April 26, 2017

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

Re: OSC File No. DI-16-1151

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding a Department of Veterans Affairs (VA) report based on disclosures of wrongdoing at the Chalmers P. Wylie VA Ambulatory Center (the Medical Center), Columbus, Ohio. I have reviewed the agency report and, in accordance with 5 U.S.C. §1213(e), provide the following summary of the report, and my findings.¹ The whistleblower, who chose to remain confidential, alleged that an orthopedic surgeon in the Orthopedic Surgery Clinic repeatedly ignored patient alerts and directed registered nurses to practice outside the scope of their licensure.

The whistleblower’s allegations were referred to former Secretary Robert McDonald for investigation pursuant to 5 U.S.C. §1213 (c) and (d). The Office of the Medical Inspector investigated the allegations, and former Chief of Staff Robert D. Snyder was delegated the authority to review and sign the OMI report. On December 13, 2016, Mr. Snyder submitted the report to the Office of Special Counsel (OSC). The whistleblower did not provide comments to the report.

The agency substantiated the whistleblower’s allegations in part. The report explained that patients experienced delays in care due to inadequate follow up on study results or discontinued consultations, and that these deficiencies constituted a substantial and specific danger to public health. The report did not substantiate that the orthopedic surgeon directed RNs to practice outside the scope of their licensure.

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(c)(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(c)(1).
OMI identified 20 instances in which patients potentially suffered delays in care. OMI determined that care was improperly delayed for three patients. In addition, during an initial audit of the orthopedic surgeon, the Medical Center chief of surgery identified five additional cases of delayed care. OMI asserted that no “single Orthopedic Surgery Clinic staff member was responsible for this lack of timely follow up,” but, rather, that collaboration between care providers within the clinic was not sufficient to ensure timely follow up of physician orders in these instances. Orthopedic Surgery Clinic personnel followed up with each of these patients and found no adverse outcomes.

Despite finding that no employee was responsible for these delays, the agency noted that the orthopedic surgeon was verbally counseled regarding delays in care and received additional training on the appropriate disposition of alerts. A subsequent audit determined that there were no deficiencies in the timely follow up of physician orders after the counseling and training. The Medical Center also hired an additional RN to track provider orders and is conducting audits of the unit on a recurring basis.

With respect to allegations concerning the orthopedic surgeon directing RNs to act outside the scope of their practice, the agency explained that, in one instance, the orthopedic surgeon verbally directed an RN to enter orders at his request and in his presence, which is permissible under agency policy. The RN did not have the permission to activate these orders, and the orthopedic surgeon reviewed and activated them subsequent to this interaction. As such, no violations of agency policy occurred.

I have reviewed the original disclosure and the agency report. The agency took action to ensure that the identified issues were resolved and will not happen in the future. However, I am concerned that OMI chose not to attribute responsibility to any staff member, despite the fact that the Medical Center chief of surgery counseled and ordered additional training for the orthopedic surgeon, due to delays in patient care. Despite these reservations, I have determined that the report meets all statutory requirements and the findings appear reasonable.

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

Respectfully,

Carolyn N. Lerner

Enclosures