United States Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

September 16, 2025

Re: OSC File No. DI-24-000312

To whom it may concern:

My name is [redacted], MD MBA and I am the non-anonymous whistleblower who initiated the complaint for the above OSC file related to my prior employment with the Lt Colonel Charles S. Kettles VA Medical Center in Ann Arbor, Michigan. I have previously provided my comments on the initial OIG response from the Department of Veterans Affairs (VA).

As part of that referral, and pursuant to 5 U.S.C. § 1213(e)(1), I am providing my comments on the supplemental response from VA dated September 5, 2025.

I have provided my assessment of the VA Office of Inspector General (OIG) investigation and report in detail, with point by point rebuttal in my comments on the initial repose from VA. I will not spend the time doing the same here. I will, however, speak to two of their responses and then more broadly about this experience.

In the case of qualified inpatient coverage, where my complaint was “unsubstantiated”, I find the response to the OSC related to the supplemental request quite validating. As framed in the supplemental question, the VA was asked how many of the cases I referred met any one of the requirements for VA OIGs stated qualified coverage. The answer was “none”. Short, simple, and completely unjustifiable given that they deemed the complaint “unsubstantiated”. I find it hard to reconcile these things without seeing them an an effort to undercut the credibility of whistleblowers. And I am convinced at this point that it is deliberate.

In the case of unauthorized computer access, where my complaint was substantiated but in my interpretation downplayed, I will defer to the Office of Special Counsel attorneys to interpret in greater detail the need for intent for wrongdoing despite unauthorized access of information. However in the most recent response from OIG, they appear to reject the premise of the question. Instead they explain away the action, site case law that applies to authorized users misuse of information, while this specific question relates to access in the absence of authorization. Instead of oversight and accountability, we find justification and dismissal of concerns. Despite the admission in their earlier reporting that the root cause is a nationwide deficiency in house officer onboarding. Ann Arbor is unlikely the only facility with this issue.

To me the most important finding of this entire experience as a whistleblower, more important than any specific deficiency that I identified in my complaint, is that the VA OIG does not represent meaningful oversight over VA. This has significant implications for the future of VA, and for whistleblowers. When I contacted the Michigan Attorney General, they referred me back to OIG. When I contacted the US Senate, they referred me back to OIG.

In 2018 there was an article published in the New England Journal of Medicine by Kyle Sheetz M.D. and David Shulkin M.D. describing why they felt the VA needed more competition. Dr Shulkin was the VA Secretary at the time, serving both presidents Obama and Trump. Dr Sheetz trained at Michigan, and was a resident within our VA hospital during my tenure as

faculty there. I have great respect for both authors, but I fundamentally disagree with their conclusions. The VA does not need competition so much as it needs oversight.

There was a separate, publicized VA OIG investigation in Michigan several years ago. The John D Dingell VA Medical Center also experienced issues related to procedural care. Secretary Dennis McDonough visited in 2023 after both Office of Medical Inspector (OMI) and OIG reports demonstrated years long failures in oversight, and facility failures in timely corrective action based on reports by those bodies detailing deficiencies and substandard care. But we knew this all in Ann Arbor. Members of my department knew the whistleblowers there personally. There were multiple. It must have been nearly a decade, maybe more from the first reports until Secretary McDonoughs visit. And we saw it first hand. I personally cared for patients harmed in Detroit who were then referred to Ann Arbor for subsequent care. We experienced the moral injury inflicted by the lack of oversight of other VA facilities. We saw that veterans suffered.

It must not take this long to adjudicate deficiencies. My initial whistleblower complaint made to VA OIG was in March of 2023, 2.5 years ago this month. Part of this process is a war of attrition, they create barriers and make it difficult to report and hope you just go away. I left VA employment nearly 2 years ago, but I will continue to advocate for veterans.

And I am convinced that the VA OIG either can not, or will not, but ultimately does not provide the oversight needed to mitigate the risk to veterans.

Sincerely,

/s/ [redacted]

[redacted], MD MBA