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The Special Counsel

June 13, 2013

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

Re: OSC File No. DI-10-3763 et al.

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports based on disclosures made by nine whistleblowers at the Department of Veterans Affairs (VA), VA Medical Center (Medical Center), Washington, D.C. The whistleblowers alleged that key Medical Center Anesthesia Section doctors engaged in gross mismanagement and a substantial and specific danger to public health and safety by repeatedly failing to provide adequate staff assistance to anesthesiologists during complicated procedures on eight separate occasions. Moreover, the whistleblowers alleged that Anesthesia Section management instituted policies that do not prioritize the most complex cases. The whistleblowers have consented to the release of their names. They are: anesthesiologists Apolonia Canaria, M.D., Karen Edwards, M.D., and Punam Mukherjee, M.D.; Certified Registered Nurse Anesthetists (CRNAs) Tess Banez, Danny Dearing, Jason Horwell, Lotika Sharma, and Jackie Tyson-Hope; and Anesthesia Technician Barry Fishe.

The agency's reports did not substantiate the whistleblowers' allegations. With one notable exception, I have determined that the agency's reports contain all of the information required by statute, and the findings appear to be reasonable. While the reports suggested that the whistleblower anesthesiologists received assistance less frequently in their cases than non-whistleblower anesthesiologists in late 2010, our analysis of the additional data we requested from 2011 and 2012 found no such discrepancy. However, the agency's contention that the absence of assistance to aid anesthesiologists never compromises patient care is contradicted by the VA's own staffing practices, and thus appears to be unreasonable.

The whistleblowers' allegations were referred to the Honorable Eric K. Shinseki, Secretary, VA, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d) on December 8, 2010. On April 15, 2011, the Secretary submitted the agency's report to this office. We received supplemental reports in this matter on October 17, 2011 and March 7,

2012. Six of the whistleblowers provided comments on the initial and first supplemental reports and none provided comments on the second supplemental report. Pursuant to 5 U.S.C. § 1213(e)(1), I am now transmitting the reports to you. [1]

Background

The whistleblowers alleged that Chief of Anesthesia Charise Petrovitch, M.D., and Clinical Coordinator Benedicta Balagtas, M.D., have instituted scheduling policies that do not prioritize the most difficult anesthesia cases. As a result, some anesthesiologists have

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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) and (g).

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 agency's initial report omitted the names of the employees involved, and instead referred to the employees by title only. The agency did not provide a written legal basis for the omission of the employee names in these matters, as is customary under OSC's accommodation policy for the removal or redaction of employee names. Under the accommodation policy, which was instituted by OSC in April 2011, OSC maintains its objection to the redactions on the basis that the public has an interest in knowing the names of those employees involved, but allows the agency to redact employee names from the public version of its report. The agency still provides an unredacted report for transmittal to you, Congress, and the whistleblower.

However, beginning in August 2011 and continuing through 2012, the VA began objecting to the inclusion of information other than employee titles in any version of its reports. As a result, the agency began, in many cases, to provide one version of its reports containing only employee titles. In an attempt to address the agency's concerns and OSC's objections to this approach, OSC staff met with VA Office of General Counsel staff on April 13, 2012. No agreement was reached at that meeting, but the agency indicated to OSC that they would submit a final determination on the matter by June 11, 2012. The agency was aware that, while awaiting the agency's response, OSC found it necessary to refrain from transmitting to you and Congress any pending 1213 matters that were affected by the VA's refusal to include employee names. The VA failed to respond to OSC by June 11, 2012, but multiple conversations with OSC, VA General Counsel staff, and the White House Counsel's Office ensued. On August 30, 2012, OSC reached an agreement with the VA, wherein, for all future matters, the VA will provide OSC with an unredacted report containing employee names and titles for you, Congress, and the whistleblower, and a redacted report, containing titles only, for inclusion in our public file. For pending matters, such as these, the VA provided amended reports and/or addenda containing employee names and titles. OSC received the unredacted report, dated November 26, 2012, in these matters. The whistleblowers were provided a copy of the November 26, 2012, unredacted report and did not provide comments on it.

had to work on difficult cases with insufficient or no assistance while others are assigned to less difficult cases with the assistance of CRNAs. According to the whistleblowers, these discrepancies result from Drs. Petrovitch and Balagtas's practice of favoring certain employees and providing them with adequate assistance on each of their cases. The whistleblowers maintained that these actions create a significant, unnecessary risk for the patients receiving anesthesia from any of the disfavored providers. The whistleblowers provided eight instances of this problem since Dr. Petrovitch's arrival as Chief of Anesthesia in April 2008.

The Initial and First Supplemental Reports of the Department of Veterans Affairs

The agency's review was conducted by its Office of Medical Inspector (OMI). The investigation did not substantiate any of the allegations. The report stated that Dr. Petrovitch's tenure as Chief of Anesthesia began in February 2008. Dr. Petrovitch initiated a number of transformational changes within the Anesthesia Section to improve effectiveness and efficiency.[2] According to the Medical Center's policy, the Chief of the Anesthesia Section is to recommend "a sufficient number of qualified and competent providers to deliver the highest quality of care and services." The agency reported that for seven of the eight cases cited by the whistleblowers, an anesthesiologist and a CRNA or student registered nurse anesthetist (SRNA) were present in the operating room. The whistleblowers were reported to have told investigators that they could not provide examples of any adverse events, close calls, or reportable safety events in the eight cases cited in the OSC referral letter to the Secretary. Rather, the whistleblowers stated the risk was the potential for something to go wrong.

The agency report included a table of each of the eight cases cited by the whistleblowers. The table listed the age, height, and weight of the patient; the type of surgery; the American Society of Anesthesiology Physical Status Classification (ASA);[3] and Mallampati score.[4] Using this information, the OMI investigators found no evidence that the whistleblowers were assigned cases of greater complexity or cases outside their scope of practice.

The agency report also addressed the whistleblowers' allegation that the Anesthesia Section's scheduling policies do not prioritize the most difficult cases, resulting in some anesthesiologists having to work on difficult cases with insufficient or no assistance while

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[2] The Anesthesia Section at the time of the report consisted of the Chief, five general anesthesiologists, two cardiothoracic anesthesiologists, six CRNAs, an anesthesia technician, and student nurse anesthetists on rotation.

[3] According to the agency report, an ASA is the commonly accepted method to assess the general health of the individual. The classification ranges from 1 to 6. A 1 indicates the patient is generally healthy and has few medical risk factors. A 5 means a patient is near death and a 6 means a patient is brain dead.

[4] A Mallampati score is used to represent the competency of an airway. It ranges from Class I to Class IV. Classes I and II suggest that the induction of an airway should be relatively uncomplicated while Class III suggests a moderately complicated airway, and Class IV suggests a difficult airway.

others are assigned less difficult cases with CRNAs. In support of its finding that this allegation was not substantiated, the report included a chart that explains the distribution of anesthesia cases by complexity for each of the anesthesia providers.

On August 18, 2011, OSC requested additional information from the agency concerning the eight cases cited by the whistleblowers. First, OSC requested the names of the CRNAs or SRNAs who had assisted on two of the cases and information on whether they had been assigned to these cases or voluntarily assisted on them. The whistleblowers maintained in their initial disclosures that no CRNA or SRNA assisted on these two cases. Second, OSC requested information regarding whether one of the CRNAs was assigned to the case or assisted on the case voluntarily, because the agency report made no such distinction. Third, OSC requested that the agency address the whistleblowers' claim that an anesthesiologist was assisted by a SRNA during only the initial few minutes of the case; the agency's report did not list the duration of assistance provided by CRNAs or SRNAs. Fourth, in two cases in which the whistleblowers believed assistance should have been provided by more experienced CRNAs due to a difficult patient or procedure, OSC requested that the agency explain why it believed assistance from SRNAs was appropriate. Fifth, in a case where no CRNA or SRNA was assigned to assist an anesthesiologist, OSC requested that the agency determine whether a second anesthesiologist had voluntarily assisted during most of the procedure and explain why it believed that no assistance was necessary on this case. Finally, OSC requested that the agency explain why a non-cardiac anesthesiologist was initially assigned to two cardiac anesthesiology cases when a cardiac anesthesiologist was available.

The agency provided a supplemental report dated October 17, 2011. The agency determined that the Medical Center does not maintain records of initial or interim anesthesia case assignments. In addition, the anesthesia records maintained by the anesthesiologists and CRNAs did not include this information. Consequently, the agency was not able to provide much of the information requested by OSC. The supplemental report stated that the three anesthesiologists, who are certified by the American Board of Anesthesiology (ABA), are required to "be capable of performing independently the entire scope of practice in the specialty or subspecialty without accommodation or with reasonable accommodation," according to the February 2011 ABA Booklet of Information—Certification and Maintenance of Certification. Thus, the agency concluded that the absence of a second provider did not increase any risk of harm to the patients, and that "it can only be assumed that the requests for assistance were made for the convenience of the anesthesiologists in question." Further, OMI added that it was unable to find any evidence that it is safer for a patient to be treated by an anesthesiologist who is assisted by a CRNA or SRNA than by an unassisted anesthesiologist. It also cited a July 2000 article in *Anesthesiology* titled "Anesthesiologist Direction and Patient Outcomes," which "concludes that both 30-day mortality rate and mortality rate after complications (failure-to-rescue) were lower when anesthesiologists directed anesthesia care."

Additionally, the agency clarified in its supplemental report that the participation of a SRNA in a case is for educational purposes and not to function as an assistant. As a result, the absence of a SRNA participating on a case permits an anesthesiologist to devote more time concentrating on his or her patient rather than instructing the trainee. With respect to a non-cardiac anesthesiologist being initially assigned to two cardiac anesthesiology cases, the agency found that according to Veterans Health Administration Handbook 1102.3, the expertise of a cardiothoracic anesthesiologist is only required for patients on cardiac bypass. Neither patient in these cases was placed on cardiac bypass.

The Whistleblowers' Comments on the Initial and First Supplemental Reports

Whistleblowers Drs. Mukherjee and Edwards, Mr. Dearing, Ms. Banez, Ms. Tyson-Hope, and Ms. Sharma submitted comments through their attorney.[5] The whistleblowers maintained that the agency was looking for proof of actual harm and stated that the agency dodged the question of whether the standard of care was a "best practice." Several documents were included listing the functions that CRNAs perform in an effort to demonstrate their usefulness in providing proper medical care.

Drs. Mukherjee and Edwards jointly submitted additional comments. They explained that it is not customary in any hospital to write in a patient's record the names of additional anesthesia providers who provide assistance. Notwithstanding the absence of the names of the additional providers in a patient's record, they questioned why the testimony of those who were listed on the record was not deemed to be adequate. Drs. Mukherjee and Edwards reasserted their claim that assigning assistance to only favored anesthesiologists and denying help to the whistleblowers creates an increased risk of harm to patients. They disputed the agency's contention that a sole provider is the safest method for delivering anesthesia care, and they disagreed that the *Anesthesiology* article cited by the agency supported the agency's contention on this point. With respect to the usefulness of SRNAs, these anesthesiologists stated that SRNAs "provide valuable help at critical junctions as asked to by the anesthesiologist and learn at the same time."

Drs. Mukherjee and Edwards also provided specific comments on several of the eight cases mentioned in the agency's report. In the case where Dr. Mukherjee assisted Dr. Edwards because no CRNA had been assigned,[6] they contended that on an extremely critical case, such as this one, it would be standard practice in any hospital to have more than one provider. They disagreed with the agency's assessment of the case involving a morbidly obese patient because in morbidly obese patients, the airway can be lost very easily.[7] Rather,

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[5] Eight of the whistleblowers, including these six as well as Dr. Canaria and Mr. Horwell, were represented by counsel.

[6] This case involved a patient undergoing a vascular procedure. The patient was classified as a 5E, which meant that he was moribund. Dr. Edwards was assigned to the case with a SRNA but believed additional trained skills were needed to handle the hemodynamics of the patient. The procedure was performed successfully because Dr. Mukherjee came to assist during most of the procedure even though she was not assigned to do so.

[7] This case involved the colonoscopy of a morbidly obese patient who weighed more than 300 pounds.

they maintained that having additional providers in a case such as this can be critical to patient safety. Finally, they reported that the failure to provide assistance to disfavored employees continues, citing an example on November 2, 2011.

The Second Supplemental Report of the Department of Veterans Affairs

The agency submitted a second supplemental report on March 7, 2012. The report included the case assignment data, taken from November and December 2010, that was used to create two of the charts in the initial report. The report lists information about several hundred individual case assignments, including the complexity of the case and whether a CRNA or SRNA was assigned to a specific case. Two of the three whistleblower anesthesiologists had the most cases without assistance from a CRNA or SRNA; the third whistleblower anesthesiologist was tied for the third fewest cases without assistance out of eight providers. In providing this data, the agency cautioned that many factors are used to determine case assignments of CRNAs and SRNAs, and causal relationships should not be inferred. The whistleblowers did not submit comments on the second supplemental report.

The Special Counsel's Findings

I have reviewed the original disclosure, the agency's unredacted reports and the whistleblowers' comments. Based on that review, I have found two items in the agency's reports that suggest some cause for concern, the first of which I find unreasonable. Nonetheless, I have determined that the remainder of the agency's reports contains all of the information required by statute, and the findings appear to be reasonable.

First, the agency's references to and reliance on the ABA requirement and the *Anesthesia* article are inconsistent with the agency's own practice. The agency argues that since the whistleblower anesthesiologists are capable of handling cases without assistance, the absence of any assistance in any particular case does not increase the risk of harm to the patient. Furthermore, the agency's assumption about the whistleblower anesthesiologists' requests for assistance insinuates that the whistleblowers are solely concerned with personal convenience. However, it cannot be disputed an anesthesiologist assisted by a CRNA could provide better care in some situations than one working alone. Indeed, the Chief of the Anesthesia Section receives CRNA assistance in all cases.

Second, the whistleblower anesthesiologists appeared to receive assistance from CRNAs and SRNAs less frequently than their non-whistleblower colleagues. Consequently, we requested and analyzed similar data from 2011 and 2012 to better understand whether

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Dr. Mukherjee was assisted by a SRNA. The procedure was initially scheduled to take place in the gastrointestinal (GI) suite on a different floor in the hospital than the operating room. However, Dr. Mukherjee insisted that the procedure be relocated to the main operating room so that another trained anesthesia provider could be more easily summoned, if necessary. Dr. Mukherjee maintained that due to the difficulty of the case, she should have been assisted by an anesthesiologist or a CRNA and the case should never have been assigned to the IG suite.

these data were the result of retaliatory treatment against the whistleblowers or a statistical aberration due to the limited sample size.[8] The 2011 and 2012 data suggest that the whistleblower anesthesiologists received assistance at similar rates to their colleagues. As such, I have determined that the agency's reports are reasonable and that the agency should continue to ensure that these whistleblowers receive assistance at the same rate as other employees.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency's reports and the whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of the reports and comments in our public file, which is now available online at www.osc.gov.[9] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[8] These data are not part of the agency's reports.

[9] The VA provided OSC with a report containing employee names (enclosed), and a redacted report which removes employees' names. The VA cited 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 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).