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The Special Counsel

February 10, 2014

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-13-0416

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find an agency report based on disclosures made by a whistleblower at the Department of Veterans Affairs (VA) Medical Center in Wilkes-Barre, Pennsylvania. The whistleblower, Dr. Thomas Tomasco, who consented to the release of his name, was employed as a hospitalist at the Medical Center. He alleged serious health and safety risks stemming from flawed on-call procedures utilized by the facility.

The agency investigation did not substantiate Dr. Tomasco's allegations. The agency concluded that the Medical Center's policy did not run contrary to that of other VA or private facilities, nor did it put patients at risk or lead to delays in treatment. The investigation found no evidence of a substantial and specific danger to public health and safety. I have determined that the agency report contains all of the information required by statute and that the findings of the agency head appear reasonable.

The allegations were referred to VA Secretary Eric K. Shinseki, on March 21, 2013. The Secretary requested the Under Secretary for Health to review the matter, and the Under Secretary tasked the investigation to the Office of Medical Inspector (OMI). The Secretary transmitted the agency's report to the Office of Special Counsel on June 4, 2013. Dr. Tomasco provided comments on the report on July 9, 2013. As required by 5 U.S.C. § 1213(e)(3), I am transmitting the report and Dr. Tomasco's comments to you.[1]

[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) and (g).

Dr. Tomasco's Allegations

Dr. Tomasco alleged that the Medical Center implemented a policy of granting physicians the prerogative to choose whether or not to come in when summoned as a part of their "on-call" duties, even in instances in which a treating physician believed immediate evaluation or treatment was required. According to Dr. Tomasco, the Medical Center's lax policy caused numerous incidents in which patients were made to wait to be seen by a specialist, despite presenting with issues requiring immediate assistance. In these instances, Dr. Tomasco, as the treating physician, determined a patient needed to be seen or evaluated for surgery immediately, and/or that the necessary treatment fell outside the scope of that which Dr. Tomasco or anyone else then present could provide. Yet in each case in which Dr. Tomasco requested the on-call physician in the relevant specialty to report to the Medical Center, the specialist refused to come in, opting instead to manage the patient's care over the telephone. Dr. Tomasco believes that this policy led to patients being put in unnecessary danger because of the delay in treatment. Moreover, in some cases, patients were transferred to other facilities for emergency treatment, subjecting them to the risks associated with transfer.

The Agency Report

According to the report, the investigation entailed a review of the relevant policies, procedures, reports, memoranda and other documents as well as the electronic health records of four veterans named by the whistleblowers. The investigators also interviewed over twenty physicians and nurses, including Dr. Tomasco, as well as the Director of the Medical Center. None of the allegations were substantiated.

The investigation did not substantiate the allegation that the on-call requirements at the Medical Center were insufficient. The investigators noted that on-call policies are a local issue and vary from facility to facility depending on the staffing available. They further noted that many facilities, both private and VA, have limited resources and their on-call practices are shaped by the available resources and transfer agreements with local community hospitals. The investigators found that the resources available to the Medical Center justified the use of a "telephone only" coverage schedule for some physicians. Moreover, all the hospitalists at the facility were able to voice an understanding of the on-call policy and its relevant processes and to provide adequate and safe patient care as a result.

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).

OMI reviewed the multiple cases presented by Dr. Tomasco as evidence that the on-call policies led to delays in treatment at the Medical Center and found that that the cases did not support such a conclusion. OMI concluded that the Medical Center's policy ensured availability of consultation at all times, even during periods when Medical Center staff would not have any coverage available. In these specific cases, OMI found that physicians involved adhered to the relevant policies and that the care administered was not delayed as a result of the on-call policy.

Dr. Tomasco's Comments

Dr. Tomasco commented that the VMAC Wilkes-Barre is held to a separate standard than that of other public and private hospitals, and stated that he personally witnessed the negative repercussions of the on-call system of the Medical Center. He believes that the system is irresponsible and will only result in inferior treatment for veteran patients.

Dr. Tomasco's recollection of events as reflected in the medical records reviewed by the OMI was not entirely supported by the evidence. His allegations that the on-call policy delayed necessary treatment for patients were not substantiated, nor were his disclosures corroborated by the other physicians, including hospitalists who use the system of telephone consultations employed by the Medical Center. For example, in his comments, Dr. Tomasco maintains that in one case the radiologist on duty incorrectly interpreted the patient's CT scan, and the investigative team did not review the correct scan in reaching the conclusion that the patient did not have a condition requiring immediate surgical intervention. A careful review of the agency report reflects that the OMI did review the CT scan in question, with a radiologist previously unfamiliar with the case. This review confirmed that the original radiologist's reading was correct. Moreover, the OMI also reviewed the patient's medical records following transfer and confirmed that the patient did not need emergent operative intervention.

Nevertheless, Dr. Tomasco raised a reasonable concern about whether it is the best medical practice to permit on-call physicians to use their medical judgment in determining how they provide consultations, by telephone or in-person, and whether this too often results in a decision to transfer a patient from the Medical Center to another local hospital. The agency report provides a satisfactory explanation for the use of the on-call response system at the Medical Center, citing the lower complexity level of the facility and its well established patient transfer sharing agreements with community health care systems.[2] These sharing agreements are used either when the Medical Center does not provide the required level of care, or during a period of "telephone-only" coverage for a particular specialty.

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[2] According to the agency report, there are five levels of hospital complexity: 1a, 1b, 1c, 2, and 3, in descending order of complexity. The Medical Center is a level 2 facility.

Dr. Tomasco also raised a concern that the Medical Center is non-compliant with the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). The agency report explained that EMTALA is designed to address the problem of "patient dumping," which occurs when hospital emergency rooms deny uninsured patients the same treatment provided paying patients. The report reiterated that VHA policy provides 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. According to the report, for this lower complexity level facility, the established policy of a 15-minute telephone response by the on-call physician specialist, together with the transfer sharing agreements, ensure the expedient and safe transfer of patients requiring a higher level of care and comply with the intent of EMTALA.

The Special Counsel's Findings

I have reviewed the original disclosure, the agency report, and Dr. Tomasco's comments. Based on that review, I have determined that the agency report contains all of the information required by statute and that the findings of the agency head appear reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent unredacted copies of the agency report and the whistleblower's comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed a redacted copy of the report and Dr. Tomasco's comments in our public file, which is now available online at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn Lerner

Carolyn N. Lerner

Enclosures