U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

November 18, 2011

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

RE: OSC File No. DI-10-1024

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find an agency report and supplemental reports based on disclosures made by Colin Clarke, M.D., a whistleblower at the Department of Veterans Affairs (VA), VA Medical Center (VAMC-Northport), Nuclear Medicine Service, Northport, New York. Dr. Clarke, who consented to the release of his name, alleged that VAMC-Northport was operating an unauthorized nuclear medicine program, and improperly submitting bills to third-party payers for services provided by Nuclear Medicine Service residents in a violation of law, rule, or regulation.

On June 18, 2010, the Office of Special Counsel (OSC) referred Dr. Clarke's allegations to the Honorable Eric K. Shinseki, Secretary of Veterans Affairs, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki tasked the investigation to the Honorable George J. Opfer, Inspector General, and John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections (OHI). OSC received an agency report from Secretary Shinseki dated March 30, 2011. On July 15, 2011, and October 13, 2011, the VA Office of General Counsel submitted supplemental reports providing updated information on the agency's corrective actions and providing the number of patients that were treated by medical professionals at VAMC-Northport during the course of the unaccredited time period.

The agency report largely substantiated Dr. Clarke's allegations. It concluded that VAMC-Northport operated an unaccredited residency training program in nuclear medicine from July 2007 until June 2010, when the program was discontinued as a result of the agency investigation. Over 4,000 patients were treated by nuclear medicine professionals during the relevant unaccredited time period. There was no information to indicate that any patients were harmed during this time. Investigators could neither substantiate nor refute the allegation that trainee physicians were permitted to function as attending physicians. Similarly, the investigation did not substantiate that VAMC-Northport improperly submitted bills to third-party payers for services provided by the trainee physicians.

VHA Handbook 1400.1, *Resident Supervision,* requires that residency training programs be accredited by the Accreditation Council for Graduate Medical Education

(ACGME) or other accrediting or certifying bodies, such as the American Osteopathic Association (AOA). The completion of ACGME-accredited residency training programs is a requirement for obtaining state medical licenses and specialty board certifications. Despite the unaccredited status of the program, the Chief of the VAMC-Northport Nuclear Medicine Service continued to recruit and accept trainee physicians in nuclear medicine. As discussed below, from July 2007 until June 2010, VAMC-Northport accepted four trainee physicians into its Nuclear Medicine Residency Training Program.

In addition, while the unaccredited status of the program was found by OIG to be known by employees at VAMC-Northport, OIG concluded that officials did not proactively communicate the unaccredited status to Veterans Health Administration's (VHA) Office of Academic Affiliations (OAA). The agency report states that there was no evidence that VAMC-Northport officials included OAA in their correspondence with ACGME or properly notified OAA when the facility voluntarily withdrew its accreditation status in nuclear medicine. Instead, according to officials, the VAMC-Northport notified OAA of the voluntary accreditation withdrawal through OAA's online Support Center website. As a result, reports from VAMC-Northport to OAA about the status of the Nuclear Medicine Residency Training Program were "misleading," according to one OAA official.

The agency report concluded that the VAMC-Northport's reports to OAA on its academic affiliation with State University of New York (SUNY) Stony Brook for residency programs appears to have been used to suggest an affiliation or endorsement with the nuclear medicine program, which after mid-2007, was not the case. As a result of the misleading information provided to OAA about the status of the residency program, OIG proactively investigated the status of residency programs, but found no other unaccredited programs operating improperly. Therefore, because the Nuclear Medicine Residency Training Program was unaccredited and, thus, fell outside established VA residency training program policies and personnel policies, the agency report substantiated the allegation that the Chief, Nuclear Medicine Service, improperly allowed unqualified individuals to work in Nuclear Medicine Service.

Furthermore, the agency report found that the Chief of the Nuclear Medicine Service improperly allowed unqualified individuals, not licensed to practice medicine in the U.S., to practice in the area of nuclear medicine. Specifically, two trainee physicians had no prior residency training in the U.S., despite an ABNM requirement that trainees satisfactorily complete one or more years of training in an accredited residency training program that provides broad clinical education, such as internal medicine or surgery. These physicians reportedly participated in the program to obtain clinical experience to facilitate their future acceptance into accredited residency programs. One of these trainee physicians had completed a medical internship and radiology residency in his country of origin, but not in the U.S. At the time the Chief, Nuclear Medicine Service, accepted the physician into VAMC-Northport's Nuclear Medicine Residency Training Program, the trainee did not have a medical license in the U.S. and was working as an ultrasound technologist at a private hospital. The other trainee physician had only completed "observerships" in various private medical practices prior to his acceptance into the Nuclear Medicine Residency Training

Program. He had not completed an internship in the U.S. and was not licensed to practice medicine. Because VAMC-Northport's Nuclear Medicine Residency Program was no longer accredited and the trainee physicians were not licensed but were, nevertheless, engaged in clinical activities, officials were permitting the trainees to practice medicine without proper licensure.

In sum, from July 2007, through June 2010, VAMC-Northport employed unlicensed physicians in an unaccredited nuclear medicine residency program that fell outside established VHA residency training policies and VA personnel policies. OIG could neither substantiate nor refute an allegation that trainee physicians were permitted to function as attending physicians and, after an audit, did not substantiate that VAMC-Northport improperly submitted bills to third-party payers for services provided by the trainee physicians in the unaccredited Nuclear Medicine Residency Training Program. As a result of the agency investigation, the VAMC-Northport Director discontinued the Nuclear Medicine Residency Training Program in June 2010, and removed the two trainee physicians. In addition, OAA discontinued funding nuclear medicine resident positions at VAMC-Northport.

Additionally, the agency's supplemental reports reflected that the VA leadership conducted additional administrative reviews and reprimanded two VA officials, including the Chief of Staff. VAMC-Northport further modified its residency validation process: the Associate Chief of Staff must verify the accreditation status of a residency program and submit the accreditation status to the Chief of Staff for additional verification and approval prior to submitting a request to fund a residency program.

Pursuant to 5 U.S.C. § 1213(e), Dr. Clarke had the opportunity to review and comment on the agency report and supplemental reports. Dr. Clarke stated that he found the VA's ongoing efforts adequate in addressing his disclosures and preventing a recurrence of those problems in the future.

I reviewed the original disclosures, the agency reports, and Dr. Clarke's comments. Based on that review, I have determined that the agency reports contain all of the information required by statute, and that the findings appear to be reasonable. Notwithstanding this conclusion, I note that the agency failed to provide any version of the report containing the names of the individuals involved, including the subject officials, for review by you, the Congressional oversight committees, the whistleblower, or OSC.[1] I find that the agency's decision not to identify the subject officials by name is not reasonable.

[1] The VA cited privacy concerns as the basis for not providing names in the report produced in response to 5 U.S.C. § 1213. OSC objects to the VA's assertion of privacy interests as a basis for withholding the names of individuals on the grounds that the public interest in this information outweighs the privacy interests of the unnamed individuals.

As required by law, 5 U.S.C. § 1213(e)(3), I have sent a copy of the agency reports and Dr. Clarke's comments to the Chairmen and Ranking Members of the Senate and House Committee on Veterans' Affairs. I have also filed a copy of the agency reports and the whistleblower's comments in our public file, which is available online at www.osc.gov, and closed the matter.

Respectfully,

Carolyn N. Lerner

Enclosures