Whistleblowers comments to the VA's supplemental investigation for OSC Complaint Di-13-1713

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Radiology

#22. The most glaring deficiency in the VA's Resolution is that the physician expert of these cases, Dr. Margaret Hatten has never been used as a resource in the evaluation of these cases. She is the only expert of the list of patients with identified harm or death, and she was used as a resource by the Clinical Review Board that performed the primary investigation of my OSC complaint. She has served with distinction as Acting Chief of Radiology for the past several years. Yet, she has been overlooked to provide her unique expertise to this VISN 16 radiologist appointed to review these cases who is referenced in the VA's supplemental response. Nor was she utilized by the VA in any prior review of these cases, although her knowledge of them is unique. The fact that she was the reporting physician and a plaintiff in the lawsuit against the VA can excuse this oversight. Her detailed information as the creator of the patient list (plaintiff's exhibit 25) about these cases should have been sought for all the clinical reviews,

Another concern is that the selection criteria for the appointed staff physician is unstated. Was he/she selected for a primary allegiance to the VISN management? We have no way of evaluating this person's relationships with the supervisors he serves. We have no idea of his clinical qualifications. Why isn't this individual identified?

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 following excerpt from VHA Handbook 1004.08:

a. **Adverse Event.** *Adverse events are untoward incidents, diagnostic or therapeutic misadventures, iatrogenic injuries, or* ***other occurrences of harm or potential harm*** *directly associated with care or services provided within the jurisdiction of the Veterans Healthcare System. NOTE: To determine which incidents need to be considered for RCA, consult VHA Handbook 1050.01.*

c. *Whenever a **potential harm** is disclosed to a patient, it may be necessary, after an investigation has been conducted, to follow up with the patient to inform the patient whether the potential harm that was initially disclosed did or did not, in fact, occur (e.g., a patient who is initially told that the patient may have been exposed to a blood-borne virus as a result of improperly sterilized equipment, must be informed of investigation results that would have a significant impact on the patient's health or wellbeing).*

*d. For the **patient who is deceased, incapacitated, or otherwise unable to participate in the process of adverse event disclosure, any clinical or institutional disclosure must be communicated to the patient's personal representative** and may involve others, as designated by the personal representative in accordance with VHA Handbook 1605.1.*

The VA has for years now conveniently evaded complying with its own policy requirements that I have reproduced in the preceding paragraphs. Furthermore, NO management official responsible for oversight and enforcement of these policies has ever been disciplined or adversely affected for their failure to adhere to policy. The relevant elements of the policy is in bold underline above.

#23. 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.

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. That 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 and preposterous. 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.