the images, and at times, failed to read them at all; (b) the failure to properly read these images, or at times, to read them at all, led to numerous missed diagnoses of serious, and in some cases, fatal conditions including inoperable cancers, neck fractures, and enlarged lymph nodes; (c) medical records were falsified to cover-up the treatment and diagnostic errors; (d) management was aware of this malfeasance but never required that the images be re-reviewed or took steps to remedy this problem, and instead acted to protect the radiologist at fault; and (e) the agency failed to notify the large number of patients who were potentially affected by this lapse in clinical care. Additional concerns and related matters involving improper pay structure and leadership issues were also identified.

I asked the Under Secretary for Health to review this matter and take any actions necessary under 5 U.S.C. § 1213(d)(5). He, in turn, directed the Deputy Under Secretary for Health for Operations and Management to investigate the allegations. The Review Team's findings are contained in the enclosed report. In its investigation, the team did not substantiate the specific allegations. Eight cases were, however, identified as being of moderate or high concern to patient care. The facility will be directed to review these cases to determine the degree of harm, if any, and to conduct appropriate disclosures to patients and/or their families in accordance with the Veterans Health Administration's (VHA) policy concerning institutional disclosure. The team also determined that the facility did not maintain a credible peer review process within Radiology Service during 2003-2007. Consequently, the VHA Chief Consultant for

Page 2.

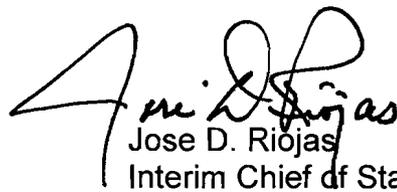
The Honorable Carolyn N. Lerner

Diagnostic Services will identify an appropriate number of studies of Dr. (b) (6) drawn from the period of July 2003-November 2007 so that an external peer review can be conducted on those cases. The facility, in consultation with the Chief Consultant, will determine if any further action is required if the discrepancy rate is outside the expected baseline.

Finally, VA Central Office is in the process of developing a tabulated action plan (with applicable time-frames and monitoring responsibilities) for each of the recommended actions described in the report. We will provide you with a copy of the action plan (in the form of a supplemental report) as soon as it becomes available.

I have reviewed the report and concur with the findings, conclusions, and recommendations. Thank you for the opportunity to respond to this issue.

Sincerely,

  
Jose D. Riojas  
Interim Chief of Staff

Enclosure

**VETERANS HEALTH ADMINISTRATION (VHA)**

**Report to the  
Office of Special Counsel  
OSC File Number DI-13-1713**

**G.V. (Sonny) Montgomery  
Department of Veterans Affairs  
Medical Center  
Jackson, MS**



**Report Date: June 20, 2013**

**Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.**

## Executive Summary

The Deputy Under Secretary for Health for Operations and Management appointed a Fact Finding Team to investigate a whistleblower disclosure submitted to the Office of Special Counsel (OSC) by (B)(6). (B)(6) was identified by OSC as the former Chief of Ophthalmology at the G.V. (Sonny) Montgomery Department of Veterans Affairs (VA) Medical Center (hereafter, the Medical Center). He retired from VA in 2011. (B)(6) allegations are based on sworn testimony and exhibits presented by others during a discrimination lawsuit filed against VA by three radiologists at the facility. On August 2010, a Federal jury returned a verdict in favor of the radiologists on their discrimination claims against VA and awarded damages totaling \$183,781.

The whistleblower alleged that:

- A former radiologist, (B)(6), at the Medical Center regularly marked patients radiology images as "read" when, in fact, he failed to fully or properly review the images, and at times, failed to read them at all;
- The failure to properly read these images, or at times, to read them at all, led to numerous missed diagnoses of serious, and in some cases, fatal conditions including inoperable cancers, neck fractures, and enlarged lymph nodes;
- Medical records were falsified to cover-up the treatment and diagnostic errors;
- Management was aware of this malfeasance but never required that the images be re-reviewed or took steps to remedy this problem, and instead acted to protect the radiologist at fault; and
- The agency failed to notify the large number of patients who were potentially affected by this lapse in clinical care.

(B)(6) was employed as a staff radiologist at the Medical Center from July 18, 2003, until his resignation on November 15, 2007. (B)(6)

(B)(6)

(B)(6)

Additional concerns and related matters were also identified by OSC. These concerns related to: (a) Improper Pay Structure; and (b) Leadership Issues. The team conducted a site visit on April 15-19, 2013. The team also interviewed (B)(6) completed a clinical review of all cases identified in the referral as being misread or containing falsified medical records; assessed appropriateness of communications, if any, to patients related to potential harm; and assessed appropriateness of actions by VA leaders related to unread or misread radiology images.

## Summary of Conclusions

**Allegation #1:** (B)(6) regularly marked patients' radiology images as "read" when, in fact, he failed to fully or properly review the images, and at times, failed to read them at all.

This allegation is not sustained. Various VistaRad datasets reviewed during the course of this investigation did not support that (B)(6) read faster than was appropriate. (B)(6) was not outside his peer group in any of the types of films considered or in his total time reviewing films. Further, there is additional objective data confirming that (B)(6) viewing station was open approximately 26 hours per month more, on average, than other radiologists providing him with a greater window for interpreting more cases than his peers.

There was a related allegation that (B)(6) stated he did not have time to look at all images. The team found that this statement was made during a peer review session when (B)(6) was explaining that he did not reference an infarct while viewing a CT angiogram because he had already identified the infarct on a preceding recent study. Based on the evidence of record, (B)(6) met the standard of care because he interpreted the infarct on the previous CT of the head, even if it was not specifically identified on the subsequent angiogram. Simply put, the infarct was a known finding before the angiogram study was conducted and he felt there was no need to repeat that information.

**Allegation #2:** The failure to properly read these images, or at times, to read them at all, led to numerous missed diagnoses of serious, and in some cases, fatal conditions including inoperable cancers, neck fractures, and enlarged lymph nodes.

This allegation is not sustained. The findings of this review do not support the allegations that (B)(6) readings were disproportionately incorrect. The team does conclude that the peer review process within Radiology Service was broken during this time and the monitoring for competency for all providers was ineffective.

Based on the results of prior random peer reviews consisting of 321 cases, (B)(6) discrepancy rate for both minor and major discrepancies is 3.7 percent (12/321). This is within the generally accepted 3-5 percent error rate. Another review of an additional 30 random cases in which specific numbered discrepancies were not identified, noted that no major findings or diagnoses were missed.

Fifty-eight selected cases were presented by the Whistleblower as containing specific errors resulting in harm to patients. These cases were compiled by a staff radiologist at the facility and presented to the Chief of Staff in 2007. The cases were reviewed by the Chief of Radiology who identified two cases of which the facility was already aware with no other significant findings. As part of the team's investigation, an independent review of the 58 cases was conducted by Lumetra Healthcare Solutions. Lumetra found that:

- 27 cases (46%) were considered Level 1 - Most experienced, competent practitioners would have managed the case in a similar manner.
- 12 cases (21%) were considered Level 2 - Most experienced, competent practitioners might have managed the case differently.
- 19 cases (33%) were considered Level 3 - Most experienced, competent practitioners would have managed the case differently.

Of the 31 total cases described as Level 2 or 3, eight cases were identified as having moderate or high impact to patients.

The difficulty is determining the denominator of total cases the 58 selected cases represents. Since (B)(6) read tens of thousands of radiology studies during his tenure, it is not known what percentage the 58 cases represent. Review of the 58 cases can be used to determine if patients were harmed; however, consideration of these cases does not allow for comparison to others in (B)(6) peer group to determine if his error rate was disproportionately high.

**Allegation #3: Medical records were falsified to cover-up the treatment and diagnostic errors.**

This allegation is not sustained. In one occurrence, shortly after his arrival, (B)(6) was alleged to have misstated the sequence of events in which a guide wire was broken during an angiogram and also failed to identify the event as a specific complication. In a second occurrence, a few days later, (B)(6) deleted a previously dictated report and substituted a different finding rather than completing an addendum to describe the subsequent finding. There is no evidence that in either of these instances, (B)(6) intentionally falsified medical records for the purpose of covering up treatment and diagnostic errors. In the first instance, the issues involving the guide wire were described in the record, and disclosed to the patient, but not specifically listed as a complication. In the second instance, it appears that the service's policy regarding the preparation of addendums was not clear and (B)(6) was instructed to prepare addendums for similar future situations.

It was also alleged that (B)(6) described body parts for images he did not read. This relates to his statement to the effect that he did not review all images. The Review Team did not substantiate that (B)(6) engaged in this practice.

**Allegation #4: Management was aware of this malfeasance but never required that the images be re-reviewed or took steps to remedy this problem, and instead acted to protect the radiologist at fault.**

**Conclusion:** This allegation is not sustained. Throughout 2003-2007, management undertook a variety of measures in response to concerns regarding the alleged poor

quality of (B)(6) work. There is no evidence management intentionally acted to protect him at the risk of patient care. However, it is clear management was ineffective in resolving underlying conflict and hostility that existed within the service, including those administrative areas in which management was found to have engaged in discriminatory actions.

The Review Team concludes that the facility should have obtained a thorough external review of all 52 cases reported by (B)(6) in 2007. If the results of that review raised concerns, an additional review of a significantly larger sample size, as described by the administrative board, should have been conducted.

**Allegation #5: The agency failed to notify the large number of patients who were potentially affected by this lapse in clinical care.**

**Conclusion:** This allegation is not sustained. Three disclosures were previously made (consistent with Veterans Health Administration (VHA) policy requirements) for patients who were identified by the facility as having possible errors in the interpretations of their studies. Only one of these three cases resulted in litigation, and it was ultimately settled by the Government. The Office of Medical-Legal Affairs has indicated it has preliminarily determined that (B)(6) should be reported to the National Practitioner's Data Bank as a result of the monetary settlement. We understand that currently there are no active or pending Federal tort claims involving (B)(6)

**Additional Allegations/Related Matters**

**Improper Pay Structure**

This allegation is not sustained. Results of data gathered were generally in line with other VHA facilities. VHA's use of Relative Value Units (RVU) is consistent with external benchmarks and industry practice and is in accordance with VHA Directive 2008-009, Productivity and Staffing Guidance for Imaging Physicians (February 7, 2008). The investigation found no evidence that such use within VHA creates a unique perverse incentive for physicians or inherently undermines their professionalism.

**Leadership Issues**

Significant interpersonal conflict among radiologists, divided by national origin and gender, undermined the objectivity and reliability of the facility's local peer review process, often resulting in mutual accusations. The Radiology Chief failed to effectively address these issues. Changes in leadership at the facility and in the service, along with the departure of (B)(6) appear to have reduced or eliminated these conflicts, and we note that none of the witnesses reported continuation of these problems during the site visit. The radiologist peer review process remains in-house, and it has been improved, particularly in terms of efficiency and related reporting mechanisms.

## Summary of Recommendations

1. The facility should review all eight cases identified by Lumetra as having moderate to high assessed impact, including all relevant medical records and appropriate subspecialty consultation, to determine the degree of harm, if any, and to conduct appropriate disclosures to patients and/or their families in accordance with VHA policy concerning institutional disclosure.
2. (B)(6) Chief Consultant, Diagnostic Services, VHA, should identify an appropriate number of (B)(6) studies drawn from the period July 2003 – November 2007, so that an external peer review may be conducted for these cases. The facility, in consultation with (B)(6) should determine any further action required if the discrepancy rate is outside the expected baseline.

## Final Report to the Office of Special Counsel

### I. Summary of Allegations

The Deputy Under Secretary for Health for Operations and Management (DUSHOM) appointed a fact-finding team to investigate a whistleblower disclosure submitted to the Office of Special Counsel (OSC) by (B)(6). (B)(6) was identified by OSC as the former Chief of Ophthalmology at the G.V. (Sonny) Montgomery VA Medical Center (hereafter, the Medical Center), in Jackson, Mississippi.<sup>1</sup> He retired from the Department of Veterans Affairs (VA) in 2011 after 30 years of service.

(B)(6) alleged that: (a) a former radiologist (B)(6) at the Medical Center regularly marked patients radiology images as “read” when, in fact, he failed to fully or properly review the images, and at times, failed to read them at all; (b) the failure to properly read these images, or at times, to read them at all, led to numerous missed diagnoses of serious, and in some cases, fatal conditions including inoperable cancers, neck fractures, and enlarged lymph nodes; (c) medical records were falsified to cover-up the treatment and diagnostic errors; (d) management was aware of this malfeasance but never required that the images be re-reviewed or took steps to remedy this problem, and instead acted to protect the radiologist at fault; and (e) the agency failed to notify the large number of patients who were potentially affected by this lapse in clinical care.<sup>2</sup>

### II. Facility Profile

The Medical Center, part of the Veterans Integrated Service Network (VISN) 16, consists of the main facility in Jackson and seven community-based outpatient clinics. The main facility operates 128 inpatient beds for general medicine, surgery, neurology, and mental health services. The facility’s Medical Intensive Care Unit has a 12-bed capacity and an average occupancy rate of 62 percent. The Surgical Intensive Care Unit has 8 beds, with an average occupancy rate of 47 percent. The Medical Center is affiliated with the University of Mississippi, training resident physicians in internal medicine and other specialty areas.

### III. Conduct of the Investigation

The fact-finding team was instructed to interview (B)(6) complete a clinical review of all cases identified in the referral as being misread or containing falsified

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<sup>1</sup> To clarify (B)(6) specific position, (B)(6) served as the Ophthalmology Section Chief.

<sup>2</sup> (B)(6) allegations are based on sworn testimony and exhibits presented by others during a discrimination lawsuit filed against VA by three radiologists at the Medical Center. McIntire v. Peake, No. 3:08cv148-TSL-FKB (S.D. Miss. Aug. 10, 2010). (B)(6) does not have personal knowledge of the submitted allegations.

medical records;<sup>3</sup> assess appropriateness of communications, if any, to patients related to potential harm; and assess appropriateness of actions by VA leaders related to unread or misread radiology images.

The investigation team was chaired by: (B)(6), Director, VA Capitol Health Care Network (VISN 5). Appointed members included: (B)(6) Quality Management Officer, VA Capitol Health Care Network (VISN 5); (B)(6) Chief Medical Officer, VA Health Care Upstate New York (VISN 2); (B)(6) Human Resources (HR) Consultant, Veterans Health Administration (VHA) Workforce Management and Consulting Office; and (B)(6) Chief Safety and Risk Awareness Officer, National Center for Patient Safety. Subject-matter experts assisting the appointed members included (B)(6) Program Manager, National Center for Patient Safety; (B)(6) Patient Aligned Care Team Coordinator, VA Capitol Health Care Network (VISN 5); and (B)(6) HR Consultant, VHA Workforce Management and Consulting Office. (B)(6) and (B)(6) primarily focused on OSC Referral DI-12-3816: Primary Care Issues; (B)(6) and (B)(6) primarily focused on OSC Referral DI-13-1713: Radiology Issues; and (B)(6) was unable to participate in the on-site review.)

A site visit was conducted on April 15-19, 2013. A team representative contacted (B)(6) prior to the site visit to describe the nature of the upcoming review and ensure the team understood the full scope of his concerns.

A list of the documents reviewed is found in Attachment A.

Lumetra Healthcare Solutions was contracted to conduct an independent external peer review of all allegedly misread cases to determine the quality of the reading and address the clinical significance of any identified misreading.<sup>4</sup>

The following individuals were interviewed in person (unless otherwise indicated):

- (B)(6), Chief Consultant, Diagnostic Services, VHA, VA Central Office (telephone interview).
- (B)(6) U.S. Air Force (Retired).<sup>5</sup>

<sup>3</sup> The information presented by (B)(6) includes a list of 52 cases allegedly misread by (B)(6) which purportedly led to missed diagnoses of serious or fatal conditions. The list was compiled by (B)(6) another VA radiologist who is currently serving as the Acting Radiology Service Chief at the Medical Center. The list of cases was presented as Exhibit P-25 during the Federal trial.

<sup>4</sup> Lumetra Healthcare Solutions is qualified by the General Services Administration to provide in-depth health care consulting services for mission oriented business integrated service projects. Lumetra also provides independent peer review to evaluate the quality of care delivered by an individual clinician. <http://lumetrasolutions.com/>.

<sup>5</sup> (B)(6) is active in Veterans' issues and had previously contacted VA officials regarding concerns at the Medical Center.

- (B)(6), Acting Chief of Radiology, Central Arkansas Healthcare System, Little Rock, Arkansas (telephonic interview).
- (B)(6) Director, South Central VA Health Care Network (VISN 16).
- (B)(6) Chief Medical Officer, South Central VA Health Care Network (VISN 16).
- (B)(6) Whistleblower, Accompanied by Attorney (B)(6)
- (B)(6) (telephone interview), Quality Management Officer, South Central VA Health Care Network (VISN 16).

Employees or Former Employees at the Medical Center:

- (B)(6) Medical Center Director.
- (B)(6) Staff Nephrologist (former Chief of Staff during relevant time periods).
- (B)(6) former Quality Management Director.
- (B)(6) M.D., Staff Radiologist, Accompanied by Attorney (B)(6)
- (B)(6) Staff Radiologist, Accompanied by Attorney (B)(6)
- (B)(6) Staff Radiologist, Accompanied by Attorney (B)(6)
- (B)(6) Radiology Technician.
- (B)(6) Administrative Officer, Radiology Service.
- (B)(6) Acting Chief of Quality Management.
- (B)(6) Quality Management Program Analyst.
- (B)(6) Acting Director of Emergency Department.
- (B)(6) Chief of Neurology.
- (B)(6), Associate Chief of Staff for Education and Ethics.
- (B)(6) Chief of Mental Health.
- (B)(6) Radiologist.

(B)(6) National Federation of Federal Employees' President, Local 589, met with the team but had no personal knowledge of the radiology issues under investigation and did not participate in a formal interview. (B)(6) American Federation of Government Employees' President, Local 589, was notified of the on-site visit and invited to meet with the interviewing members of the team. (B)(6) was unavailable for his scheduled appointment and did not reschedule.

Information used to compile the VistaRad reports was provided by (B)(6) and (B)(6) VA Office of Information Technology.<sup>6</sup>

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<sup>6</sup> VistaRad is a software application used for primary interpretation of digital images acquired by computed radiography, computed tomography, magnetic resonance, and other modalities.

## IV. Summary of Evidence Obtained from the Investigation

### a. Background

- 1) (B)(6) was employed as a staff radiologist at the Medical Center from July 18, 2003, until his resignation on November 15, 2007. (B)(6)  
(B)(6)  
(B)(6)
- 2) Core radiology privileges were granted on July 19, 2003, and accepted by (B)(6) on August 29, 2003. These privileges included general diagnostic radiology, diagnostic ultrasound, diagnostic nuclear medicine studies, diagnostic neuroradiology, diagnostic invasive procedures, and diagnostic body imaging.
- 3) (B)(6) received a medical degree from Government Medical College in Srinagar, India, in July 1992, and completed various internships and residencies in internal medicine and radiology in India and Nassau University Medical Center, East Meadow, New York. (B)(6) also completed a neuroradiology fellowship in June 2003 at Johns Hopkins Hospital, Baltimore, Maryland. (B)(6)'s board certified in diagnostic radiology.

### b. Findings of Fact<sup>7</sup>

- 1) On September 2, 2003, (B)(6) performed an angiogram during which the guide wire broke while it was being removed.<sup>8</sup> (B)(6) did not recognize that the guide wire was broken, and it was identified by the vascular technologist who reported the event to the Acting Chief of Radiology. At the request of the Acting Chief of Radiology, (B)(6) informed the patient and the patient's wife of what had occurred. No administrative tort claim or suit was filed. Subsequently, in his dictated report, (B)(6) indicated that the patient tolerated the procedure well with no immediate complications. (B)(6) also indicated that the wire broke near the end of the procedure when the event actually occurred earlier. The broken wire was removed without complications the following day during a previously planned vascular surgical procedure. (B)(6) was instructed not to perform any vascular or interventional procedures until the Radiology Chief was scrubbed and present in the room. (B)(6) stated during his interview that this level of oversight continued for about 3-4 months, by which time his diagnostic workload was increasing and he no longer wished to perform interventional procedures.)<sup>9</sup>

<sup>7</sup> All relevant findings are presented, to the extent possible, as a sequential timeline. Since all allegations are interrelated, the Review Team did not attempt to associate each finding of fact with a corresponding allegation in this section of the report. Specific conclusions related to each allegation are provided elsewhere in the report.

<sup>8</sup> (B)(6) the vascular technologist who was assisting (B)(6) indicated that it was actually the coating on the guide wire that sheared off.

<sup>9</sup> The record does not indicate that (B)(6) was formally placed on a proctorship and, further, one where the proctor would do more than just observe. Thus, it does not appear that reporting requirements were

2) On September (B)(6) 2003 (B)(6) did not identify a cervical spine fracture that, according to the Radiology Chief, was obvious and should not normally be missed. (Note: The fracture was also reportedly missed by a contract physician on September 2, 2003.) The fracture was identified by (B)(6) following a magnetic resonance imaging (MRI) study a few days later. (B)(6) re-dictated his report on or about September (B)(6) 2003, to include identification of the fracture and asked the transcriptionist to delete the previous report. The Radiology Chief discussed this case with (B)(6) and also stressed that dictated reports cannot be deleted and addendums should be dictated as needed. (B)(6) was also instructed to review the patient's history before reading films, slow down on his dictation, and if he has doubts, to review with other radiologists.

3) In taking these actions, the Radiology Chief considered that (B)(6) had only recently completed training and was working with unfamiliar equipment. The Radiology Chief notified (B)(6) the Chief of Staff of the actions he had taken and indicated that he (Radiology Chief) would monitor (B)(6) very closely.

4) On September 30, 2003, (B)(6) reported to the facility compliance officer that (B)(6) submitted false documentation in the angiogram broken wire case when he failed to identify this issue as a complication and stated in his dictation that the wire sheared at the end of the procedure instead of the beginning of the procedure. (B)(6) also reported that (B)(6) submitted false documentation in the cervical fracture case when he deleted his original dictation rather than submitting an addendum to the original report. (B)(6) also alleged that (B)(6) in his second dictation, falsely stated that he notified another physician regarding the fracture, when it was (B)(6) understanding that (B)(6) had not done so.

5) On October 1, 2003, the Chief of Staff notified (B)(6) that his clinical privileges were being reduced according to VHA Handbook 1100.19 until a thorough fact-finding review was completed regarding his clinical practice.<sup>10</sup> The notice provided that (B)(6) general practice would be reviewed as well as the following specific incidents: (1) a technical error related to a guide wire sheared and left in artery on September (B)(6) 2003; (2) missed cervical spine fracture on September (B)(6) 2003; and (3) a patient ID error where the wrong patient underwent a computed tomography (CT) angiogram with IV contrast on September (B)(6) 2003. In accordance with this notification, a confidential quality assurance (QA) review pursuant to 38 U.S.C. 5705 was conducted on October 3-9, 2003.

6) In addition, 100 of (B)(6) cases, representing 20 percent of his workload from the time of his appointment until October 1, 2003, were internally peer reviewed. Twenty cases each were provided to five different radiologists in (B)(6) peer group. The Radiology Chief reported less than five minor discrepancies and one major

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triggered pursuant to VHA Handbook 1100.19. See VHA Handbook 1100.19, paragraph 6k(2). It appears the Radiology Chief was only observing as part of a Focused Professional Practice Evaluation of (B)(6) care, and as such this would not have constituted a reduction of privileges.

<sup>10</sup> See Footnote 9.

discrepancy involving a possible mass in the cecum on a CT scan. Gastroenterology Service was notified to follow up on this patient.

7) On October 14, 2003, the Chief of Staff notified (B)(6) that his full clinical privileges were restored.

8) Additional probationary peer reviews were conducted as follows:

a. October 13 – November 13, 2003, 48 cases representing 10 percent of workload. Two minor discrepancies and no major discrepancies were identified.

b. December 2003, 83 cases representing approximately 7 percent of workload. No discrepancies were identified.

c. January 2004, 60 cases representing approximately 7 percent of workload. Two minor discrepancies and one major discrepancy were identified. (The major discrepancy was not determined to be Level 3).<sup>11</sup>

9) Probationary peer reviews were discontinued in January 2004 and additional monthly peer reviews were accomplished as part of the overall Radiology Department peer review program. Approximately 22 random cases representing each modality were selected by the Radiology Quality Manager for each radiologist per month and peer reviewed by another staff radiologist. Individual radiologists, on their own, would also bring alleged misreads by other radiologists to peer reviews. Although no records are available for this time period showing specific findings, several of the radiologists indicated that (B)(6) cases contained the most frequent discrepancies, while (B)(6) stated he found discrepancies in the cases of other radiologists. Additionally, witness interviews revealed that significant conflict began to develop among the radiologists regarding the quality of individual readings.

10) (B)(6) was granted additional privileges to perform image-guided percutaneous biopsies, aspirations, drainage procedures, and myelogram and percutaneous musculoskeletal procedures on January 28, 2005, and accepted on February 10, 2005.

11) In May 2005, a patient was found to have advanced colon cancer and later died. A previous barium enema was read by (B)(6) in 2003 as showing diverticulitis. The Radiology Chief reviewed the prior barium enema and identified an abnormality which was consistent with colon cancer. A subsequent tort claim was settled by the U.S. Attorney's Office. (The VA Office of Medical-Legal Affairs informed the team on June 20, 2013, that it has preliminarily determined that (B)(6) should be reported to the National Practitioners Data Bank as a result of the monetary settlement in this case).

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<sup>11</sup> Level 3 represents those cases in which most experienced, competent practitioners would have managed the case differently.

12) (B)(6) core radiology privileges were renewed on July 15, 2005, and accepted on July 26, 2005. (B)(6) who was acting Service Chief at the time, recommended that the privileges be approved.<sup>12</sup>

13) In December 2005, (B)(6) performed a myelogram during which a small amount of contrast media instilled into the patient's spinal cord. A medical review conducted by staff from the Department of Neurosurgery at a VA facility outside of VISN 16 found no evidence of negligence. The patient's administrative claim was denied and no suit filed.

14) On April 13, 2007, a draft VHA Directive defining policy for tracking imaging physician (i.e. radiologist or nuclear medicine physician) productivity was distributed to the radiologists at the Medical Center by the Chief of Staff.<sup>13</sup> The draft provided that each VHA imaging service practice will strive to achieve an average physician productivity per full-time equivalent radiologist of at least 5,000 work relative value units (wRVU). The draft also provided that there is no minimum or maximum productivity standard for individual imaging physicians so long as health care quality and access is not compromised. Loss of diagnostic accuracy and lack of availability for consultations were identified as indicators of excessive workload.

15) On April 20, 2007, three radiologists (B)(6) contacted the VA Office of Resolution Management alleging discrimination on the bases of sex (female), national origin (American), and reprisal for prior equal employment opportunity (EEO) activity based upon harassment and hostile work environment related to a variety of workplace issues including the manner in which radiology films were read. Formal EEO complaints were filed on May 30, 2007. A fourth radiologist (B)(6) stated that she would have joined the EEO complaint; however, health issues prevented her from participating.

16) During an internal peer review in May 2007, (B)(6) made a statement to the effect that he did not look at all images.

a. This issue was first raised externally by (B)(6) in an e-mail to (B)(6) dated August 22, 2007. Specifically, (B)(6) reported that (B)(6) stated he had not been looking at the axial images accompanying CT and MR angiographic studies. (B)(6) added that (B)(6) was describing those body parts in his reports even though he stated that he did not look at them.

b. During a subsequent administrative investigation conducted in December 2007, (B)(6) testified that (B)(6) comment occurred during a discussion of a "very large pontine infarct" (B)(6) had allegedly missed on a CT angiogram which

<sup>12</sup> During her witness interview, (B)(6) stated that although she had concerns regarding (B)(6) practice, she knew that the Service Chief for whom she was acting would recommend approval and that she was seated at a table with other clinical service chiefs and the Chief of Staff who were expecting her to sign recommending approval.

<sup>13</sup> The draft directive was subsequently implemented as VHA Directive 2008-009, "Productivity and Staffing Guidance for Imaging Physicians," dated February 7, 2008.

had about 200-300 slice studies. According to (B)(6) became very angry and stated that he did not have time to look at all those images, that all he looked at was the vascular part of it.

c. (B)(6) testified during the 2007 administrative investigation that he also heard (B)(6) comments and recalled that (B)(6) said something like he reads films with lots of frames and lots of images and does not have time to focus on every frame. (B)(6) stated that (B)(6) was focusing on the things for which the film was ordered, which, according to (B)(6) was consistent with the training he had received. (B)(6) confirmed that (B)(6) told him during the September 2007 site-review (discussed later in this report) that radiologists are responsible for everything that is on every film that is taken as part of a study.<sup>14</sup>

(B)(6) testified during the Federal EEO trial that in response to (B)(6) comments, he (B)(6) told the Radiology Chief to instruct (B)(6) to slow down and stop doing that.

d. (B)(6) who did not testify during the 2007 administrative board, told the review team during her interview that (B)(6) stated he did not have time to read all the images and that it was her impression that he was speaking of all vascular cases with source images. (B)(6) stated that, at the time (B)(6) made this statement, she recalled thinking that there are probably a lot of people in private practice who don't do that either.

e. (B)(6) explained during his interview with the Review Team that his specific statement was made in connection with one case involving a CT angiogram of the head and neck to look at the arteries supplying blood to the brain. According to (B)(6) he had looked at the routine CT head images recently and had appropriately noted the infarct. (B)(6) acknowledged that he stated during the peer review that he only read the angiogram part.<sup>15</sup> (B)(6) stated that his comments have been misrepresented in an effort to claim that he doesn't read soft tissues or other important things on any CT angiograms. (B)(6) did acknowledge that, with regard to CT angiograms, he reads reconstructed images (instead of source images) first because reconstructed images are easier to see. If an abnormality is identified on reconstructed data at a particular level, he stated that he then goes back to the source data on the same level and looks hard at the source data. (B)(6) stated that he was trained to read in that manner and he continues to do so.<sup>16</sup>

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<sup>14</sup> The Review Team conducted a follow-up call with (B)(6) to clarify the standard of care regarding viewing of images. During this call, (B)(6) stated that radiologists are responsible for the entire region, including adjacent structures, within the study. In this case, according to (B)(6) (B)(6) met the standard of care if he interpreted the infarct on the previous CT head even if it was not specifically identified on the subsequent angiogram.

<sup>15</sup> See Footnote 14.

<sup>16</sup> (B)(6) explanation to the Review Team in April 2013 was generally consistent with his sworn testimony during the EEO litigation.

17) VA's Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection on June 26-28, 2007, to determine the validity of allegations regarding radiology issues. The anonymous complainant alleged that a radiologist had extremely high misread rates causing life shortening and life threatening outcomes for patients.<sup>17</sup> The complainant further alleged that a new process for monitoring radiology productivity does not contain quality standards, but focuses on speed, leading to higher misread rates. The complainant also alleged that RVUs are now the basis for performance pay and that some radiologists are not spending enough time reading films or are not reviewing all images. The final OIG report was issued April 8, 2008. Findings and recommendations in the report are summarized as follows:

a. Higher misread rates: One misread attributed to (B)(6) and affecting patient outcome was identified. The medical center had already initiated a root cause analysis for that case.<sup>18</sup> OIG was also informed that the same radiologist missed a brain lesion on another patient because the person read too fast or did not read all images. OIG requested that the medical center immediately send this radiologist's cases for peer review outside the facility. Approximately 30 randomly selected cases read by (B)(6) were sent to (B)(6) Diagnostic and Therapeutic Care Line Executive, (B)(6) VA Medical Center, Houston, Texas, (results returned July 3, 2007). As a result of staff radiologists questioning the ability to obtain an objective review within VISN 16, OIG also asked that a random sample of all radiologists' cases be peer reviewed outside the VISN. Approximately 30 randomly selected cases for each radiologist, including the Radiology Chief, were sent to the University of South Alabama Medical College (results returned September 5, 2007).

b. (B)(6) noted that (B)(6) reports were complete and clinically pertinent with good content and an analytic approach to diagnosis. She indicated that (B)(6) was consistent about answering the specific clinical question posed and describing major findings. (B)(6) did note that (B)(6) did not reference a variety of minor findings and abnormalities and on occasion also neglected to describe findings of greater clinical relevance such as the presence of two kidney stones on one occasion and air in the prevertebral soft tissues on another occasion. (B)(6) concluded by stating that she suspected this radiologist is a well-trained and competent physician who has allowed himself to "get in a hurry" as he interprets imaging exams. She stressed that she did not find any instances where he missed a major finding or diagnosis.

c. The Chairman of the Radiology Department, at the University of South Alabama, reported that three faculty reviewed each of the cases submitted. With regard to (B)(6) the report identified three minor disagreements and concluded

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<sup>17</sup>(B)(6) indicated in an e-mail that she provided her list of (B)(6) misreads to OIG; however, OIG does not address these cases in its report.

<sup>18</sup> In his subsequent report, (B)(6) refers to this case as the "air contrast barium enema case." See paragraphs IV.b.11, and IV.b.18.

that, basically (B)(6) readings were very adequate. The complete results are provided below:

Physician	Minor Disagreements	Major Disagreements	Comments
1	0	0	"all cases in agreement"
2	1	0	"interpretations thorough and accurate"
(B)(6)	3	0	"basically, readings were very accurate"
4	0	0	"all in agreement"
5	6	1	"good correlations"
6	3	1	"basically, readings quite accurate"

d. The OIG report noted that the Radiology Chief concluded that the quality of work performed was good and he was pleased with the Department's clinical performance. The Neurology Chief was also interviewed by OIG and indicated that he was pleased with the quality and timeliness of radiology services. Ultimately, OIG did not substantiate that higher misread rates affected patient outcomes, but found that the current peer review process was ineffective. OIG recommended that until the atmosphere becomes more collegial and professional, another VA medical center should perform peer reviews.<sup>19</sup>

e. Radiology Productivity: The OIG report noted that the medical center had recently implemented pay for performance standards based on RVUs. OIG did not substantiate that this standard was excessive or contributed to higher misread rates. OIG asked the Medical Center Director to consider a consultative visit from the Chief Consultant, Diagnostic Services, (B)(6) because radiologists were confused about productivity requirements and workload distribution.<sup>20</sup>

f. Other Radiology Issues: OIG also reviewed a variety of miscellaneous administrative concerns (not relevant here).

18) On August 22, 2007, (B)(6) sent an e-mail to (B)(6) in which she stated that the new productivity directive had caused excessive read rates, "stealing" of cases from other radiologists, and a decrease in the quality of care. (See Paragraph 14 above). The e-mail was copied to the VHA Radiology Chiefs and VHA Radiology Chief Techs mail group, as well as (B)(6)

<sup>19</sup> In response to this recommendation, the Medical Center pursued an external peer review process with another VA medical center, but these efforts were unsuccessful due to the inability to resolve technical security issues. Alternative peer reviews conducted by locum tenens staff was established, and, additionally, a Mortality and Morbidity conference was implemented.

<sup>20</sup> (B)(6) Chief Consultant Diagnostic Services, VHA, conducted a site visit on September 11, 2007. The results of this site visit are provided in paragraph IV.b.19.

a. The 2.5 page e-mail stated that several radiologists were reading much more rapidly and signing onto high relative value cases to prevent others from dictating those exams. According to (B)(6) this practice resulted in plain films not being read. (B)(6) attributed this behavior to concerns about pay raises and promotions. (B)(6) stated that those who were reading at excessive rates were missing obvious abnormalities and not properly comparing prior exams, but nevertheless received larger pay raises. (B)(6) stated that no one was behaving in this manner until the possibility of more money entered the picture. (B)(6) also described the interpretation rate of some radiologists as impossible” She described one radiologist as reviewing 9,500 images in a 10 hour period, not including reviewing comparison studies, dictating and verifying the exams, answering the phone, and phoning results.

b. (B)(6) also stated that one of the radiologists admitted during a peer review session that he had not been looking at the axial images accompanying the CT and MR angiographic studies, but has been describing all those body parts in his reports. (B)(6) stated that cases with delays in care, life threatening outcomes, and those returning inoperable have increased. (B)(6) indicated that the Radiology Service Chief and Chief of Staff have denied that there are problems. (B)(6) stated that she believed administration was willing to compromise patient care to avoid hiring more radiologists.<sup>21</sup>

19) (B)(6) and (B)(6), conducted a site visit on September 11, 2007.<sup>22</sup> The four page report is dated September 20, 2007, and indicates that the purpose of the visit was to evaluate radiologist productivity in order to ascertain whether there was any validity to the claim that some radiologists were reading too few studies, while others were reading too many. (B)(6) also noted that a request was made for recommendations to improve collegiality and morale as it related to workload assignments.

a. Background: In his report, (B)(6) referenced the allegations that (B)(6) was reading studies too quickly and was making an unusually large number of errors. (B)(6) also referenced the peer review conducted at Houston and the conclusion that the reports were brief, did not mention incidental findings, but were without major errors. (B)(6) also identified the root cause analysis (RCA) underway to examine an air contrast barium enema that had been misinterpreted by (B)(6)

<sup>21</sup> Following (B)(6) e-mail, the Chief of Staff notified (B)(6) VISN 16 Chief Medical Officer, of the following actions: 1) awaiting completion of EEO investigation; 2) awaiting formal written findings from OIG visit; 3) had two meetings with radiology staff over time and attendance issues; 4) have made arrangements with outside group to review random films from each radiologist for quality; 5) are trying to arrange monthly film exchange with the Charlie Norwood VAMC for continuing peer review; and 6) have discussed with (B)(6) a visit to assess operational issues.

<sup>22</sup> (B)(6) is the Director, Office of Productivity, Efficiency, and Staffing.

b. Productivity: (B)(6) determined that the Department's overall productivity was 7,418 wRVUs and noted that the Radiology Service Chief and (B)(6) were reading significantly more studies than (B)(6) and (B)(6) even when taking types of studies into account. (B)(6) opined that the Radiology Service Chief's higher numbers could be explained by the fact that he is an interventional radiologist who reads extra cases beyond his tour of duty resulting in a greater than 1.0 full-time equivalent effort. (B)(6) stated that (B)(6) workload would not be unusual if he were putting in long hours. (B)(6) noted that the important factors were the time spent on a study, thoroughness of the examination, and the completeness of his dictation.<sup>23</sup>

c. Alleged Errors: (B)(6) report reflected that several radiologists stated that they had collected a large number of errors made by (B)(6) and that (B)(6) spent very little time reviewing studies. (B)(6) stated that it was not within the scope of the one-day visit to decide whether the alleged errors were representative of a statistically significant error pattern and no data was collected to support or refute the allegation that (B)(6) spent little time reviewing studies.<sup>24</sup> (B)(6) noted that he and (B)(6) were told that (B)(6) did not review source images when reading computed tomography angiography(CT), and that this caused him to miss a brain lesion. The report stated that it was the position of the American College of Radiology that radiologists should examine all parts of the anatomy when interpreting a study rather than limiting the interpretation to answering the clinical question, and that radiologists were expected to inspect extravascular structures. Given concerns raised regarding the accuracy of (B)(6) interpretations, as well as the external review that revealed that his dictations were incomplete, the report noted it would be prudent to counsel (B)(6) regarding the expectation that all organ systems are reviewed and reported.<sup>25</sup>

d. Recommendations: (B)(6) specific recommendations focused on staffing, operational management of the service, and quality oversight. There was no specific recommendation in connection with (B)(6) practice.

20) In November 2007, (B)(6) read an emergency abdominal CT in which he suspected a perforated duodenal ulcer. During the subsequent surgery, a leaking duodenal artery aneurysm was discovered which was determined to have been present, but not identified, on the CT. Additionally, the aneurysm was also present on an earlier

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<sup>23</sup> The report also notes that it would raise concerns if (B)(6) were able to read this many studies while working significantly less than 80 hours per week. (B)(6) clarified in an e-mail to the review team that the reference to working 80 hours per week was an error and was intended to state 80 hours per two week pay period.

<sup>24</sup> (B)(6) did indicate that the case involving the air contrast barium enema was inspected and the lesion was conspicuous and unequivocal.

<sup>25</sup> See Footnote 14.

CT read by a different radiologist a few days earlier. Disclosure was made to the patient, but no administrative tort claim or suit was filed.

21) On November 6, 2007, (B)(6) sent an e-mail to the Under Secretary for Health, (B)(6) in which she stated that from 2003 until the present, the Radiology Chief at the Medical Center had been made aware on multiple occasions of poor radiologic practices, including falsification of records, by a J1 visa physician (B)(6). She stated this has included an inordinate number of misreads with harm to patients including some returning inoperable. (B)(6) stated that the Chief of Staff has also been made aware of this for several years. She stated that the Radiology Chief and Chief of Staff have denied there is a problem, encouraged this practice, and protected this physician. She also stated that those who have reported this practice have endured a hostile response for many months. (B)(6) noted that extensive documentation was provided to OIG in February 2007 with a visit taking place in June 2007. (B)(6) also stated that (B)(6) was notified. She stated, according to the Chief of Staff, no formal reports or recommendations had been provided. Lastly, (B)(6) pointed out that the physician intended to leave VA by November 15, 2007, for private practice. She indicated that if VA did not act, it would be releasing this physician to practice in the private sector with full knowledge of his negligence.

22) On November 9, 2007, the facility submitted an Issue Brief (IB) to VA Central Office (VACO) through VISN 16 in response to (B)(6) e-mail. The IB covered the following areas:

a. Alleged poor radiologic practices: The facility acknowledged one current malpractice case pending for (B)(6). The facility indicated it had no authority to report this to the National Practitioner's Data Bank or State Licensing Board and that, if payment was made, the Office of Medical-Legal Affairs would make that determination. The IB also noted the two prior reviews of 30 random readings each. The facility summarized the findings of the first audit as "satisfactory with minor suggestions" and the results of the second audit as "there were 3 minor disagreements. Basically, (B)(6) readings were very adequate." The IB also indicated that the Radiology Chief had conducted multiple reviews of (B)(6) work and it was viewed as fully satisfactory.

b. Alleged Falsification of Records: The facility reported that it was unsure of the specific event to which this referred, but believed it might involve an addendum made to a computerized medical record. If more details could be determined, management stated it would review further.

c. Alleged Denial of Problem and Protection of Physician: The facility Director strongly disagreed with this allegation pointing to the previously referenced peer reviews and noting that the Chief of Staff had been very involved in the conflict between (B)(6) and (B)(6). The Director noted that management was treating (B)(6) fairly with regard for his rights as a bargaining unit member and minority employee.

d. Summary: The IB noted the obvious intense personal conflict between (B)(6) and (B)(6) and Management's belief that radiology quality was fully satisfactory. It also noted (B)(6) pending departure, which had been planned for many months. Lastly, the IB stated that Management would ensure VA Handbook 1100.17 regarding reporting of practitioners would be followed if the Office of Medical-Legal Affairs determined that (B)(6) should be reported.

23) (B)(6) resigned November 15, 2007. The same day the facility updated its IB to show that the Facility Director and Chief of Staff provided the recommendations from (B)(6) visit to all radiologists on November 14, 2007. The updated IB also stated that the Chief of Staff met privately with (B)(6) to explain the practitioner reporting process, review the status of the pending tort claim, and emphasize that two prior independent peer reviews indicated (B)(6) readings were satisfactory. The IB also indicated that, on November 14, 2007, the Chief of Staff requested that (B)(6) provide him all information concerning her allegations about (B)(6) (B)(6) informed the Chief of Staff that she would provide the information the following week. According to the IB, the Chief of Staff and Radiology Chief would both review the information and discuss with (B)(6) when it was provided. The IB noted that (B)(6) a board certified radiologist, was leaving VA to become a full-time faculty member at the (B)(6) with very high standards for faculty positions. The facility Director also noted his concern that (B)(6) would charge VA with harassment and/or discrimination should the facility not continue to handle this situation carefully and professionally.

24) On November 19, 2007, (B)(6) provided the Chief of Staff with handwritten notes concerning approximately 52 radiology cases from 2003-2007 she alleged demonstrated negligence by (B)(6). In her cover memo, (B)(6) stated that she had tried to alert him (Chief of Staff) in e-mails that there was a problem and on April 13, 2007, she stated that "four of us were in your office and we tried to tell you verbally. At that time I told you that we had numerous cases you could look at." With regard to CT and magnetic resonance MR angiography (B)(6) repeated an earlier concern that (B)(6) had acknowledged he did not look at those images because he didn't have time. (B)(6) indicated that (B)(6) reports describe all the parts that he (B)(6) admitted not viewing which she characterized as falsification of the radiographic report.

25) On November 21, 2007, the Radiology Chief informed the Chief of Staff and Director via e-mail that he spent ten hours thoroughly reviewing the cases presented by (B)(6). Other than the two cases of which the facility was already aware, the Radiology Chief stated that he did not find any cases in which the management of the patient would have changed. He stated that ten different radiologists could read most of the cases ten different ways and not make any changes in how these patients were managed. The Radiology Chief also identified a case in which he stated that (B)(6) and another radiologist he did not name, incorrectly identified a renal mass as malignant causing the patient to undergo a nephrectomy (kidney removal) instead of

suggesting possible benign mass.<sup>26</sup> The Radiology Chief also questioned (B)(6) concern for patient care by pointing out that she made the daily schedule, kept herself free, and called in for the morning. He also indicated that (B)(6) had almost no annual or sick leave.

26) On November 26, 2007, the Radiology Chief submitted a memo to the Director through the Chief of Staff in which he again confirmed that he had reviewed all original images and reports picked by (B)(6). He stated that his review showed that two cases (i.e. colon cancer and the case involving a wire broken during the insertion of a catheter) have been reviewed by Quality Management with full peer review reports. He also identified a chest x-ray showing a lung nodule, which in his opinion, was a difficult diagnosis unless one were aware of it. He repeated his position as previously provided in the November 21 e-mail that none of the remaining cases showed anything that would have changed the treatment plan and ten different radiologists would generate ten different reports. His memo did not include any reference to (B)(6) allegedly incorrect identification of a benign renal mass or her alleged lack of concern for patient care.

27) On November 30, 2007, the facility Director placed the Radiology Chief on administrative leave pending a review of leadership and management of Radiology Service. In an e-mail to the Network Director and the Network Chief Medical Officer, the facility Director provided several reasons for this action. He stated he did not think the radiology situation would be resolved with the current players remaining in place, nor did he feel the Radiology Chief could deal with the current challenges. He also acknowledged that he had reached a point where he was no longer sure of the Radiology Chief's objectivity.

28) On December 3, 2007, the facility Director appointed an administrative investigation board (AIB) to review alleged failures in quality oversight by the Radiology Chief of (B)(6) work. The Board consisted of (B)(6) Program Analyst at Jackson (Chair), (B)(6) Staff Radiologist, Little Rock, Arkansas VAMC (Member), and (B)(6) Associate Chief of Staff/Research at Jackson (Member). Two specific issues were presented: (a) In connection with a CT exam performed on November 1, 2007, by (B)(6) with addendum added by (B)(6) the Board was asked to determine correct procedure for recording addenda to radiology procedure reports and to identify deviations, and causative factors, in addenda dated November 2 and 8, 2007; (b) In connection with a focused professional practice evaluation of (B)(6) cases performed by the Radiology Chief, the Board was asked whether the assessments with pulled cases were consistent with Radiology standards of practice and whether the overall assessment was reasonable.<sup>27</sup>

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<sup>26</sup> During his EEO trial testimony, (B)(6) retracted any allegation of wrongdoing involving (B)(6).

<sup>27</sup> This issue related to whether the Radiology Chief fairly evaluated the list of (B)(6) alleged misread cases presented by (B)(6).

29) AIB submitted its report on December 7, 2007. The Board reached the following conclusions:

- a. Alleged failures in quality oversight by the Radiology Chief were not substantiated;
- b. The Radiology Chief followed the correct procedure for recording addenda on November 2, 2007, but did not properly sign and date the addendum on November 8.
- c. Neither (B)(6) report nor the Radiology Chief's addendum on November 8, 2007, in computerized patient record system matched the correct patient (patient misidentification). The Radiology Chief's addendum was also not properly signed and dated; however, there was no evidence the Radiology Chief minimized or tried to cover up (B)(6) missed readings.
- d. Radiology standards of practice cannot be assessed by evaluating a small number of cases that contain perceived errors.
- e. The AIB recommended development of a standard procedure for preparing addenda to radiology reports and expedited installation of the latest version of "Talk Tech" to reduce the chance of dictating the wrong study in a patient record. The AIB also recommended that a Radiology QA program to identify, track, and trend provider error rates be created. The AIB also stated in its recommendations:

*(B)(6) [sic] cases were a collection of perceived misses by the other Staff Radiologist. These cases of themselves do not provide any information regarding perceived error rate. However, given the continued concern by some of the local staff, the apparent internal departmental conflicts with issues of RVU's, speed of interpretation, and perceived preferential treatment, an outside review of a large sample size (2,000-3,000) of (B)(6) [sic] work may be warranted.*

30) On December 17, 2007, the Radiology Chief stepped down as Service Chief and remained on staff as an interventional radiologist pending his retirement the following year.

31) On January 31, 2008, the facility Director convened a special meeting of the Professional Standards Board (PSB) to obtain a recommendation concerning possible reporting of (B)(6) to the National Practitioner Data Bank and State Licensing Board. The PSB was provided the following specific question:

Do you believe that (B)(6) clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concerns for the safety of patients?<sup>28</sup>

a. The PSB reviewed the following documents:

- i. Peer review of 30 random cases conducted by Chief of Radiology, Houston VAMC;
- ii. Radiology Chief's (Jackson) comments regarding Houston's review;
- iii. Peer review of 30 random cases for each radiologist conducted by University of South Alabama Medical College Radiology Department;
- iv. Radiology Chief's (Jackson) comments regarding South Alabama review;
- v. Report from Chief Consultant, Diagnostic Services, VHA, VACO;
- vi. Handwritten list of alleged misreads provided by (B)(6)
- vii. Radiology Chief's (Jackson) comments regarding cases provided by (B)(6)
- viii. AIB appointment memo and report;
- ix. Chief of Staff's synopsis of (B)(6) major errors,<sup>29</sup>
- x. VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards, dated February 17, 2004; and
- xi. VHA Handbook 1100.19, Credentialing and Privileging, dated October 2, 2007.

b. PSB members included all clinical service chiefs except (B)(6) Acting Chief, Radiology Service, who was recused due to a potential conflict of interest.<sup>30</sup> The Quality Management Officer and the Chief, Chaplain Service, served as consultants.

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<sup>28</sup> The wording of the question presented to PSB is taken directly from VHA Handbook 1100.17, National Practitioner Data Bank Reports, dated March 21, 2002.

<sup>29</sup> The Chief of Staff's list consisted of a summary of the four cases previously discussed in this report. (See paragraphs IV.b.1; IV.b.11; IV.b.13; IV.b.20.)

<sup>30</sup> PSB members were (B)(6) Chief, Medical Service; (B)(6) Chief, Neurology Service; (B)(6) Chief, Radiation Therapy; (B)(6) Chief of Mental Health; (B)(6) Chief Surgical Service; (B)(6) Chief, Physical Medicine and Rehabilitation Service; (B)(6) Chief Anesthesia Service; and (B)(6) Chief, Pathology and Laboratory Medicine Service. (B)(6) Associate Chief of Staff for Education and Ethics, did not attend the first meeting.

c. The facility Director and Chief of Staff conducted an introductory meeting with PSB on January 31, 2008, in which PSB was "encouraged to interview radiology staff to determine any concerns they may have." Subsequently, the Director and the Chief of Staff excused themselves from the meeting. (B)(6) Neurology Chief, was selected by the members as the leader for this assignment. PSB was instructed to review the document file and a second meeting was scheduled.

d. The second PSB meeting was held on February 12, 2008. Meeting minutes reflect the following summary points:

- i. Houston peer review indicated that (B)(6) was well trained and competent;
- ii. Radiology Chief's second review confirmed Houston's findings;
- iii. South Alabama review indicated (B)(6) had fewer additional findings than three of the other radiologists;
- iv. Radiology Chief's second review confirmed South Alabama's findings;
- v. The Board was concerned that (B)(6) 45" reported cases were handpicked over 4.5 years, there was no similar review for other radiologists, errors were not confirmed by a third party and there was no denominator given;
- vi. The AIB did not substantiate that the Radiology Chief was biased in his review of (B)(6) cases; and
- vii. The radiologist assigned to the AIB reviewed half of the cases reported by (B)(6) agreed with the Radiology Chief's judgment, and felt a review of the other half of the cases was not necessary.

e. In light of this information, PSB unanimously agreed that there was a lack of quality evidence to conclude that (B)(6) clinical practice failed to meet generally accepted standards of clinical practice as to raise concerns about the safety of patients. PSB also unanimously agreed that the facility had performed a comprehensive review of (B)(6) work and no further review was indicated.

f. After PSB completed its review without interviewing anyone, the facility Director asked (B)(6) the elected PSB leader, to provide the radiologists with an opportunity to provide information. On February 14, 2008, (B)(6) sent an e-mail to the PSB members with the subject: "Special PSB revival". The e-mail stated in pertinent part:

*The director has asked me to allow the passionate believers an opportunity to voice their concerns to us. He feels that if we don't give them an opportunity to speak our process may be found inadequate by higher reviewing administrative*

authorities. He's also asked me to brief everyone before this meeting takes place.

g. Each staff radiologist was given the opportunity to address PSB with concerns or comments regarding (B)(6) work. PSB met again on February 22, 2008. (B)(6) and (B)(6) read from prepared written statements. Both identified the two incidents from 2003 described in Paragraphs IV.b.1 and IV.b.2 herein, described (B)(6) as reading and dictating too fast, and refusing to prepare addenda when mistakes are pointed out. Both also stated that (B)(6) admitted that he did not look at all images because he did not have time, yet his reports describe the organs and body parts he said he does not look at. (B)(6) also spoke. He described a high level of confidence in (B)(6) work based on four years of internal peer review prior to all the complaints being made. He said there was no indication that (B)(6) had more errors than other radiologists and that the recent reviews were not a fair comparison. PSB discussed the presentations and recognized the strong feelings on both sides. The Board concluded that the evidence did not support a finding that (B)(6) clinical practice failed to meet generally accepted standards of clinical practice as to raise concerns about the safety of patients. The minutes state that one member of PSB wished to hear from the newest radiologist to attempt to obtain an unbiased opinion.

h. PSB met for a fourth time on March 11, 2008. (B)(6) and the former Radiology Chief made presentations. (B)(6) indicated that (B)(6) read at an extremely fast rate and admitted that he did not have time to look at all the images. (B)(6) who had only worked with (B)(6) for two weeks, felt that (B)(6) read too fast, missed more abnormalities, and had more incomplete reports. He added, however, that he had not conducted a statistical analysis to evaluate misses with a proper denominator and that (B)(6) error rate compared with his workload may be consistent with other radiologists. The former Radiology Chief acknowledged a couple of major errors by (B)(6) but feels (B)(6) targeted him. He said (B)(6) only picked (B)(6) cases to criticize. The former Radiology Chief pointed out that (B)(6) had filed EEO and other complaints, but none had been substantiated. He stated (B)(6) was the lowest producer in the department and two of the other radiologists who expressed concerns have been unable to pass their boards. He stated that they refused to read cases with large numbers of images, but were critical of (B)(6) when he missed a lymph node in an angiogram with approximately 500 images.

i. Meeting minutes reflect that after discussing the recommendations, the PSB unanimously maintained its earlier position that no further review of (B)(6) cases was indicated.

32) On April 29, 2008, (B)(6) sent an e-mail to the Under Secretary for Health in which she repeated her concerns regarding (B)(6) work and also criticized the OIG review and special PSB review.

a. With regard to the OIG report, (B)(6) noted the following perceived deficiencies:

- OIG's conclusion that patient care was not compromised due to misuse of productivity system ignored extensive documentation;
- OIG's finding that only "1 misread affected patient outcome" is factually false;
- OIG made no reference to numerous cases and documentation related to the rate at which (B)(6) turned out essentially canned reports;
- OIG made no reference to falsification of medical records;
- OIG made no reference to (B)(6) admission in front of 10 witnesses including the Radiology Chief and Chief of Staff that he was not looking at all the images;
- OIG made no reference to the brief amount of time (4-5 hours per day) (B)(6) spent reading VA films between November 2006 and June 2007. According to (B)(6) the remaining time was spent interpreting neuroradiology MRI studies for the University Medical Center; and
- Previous peer reviews consisting of 30 studies were not statistically significant since (B)(6) reads 8000-9000 RVU per year.

b. With regard to the special PSB, (B)(6) noted the e-mail (B)(6), the PSB Lead, sent to all PSB members in which he referred to (B)(6) and other staff radiologists who reported (B)(6) as "passionate believers."<sup>31</sup> (B)(6) stated that the mocking and sarcastic e-mail revealed that (B)(6) mind was "poisoned" and that he probably "poisoned" some or all of the other PSB members.

c. (B)(6) also addressed erroneous assumptions she believed had been made regarding the motives of those who criticized (B)(6) work. She stated the criticism was not based on (B)(6) national origin because there were three other radiologists of the same national origin with whom there were no concerns. She stated the OIG's assessment that the criticism could be attributed to factions within the service was not true because concerns were raised months and years prior to divisions occurring in the service and prior to the initiation of any EEO activity. With regard to the perceived claim that some were purposely looking for (B)(6) mistakes, (B)(6) stated that the cases that were presented were all found randomly during the regular course of comparing current exams with previous exams and were found by multiple radiologists.

33) On May 5, 2008, a staff member for the USH notified (B)(6) that her (B)(6) e-mail dated April 29, 2008, was being provided to OIG to determine whether the allegations would be re-reviewed based on new information. On May 6, 2008, (B)(6) acknowledged the referral and described another patient who had recently presented with a metastatic renal mass that, she alleged, was missed by (B)(6) in January 2005.

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<sup>31</sup> See paragraph IV.b.31f.

34) On June 6, 2008, (B)(6) was notified that OIG had reviewed (B)(6) earlier e-mail from April 29, 2008, and would not be re-opening the review of radiology issues at the Medical Center. Later the same day, (B)(6) responded that this was unacceptable and again summarized her concerns about local management's failure to act despite repeated requests.

35) On July 21, 2008, the Chief of Staff issued (B)(6) written instructions to direct patient care concerns through her supervisory chain, the VA Office of Inspector General, National Patient Safety Office, or the VA Office of Medical Inspector. The memo pointed out that (B)(6) efforts to correspond directly with the USH resulted in additional work and interfered with the timely resolution of patient care concerns.

36) In August 2010, a Federal jury returned a verdict in favor of (B)(6) and (B)(6) on their discrimination claims against VA and awarded damages totaling \$183,781. The jury also found for the plaintiffs on their hostile work environment claims and in favor of (B)(6) on her retaliation claim.

a. During the course of the trial, there was a significant amount of testimony related to (B)(6) alleged excessive read rate. As an example that (B)(6) was reading too rapidly, (B)(6) specifically referred to a dictation log and testified that on one occasion (B)(6) dictated a CT of the head, an MRI of the lumbar spine, an MRI of the cervical spine, and a plain film of the abdomen in approximately two minutes.<sup>32</sup> (Using VistaRad data, the Review Team found that (B)(6) had an open viewing monitor for these cases as follows: CT of the head – 9 minutes; MRI of the lumbar spine – 20 minutes; MRI of the cervical spine – 16 minutes; and plain film of the abdomen – 1 minute. Consequently, although dictation of the reports took about two minutes, it appears considerably more time was taken to review the studies.)

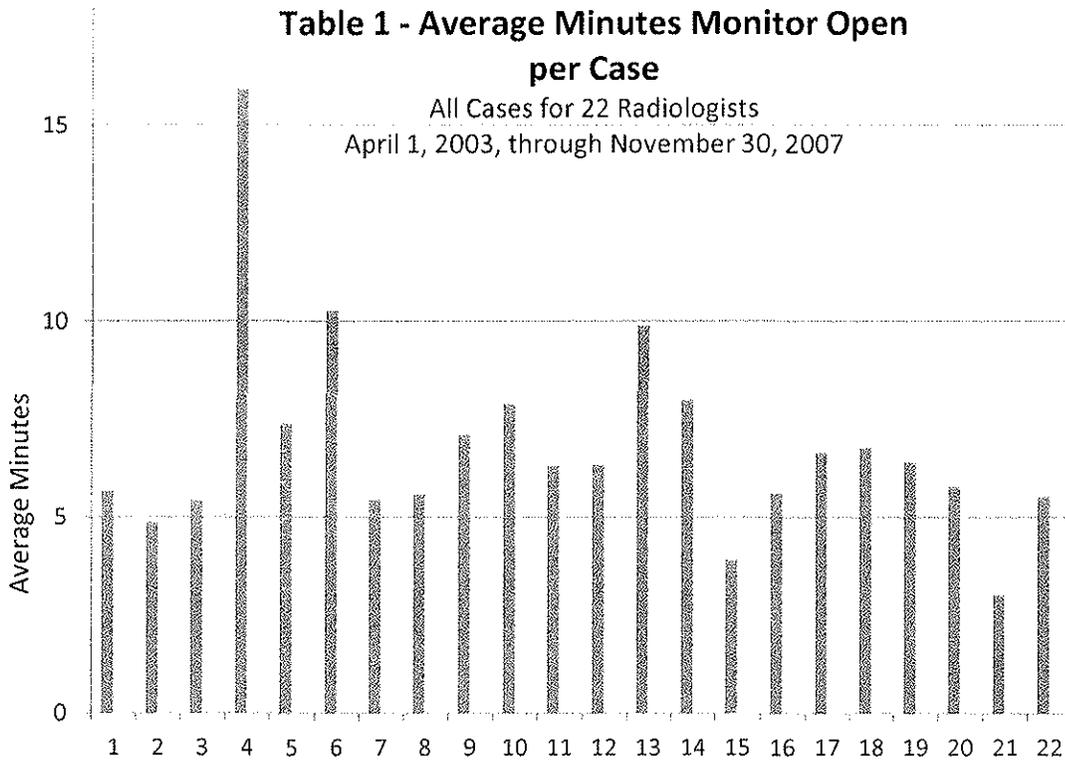
b. There was also testimony concerning an alleged admission by (B)(6) that he didn't look at all images. (B)(6) acknowledged that he made a similar statement, but explained that he was only referring to an earlier study he had already reviewed either earlier that day or the previous day and thus did not require that he review all the images a second time. The Chief of Staff acknowledged during his trial testimony that he heard (B)(6) say that he did not review all images because he (B)(6) did not have time.

37) On June 20, 2013, VHA Office of Medical-Legal Affairs informed the fact finding team that it has preliminarily determined that (B)(6) should be reported to the National Practitioner's Data Bank as a result of the monetary settlement arising from the missed colon lesion case. (See paragraph IV.b.11.)

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<sup>32</sup> See (B)(6) testimony in Trial Volume V, page 434. Note: (B)(6) testified this event occurred on April 8, 2007; however, April 8, 2007, was a Sunday. (B)(6) did not have an open viewing monitor on that day. Using VistaRad data and available accession numbers, the Review Team determined that these cases were dictated on August 9, 2007, between 9:25 and 9:27.

38) Tables 1-8 below reflect the average minutes each radiologist had an “open monitor” for all cases (including different modalities) for the period April 1, 2003 – November 30, 2007. <sup>33</sup> (B)(6) is identified as “Radiologist 7” on each table.) The Review Team recognizes the “minutes” value only represents the time when a specific exam (w/images) was opened on the provider’s workstation monitor until the exam was marked as interpreted and may not reflect the precise time the radiologist was reviewing images; however, for comparison purposes, this is believed to provide the best correlation to actual time spent interpreting cases.



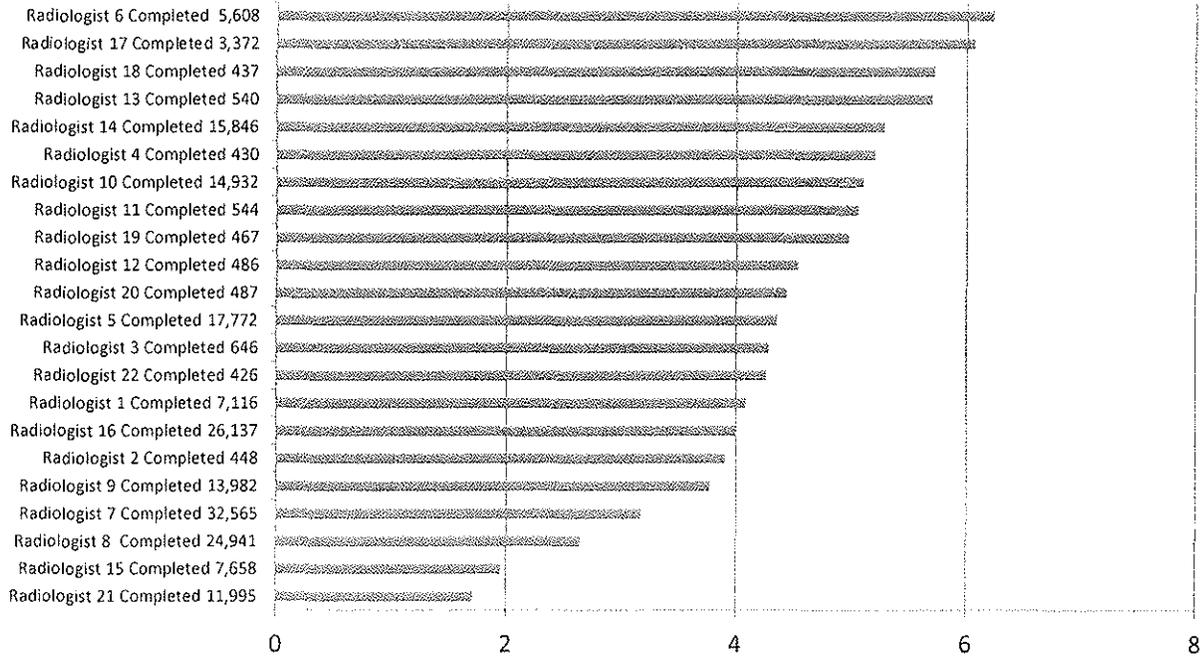
<sup>33</sup> A total of 265,295 records interpreted by 22 different radiologists were included in the analysis. Radiologists interpreting fewer than 500 cases during the date range were excluded.

**Table 2 - Computed Radiography  
(Plain Films)**

April 1, 2003, through November 30, 2007

Total of 186,835 Records

Average Minutes Computer Monitor Open

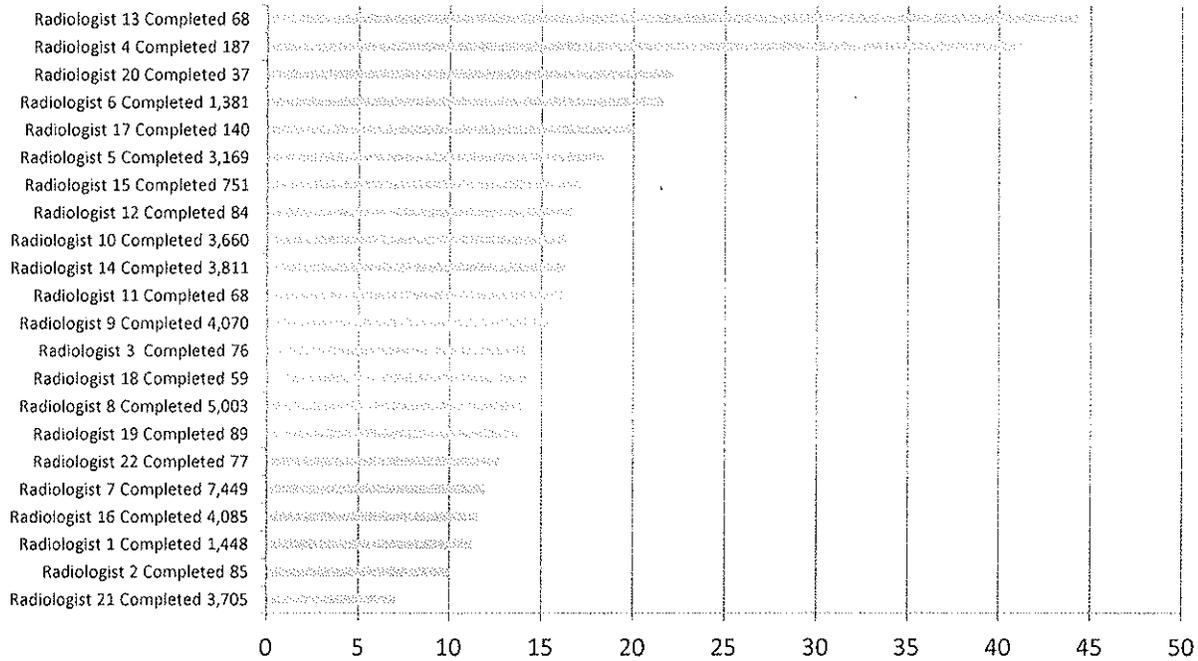


### Table 3 - Computerized Tomography

April 1, 2003, through November 30, 2007

Total of 39,502 Records

Average Minutes Computer Monitor Open

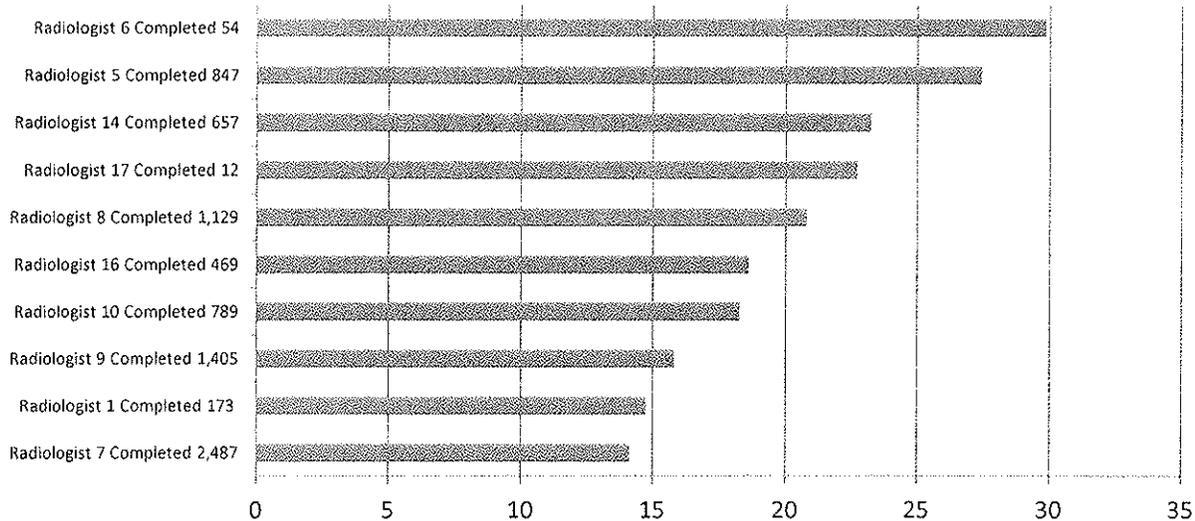


### Table 4 - Magnetic Resonance Imaging

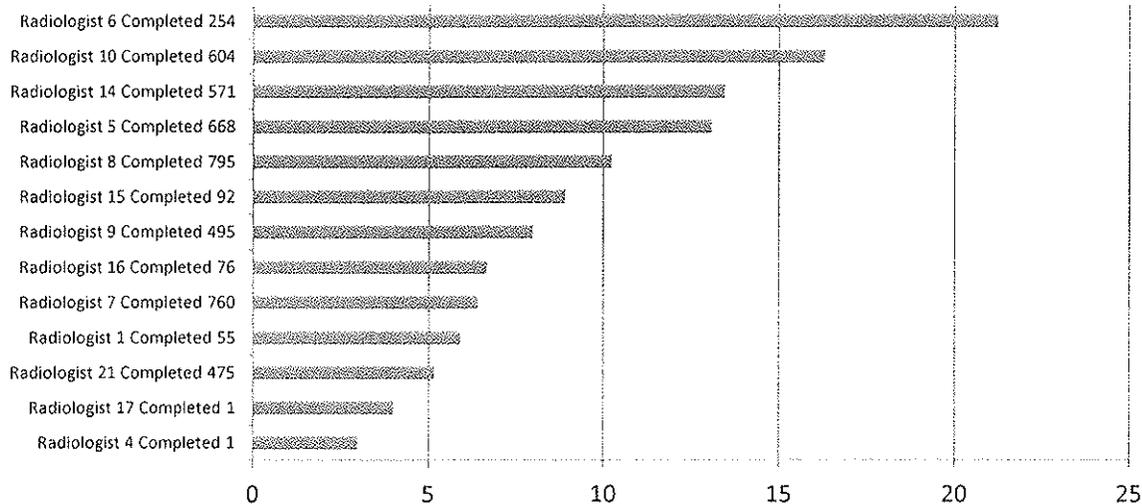
April 1, 2003, through November 30, 2007

Total of 8,022 Records were Interpreted by 10 Radiologists

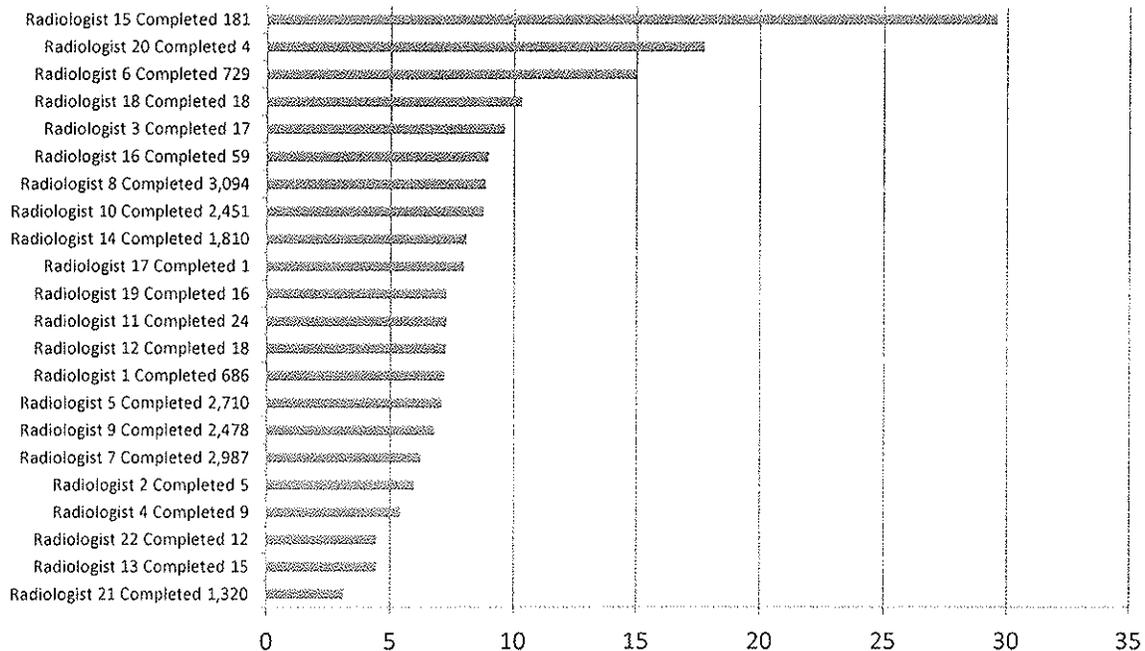
Average Minutes Computer Monitor Open



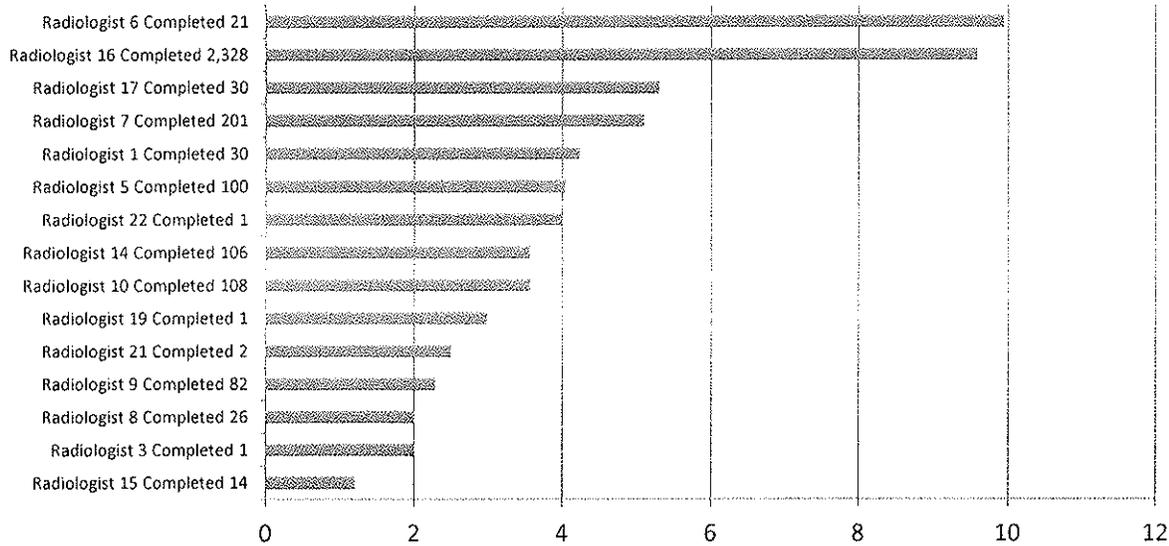
**Table 5 - Fluoroscopy**  
 April 1, 2003, through November 30, 2007  
 Total of 4,847 Records  
 Average Minutes Computer Monitor Open



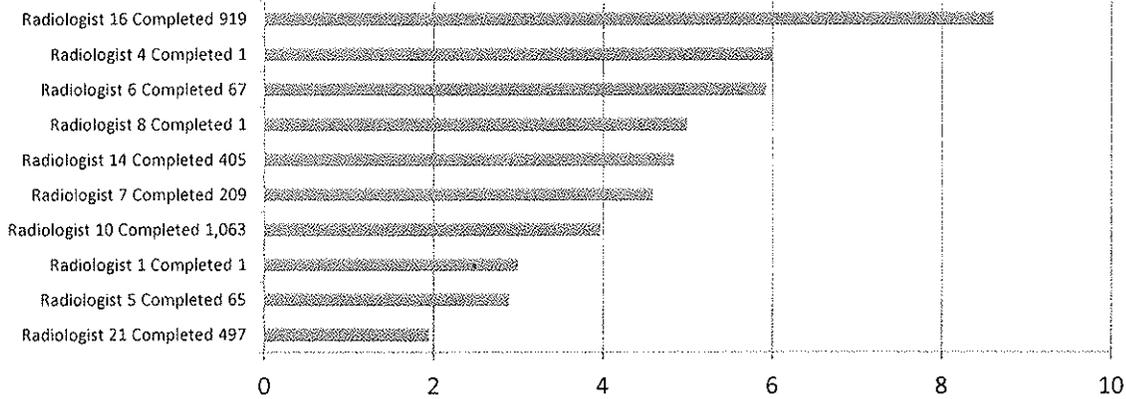
**Table 6 - Ultrasound**  
 April 1, 2003, through November 30, 2007  
 Total of 18,632 Records  
 Average Minutes Computer Monitor Open



**Table 7 - Angiography**  
 April 1, 2003, through November 30, 2007  
 Total of 3,051 Records  
 Average Minutes Computer Monitor Open

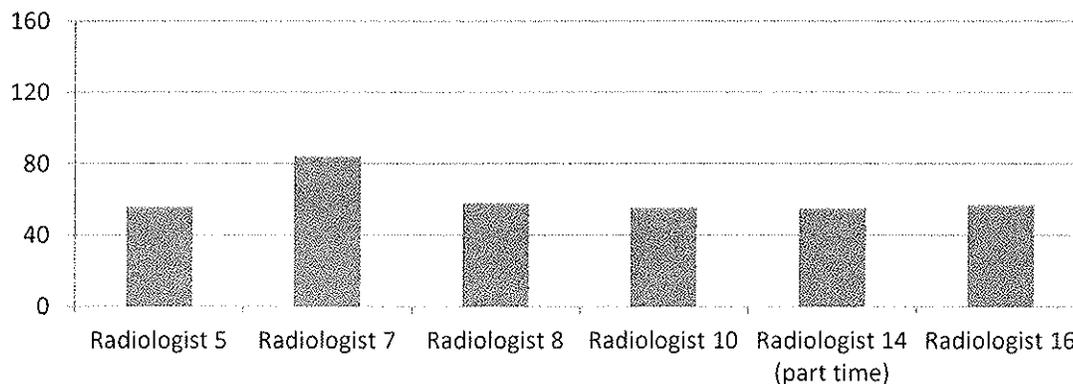


**Table 8 - Other**  
 April 1, 2003, through November 30, 2007  
 Total of 3,225 Records were Interpreted by 10 Radiologists  
 Average Minutes Computer Monitor Open



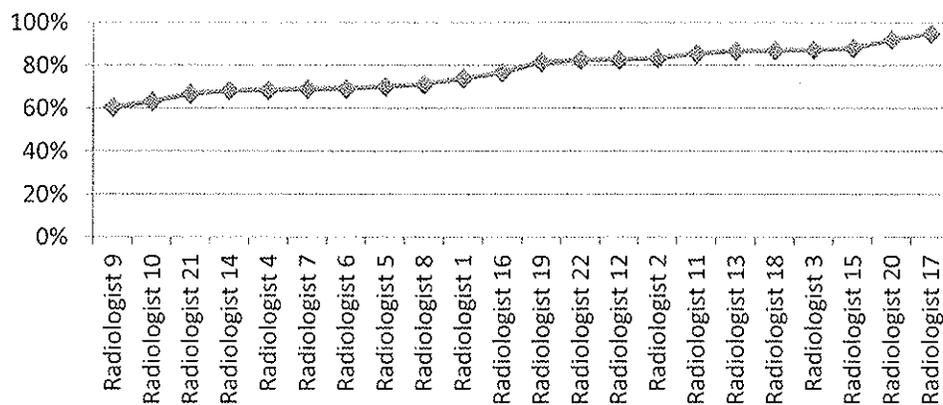
39) Table 9 reflects the average number of hours per month that (B)(6) and selected colleagues had an "open" monitor. The Review Team recognizes this data does not confirm that individual radiologists were actually viewing images during the entire period the monitor was open, but for comparison purposes, this is believed to be a useful indicator of actual time spent interpreting cases. This data does not incorporate leave or administrative time.

**Table 9 - Average Hours/per Month Monitor Open  
for Selected Radiologists  
April 1, 2003, through November 30, 2007**



40) Table 10 reflects the percentage of “plain films” (computerized radiography) each radiologist read (as part of total cases interpreted).

**Table 10- Percentage of His/Her Total Cases  
were Computerized Radiography  
(Plain Films)  
Data April 2, 2003, through November 30, 2007**



41) Fifty-eight cases identified by (B)(6) as containing errors by (B)(6) were presented to Lumetra Healthcare Solutions to conduct a radiology peer review of the original interpretations. Lumetra provided the following results.<sup>34</sup>

<sup>34</sup> The original list compiled by (B)(6) included 52 cases. One case was removed by (B)(6) and three additional cases were subsequently added. Four patients had two cases listed.

- 27 cases (46%) were considered Level 1 - Most experienced, competent practitioners would have managed the case in a similar manner.
- 12 cases (21%) were considered Level 2 - Most experienced, competent practitioners might have managed the case differently.
- 19 cases (33%) were considered Level 3 - Most experienced, competent practitioners would have managed the case differently.

42) Lumetra was also asked to provide a review by internal medicine specialists to determine the clinical significance, if any, for cases identified as Level 2 or Level 3. Thirty-one cases were reviewed for this purpose, and 8 cases were found to be of concern (4 of moderate concern and 4 of high concern).

## Conclusions and Recommendations

**a. Allegation #1:** (B)(6) regularly marked patients' radiology images as "read" when, in fact, he failed to fully or properly review the images, and at times, failed to read them at all.

This allegation is based upon the perception that (B)(6) was reading images at a rate faster than could be expected to result in proper diagnoses and, further, that (B)(6) made a statement during a peer review discussion which was interpreted by others as acknowledging that he did not look at all images.

### Conclusion:

This allegation is not sustained. Various datasets reviewed during the course of this investigation do not support that (B)(6) read faster than was appropriate.<sup>35</sup> Although the subjective appearance of concerning behavior is appropriate to investigate, since overly rapid work can result in patient harm, the allegation that (B)(6) read too fast is not supported by VistaRad data. There was also testimony during the EEO trial that (B)(6) was reading only higher RVU images to the exclusion of reading plain films. Likewise, this is not supported by the data. In fact, (B)(6) percentage of plain films read (as part of total cases interpreted) was consistent with his colleagues. (B)(6) was not outside his peer group in any of the types of films considered or in his total time reviewing films. Further, there is additional objective data confirming that (B)(6) viewing station was open approximately 26 hours per month more, on average, than other radiologists providing him with a greater window for interpreting more cases than his peers.<sup>36</sup>

<sup>35</sup> See Tables 1-8, paragraph IV.b.38.

<sup>36</sup> See Table 9, paragraph IV.b.39.

There was an allegation that (B)(6) stated he did not have the time to look at all images. The team found that this statement was made during a peer review session when (B)(6) was explaining that he did not reference an infarct while viewing a CT angiogram because he had already identified the infarct on a preceding recent study. Based on the evidence of record, (B)(6) met the standard of care because he interpreted the infarct on the previous CT of the head, even if it was not specifically identified on the subsequent angiogram. Simply put, the infarct was a known finding before the angiogram study was conducted and he felt there was no need to repeat that information.

**Recommendation:** None. (B)(6) is no longer employed by VA.

**b. Allegation #2: The failure to properly read these images, or at times, to read them at all, led to numerous missed diagnoses of serious, and in some cases, fatal conditions including inoperable cancers, neck fractures, and enlarged lymph nodes.**

**Conclusion:** This allegation could not be sustained. Additional reviews are recommended as described more specifically in the "Recommendations" below.

Based on the results of prior random peer reviews of (B)(6) work, his performance can be viewed as follows:

Out of 321 randomly chosen cases with a mention of both minor and major findings, (B)(6) had two major discrepancies (2/321) representing a 0.623 percent discrepancy rate.<sup>37</sup> When ten minor findings are considered (12/321), his total discrepancy rate for these 321 randomly selected cases is 3.7 percent. This is within the generally accepted 3-5 percent error rate noted in the literature for radiologists.<sup>38</sup> (Both (B)(6) and (B)(6) indicated that the 3-5 percent error rate applies to major significant misses and the accepted rate for minor issues is likely higher). Additionally, another peer review of an additional 30 random cases in which specific numbered discrepancies were not identified, noted that no major findings or diagnoses were missed.

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<sup>37</sup> See paragraphs IV.b.6-8 and IV.b.17.

<sup>38</sup> Pinto, A.; Brunese, L.; Pinto, F.; Reali, R.; Daniele, S.; Romano, L. *Semin Ultrasound CT MR. RadiolClinMed*, 2012 Aug;33(4):275-9. doi: 10.1053/j.sult.2012.01.009, *The concept of error and malpractice in radiology*. "In radiology, the first step is to become aware of the errors and adverse events that may occur during diagnostic activity: in daily practice, around 3%–5% of radiological interpretations contain errors, but risks and possible adverse events may be identified at all levels of a radiological process. The many literature reviews on the main causes of errors describe risks related to problems of technique perception, knowledge, evaluation and judgment, communication and interventional radiology procedures" [Pinto et. al, at p7, 18–27].

Specific to the 58 cases identified by (B)(6) as being incorrectly read by (B)(6) the Lumetra external peer review found that 27 (46 percent) had no concerns (Level 1). Twelve cases (21 percent) were possibly of concern (Level 2) and 19 cases (33 percent) had verified findings of concern (Level 3). Of the 31 cases described as Level 2 or 3, eight were identified as having moderate or high impact to patients.

While these numbers may appear to represent a high discrepancy rate, it is important to consider that this subset of studies was not randomly chosen for review but was specifically presented as having been incorrectly interpreted by (B)(6) resulting in harm to patients. However, the Lumetra review found that this collection of films, which have all been presented as having been read incorrectly by (B)(6) had a definitive incorrect rate of 33 percent, a possible miss rate of 21 percent, and a correctly read rate of 46 percent. This point is made because if a radiologist miss findings on a radiology test this can cause delays in diagnosis and harm to patients. However, seeing things on radiology tests that are not present can cause over diagnosis, additional testing, and also can cause harm to patients.

The genesis of these 58 cases becomes important to understanding whether (B)(6) had a disproportionately high error rate. The 58 cases are not a random sample of cases taken from (B)(6) total body of work. They are a collection of specific cases that one of his peers believes represent errors. If all Level 2 and 3 cases are considered, 31 (54 percent) cases were not correctly read. Based on the Lumetra review, this may have resulted in eight cases of patient harm (all Level 2 and 3 radiology cases were sent for external review and of the 31 total potential misreads, eight were determined to have moderate or high impact to patients). The difficulty is determining the denominator of total cases this represents. In other words, (B)(6) read tens of thousands of radiology tests during his tenure, and it is unknown what percentage the 58 cases (of which only 31 were actually verified as having been misread) represents. However, we know that (B)(6) alleged misread cases were being collected and saved when they were found. This additional peer scrutiny allows for the opportunity to find errors that otherwise may not have been identified and can be used to determine if patients were harmed. However, it does not allow comparison to others in (B)(6) peer group to determine if his error rate was disproportionately high.

The appropriate number of films to randomly peer review amongst radiologist per year has not been determined.<sup>39</sup> (B)(6) misread rate of randomly selected films that was done several times over the course of his time with the VA is well within the range suggested by existing radiology medical literature. (B)(6) rate of reads was not

<sup>39</sup> A few years ago (B)(6) indicated that 30 cases were felt to be an adequate number for annual peer review. (B)(6) stated that currently he considers 60 cases annually to be a better representation of a practitioner's performance. The investigation team confirmed that no clear standard exists either in the medical literature or within generally accepted standards of medical practice that definitively defines the specific number of subject cases/studies or the workload percentage to be used when conducting a quality assurance activity/peer review. Ultimately, clinical managers, acting within their discretion, must exercise judgment in determining the number or percentage. They must then consider the results of the peer review, together with all relevant factors, to determine if an individual radiologist's acceptable error rate exceeds the generally accepted standard of 3-5 percent.

outside the norm of his peer group based on the existing data despite perceptions to the contrary. This type of data was not previously reviewed to help separate people's perceptions of performance from actual performance based upon analysis of existing data.

Additionally, the Review Team concludes that the local radiology peer review process was broken during the relevant time period and the monitoring of competency for all providers was ineffective.

### **Recommendations:**

The facility should review all eight cases identified by Lumetra as having moderate to high assessed impact, including all relevant medical records and appropriate subspecialty consultation, to determine the degree of harm, if any, and to conduct appropriate disclosures to patients and/or their families in accordance with VHA policy concerning institutional disclosure.

(B)(6) VHA Chief Consultant Diagnostic Services, should identify an appropriate number of (B)(6) studies drawn from the period July 2003 – November 2007 so that an external peer review can be conducted for these cases. The facility, in consultation with (B)(6) should determine any further action required if the discrepancy rate is outside the expected baseline.

### **c. Allegation #3: Medical records were falsified to cover-up the treatment and diagnostic errors.**

**Conclusion:** This allegation is not sustained. In one occurrence, shortly after his arrival (B)(6) was alleged to have misstated the sequence of events in which a guide wire was broken during an angiogram and also to have failed to identify the event as a specific complication. In a second occurrence, a few days later, (B)(6) deleted a previously dictated report and substituted a different finding rather than completing an addendum to describe the subsequent finding. There is no evidence that in either of these instances (B)(6) intentionally falsified medical records for the purpose of covering up treatment and diagnostic errors. In the first instance, the issues involving the guide wire were described in the record, and disclosed to the patient, but not specifically listed as a complication. In the second instance, it appears that the service's policy regarding the preparation of addendums was not clear and (B)(6) was instructed to prepare addendums for similar future situations.

(B)(6) has also alleged that (B)(6) was describing body parts for images he did not read. This relates to his statement to the effect that he didn't review all images. The Review Team did not substantiate that (B)(6) engaged in this practice. The context in which this statement was made is described in Conclusion A (Allegation 1) above.

**d. Allegation #4: Management was aware of this malfeasance but never required that the images be re-reviewed or took steps to remedy this problem, and instead acted to protect the radiologist at fault.**

**Conclusion:** This allegation is not sustained. Throughout 2003-2007, Management undertook a variety of measures in response to concerns regarding the alleged poor quality of (B)(6) work. There is no evidence Management intentionally acted to protect him at the risk of patient care. However, it is clear Management was ineffective in resolving the underlying conflict and hostility, including those administrative areas in which Management was found to have engaged in discriminatory actions. Nevertheless, the Review Team also concludes that the facility should have obtained a thorough external review of all 52 cases reported by (B)(6) in 2007. If the results of that review raised concerns, an additional review of a significantly larger sample size, as described by the administrative board, should have been conducted.

Upon identifying two confirmed errors shortly after (B)(6) arrived, about 291 cases read by (B)(6) were reviewed during a 5-month period. Eight minor discrepancies and two major discrepancies were identified, but no significant concerns regarding (B)(6) competence were noted.

Conflict, however, clearly began to develop as (B)(6) and others reported their perceptions that (B)(6) was reading too rapidly and had high numbers of misreads. The conflict quickly escalated when the RVU productivity system was implemented in 2007. (B)(6) and other radiologists felt (B)(6) was deliberately selecting high RVU cases to the exclusion of older, lower value cases and reading them too fast. Management was obviously ineffective in resolving this underlying conflict and hostility continued to increase.

Thirty of (B)(6) cases were peer reviewed at the Houston VAMC and shortly thereafter 30 additional cases for each radiologist were peer reviewed at the University of South Alabama Medical College. Although neither peer review identified major discrepancies, the VA peer reviewer did note that (B)(6) appeared to have allowed himself to get in a hurry, which was consistent with (B)(6) claims.

Subsequently, (B)(6) presented a list of approximately 52 alleged misses by (B)(6) some of which she claimed resulted in inoperable cancer diagnoses. The Radiology Chief determined that only two of these cases constituted major discrepancies and these two cases had already been identified. A subsequent partial review of the cases by an administrative board seemed to confirm the Radiology Chief's findings; however, the board did note that radiology standards of practice cannot be determined by reviewing a small number of cases that contain perceived errors. Additionally, the board recognized the deep-seated and ongoing departmental conflict and indicated that an external review of 2,000-3,000 cases should be considered.

A PSB was convened and determined that additional case review was not warranted. There is an appearance, however, that the PSB leader had a preconceived bias based

upon his earlier support for (B)(6) and a reference to (B)(6) and others as “passionate believers” prior to hearing their statements.

**e. Allegation #5: The agency failed to notify the large number of patients who were potentially affected by this lapse in clinical care.**

**Conclusion:** This allegation is not sustained.

It is alleged that the facility violated VHA Directive 2008-002 (January 18, 2008) by not performing a large-scale disclosure to patients whose films/studies were read by (B)(6) and informing those patients of possible errors in the interpretations of their studies. This allegation is based on an assumption that all 52 cases identified by (B)(6) involved erroneous interpretations and also that such pattern of erroneous readings can be extrapolated to all of his readings during his VA tenure. Plus, there is an assumption that his pattern of erroneous readings, and hence the risk to patient harm, is greater than the three cases of record in which institutional disclosures were made by the facility. We underscore that not all perceived errors or differences in opinion among radiologists signify error, and also that even where there is a finding of unequivocal error, that alone does not mean the error has clinical significance. Each case must be assessed in terms of all its relevant clinical facts.

Three disclosures were made (consistent with VHA policy requirements) for patients who were identified by the facility as having possible errors in the interpretations of their studies. Only one of these three cases resulted in litigation, and it was ultimately settled by the Government.<sup>40</sup> The Office of Medical-Legal Affairs informed the Review Team that it has preliminarily determined that (B)(6) should be reported to the National Practitioner’s Data Bank. The statute of limitations would now bar any actions (in tort) being filed by the Veterans or their families in the other two cases. We understand that currently there are no active or pending Federal tort claims involving (B)(6).

It is unclear from the record whether a fourth case involving a possible misreading by (B)(6) that was referred to the gastrointestinal service for consult and follow up (discussed in the above time-line) was ever assessed by the facility in terms of any need to perform an institutional disclosure. We are also unable to determine whether this case was included in any of the external reviews performed.

**Recommendation:** Since the Lumetra review has identified eight additional cases of concern, disclosure is recommended in accordance with the earlier discussion for Allegation 2 above.

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<sup>40</sup> One of the other two remaining cases resulted in the filing of an administrative claim by the Veteran pursuant to 38 U.S.C. 1151, but the denial of that claim was never appealed.

## **Additional Concerns/Related Matters<sup>41</sup>**

### **4a. Improper Pay Structure**

It is alleged that the use of RVUs in association with the current performance and compensation structure is at the root of the problems in the radiology service and that such structure contributes to unsafe patient safety practices and abuses by those trying to take advantage of financial and performance related incentives inherent in such a system.

#### **Findings:**

As stated in VHA Directive 2008-009, Productivity and Staffing Guidance for Imaging Physicians (February 7, 2008), the Deputy Under Secretary for Health tasked a VHA Advisory Group in January 2003 with developing productivity models for physicians in VHA in an effort to meet the following goals: (1) Evaluate the relative productivity of full-time and part-time VA physicians in comparison with external benchmarks (as that term is defined in the policy); (2) Improve the management of providers and better understand how resources become services in outpatient care; (3) Demonstrate how Veteran perceptions and needs are related to physician and other support staffing; (4) Develop incentives to improve the delivery of care by clinical providers; and (5) Develop a prototype infrastructure for conducting physician productivity and staffing studies in other specialties. The policy explains that to meet these goals, the Advisory Group developed a RVU-based model for measuring productivity of specialty providers and providing staffing guidance for specialty services. For purposes of physician productivity measurement, only the physician work component of the RVU value is utilized, and is referred to as wRVU. The policy notes that this is consistent with external benchmark data. The policy does not establish a minimum or maximum productivity standard for individual imaging physicians. It does require that health care quality and access not be compromised by its use and, to that end, identifies loss of diagnostic accuracy and lack of availability for consultations as indicators of excessive workload.

#### **Conclusion:**

VA's use of RVUs to measure the productivity and workload of physicians is appropriate and indeed a standard tool in the health care industry, particularly by the Centers of Medicare and Medicaid. See the discussion in the above-subject policy. While RVUs are primarily designed for reimbursement purposes, they have been widely employed to measure workload as well. Also, while VA physicians' basic salary rates are generally set by law (and performance and contributions awards permitted but only within Departmental parameters), RVUs are nonetheless needed to determine, among other things, their productivity, service-line staffing requirements, and to set appropriate compensation rates for contract-physicians. In short, VHA's use of RVUs is consistent

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<sup>41</sup> These allegations were contained within the OSC referral memo, but were not identified as primary allegations.

with external benchmarks and industry practice. We are aware of no evidence that such use within VHA creates a unique perverse incentive for physicians or inherently undermines their professionalism.

#### **4b. Leadership Issues**

##### **Findings:**

Significant interpersonal conflict among radiologists, divided by national origin and gender, undermined the objectivity and reliability of the facility's local peer review process, often resulting in mutual accusations. Subsequent rifts developed regarding salary, performance bonuses, processes for film selection, leave usage, and other administrative matters. The Radiology Chief failed to effectively address these issues, and was perceived to strongly favor male physicians of Indian origin, causing existing deep-seated feelings to further intensify. (This perception was later validated by the adverse jury verdict rendered against VA during the discrimination litigation.) In retrospect, these challenges, though difficult, also required earlier, and more focused, intervention by senior leadership to identify and effectively resolve these issues.

Changes in leadership at the facility and in the service, along with the departure of (B)(6) appear to have reduced or eliminated these conflicts, and we note that none of the witnesses reported continuation of these problems during the site-visit. The radiologist peer review process remains in-house, and it has been improved, particularly in terms of efficiency and related reporting mechanisms. Over 1,000 cases a month are reviewed, and these reviews are documented. Each month an anonymous peer session is held and attended by all radiologists. Results of the peer review are shared with the provider whose case is the subject of the monthly peer review and, if appropriate, follow-up action is taken.

##### **Conclusion:**

The facility has taken steps to ensure the radiology peer review process operates appropriately and as intended by VA policy.

##### **Recommendation**

None.

#### **V. A Listing of Any Violation or Apparent Violation of Any Law, Rule, or Regulation**

As described in the discussion and conclusion for Allegation 2 herein, the facility did not maintain a credible or reliable peer review process within Radiology Service during the relevant time period in violation of VHA policy.

## VI. Description of Any Actions to be Taken as a Result of the Investigation

a. The facility should review all eight cases identified by Lumetra as having moderate to high assessed impact, including all relevant medical records and obtain appropriate subspecialty consultation, to determine the degree of harm, if any, and to conduct appropriate disclosures to patients and/or their families in accordance with VHA policy concerning institutional disclosure.

b. (B)(6) VHA Chief Consultant Diagnostic Services, should identify an appropriate number of (B)(6) studies drawn from the period July 2003 – November 2007 so that an external peer review can be conducted for these cases. The facility, in consultation with (B)(6) should determine any further action required if the discrepancy rate is outside the expected baseline.

**ATTACHMENT A**

**Document Index  
Fact-Finding Inquiry  
Office of Special Counsel File No. DI-13-1713  
G. V. (Sonny) Montgomery VA Medical Center**

**Site Visit April 15-19, 2013**

<b>Number</b>	<b>Description</b>	<b>Source</b>
1	OSC Referral Memo dated March 5, 2013.	Office of Special Counsel
2	Fact-Finding Appointment Memo dated March 27, 2013.	VHA Deputy Under Secretary for Health for Operations and Management
3a	Privilege Time Line.	Former Facility Quality Management Officer
3b	Initial Clinical Privileges Application/Approval – July, 18, 2003.	Credentialing and Privileging Folder
3c	Additional Clinical Privileges Application/Approval – January 28, 2005.	Credentialing and Privileging Folder
3d	Renewal of Clinical Privileges Application/Approval – July 15, 2005.	Credentialing and Privileging Folder
3e	Renewal of Clinical Privileges Application/Approval – July 13, 2007.	Credentialing and Privileging Folder
4a	Report of Contact dated October 1, 2003, from Compliance Officer; Subj: Alleged false documentation as reported by (B)(6) (wire sheared).	Facility
4b	Report of Contact dated October 1, 2003, from Compliance Officer; Subj: Alleged false documentation as reported	Facility

	by (B)(6) (cervical spine fracture).	
4c	Fact-Finding Appointment Memo dated October 1, 2003, (NOTE: Team's report is a confidential document under 38, U.S.C. 5705).	Facility
4d	Report of Contact dated October 3, 2003, from Chief, Radiology Service (angiogram and cervical spine fracture).	Facility
5	Memo dated October 9, 2003, from Radiology Chief to Chief of Staff; Subj: Peer Review	Facility
6	Memo dated October 14, 2003, from Chief of Staff to (B)(6) Subj: Reduction of Privileges.	Facility
7a, b, c	Memos (with attachments) dated November 13, 2003, January 27, 2004, and April 28, 2004, from Radiology Chief to Chief of Staff; Subj: Monthly Peer Review Report.	Facility
8	E-mail dated April 13, 2007, from Chief of Staff to Radiologists; Subj: Radiology Productivity (with attachment).	Facility
9	EEO Investigative Reports (cover sheets only) for (B)(6) (B)(6)	Facility
10a, b	(a). Peer review results dated July 3, 2007, from Diagnostic and Therapeutic Care Line Executive, Michael E. DeBakey VA Medical Center; (b). Radiology Chief's review of peer review dated August 23, 2007.	Facility

11	E-mail string from (B)(6) to VHA Chief Consultant, Diagnostic Services, dated August 22, 2007; Subj: problems in radiology Jackson VAH.	Facility
12a, b	(a). Peer review results dated September 5, 2007, from University of South Alabama, College of Medicine, Department of Radiology; (b). Radiology Chief's review of peer review dated October 17, 2007.	Facility
13	Memo dated September 30, 2007, from Chief Consultant, Diagnostic Services to Triad; Subj: Jackson VAMC Radiology Service Site Visit (with attachments).	Facility
14	E-mail from Center Director to OIG dated October 17, 2007; Subj: Hotline Follow-up.	Facility
15a, b, c	(a). E-mail string from (B)(6) to Under Secretary for Health dated November 6, 2007; (b). Issue Brief dated November 9, 2007; (c). Issue Brief dated November 15, 2007.	Facility
16	Memo dated November 19, 2007, from (B)(6) to Chief of Staff with handwritten list of approximately 52 radiology cases (known as Exhibit P-25 during EEO litigation).	Whistleblower
17	Radiology Chief's review (e-mail) of "P-25" dated November 21, 2007.	Facility
18	Radiology Chief's review (memo) of "P-25" dated	Facility

	November 26, 2007.	
19a, b, c, d, e	<p>(a). Issue Brief dated November 30, 2007; (b). Memo dated November 30, 2007, from Center Director to Chief Radiology Service; Subj: Administrative Leave.</p> <p>(b). E-mail from Chief Medical Officer to Center Director and Chief of Staff dated November 30, 2007; Subj: Issue Brief.</p> <p>(c). E-mail from Center Director to Network Director and Chief Medical Officer dated November 30, 2007 (no subject).</p> <p>(d). Memo dated December 5, 2007, from Center Director to (B)(6) Subj: Acting Chief, Radiology Service.</p> <p>(e). Memo from Radiology Chief to Chief of Staff dated December 17, 2007; Subj: Stepping Down as Chief, Radiology Service.</p>	Facility
20a, b	<p>(a). Appointment memo dated December 3, 2007, for Administrative Board of Investigation (ABI) – Alleged Failures in Quality Oversight.</p> <p>(b). ABI reported dated December 7, 2007.</p>	Facility
21a, b, c	<p>(a). Appointment memo dated January 31, 2008, for Professional Standards Board (PSB).</p> <p>(b) PSB meeting minutes dated January 31, February</p>	Facility

	<p>12, February 22 and March 11, 2008 (with attachments).</p> <p>(c). E-mail dated February 14, 2008 from PSB Lead to PSB members; Subj: Special PSB revival (known as Exhibit P-17 during EEO litigation).</p>	
22	OIG Healthcare Inspection Report; "Radiology Issues at a VA Medical Center" dated April 8, 2008.	Facility
23a, b	<p>(a). E-mail dated April 29, 2008 from (B)(6) to Under Secretary for Health; Subj: continued cover up of JVAH patient care issue and suspect e-mail.</p> <p>(b). Issue brief dated May 1, 2008.</p>	Facility
24	E-mail string dated June 6, 2008, from (B)(6) to the Under Secretary for Health and Secretary of Veterans Affairs (known as Exhibit P-28 during EEO litigation).	Whistleblower
25	Memo dated July 21, 2008, from Chief of Staff to (B)(6) Subj: Confirmation of Instructions Regarding Communications (known as Exhibit P-16 during EEO litigation).	Whistleblower
26a, b, c, d	<p>Documents prepared by Whistleblower dated April 16, 2013 and submitted to Fact-Finding team.</p> <p>(a). General Comments;  (b). Specific remarks re: fact-finding team's charge;  (c). Index to Federal trial transcript;</p>	Whistleblower

	(d). Specific comments re: (B)(6) and VAMC Management.	
27a, b, c, d, e, f, g, h	(a). Biographical - Supplement. (b). VA project Clarion Ledger 130404 VA Town Hall Meeting. (c). VA project New York Times 130404. (d). 130405 Clarion Ledger Editorial. (e). 130403 Clarion Ledger Nurse Licenses. (f). VA project Erik's comments for April 3, 2013 mtg; revised April 17, 2013 (g). DVD entitled VA sponsored "Town Hall" Meeting; War Memorial Building, Jackson, MS, 3 April 2013; 1300 (h). DVD entitled VA Town Hall dated April 3, 2013.	(B)(6) USAF (Retired)
28	Federal Trial Transcripts Volumes 3-8.	Whistleblower
28	Written supplemental response from (B)(6) (B)(6) PSB member, presented to fact-finding team on April 17, 2013.	(B)(6)
29	Radiology Dictation Logs (known as Exhibits P-65a, b, c, and d during EEO litigation.	(B)(6)