

**Report of Investigation for the
Office of Special Counsel**

On-Call Physicians

Department of Veterans Affairs

Wilkes-Barre VA Medical Center

Wilkes-Barre, PA



Veterans Health Administration

Washington, DC

Report Date: May 8, 2013

OMI TRIM # 2013-D-443

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THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 4, 2013

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

RE: OSC File DI-13-0416

Dear Ms. Lerner:

I am responding to your letter regarding alleged violations at the Wilkes-Barre Department of Veterans Affairs Medical Center in Wilkes-Barre, Pennsylvania. These allegations were made by whistleblower ^{(B)(6)}, a hospitalist physician at that Medical Center, who charged that on-call physicians were not required to report to the facility in response to emergency calls from treating physicians, which placed patients at risk by delaying treatment or necessitating transfers to other hospitals, thereby endangering their health and safety. You asked me to determine if the alleged misconduct constituted gross mismanagement or a substantial and specific danger to public health and safety.

I asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under 5 U.S.C. Section 1213(d). He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation. In its investigation, OMI did not substantiate any of the allegations made by the whistleblower that patients were placed at risk by the Medical Center's procedures, and found no evidence of any violation of law, rule, regulation, gross mismanagement, or danger to patients; they made no recommendations. Findings from OMI's investigation are contained in the enclosed Final Report, which I am submitting for your review.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric K. Shinseki".

Eric K. Shinseki

Enclosure

Executive Summary

Summary of Allegations

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate a complaint filed with the Office of Special Counsel (OSC) by (b) (6) MD, a hospitalist physician and the whistleblower, at the Wilkes-Barre Veterans Affairs (VA) Medical Center, Wilkes-Barre, Pennsylvania (hereafter, the Medical Center). The whistleblower alleged that employees are engaging in conduct that may create a substantial and specific danger to public health and safety at the Medical Center. OMI conducted a site visit to the Medical Center on April 10-12, 2013.

The whistleblower alleges that:

- Employees at the Medical Center failed to require “on-call” physicians to report to the Medical Center when an on-site treating physician makes an emergency call.
- Employees at the Medical Center placed patients at risk by delaying treatment or necessitating their transfer to other facilities when “on-call” physicians failed or refused to report to the Medical Center.

Conclusions

- OMI did not substantiate the allegation that the Medical Center did not have a timely on-call response system.
- The Medical Center’s practice of allowing specialist physicians to use their medical judgment in determining how they provide consultations for the care of patients and holding them accountable for their decisions is not contrary to that of other VA hospitals or hospitals in the private sector.
- Except for the whistleblower, all Medical Center hospitalists voiced an understanding of the on-call policy, procedures, and practices, and they could accurately describe these processes. The Medical Center has ensured adequate and safe patient care with their on-call physician specialist coverage.
- The Medical Center is in compliance with the intent of the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA).
- OMI did not substantiate the whistleblower’s allegation that the Medical Center’s on-call policies resulted in numerous cases when patients required immediate treatment which was delayed.
- In the cases reviewed, OMI did not substantiate the whistleblower’s allegation that emergency surgical care was not available when needed.

- In the treatment of any patient, it is important to evaluate both the patient and the diagnostic studies together to make appropriate clinical decisions.
- The Medical Center's "telephone-only" call policy ensures availability of consultation 24/7, during periods of time when they would not have any coverage available.
- A VA orthopedic surgeon, who had agreed to fulfill a "telephone-only" on-call consultation need for the Medical Center, did respond telephonically while on scheduled leave.
- OMI did not substantiate the allegation that employees at the Medical Center placed patients at risk by delaying treatment or necessitating their transfer to other facilities when "on-call" physicians failed or refused to report to the Medical Center.

Recommendations

- None

Summary Statement

OMI's investigation and review of its findings did not reveal any evidence of substantial and specific danger to public health and safety. Review of the investigation did not find any violation or apparent violation of statutory laws or mandatory rules or regulations set forth in the Code of Federal Regulations.

I. Introduction

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate a complaint filed with the Office of Special Counsel (OSC) by (b) (6) MD, a hospitalist physician and the whistleblower, at the Wilkes-Barre Veterans Affairs (VA) Medical Center, Wilkes-Barre, Pennsylvania (hereafter, the Medical Center). The whistleblower alleged that employees are engaging in conduct that may create a substantial and specific danger to public health and safety at the Medical Center. OMI conducted a site visit to the Medical Center on April 10-12, 2013.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network 4, is a 68-bed facility, complexity level 2 hospital that provides a full range of patient care services and comprehensive health care through primary and tertiary care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, hematology, and nephrology.¹ It has a 30-bed medical-surgical unit, a 16-bed combination intensive care unit (ICU)/Telemetry unit (6 and 10 beds respectively), a 12-bed inpatient mental health unit, and a 10-bed substance abuse residential treatment unit. In addition, there is a 105-bed community living center (CLC).

The Medical Center is an intermediate surgical complexity level facility that runs two operating rooms (OR) and one procedure room.² From June 2012 through March 2013, the Medical Center performed eight emergency surgeries after normal duty hours, night shift or weekends, requiring an OR team to be called in. The cases included: six general surgery operations (three appendectomies, one incarcerated hernia repair, one exploratory laparotomy, and one umbilical hernia repair) and two orthopedic operations (open reduction and internal fixations of the hip.) The number of surgical patients transferred out to non-VA (community hospitals) during this timeframe was 132 unique patients.

There was an average of 8.5 patients seen in the emergency department (ED) on the night shift for FY 2012.

The Medical Center has a close collaborative relationship and sharing agreements with several health care systems in the community surrounding the Medical Center, to include: Geisinger Health System (Geisinger Wyoming Valley, their most frequently used referral site, and Geisinger South Wilkes-Barre); Wyoming Valley

¹ There are five levels of hospital complexity: 1a, 1b, 1c, 2, and 3, in descending order of complexity. VA determines facility complexity based upon a formula that considers the patient population, the patient risk, the level of intensive care unit and complex clinical programs, as well as education and research indices.

² Hospitals assigned a "complex" rating require special facilities, equipment and staff for difficult operations, such as cardiac surgery and craniotomies. Those with an "intermediate" rating may perform less complex surgeries, such as partial colon removal and complete joint replacement. Those with a "standard" rating may perform inpatient surgeries, such as hernia repair and ear, nose, and throat (ENT) surgeries.

Health Care System (Wilkes-Barre General Hospital and First Hospital Wyoming Valley); and Kindred Hospital-Wyoming Valley.

III. Summary of Allegations as Provided by OSC

- Employees at the Medical Center failed to require "on-call" physicians to report to the Medical Center when an on-site treating physician makes an emergency call.
- Employees at the Medical Center placed patients at risk by delaying treatment or necessitating their transfer to other facilities when "on-call" physicians failed or refused to report to the Medical Center.

IV. Conduct of Investigation

An OMI site visit team consisting of (b) (6) M.D., Medical Inspector, (b) (6) (b) (6) M.D., Deputy Medical Inspector, Professional Services, and (b) (6) RN, Clinical Program Manager, conducted the site visit. The OMI site visit team and (b) (6) M.D., Medical Investigator, reviewed relevant policies, procedures, reports, memorandums and other documents, as well as the electronic health records (EHR) of four Veterans named by the whistleblower. A full list of the documents reviewed is in the Attachment. OMI held entrance and exit briefings with Medical Center leadership.

The whistleblower was interviewed prior to (by telephone conference), and during the site visit. During his interview at the Medical Center, he was accompanied by (b) (6) (b) (6) a non-VA representative; who sat in as an observer. OMI also interviewed the following individuals during the site visit: (b) (6) Medical Center Director; (b) (6) M.D., Chief of Staff; (b) (6) Nurse Executive; (b) (6) Interim Associate Director; (b) (6) M.D., Chief, Medical Service; (b) (6) (b) (6) M.D., Chief Surgical Service; (b) (6) M.D., Associate Chief, Medical Service and the whistleblower's direct supervisor; (b) (6) M.D., orthopedic surgeon; (b) (6) M.D., orthopedic surgeon; (b) (6) M.D., general surgeon; (b) (6) M.D., general surgeon; (b) (6) M.D., psychiatrist; (b) (6) M.D., Director, ED; (b) (6) M.D., ED physician; (b) (6) (b) (6) M.D., hospitalist; (b) (6) M.D., hospitalist; (b) (6) M.D., hospitalist; (b) (6) M.D., hospitalist (by telephone conference); (b) (6) M.D., hospitalist (by telephone conference); (b) (6) M.D., radiologist; (b) (6) M.D., Radiologist; (b) (6) RN, night shift Nurse Supervisor; and (b) (6) RN, night shift ED staff nurse. Additionally, after the site visit, (b) (6) M.D., general surgeon; (b) (6) M.D., hospitalist, and (b) (6) M.D., hospitalist, were interviewed individually by telephone conference, because they were off duty at the time of the site visit.

The Office of General Counsel reviewed OMI's findings to determine if there was any violation of law, rule, or regulation.

OMI **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. OMI **did not substantiate** allegations when the facts showed the allegations were unfounded. OMI **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegations.

V. Findings, Conclusions, and Recommendations

Allegation 1

Employees at the Medical Center failed to require “on-call” physicians to report to the Medical Center when an on-site treating physician makes an emergency call.

The whistleblower alleged that:

- The Medical Center implemented a policy, specified in an email from Dr. (b) (6) (b) (6) the Chief, Medical Service, granting doctors the prerogative to choose whether or not to come in when summoned as a part of their on-call duties.
- The on-call policy at the Medical Center is contrary to that of most other hospitals in the country, both VA and otherwise.
- The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), 42 U.S.C. § 1395dd, guidelines require summoned on-call physicians to report to the hospital within a certain time period. One Veterans Health Administration (VHA) Directive indicates that the VHA complies with the intent of EMTALA, specifically in regard to the Inter-Facility Transfer Policy, VHA Directive 2007-015.

Findings

The whistleblower is one of eight hospitalists employed at the Medical Center as full time VA personnel. According to the Medical Center policy, *Hospitalist Program*, a hospitalist is an internal medicine or family medicine board-certified/board-eligible physician responsible for management of inpatient care, 24 hours per day, 7 days a week (24/7). The hospitalists work 12-hour shifts, 7 days on followed by 7 days off. While working days they work from 8 a.m. - 8 p.m. and while working nights they work from 8 p.m. - 8 a.m. During a 6 week period, they work 2 weeks of days and 1 week of nights; they have 1 week off after each week of work. There are usually three hospitalists working during the day shift: two cover the inpatient ward and one assists in the ICU/telemetry unit. The ICU also has an intensivist (a board-certified/board-eligible internist with critical care training and experience) who provides coverage in the ICU 8 hours a day, Monday through Friday. There are several physician extenders that assist the hospitalists at various times during the day and night shifts. During the night shift, the hospitalists are responsible for management of inpatient care (medical ward and ICU), new admissions to the

Medical Center, the CLC, and issues that might arise with inpatient surgery and psychiatry patients.

After normal duty hours, the ED physician notifies the on-duty hospitalist when a patient requires admission to one of the units. If the hospitalist evaluates an ED patient who requires surgical or more complex treatment than he or the ED physician is able to provide, the hospitalist would then have the ED physician notify the on-call physician consultant. The on-call schedule is updated monthly and available to the Medical Center telephone operators who are responsible for calling the specific on-call employee or physician specialist.

Through the years, the Medical Center has had difficulty recruiting some specialty physicians, especially surgeons. For example, prior to 2010, there was only one orthopedic surgeon employed at the Medical Center. For approximately 6 to 7 years, he worked during normal duty hours and after hours he provided "telephone-only" consultations. He had an agreement and understanding that he would not be required to come in at night after working all day. Being available to the hospital 24/7 was not expected and would not have been consistent with a patient safety environment. After the hiring of a second orthopedic surgeon, these physicians were scheduled for "telephone-only" consultation from 2010 until August 2012. Currently, each orthopedic surgeon, in addition to working their day schedule, usually is on-call 15 days per month, with half of the call being regular and half "telephone-only." As agreed to previously, they are not required to come in when scheduled for "telephone-only" on-call coverage. Also, due to limited staffing of physicians in other specialties, e.g., urology and psychiatry, physician call is sometimes limited to "telephone-only." When there is "telephone-only" consultation from on-call physicians, it is annotated on the on-call schedule in advance.

The Medical Center has well established patient transfer sharing agreements with several community hospitals to accept patients who need emergent specialty care or a tertiary level of care that cannot be provided at the Medical Center. This could be either because the Medical Center does not provide the required level of care or because it is during a period of "telephone-only" coverage for that specialty.

VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, addresses which surgical procedures a facility is allowed to perform based on the complexity of the surgical procedure and the level of requirements for postoperative care. Surgical complexity is designated as standard, intermediate, or complex. Based on VA criteria, the Medical Center is an intermediate complexity facility for surgery. Once a determination has been made that the Veteran has a condition that should be referred out, the Medical Center calls the transfer center at the community hospital whose staff receives the transfer information and connects the Medical Center's ED physician or hospitalist with a hospitalist at the community hospital. The primary community hospital where the Medical Center refers the majority of their emergent complex patients, Geisinger Wyoming Valley, is 2.5 miles/6 minutes away from the

Medical Center. The patients are immediately referred and as soon as a bed is available transferred to the community hospital. Multiple providers reported to OMI that this practice expedites the definitive care of the Veteran.

VHA Directive 2010-018 also delineates the requirement for surgical physician staffing call schedules at intermediate facilities, "Formal General Surgery and Specialty Service Call Schedule, availability 24/7 within 60 minutes....there must be coverage by surgical staff...within 15 minutes by telephone or 60 minutes in person." The Medical Center policy 112-11-160, dated April 12, 2011, *On-Call Status*, requires that, "Individuals placed in on-call status must meet the 15 minute response time criteria established by the Medical Center. The on-call individual and the medical officer of the day (MOD) will determine the next level of treatment required, e.g., time of physician arrival, orders needed to stabilize the patient, and/or determination to transfer the patient to another facility." When contacted, the surgeon makes a clinical medical decision based on their knowledge and experience to provide treatment advice or come in to evaluate the patient. The treatment advice can include a recommendation for transfer to a tertiary facility, if clinically appropriate. The expected response time is 15 minutes by telephone or 60 minutes in person.

In response to an incident that occurred on the night of August 27, 2012, where the whistleblower and the general surgeon on-call were in disagreement (described under Allegation 2, Veteran 1), Dr. (b) (6) the Chief, Medical Service, sent an email to the hospitalists on August 28, 2012, that read:

Please remember when you are asking for a stat consult off hours, you have to call the consultant and present the case history to the consultant. The consultant after hearing the history and other pertinent information may advise you to manage/treat the patient in a certain manner and order further testing according to the clinical scenario. The consultant may opt to wait till the morning to physically see the patient. You need to document in your note that you discussed the case with the consultant and the recommendations made by him/her. It is the consultant's prerogative to either come in or not and they have the legal responsibility for their decision thereafter. The hospitalist/ER MOD cannot require the consultant to come in right away. The hospitalist/ER MOD cannot refuse to give the details about the patient to the consultant.

If after discussing the case with the consultant you are not satisfied about the advice you receive you can contact the Service Chief, Dr. (b) (6) [Associate Chief, Medical Service], Dr. (b) (6) [Chief, Medical Service] or the COS [Chief of Staff] for further guidance.

Please talk to each other in a professional manner and act in the best interest of the Veteran patient. During non admin hours you [the hospitalist] are in charge of the entire inpatient services and it is your duty and responsibility to take care of the patients in all the areas.

OMI was informed that the on-call physician specialists accept responsibility for their recommendations based on the information provided by the hospitalist and are held accountable for these recommendations.

On-call policies are a local issue and vary from facility to facility depending on the staffing available. Many facilities, both private and VA have limited physician resources and their on-call practices are shaped by their available resources and transfer agreements. The American Board of Medical Specialties defines six core competencies for physicians: Professionalism, Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, and Systems-based Practice. The Systems-based Practice competency requires the physician to: demonstrate awareness of and responsibility to larger context and systems of healthcare, and be able to call on system resources to provide optimal care (e.g., coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites). This requires an understanding of the system of care of your Medical Center.

Except for the whistleblower, all the Medical Center hospitalists voiced an understanding of the limitations of complexity at the Medical Center, and the on-call policies to include the "telephone-only" consultations. Although, a couple of the hospitalists reported that in the past there had been issues with orthopedic and urology specialists on-call, currently they all, except the whistleblower, described a collaborative relationship with the on-call specialty physicians, and reported that they do not have a problem getting them to come in when needed or getting the necessary consultation, and reported that they felt secure in providing safe care to their patients.

EMTALA "was passed in 1986 amid growing concern over the availability of emergency health care services to the poor and uninsured. The statute was designed principally to address the problem of "patient dumping," whereby hospital emergency rooms deny uninsured patients the same treatment provided paying patients, either by refusing care outright or by transferring uninsured patients to other facilities."³ It is VHA policy that all transfers in and out of VA facilities are accomplished in a manner that ensures maximum patient safety and are in compliance with the transfer provisions of EMTALA and its implementing regulations. The established policy of a 15 minute telephone response by the on-call physician specialists in conjunction with the transfer agreements, which includes payment between the Medical Center and the community hospitals, ensure the expedient and safe transfer of patients requiring a higher level of care.

Conclusions

- OMI did not substantiate the allegation that the Medical Center did not have a timely on-call response system.

³ "The History of EMTALA," www.EMTALA.com.

- The Medical Center's practice of allowing specialist physicians to use their medical judgment in determining how they provide consultations for the care of patients and holding them accountable for their decisions is not contrary to that of other VA hospitals or hospitals in the private sector.
- Except for the whistleblower, all Medical Center hospitalists voiced an understanding of the on-call policy, procedures, and practices, and they could accurately describe these processes. The Medical Center has ensured adequate and safe patient care with their on-call physician specialist coverage.
- The Medical Center is in compliance with the intent of EMTALA.

Recommendations

- None

Allegation 2 and Supporting Information in OSC Letter

Employees at the Medical Center placed patients at risk by delaying treatment or necessitating their transfer to other facilities when “on-call” physicians failed or refused to report to the Medical Center.

The whistleblower alleged that:

- The Medical Center's lax on-call policy has caused numerous incidents in which patients were made to wait to be seen by a specialist, despite presenting with issues requiring immediate assistance.
- When he called an on-call specialist to come in to see an emergency surgical patient, the on-call specialist refused to come in, opting to manage the patient's care over the telephone.
- In some cases patients were transferred to other facilities for emergency treatment, subjecting them to the unnecessary risks associated with transfer.
- The letter from OSC to the Secretary of Veterans Affairs detailed three Veteran patients that the whistleblower provided as evidence of the above allegation. During his interview with OMI, he provided information about a fourth case.

Findings

An on-call surgeon refused to come in to see a patient who had a bowel obstruction that required emergency surgical intervention. The whistleblower submitted the following synopsis as part of the OSC letter.

On August 28, 2012, a patient came through the emergency department with stomach pain. The emergency department physician advised that the patient be admitted to the medical service where the whistleblower was working. The radiologist in medical services read the CT scan that came with the patient's file and found a bowel obstruction to the level of a surgical emergency. The whistleblower wanted a surgeon to come in so he had someone from the emergency department contact the on-call surgeon, Dr. (b) (6) and summon him to look at the patient. The surgeon suggested the emergency department physician use a nasogastric (NG) tube to evacuate the stomach contents and help relieve the patient's vomiting. The whistleblower felt that additional treatment was necessary, and instructed the emergency department physicians to contact the on-call surgeon again and tell him to come in. The surgeon called the whistleblower, screamed at him, called him an idiot, and remarked that all the patient needed was a NG tube. The whistleblower informed the surgeon that the reading of the CT scan provided by the radiologist indicated a serious bowl obstruction, but the surgeon disagreed. The whistleblower asked the surgeon, "Are you refusing to come in?" and he said, "Yes." The whistleblower then had the patient admitted to the medical service to have a NG tube put in.

Veteran 1 is a (b) (6) male with a history of uncontrolled diabetes, chronic nausea (for at least the last year), chronic constipation, and diabetic gastroparesis.⁴ On (b) (6) (b) (6) 2012, at approximately (b) (6) p.m., he was seen in the ED with complaints of generalized weakness, nausea, constipation, and the inability to eat for two days without vomiting. He had been hospitalized at the Medical Center in (b) (6) of 2012, with similar symptoms, and at a local facility on (b) (6) 2012, with a diagnosis of diabetic ketoacidosis; in each admission, he was managed medically with improvement. He had no history of prior abdominal surgery. His vital signs were stable with a temperature (T) of 96.8, a pulse rate (P) of 69, respiratory rate (R) of 18, and a blood pressure (BP) of 145/82. The Veteran was evaluated by the ED attending who annotated in his EHR that his abdomen was soft, non-tender, non-distended with hypoactive bowel sounds, and that there was no rebound, guarding, or rigidity (no acute surgical signs). In addition, the Veteran denied having any abdominal pain. The ED nurse inserted an intravenous (IV) line to hydrate and medicate him. He had a blood sugar of 268, and an acute abdominal series of x-rays showed no acute findings and no significant changes compared to films taken 2 ½ months ago, during a prior admission.

Because of his history of nausea with constipation and a normal acute abdominal series, Veteran 1 underwent a computerized tomography (CT) scan of the abdomen and pelvis, with and without contrast.⁵ He tolerated drinking the oral contrast without vomiting. The CT scan impression reported "small bowel obstruction." Sometime before the ED received this report, the Veteran was served and ate dinner in the ED.

⁴ Gastroparesis, common complication of diabetes, is a condition that reduces the ability of the stomach to empty its contents. It does not involve a blockage (obstruction). The exact cause of gastroparesis is unknown. It may be caused by a disruption of nerve signals to the stomach.

⁵ A CT scan combines a series of x-rays and computer processing to create cross-sectional images of the body.

After receiving the CT report, the patient was ordered to have nothing by mouth and the ED nurse inserted an NG tube to drain his stomach. There was no reported clinical evidence that the Veteran had a small bowel obstruction. Before he would admit the patient, the whistleblower reported that he had insisted that the general surgeon come in from home to evaluate Veteran 1. Both providers reported a heated discussion about this issue. The whistleblower reported to OMI that he was aware of the CT results. The ED nurse annotated in the EHR, that Dr. (b) (6) (the general surgeon) evaluated the patient in the ED, but there was no documentation of the whistleblower evaluating the patient in the ED. At (b) (6) p.m., the general surgeon noted in the Veteran's EHR that he had seen and examined the Veteran after being consulted. He concluded that Veteran 1 had poorly controlled diabetes, severe gastroparesis with no clinical evidence of bowel obstruction, and no evidence of a surgical emergency.

At (b) (6) p.m., Veteran 1 was admitted to the medical ICU for further observation and management. The whistleblower completed his history and physical note in the EHR after the Veteran arrived on the unit.

During his hospitalization, the Veteran's symptoms were managed medically; he was evaluated by gastroenterology which also noted that he did not have evidence of a small bowel obstruction. The patient was discharged home on (b) (6) 2012, without surgical intervention.

The ED physician called an on-call orthopedic surgeon to come in to assess a patient requiring an immediate orthopedic surgical intervention and was told the surgeon was out of state. The whistleblower submitted the following synopsis as part of the OSC letter.

In late June, 2012, a patient presented to the emergency department on a Friday evening. The emergency department physician called the on-call orthopedic surgeon and was told that he was out of state. The emergency department physician called the whistleblower to admit the patient to the medical service, but the whistleblower could not do so because the patient required immediate orthopedic surgical intervention. The emergency department physician attempted but was unable to transfer the patient to another facility for appropriate care. On Saturday morning, the emergency department physician again called the whistleblower requesting that the patient be admitted to the medical service. The whistleblower repeated his concern that the patient required immediate surgical intervention that he was unable to provide. After the emergency department physician sought Dr. (b) (6) (the Chief, Medical Service) intervention, the whistleblower was ordered to admit the patient to the medical service, which he did. The whistleblower initiated antibiotic therapy and pain medication. On Monday morning, the patient was taken to the operating room for the appropriate surgical procedure.

Veteran 2 is a (b) (6) male with a history of left open rotator cuff repair at the Medical Center on (b) (6) 2012. He received perioperative antibiotics. He was discharged to home on (b) (6)

He was seen in the Orthopedic Clinic multiple times postoperatively. On (b) (6) his left shoulder wound was noted to be healed, with some redness on the superior aspect of the incision. He was afebrile and without pain. He was diagnosed with possible wound cellulitis and treated with an oral antibiotic. On (b) (6) Veteran 2 called the orthopedic clinic; he had completed his antibiotics and reported that he "got worse." He reported that 2 days prior to this visit, the incision became painful and began draining fluid; the drainage required dressing changes three to five times a day. Upon examination, he was afebrile and the orthopedic surgeon noted a small open area with yellowish drainage, which he cultured. The incision was opened further to allow for additional drainage, and a dressing applied. The Veteran was advised to return in two days for culture and sensitivity results. He was also started on a different oral antibiotic course.

Two days later, on (b) (6) the Veteran reported that his pain had decreased, but he continued to have a large amount of watery drainage. He was evaluated by the other orthopedic surgeon and on examination was noted to have a large amount of yellow-tinged, relatively clear drainage on the dressing. The Veteran did not complain of pain when pressure was applied to the area. The surgeon's impression was: "Cellulitis and abscess of anterior aspect of incision of shoulder, with improvement on antibiotics." The plan was to continue on the oral antibiotics, and to return for followup in 5 days with the surgeon who performed his surgery or sooner if he became febrile, had increased pain, or developed any other signs of worsening infection.

On Saturday, (b) (6) at approximately (b) (6) p.m., Veteran 2 presented to the ED with complaints of pain, swelling, and redness over the left shoulder with continued drainage. His vital signs were stable; he was afebrile with a T- 98, P-75, R- 20 and a BP of 179/98. His white blood cell count was normal at 7.6. Upon examination by the ED physician, his skin was warm and dry, and his left shoulder joint red, warm, and tender to touch. There was seropurulent discharge from the shoulder. A chest x-ray was taken with normal results, and a left shoulder x-ray showed evidence of interval surgery, but was otherwise "unremarkable and stable." An IV was started and IV antibiotic administered. An EKG was done and the appropriate blood cultures drawn.

Both orthopedic surgeons were out of town; however, one was providing "telephone-only" coverage while on annual leave. The ED physician discussed the case with the orthopedic surgeon providing "telephone-only" consultation and they concluded the patient had failed treatment with oral antibiotics and should be treated with IV antibiotics. In addition, the consulting orthopedic surgeon recommended transfer to a private facility as there was "telephone-only" orthopedic consultation over the weekend at the Medical Center. At (b) (6) p.m., a note was annotated in the EHR that the Veteran was to be transferred to a community hospital. The ED physician also discussed the case with the in-house hospitalist, the whistleblower.

The ED physician attempted to get the patient admitted to a community hospital's orthopedic service, but could not find an accepting orthopedic surgeon. He discussed the case with both the Chief of Surgery and the Chief of Medicine and they recommended transferring the patient to the hospitalist service at the community

hospital-- utilizing their transfer agreements. Veteran 2 was accepted to the hospitalist service at the community hospital; however, at that time, there was not an available open bed. The plan was to treat Veteran 2 in the ED until a bed was available. The Veteran was appropriately treated with IV antibiotics and pain medications in the ED while awaiting transfer.

The following morning, on (b) (6) a bed was still not available at the accepting facility. The Medical Center contacted all of their other referral hospitals and they too had no beds available. As Veteran 2 had remained in the ED overnight, since there were still no beds available in the community, the ED physician requested that the whistleblower admit the patient to the Medical Center to continue his IV antibiotic treatment. The ED physician again discussed the situation with the Chief of Medicine who decided to admit the patient to the Medical Center's hospitalist's service for continued IV antibiotic treatment. The whistleblower ordered a CT of the shoulder which was interpreted as, "There is a focal area of subcutaneous induration and subcutaneous soft tissue increased density superior and lateral to the left acromion. Clinical correlation for possible site of surgery. No other abnormality seen and no other interval change noted."

The Veteran's wound continued to drain and he remained stable over the entire 48 hours on IV antibiotics. On the morning of (b) (6) he was evaluated by his orthopedic surgeon, who concluded Veteran 2 had a wound infection and a possible infected joint. That afternoon, he performed a thorough irrigation and debridement of his left shoulder joint and found a complete failure of his rotator cuff repair; a repeat culture of the wound was negative. Veteran 2 remained in the hospital for 4 days receiving IV antibiotics and pain management. Infectious disease was also consulted and noted that Veteran 2 has remained afebrile with a normal white blood cell count and negative cultures. They recommended insertion of a peripherally inserted central catheter so he could be discharged to home where he would receive 4 weeks of outpatient IV antibiotics.

Six months later in (b) (6) 2013, Veteran 2 on examination was noted to have no signs of infection, a well-healed, non-tender anterior scar and left shoulder, and a range of motion similar to his right side.

An inpatient, who developed an incarcerated bowel, was transferred to a community hospital because the on-call surgeon did not want to come in. The whistleblower submitted the following synopsis as part of the OSC letter.

On (b) (6) 2012, a patient had been in the hospital for a week when he developed acute abdominal pain, nausea and vomiting. The whistleblower ordered a CT scan for the patient. The whistleblower determined that the patient's hernia had become incarcerated (a serious issue in which the bowel is trapped in a hole too small for blood or stool to pass through). According to the whistleblower, there are some ways that the problem can be repaired without surgery, but he had attempted them and was unsuccessful. The whistleblower noted that these symptoms, along with the failure of nonsurgical interventions, indicate a surgical emergency. The

whistleblower then had the surgeon on-call, Dr. (b) (6) called. Dr. (b) (6) (the surgeon) advised transferring the patient to a different facility, not wanting to come in. The whistleblower called the Geisinger Medical Center (a local facility) to arrange for the patient's transfer. The whistleblower and Geisinger staff arranged for the patient to be transferred, and the general surgeon was able to repair the problem through nonsurgical means.

Veteran 3 is a (b) (6) male with a history of multiple co-morbid medical conditions including diabetes, alcohol abuse in remission, and chronic pancreatitis. He was admitted to the medical telemetry unit, on (b) (6) 2012, "in poor condition", with complaints of nausea with vomiting, and weakness for three weeks. He reported experiencing diarrhea for over a year. In addition, he complained of dizziness and falling twice a day for the three days prior to admission. The Veteran also stated that he hurt all over. His blood pressure was 101/58, but the other vital signs were within normal limits. During this hospitalization, he was found to have an acute kidney injury, multiple electrolyte abnormalities, colitis, pneumonia, and anion gap metabolic acidosis.⁶ His lactate level went as high as 3.2 (high normal 2.6). He was aggressively treated for his acute renal failure, septic shock, and severe fluid and electrolyte abnormalities.

On (b) (6) at approximately (b) (6) a.m., Dr. (b) (6), the Chief of Surgery, completed a surgical consultation on the patient. He noted that the Veteran's abdominal exam was soft and non-distended, and documented multiple abdominal wall defects, with a reducible hernia, and that was not incarcerated. He also noted that the Veteran seemed a little worse with acidosis probably secondary to renal failure, and possible colitis or bowel ischemia. He recommended a CT scan, and a nephrology consult. In addition, he noted, "if the CT scan shows worsening or concern for compromised bowel, he will need to be transferred to appropriate facility for any surgical intervention."

That morning, the Veteran underwent a CT of his abdomen without contrast, which was reported as showing mural thickening of the colon with possible increased mesenteric fat stranding, suspicious for ischemia versus colitis. The radiologist called the ordering physician and recommended correlation with a serum lactate level, and documented the notification on the radiology report.

At (b) (6) p.m., the patient underwent another surgical consultation requested because of his non-functioning dialysis catheter; Dr. (b) (6) (a general surgeon) examined the Veteran and inserted a new dialysis catheter. He noted that Veteran 3 was alert and oriented, not in distress, and tolerated the procedure well. The Veteran went to dialysis.

⁶ Metabolic Acidosis is a condition in the body in which there is an excess of acid. This is either because the body naturally produces too much acid for the kidneys to filter at once or it is because the kidneys are simply not filtering acid at a normal pace. The "anion gap" portion is in reference to a system of calculation of ions. The causes of an increased anion gap metabolic acidosis are: chronic renal failure, rhabdomyolysis, ketoacidosis (which is often in conjunction with diabetes) and lactic acidosis.

At (b) (6) p.m., he completed the dialysis, and received three units of blood. His vital signs were stable. He was complaining of abdominal pain. Post dialysis blood work was drawn, and a repeat CT scan was ordered. He continued to have marked electrolyte abnormalities. At (b) (6) p.m., the whistleblower reviewed the results of the repeat CT and in his interview with OMI reported that he spoke to the radiologist who told him the CT scan demonstrated an incarcerated hernia. However, the CT report documents "no intestinal obstruction," and does not report any discussion with the whistleblower. The whistleblower reported that the results revealed "an incarcerated loop of bowel in an anterior abdominal wall hernia that was not present on the CT of the abdomen done earlier in the day." The whistleblower spoke with Dr. (b) (6) the general surgeon on-call that evening, (not Dr. (b) (6) another general surgeon, as stated in the OSC letter), who told him that if he felt the Veteran had a surgical emergency the whistleblower needed to transfer him to a facility that could provide the appropriate level of care, as annotated in the general surgery consult already completed that day, and that his evaluation would only delay the potential surgical care of the patient.

On (b) (6) at approximately (b) (6) a.m., after being stabilized, Veteran 3 was transferred to a community hospital. The internal medicine service at the community hospital managed his medical problems. The community hospital surgeons evaluated the patient; they concluded there was no evidence of any incarcerated hernias and that the patient did not need emergent operative intervention. The Veteran was discharged to home on (b) (6) 2012.

OMI reviewed the CT scan in question with a Medical Center radiologist previously unfamiliar with the case who determined the CT did demonstrate a loop of bowel in an abdominal wall hernia but without evidence of incarceration – contrast freely flowed into the bowel; there was no bowel wall thickening, or surrounding edema.

During his on-site interview with OMI, the whistleblower alleged that a patient was not appropriately examined by a Medical Center cardiologist, necessitating the emergency transfer of the patient to a community hospital, three days after being seen. The whistleblower verbally provided OMI the Veteran's name, the last four numbers of his Social Security number, and the below clinical information. This information was not in the OSC's letter, and is therefore not in italics.

On (b) (6) 2013, a (b) (6) patient, with a history of complete heart block and a pacemaker was seen at the Medical Center in cardiology for followup pacemaker placement and then went home. On (b) (6) he was seen in the Medical Center's ED where he was emergently transferred to a community hospital with multisystem failure and endocarditis. The whistleblower reported that he works part time at the community hospital, and had run into the Veteran's wife who informed him, that she told a nurse during her husband's cardiology appointment that he had a red spot and swelling over his pacemaker site. The

wife also reported that the nurse told her that her husband's blood pressure was low, and that her husband should have been treated differently. The whistleblower reported that he had reviewed the patient's Medical Center EHR, and in a nurse's note observed that the patient's blood pressure was annotated as 81/40 and 107/51, during the cardiology visit. He also said that the cardiologist had not performed a skin examination. The whistleblower later stated, during the OMI interview, that he had reviewed the Veteran's EHR with the permission of his supervisor.

Veteran 4 is a (b) (6) male with a past medical history of ischemic cardiomyopathy and congestive heart failure.⁷ On (b) (6) 2013, the Veteran was evaluated in the ED for shortness of breath and pedal edema of 1 week duration. The evaluation revealed an exacerbation of congestive heart failure, and a new diagnosis of complete heart block that warranted transfer to a community hospital for the placement of an implantable cardiac pacemaker.⁸ Following implantation of a cardiac pacemaker and a 7-day hospitalization, the community hospital physicians discharged the Veteran to home.

On (b) (6) 2013, the Veteran's primary care physician at the Medical Center evaluated him. The EHR documented the presence of multiple chronic ecchymosis and a surgical scar at the pacemaker placement site.⁹ It was also documented that the skin was clean and dry, and that there were no signs of infection.

On (b) (6), the Veteran reported for a scheduled followup with a cardiologist at the Medical Center. The nurse's note documented the Veteran had "no [complaints of] pain; however [he] does state [that the] home health nurse feels his [blood] pressure is too low." The EHR contains documentation that Veteran 4 "reports having some pinkish skin on the pacemaker site and he feels that it is swollen as well." The Veteran's vital signs were notable for a normal temperature, a pulse ranging between 93 and 98, and a blood pressure ranging between 81/40 and 107/51. The cardiologist evaluated the Veteran, and generated a progress note that was entered after the nurse's note. The cardiologist documented that the Veteran "has done well" since the pacemaker placement, but that "he does have red spots all over which he says are secondary to a skin problem that he has had for a long time" and for which he is followed by dermatology. The cardiologist does not mention specifically the pacemaker site. The cardiologist does not document any complaints of chest or left shoulder pain and having identified no additional concerns, he discharged the Veteran home. The whistleblower reports the Veteran and his wife indicated to him at the community hospital (where he

⁷ Ischemic cardiomyopathy is a condition that occurs when the heart muscle is weakened due to a heart attack or coronary artery disease. In this condition, the heart muscle is enlarged and dilated, which causes an inability to effectively pump blood. Congestive heart failure manifests as shortness of breath, leg swelling, and exercise intolerance.

⁸ Complete heart block is a life threatening medical condition in which the electrical impulses generated in one chamber of the heart, the atrium, is not propagated to the second chamber, the ventricle.

⁹ Ecchymosis is the medical term for subcutaneous, purplish discolorations that are caused by bleeding underneath the skin.

was working as a private physician) that the Veteran complained of left shoulder blade pain to the cardiologist.

Two days later, on (b) (6) the Veteran was admitted to another community hospital with left shoulder blade pain, an elevated troponin level, hypotension, and anemia. He was diagnosed with a myocardial infarction and sepsis.¹⁰ The pacemaker implantation site was reported as being healthy and did not have edema or evidence of a hematoma or infection.¹¹ The Veteran was diagnosed with methicillin-resistant staphylococcus aureus bacteremia most likely related to the recent pacemaker placement, and was admitted to the intensive care unit.¹² The community hospital cardiologist completed a transesophageal echocardiogram that revealed mitral valve vegetations and a suggestion of pacemaker involvement. The Veteran's treating physicians did not remove the pacemaker; they did treat him for subacute bacterial endocarditis.¹³

Conclusions

- OMI did not substantiate the whistleblower's allegation that the Medical Center's on-call policies resulted in numerous cases when patients required immediate treatment which was delayed.
- In the cases reviewed, OMI did not substantiate the whistleblower's allegation that emergency surgical care was not available when needed.
- In the treatment of any patient, it is important to evaluate both the patient and the diagnostic studies together to make appropriate clinical decisions.
- The Medical Center's "telephone-only" call policy ensures availability of consultation 24/7, during periods of time when they would not have any coverage available.
- A VA orthopedic surgeon, who had agreed to fulfill a "telephone-only" on-call consultation need for the Medical Center, did respond telephonically while on scheduled leave.
- OMI did not substantiate the allegation that employees at the Medical Center placed patients at risk by delaying treatment or necessitating their transfer to other facilities when "on-call" physicians failed or refused to report to the Medical Center.

¹⁰ A myocardial infarction is also known as a heart attack. Sepsis is a potentially fatal medical condition caused by an overwhelming bloodstream infection which causes a systemic inflammatory state.

¹¹ A hematoma is a localized collection of blood outside of a blood vessel.

¹² Methicillin-resistant Staphylococcus aureus is a bacterium responsible for several difficult-to-treat infections in humans.

¹³ A transesophageal echocardiogram uses an ultrasound transducer probe placed into the esophagus to produce clear images of the heart and its structures. Mitral valve vegetations represent groups of bacterial colonies and products of the body's inflammatory response on the mitral valve. These vegetations are visible by echocardiography. Subacute bacterial endocarditis is the constellation of conditions which include inflammation of the inner layer of the heart and its valves due to a bacterial infection.

Recommendations

- None

Summary Statement

OMI's investigation and review of its findings did not reveal any evidence of gross mismanagement or substantial and specific danger to public health and safety. Review of the investigation did not find any violation or apparent violation of statutory laws, or mandatory rules or regulations set forth in the Code of Federal Regulations.

Attachment

Documents Reviewed by OMI

- VHA Directive 2007-015, *Inter-Facility Transfer Policy*
- VHA Directive 2009-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities.*
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, of Complex Surgical Procedures*, Attachment A (lists the on-call requirements for different facility complexity levels)
- VHA Handbook 1101.05, *Emergency Medicine Handbook*
- VA HR Handbook 5011, *Establishment of Workweeks, Tours of Duty, and Work Scheduled for Employees appointed to Title 38 Positions*, January 12, 2007
- Medical Center Policy 16-11-299, *Patient Transfers/Referral Policies*, April 13, 2011
- Medical Center Policy 111-11-106, *Hospitalist Program*, April 7, 2011
- Medical Center Policy 112-11-160, *On-Call Status*, April 14, 2011
- Medical Center Memo re: Job Opportunity #2010-D-17, *Medical Service Hospitalist Duties*
- *Medical Center Bylaws and Rules of the Medical Staff of VHA*, March 8, 2013
- Electronic Health Records of the four Veterans named by the whistleblower
- On-call Schedules for all physician specialists, January-April 2013 and July and August 2012