**Unprotected Management Review for the Office of Special Counsel (OSC) Case DI-11-3203**

**August 13, 2013**

Within VHA, peer review is defined as an organized process carried out by an individual health care professional or select committee of professionals, to evaluate the performance of other professionals.[1] These "peer reviewers" possess similar or more advanced education, training, experience, licensure, clinical privileges, or scope of practice, which enables them to make a fair and credible assessment of the actions taken by the health care professionals relative to the episode of care under review. Within VHA, peer reviews are confidential and privileged under 38 U.S.C. § 5705, and as protected activities, are intended to promote confidential and non-punitive processes that consistently contribute to quality improvement efforts at the individual health care professional level.

As such, in accordance with VHA Directive 2010-025, *Peer Review for Quality Management*, the Medical Center completed a protected peer review of the individual health care professionals involved in the clinical care episode of concern.

Reviews that are conducted, which are not confidential and privileged under 38 U.S.C. § 5705, and its implementing regulations, are not considered quality assurance activities and fall under the category of management reviews.

At the request of the Office of Special Counsel (OSC), the Office of the Medical Inspector (OMI) conducted a management review of the care provided to this patient. Also at the request of OSC, OMI contacted the whistleblower to receive additional information pertaining to this investigation. It was the whistleblower's concern that:

1. She had not been interviewed by the OMI regarding the clinical case.
2. She had not been involved in the Medical Center's peer review of the clinical case.

On August 9, 2013, the OMI re-interviewed the whistleblower pertaining to these concerns. The whistleblower stated that her concern regarding the clinical case was that the radiologic technologist who had staffed the room following the previous case had not replaced all supplies, including suction canisters and tubing, as required. The OMI acknowledged the whistleblower's concerns, and reminded her that, in fact, she did share this information during the original investigation in 2011, and the OMI substantiated her allegation.

[1] Health care professionals are authorized to deliver health care exercising autonomous clinical judgment.

As documented in the OMI's original report,

"The Medical Center did an investigation of the availability of suction equipment, and determined that the RT (radiologic technologist ) who had staffed the room on the previous case had not replaced all supplies, including suction canisters and tubing, as required. The Medical Center conducted training for appropriate personnel."

The role of the radiologic technologist, who is not a licensed independent practitioner, was appropriately not included in the protected peer review process and has already been addressed by the Medical Center.

The OMI completed an unprotected management review of the clinical care provided to this Veteran and finds that the medical care provided by the clinical team meets the standard of care.