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The Special Counsel

November 24, 2015

The President
The White House
Washington, D.C. 20510

Re: OSC File No. DI-14-1588

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veteran Affairs' (VA) reports based on disclosures of wrongdoing at the Carl T. Hayden Veterans Affairs Medical Center (Hayden VAMC), Phoenix, Arizona. The Office of Special Counsel (OSC) has reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the investigation, the whistleblower's comments, and my findings.

The whistleblower, who chose to remain anonymous, asserted that employees at Hayden VAMC engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; an abuse of authority; and a substantial and specific danger to public health and safety. The whistleblower disclosed that senior practitioners at the facility failed to properly supervise physician residents and performed surgical procedures that they were neither certified nor trained to perform. The whistleblower further disclosed that after voicing concerns regarding these practices, employees at the facility improperly accessed his medical records.

**The agency did not substantiate the whistleblower's allegations concerning surgical misconduct. It determined that residents were properly supervised and that attending surgeons only performed procedures for which they were credentialed and privileged. Notwithstanding these conclusions, the initial report recommended ongoing monitoring of surgical documentation, the development of a standard operating procedure for record keeping, and training. The agency acknowledged that the whistleblower's medical records were improperly accessed on one occasion, in violation of agency policy and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule, but the VA claimed his records were viewed to obtain his home address for legitimate work-related purposes. Given the sensitivity of these records, and the fact that his address could have been found via another agency system, this explanation does not obviate the violation of law.**

**I have reviewed the agency's reports and the whistleblower's comments, and determined the agency's findings are reasonable in part. While the reports meet all statutory requirements, the accessing of the whistleblower's medical records is troubling and a recurring pattern within the VA.**

The whistleblower's allegations were referred to then-Secretary Eric K. Shinseki, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki asked the Under Secretary for Health to refer the whistleblower's allegations to the Office of the Medical Inspector for review. Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report. On February 25, 2015, Mr. Riojas submitted the initial report to OSC. On June 1, 2015, the agency provided additional documents associated with the initial report to assist with OSC's review of the matter. Pursuant to 5 U.S.C. § 1213(e)(1), the whistleblower provided comments on the agency report on May 11, 2015, and revised comments on July 12, 2015. On October 13, 2015 OSC received a supplemental report in response to a request for additional information, which the whistleblower also commented on. The whistleblower consented to the public disclosure of these comments on November 9, 2015. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and the whistleblower's comments to you.[1]

## I. The Whistleblower's Disclosures

The whistleblower disclosed that approximately 30 to 40 percent of minor surgeries and five percent of major surgeries were performed by unsupervised residents, with no attending physician present, in violation of agency policies. Surgical records were allegedly falsified to conceal this practice. The whistleblower also claimed that he personally observed supervising physicians performing minimally invasive laparoscopic surgeries for which they were neither certified nor qualified to perform, while allowing untrained residents to participate in surgeries. The whistleblower asserted this conduct contributed to serious post-surgical complications and patient deaths. After raising concerns regarding these practices, the whistleblower alleged that the scope of his involvement with training residents was improperly restricted.

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[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). 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).

The whistleblower also filed a request for his Sensitive Patient Access Report from January 1, 2012, to June 2013. Based on this report, the whistleblower alleged his medical records were improperly accessed four times by three different individuals, in violation of the Privacy Act of 1974, HIPAA, and Veterans Health Administration (VHA) Handbook 1605.2. The whistleblower contended that the three individuals who accessed his medical records were administrative employees with no legitimate reason for doing so.

## II. The Agency Reports

The initial report explained that interviews conducted with supervising physicians, service chiefs, and residents directly contradicted the whistleblower's allegations concerning resident supervision. The initial report also reviewed surgical documentation of resident supervision. During the relevant time frame, on average, 93 percent of surgeries had documentation reflecting resident supervision. Investigators also reviewed electronic health records concerning specific incidents that the whistleblower disclosed and determined that in all cases documentation was proper. The investigation further reviewed mortality and morbidity conferences that the whistleblower highlighted to support allegations concerning resident supervision. Investigators could find no evidence indicating that unsupervised residents performed these procedures. With regard to the allegation that the whistleblower's resident involvement was improperly restricted, the initial report explained that the general surgery resident associate program director had a professional disagreement with the whistleblower concerning teaching styles, and suggested adjustments to support training requirements and graduated levels of responsibility, rather than improperly restricting his clinical directions.

The agency further determined that the credentialing and privileging files of surgeons identified in OSC's referral were appropriate given the procedures they performed. In response to questions concerning a specific surgery, the initial report noted that operative records indicated that senior supervisory physicians issued appropriate surgical instructions. While the agency did not substantiate the whistleblower's allegations regarding surgical misconduct, the initial report recommended continuing appropriate resident supervision audits and documenting corrective actions as needed. In addition, the initial report recommended developing a template and a standard operating procedure to improve nursing documentation of attending and resident surgical participation. An update from the agency reported that these recommendations are currently being followed or implemented.

As to the whistleblower's allegations that his medical records were inappropriately accessed, the agency determined that the identified instances where his records were accessed by administrative personnel were legitimate and work-related. There were three specific instances highlighted in the initial report and discussed in greater detail in the supplemental report. The first was by an information technology

employee who set up the whistleblower's electronic health records. The second was by a VA police officer who accessed the records to obtain the whistleblower's work address to complete a police report concerning a dangerous patient. The reports noted that at the time, this was not a violation of VA Handbook 1605.02, which permitted VA police officers to access patient records. Finally, the reports detailed an instance where an executive assistant accessed the whistleblower's medical records to obtain his address to write official correspondence. The supplemental report indicated that this was against policy and unauthorized under the HIPAA privacy rule. Notwithstanding these conclusions, the supplemental report stated that this instance was not a violation of law but rather was authorized because it was related to an employee's official duties. Despite its refusal to acknowledge any violation of law, the VA entered this "improper access" into its Privacy and Security Event Track system for appropriate notification or remediation and provided training to the employee on privacy issues.

## IV. The Whistleblower's Comments

The whistleblower asserted that investigators minimized findings concerning resident supervision and did not access surgical records which would show complications and deficiencies in operating techniques. The whistleblower further disputed the findings contained in the reports. He asserted that under HIPAA, it is a violation for employers to access employee medical records for demographic information, such as to find a home address, and as such the conclusions reached in the reports were improper.

The whistleblower further criticized the manner in which the investigation was conducted, and suggested that investigators relied on improper information to reach their conclusions. Finally, the whistleblower alleged that investigators improperly disclosed his name to interview subjects, which biased their responses.[2] In addition, although OSC requested documents that investigators used, in order to assist the whistleblower with writing comments, the agency only provided a limited number, citing privacy concerns. The whistleblower asserted that this limited response indicated that the agency did not make a good faith effort to investigate his allegations. He maintained that a more complete review would have substantiated his assertions.

## V. The Special Counsel's Findings

I have reviewed the original disclosure, the agency reports, and the whistleblower's comments. I have determined that the reports contain all the information required by statute. Nevertheless, the agency's findings are only reasonable in part. While the agency did not substantiate the whistleblower's allegations concerning surgical misconduct, the VA acknowledged that the whistleblower's medical records were

[2] The whistleblower initially consented to the release of his name to the agency, prior to the start of the agency investigation.

improperly accessed, in violation of agency policy and HIPAA. Notwithstanding, the agency justified its actions by claiming the records were viewed to obtain the whistleblower's home address for legitimate work-related purposes. This is an unsupportable conclusion.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the agency reports and the whistleblower's comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports and the whistleblower's comments in our public file, which is available at www.osc.gov.[3] OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

[3] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.