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September 12, 2022

Response of Dr. [redacted] M.D.
Re: OSC File Nos. DI-21-000470 and DI-21-000503

Dear Ms. [redacted]

1. Thank you for the OSC report that you sent to me on August 1, 2022. Thank you for granting extension to my response until September 15, 2022. Also, I thank all those who participated in this comprehensive investigation and preparers of this report. However, I note flaws in the response of Dr. [redacted] Director VISN-17, and in the OMI Report of Investigation.

2. I am a busy pain management clinician, I do not have the time to reiterate the voluminous amount of fact-supported material that I have already prepared and submitted over the last two years, specifically since August 2020 to the CTVHCS leadership, VISN-17 leadership, OSC, OIG, OAWP, OMI, the House and Senate committees on Veteran Affairs, our local representatives, and the EEOC. The effort, time, and money that I have spent and that my colleague Dr. [redacted] has spent in this case is enormous but was worth it as it contributed to the safety and betterment of medical care that is rendered to our Veterans at the CTVHCS.

3. **I am requesting that this response with all its exhibits be attached as permanent record along with your report, be sent with your report to the House and Senate Committees on Veteran Affairs and be published whenever and wherever your report is published.**

4. Please note that the report by Dr. [redacted] Director of VISN-17, is inaccurate, misleading, and biased. It is a manipulation of the facts on the matter.

5. This investigation was supposed to be against the leadership of Dr. [redacted] the Chief of Staff (COS) at the CTVHCS, and his manipulative and counterproductive decisions and actions. However, this investigation has been manipulated and redirected towards pre-determined conclusions to exonerate and protect the COS at the CTVHCS and to scapegoat Dr. [redacted] who did exactly what Dr. [redacted] had ordered him to do.

6. <u>All the allegations in this report are true and are supported by facts.</u> Please note the following:

    a. At least two allegations regarding pending actions that would have harmed our Veterans were blocked because of the vigilance and courage of the whistleblowers in reporting these pending actions to the proper authorities before they occur. This produced fear and retraction of plans by the culprits. Examples of these are plans to redact medical records and plans to replace the RN level of nursing in the Pain Procedure Room by an LVN level of nursing.

    b. The allegations were made independently by the <u>only two pain medicine specialists for the whole of the CTVHCS</u>. Please note that Dr. [redacted] and Dr. [redacted] are the only American Board-Certified Pain Medicine Specialists at the CTVHCS. None other has any Pain Medicine

accredited training or certification, even if their practice is in Pain Management.

c. Furthermore, Dr. [redacted] and Dr. [redacted] participate in a daily manner with patients and administration and are quite informed of what goes around at the CTVHCS.

d. Neither of these pain medicine specialists would risk their career by giving false allegations. Therefore, it would be to the favor of our Veterans and the VA to listen to these two pain medicine specialists to see where the problems lie and how to correct them. All to the benefit of our Veterans.

e. It appears like the majority of the submitted evidence was ignored and not addressed by the OMI investigators. A couple of claims were substantiated, not because the OMI investigators paid more attention to these claims, but because their investigative report would have appeared fake had they unsubstantiated all the allegations. To those who are well informed, the OMI report still looks deficient.

7. We need to clarify the semantics of Pain Management at the CTVHCS. Please note the following:

   a. <u>The Pain Management Section</u> is a small section consisting of three pain management providers. This section was under the Surgical Services, but was realigned by Dr. [redacted] the COS, as a section under Whole Health Services on October 11, 2020. Dr. [redacted] leads this section and supervises two other pain management physicians in this section.

   b. <u>Pain Management at the CTVHCS that involves multiple Services and Committees</u> that engage in the implementation of the VHA Stepped Care Model for Pain Management at the CTVHCS

i. Services that are primarily involved in Pain Management at the VA include, Primary Care, Mental Health, Whole Health, and Pharmacy. This is to be contrasted but not confused with the Pain Management Section, which is a small section of only three members that was within the Surgical Service and was then realigned under Whole Health Service on October 11, 2020, by Dr. [redacted]

ii. The Pain Oversight Committee (POC)

iii. The Comprehensive Addiction and Recovery Act Mandated Pain Management Team (PMT)

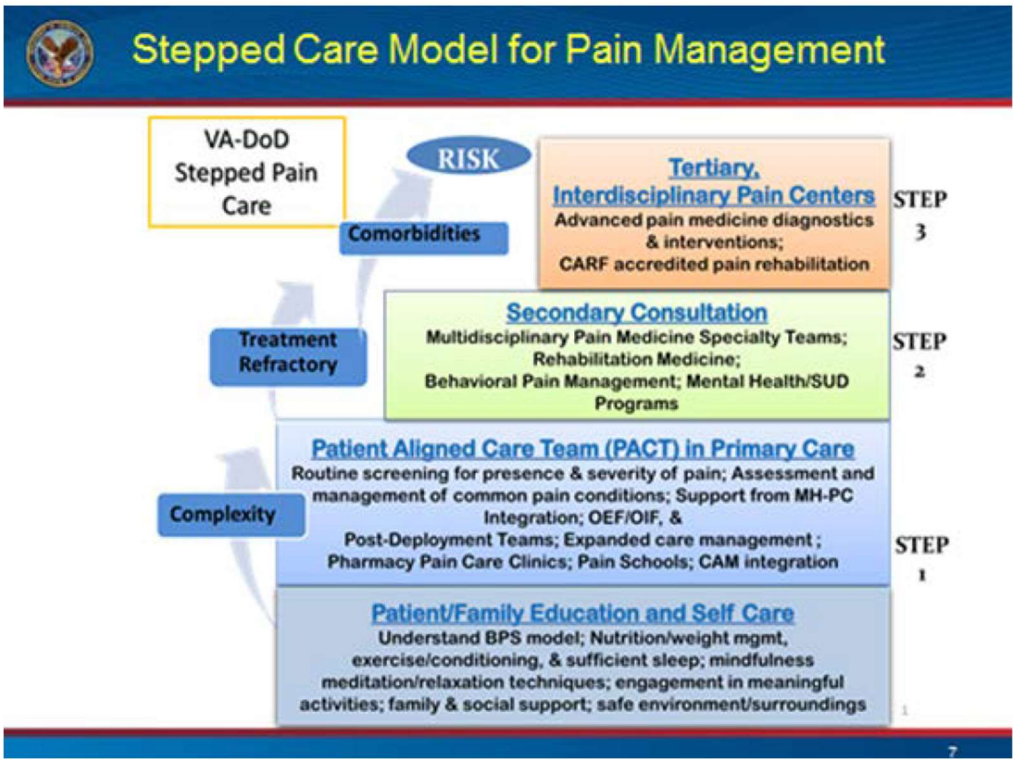
c. Dr. [redacted] Supervises and controls the Pain Management Section only, but has no control over Primary Care Service, Mental Health Service, Pharmacy Service, or Whole Health Service. These services fall under the authority of Dr. [redacted] [redacted] the COS. Also, both committees, the POC and the PMT, are under the authority of the COS who appoints their chairperson and dictates their members and direction.

d. The problems with pain management at the CTVHCS are, therefore, not due to the leadership of Dr. [redacted] but due to the leadership of Dr. [redacted] the COS, who has power over the Services and Committees mentioned above. By transferring the Chair of the POC and the PMT, these two most important pain committees, from Dr. [redacted] to Dr. [redacted] in October 2020, Dr. [redacted] has effectively removed Dr. [redacted] from leading pain management at the CTVHCS to the favor of Dr. [redacted] who became the de facto pain management director for the CTVHCS.

8. Engaging in the substantiating and the unsubstantiating of allegations in this report, serves as a distraction from the real problem. Most importantly here is a root-cause analysis to pinpoint the origin and the culprits of the problems and to embark upon

correcting the breaches in Pain Management at the CTVHCS and holding the culprits accountable for their actions or inactions. This is the proper way that a Highly Reliable Organization (HRO) such as ours must address such issues. All to the favor of our Veterans who suffer because of counterproductive leadership at the CTVHCS. Namely, the leadership of the Chief of Staff (COS), Dr. [redacted] and his Deputy Chief of Staff (DCOS), Dr. [redacted] who:

a. Both the COS and the DCOS failed to support the implementation of the VHA Stepped Care Model for Pain Management at the CTVHCS. The VHA Stepped Care Model for Pain Management is based in Primary Care Service. While Dr. [redacted] through Dr. [redacted] tried to oblige the three interventional pain management physicians to write all opioid prescriptions for the whole of CTVHCS and to treat OUD, while totally ignoring the obligation of primary care to prescribe opioids as per the VHA Stepped Care Model and the obligation of Mental Health Substance Abuse Treatment Program (MH/SATP) to treat Opioid Use disorder (OUD) as they are supposed to do.



b. There are three interventional pain management providers in the Pain Management Section (PMS). This number of providers has not increased since 2014 and until to date, while the number of Veterans at the CTVHCS has significantly increased and more satellite OPCs were established for the CTVHCS. The COS has consistently opposed and blocked the hiring of additional providers to the PMS to meet the growing needs of our Veterans. This has resulted in decrease access to the Pain Management clinics and increased referral to community care pain management providers.

c. Both the COS and the DCOS failed to oblige Mental Health Substance Abuse Treatment Program (MH/SATP) at the CTVHCS to take the lead in the management of Opioid Use Disorder (OUD). The involvement of MH/SATP here is critical. The DEA X-Waiver that allows practitioners to treat OUD with Medication Assisted Therapy (MAT) such as Suboxone is issued to Addiction Specialists but is not issued to non-addiction specialist providers such as primary care or pain specialists unless these work in an environment that is supported by addiction specialists. This is not the case at the CTVHCS where MH/SATP decline to treat OUD and decline consultations from other providers to this regard. This fact is obvious by the number of Suboxone prescriptions that is issued by Mental Health providers that by no means matches the number of OUD cases at the CTVHCS. In this context, The COS and the DCOS choose to do nothing about MH/SATP but try to enforce the three interventional pain management providers to treat OUD, when none of them is trained in addiction or credentialed to manage addiction at the CTVHCS. Additionally, these three providers get absolutely no support from MH/SATP who decline their consultation for OUD. **The attitude of MH/SATP at the CTVHCS is an anomaly at the VA and CTVHCS leadership chose to do nothing about it.**

d. To further exempt MH/SATP from treating OUD, they use a make-up diagnosis of Complex Persistent Opioid Dependence (CPOD) which in effect is OUD but helps in confusing providers and blurring the diagnosis of OUD that comes in mild, moderate, and severe stages. This diagnosis never made it to ICD-10 which is the list of proper medical diagnoses.

9. The following are the facts about the listed investigations into the subject matter:

a. March 21, 2021, VISN-17 Investigation by Dr. [redacted] Dr. [redacted] Director of VISN-17, suppressed the results of this investigation claiming the level of the officials involved. Dr. [redacted] kept this report as secret and never shared it with us. Perhaps because the conclusions of this report were honest and incriminated leadership at the CTVHCS. The fact is that Dr. Wixtrom would be the best to investigate these claims because he is a primary care physician with specific interest in pain management and an active member of VISN-17 Pain Stewardship Committee. Dr. Wixtrom is aware of the VHA Stepped Care Model for Pain Management and its implementation at the VA.

b. April 20, 2021, Investigation of Dr. [redacted] The facts about this investigation are as follows:

i. This investigation was called upon to investigate the Hostile Work Environment of Threats and Harassment that was imposed by Dr. [redacted] Chief of Whole Health, and Dr. [redacted] COS, against members of the Pain Management Section. (Exhibit A)

ii. **This investigation was in violation of Policy. Specifically, VHA Directive 0700 on Administrative Investigations has been breached. Dr. [redacted] was requested by Director Mr. [redacted] to convene the investigation. Dr. [redacted] should recuse self from convening the investigation because of the following:**

1. **Dr. [redacted] being a defendant in the hostile work environment claim he ought not convene the investigation against himself. (Exhibit B)**
2. **Dr. [redacted] is aware of at least two recent EEO cases (protected activity) that Dr. [redacted] has filed against him, one in March 2019 and one in August 2020 plus several whistleblowing events (Prohibited Personnel Practices) against Dr. [redacted]**

iii. Additionally, Dr. [redacted] could not commit to reading and considering all the factual material that were supplied to him during his investigation. This reflects bias and pre-determined conclusions. As such Dr. [redacted] investigation is fake, unreliable, and cannot be the basis for any proper decisions or actions. (Exhibit C)

c. August 3, 2021, the OMI Investigation: Members of the investigating OMI team were given proof of all the allegations, but they seemed to have ignored most of them.

d. December 5, 2021, Dr. [redacted] investigation.

10. The following is a list of supported facts regarding the performance of Dr. [redacted] MD, Chief of the Pain Management Section at the CTVHCS as this relates to the practice of pain management in this Medical Center:

a. Dr. [redacted] was hired by the CTVHCS in June 2015. Dr. [redacted] has served our Veterans at the VA in the capacity of a pain management physician continually for more than 21 years, since June 2001.
b. Dr. [redacted] holds an active certification of the American Board of Anesthesiology, and the American Board of Anesthesiology Subspecialty is Pain Medicine.
c. Dr. [redacted] chaired the Pain Oversight Committee (POC) from September 2015 and until September 2020, when Dr. [redacted] replaced him by Dr. [redacted]
    i. Dr. [redacted] wrote an all-new Charter for the POC on December 3, 2015. and updated that every two years.
    ii. Dr. [redacted] led the monthly meetings of the POC with busy agendas and perfect minutes that have advanced the Opioid Safety Initiative (OSI) to the most desirable numbers among all other Medical Centers in VISN-17, in addition to advancing all other pain related issues.
    iii. On April 24, 2018, as the Chair of the POC, Dr. [redacted] wrote and brought into effect the all-new PAIN MANAGEMENT AND ASSESSMENT Policy for the CTVHCS (Memorandum 011-001).
    iv. On August 6, 2019, as the Chair of the POC, Dr. [redacted] wrote and brought into effect the all-new comprehensive CTVHCS OPIOID USE POLICY (Memorandum 011-013).
    v. Dr. [redacted] is not aware of any complaint against him during his tenure as the chair of the POC. Despite that, in October 2020, Dr. [redacted] the COS at the CTVHCS, appointed Dr. [redacted] to replace Dr. [redacted] as the Chair of the POC.

d. After the Comprehensive Addiction and Recovery Act (CARA) Public Law was enacted and as soon as the VHA related directive was issued,

i. Dr. [redacted] wrote the Charter for the newly formed CARA-Mandated Pain Management Team (PMT) and had it approved by the Clinical Executive Committee on July 18, 2017.

ii. Despite complete lack of help from the COS, Dr. [redacted] was able to gather a team of experts to attend the Pain Management Team Interdisciplinary Clinic that started operating in March 2018, and continued operating with 100% Clinic utilization data, successfully treating the most complex pain management patients at the CTVHCS. Boasting at least 50% of patients seen on megadose opioids were completely off opioids and the remaining were on safer opioid medication regimens.

iii. Dr. [redacted] is not aware of any complaint against him during his tenure as the chair of the PMT. Despite that, in October 2020, Dr. [redacted] the COS at the CTVHCS, appointed Dr. [redacted] to replace Dr. [redacted] as the Chair of the PMT.

e. Dr. [redacted] always updated and renewed the charters for the POC, the PMT, the Pain Management Policy, and the Opioid Use policy on time and as was required during his tenure as chair of the POC and the PMT.

f. Because of Dr. [redacted] effective and successful leadership in pain management at the CTVHCS, Dr. [redacted] was given Outstanding evaluations on all elements of the ECF for the years 2020, 2019, 2018, and 2017. Contrast these four outstanding evaluations given by three different chiefs of Surgical Services and supervisors of Dr. [redacted] namely Dr. [redacted] Dr. [redacted] and Dr. [redacted] as contrasted with the 2021 evaluation by Dr. [redacted] that reflects his retaliation against Dr. [redacted] (Exhibit D)

g. Consider the productivity of Dr. [redacted] and of the Pain Management Section for 2019, 2020, 2021, and 2022 as of September 7, 2022. Dr.

[redacted] productivity has exceeded the productivity target in each of these dates and the Pain Management Section productivity has exceeded the productivity target for all years except for 2020, because of the enforced clinic closures due to COVID-19 Pandemic and because of Dr. [redacted] Joined our team late in March 2020.

Productivity Pain Management 2022:

VA, FY 2022, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	3,359.19	1,817	3,063	
	[redacted]	3,495.69	1,817	3,063	
		2,970.11	1,817	3,063	
		3,703.62	1,817	3,063	

Productivity Pain Management 2021:

VA, FY 2021, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	4,267.76	2,249	3,792	
	[redacted]	4,190.98	2,249	3,792	
		3,647.96	2,249	3,792	
		5,385.80	2,249	3,792	

Productivity Pain Management 2020:

VA, FY 2020, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	2,648.12	2,249	3,792	
	[redacted]	1,442.38	2,249	3,792	
		2,489.82	2,249	3,792	
		4,126.91	2,249	3,792	

Productivity Pain Management 2019:

VA, FY 2019, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	4,177.05	2,249	3,792	
	[redacted]	4,020.45	2,249	3,792	
		4,201.95	2,249	3,792	
		4,370.03	2,249	3,792	

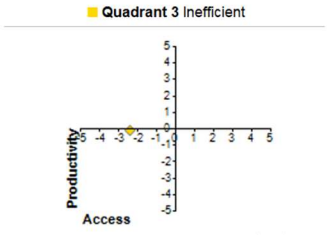
h. Now consider the Specialty Productivity - Access Report and Quadrant Tool (SPARQ) data. Please look at the plots and note the following points:

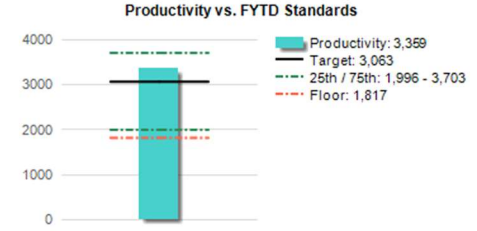
i. Please note that the Pain Management Section performance has exceeded the productivity target for all years, 2019, 2021, and 2022 as of September 7, 2022, except for 2020, because of the enforced clinic closures due to COVID-19 Pandemic and because of Dr. [redacted] Joined our team late in March 2020.

ii. Please note that the problem was not in productivity as the pain management section exceeded the target that was set forth by the VHA. The problem was Access to the pain management clinics.

FiscalYear: FY 2022 | **Facility:** (V17) (674) Temple, TX HCS | **Specialty:** Pain Medicine

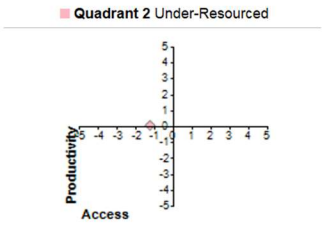
Average New Patient Wait from Create Date	**45.65** Days
Productivity	**3,359**
Productivity Target (FYTD)	**3,063**
% RVU Capacity	**0%**

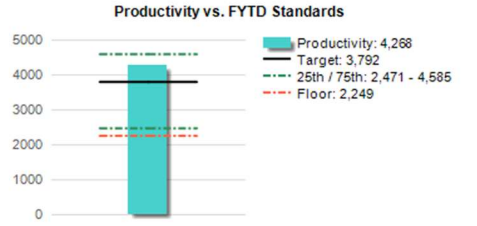




FiscalYear: FY 2021 | **Facility:** (V17) (674) Temple, TX HCS | **Specialty:** Pain Medicine

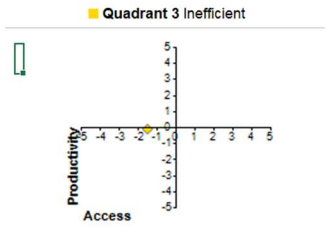
Average New Patient Wait from Create Date	**34.61** Days
Productivity	**4,268**
Productivity Target (FYTD)	**3,792**
% RVU Capacity	**0%**

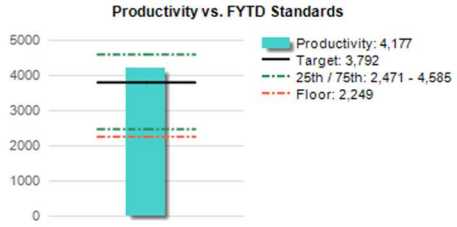




FiscalYear: FY 2019 | **Facility:** (V17) (674) Temple, TX HCS | **Specialty:** Pain Medicine

Average New Patient Wait from Create Date	**41.56** Days
Productivity	**4,177**
Productivity Target (FYTD)	**3,792**
% RVU Capacity	**0%**





iii. The problem of reduced access to the Pain Management Clinics at the CTVHCS is that of the COS, Dr. [redacted] here are the reasons why:

1. There have been three pain management providers at the CTVHCS since 2014 and until to date. This is despite the increase in Veteran population in Central Texas, and the fact that the CTVHCS has established additional OPCs in the area. **Pain Management has repeatedly submitted ERCs to hire additional providers and support staff, all of which have been repeatedly and consistently rejected by the COS.**

2. Dr. [redacted] rejected multiple ERC requests to hire staff to meet the growing demands of pain management in 2018 (Exhibits E &F), 2019 (Exhibit G), and 2021 (ERCs written by Dr. [redacted] and submitted by Dr. [redacted] to Dr. [redacted] Read the reason for hiring additional staff on page 2 of each of the attached ERCs. It is specifically stated that the reason is to meet the growing demands of our Veterans and to reduce referral to community care pain management by increasing access to our pain clinic services.

3. Additionally, Dr. [redacted] cancelled the Pain Management Nurse Practitioner's (NP) position after our NP transferred to work at the DOD in [redacted] in August 2018. Also, Dr. [redacted] obstructed us from hiring RNs and other personnel to help us out at the Pain management Suite.

4. Even when funding for hiring a pain management provider was supplied by VISN-17 in 2022, Dr. [redacted] repeatedly refused hiring a pain management provider and advocated for sending patients to Community Care pain management providers. This needs to be investigated. (Exhibits P & Q)

5. Effectively the actions of the COS tied our hands at the pain management section, reduced access of our Veterans to the pain clinic services, increased community care referrals to pain management, and set us and our Veterans up for failure.

6. It is clearly documented with facts that the increased in Community Care Pain Management referrals is due to the failure of the COS who obstructed every effort we put to hire more personnel to meet the demand of a growing population of Veterans in the area. This is not the failure of the Chief of the Pain Management Section. The evidence presented above proves proper productivity by the pain management section providers but decreased access to the pain management clinics is due to insufficient pain management providers and that is because the COS blocked all our efforts to hire additional providers.

11. The following is a list of supported facts regarding the performance of Dr. [redacted] MD, Chief of Staff, as this relates to the practice of pain management at the CTVHCS:

    a. As pointed above, Dr. [redacted] has undermined Pain Management at the CTVHCS and reduced access to the Pain Management Clinics by obstructing efforts to hire needed personnel.

b. Dr. [redacted] the COS, has authority over all medical services at the CTVHCS, but failed to implement the Stepped Care Model for Pain Management. This involves Primary Care, Whole Health, Mental Health, and Pharmacy Services. None of these services fall under the Chief of the Pain Management Section but fall under the responsibility and authority of the COS, Dr. [redacted] and the DCOS, Dr. [redacted]

c. Mental health Substance Abuse Treatment Program (MH/SATP) at the CTVHCS has traditionally refused to treat OUD, or even help those who treat it.

    i. This fact is supported by the number of Suboxone prescriptions (MAT for OUD) that are issued by MH providers compared to the number of patients with OUD at the CTVHCS.

    ii. Also, the number of patients referred to Community Care Providers for Suboxone management is unjustifiable when we have specialized MH providers at this Medical Center who can do so.

    iii. The COS and the DCOS at the CTVHCS who are over the MH Service are aware of these facts but are complacent about it. They choose to take a passive role and to do nothing.

    iv. Instead, the COS has ordered Dr. [redacted] to force providers at the Pain management Section to obtain their X-Waiver and start treating OUD.

d. Providers at the Pain Management Section never denied any patient chronic opioid management when these were medically indicated. Also, I note that the providers at the Pain Management Section are pain medicine

specialists and have better, more effective, and much safer means than chronic opioids for treating chronic pain. At the Pain Management Section and through the PMT, we have been able to get many patients off mega doses of opioids and give them a better life with more effective pain management. This has been so important during the current opioid epidemic that is claiming the lives of many citizens.

e. **The sine qua non of Dr. [redacted] tenure as the COS at the CTVHCS from July 2014 and until present is securing his position and power. His actions and decisions do not appear to benefit of our Veterans**. Consider the following:

   i. Dr. [redacted] gets rid of all Associate Chiefs of Staff (ACOS) who may compete for his job. Examples Dr. [redacted] who was the ACOS over PMRS, and Dr. [redacted] who was ACOS over Internal Medicine and then became Deputy COS before Dr. [redacted] got rid of him. More cases exist.

   ii. Dr. [redacted] appoints over services ACOSs who do not constitute a threat to his position, such as putting a podiatrist (Dr. [redacted] as ACOS over the Surgical Services instead of an MD, and appointing a PhD (Dr. [redacted] as ACOS over Mental Health and not an MD. None of those constitute a threat to Dr. [redacted] position.

   iii. Dr. [redacted] discriminates against Asians and practices Ethnic Nepotism. In late 2018, he removed Dr. [redacted] (Asian) from DCOS office, and in an act of Ethnic Nepotism he assigned the position to his fellow Nigerian, Dr. [redacted] who is still his faithful DCOS until to date.

iv. During my discussion with Dr. [redacted] the chair of the VISN-17 Pain Stewardship Committee, she stated that the CTVHCS lacked a Pain Management Point of Contact (POC) who ought to be a member of that committee and carry over the duties as the POC. I nominated my colleague, Dr. [redacted] as he is best qualified for this position besides myself, as I was too busy at that time. I nominated Dr. [redacted] to Dr. [redacted] our COS who rejected the idea and falsely claimed that he has already chosen Dr. [redacted] the ACOS for Anesthesia for this position. Here I must mention that Dr. [redacted] is an Anesthesiologist who is not trained, not experienced, and not credentialed at the CTVHCS to practice as a Pain Management Physician, yet despite that Dr. [redacted] chooses her as the POC for pain management over Dr. [redacted] (Asian). This is a clear and blatant discrimination against Asians by Dr. [redacted] and he gets away with it. (Exhibits I & J)

f. In a recent "PMOP Gap Analysis Summary Report: VISN 17" from May 2022, I quote the following tables from (Exhibit H):

i. As you can see that the CTVHCS has no Pain Management Team, has no experts working at the PMT clinic, and the reason for this is the lack of "Support of Medical Leadership." It is Dr. [redacted] and not Dr. [redacted] who has destroyed the PMT at the CTVHCS.

ii. Contrast this with a fully established and a fully functional PMT at the CTVHCS since 2017, under the leadership of Dr. [redacted] Dr. [redacted] has destroyed the PMT at the CTVHCS by replacing Dr. [redacted] with Dr. [redacted] in October 2020, who has rendered the PMT completely unproductive and nonfunctional.

iii. For how much longer will the CTVHCS and its Veterans bear the wrath of this toxic and counterproductive medical leadership? For how much longer will VHA leadership coverup for such gross incompetence and abuse of authority?

Pain Management Teams

	Does your facility have a PMT?	For how long?	Main service line
(504) Amarillo VA	No	-	-
(519) West Texas VA	No	-	-
(549) Dallas VA	Partially staffed	> 5 years	Anesthesiology
(671) South Texas- San Antonio	Fully staffed	2 to 5 years	PM&R
(674) Central Texas	No	-	-
(740) Texas Valley Coastal Bend	Partially staffed	1 to 5 years	Pain Medicine
(756) El Paso	Partially staffed	2 to 5 years	Surgery

PMT Staffing

	Medical Provider with Pain Expertise				Provider with Addiction Expertise				Provider with Behavioral Medicine Expertise			Provider with Rehabilitation Expertise		
	Yes/ no	Head count	Hours/ week	# X-wav	Yes/ no	Head count	Hours/ week	# X-wav	Yes/ no	Head count	Hours/ week	Yes/ no	Head count	Hours/ week
(504) Amarillo VA														
(519) West Texas VA														
(549) Dallas VA	Yes	1	1 to 4	1	No	-	-	-	Yes	1	17 to 40	Yes	1	17 to 40
(671) San Antonio	Yes	8	>160	2	Yes	6	41 to 80	2	Yes	2	41 to 80	Yes	3	41 to 80
(674) Central Texas														
(740) TX Coastal Bend	Yes	2	1 to 4	1	Yes	1	9 to 16	1	Yes	1	17 to 40	Yes	1	1 to 4
(756) El Paso	Yes	BLANK	BLANK	3	Yes	3	1 to 4	3	Yes	2	1 to 4	No	-	-

Barriers to PMT Implementation

	Staff Recruit	Staff Retain	Team Integration	Team engagement	Unfilled positions	Insufficient Resources	Primary care collaboration	Protected Time	COVID-19	Other
(504) Amarillo VA	X	X	X		X	X		X		Not implemented as a full team, tasks are divided
(519) West Texas VA	X	X	X		X			X		
(549) Dallas VA	X	X				X		X		
(671) San Antonio	X							X		
(674) Central Texas			X	X			X	X		Support of medical leadership
(740) TX Coastal Bend	X									
(756) El Paso	X	X								

g. Dr. [redacted] [redacted] the COS, always grooms a scapegoat to sacrifice for his own blunders. The scapegoat is naïve and inapt for the chosen position so that Dr. [redacted] can control him as he pleases. Through such a naïve and inapt person, Dr. [redacted] can retaliate against staff, break the

rules, and abuse his authority. When these breaches and abuses are discovered, Dr. [redacted] sacrifices the scapegoat and maintains his position as the COS unaffected and unscathed to go on repeating his game over again. (Exhibits K & L)

i. This is what happened in this case. The scapegoat was Dr. [redacted] Dr. [redacted] was obsessed with power and was elevated by Dr. [redacted] to a position and to a salary that he would have never even dreamed of. Dr. [redacted] hired Dr. [redacted] as the de facto Chief of Pain Management at the CTVHCS despite the lack of expertise, experience, training, or credentials of Dr. [redacted] in Pain Management. Dr. [redacted] bestowed upon Dr. [redacted] the Chairs of the POC and the PMT and realigned the Pain Management Section under Dr. [redacted] to give him full control over Pain Management. However, effectively Dr. [redacted] was in control of Pain Management.

ii. Because Dr. [redacted] did exactly what Dr. [redacted] ordered him to do, including retaliation against members of the pain management section, abuse of authority, and breaches of multiple VHA directives. But these were all under the orders of Dr. [redacted] the COS and the direct supervisor of Dr. [redacted]

iii. Despite our repeated complaints, Dr. [redacted] never addressed any of our complaints until the OSC, the OMI, and all branches of government were involved. Then and only then, did Dr. [redacted] move to effectively fire his scapegoat, Dr. [redacted] from all clinical, all administrative, and all supervisory duties, in addition to firing him from the Chair and membership of both the POC and the PMT.

iv. How much easier it would have been had the COS at the CTVHCS heeded to the concerns of the experts in Pain Medicine? But again, this would be assuming that Dr. [redacted] is an effective COS without a vindictive agenda to undermine pain management at the CTVHCS. There need to be an honest investigation into the matter of Dr. [redacted] leadership at the CTVHCS. That is difficult to obtain under the leadership of Dr. [redacted] [redacted] VISN-17 director, who is a long-term comrade of Dr. [redacted]

h. More concerns regarding Dr. [redacted] [redacted] the COS at the CTVHCS. (Exhibits M, N, & O)

12. Please note that some exhibits below, have their own exhibits. These may be supplied upon request.

13. **If all the facts that are presented in this response and in its attached exhibits do not hold the counterproductive medical leadership at the CTVHCS accountable, then our Veterans and our Medical Center are in dire trouble. It so appears that Dr. [redacted] [redacted] is well above the law because none of these investigations and none of the well-documented facts that were presented over the last two years were able to hold him accountable for his many abuses, breaches, and blunders. I am requesting an honest investigation into the claims against Dr. [redacted] [redacted] that I have presented in this document and in the attached exhibits.**

Sincerely,

[redacted] [redacted] MD
Telephone: [redacted]
Email 1: [redacted]gmail.com
Email 2: [redacted]va.gov

ATTACHMENTS:

1. EXHIBIT A_20210703_HOSTILE WORK ENVIRONMENT & POLICY VIOLATIONS
2. EXHIBIT B_20210517_Threats and harassment
3. EXHIBIT C_20210520_[redacted] COULD NOT COMMIT
4. EXHIBIT D_ANNUAL PERFORMANCE EVALUATIONS_[redacted]X5 YEARS
5. EXHIBIT E_20180117_ERC Staffing Request-PAIN MGMT_REJECTED by COS
6. EXHIBIT F_20180607_ERC Staffing Request-PAIN MGMT_REJECTED by COS
7. EXHIBIT G_20190307_ERC Staffing Request-PAIN MGMT_REJECTED by COS
8. EXHIBIT H_PMOP Gap Analysis Summary Report VISN 17
9. EXHIBIT I_20220521_Central Texas Pain Point of Contact (POC)
10. EXHIBIT J_20220610B_TO [redacted]CTVHCS Point of Contact (POC)
11. EXHIBIT K_20220324_OSC_NEW INTAKE_DR. [redacted]
12. EXHIBIT L_20220110_LETTER TO PSB
13. EXHIBIT M_COS_DR. [redacted] [redacted]CONCERNS_2018-2019
14. EXHIBIT N_COS_DR. [redacted] [redacted]CONCERNS_2020-2021
15. EXHIBIT O_COS_DR. [redacted] ABUSIVE LEADERSHIP
16. EXHIBIT P_20220220A_[redacted]_DR. [redacted] PATIENTS_Redacted
17. EXHIBIT Q_20220220B_[redacted]_I can take OUD_Pain w_Suboxone_Redacted