Title 38 Decision Paper
Department of Veterans Affairs (VA)
Sheridan VA Medical Center (VAMC)

FACTS

On October 18, 2011, s, a Title 38 physician, was serving as the Medical Officer of the Day (MOD) at the Sheridan VAMC in Sheridan, Wyoming. While he was on duty, a patient presented via ambulance for admission to ambulatory care. After learning that the patient was expected in the nursing home unit ("Mountain View Living Center," hereafter "MVLC"), ordered the patient to be admitted to the nursing home unit without first conducting an examination, issuing orders, or completing an admission work-up. (Exhibit A). The medical center policies and procedures require medical staff to examine patients presenting for care and document the results of the examinations. (Exhibit B). The nursing home did not admit the patient and sent him back to an ambulatory care unit. then wrote orders for the patient's care but did not complete a History and Physical Examination (H&P). He reported the incident the next day at morning report. When asked if he had completed an H&P, he acknowledged that he had not.

On November 21, 2011, management issued a Notice of Proposed Admonishment based on the October 18 incident. (Exhibit C). responded both orally and in writing, asserting that his actions were appropriate given his knowledge of the circumstances at that time. In his response, he claims that he was told that the patient's admission work-up had already been completed by the nursing home unit that was admitting him. noted that the Sheridan VAMC's medical bylaws require a complete H&P within 24 hours of admission. Thus, his failure to do the H&P in the first 12 hours of the patient's arrival when he was MOD was not a violation of the policy. On January 6, 2012, management issued an Admonishment. (Exhibit D). In response, AFGE Local 1219 submitted a step one grievance on January 31, 2012. (Exhibit E). On February 7, 2012, management advised the Union that the grievance involved a matter of professional conduct and competence of a Title 38 employee and therefore it was seeking a 38 United States Code (U.S.C.) §7422(b) ruling. (Exhibit F).

By memorandum dated February 7, 2012, the Sheridan Medical Center Director requested a Secretarial determination that the issues raised in the grievance were excluded from collective bargaining because they involved direct patient care as defined in 38 U.S.C. §7422(b). The union also requested a determination, citing the unique circumstances of the direct admission at issue, and asserting that §7422(b) would not operate to exclude issues "peripheral" to an exempted issue from collective bargaining. In the request, the union also reiterated the assertions presented in ' oral and written responses to the Notice of Proposed Admonishment. (Exhibit G).

AUTHORITY

Authority is vested in the Secretary to determine whether a matter or question concerns or arises out of professional conduct or competence (direct patient care or clinical competence), peer review, or the establishment, determination, or adjustment of employee compensation within the meaning of 38 U.S.C. §7422(b).

ISSUE

Whether the Union's grievance challenging the Agency's decision to admonish involves matters or questions which concern or arise out of professional conduct or competence within the meaning of 38 U.S.C. §7422(b).

DISCUSSION

The Department of Veterans Affairs Labor Relations Improvement Act of 1991 granted collective bargaining rights to Title 38 employees but specifically excluded from collective bargaining and any grievance procedures provided under a collective bargaining agreement, matters or questions concerning or arising out of professional conduct or competence, peer review, or employee compensation, as determined by the Secretary. 38 U.S.C. § 7422

In its grievance, the Union challenges management's decision to admonish . The Union claims that under the circumstances involving the admission of the patient, it was reasonable for to assume that a complete work-up had already been completed on the patient. The Union further asserts that the VAMC medical bylaws provide for completion of an H&P within 24 hours of admission of the patient. (Exhibit B). Since a full day had not elapsed when ; reported the incident in morning report, he still would have had time to complete the exam if he had received such direction at morning report.

The Union explains that when ; was advised by the MVLC charge nurse that there had been prior problems in dealing with the patient in MVLC, he proceeded to the ambulatory care unit where the patient had been sent and asked the nursing staff to write appropriate orders and to advise him of any urgent or emergent care needs. The Union also blames the releasing facility for failing to ensure that the patient could be admitted to MVLC.

The VAMC issued the admonishment for ordering a patient to be taken to a unit without first conducting an examination of the patient, without any admission work-up and without any orders. Management contends that as the MOD, ; was "charged with the proper care of all patients in the medical center during other than regular duty hours" and was required to "examine each patient prior to admission." (Exhibit H). Further, his decision not to see the patient and ascertain his condition and vitals constituted a deviation from the appropriate standard of care within the meaning of the medical staff rules and medical center bylaws, which state, "Emergency services

will be limited to first aid and life-saving measures to the treatment of on-the-job injuries on station and to the diagnosis, evaluation, and stabilization of emergency situations, as far as possible." (Exhibit B). Since ; did not diagnose, evaluate, examine or stabilize the patient, the admonishment was warranted.

Despite the Union's assertions, the admonishment for failure to follow applicable procedures and deviation from an acceptable standard of care involves direct patient care. *VA Tennessee Valley Healthcare System/AFGE* (Jan. 23, 2008) (holding that the Medical Center Director's decision to discipline a nurse for his interactions with a patient "involves issues concerning or arising out of professional conduct and competence)."

The Union questions the substantive admonishment decision by citing mitigating circumstances such as the time of day and lack of information.[1] In so doing, the Union highlights why the actions described in the admonishment affected and related directly to patient care. The matters that are the basis for the grievance concern or arise from professional conduct or competence, i.e. direct patient care, and are excluded from collective bargaining, including negotiated grievance procedures, pursuant to 38 U.S.C. §7422(b).

The Union also raises procedural challenges to the admonishment. It argues that the VAMC should not have chosen to conduct the inquiry into the incident. VA Handbook 5021, Part II, Chapter 1 §6(a)(1)(A) provides that it may be necessary for officials other than the immediate supervisor or deciding official to make the preliminary inquiry into an incident. (Exhibit I) Because was allegedly the accepting physician for the patient at MVLC, the Union believes that he had a conflict of interest and therefore should not have been involved.[2] The Union further challenges whether the action to admonish was timely, asserting that the lapse of 34 days from the date of the incident to the issuance of the admonishment was unreasonable and a violation of the master labor agreement.

These challenges do not change the basis for the admonishment – matters related to patient care - or the fact that it arises out of professional conduct or competence within the meaning of §7422(b). The claim of untimeliness in the instant case is merely a disagreement as to whether a subjective condition has been met. Similarly, the challenge to ; appointment to investigate the incident does not allege a failure to follow Agency policy, but amounts to a disagreement about how management exercised its right to conduct an inquiry into the incident, a right specifically provided for in the Handbook.[3]

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[1] The Union challenges management's descriptions of the factors considered in issuing the admonishment. These 12 factors are commonly referred to as the *Douglas* factors, first identified by the Merit Systems Protection Board in *Douglas v. Veterans Administration (5 MSPR 280)*. By challenging the asserted bases for each of the 12 factors, the Union challenges the underlying support for and validity of the substantive action. Thus, the challenges to the factors also arise from or concern professional conduct or competence.

[2] The statement of witness ;e indicates that r might have been the "accepting doctor." She was not certain of this. Management's submission to the file is silent on this question.

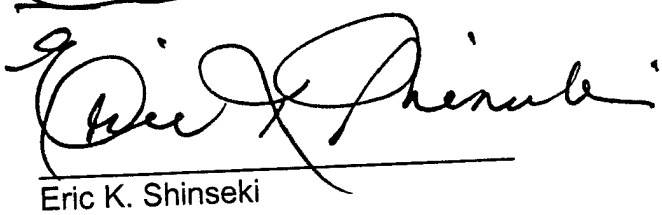
[3] In its February 16, 2012, request for determination, the union claims that issues "peripheral" to an exempted issue should not be excluded from collective bargaining by operation of 38 U.S.C. §7422(b). By advancing this

Accordingly, the claims raised in the grievance concerning whether the action was taken timely, and whether r should have conducted the investigation into the incident pursuant to VA Handbook 5021, also arise from and concern professional conduct or competence.

RECOMMENDED DECISION

The grievance challenging the validity of the admonishment of concerns professional conduct or competence within the meaning of 38 U.S.C. §7422(b), and is thereby excluded from collective bargaining.

APPROVED/DISAPPROVED



8/16/2013

Eric K. Shinseki
Secretary

Date

argument, the Union concedes that the matter for which was admonished involved direct patient care.