DI-13-1713

Whistleblower's Comments to Supplemental Response of the VA Office of Medical Inspector dated 4/11/2014 and received on 5/2/2014.

Comment on Recommendation #22:

My comments made to the prior VA supplemental response was sent on December 12, 2013. The short comings of the VA's ardor in responding to my comments is nothing short of astounding. This supplemental reply makes no attempt to explain what data were provided to Lumetra. Withholding that information makes it impossible to know if all relevant data were considered in Lumetra's conclusions, and that bears directly on the validity of Lumetra's conclusions. My previous comment is still valid:

The VA continues to remain silent about the resources this VISN 16 radiologist will have at his/her disposal to fully, appropriately, and convincingly make decisions about the "Lumetra" cases. The same disclosure failure by the VA also applies to the decision about the "moderate to high impact" cases. The VA never disclosed the level of resources that it supplied to Lumetra; for example, were the Lumetra physicians supplied the patient's complete medical records from the Computerized Patient Record System? Were all VISTA radiology report alterations available to Lumetra which would have indicated if the alleged falsification of the imaging report were present? Were prior source imaging studies available for comparison with Dr. Khan's work and were they consulted? These prior source images are a key element in determining the severity of Dr. Khan's errors.

The VA could take the appropriate administrative action concerning its former employee, Dr. Khan, by complying with the subpoena from the Mississippi State Board of Medical Licensure. The Mississippi State Board of Medical Licensure is a law

enforcement agency, exempt from the privacy laws that the VA is hiding behind in order to defy compliance with the subpoena. Compliance with this subpoena is the right and lawful action the VA must take to allow the Mississippi State Board of Medical Licensure to complete its investigation of Dr. Khan. VA Headquarters in Washington, D.C. could resolve this issue easily by ordering VISN 16 Network Director, Rica Lewis-Peyton, to comply immediately with the subpoena. This supplemental response from the VA omits any comment in the resolution to its legal and moral responsibility to comply with this subpoena.

Finally, I must comment on the cover letter from Dr. Robert L. Jesse, MD, PhD that accompanied the VA's supplemental response. Dr. Jesse's statements in his third paragraph to Ms. McMullen are absurd. Of course Dr. Khan's non-VA work can be investigated. My prior whistleblower comments made it clear that Dr. Khan worked on a full function, custom diagnostic radiology display provided by the University of Mississippi Medical center for Dr. Khan in the VA department of radiology. This dedicated diagnostic radiology display unit had a dedicated connection to the University of Mississippi's computer system. The idea that a computer laptop was used for this non-VA work is silly. There is federal trial testimony explaining what was used and when and why it was removed. Dr. Jesse clearly did not avail himself of the available factual information, preferring instead to present a guess, off the top of his head, as factual. I made it very clear that Dr. Khan's non-VA work was performed under a VA contract with the university medical center, That contract, and the payments paid to the VA as a result, should be easily identified. Once identified, this contract should provide information useful in determining exactly how much time and effort was spent on this non-VA radiologic activity compared to the time and effort he spent during the same time interval on VA imaging studies.

Comparing this VA supplemental response to my complaint as well as the others that preceded it, with this and my other responses should confirm one conclusion to anyone who reads them. That conclusion is that the VA's logic and arguments

submitted as a response are worthy of an episode on Rod Serling's television program, The Twilight Zone. The VA prefers fantasy over rational self examination.

Dr. Robert Jessie's cover letter to Ms. Lerner, Special Counsel, states that the monitoring of the implementation of the recommendations of the Department's action plan will be performed by the Office of the Medical Inspector and the Deputy Under Secretary for Health for Operations and Management. This statement is worthy itself of commentary. According to the VA's official website, the office of Deputy Under Secretary for Health for Operations and Management has been vacant since October of 2013:

http://www.va.gov/directory/guide/manager.asp?pnum=30289

In addition, both of these VA departments assigned to monitor the implementation of the action plan report directly to the Deputy Undersecretary for Health, Dr. Robert Petzel. As I have previously confirmed in my initial comment on the VA's response to my OSC complaint, Dr. Petzel has self acknowledged his bias against any finding against the VA concerning my OSC complaint. See my original statement below:

The VA's desire to shield Deputy Under Secretary Robert Petzel for his conflict of interest in the VA's response to my complaint. Dr. Petzel made public statements prejudicial to this CRB investigation before it was undertaken. His statements were reported in the April 3, 2013 New York Times. Dr. Petzel declared his emphatic pre-judgment of the final outcome of the Clinical Review Board (CRB) investigation. All members of the Clinical Review Board who conducted the investigation are subordinate employees of Dr. Petzel. And finally, this VA response required the approval of Dr. Petzel before its release to the OSC.

It is simply not credible to believe the offices charged with monitoring the implementation of Department's action plan could or would find dissent with Dr. Petzel's expectations. There is no honest broker in this arrangement.

Why isn't the Office of Medical Inspector and the Under Secretary for Health disclosing to the OSC, the President, and Congress the exact number of veterans or the families of

veterans that were provided disclosures, institutional or other, as a result of OSC complaint DI-13-1713? It is inexcusable that this information is not provided by this latest Office of Medical Inspector supplemental response. In fact, this failure is an insult to all veterans, taxpayers, the President, and Congress.

Comment on Recommendation #23:

It appears that the Office of Medical Inspector has elected to "cut and paste" an earlier supplemental response to my comments on the VA's original response to my OSC complaint. This was my comment at the time, which deserves no alteration:

The VA's resolution has conveniently ignored these facts which were clearly stated and document in trial testimony. Dr. Anderson has apparently backed away from his own conclusions as documented in the trial (Federal trial transcript vol 7, p 1059, line 20-25). Testimony at trial indicated that Dr. Anderson and Dr. Majors, in consultation with each other, jointly decided that a review of 3000 cases was the MINIMUM number that would be required to perform a review with enough statistical power to detect Dr. Khan's error rate and pattern. In fact, Dr. Kirchner, Chief of Staff, testified under oath that Dr. Anderson, Chief Consultant Diagnostic Services, held discussions with Dr. Majors, the outside radiologist on the AIB, to come up with the number of 3,000 for the imaging studies that should be reviewed.

I have pointed out previously in my whistleblower comments the following: "The VA's response aggregates data over the period from 2003 -2007, which deliberately dilutes the effect on Dr. Khan's conduct during the period when his RVU capture was most intense, which began in 2005 as documented in trial testimony (Federal trial transcript vol. 4, p 427, line 2 through page 435, line 6). The primary time period of concern about Dr. Khan's error rate and reading speed was for the years 2005-2007. The relevance of this is that Dr. Khan's 300 case quality review was completed for 2003-2004, before the RVU/ pay issue influenced Dr. Khan's reading behavior. Therefore, not 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.

The most ethically appalling and simply preposterous statement in the VA's resolution is the concern about the appearance of malevolence if Dr. Khan's radiologic studies were reviewed. It is galling and disgusting that the upper echelons of VA management is NOT concerned with the appearance of malevolence against both the known injured patients and those unknown and potentially injured. The VA unabashedly and unapologetically abandoned any responsibility to the general public to protect it from a physician whose care is in question. Why has the VA failed at every juncture to consult its own National Center for Ethics in Healthcare about the issues that I raise? The failure to use this institutional resource highlights once again that VACO has not thought or treated the issues that I raise in a serious manner. The issues that I raised in my OSC complaint are certainly within the mission scope of the National Center for Ethics in Healthcare: http://www.ethics.va.gov/about/about_us.asp

The VA's resolution sets up a "straw man" argument when it states that a large number of cases from every radiologist on VA staff would have to be reviewed to compare to Dr. Khan's error rate to see he performed at a lower standard. There are established error rate norms for radiologic studies. Dr. Khan's actual error rate, which remains unknown as a result of the VA's refusal to perform the large case review, can be compared against nationally accepted norms. There is NO reason to perform large case number reviews of every VA radiologist at the Jackson VA. There is no reason to offer such an argument other than to mislead the reader by making the problem appear to be too big and costly to undertake.

Dr. Gregg Parker testified before the Subcommittee on Oversight and Investigations of the House Veterans Affairs Committee that all fifty-eight radiology cases reported to the Veterans Administration's highest administrative officers by Margaret Hatten, MD would be reviewed by the Office of Medical Inspector. (See the 2

hour and 28 minute mark of the video testimony: *http://www.ustream.tv/recorded/40735344*) However, this supplemental response confines itself to only eight of the reported cases. This is a blatant disservice to fifty veterans and their families.

COMMENT SUMMARY:

When taken as a whole, initial response from the VA and its subsequent supplemental submissions to the OSC, are, in fact, a superb example of what results when an agency of government is allowed to investigate itself. It also is a prime example of an outcome that should be expected when the watch dog agency, the Office of Special Counsel, has no enforcement authority. At the very least it begs the question: When will the Office of Special Counsel be granted the authority to conduct independent investigations in the manner of a genuine oversight agency?

In my comment to the last supplemental response from the VA I made the following remarks:

Comparing this VA supplemental response to my complaint as well as the others that preceded it, with this and my other responses should confirm one conclusion to anyone who reads them. That conclusion is that the VA's logic and arguments submitted as a response are worthy of an episode on Rod Serling's television program, The Twilight Zone. The VA prefers fantasy over rational self examination.

I stand by these remarks more than ever, especially in light of the revelations that have occurred at the Phoenix VA this month. Revelations of VA administrative misconduct at so many VA facilities since my original OSC complaint was filed are testament to the systemic nature of the VA's problems. These are NOT problems of incompetence or inadequate resources. **Instead these problems represent failures of integrity, accountability, honesty, and simple human empathy for their fellow man of individuals at all levels of leadership in the VA.** VA leadership does not hold

itself to the standards it espouses. Like the emperor with no clothes, the VA touts its superior performance and concern for veterans and their families while the public can see this is a farce of the most tragic proportions. It is now apparent to even the most scarcely concerned that VA leaders have a callous, willful disregard for those whom they are charged and paid to serve. The tragedy is that this callous and willful disregard affects real people with real families who care about their loved ones.