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The Special Counsel

August 29, 2016

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

Re: OSC File No. DI-15-4557

Dear Mr. President:

Pursuant to my responsibilities as Special Counsel, I am forwarding a report from the U.S. Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Philadelphia VA Medical Center (Philadelphia VAMC), Pathology and Laboratory Medicine Service (P&LMS), Philadelphia, Pennsylvania. The whistleblower, who chose to keep their identity confidential, disclosed that Dr. Eugene Einhorn, Director, Electron Microscopy Unit (EM), failed to comply with P&LMS procedures and requirements contained in Veterans Health Administration Handbook 1106.01 (Handbook). In accordance with 5 U.S.C. § 1213(e), I now provide the following summary of the investigation, whistleblower comments, and my findings.[1]

The whistleblower alleged that Dr. Einhorn was not an American Board of Pathology (Board) certified anatomic pathologist and, as such, was not qualified to serve as EM Director. The whistleblower also alleged that under Dr. Einhorn's leadership, EM routinely failed to issue written reports on specimens transmitted for EM study within 10 working days using the Veterans Health Information Systems and Technology Architecture (VistA), as required by the Handbook. The whistleblower stated that the absence of written reports on EM studies in VistA deprived clinicians of the results, which negatively affected patient treatment. The agency investigation substantiated the whistleblower's allegations that Dr. Einhorn is not Board certified and, therefore, would

[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).

not be qualified to serve as director of a diagnostic electron microscopy program. However, the agency determined that EM was non-diagnostic. The agency also found that EM did not routinely issue written reports on specimens accessed for EM study within 10 working days using VistA. However, the agency noted that because Philadelphia VAMC's EM program is not functioning as a diagnostic EM program, Dr. Einhorn violated neither P&LMS procedures nor the Handbook, and patient treatment was not negatively affected.

The whistleblower's allegations were initially referred to the Honorable Robert A. McDonald, Secretary, for investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary McDonald directed that the matter be referred to the Office of Medical Inspector (OMI) for investigation, and he delegated authority to Chief of Staff Robert D. Snyder to submit the agency's report to the Office of Special Counsel (OSC).

The VA noted in its report that Philadelphia VAMC's EM program has not functioned as a diagnostic program since 1999, when Dr. Einhorn became its Director. At that time, Philadelphia VAMC conducted a cost-benefit analysis and decided to send all specimens to the University of Pennsylvania for diagnosis. Currently, the main purpose of EM within the facility is institutional quality control, research, and education. Thus, the VA determined that Dr. Einhorn is not prohibited from serving as EM Director.

The VA's investigation also found that only 23 of the 2,021 specimens accessed in VistA between January 1, 2000 and October 22, 2015 went to final diagnosis and closure, with an average turnaround time of 127 days. The VA noted, however, that Philadelphia VAMC's EM did not use its accessions to make patient diagnoses, and according to the Handbook, only diagnostic reports must be entered into VistA within 10 working days. Furthermore, a VA audit of EM's paper files showed completion of all processes within the required timeframes. Thus, the VA determined that EM's failure to close accessions in VistA within 10 working days did not constitute a violation of the Handbook. Nonetheless, the VA acknowledged that EM's lack of closure of accessions even for quality control, education, and research purposes, was problematic, as it created the misperception of unfinished diagnostic work. As such, the VA recommended that EM close the open accessions within VistA, use existing paper records to reflect the actual date of completion, and establish a practice of closing accessions when the final dispositions are determined, regardless of testing category. The VA also recommended that VHA review accession closure practices at the other seven diagnostic EM facilities to ensure that they are closing out accessions as required by the Handbook.

In July 2016, the VA provided an update to OSC that Philadelphia VAMC has electronically closed all of its open EM accessions within VistA and established a practice of closing all accessions as the final dispositions are determined. The VA also stated that the VHA National Diagnostic EM Program has reviewed the practices at the

seven VA EM facilities, all of which are in the process of closing out all accessions in accordance with the Handbook.

The whistleblower submitted comments questioning the wisdom of Philadelphia VAMC's transition from a diagnostic EM program to one that focuses on research, education, and quality control, and asserting that the timing of the transition suggests that it was made to accommodate Dr. Einhorn's lack of Board certification. The whistleblower also disagreed with the VA's contention that Dr. Einhorn is qualified to serve as EM Director, because Philadelphia VAMC no longer maintains a diagnostic EM program. Finally, the whistleblower expressed distrust of EM's paper records, which the whistleblower said "could be made to say anything by anyone." According to the whistleblower, EM's failure to close accessions in VistA within 10 working days establishes that it had not completed its work within the required timeframes.

I have reviewed the VA's report and determined that it contains all the information required by statute and that the findings appear reasonable. While I acknowledge the whistleblower's concerns regarding EM's transition from a diagnostic program to one that focuses on research, education, and quality control, there is no indication that patient care suffered as a result. Moreover, it appears that the VA acted within its discretion based on its analysis of the costs and benefits associated with operating a diagnostic EM program at Philadelphia VAMC.

As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the unredacted agency report and the whistleblower comments to you and to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of this letter, the redacted agency report, and the whistleblower comments in OSC's public file, which is available online at www.osc.gov.[2] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

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[2] The VA provided OSC with a report containing employee names (enclosed), and a redacted report 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 report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report 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 report as an accommodation.