DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

NOV 9 2012

In Reply Refer To:

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

RE: OSC File Nos. DI-10-3889

Dear Ms. Lerner:

This letter responds to your inquiry regarding alleged violations at the Department of Veterans Affairs (VA) Carl Vinson Medical Center, Dublin, Georgia, referenced above. Per your recent discussion with VA's General Counsel, we are providing you with a revised report that contains the names and titles of the witnesses interviewed.

Please note that in this revised report dated November 7, 2012, we have included the titles and names of two additional individuals (the Chief, Quality Management, and the Patient Safety Manager) who were interviewed during the course of the investigation but whose titles were inadvertently omitted from the original report dated October 31, 2011. Also note that there is no record of the VISN staff who participated by phone in the entrance and exit briefings referenced on page 6 (first paragraph of Section III, Conduct of the Investigation). Also, the OMI has no information regarding the identity of the contract radiologists that provide professional services to the VAMC. The identities of those individuals who participated in the peer review referenced on pages 9-10 of the revised report are protected by 38 U.S.C. § 5705.

A redacted version of the revised report (for the public file) will follow as soon as it is available.

Sincerely yours,

Walter A. Hall
Assistant General Counsel

Enclosure

OFFICE OF THE MEDICAL INSPECTOR
Revised Final Report to the Office of Special Counsel
OSC File Number DI-10-3889

Radiology Service
Department of Veterans Affairs
Dublin, Georgia

Veterans Health Administration
Washington, DC

Report Date: November 7, 2012
OMI TRIM # 2011-D-1075

Executive Summary

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate complaints submitted to the Office of Special Counsel (OSC) by a radiologist, (b)(6) (b)(6) (hereafter, the whistleblower) at the Department of Veterans Affairs (VA), Carl Vinson VA Medical Center, Dublin, Georgia (hereafter, the Medical Center). The whistleblower alleges that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by requiring the whistleblower, to read magnetic resonance imaging (MRI) scans despite his limited experience and training reviewing them, assigning him a reviewing station with display and picture archiving problems, and falsely telling him that his work would be reviewed by more experienced radiologists.[1] The OMI conducted a site visit to the Medical Center on July 19-21, 2011.

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

Conclusions

1. The OMI **did not** substantiate the allegation that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by requiring the whistleblower to read MRI scans.

    a. Upon hiring the whistleblower, the Medical Center had no reason to believe that he was not clinically competent to read MRIs.

    b. The Medical Center appropriately completed a review of the whistleblower's work through the Focused Professional Practice Evaluation (FPPE) and responded to the findings of the FPPE.

    c. If the whistleblower was not aware of the modification of his privileges to include MRIs, he would have been practicing medicine outside of the scope of his requested privileges by reading and signing final reports on the hundreds of MRIs he had read.

2. The OMI **did not** substantiate the allegation that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by assigning the whistleblower a reviewing station with display and picture archiving problems, as a technical review by a radiology consultant found the equipment fully functional.

[1] Magnetic resonance imaging (MRI) is a technology that uses a magnetic field and pulses of radio wave energy to make visualize detailed internal structures. A display and picture archiving system is a medical imaging technology that provides storage of, and convenient access to, images from multiple devices such as general x-rays, ultrasound , computed tomography, and MRI.

a. As viewing station technology is continuously changing, the VISN's ongoing plans to modify facility viewing stations are consistent with keeping up with the advancements in technology.

b. As there were no problems identified with the viewing stations, the OMI is concerned that new providers may not be receiving adequate orientation to efficiently work on the available imaging system.

3. The OMI **did not** substantiate the allegation that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by falsely telling the whistleblower that his work would be reviewed by more experienced radiologists.

   a. As a fully-trained diagnostic radiologist, the whistleblower would have been expected to function in this capacity. The expectation that 100 percent of his MRI work would be reviewed by more experienced radiologists, without cause, is implausible.

4. The Medical Center did not fully comply with VHA Handbook 1100.19 in credentialing the whistleblower.

5. The changes made to the whistleblower's Initial Clinical Privileges Application, although initialed, are confusing and difficult to interpret.

6. The Medical Center could have eliminated the misunderstanding about the modification of the whistleblower's privileges if they had had the whistleblower acknowledge his final approved privileges prior to initiating his practice at the Medical Center.

7. The Medical Center responded to concerns about the whistleblower's ability to practice to the standard of care by removing him from clinical duties.

8. The OMI is concerned that the status of the whistleblower's clinical privileges was still not resolved over a year after they were suspended.

9. The OMI is concerned that the amount of time the whistleblower was on paid authorized absence was excessive.

10. The Medical Center did not take appropriate actions to comply with requirements under 38 Code of Federal Regulations (C.F.R.) Part 46, and VHA Handbooks 1100.19 and 1100.17 when the whistleblower's privileges expired while his clinical competency was under investigation.

Summary of Recommendations

1. The VISN should continue with its routine ongoing updates to the Medical Center's imaging systems.

2. The Medical Center should ensure that all radiologists, especially new hires, are oriented to the imaging systems utilized in the facility and that they are competent to utilize the systems.

3. The Medical Center should ensure compliance with VHA directives when processing employees that require credentialing and privileging.

4. The Medical Center should conduct an audit of credentialing and privileging folders to verify that they are compliant with VHA Handbook 1100.19.

5. The Medical Center should evaluate their approach to handwritten changes made to privileging applications.

6. VHA should consider requiring clinicians to acknowledge in writing receipt of their approved privileges, prior to starting work.

7. VHA should consider placing a limit on the amount of time an employee can remain in paid, non-duty status.

8. VHA should consider placing a limit on the allowable time period for summary suspension of privileges of providers. If a facility is unable to make a decision about the reinstatement or revocation of the suspended privileges within the established time frame, notification of the VISN and VA Central Office (VACO) should occur. In addition, if a provider's clinical privileges expire while they are in a suspended status, the Medical Center should take appropriate steps to comply with the requirements of 38 C.F.R. Part 46 and VHA Handbooks 1100.19 and 1100.17.

9. VHA should determine what corrective action may be required in regard to the expiration of the whistleblower's privileges.

I. Summary of Allegations

The Under Secretary for Health requested the Office of the Medical Inspector (OMI) investigate complaints submitted to the Office of Special Counsel (OSC) by a radiologist, (b)(6) (b)(6). (hereafter, the whistleblower), at the Department of Veterans Affairs (VA), Carl Vinson VA Medical Center, Dublin, Georgia (hereafter, the Medical Center). The whistleblower alleges that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by:

1. Requiring the whistleblower to review (read) Magnetic Resonance Imaging (MRI) scans despite his limited experience and training reviewing (reading) them.[2]

The letter from the OSC provided the following in reference to the above allegation. The whistleblower is a board-certified radiologist with 30 years of experience. He did not apply for MRI privileges, because the job announcement did not include duties related to MRI, and he lacked expertise in this area. (b)(6) (hereafter, the supervisor) altered the *Initial Clinical Privileges Application* to request that MRI privileges be given to him without his knowledge or consent. He did not receive a copy of his approved privileges, dated May 7, 2009, until December 2009. Between August 2009 and March 2010, he was assigned to read hundreds of MRIs, most commonly scans of cervical spines, thoracic spines, and lumbar spines, despite his lack of training to do so. Upon receiving his first MRI assignments, he told his supervisor that he was uncomfortable interpreting the studies due to his lack of experience and expertise with this type of work. He alleges that his supervisor promised to make arrangements for additional training in MRI at a VA facility in either Augusta, Savannah, or Atlanta, Georgia, but that training did not take place.

2. Assigning him a reviewing station with display and picture archiving problems.

The whistleblower expressed concerns to his supervisor about display and picture archiving problems with his MRI reviewing station at the Medical Center. His reviewing station did not contain a sufficient degree of detail to permit him to measure certain masses and spaces, and it was not possible for him to verify that all the images taken were being displayed.

3. Falsely telling him that his work would be reviewed by more experienced radiologists.

The whistleblower alleges that his supervisor told him not to worry about these issues because all of his MRI reports were being reviewed by other VA radiologists in Atlanta. In March 2010, after the whistleblower had read hundreds of MRI scans, the supervisor disclosed to the whistleblower that these scans had not been reviewed by other radiologists. The whistleblower alleges that this information was confirmed by (b)(6), the Medical Center Director. Consequently, his reading of MRI scans exposed Veterans to a substantial and specific danger to public health and safety because of his supervisor's misstatements, and the possibility that he did

[2] A reading of a radiology image is conducted by the radiologist interpreting the images and issuing a report which is signed. A review of a radiology image is conducted by a radiologist evaluating the images and the report, making an assessment of the interpretation, which often does not result in an additional written document. The whistleblower uses the term review MRIs; however he was actually reading MRIs.

not correctly interpret the MRIs due to both insufficient training and the display and picture archiving problems with the reviewing station.

II. Facility Profile

The Medical Center is a Veterans Integrated Service Network (VISN) 7 facility that provides comprehensive primary and specialty care to veterans in middle and south Georgia. It has 340 beds: 34 medical/surgical, 161 extended care, and 145 domiciliary care. Services provided at the Medical Center include primary care, mental health, ambulatory care, optometry, women's health, and extended care, as well as specialized programs to include cardiology, pulmonology, general surgery, podiatry, urology, and physical therapy. Mental health services available include treatment for substance abuse, post-traumatic stress disorder, and general psychiatric care.

The Medical Center's Department of Radiology and Nuclear Medicine conducts a full spectrum of radiologic studies to include: general x-ray and fluoroscopy, ultrasound (US), computer tomography (CT) scans, MRIs, and nuclear medicine imaging. The Department has two general x-ray rooms; two general x-ray/fluoroscopy rooms; one 16 slice CT scanner; two ultrasound scanners, one gamma camera; three portable x-ray units; one bone density unit, and one mobile MRI unit. There are three physician image viewing stations in the radiology suite. Staffing consists of 3.75 radiologists, which includes the whistleblower, who had been out on paid, administrative absence for approximately 15 months; 12 technicians including the administrative radiology manager; and the Chief of the Department, who is a nuclear medicine physician. From January 1 through December 31, 2010, the Department of Radiology and Nuclear Medicine performed a total of 37,287 radiological studies: 23,798 general x-rays, 2,499 ultrasounds, 7,320 CT scans, 2,517 MRIs, and 1,153 nuclear medicine studies. During this period, a fee-based radiology consultant group in Atlanta read 60 percent (22,337) of the studies: 13,883 general x-rays, 542 ultrasounds, 5,445 CT scans, and 2,467 MRIs.

III. Conduct of the Investigation

The OMI conducted a site visit at the Medical Center on July 19-21, 2011. The OMI team included (b)(6)., the Deputy Medical Inspector for Professional Services (a general surgeon), (b)(6) a Medical Investigator (an internist), and (b)(6) a Clinical Program Manager. The team members reviewed the original job announcement that the whistleblower responded to, his initial credentialing and privileging documents, and summary review documents pertaining to his practice of radiology at the Medical Center. The team held an entrance and exit briefing with leadership from the Medical Center (as listed below) and the VISN via telephone.

The OMI interviewed the following individuals: (b)(6) Medical Center Director; (b)(6) Chief of Staff; (b)(6), Associate Chief of Staff; (b)(6) Chief, Radiology and Nuclear Medicine (hereafter, Chief of Radiology); (b)(6) Human Resources officer; (b)(6), radiology manager; (b)(6) staff radiologist; (b)(6)., staff radiologist; (b)(6) human resource specialist (physician hiring); (b)(6) Credentialing and Privileging officer; (b)(6)

(b)(6), Chief, Quality Management; (b)(6) Patient Safety Manager; and (b)(6) (b)(6) the whistleblower. In addition, the OMI contacted the National Director of Radiology who assigned a radiologist (b)(6) to evaluate the equipment at the facility. After his site visit and evaluation, he was interviewed by the OMI. The OMI contacted the VHA Office of Quality and Safety/Credentialing and Privileging, who provided a review of the Medical Center's actions with regard to the credentialing and privileging of the whistleblower. The Office of General Counsel (OGC) reviewed the findings to determine if there was any violation of law, rule, or regulation.

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

IV. Findings

A. Allegations in the letter from the OSC to the Secretary of Veterans Affairs

Allegation #1

Employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by requiring the whistleblower to review (read) MRI scans despite his limited experience and training reviewing them.

Findings

The whistleblower completed a 12-month general internship, followed by a 36-month residency in diagnostic radiology, and a 12-month fellowship in US and CT. He completed his training in 1982; he is not board-certified. Between 1982 and 2009, the whistleblower provided general radiology services for both inpatients and outpatients through his private practice and as a staff physician for several non-VA hospitals. During his interview with the OMI, the whistleblower reported that in his private practice he had read and issued final reports on hundreds of MRIs. He said he was comfortable reading MRIs in private practice.

In 2009, the whistleblower responded to VA job announcement 557-09-057-JB. The announcement delineated the following major duties: "The selectee will be responsible for providing a full range of radiology/nuclear medicine procedures and reports of interpretation as follows: diagnostic readings; fluoroscopy; ultrasound; diagnostic obstetrics and gynecology studies; nuclear medicine; doppler vascular studies; CT scans; 3-D image manipulation; also responsible for understanding the aging process and to modify readings to accommodate the changes that occur with aging." The Medical Center did not include MRI reading in the job announcement. Qualifications included being a U.S. citizen; possessing a degree of doctor of medicine or an equivalent degree; possessing a current, full and unrestricted license to practice medicine or surgery in a state, territory or commonwealth of the United States; being proficient in spoken and written English; and being board-eligible or board-certified.

The whistleblower did indicate that he was not board certified by an American Specialty Board when completing VA Form 10-2850, *Application for Physicians, Dentists, Podiatrists, and Optometrists & Chiropractors.* He informed the OMI that he was still considered "board eligible." The whistleblower has until 2014 to complete his certification.[3]

Following his preliminary selection for the job, the whistleblower completed and signed the *Initial Clinical Privileges Application* on March 25, 2009. In completing the form, he did not apply for MRI privileges. He told the OMI it was because they did not list MRI in the job description.

There is evidence that the Medical Center attempted to clarify the fact that MRI readings would be a job expectation. On April 20, 2009, the Chief of Radiology made a notation on the *Initial Clinical Privileges Application* that states "talked to [whistleblower] on phone about his delineation of privileges and modified accordingly." The Chief of Radiology informed the OMI that he spoke with the whistleblower about his MRI experience and about adding MRI to his privileges' and added MRI to the privileging form after this discussion. The whistleblower was not physically present at the Medical Center at the time of this modification, and he did not initial or sign these additions to his clinical privileges.

On the *Initial Clinical Privileges Application* form, under the category other procedures/MRI, there is a qualifier that states "Such requests should include documentation of experience, expertise, or competence in the area/ procedures requested." In the OSC letter, the whistleblower alleges that he did not discuss adding MRI privileges with the Chief of Radiology; however, 2 days after the Chief of Radiology reported that he discussed with the whistleblower adding MRI to the request for privileges, the whistleblower sent a letter delineating that he had "Interpreted approximately 228 MRI cases over a 12 month period." Five days later, the whistleblower sent another letter "This letter is a confirmation of our prior discussion this morning regarding the number of x-rays cases that I feel comfortable providing interpretation for within an 8 hour period. I have experience with reading up to 80 cases per day, with a variety of studies, including fluoroscopy, plain films, ultrasound, CT and MRI." Copies of these letters are Attachments A and B.

The Medical Center's Professional Standards Board (PSB) recommended approval as amended and the whistleblower was appointed to the Medical Staff for a 2-year time period on May 4, 2009. The Medical Center mailed the official notification of privilege approval, along with a copy of the amended privileges, to the whistleblower at the Medical Center's Department of Radiology and Nuclear Medicine address. The whistleblower alleges that he did not receive

[3] According to the American Board of Medical Specialties, the term, "board-eligible," is no longer used by them or their member boards because it does not accurately indicate a physician's progress toward completing certification. Board certification means that a physician has successfully completed the education, post-doctoral training, and an examination process that ensures he or she possesses the knowledge, skills, and experience necessary to provide quality patient care in that specialty. The current terminology used is "board-certified," or "seeking board-certification." In 2004, the American Board of Radiology amended their policies and radiologists now have 10 years from the completion of training to obtain board-certification. Because of this change in policy, the American Board of Radiology extended the post-training time frame to obtain board-certification for radiologists trained prior to 2004 until 2014. After 2014, all radiologists must complete the certification process within 10 years of completing their training.

this letter on arrival to the Medical Center. Approximately 6 months after he began reading studies at the Medical Center, in February 2010, he requested and was provided a copy of the modified and approved *Initial Clinical Privileges Application.*

Upon receiving his first MRI assignments, he alleges that he informed the Chief of Radiology, that he was uncomfortable with interpreting Veterans' studies due to his lack of experience and expertise. During his interview with OMI, the whistleblower stated that although he was comfortable reading the MRIs in his private practice, his source of discomfort in reading MRIs at the Medical Center was the complexity of injuries in Veterans. The whistleblower alleges that his supervisor promised to make arrangements for additional MRI interpretation training at a VA facility in Augusta, Savannah, or Atlanta, Georgia; however, that training did not take place.

When questioned about allowing the whistleblower to obtain additional MRI training, the Chief of Radiology reports that the discussions he recalls were about the use of the picture archiving and communication system (PACS), which is the medical imaging technology that provides storage of, and convenient access to, images from multiple modalities. For further discussion on this topic see page 11.

The Chief of Radiology told OMI that he reviewed the Medical Center's funding policy, which allows for one funded continuing medical education (CME) course per year.[4] The whistleblower was approved for and participated in a CME program in April 2010.

Between August 2009 and March 2010, the whistleblower was assigned, read, and signed, as final, hundreds of MRI reports, most commonly scans of cervical spines, thoracic spines, and lumbar spines.[5]

The Medical Center states that the planned review of the whistleblower's work was under the initial VHA 2-year probationary period when all privileged providers undergo a Focused Professional Practice Evaluation (FPPE). Per the FPPE policy, a sample of a provider's cases from their first 2-6 months are to be peer reviewed, but not 100 percent of their cases.[6] Another Medical Center radiologist peer reviewed 24 of the whistleblowers studies, which included only general x-rays and CTs and reported her findings as "generally agree."[7] At a meeting of the Medical Executive Committee on February 16, 2010, the Chief of Staff said that she deemed this peer review inadequate to assess the whistleblower's clinical practice, because the review did not include his entire scope of practice, e.g., MRIs.

The Chief of Staff recommended an extension of the FPPE to ensure a full spectrum of his practice was peer reviewed. The Medical Center requested peer reviews to be done by other facilities within the VISN. Those facilities reviewed an additional 45 studies, which included general radiology x-rays, US, CT, and MRI. The reviewers agreed with the readings as follows:

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[4] Continuing medical education (CME) is required of licensed healthcare professionals to maintain an active license to practice medicine in most states.

[5] Final Report is the official medical-legal reading of the study, and results in a written report that is signed by the interpreting radiologist.

[6] Medical Center Memorandum No. 00-371, *Focused Professional Practice Evaluation*, May 2008.

[7] Peer reviews are protected documents, and may not be used for disciplinary actions.

50 percent of the general radiology x-rays, 0 percent of the US, 25 percent of the CTs, and 18 percent of the MRIs. This resulted in an overall agreement rate of 20 percent. One of the reviewing sites, which reviewed 19 of the 45 studies, reported, "Overall impression: The reports are ambiguous and unclear with non-standard terminology and not particularly thorough." As a result of the expanded FPPE, the Medical Center placed the whistleblower on authorized absence with pay on April 5, 2010.

To ensure that patients had not been adversely affected by the whistleblowers' readings, the Medical Center conducted an unprotected administrative professional review of all of the CT and MRI spine scans read by the whistleblower by having their contracted radiologists re-read these studies. The Medical Center informed the clinical providers, who had ordered these tests, that they would receive both copies of the report and should consider the contractor's readings as the final official interpretation. The clinicians were also asked to provide feedback on the clinical impact of the new readings. The Medical Center tabulated the review with one of three outcomes: no effect on the clinical outcome, minimal effect on clinical outcomes, and significant /major effect on clinical outcomes. Note, these observations were made by the ordering clinical providers and do not directly reflect the radiologic discrepancies observed by the reviewing radiologists. The Medical Center performed 693 re-reads. Of these re-reads, the clinical providers noted that 671 were classified as no effect on clinical outcome, 21 were classified as minimal effect on clinical outcome, and 1 was classified as a significant/major effect on clinical outcome. The Medical Center informed patients of the change in their reports and took appropriate clinical actions.

Summary of Findings

When applying for privileges at the Medical Center, the whistleblower did not request MRI privileges as they were not on the job announcement. The Chief of Radiology told the OMI that he spoke with the whistleblower and annotated the privileging form, "talked to (b)(6) on phone about his delineation of privileges and modified accordingly." Within 2 days and 5 days the whistleblower responded with two letters that indicated that he had experience reading MRIs and had done so on a regular basis. The Medical Center granted clinical privileges based on their credentialing of him, his modified application, and the letters he supplied. The Medical Center sent a copy of his approved privileges to the whistleblower's clinical department. However, this was about 3 months before the whistleblower reported for work and he told OMI that he never got this letter. After reporting to work in August 2009, the whistleblower read and signed as final, hundreds of MRI reports.

The discussions about providing further training in reading MRIs were reported differently by the whistleblower and by the Chief of Radiology.

The Medical Center followed their policy when evaluating the whistleblower's clinical practice. Based on the results of the FPPE, the Medical Center took appropriate actions to ensure patient safety by placing the whistleblower on paid leave, while conducting a review of his clinical practice.

A timeline of events related to the whistleblower's credentialing and privileging at the Medical Center is shown in Attachment C.

Conclusions

1. The OMI **did not** substantiate the allegation that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by requiring the whistleblower to read MRI scans.

    a. Upon hiring the whistleblower, the Medical Center had no reason to believe that he was not clinically competent to read MRIs.

    b. The Medical Center appropriately completed a review of the whistleblowers work through the Focused Professional Practice Evaluation (FPPE) and responded to the findings of the FPPE.

    c. If the whistleblower was not aware of the modification of his privileges to include MRIs, he would have been practicing medicine outside of the scope of his requested privileges by reading and signing final reports on the hundreds of MRIs he had read.

Recommendation

The OMI makes no recommendation.

Allegation #2

Employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by assigning the whistleblower a reviewing station with display and picture archiving problems.

Findings

The whistleblower alleges that he expressed concerns about display and picture archiving problems with his MRI reviewing station at the Medical Center. He alleges that his reviewing station did not contain a sufficient degree of detail to permit him to measure certain masses and spaces, and it was not possible for him to verify that all the images that had been taken were being displayed. The whistleblower also alleges that his supervisor told him not to worry about these issues because all of his MRI reports were being reviewed by other VA radiologists in Atlanta.

The Chief of Radiology said that the whistleblower reported that the VA system was different from the system he had previously used. The Chief told OMI that they had discussed with the whistleblower that the VISN PACS expert was in Charleston, and in addition, there was an information technology (IT) specialist at the Medical Center who could provide him training. He states that the whistleblower worked with the Medical Center's IT specialist and never requested to go to another medical center for PACS training.

Similar concerns were expressed by (b)(6) a new staff radiologist, who informed the OMI that if he experienced poor viewing capabilities, he would not read the study or issue a final report. Instead, he would send the images to the contract radiologists for reading.

The OMI contacted the National Director of Radiology and asked him to perform an assessment of the equipment at the Medical Center's Department of Radiology and Nuclear Medicine viewing stations. The National Director of Radiology assigned (b)(6) as a reviewer. He conducted a site visit to the Medical Center on August 8, 2011, to evaluate the radiology viewing stations. He reported evaluating multiple studies across multiple modalities to include general x-ray, US, CT, and MRI. The reviewer found the workstations to be "adequate; a radiologist utilizing these workstations would have all of the imaging and information required/expected to render an interpretation." Additionally, he did not perceive errors in these systems. He reported that the workstations are "standard" and essentially interchangeable with those utilized in his VAMC's Radiology Department. Specifically, he addressed the following questions raised by the whistleblower: Do the review stations have enough detail to measure masses or spaces (MRI)? Yes. Can the viewer verify that they have all of the images on their display? Yes. Are the stations adequate to view images? Yes.

The OMI was told that the VISN is in the process of updating their image viewing stations as part of their routine updating of technology.

Summary of Findings

The Medical Center utilizes reviewing stations which are comparable to other facilities within the VISN and were found to be adequate for rendering readings by a nationally directed radiology review.

Conclusions

2. The OMI **did not** substantiate the allegation that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by assigning the whistleblower a reviewing station with display and picture archiving problems, as a technical review by a radiology consultant found the equipment fully functional.

    a. As viewing station technology is continuously changing, the VISN's ongoing plans to modify facility viewing stations are consistent with keeping up with the advancements in technology.

    b. As there were no problems identified with the viewing stations, the OMI is concerned that new providers may not be receiving adequate orientation to efficiently work on the available imaging system.

Recommendations

1. The VISN should continue with its routine ongoing updates to the Medical Center's imaging systems.

2. The Medical Center should ensure that all radiologists, especially new hires, are oriented to the imaging systems utilized in the facility and that they are competent to utilize the systems.

Allegation #3

Employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by falsely telling him that his work would be reviewed by more experienced radiologists.

Findings

As noted above in Allegation #1, the whistleblower acknowledged that his prior practice of radiology included general x-rays, US, CT and MRI. In his interview with the OMI, he cited the complexity of findings in Veterans as the source of his discomfort in reading their MRIs. The whistleblower alleges that he was informed that 100 percent of his MRIs readings would be reviewed by other radiologists. The OMI asked the whistleblower if he had attempted to examine the reviews he thought were being done to ensure he was reading correctly, prior to signing off on the final reports of MRIs. He responded, "No, I was told I was OK."

In March 2010, after he had read hundreds of MRI scans, the whistleblower alleges that Chief of Radiology disclosed to him that none of his MRI reports had been routinely reviewed by other radiologists. The whistleblower alleges that this information was confirmed by the Medical Center Director. The whistleblower is concerned that the Veterans whose MRI scans he read may have been exposed to a substantial and specific danger to public health and safety because of his supervisor's misstatements; the possibility that he did not correctly interpret the MRIs due to his insufficient training; and the display and picture archiving problems with his reviewing station. (Note: See allegation #2 with regard to the claims of the display and picture archiving problems with the reviewing stations).

Summary of Findings

During interviews with the whistleblower and with the Chief of Radiology, it became apparent that there was a misunderstanding of the initial intended breadth and scope of the reviews of the whistleblower's practice. It was never the intent of the Chief of Radiology to review 100 percent of the whistleblower's MRI readings. The Medical Center conducted a review of his practice via their new provider FPPE. The Medical Center then expanded the evaluation of the whistleblower's clinical practice by having all of his CTs and MRIs re-read and assessing the clinical impact of the re-reads.

Conclusions

3. The OMI **did not** substantiate the allegation that employees at the Medical Center engaged in conduct that created a substantial and specific danger to public health and safety by falsely telling the whistleblower that his work would be reviewed by more experienced radiologists.

    a. As a fully-trained diagnostic radiologist, the whistleblower would have been expected to function in this capacity. The expectation that 100 percent of his MRI work would be reviewed by more experienced radiologists, without cause, is implausible.

Recommendation

The OMI makes no recommendation.

Additional Findings

The credentialing and privileging of the whistleblower

A timeline of events related to the whistleblower's credentialing and privileging at the Medical Center is shown in Attachment C.

The OMI contacted the VHA Office of Quality and Safety/Credentialing and Privileging who provided a review of the whistleblowers credentialing and privileging actions. The whistleblower initiated his credentialing and privileging process with the Medical Center on February 12, 2009, and was appointed to the medical staff on May 4, 2009. He reported for duty on August 3, 2009.

Practice History - In his personal history, the physician indicates that from July 1982 to March 2009 he owned a private consulting practice. He explained to the OMI that he decided to leave private practice because of issues with reimbursement. VHA's Office of Quality and Safety/Credentialing and Privileging noted that the pre employment history for providers who have been in private practice is difficult to validate. To verify professional qualifications, VHA Handbook 1100.19 requires contact with any institutions where clinical privileges were held, other agencies where the applicant worked, and professional organizations in which the applicant held membership. There is no evidence identified in this review to substantiate that significant effort was made to do so.

Professional Peer References - VHA Handbook 1100.19 requires that a peer reference address clinical judgment, technical skills, professionalism, and health status. Peer references are used to assess clinical competence. Peer references are best obtained from providers of the same discipline or profession who practice with, and know the practitioner's practice. If possible, at least one of the peer references needs to be obtained from someone of the same discipline or profession who can speak with authority on the practitioner's clinical judgment and technical skill. Where there is no one of the same discipline or profession with knowledge of the practitioner's practice, at least one peer reference must be obtained from a health care

professional with essentially equal qualifications and comparable privileges with knowledge of the practitioner's performance and practice patterns. A second peer reference can be obtained from a health care professional who has a referral relationship with the practitioner.

In instances where at least one peer reference cannot be obtained from a peer of the same specialty or a provider with comparable privileges, assistance for the peer reference needs to be sought from the VISN Chief Medical Officer or VHA Program Director for the specialty. The whistleblower provided no radiologists as peer references. One of the peer references was a research colleague who could not attest to his clinical competence. Current competence must be re-verified if the original verification was over 120 days from the reporting for duty date. This was not done.

Department Chief Concurrence - In this case, the Chief of Radiology concurred with appointment without having the required peer references. He did not indicate the basis of his "recommendation for approval;" his only comment was "approved."

Professional Standards Board (PSB) - The PSB had received only two of the required three peer references at the time of their meeting. The Medical Center received the third peer reference 13 days after the whistleblower had been appointed to the medical staff.

The whistleblower's appointment to the medical staff was in accordance with VHA Handbook 1100.19, however, the appointment occurred approximately 3 months before he reported for duty.

The OMI is concerned about the amount of handwritten changes made to the whistleblower's Initial Clinical Privileges Application. Attachment D, page 3 of 4 of his application, is an example of the changes made to his Initial Clinical Privileges Application; this page is specifically related to his MRI privileges.

VHA does not have a requirement for independently licensed providers to acknowledge their final approved privileges.

Summary of Findings

The Office of Quality and Safety/Credentialing and Privileging found a number of instances when the Medical Center did not fully comply with VHA Handbook 1100.19 in credentialing the whistleblower. Most of these revolved around the lack of re-verifying previous findings as it was more than 120 days from the initial verification and when the whistleblower reported for work. These were re-verification of medical license, query to the Federation of State Medical Boards, and having the whistleblower respond again to the supplemental questions.

Conclusions

4. The Medical Center did not fully comply with VHA Handbook 1100.19 in credentialing the whistleblower.

5. The changes made to the whistleblower's Initial Clinical Privileges Application, although initialed, are confusing and difficult to interpret.
6. The Medical Center could have eliminated the misunderstanding about the modification of the whistleblower's privileges if they had had the whistleblower acknowledge his final approved privileges prior to initiating his practice at the Medical Center.

Recommendations

3. The Medical Center should ensure compliance with VHA directives when processing employees that require credentialing and privileging.

4. The Medical Center should conduct an audit of credentialing and privileging folders to verify that they are compliant with VHA Handbook 1100.19.

5. The Medical Center should evaluate their approach to handwritten changes made to privileging applications.

6. VHA should consider requiring clinicians to acknowledge in writing receipt of their approved privileges, prior to starting work.

Actions on concerns about the whistleblower's clinical practice

After completing the FPPE on April 5, 2010, Medical Center placed the whistleblower on paid, non-duty status. This decision was made because of concerns for patient safety and was pending an unprotected administrative professional review of the whistleblower's clinical practice. This review took place between April and July 2010.

On July 30, 2010, the Medical Center notified the whistleblower that his privileges were summarily suspended as "concerns had been raised to suggest that aspects of his clinical competency did not meet the accepted standards of practice and potentially constitute an imminent threat to patient welfare."

On September 13, 2010, the Medical Center selected three VISN 7 physicians to serve on the Special PSB. On September 20, 2010, the chairperson discussed with the other physicians that the intent of the Special PSB was to assess the whistleblower's clinical competency. The Medical Center prepared an evidence file, which they mailed to the Special PSB members on November 18, 2010; however, it was not received by all members until November 29, 2010. On that same date, one of the members of the Special PSB stated "I do not feel comfortable serving on this PSB." However, the physicians assigned to the Special PSB were not changed by the Medical Center leadership. Several discussions ensued in December 2010 and January 2011 pertaining to scheduling an initial meeting of the Special PSB. It is unclear if the Special PSB convened in January 2011. On April 17, 2011, the chairperson of the Special PSB made a request to step down as the chairperson, and the member who had expressed a desire to not serve on the board was tasked with chairing the committee. The physician expressed concerns about

functioning in this role. Attempts to convene the Special PSB on May 4, 2011, were unsuccessful. On June 17, 2011, attempts were made to convene the Special PSB on July 11 and 12, 2011, and then subsequently, July 22, 2011, and July 28, 2011. At the time of the OMI site visit, the Special PSB had not convened.

The whistleblower remained on paid, administrative absence from April 5, 2010, until July 29, 2011, a period of over 15 months. VA Handbook 5011, Part III, Chapter 3 states, "Ordinarily, employees will be retained in a pay and active duty status during an inquiry or investigation into an incident of misconduct or pending a decision on a proposed discharge. In instances where it is determined that an employee's continued presence at work might reasonably pose a threat to the employee or others, result in loss of or damage to Government property, or otherwise jeopardize legitimate Government interests, the employee may be placed in a paid, non-duty status (i.e. authorized absence for timekeeping purposes) for a brief but reasonable period of time."

The whistleblower did not request renewal of his clinical privileges, and they expired on May 3, 2011, while under suspension but without adverse action. VHA Handbook 1100.19, paragraphs 6i(1)(a) and 6i(2)(a), require reappraisal of the professional credentials, clinical competence, and relevant health status of practitioners who hold clinical privileges within the facility, and re-privileging, at least every 2 years. Paragraph 6k(3)(d) of that handbook provides that the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct is a surrender of clinical privileges that must be reported to the National Practitioner Data Bank (NPDB) in accordance with VA regulations 38 CFR Part 46 and VHA Handbook 1100.17. Under paragraph 6a(2) of VHA Handbook 1100.17, the Medical Center is required to offer practitioners who surrender clinical privileges while under investigation appropriate internal VA medical center due process procedures, as outlined in VHA Handbook 1100.19 regarding reduction and revocation of privileges. Paragraph 6a(2) also provides that individuals who choose not to avail themselves of the due process procedures waive their right to due process and must be reported.

The investigation found no violation of any statutory laws. However, we did find that VA regulations in 38 Code of Federal Regulations (C.F.R.) Part 46, Policy Regarding Participation in National Practitioner Data Bank (NPDB), and two VHA policies were violated. Title 38 C.F.R. § 46.4(a)(2) requires VA to report to the NPDB the surrender of clinical privileges by a physician or dentist either while under investigation by the health care entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding whether or not the individual remains in VA service. VHA Handbook 1100.17, *National Practitioner Data Bank Reports*, contains VA policy implementing the regulations, including the requirement to report a surrender of privileges while under investigation for professional incompetence or professional misconduct. VHA Handbook 1100.19, *Credentialing and Privileging*, provides that a reportable surrender of privileges includes the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct. Prior to reporting such a surrender of privileges to the NPDB, VHA Handbook 1100.17 requires VA to offer the physician or dentist appropriate internal VA medical center due process procedures, as outlined in VHA Handbook 1100.19, *Credentialing and Privileging*, regarding reduction and revocation of privileges.

Individuals who choose not to avail themselves of the due process procedures waive their right to due process and must be reported.

Summary of Findings

To assess the whistleblower's clinical practice, the Medical Center completed an FPPE and an expanded FPPE in accordance with VHA policy. The whistleblower was removed from clinical duties on April 5, 2010. The Medical Center also completed an unprotected administrative professional review. His clinical privileges were suspended on July 30, 2010. A Special PSB was appointed on September 13, 2010, but had not met at the time of OMI's site visit in July 2011. The whistleblower did not request renewal of his clinical privileges, and they expired on May 3, 2011 while under suspension but without adverse action.

Based on the findings reported by OMI, OGC has advised that there is evidence that the Medical Center did not comply with the requirements of 38 C.F.R. Part 46, and VHA Handbooks 1100.19 and 1100.17.

Conclusions

7. The Medical Center responded to concerns about the whistleblower's ability to practice to the standard of care by removing him from clinical duties.

8. The OMI is concerned that the status of the whistleblower's clinical privileges was still not resolved over a year after they were suspended.

9. The OMI is concerned that the amount of time the whistleblower was on paid authorized absence was excessive.

10. The Medical Center did not take appropriate actions to comply with requirements under 38 C.F.R. Part 46, and VHA Handbooks 1100.19 and 1100.17 when the whistleblower's privileges expired while his clinical competency was under investigation.

Recommendations

7. VHA should consider placing a limit on the amount of time an employee can remain in paid, non-duty status.

8. VHA should consider placing a limit on the allowable time period for summary suspension of privileges of providers. If a facility is unable to make a decision about the reinstatement or revocation of the suspended privileges within the established time frame, notification of the VISN and VA Central Office should occur. In addition, if a provider's clinical privileges expire while they are in a suspended status, the Medical Center should take appropriate steps

to comply with the requirements of 38 C.F.R. Part 46, and VHA Handbooks 1100.19 and 1100.17.

9. VHA should determine what corrective action may be required in regard to the expiration of the whistleblower's privileges.

Attachments

A. Letter from the whistleblower dated April 22, 2009
B. Letter from the whistleblower dates April 27, 2009
C. Timeline of events related to the whistleblower's credentialing and privileging
D. Copy of page 3 of 4 from the whistleblower's privileging request form

Attachment A

APR-27-2009 09:52 FROM:[redacted] 5817462643 T:+14782745625 P.1/1

[redacted]

April 27, 2009

[redacted]
Carl Vinson VA Medical Center
1826 Veterans Boulevard
Dublin, GA 31021

This letter is a confirmation of our prior discussion this morning regarding the number of x-rays cases that I feel comfortable providing interpretation for within an 8 hour period. I have experience with reading up to 80 cases per day, with a variety of studies, including fluoroscopy, plain films, ultrasound, CT and MRI. Of course, adequate support personnel, high quality examinations, and an efficient system of interpretation and viewing is assumed, including films loaded on viewers or a digital system.

Many thanks,

[redacted]

Attachment B

[redacted] [redacted] [redacted] [redacted]

April 22, 2009

I have interpreted approximately 228 MRI cases over a 12 month period.

[redacted]

Attachment C

Timeline

1982 – the whistleblower completes general radiology residency and CT and US fellowship training

1982-2009 – private practice

February 12, 2009 – the whistleblower initiated his credentialing and privileging process with the Medical Center

March 25, 2009 – the whistleblower completed his Medical Center privileging form

April 20, 2009 – Chief of Radiology talks with whistleblower and annotates privileging form

April 22, 2009 – first letter from whistleblower includes a reference to MRI

April 27, 2009 – second letter from whistleblower includes a reference to MRI

May 4, 2009 – whistleblower appointed to medical staff

May 7, 2009 – a letter informing the whistleblower of his appointment, sent to him at the Medical Center's Department of Radiology and Nuclear Medicine address

August 3, 2009 – whistleblower reported to work

February 16, 2010 – Focused Professional Practice Evaluation (FPPE) reported to Medical Executive Committee; expanded FPPE requested by Chief of Staff

April 5, 2010 – the whistleblower is sent home on paid administrative leave

July 30, 2010 – the whistleblower's clinical privileges suspended

September 13, 2010—the Medical Center selects three VISN 7 physicians to participate in the Special Professional Standards Board

December 15, 2010 – Special Professional Standards Board charged

May 3, 2011—the whistleblower's privileges at the Medical Center expired while under suspension but without adverse action

Attachment D

NAME: [redacted]

OTHER PROCEDURES/MRI: Individuals desiring privileges in an area not outlined above or who desire specific privileges within one of the above categories should request such privileges in this section. Such requests should include documentation of experience, expertise, or competence in the area/procedure requested.

1	2	3
[X]	[redacted]	[X] ~~Provide radiology services via remote access~~ MRI
[ ]	[redacted]	[ ]
[ ]	[ ]	[ ]

I hereby request the privileges for the conditions/procedures in Radiology indicated above.

[redacted]
Applicant Signature

03-25-09
Date

NOTE:
Talked to [redacted] on phone about his delineating privileges and modified accordingly
[redacted]
4/28/09

APPROVAL OF CLINICAL PRIVILEGES

I hereby certify that I possess the necessary skill and expertise to justify granting of clinical privileges which I have

3 of 4