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Analysis of Disclosures, Agency Investigation and Report, and Whistleblower Comments

OSC File Nos. DI-12-3816 and DI-13-1713 (Jackson, Mississippi, VAMC)

OSC submits the following analysis and a final agency report based on disclosures from two physicians at the Veterans Affairs Medical Center in Jackson, Mississippi (Jackson VAMC), Dr. Phyllis Hollenbeck and Dr. Charles Sherwood. The agency produced initial reports in response to the allegations raised by Dr. Hollenbeck and Dr. Sherwood, which were forwarded to the President and congressional Veterans' Affairs Committees in September 2013. Those reports substantiated a significant portion of the whistleblowers' allegations and offered corrective action plans. However, the status of the recommended corrective actions was unclear. As a result of the apparent lack of progress in implementing the reports' recommendations, and on the basis of the whistleblowers' ongoing concerns about patient safety, OSC found the agency's response unreasonable and requested an update on the status of the corrective actions. The reports OSC addresses here are the Department of Veterans Affairs' (VA) responses to that request. Unfortunately, the agency's latest reports continue to lack specificity and show limited progress in the implementation of some recommendations. Thus, OSC finds the agency's supplemental reports to be unreasonable with regard to Dr. Hollenbeck's and Dr. Sherwood's allegations.

Dr. Hollenbeck's and Dr. Sherwood's allegations were initially referred to then-Secretary Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d).[1] The matters were then referred to the Under Secretary for Health, who tasked the Deputy Under Secretary for Health for Operations and Management to conduct the investigations. The interim Chief of Staff submitted the agency's report on Dr. Hollenbeck's allegations to this office on July 15, 2013, and the report on Dr. Sherwood's allegations on July 29, 2013. The Office of the Medical Inspector was

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

Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable.

5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

subsequently assigned to monitor the implementation of the agency's corrective action plans in both cases. The interim and final supplemental reports of the Medical Inspector, covering both Dr. Hollenbeck's and Dr. Sherwood's allegations, were submitted by the Principal Deputy Under Secretary for Health on November 12, 2013, and May 1, 2014, respectively. Pursuant to 5 U.S.C. § 1213(e)(1), Dr. Hollenbeck and Dr. Sherwood were offered the opportunity to comment on the agency's supplemental reports, and did so.

OSC File No. DI-12-3816 – Dr. Hollenbeck's Allegations

The Jackson VAMC Primary Care Unit is Chronically Understaffed

The Allegations

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

Dr. Hollenbeck further alleged that the Jackson VAMC overschedules patients for both physicians and NPs, resulting in an overworked and understaffed primary care clinic. The clinic policy, Dr. Hollenbeck explained, is that walk-in patients must be seen. These walk-ins are added to a schedule that is already overbooked. When a physician or NP left the Primary Care Unit, patient appointments scheduled months in advance were neither cancelled nor properly rescheduled; instead, patients were frequently scheduled in nonexistent, or "ghost," clinics. According to Dr. Hollenbeck, patients scheduled in ghost clinics were shuffled to physicians or NPs in existing clinics as space and time allowed. In some cases, patients assigned to a ghost clinic would not be seen at all on the day they were scheduled, other than by the nurse who checked them in.

The Agency's Original Findings and Recommendations

The agency substantiated the allegation that the Jackson VAMC Primary Care Unit has a shortage of physicians. The report explained that pursuant to Veterans Health Administration (VHA) Directive 2009-055, *Staffing Plans* (November 2, 2009), facility directors must ensure that staffing is part of the facility's strategic and operational plans, and that the staffing plans receive annual reviews and revisions as necessary. The report stated that in primary care, staffing levels are partially based on patient panel size, which is defined as the number of patients assigned to a specific primary care provider. VHA Handbook 1101.2, *Primary Care Management Module* (April 21, 2009), describes specific program requirements for Primary Care Units, stating that staffing of Primary

Care Units is a local decision and is affected by the amount of support staff, space, and administrative support available. VHA Handbook 1101.2 further indicates that for a site such as the Jackson VAMC, a typical panel would be 1,200 patients for a full-time primary care physician. VHA Handbook 1101.2 indicates that a NP is expected to carry a panel that is 75 percent the size of a full-time physician.

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

Despite the finding that Jackson VAMC physicians were not generally over-scheduled or "over-paneled," witness accounts indicated that physicians frequently worked late to accommodate new patients and walk-ins, who are not counted in panel sizes. The report noted with concern that Primary Care Unit physicians are often unable to review and address "View Alerts"—daily electronic notifications about patients—for two to three weeks.[3] View Alerts require immediate attention because of the possible serious nature of their content. Critical medical information is noted on these alerts, and facility policy requires communication of this information to providers. While the agency found no evidence of patient harm as a result of the delay in reviewing View Alerts, the report noted that the review team was unable to thoroughly assess the issue within the timeframe of OSC's referral, and recommended further review of the situation.

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

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[2] The ratio of patient panel size to adjusted capacity, as described above, "defines the number of patients assigned to a primary care provider in relation to that provider's capacity to see patients based upon the provider's time in the clinic, number of exam rooms, and support staff available." Agency Report, pg. 25.

[3] View Alerts include lab, imaging, and pathology results, consult recommendations, and other medical notes for co-signatures.

The policy does not set requirements for walk-in patients other than to require sufficient capacity for accommodation, but the report explained that Jackson VAMC's practice is to see Primary Care Unit walk-ins the day they arrive. Nevertheless, multiple walk-ins are often booked into a single appointment slot for one provider, and must wait hours to see a doctor. This double-booking also creates a delay in the wait time for regularly-scheduled patients. Indeed, the report confirmed the existence of ghost clinics. For example, the facility created a "Vesting Clinic" for initial appointments of new Primary Care Unit patients. The report found that the Vesting Clinic was a unique practice by the Primary Care Unit and was created without an assigned dedicated provider. When a patient checks in for an appointment in the Vesting Clinic, he or she is scheduled on another provider's schedule as an overbooked or double-booked appointment. This practice places two patients into one 30-minute appointment time slot.

The agency made a number of recommendations as a result of its findings, including consulting with the Office of Workforce Management and Consulting to ensure the use of all available resources for recruitment. The agency stated that Jackson VAMC leadership should continue to work aggressively to hire permanent, full-time physicians for the Primary Care Unit until a physician-to-NP ratio of 1:1 is reached. When a sufficient number of physicians is hired, the Jackson VAMC should reduce panel sizes for NPs to be in line with VHA guidelines.

Nurse Practitioners are not Properly Supervised or Licensed

The Allegations

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

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

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

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

The Agency's Findings and Recommendations

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

The agency found that at the time of the investigation, only two Jackson VAMC Primary Care Unit NPs held state licenses permitting independent practice. The report stated that since 2010, a total of 42 NPs have worked in the Primary Care Unit, and 16 are currently employed there.[4] Nineteen of the NPs are still employed by other units within the VAMC, while seven are employed elsewhere. Under VHA and local policy, NPs who are not licensed to practice independently must practice within a specialty area or in primary care in collaboration with a supervising physician and underwritten practice guidelines or "scope of practice." The report noted that states set the terms of individual collaborative agreements.

The agency found that the 42 NPs who worked in the Primary Care Unit since 2010 all had the required state licenses and certifications, except for three who were grandfathered as NPs under the agency's staffing policy, VHA Handbook 5005/27.[5] These three NPs hold Mississippi RN licenses. The report found that 8 of the 42 NPs at some point lacked a required collaborative agreement. Further, 13 of the 15 NPs currently in primary care are required by their state licensing bodies to have collaborative

[4] The Primary Care Unit employs 15 practicing NPs and one NP who serves as a supervisor and does not see patients.
[5] The report explained that prior to 2003, NPs were qualified based upon then-existing nurse qualification standards that did not contain additional requirements for NPs. The nurse qualification standards were revised in 2003, requiring NPs to be licensed or otherwise recognized as a NP by a state and to be nationally certified. The revised standard exempted NPs from the additional requirements if they were VA employees before the standard was implemented and had no break in service. The nurse qualification standards were revised again in 2009, adding that NPs must be nationally certified in the specialty of assignment. NPs hired between 2003 and 2009 were thus only exempted from the requirement that they have a national specialty certification.

agreements, but only ten had such an agreement. Of the remaining three, one had an agreement as of April 29, 2013, but it had not yet been approved by the NP's licensing state. The report noted that this was the NP's first collaborative agreement, despite a VAMC tenure of several years. The two remaining NPs had agreements with a *locum tenens* physician, who resigned from the Jackson VAMC. As of the date of the report, these two NPs had not been assigned a new collaborator.

The report noted that the Jackson VAMC had no process to meet state monitoring requirements, leading to lapses in compliance with these requirements.[6] Further, the report indicated a lack of understanding within the Jackson VAMC leadership about NP practice and licensure requirements. Thus, the agency found that NPs in the Primary Care Unit, who were erroneously declared to be LIPs, practiced outside the scope of their licensure.

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

The agency's report also recommended an external clinical quality review of all primary care providers at the Jackson VAMC. The recommendation directed that a representative sample of patient care records be reviewed for all 42 NPs, as well as for physicians, who worked in the Primary Care Unit from 2010 on. The report instructed staff from Veterans Integrated Service Network (VISN) 16 to work with Jackson VAMC staff to determine the necessary sample size to ensure that the quality of care delivered by the providers was appropriate. The recommendation further directed that the Jackson VAMC should consider expanding the sample if any clinical care issues were identified, and specific cases involving unresolved quality of care issues should be forwarded to the Office of the Medical Inspector for further investigation.

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

Medicare Home Health Certificates are Improperly Completed

The Allegations

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

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

The Agency's Findings and Recommendations

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

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

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

Improper Procedures for Issuing Narcotics Prescriptions

The Allegations

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

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

The Agency's Findings and Recommendations

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

The report further explained that controlled substance prescriptions must be for a legitimate medical purpose and be issued by an individual practitioner in the usual course of practice. States regulate what constitutes a bona fide patient-provider relationship,

which generally includes at least one in-person examination of the patient. However, the report noted that permissible exceptions to the in-person requirement might include a prescription by a "covering practitioner." In Mississippi, a prescription is considered valid when it is issued by a practitioner who has conducted at least one in-person medical evaluation of the patient, or when it is issued by a covering practitioner. Mississippi defines a practitioner as a "physician...or other person licensed, registered, or otherwise permitted to dispense...a controlled substance...." A covering practitioner is defined as a practitioner who conducts an evaluation other than an in-person examination at the request of a practitioner who has conducted an in-person evaluation of the patient within the previous 24 months.

The agency explained that the Jackson VAMC's past practice was to authorize its advanced practice registered nurses[7] to prescribe controlled substances under the facility's institutional DEA number. The facility suspended this practice following a review, and NPs were instructed to ask physicians to sign the prescriptions. According to the report the facility determined in July 2012 that there was no prohibition against covering physicians renewing controlled substances prescriptions after reviewing a patient's chart but without seeing the patient. Thus, staff physicians were asked to work with NPs to review patient charts and renew the prescriptions accordingly. However, in August 2012, a DEA agent informed management that this practice was not allowed. Jackson VAMC then suspended the practice and created the Controlled Substances Clinic. According to the report, the Controlled Substances Clinic closed in November 2012 because many NPs had obtained individual DEA certifications.

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

OSC File No. DI-12-3816 – The Agency's Supplemental Reports

In his cover letter to the agency's interim supplemental report, Principal Deputy Under Secretary for Health Dr. Robert L. Jesse addressed the status of disciplinary action at the Jackson VAMC. Specifically, Dr. Jesse explained that the corrective action plan did not address disciplinary action because "the non-compliant practices [at the Jackson VAMC] uniformly stem from the...institutional failure to adhere to/or enforce current Federal laws and VA rules, regulations, and policies." Dr. Jesse further stated that, because OSC's original referral of the allegations did not require VA to investigate

[7] Advanced practice registered nurses hold masters degrees and advanced clinical certifications. The term includes NPs, clinical nurse specialists, and certified registered nurse anesthetists. It does not include RNs.

historical actions that led to such institutional failures, and the former leadership of the facility was already departed, no disciplinary action was required.

The interim and final supplemental reports both stated that licensure requirements were identified and obtained for all NPs in the Jackson VAMC. Each NP was notified by letter of their LIP or non-LIP status, and NPs in non-LIP status will perform duties under a scope of practice as required by the licensing state in question. Scopes of practice were reviewed and issued to all affected NPs, and appropriate collaborative agreements were put into place. Further, the facility is in compliance with state limitations on the number of collaborative agreements held by individual physicians and has a ratio of four NPs to every one physician. Additionally, the facility will track NP data, such as states of licensure and individual DEA certifications. The agency's final supplemental report further noted that the facility's medical staff bylaws were amended to indicate that NPs are considered LIPs only when permitted by state licensure. The amended bylaws were approved by the medical staff and facility Executive Board Governing Body in October 2013. In addition, the Jackson VAMC's NP functional statements, qualification standards, and dimensions of practice were revised to be consisted with national agency policy.

The Jackson VAMC also encouraged all NPs to obtain individual DEA certificates. During the agency's initial investigation, three NPs did not have individual DEA certification. Since the original report, two of those NPs obtained their certificates and one retired. The facility will monitor compliance with DEA requirements on an ongoing basis. The supplemental reports also noted that in October 2013, the Jackson VAMC Pharmacy Service reviewed all relevant prescriptions for the preceding three months and did not find any that were unauthorized.

The agency's original report also directed the Jackson VAMC to conduct a clinical review of a random sample of patient care records for NPs who were prescribing controlled substances. The report specifically noted that the review should focus on patients who were actually prescribed controlled substances. The agency's final supplemental report stated that the facility combined this review with the overall patient care records review, discussed in more detail below. The supplemental reports found all prescriptions of controlled substances to be appropriate, but did not specify the number of reports within the sample that were reviewed as part of this recommendation.

The reports also stated that no *locum tenens* physicians are currently employed in the Primary Care Unit, and the facility will limit the use of *locum tenens* physicians when possible and as patient needs dictate. Further, the facility is committed to avoiding, when possible, the use of *locum tenens* physicians as physician collaborators should any be hired in the future. With regard to proper oversight of NPs by collaborating physicians, the reports note that physicians were provided with the appropriate state guidelines for monitoring of NP practice. The facility's clinical service chiefs monitor physician collaborator requirements, and report compliance to leadership during Quarterly Service

Performance Dashboard Reports. The final supplemental report notes that as of the date of the report, Dashboard compliance was at 100 percent.

The agency's original report strongly recommended that the Jackson VAMC work aggressively to hire permanent, full-time physicians for the Primary Care Unit, with the goal of a physician-to-NP ratio of 1:1. The final supplemental report stated that, as of the date of the report, the facility had hired additional full-time physicians, with a total of nine physicians and 14 NPs in the Primary Care Unit. Further, the facility committed to reducing NP panel sizes as physician panel sizes increase, in order to comply with patient-aligned care team model recommendations. The supplemental reports noted that the Jackson VAMC uses the VISN 16 recruiter, along with various advertising media, to recruit new staff. The facility also has a comprehensive recruitment action plan in place with the VA Office of Workforce Management and Consulting.

The supplemental reports state that all ghost clinics have been eliminated. Clinics that are no longer necessary have been closed, and assigned patients have been transferred to newly-hired providers. The final supplemental report indicated that overbooked and double-booked appointments were still occurring, but were expected to continue to decline with the hiring of additional staff. The Jackson VAMC began to transition to open access scheduling on May 1, 2013, with an expected completion date of July 31, 2014. Patients were also notified of the scheduling changes.

The facility was also required to move all providers from a six-part credentialing and privileging folder to the agency's VetPro system. The supplemental reports stated that the scanning of appropriate documentation into VetPro was completed on October 15, 2013. All primary care NP folders were reviewed on October 22, 2013, and found to have no deficiencies.

As noted above, the agency also recommended that the Jackson VAMC conduct an external quality review of its primary care providers. According to the supplemental reports, the VISN and the facility established that 30 patient care records, as well as ongoing professional practice evaluations, would be reviewed for each provider. The VISN-appointed clinical reviewers and created a review tool to be used in the review process. A total of 2,010 cases from 42 NPs and 25 physicians were reviewed via a 38 U.S.C. § 5705-protected peer review. The final supplemental report found that no patients were revealed to have had an adverse event. However, six of the providers who were reviewed met the threshold for further review, three of whom are no longer employed by the VA. The remaining three are expected to undergo a focused professional practice evaluation of additional cases. Thus, this recommendation is not completed.

With regard to Home Health Certifications, the OMI reported that investigators interviewed NPs and physicians during their site visit to the Jackson VAMC and via telephone the week after. The supplemental reports explained that Home Health Certificates are not scanned into patients' electronic health records, and are therefore

unavailable for review as recommended by the agency's original report. The supplemental reports note that forms completed by NPs are submitted to a collaborating physician for signature, and improperly completed reports are returned to the appropriate physician.

OSC File No. DI-12-3816 – Dr. Hollenbeck's Comments

Dr. Hollenbeck submitted comments on all three of the agency's reports in this matter. A summary of Dr. Hollenbeck's comments on the initial report were included in our September 17, 2013, letter conditionally closing this matter. Thus, we will focus here on Dr. Hollenbeck's comments on the agency's supplemental reports.

In her comments on the agency's interim supplemental report, Dr. Hollenbeck highlighted the agency's determination that the ongoing problems at the Jackson VAMC were "institutional" and thus that no disciplinary action was required. Dr. Hollenbeck noted that despite the agency's statements, many of the staff involved are still employed at the Jackson VAMC. According to Dr. Hollenbeck, facility director Joe Battle has held his position for two years, and participated in the substantiated wrongdoing with full knowledge from the start of his tenure. Further, two physicians were also involved in the ongoing wrongdoing and are still employed by the Jackson VAMC. A third physician continues to work for the VA at the Mountain Home VAMC in Tennessee. Additionally, several members of the VISN 16 leadership in Jackson are still employed by the VISN. Thus, Dr. Hollenbeck contends that a further investigation into the individuals involved in the substantiated wrongdoing was feasible and disciplinary action appropriate.

Dr. Hollenbeck confirmed that NPs were notified of their state licensure requirements, but that it was unclear who was handling the NP's personnel folders. Historically, all NP evaluations and promotions were handled by the Department of Nursing, regardless of the specific departments in which the NPs worked. Dr. Hollenbeck stated that each supervisor should be identified by the agency, and it should be verified that the proper schedule is followed for evaluations.

Dr. Hollenbeck also confirmed that the facility's bylaws were appropriately changed to reflect NP status. However, she noted that the interim supplemental does not address whether the facility or VA Central Office obtained letters of policy from each state that allows NPs to practice as LIPs. Dr. Hollenbeck contends that such letters would clarify when an NP practicing out of state requires a physician collaborator, an issue that was not addressed by the reports. This is crucial, according to Dr. Hollenbeck, because following the agency's report, a large number of Mississippi-licensed NPs at the Jackson VAMC quickly obtained Iowa licenses to avoid the need for collaborative agreements. However, in a letter addressed to Charlene Taylor, of the Credentialing and Privileging Department in Jackson, the Iowa State Board of Nursing stated that Iowa's regulations require Iowa-licensed NPs practicing outside of Iowa in a state that requires collaborative agreements to have a collaborative agreement with a physician. Despite this, the Jackson VAMC memorandum to NPs stated, "Per the Nurse Practice Act of the

State of Iowa, you are not required to have a collaborative/consultative relationship with a physician." According to Dr. Hollenbeck, this is a misstatement of Iowa's requirements. Dr. Hollenbeck also noted the report's determination that collaborative agreements do not need to be forwarded to states for approval. She indicated that this is not the case for Mississippi, which requires that NPs and collaborating physicians notify their licensing boards of their status and forward a copy of the collaborative agreement.

Further, Dr. Hollenbeck noted that despite the agency's report, the Jackson VAMC is not in compliance with Mississippi requirements for NP-to-physician ratios, which she reported should be a maximum of four-to-one. Dr. Hollenbeck stated that it is well known within the facility that the chief of medicine continues to have at least ten NPs with whom she collaborates. Per Dr. Hollenbeck, this has been publicly confirmed by Mr. Battle. According to Dr. Hollenbeck, there is no indication that the chief of medicine has reviewed the appropriate number of NP charts each month, kept a log of each chart reviewed and the outcome, or met quarterly with each NP. Dr. Hollenbeck expressed concern about oversight in general with regard to NPs. She stated that the number of acting chiefs of staff within the Jackson VAMC hinders the ability of leadership to keep track of who is monitoring whom and when. In addition, Dr. Hollenbeck stated that during the agency's clinical review of providers, NPs were assigned to review other NPs' patient records. She contended that the NPs chosen to review their fellow NPs' charts would be disinclined to find any fault in the care provided, and noted that many NPs at Jackson feel they are "the same as physicians."

Dr. Hollenbeck provided several examples of veterans who received substandard care while seeing solely NPs at the Jackson VAMC. In one instance, a patient's lab results showed diabetes three years before he was diagnosed. During those years, the patient saw only an NP who was unlawfully unsupervised. In another instance, a patient who was seen only by NPs showed symptoms of diabetes for two years, but his records reflected no mention of his abnormal lab results, treatment, or communication about his condition. During that period, the patient developed renal damage. According to Dr. Hollenbeck, the NPs note in the patient's chart, which did not offer a diagnosis, was signed by the chief of medicine.

Dr. Hollenbeck expressed strong dismay at VHA's current push to change its nursing handbook guidelines to allow all NPs, regardless of state licensure requirements, to practice independently. She noted that she sees routine misdiagnoses by NPs, which directly affect patient health and compensation. These mistakes are compounded by the Jackson VAMC method of "chart consults," in which specialists review charts for patients they do not see and then make diagnoses using NP notes in the chart. These concerns, along with the initial and ongoing educational differences in NP and physician training, pose an important challenge for NPs if they are permitted to practice independently regardless of licensure.

With regard to the elimination of ghost clinics, Dr. Hollenbeck reported that instead of simply removing the ghost clinic, the facility removed all provider names for all of the

Primary Care clinics. As a result, the patient's assigned provider is not listed in the computerized medical record, nor can it be seen whether the patient saw a physician or NP. In addition, Dr. Hollenbeck contended that physicians are still being overbooked, despite the agency's promise to reduce overbooking with the addition of providers. Furthermore, physicians are not given time in their schedules to properly review View Alerts, as required, or to meet with NPs to fulfill collaborative agreement requirements.

Dr. Hollenbeck also expressed reservations about the facility's handling of its narcotics chart review. She pointed out that the original agency recommendation specifically stated that only those charts that contained narcotics prescriptions should be reviewed, but that the agency ultimately combined this review with its overall clinical care review of NP charts. Thus, it is unclear who performed the review, the credentials of the reviewers, and whether the reviewers were physicians. Further, Dr. Hollenbeck noted that scant background is given on Lumetra, the contractor that conducted the outside review, and that little information was offered with regard to the disclosures made as a result of Lumetra's review.

OSC File No. DI-13-1713 – Dr. Sherwood's Allegations

Failure to Properly Read Patient Images Directly Affected Patient Outcomes

The Allegations

Dr. Sherwood was the chief of ophthalmology at the Jackson VAMC. He retired in 2011 after 30 years of service. Prior to his retirement, Dr. Sherwood testified as a witness on behalf of several plaintiffs who were radiologists at the Jackson VAMC and who filed a discrimination lawsuit against the hospital.[8] Beginning in the late 1990s, the agency started correlating physician performance bonus awards to performance metrics. By 2004, the agency was basing radiologist pay on performance metrics. One of the metrics used is the Relative Value Unit (RVU), a system originally developed for Medicare. To quantify the relative difficulty of radiology readings, images are assigned a RVU that takes into account the number of images reviewed by the radiologist and the difficulty of the image. Images that are more difficult to read receive a higher RVU and result in higher compensation for physicians and management.

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

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

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

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

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

The Agency's Findings and Recommendations

The agency did not substantiate the allegation that Dr. Khan failed to fully or properly review radiology images. The agency relied on its review of several data sets related to Dr. Khan's productivity and found that the amount of time Dr. Khan spent on each image was not significantly shorter than his colleagues' times. Further, the agency found that Dr. Khan read an average number of lower-value images in comparison to his colleagues. The agency further found that on a monthly basis Dr. Khan's monitor was open 26 hours longer than his colleagues, giving him additional time to read images. The agency concluded that Dr. Khan was reading images of a similar type and with similar variety as those read by his colleagues. The agency found that Dr. Khan's comments regarding his failure to read every image were related to a specific instance in which he did not read an image for an abnormality that he had identified previously.

The agency found that Dr. Khan's actions did not affect patient outcomes and referred to a prior review of 321 cases that was undertaken during Dr. Khan's tenure. Out of those 321 cases, the agency reported that two had major discrepancies, while ten had minor discrepancies. Combined, the discrepancies represented 3.7 percent of the total cases reviewed. The agency found that this percentage fell within the accepted error

rate of three to five percent. The agency noted that in another review of 30 cases undertaken while Dr. Khan was with the VA, no major findings or diagnoses were missed.

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

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

The Whistleblower's Comments

In his initial comments, Dr. Sherwood raised significant concerns with the agency's findings. First, although Dr. Khan's relationship with the University of Mississippi was mentioned in OSC's referral, the agency's report failed to address it. While the report included a variety of data reflecting Dr. Khan's work productivity, Dr. Sherwood noted that the report ignores the fact that between 2006 and 2007, Dr. Khan was reading University of Mississippi studies for a significant portion of his tour of duty. Dr. Sherwood further commented that the reading monitor used for university studies was separate from the VAMC monitor, and was not connected to VistaRad, the VA's radiology data system. Thus, these studies are not included in the data produced by the agency, and the agency did not explain how Dr. Khan could maintain a high read rate of VA studies while also completing university work.

The agency also failed to address Dr. Anderson's statement from a memorandum dated September 20, 2007, that if Dr. Khan was reading such a high level of image

studies while working fewer than 80 hours a week, it would raise concerns. Dr. Sherwood noted that data was submitted at trial reflecting Dr. Khan's RVU productivity workload, which according to the whistleblower is far more accurate than the data provided by the agency. The RVU productivity data measures the number of studies read or RVU, depending on the date the RVU was instituted. Dr. Sherwood contended that this data shows that Dr. Khan's read rates were significantly higher than those of his colleagues.

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

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

Management Was Aware of Radiology Shortcomings but Took No Action

The Allegations

It was also alleged that, although the plaintiffs repeatedly told management in the underlying discrimination matter that Dr. Khan's work was sub-standard, Jackson VAMC took no definitive action to resolve the problem. In 2007, the Jackson VAMC conducted its own internal review of the flawed reports identified by the plaintiffs. In a November 21, 2007, memorandum, the former chief of radiology stated that he spent ten hours reviewing the reports and found no instances in which he would have altered the patients' care. It was alleged, however, that this report was flawed and the outcome could not be trusted because of underlying tensions within the department. In June 2007, the VA Office of the Inspector General (OIG) conducted an investigation into the plaintiffs' allegations. The OIG report, dated April 8, 2008, did not substantiate the plaintiffs' allegations, but instead determined that the data provided to investigators was biased, and found only one patient outcome affected by Dr. Khan. As a part of its investigation, the OIG sent the 30 cases discussed above to an outside peer reviewer. While the external peer review report did not find that Dr. Khan's error rate was higher than his colleagues' error rates, it did find that the Jackson VAMC's internal peer review process was flawed,

and recommended that another VA medical center conduct the Radiology Department's peer reviews.

The Agency's Findings and Recommendations

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

The Whistleblower's Comments

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

Dr. Sherwood also noted that Dr. Patel was an active researcher and editor of a peer-reviewed medical journal. As such, he would have been aware that a sample size of 30 cases would not yield a statistically valid result. Dr. Sherwood contended that the small sample size was intended for use in routine annual screening, not for practitioner performance concerns of the type associated with Dr. Khan. Dr. Sherwood further noted that the report itself stated that a sample size of 30 has been deemed too small, even for routine evaluation.

Additionally, Dr. Sherwood explained that prior to the PSB, Dr. Patel circulated an e-mail to the participating service chiefs regarding the list of 58 cases and the motivations behind it. However, according to Dr. Sherwood, Dr. Patel admitted during trial testimony that he lied in that e-mail. Dr. Sherwood contended that the purpose of the e-mail was to discredit the claims against Dr. Khan and shield him from closer scrutiny, and that the e-

mail served to influence the conclusions of the PSB. Dr. Sherwood noted that the report characterizes Dr. Patel as having retracted the claims of wrongdoing made in his e-mail. However, Dr. Sherwood stated that Dr. Patel was forced during trial to confess to making false claims in his e-mail.

The Agency Failed to Notify Potentially Affected Patients

The Allegations

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

At trial, testimony indicated management's awareness of four instances in which Dr. Khan failed to properly read patient studies and the patients subsequently returned with serious illnesses, including cancer. In each of those instances, an Institutional Disclosure was conducted, which is also described in the Directive.[9] However, it was alleged that the agency appeared to have made no efforts to inform all the patients potentially affected by Dr. Khan's alleged malfeasance. It also did not appear that the agency conducted the required Clinical Review Board or Subject Matter Expert Review Panel.

The Agency's Findings and Recommendations

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

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

disclosures to affected patients, or whether the case was included in any external reviews. However, the agency recommended disclosures of the eight cases Lumetra identified.

The Whistleblower's Comments

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

OSC File No. DI-13-1713 (Dr. Sherwood) – The Agency's Supplemental Reports

In his cover letter to the agency's interim supplemental report, Dr. Jesse, discussed above, reiterated that the agency's determination that it could not investigate the allegation that Dr. Khan spent a portion of his time at the VA working on radiology images from the University of Mississippi. Dr. Jesse explained that Dr. Khan could not have looked at such images using VA equipment, and that in any event, Dr. Khan's VA laptop would have been wiped clean by the Jackson VAMC technology staff at the time of his departure from the VA.

The agency's final supplemental report indicated that the VISN appointed a staff physician from a different facility to review the eight cases identified above alongside the Lumetra data. The report stated that following that review, the Jackson VAMC conducted appropriate disclosures to patients and families and forwarded its findings to the VISN. However, the report did not indicate the number of disclosures that occurred, the type of disclosure made, or the type and severity of the harm that was disclosed.

The interim and final supplemental reports also stated that Dr. Anderson, discussed above, "thoughtfully determined" that no further cases needed to be reviewed in this matter. Rather, the reports stated that several reviews have already been undertaken, and that those cases met the standard of care. The reports further stated that "to review this radiologist again…would appear malevolent." Further, to do such a large review would require reviewing very large numbers of cases from each radiologist at the Jackson VAMC, and that administrative or legal actions are no longer viable options.

OSC File No. DI-13-1713 – Dr. Sherwood's Comments

Dr. Sherwood submitted comments on the agency's interim and supplemental reports. In his interim comments, Dr. Sherwood remarked that the investigation failed to consult Dr. Margaret Hatten, one of the plaintiffs in the suit regarding Dr. Khan, about her knowledge of the list of 58 potentially affected patients. Dr. Sherwood noted that Dr. Hatten had the most intimate knowledge of the information contained in the list, and is a respected physician who served with distinction as the acting chief of radiology for several years. Dr. Hatten's standing as a former plaintiff aside, Dr. Sherwood believed

that Dr. Hatten's detailed information on the list should have been sought for all clinical reviews.

Further, the interim and final supplemental reports did not identify the staff physician appointed to review the eight Lumetra cases, and provides no criteria for how the physician was selected. Dr. Sherwood noted in both of his comments that the supplemental reports also failed to provide information on the resources given to Lumetra during its review. For example, the agency did not specify whether Lumetra was provided with each patient's complete medical records, a list of all the VistaRad report alterations, or prior source imaging studies to compare against Dr. Khan's work. Dr. Sherwood argued that these items are crucial to determine the severity of Dr. Khan's errors. Further, Dr. Sherwood maintained that neurologist Dr. Gregg Parker, chief medical officer of VISN 16, G.V. (Sonny) Montgomery VAMC, testified before the Subcommittee on Oversight and Investigations of the House of Representatives Veterans' Affairs Committee that all 58 cases identified in the report would be reviewed by the Office of the Medical Inspector. However, the supplemental reports discussed only the eight cases identified to Lumetra.

Dr. Sherwood noted that Dr. Anderson's determination that no further review of Dr. Khan's work is required directly contradicted his trial testimony regarding this matter. That testimony indicated that Dr. Anderson, in consultation with another physician, determined that 3,000 cases was the minimum number of cases necessary to perform a review with enough statistical relevance to determine Dr. Khan's error rate. Further, Dr. Sherwood contended that the report aggregated data over the period between 2003 and 2007, which diluted the effect or Dr. Khan's actions during the most intense period of image reading beginning in 2005. This is significant because while the concerns about Dr. Khan's error rate focus on 2005 to 2007, the 300-case review that the agency now relies on occurred in 2003 and 2004, before the pay issues described above were in place. As Dr. Sherwood stated in his interim comments, "[N]ot only does the VA recommendation embrace a case review number that is low by a factor of 10, but also the time interval when these cases were reviewed avoids the time interval of greatest concern." Further, Dr. Sherwood identified as a "straw man" the agency's argument that a large number of cases for each radiologist would need to be reviewed. Rather, he noted that there are established error rate norms for radiologic studies, but the agency's refusal to perform a large case review has obscured Dr. Khan's actual error rate. If Dr. Khan's true error rate were known, a large-scale review of all radiologists would not be necessary.

In addition, Dr. Sherwood took issue with the agency's assertion that a further review of Dr. Khan's work would appear to be "malevolent." He noted his discomfort with the idea that the agency is not, however, concerned with the appearance of malevolence against known and potentially injured patients. Dr. Sherwood also noted in both his interim and final comments that Dr. Jesse's assertion that the allegations regarding Dr. Khan's work for the university cannot be investigated is "absurd." Dr. Sherwood reiterated that the allegation was that Dr. Khan read university image studies

using a university-provided display unit, and not a VA-issued laptop. This was reinforced by trial testimony describing the equipment that was used and when and why it was ultimately removed. Further, Dr. Khan performed the work under a VA contract with the university; thus, Dr. Sherwood contended that the contract and associated payments should be easily identified.