August 22, 2013

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street NW
Suite 300
Washington, DC 20036

Re: OSC File No. DI-12-3816

Dear Ms. Lerner:

Below are my comments on the Department of Veterans Affairs Investigative Committee Report of my July 2012 Whistleblower Complaints about the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi. As I stated in my testimony to the investigative committee, the committed and excellent employees in the Primary Care Service of G.V. (Sonny) Montgomery VA Medical Center, and the Veterans they serve, looked to the committee to conduct their investigation with integrity. It should be noted, however, that the team stated they would not be able to interview all of the witnesses on the list I gave them. I believe the committee understood they held in their hands the chance to finally transform the Primary Care Service at the Jackson VAMC into a proper and true "medical home" for the Veterans. This means giving the Veterans the best medical care in the world, in a place worthy of taking care of the lives of Veterans—men and

women who signed up to put his or her life on the line for people all over the world. There are no other humans on the planet like those in the United States Military.

As the team knows, I "lived" Primary Care at the Jackson VAMC for four years, and continue to be an eyewitness. The reality of the situation in Primary Care at the Medical Center is one I experienced in person, including knowing the medical and psychological effects on the Veterans and committed staff. Heartaches can be palpable and visible.

I believe the investigative report highlights the global lack of respect for both federal and state laws and regulations, as well as VA policies, which constitutes the defining culture of "leadership" at the Jackson VAMC. This milieu led to the kinds of actions—and lack of actions—that caused the problems substantiated by the investigative team. These issues define Primary Care (PC) at the Jackson VAMC; they make up the longstanding model of Primary Care at the Medical Center, and they continue. And the cruel effects on the Veterans, and the committed Primary Care staff, are still without end.

My comments give an expanded history of the issues at the Medical Center, as well as an up-to-date summary of ongoing problems and attempted approach to any remedy or improvement at our VAMC. Those of us who work in Jackson are still aghast at daily events—yet we then remind ourselves that the decisions made and policies instituted by management are all cut from the same damaged cloth. And as the investigative report states on its first page, "Federal laws and regulations, as well as state laws", and "both VA and Veterans Health Administration (VHA) policy" have not been followed "due to mismanagement". Although the report equivocates at one point when it states "may have been

violated" or "may not have been followed", later in the same paragraph it is noted that "the fact-finding team made a number of recommendations for the Jackson VAMC to adhere to or enforce current rules, regulations, or practices, and policies…to ensure the service line complies with all applicable laws and VHA policies to maintain a high quality, safe health environment for patient care." Isn't all of Primary Care under this umbrella— *everything* that happens in Primary Care—and how much more serious can it be than breaking and ignoring the litany of mandates above?

It is discouraging to see the apparent gentleness with which the facility and its leadership are sometimes referred to by the investigative team: those in administration "may not have followed" laws and regulations; or "there is a lack of understanding among Medical Center leadership" regarding rules and policies. But there cannot be any plausible deniability in the leadership of the Jackson VAMC; I personally wrote emails about the issues above over several years, and both past and current leadership at multiple levels are longtime VA employees. In addition, it is the clear and inescapable responsibility of anyone in management to acquaint his or herself with, and *follow*, all applicable standards of operation and conduct—especially in a facility whose "service line" is taking care of fellow human beings. The rules are there for a reason, and they apply to all of us. Finally, Center Director Mr. Joseph Battle in particular cannot be allowed to continue to use the phrase "these things happened before I came" as a verbal shield. The same kinds of things are still happening; and once you take over command—of a business, medical center, ship, or family or any other communal entity—everything is immediately and completely *on your watch.*

How did the G.V. (Sonny) Montgomery VA Medical Center end up in this way? Just as I tell a patient—when after years of talking about the unhealthy road he or she is on, and warning about consequences, that man or woman finally steps over the laboratory line into diabetes—this "didn't fall from the sky". One of the "vital signs" of a medical practice is that the people entrusted with others' lives *do care*. It is not enough to just "do" care, to set up a place called Primary Care on paper and in waiting and exam rooms, with staff and patients coming and going, and then measure metrics on spread sheets. Where care is delivered can't just look like a clinic; there has to be an honorable system surrounding the patient, with consistent and continuous care. And that means leadership in a medical center, the people with the power to provide the resources to do the job of committed employees, must also truly care. At the Jackson VAMC it is especially hard to read the auto-slogan at the bottom of official emails: ICARE—INTEGRITY, COMMITMENT, ADVOCACY, RESPECT, and EXCELLENCE. A clever acronym, but not one lived each day by the Medical Center leadership, especially with regards to respect for the Veterans and loyal staff.

I remember being astonished when I first came to the Medical Center in September 2008 and a physician introduced herself and immediately said, "I hope you don't quit like all the others." I soon understood why doctors left, and why I ended up two years later as one of only three primary care physicians—and the investigative team's report identifies many of the startling issues.

The strong undercurrent that allowed and even nourished the "unhealthy" and illegal conditions in the design of Primary Care at the Medical Center was the antagonism set up between nurse practitioners and physicians. Dorothy White-Taylor, PhD ascended over decades to the position of Associate Director of Patient

Care services, which essentially meant she had the power to affect everything that a medical center does—and to intersect with everyone in that facility. For almost two decades Dr. Kent Kirchner worked side-by-side with her in his capacity as Chief of Staff, and acquiesced to many of Ms. Taylor's decisions and set-up of services. When I first came to Primary Care, I was told that "Dot Taylor controls the real estate" when I wanted to move my exam room closer to where the medical assistant assigned to me sat, so we could coordinate our work with the Veterans. And most significantly, Dorothy White-Taylor was in charge of all nursing personnel, including nurse practitioners. Thus the NPs did not "answer" to any physician—and the Chief of Staff did not challenge this situation.

In addition, just before I arrived in September of 2008 Dot Taylor and Dr. Kent Kirchner proposed a plan to put an NP in charge of Primary Care instead of a doctor; I was told that several physicians rebelled, and worked with their union to make sure the idea was dropped. But even to a casual observer the idea that a department of Primary Care—in a medical Center—*could ever* be supervised and run by a nurse practitioner instead of a physician seems preposterous. But I soon also learned that the NPs constituted seventy-five to eighty-five percent of the clinicians "providing" care to the Veterans seen in PC at the Jackson VAMC; and that many times neither clerks nor other nursing staff nor the NPs themselves corrected the Veterans when they referred to an NP as their "doctor". This is an improper practice, as the investigative team report points out; and many states (including the State of Mississippi) have passed laws requiring that all people working in a healthcare facility have photo identification tags that not only prominently display the name of the employee but just as visibly show the employee's professional designation for clinical work, and level of experience.

Interestingly, the fact that Dot Taylor was always referred to as "Dr. Taylor" in a hospital setting (although her work at the Medical Center was entirely administrative, and her field of doctorate study was also not as a medical clinician) set the tone for this, at the very least, lack of clarity for the Veterans. Commenting on a new 2013 law in Texas, a woman (Helen Haskell) behind a South Carolina law on requirements for hospital ID badges calls this "the most basic level of transparency", and notes that "It's very important to know who's providing your care because people have different areas of expertise, different levels of training." She speaks from a personal tragedy experience. As the investigative team report points out (page 26), the NPs at the Jackson VAMC wear the Federal Employee "PIV" badges—which "do not identify the individual's position or title". I know, and saw daily, that the NPs in Primary Care did *not* also wear the red tags given to them that said "NP" in bold letters.

And nurse practitioners are not the same as physicians. This is not about what is commonly called "protecting turf"—with the American public getting sicker and sicker, younger and younger, sadly there is more than enough healthcare work for well-trained and experienced doctors. I have been a physician for thirty-six years, and know that like the rest of the country Veterans are on what is known as "polypharmacy"—by most definitions, the use of six or more concurrent medications. Patients are all individual walking-chemistry-experiments. And so primary care is the hardest job to do well consistently in modern medicine. It requires all the brainpower and willpower and training (and blessing) a physician can muster to take full responsibility for the *whole* life of the patient during their *entire* life.

The total hours of coursework and training for a nurse practitioner ranges from 3,500 to 6,600 hours; for a fully-trained primary care physician the number is 21,000 hours. Physicians across the country study the same undergraduate premedical courses, and then the same medical school curriculum; must pass board examinations overseen by one certification body; and have standard state medical licensing requirements. Nurse practitioners do not have a standard degree curriculum nationwide; have three different certification groups who all have different criteria; and licensing requirements vary from state to state. Physicians are taught primarily by other physicians, and for primary care must finish a three-year residency training program; nurse practitioners are taught principally by other nurses and nurse practitioners, and do not do an additional educational/clinical training program such as a residency. Family physicians must pass board recertification exams every seven years, but no such monitoring exists for nurse practitioners; and physicians must complete 150 hours of continuing medical education every three years for licensure and board certification, whereas nurse practitioners only need to complete 75 continuing education hours *or* take an appropriate recertification exam, with *no* specific requirement for "pharmacy content hours".

As Dr. Reid Blackwelder, President-Elect of the American Academy of Family Physicians has eloquently written in a 2013 Wall Street Journal essay "the work of many nurse practitioners begins only after a physician has already made a diagnosis". He notes that studies showing "similar outcomes" with physician and nurse practitioner care result from collaborative practice with physicians. He highlights that "the extensive and diverse medical education and clinical experience" that doctors receive "strengthens a physician's diagnostic skills"; and

that a primary care physician must help a nurse practitioner on the healthcare team "when chronic medical conditions become unstable—a change that is inevitable". I would add that the moment(s) of change are not always simple and straightforward.

Dr. Blackwelder states that "requiring patients to accept less" than the medical care expertise of primary-care physicians as head of the medical home team is "unacceptable". Yet that is how Primary Care at the Jackson VAMC operated—in a department set up by Dorothy Taylor and endorsed by Dr. Kent Kirchner. Dot Taylor helped several nurses obtain more education and then become "grandfathered in" as nurse practitioners at the Medical Center—even though one of these NPs never obtained a nurse practitioner *license* until 4/10/2013, and ran (and still runs) the "Women's Health Clinic" alone and unsupervised since 1994. And as the investigative report reveals, the Jackson VAMC ratio of NPs to MDs is 3:1 (75% NPs and 25% MDs)—and the VHA national average for comparable healthcare facilities is the "inverse situation, that is, 3 MDs to 1 NP."

Under the plan put in place by Dot Taylor, more and more nurse practitioners were hired, and the work environment for the few physicians left in Primary Care became harder and harder. The first year I worked at the Jackson VAMC one of Dot Taylor's assistants told me she "forgot" to block out my requested leave for the entire year—and I could just have the already-scheduled Veterans rescheduled as double-bookings for weeks, or I could just not take any annual leave. When I asked why I was overbooked most days anyway, she (not a clinical staffer) told me I saw my patients "too often"—and got Dr. Kirchner to write me an email to that effect. When a Veteran newly transferred to me walked

into the clinic three days in a row, and threatened me he wouldn't leave the clinic until I "did what he wanted", becoming delusional about surgery he'd had, I had the male head nurse in the clinic help me call the police and have the man removed from my patient panel and clinic. All of this was documented in the medical record, including a note from a psychiatrist regarding the patient—but several weeks later I saw the same patient back on my schedule and a note in the chart from the same assistant of Dot Taylor. It stated that "per Dr. Taylor" the Veteran had asked to be reassigned from the provider he was given after he threatened me—and that "per Dr. Taylor" the Veteran was being assigned again to me. Dot Taylor controlled nurse staffing and assignment in the clinics, and I was the last provider (including all NPs and the other two MDs) to have an RN assigned to my PACT (medical home model of care) team—one year after everyone else in all of the other Primary Care clinics had fully-formed teams on board, and one year after all other providers had the added vital help an RN can provide for the patient and their ongoing care, "off-loading" some of the workload of an NP or MD and making the care of the Veteran less likely to be delayed. Finally, one of the subspecialty physicians gave me copies of the reports on Primary Care provider panel sizes—and I saw that my panel was the largest of anyone in the department, with the two other physicians "capped" much lower than my total number of patients. The more patients in my panel the more Veterans needing appointments, and prescriptions, and ER and inpatient admission follow-ups, and tests and consultations and walk-ins and phone calls and letters and message "alerts"—all of which meant a lot more work and worry and responsibility for me. And I wrote emails about the dangers to the Veterans, and the ethics and consequences of overloading a primary care clinician, and got no response from leadership—including none from Dr. Kirchner. I soon saw that speaking up meant I was a

charter member of what I politely call “the feces roster”, but I kept writing and I kept records.

Because this was all still about people’s lives. One either gives up or stands up. And I didn’t look for this battle; it came to me.

The PC service then limped along with an acting physician chief, Dr. Cornelius (Sean) O’Neill, who was still overloaded with direct patient care duties (and thus weakened), as the number of MDs dwindled down and the number of NPs increased—and the dual chains of command remained in place. There was no cross-over or collaboration between the camps. The PC service ran as approximately 20-24 solo private practices, with office space grouped into 4-5 clinics; the number of NPs and MDs was always in flux, and then the number of clinics changed. And this kind of organizational chart ensured that although the few physicians in Primary Care, like all physicians on a medical staff, had a certain percentage of their charts reviewed (called Peer Review, mandated by medical staff bylaws), none of the NPs ever had any of their clinical work checked. The investigative team report substantiated this—and emphasizes the fact that all along the Medical Center leadership *never* put into effect *any* appropriate monitoring of NP clinical practice (meaning no chart review of any care given to Veterans by any and all NPs) even though leadership knew that the NPs at the Medical Center had licenses from states that *required* collaborative agreements with physicians. To date, there is still no program in place to comply with the law and regulations. And Medical Center leadership knew that each state licensing board specifically spelled out the rules and requirements for these collaborative agreements.

What is abundantly clear from the report is that no one in leadership (from the VISN to the Primary Care service) ever *cared* about the letter of the law or the implications of a proper collaboration program—what they did care about was making the physicians do what they were told so the dysfunctional and illegal practices could go on as always. To hell with the Veteran. To hell with the physician's license. To hell with any nurse practitioner licensing laws. Yet the NPs continued to provide up to 85% (at the peak of NP vs. MD numbers in PC) of the care for the Veterans. And everything that happens to the Veteran starts—or stops—in Primary Care.

I went to my 35th medical school reunion at Brown University on Memorial Day weekend in May 2012, and received a call from one of my nurses telling me that the DEA had arrested Dot Taylor on narcotic fraud. I remember saying "You're making this up" to my teammate, although Dot Taylor's prior history of being in a drug rehabilitation program in the past, and more recent concerns regarding abnormal behavior consistent with what is called an "impaired employee", especially due to possible substance abuse, were well known. It is still unclear why all charges against Dot Taylor were finally dropped, in three different counties; the investigative team report refers to certain Justice Department actions on oversight and regional jurisdictions. Inquiries regarding whether random drug testing is done in the Jackson VAMC (or other VAMCs) have not yielded a definite answer.

When I returned from leave in early June, the first thing I learned was that DEA agents had come into the Medical Center, reviewed narcotic prescribing procedures in the facility, and announced that nurse practitioners using a single "institutional" DEA number was not a valid avenue to prescriptive authority for

controlled substances. An NP in my primary care clinic came up to me my first day back and said he was supposed to ask me to review a chart on a Veteran he'd seen earlier that day, and "after discussion" with that NP order and sign for the Veteran's narcotic prescription. I told the NP that just reviewing a chart for narcotic ordering on a patient was illegal and a violation of Federal law/DEA regulations—and that NP (William Hubbard), who knew me and my ethics, smiled and said he knew I would not agree to such a process but he "had to ask" per Drs. Lockyer and Kirchner because otherwise at least 75% of the Veterans wouldn't be able to get their narcotics renewed. But who was responsible for this crisis? Clearly, it was the Medical Center leadership who set in place and kept in place the design of Primary Care at the Jackson VAMC—and now had another improper scheme to "take care of" the Veterans. Laws and regulations be damned once again.

An email soon arrived that began "per COS"—meaning Chief of Staff, Dr. Kirchner, and signed by Dr. Lockyer, head of Primary Care—and spelled out this same process for the three remaining physicians in Primary Care to "help" their "NP colleagues" and ensure that the Veterans got their narcotics. The memo stopped just short of ordering the doctors to sign the prescriptions, but its intent was abundantly clear; any doctor who didn't go along wasn't a team player and was going to hurt the Veterans. At that point I felt Medical Center leadership had definitely gone too far and I called Angela Lee at the local DEA office. She told me unequivocally that such a procedure is illegal and not to participate under any circumstances. She also gave me contact information for Jeff Jackson, the lead DEA agent on the Jackson VAMC/Dot Taylor case.

Another email came, stating that everyone hoped for a swift conclusion to the narcotic dilemma, and leadership was working with the DEA, but still asking the three Primary Care physicians to do the same illegal act. We then had the monthly Primary Care staff meeting (which includes clerical, nursing, NP, and MD employees) at which Dr. Lockyer reviewed minor issues only, never mentioning the recent DEA events and problems, and then proposed to end the meeting early. I asked for the microphone and stated it was extremely upsetting to me that we had a narcotic prescription crisis—and that he was not opening the meeting with it. Dr. Lockyer said it was not a crisis; I told him I had spoken to the DEA and the leadership proposal for even a temporary solution was illegal. He stated he hadn't told the physicians they *had* to sign the prescriptions—and I replied "Oh yes, your emails were very clever" but that the intent was clear. I reminded him that I had already sent an email to both physician and administrative leadership (including Drs. Lockyer and Kirchner, and Mr. Battle) proposing a legal interim process. My email suggested bringing in *locum tenens* doctors (temporary physicians) who could *see* each of the NPs' patients who needed narcotics, and also having the Pain Clinic physicians who already saw some of those Veterans take over writing their narcotic prescriptions instead of giving everything back to Primary Care.

What ensued were more illegal schemes to get the narcotics to the Veterans; from one email from the Red Clinic, it appears a locums physician did sign some narcotic prescriptions on NPs' patients. Another email said that written paper requests were to be given to the Primary Care office (called the "Red Clinic") at the end of each day, in a "warm hand-off" from a nurse from each clinic, and would be "reviewed" by Dr. Lockyer. One email said that an administrative aide was bringing narcotic requests late that afternoon, and pleaded with the Primary

Care staff not to "give Mr. Funchess any grief" because it wasn't his fault. "Grief" apparently meant not being happy to be asked to break the law. Interestingly, as I had made it clear in several emails that I would not break the law, I was not asked to look at prescription requests.

The next "protocol" was that the written warm hand-off requests were now to be taken to the Medicine department office (this email came from Dr. Jessie Spencer and her administrative aide Kristi Richardson) at 1600 hours each afternoon, and physicians would be "assigned" to review the requests overnight. Decisions on narcotic prescriptions would be available the next morning. However, in an outrageously unethical and illegal scheme, the "assigned physicians" turned out to be medical residents (physicians in training) from the University of Mississippi Medical Center—young doctors whose evaluations were done by Dr. Spencer and overseen by Dr. Kirchner. These young doctors' careers were in their hands—and leadership was telling them to break the law.

The investigative team report (especially on pages 41 and 42) is once again much too kind to Medical Center leadership regarding this chain of events. It appears they took the word of Drs. Kirchner, Spencer, and Lockyer, and Mr. Battle, but the report does note that Dr. Kirchner "reviewed the DEA website" as well as requesting "review and advisement" from Regional Office, DEA and VA Central Office, VISN and the Mississippi Board of Nursing. However, as DEA agent Jeff Jackson discussed with me, a graduate physician in training (resident) is expected to know that a face-to-face visit with a patient is required in order to prescribe controlled substances—and there is *no* excuse for senior physicians such as Drs. Kirchner, Lockyer, and Spencer somehow not knowing that what they were asking other physicians to do was illegal. It is clear that Medical Center leadership

were scrambling to come up with a way to get the narcotics to Veterans, a laudable goal, but this was a crisis of their own making due to years of unsupervised, not legally licensed (individual state, and Federal DEA regulations) NPs who far outnumbered physicians in Primary Care. Jeff Jackson told me that when leadership complained that the DEA was hurting the care of 43,000 Veterans connected to the Jackson VAMC, he told them he *was not* responsible for improper care/narcotic polices—*they were*.

Page 41 also states that in July 2012 Dr. Kirchner *et al* asked Primary Care physicians to sign narcotics prescriptions without a face-to-face encounter with the patient, after the above DEA and administrative reviews. However—I had already sent emails in early June 2012 telling leadership, including Mr. Battle, that such a practice was illegal per the DEA. It also defies logic to think that since the DEA arrested Dot Taylor at the end of May 2012, and in early June 2012 prohibited the prescribing of narcotics by NPs at the Jackson VAMC, *and* were asked for advisement then by leadership (per the report), that *somehow* DEA agents forgot to review with, and/or advise, the three physician chiefs and VAMC leadership, and VISN administrative (Ms. Rica Lewis-Payton) and VISN medical leadership (Dr. Greg Parker) about basic Federally-mandated controlled substance regulations. Jeff Jackson told me in person that he had personally reviewed such issues with leadership—and knowing and enforcing such regulations is what the DEA *does*.

It is not until August 2012 that a "Controlled Substances (CS) Clinic" was "developed"—although I know I suggested this legal interim solution in an email in early June 2012. Primary Care staff know that several locums physicians refused to do more work than clinically appropriate, meaning they would only write prescriptions on the Veterans scheduled to see them, and who they had time to

examine and review charts on, and not on all the walk-in patients for narcotics, or patients seen that day by their NP who also wanted narcotics—and that the "overflow" volume of narcotic requests were then taken to the Red Clinic to be addressed by either Dr. Lockyer or Dr. Kirchner.

I know from direct conversations (the physician and DEA agent Jeff Jackson) that one locums physician was horrified at the amounts, reasons for, lack of urine drug screening, trial of other non-narcotic modalities, and/or pertinent physical examinations that she found in the CS clinic—all patients of NPs. She contacted the DEA on her own regarding this issue.

The investigative team report states that on November 30, 2012 the CS clinic was closed, and that all NP-patient prescriptions were then written by NPs who had "obtained individual Federal DEA certifications, as allowed by Mississippi and other states." But the email notifying PC staff that the CS clinic was being closed went out on a late Friday afternoon—and the email response then of one NP ("Does this mean that NPs will write narcotic prescriptions on Monday morning?") was never answered. There was no smooth transition from the end of the CS to all Veterans seen by NPs getting their narcotic prescriptions as "usual"; the clinic ended because locums physicians had raised continual concerns, and were speaking up, and perhaps for economic reasons (locums are expensive). But there is an inherent contradiction in the investigative team's report. Since *none* of the Collaborative Agreements (CAs) were being *legally followed no NP was legally licensed—and* thus could *not* legally obtain an individual DEA number. Legally following the signed CAs means abiding by the strict requirements—both of the physician's professional board of licensing as well as the NP's board. But no monthly chart reviews and no quarterly face-to-face meetings with the physician

collaborator were ever done; and physicians had more than four CAs, or were out-of-state, temporary, or no longer at Jackson VAMC physicians—all violations. And the report is in error in stating that of the five physician collaborators for Primary Care NPs only three of them work in Primary Care—two work in Primary Care, and *three doctors do not.* This means those three physicians are in violation of the law, as it states the collaborator must be in the clinical discipline the NP practices. An ophthalmologist is the collaborator for two Primary Care NPs; a nephrologist is one; and one is an otolaryngologist. And one physician has 14 collaborative agreements: Dr. Jessie (Moorefield) Spencer—also, for unclear reasons, referred to as Dr. Jessie Crawford Moorefield in Attachment B of the report. The nephrologist is Dr. Kent Kirchner, who until September of 2012 served as Chief of Staff, and for years has only had very limited direct patient care. (It should be noted that although the investigative team report states I alleged that Dr. Kirchner had 160 CAs, my documented testimony to the committee states that another physician, an executive with the Mississippi Board of Medical Licensing, told me that our Chief of Staff had "163" agreements; this is Dr. Vann Craig. I referred the committee to him for specifics, and encourage this to be pursued. I can only guess that it refers to a total number of CAs over years, and that Dr. Kirchner signed off on all NP credentialing. As noted later, this NP credentialing was also not done correctly.)

And of further interest, Dr. Spencer has been Chief of Medicine for several years, with very limited direct patient interaction; and in the past year has also served as Interim Chief of Staff for several months (and will be again as of the week of 8/26/13)—and as of Friday, August 23, 2013is suddenly *also* the Medical Director of the new Women's Health Clinic at the Jackson VAMC, ribbon-cutting

August 26, 2013. **BUT**—Dr. Spencer is an internist, *not* an obstetrician-gynecologist, and does not have a clear process of coordinated care at present with the unsupervised NP (Penny Hardwick) who is the only other clinician in the Women's Health Clinic.

In October 2012, the Medical Center leadership found itself with yet another crisis in its lap; a crisis of its own doing. A quarterly medical staff meeting was held in early December—for which, for some mysterious reason, there are still no meeting minutes. (They have been requested several times.) Nurse Practitioners have been allowed to attend as nonvoting members of the staff; although as the investigative report points out, since the NPs were *not* LIPs (licensed independent practitioners), until many obtained Iowa licenses in 2013, these NPs should not have been granted clinical staff privileges but rather credentialed under a written "scope of practice". A scope of practice agreement would mean they were not independent "staff members" under Medical Staff Bylaws (standard bylaws per VHA and JCAHO). And this issue has been brought up by physicians over the years I have been at the Medical Center, but due to the fact that the NPs far outnumber MDs at the Medical Center, as well as the power of Dr. Taylor and fear of retaliation, doctors remained circumspect.

Present at this medical staff meeting were the interim Chief of Staff (Dr. Garcia-Maldonado, from a VAMC in Texas), Mr. Battle, and Dr. Greg Parker who is Medical Director for the VISN; Dr. Parker is also a Veteran and receives part of his medical care at the Jackson VAMC, as he publicly stated, and is well-acquainted with how it runs. Mr. Battle and Dr. Parker ran the meeting. The key issue was that since all NPs licensed in Mississippi renew their licenses from October 1st to December 31st, and most of the NPs at the Medical Center had

Mississippi licenses (which require a Mississippi-licensed physician collaborator), leadership needed the physicians to "do the right thing and help the Veterans" by just signing the collaborative agreements. Otherwise, most of the Veterans wouldn't have anyone to see them—which would never have been a problem if enough physicians were in Primary Care. Mr. Battle and Dr. Parker told the physicians that the agreements were "just a formality", and didn't mean anything because the NPs (especially per several who spoke up at the meeting) "don't need supervision". But several physicians spoke up, stating they had spoken with the Mississippi Board of Medical Licensing (including Drs. Vann Craig and Randy Easterling), as well as reviewed the Mississippi Board of Nursing guidelines, and all physicians understood that signing a collaborative agreement meant the physician was responsible for *everything* the nurse practitioner did. When questioned about the ramifications for a physician's license and career if the NP did something that led to a medical malpractice lawsuit, Mr. Battle stated that "you can't get sued in the VA"; when reminded you can, just via another legal route, he stated "Well, they don't put your name on it." When physicians replied that yes, they do, it doesn't just say "VAMC Jackson" on the court papers, and it will be reported permanently, as a major issue to the National Practitioner Data Bank, Mr. Battle (astoundingly, and with no interruption by Dr. Parker) told us that "Well, you can just write them a letter saying you never really supervised that nurse practitioner."

The physicians were stunned. The complete lack of decent human regard for what it means to have a medical license, and ethical care of the Veterans, and licensing laws and regulations. The flagrant disregard of the fact that the rules of

licensing are there for a reason—the reason is that the work of medicine is the care of human lives. Nothing about that work is “just a formality”.

Mr. Battle and Dr. Parker then went on to tell us how they planned to make sure the NP collaborative agreements were signed: fifty-percent of whatever “performance pay” a physician was eligible for each year was automatically off the table unless a physician signed a collaborative agreement, and any physician licensed in another state had to also get a Mississippi medical license so they could be “available” to sign a collaborative agreement. It was clear that the physicians were expected to bail out mismanagement. And one might call the plan a type of extortion.

Several physicians once again asked that Mr. Battle and Dr. Parker get written, official opinions from all state and Federal regulatory authorities so that if physicians signed CAs on NPs they didn’t interview or hire, and had no control over, that it didn’t put the doctors’ licenses at risk. Dr. Sean O’Neill gave a focused but impassioned summary that relying on verbal promises from management in the past (e.g. with regards to narcotic prescribing, as well as Medicare Home Health certifications) turned out to be dangerous for physicians and nurse practitioners. Promises were made to check into this, but no definite deadline for completion given by management; leadership reiterated that the CAs were just a piece of paper to keep the licensing boards satisfied. Finally one longtime Jackson VAMC physician choked up as she repeated to the men at the front of the room “You just don’t get it. We can’t trust you.”

A 7/24/13 General Accountability Office (GAO) report states that the “performance pay policy gives VA's 152 medical centers and 21 networks discretion in setting the goals providers must achieve to receive this pay, but does

not specify an overarching purpose the goals are to support. VA officials responsible for writing the policy told us that the purpose of performance pay is to improve health care outcomes and quality, but this is not specified in the policy. Moreover, the Veterans Health Administration (VHA) has not reviewed the goals set by medical centers and networks and therefore does not have reasonable assurance that the goals make a clear link between performance pay and providers' performance. Among the four medical centers GAO visited, performance pay goals covered a range of areas, including clinical, research, teaching, patient satisfaction, and administration. At these medical centers, all providers GAO reviewed who were eligible for performance pay received it, including all five providers who had an action taken against them related to clinical performance in the same year the pay was given. The related provider performance issues included failing to read mammograms and other complex images competently, practicing without a current license, and leaving residents unsupervised during surgery. Moreover, VA's policy is unclear about how to document certain decisions related to performance pay." This makes it clear that the Jackson VAMC currently has the right to do whatever it wants with regards to performance pay for physicians—but it also seems to make it clear that being an excellent clinician, and improving healthcare outcomes and quality, is not the main, unqualified evaluation concern of this or other VA Medical Centers.

No written, final legal opinions or decisions were ever presented to the physicians at the Jackson VAMC. The extensive Attachment B listings show how the CA issues were addressed, often in improper fashion. But it all looked good at the time. In addition, Medical Center and VISN leadership counted on what had always been true: no one looking too closely.

The investigative team report also outlines the dangers to Veterans' care when clinicians are overbooked and overloaded, and not able to keep up with an impossible workload. It *is* possible to give a human being more work than it is possible to complete in each cycle of twenty-four hours—indeed, one of the emails from Kristi Richardson/Dr. Spencer noted that there was a large volume of narcotic requests to review, and "there are limitations to what we can accomplish in one business day".

I was warned by other physicians not to speak up until I was past the two year probationary period for all employees, as leadership could fire me without reason during that time. Once I was able to do so, in October of 2010, I began to write emails (notifying the union of each concern) to both medical and administrative leadership documenting the way the policies of the Medical Center affected patient care—what it meant to work with overloaded/double-booked schedules, and no right to change that; the impossibility of even being able to read all the "alerts" (messages, results etc.) coming in twenty-four hours a day (average at least 100 per day) to a physician or nurse practitioner, never mind act on each one; and that forcing a physician to take on more work than is humanly possible to do conscientiously puts that physician in an ethical dilemma. I reiterated that state medical licensing boards require a physician to not overload themselves—and that according to the rules of our current universe one can only see one patient at a time. When I told Dr. Lockyer that one can only read one alert at a time, he asked me if I needed help reading; when I said no, but no one could keep up with the volume of work, he asked me if I was saying I couldn't do my job. I said no, that was not what I was saying. And I repeated what I had told him many times, and a concept that guided me as I tried to do my best for each Veteran in the midst of the

ugly chaos of Primary Care—a doctor can only go as fast as is safe. And the report reiterates the unsafe conditions of the set-up of Primary Care at the Medical Center.

Knowing and working in the reality of Primary Care at the Jackson VAMC means working with your heart in your mouth every day, because you know you cannot get to all the messages and results. You pray that the most important ones will rise to the top somehow and be brought to your attention by your nurse or someone else on your team or another contact by the Veteran, for the alerts are not prioritized in the computerized medical records system (called CPRS). In the year since I transferred (for serious health reasons) from Primary Care to Compensation and Pension, *six* physicians and one nurse practitioner have sat in my old seat and been responsible for my panel of patients. Every one of these clinicians has stated it is not possible to do the job as one human being—and indeed, as of late August 2013, the plan is to bring in two locum physicians to split the work.

And why locums again? Because the fourth "permanent" Primary Care physician, who only came onboard in June 2013, just gave his notice. He is an experienced doctor, who moved from another state to come to Jackson and told me he wanted to work with the Veterans and make being in the VA healthcare system a career. The Veterans and staff loved him, and everyone was finally relieved to think there would be some continuity again after a year of distress. But the same kind of scheduling was done to him—double-booked at 0800 hours on his first day, when he didn't even know, or have access to, the computer system—and when he spoke up promises to lower his daily workload were made but then broken.

Then an even more worrisome event occurred. (Nursing staff and the new physician informed me in real-time of these events, as what was happening was of grave concern to the care team and the new physician asked to speak to me.) After four other physicians, starting in the Emergency Room, had appropriately refused to write narcotics for a Veteran due to the clinical situation, this new Primary Care physician was asked repeatedly by the acting Chief of Primary Care (Dr. Alan Hirshberg, from the Lebanon, PA VAMC) to order the controlled substance. The Veteran had gone to the Primary Care administrative office and complained he wasn't getting what he wanted; of note, Dr. Hirshberg himself did not want to write the prescription. The Veteran was also not a patient assigned to the new physician, and he had never met the man. The new physician refused, putting a short note in the record that he had been asked by Dr. Hirshberg to order narcotics for the patient, and did not feel comfortable ethically or morally doing so; he also stated he had then asked the acting Chief of Staff (Dr. Fashina, here for ten weeks and now just gone back to a Texas VAMC) to talk to Dr. Hirshberg about the plan for the Veteran.

The next day (a Saturday) Dr. Hirshberg came in and told the new physician he needed to delete that note from the medical record—and altering a medical record is illegal. The new physician refused, appropriately, but the next Monday the same demand was made of him. He did not agree; it is not clear if Dr. Hirshberg himself had the note deleted.

It seems clear that Dr. Hirshberg was more concerned with keeping a complaint from a Veteran from escalating (perhaps his bonus is tied to the number/type of complaints or "Congressionals"?) than with the best clinical care for the Veteran. When "caught" on the record making an illegal request of a fellow

physician he wanted the "evidence" deleted—"as if it never happened", to quote a clean-up company's commercial slogan. This was the same scenario that I experienced in 2009, when a Veteran threatened me (and blocked the door with his chair) when I refused (on clearly evident clinical grounds) to "double his pain medicine"—the Veteran complained, and I was called to see Dr. Kirchner in the Chief of Staff's office. Dr. Kirchner told me the Veteran's wife worked at the Regional Office for the VA, and wanted me to delete my note from the medical record. I refused, and he eventually stopped asking me. However, Dr. Kirchner then lectured me on how the Veterans are in pain, and we need to be sensitive to that, and we have the Pain Clinic to help us. I told him that I had already consulted the Pain Clinic on patients, and they would write in the chart that it was not ethical to give a certain patient narcotics so "Primary Care to address pain issues". I asked Dr. Kirchner if the Pain Clinic doctor felt a controlled substance was unethical to prescribe in a certain clinical situation, why was it ethical for me to order it as a primary care physician?

Which brings us back to the investigative team's report substantiating that NPs illegally prescribed narcotics, and that unsupervised NPs took care of at least seventy-five percent of the Veterans. And these Veterans get a lot of narcotics—whether it is entirely appropriate, or not. The report notes that there is a high likelihood that the lack of proper monitoring of NPs is a serious medical care concern: "It is the professional expert opinion of the review team that there are enough problematic indicators present to suggest there may be quality of care issues that require further review" (page 3), as NPs were "practicing outside the scope of their licensure." The investigative team had the good sense to admit that when you have all this unsupervised work done by people who were supposed to

be supervised, you have no way of knowing how many things were done wrong; many issues can go under the radar until something awful surfaces. In medicine, this "something awful" affects a person's life, and can cause death. All these years no one has checked the work of the NPs; unless someone digs deep, the fact that tragic events could have been avoided can be buried in the medical records as hidden malpractice. Patient confidentiality also precluded specific cases being brought to the attention of the investigative team.

The investigative team substantiated that the Jackson VA Medical Center does not have a sufficient number of physicians; the Medical Center, in fact, has the inverse ratio of physicians to nurse practitioners compared to other VA medical centers. A further safety issue related to this fact is that we have an epidemic of prescription drug abuse in this country now; and a physician has to think as carefully about prescribing narcotics as a policeman has to think about using a gun. *Narcotics can be deadly force.* Having nurse practitioners as the bulk of the people with this "unscripted" prescriptive authority is a decision that the VHA must review carefully. Many Veterans not only have chronic pain from multiple physical injuries, they have the global experience of pain from the combination of traumatic brain damage and psychological trauma; some can't think straight under stress even with all their willpower. They are given anxiety and depression prescriptions, and drugs to help them sleep, and they can use alcohol and other street substances, and sometimes share each other's medicines. The last thing our Veterans need is to be given too many narcotics, and started on the road to addiction as young men and women. The combination of all these drugs become "brain IEDs", internal chemical weapons, and can prove fatal in some Veterans. The VA has many documents and policies on Pain Management, and so-called

multidisciplinary approaches to pan issues, but the reality at the day-to-day level of care is how easy it is for someone to point and click and order a narcotic in the computer.

The disconnection between how the people who run the Medical Center operate, and the "ICARE" slogan and the VA Motto (taken from Lincoln's Second Inaugural Address—"to take care of he (and now she) who has borne the battle" – is heartbreaking. Every decision on how Primary Care delivers that care should be based on whether it helps accomplish the mission for the Veteran. These men and women have "heart-earned" the right to the best medical care humanly available. Anything that gets in the way, or makes the work impossible or even dangerous, must be stopped. I even wrote to leadership that they would not go to a medical office that ran the way they made us operate Primary Care, so why did they think that kind of clinic was okay for the Veterans? Yet even that did not merit an email reply.

Overloaded schedules mean Veterans can't be seen when they need to be seen; they are put out for months, or have to walk-in and wait hours. The investigative team report also noted that Veteran complaints substantiated these problems. Additionally, the report stated (page 30) that when a Veteran came in for an appointment and their (expected) provider was not present, the Veteran was then double-booked onto another provider's schedule, and seen. Two points need to be made. The first is although that patient might be given an appointment time he or she cannot always wait to be seen as an overbooked patient, and it is very upsetting to a Veteran to wait for months for a scheduled appointment and then find out at the clinic that no such provider is available. One's hairdresser does not operate this way. The second point relates to what happened after I was diagnosed

with a serious medical issue in July 2011, and treatment then dictated I take extended medical leave for four weeks at the end of the year. In early November 2011my primary care team (my RN, LPN, and clerk) and I met with Dr. Lockyer to review with him the plan for coverage of my fully-booked clinics in December. He stated unequivocally that he and Dr. Kirchner had clinician coverage lined up—but when December came only on sporadic days was anyone assigned to see my patients. The Veterans scheduled for me came in, had the previously ordered follow-up labs done in the basement, and then were checked in by my clerk who had to tell them no doctor was available. The nurses then had to scramble to try to get one of the nurse practitioners in the Blue Clinic to see my patient—and weren't always successful; it was also a terrible position to be put in for both the Veteran and the staff. And the tests ordered were not followed up on, or Veterans notified. I came back from medical leave in January 2012 to an array of serious unattended problems.

The investigative team also noted that "the team cannot rule out the allegation" that Medicare Home Health Certifications forms are illegally completed, as "data pulling" is not easily available. However, the interviews the team conducted, and (once again), the lack of collaborative agreements and supervision of NPs, documented the high likelihood of such a situation. I also gave the investigative team an email memo from the Home Health Care coordinator at the Jackson VAMC in which she told the NPS to "have the doctors in your clinic sign those Medicare forms". Asking a doctor to sign such a form on a patient seen *only* by an NP is explicitly illegal, as it requests the doctor commit Medicare fraud—the form states at the bottom right corner that the physician who signs it

"certifies that this patient is under my continuing care". Yet Dr. Lockyer signed some of these forms despite *never* seeing any patients.

I feel so strongly about what it means to be a physician that I wrote a small book on it— "Sacred Trust: The Ten Rules of Life, Death, and Medicine". The practice of medicine is truly a sacred trust, and the honor of working for the Veterans is humbling. In one of Mr. Battle's emails to the Medical Center staff he used the "sacred trust" phrase, but nothing changed in the building. Yet the work of medicine is of paramount importance. It is about peoples' lives—as simple and as serious as that.

It is clear from the investigative team's findings that leadership chose not to pay attention at multiple points. (The detailed spread sheet of Attachment B of the report is particularly striking.) This means they simply did not care about the Care of the Veterans. Deliberate moves were made by men and women with power. And this report shows just how cavalierly the Medical Center leadership operates—and still does.

After Dot Taylor was arrested, I told Mr. Battle in person (at a meeting to which I brought a union representative, Mr. Harold Miller) that the nurse practitioners were operating illegally and in violation of both VA regulations and our medical staff bylaws. He reiterated that "in the VA nurse practitioners are LIPs", even when I repeated that they were not; Mr. Battle chose to believe Drs. Kirchner and Lockyer, both of whom went on to breach ethics themselves. Mr. Battle only removed Dr. Kirchner as Chief of Staff under pressure from the DEA investigators and Veterans Liaisons from US Congressmen's offices. Dr. Lockyer was only removed as Associate Chief of Staff for Primary Care when the New York Times article (about the number and type of whistleblower complaints from

the Medical Center, and a special letter sent to the President by the Office of Special Counsel) was published in mid-March 2013.

How did it come to this at the G.V. (Sonny) Montgomery VAMC? How could those in charge of healthcare for Veterans—those charged with carrying out the mission stated so simply and clearly in Lincoln's Second Inaugural Address—decide to violate, in the words of the report, "certain Federal laws and regulations, as well as state laws", as well as "due to mismanagement, both VA and Veterans Health Administration (VHA) policy"? These are not small things. And they don't happen overnight. How could a culture of leadership become so sick at a healthcare facility? The only words that come to mind are hubris, and disdain.

Conscious choices have been made over years, and continue. As honest and fact-based as the investigative report is one of its troubling aspects is the tendency to soft-peddle the mindset of the "Medical Center leadership". Calling the deliberate decisions by this leadership to use unsupervised and not duly licensed nurse practitioners a "lack of understanding" of requirements does not do justice to the intelligence of these leaders. The investigative report states that the Medical Center leadership "erroneously" declared NPs to be licensed independent practitioners (LIPs), thus granting these NPs medical staff privileges, but then also stipulated that these "independent" practitioners must have collaborative agreements per individual state licensing boards. But this is not just something that happens to be a "misunderstanding"—this kind of approach shows an obvious and clear inherent contradiction. And the Medical Center leadership is certainly blessed with the brains needed to have understood all this. And it is not just "confounded" by the fact that no one in leadership made sure that ALL collaborative agreements were followed according to the law. Again—the fact that

individual state nurse practitioner licensing boards (in particular, the state of Mississippi) had strict and precise requirements for supervision of nurse practitioners was not secret knowledge. The regulations were clear on the Board of Nursing (BON) website, and on the collaborative agreements that many physicians in leadership signed. And there is still *no* process in place for review of *any* work done by nurse practitioners. Contempt for the law, and for the welfare of the Veterans, still reigns.

This Medical Center leadership consists of the following: Rica Lewis-Payton, Greg Parker MD, Joe Battle, (previously, and for many years) Dot Taylor, Kent Kirchner MD, Jessie Spencer MD, and James Lockyer MD. All of these people kept ranks, and thought alike. Dr. Alan Hirschberg, acting Chief of Primary Care, appears to be trained at the same trough. And when Dr. Lockyer was finally made to step down as Chief of Primary Care, he subsequently went on to another job at a VAMC (in Tennessee) in charge of Primary Care. The position of Chief of Primary Care was held for this man by Medical Center leadership for a year until he came in June 2011. A simple Google search shows that in 2004 he lost (in summary judgment) a court case he brought against a private medical group; and this public document shows he had his salary dropped each year for four years due to inability to see enough patients, keep up with paperwork, and the number of patient complaints. (He never saw patients in clinic the entire time he was at the Medical Center.) *Who* at the Jackson VAMC gave him recommendations so he could do the same abysmally inadequate job as he did at the Jackson VAMC?

And things are *not* getting better. A newly trained physician (who recently finished residency) just came on staff, but the net gain now from the time of my whistleblower complaint in July of 2012 is only one doctor in Primary Care (total

of four at present). Both the physician who quit after less than three months, and the new one right out of training were immediately overloaded in their daily schedules, double-booked each day even before walk-ins started to be added to the total seen by the end of clinic; and both of these physicians were just learning our computerized medical record system (CPRS). The clinic days stay in ugly chaos. There is no end to the constant stress on the Veterans who can't get appointments, can't get routine medicines refilled (I still get automatic renewal orders come up on Veterans I took care of for four years, and prescribed medicines for, as the "loose ends" are enormous in number.) Now the new physician is needing to have her daily schedule lighter, and as the schedule for my old clinic is (as usual overbooked) for months out, each day the clerk and nursing staff on my old team are having to decide who can be cancelled and rescheduled (yet again, some patients for multiple times) farther out. As the report states, this is not what VHA policy dictates (page 29), but what else can they do? And the committed and excellent staff of the Primary Care clinics does not see any hope in sight. Mr. Battle and Ms. Lewis-Payton brought in a team from the VHA National Center for Organization Development (NCOD). This group's "goal is to strengthen VA workforce engagement, satisfaction, and development in order to improve Veterans' services". However, the NCOD team findings confirm all of the same Primary Care management and patient care issues—and staff especially hammered in the lack of the simple courtesy of communication from management.

There is no way that this egregious discontinuity of care is safe, or acceptable; whenever there is a change of physician or a nurse practitioner for a patient in any healthcare setting the likelihood of issues being overlooked or lost to follow-up multiplies. But the most direct way to think about the situation in

Primary Care at the Jackson VAMC is what some of my former patients ask when they come up to C & P to say hello: "Who is going to take care of me?"

Official emails have come out recently about identifying and "owning" a problem, and that if an employee identifies an issue he or she should be able to "shut down the service line" until the issue is fixed. This is akin to what the military calls a "safety stand-down" and it *is* something that is called for in Primary Care. But I do not believe that Medical Center leadership will follow its own preaching.

Mr. Battle has made much of the opening of the new Women's Health Clinic—but there is no physician hired for that clinic. The brochure states the services offered include "Maternity Care—7 days post-delivery only (including circumcision for newborn)—*who* is going to be doing that? (Circumcisions are also not routinely now done as part of best practices in pediatrics.) An unsupervised NP and her LPN (no RN is hired) and a clerk are the only staff for the Women's Clinic at present; this is supremely disrespectful to the Women Veterans, and also a fraudulent way to open such a clinic. No professional group I know of in any city, including the other medical groups in Jackson, would open a Women's Health Clinic without an Ob-Gyn physician on staff.

As I have written in the past to both administrative and medical management over several years, I do not believe that any of the people in leadership would tolerate going to a medical practice that ran like this—so once again, why do they think it is acceptable for the Veterans?

The investigative team asked me if "anything had changed"—and the answer is no. The paramount problems remain. The overuse and abundance of

completely unsupervised nurse practitioners in Primary Care is the same; the delivery of care to the Veterans in their "medical home" is still from 16-18 nurse practitioners and 3-4 physicians. The Veterans often still do not know whether or not they are assigned to a physician's panel of patients, or seeing a physician that day—and what happens to them in Primary Care is the mainstay of their health.

Even if a nurse practitioner is licensed in a state that requires a collaborative agreement with a physician and an agreement is signed, that physician is not doing the mandated reviewing of nurse practitioner charts, or doing the also mandated quarterly face-to-face meetings with the nurse practitioner. Thus, these nurse practitioners are not legally licensed. For those nurse practitioners who suddenly obtained licenses in Iowa because Iowa does not require collaborative agreements, there is still an open question as to whether they are legally licensed (and thus whether they can get individual DEA numbers and prescribe narcotics). The Iowa State Board of Nursing regulations require the nurse practitioner to follow the policies of whichever state that NP is practicing in—and this may mean that even Iowa-licensed NPs who work in Mississippi, even at a VA hospital, still need collaborative agreements when they work in Mississippi. And—VHA polices/medical staff bylaws do still state that the employee must have at least one *valid* state license. A valid state license for a medical professional means conforming to *any and all* state board licensing rules. The claim of "Federal Supremacy" does not trump this.

We still have unsupervised (and some not-legally-licensed) nurse practitioners with the "point and click" ability to order addicting, and potentially fatal medications—especially in combination with other psychotropics, depression, and traumatic brain injuries in patients. The simultaneous taking of these kind of

"centrally-acting" (meaning in the center of the nervous system, the brain), and often coupled with other street drugs, including alcohol, is toxic and potentially combustive; the Veterans continue to walk around with the same chemical weapon risks in their brains.

The overload of certain physicians and nurse practitioners continues: the new Blue Clinic doctor was scheduled for 14 patients, including a double-book at 0800 hours, on his first day—and he had *no* computer access and no training yet on the computerized medical record system. Veterans are still being continually cancelled and rescheduled, and cancelled and rescheduled; some elderly patients are going over a year without being seen, having labs and diseases checked and monitored; and there are not infrequent physician absences. The care of these human beings is clearly compromised and endangered. One clerk told me she has twenty pages, with sixty Veterans' names per page, of patients who are now considered "lost to follow-up" (not seen in the last twelve months)—and she has nowhere to put them on already overbooked schedules. Any walk-ins on an already overbooked schedule means the physician will end up *de facto* triple-booked. A physician can still only see one patient at a time according to the rules of physics for our universe.

There have now been *seven* physicians and one nurse practitioner in my prior office in Primary Care—a stream of temporary help—and whoever fills in stays overbooked and overloaded, with multiple "loose ends" to try to fasten or connect.

Two memos of "surveys" of Veterans (10 patients per survey) echo the concerns about medicine refills not being done, including non-narcotics, due to provider turn-over and unavailability; appointments repeatedly pushed out; and not

enough doctors. The American patient, including Veterans, is getting sicker and sicker younger and younger; each patient is a walking "chemistry experiment" of a unique recipe of all kinds of drugs and interactions. On top of that our Veterans have the more specific wounds of wars.

With regards to signing of Medicare Home Health Certifications on patients of nurse practitioners, it is unclear which physician(s) is doing these, as we have had continual turnover (or no) of a ACOS (Associate Chief of Service) for Primary Care as well as Acting Chief of Staff (COS). Dr. Kirchner may still be signing these forms, and/or Dr. Spencer, who was Chief of Medicine (COM) then Acting COS while someone else was Acting COM, and she is now back to COM. Our "Weekly Bulletin" continues to show 16-18 "acting" chiefs. It defies logic to consider this as a stable environment for the Care of the Veteran. An ugly type of chaos is still the norm. And even though he mismanaged Primary Care and put the care of Veterans at risk, broke federal law regarding signing both narcotic and Medicare Home Health forms on patients he never saw, and put in writing instructions telling the physicians in Primary Care to break federal narcotic laws, Dr. James Lockyer was somehow able to get recommendations from the Jackson VAMC and is allegedly now in a leadership position in primary care at another VA facility (Mountain Home in Tennessee). We hope that the rumor he got a bonus when he arrived is not true.

The epidemic problem of the ease and frequency of overprescribing of narcotics to Veterans has been reported on nationally; it is vital that the privilege to order such narcotics is carefully determined, and the appropriateness (or not) of use reviewed in an ongoing fashion. And at the Jackson VAMC the Pain Clinic often sends the Veteran right back, noting in the chart that the primary care physician or

nurse practitioners will write the narcotics. So we end up with many young Veterans being started on an addiction course—or quite truly, a "dead end".

I have written documentation regarding all of the issues above, and this documentation spans my four years in Primary Care, as well as several emails from prior Primary Care physicians who shared with me an outline of the long history of chronic, basic problems in the department. Correction to report on witnesses interviewed: it is Dr. Jo (not Joe) Harbour, a woman physician.

I have also identified the following nurse practitioners who recently worked at or still work at the Medical Center, many of them having spent time in Primary Care, whose credentials files were *not* addressed by the investigative team. They are:

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. [redacted]
8. [redacted]
9. [redacted]
10. [redacted]
11. [redacted]
12. [redacted]
13. [redacted]
14. [redacted]

15. [redacted]
16. [redacted]
17. [redacted]
18. [redacted]
19. [redacted]
20. [redacted]
21. [redacted]

I also think it is important to highlight that one of nurse practitioners that Dr. Kirchner collaborates with is in Women's Health—and Dr. Kirchner has not done *any* "women's health" in decades. He is a nephrologist who spent the recent years of his career in medical administration.

The investigative team report does not state what disciplinary actions will be taken against those who broke the laws and regulations, but hopefully some consequences will ensue for these people. This should include the top leadership (medical and administrative), as well as nurse practitioners who knowingly did not follow their state licensing guidelines. One hears at the Medical Center about "Federal Supremacy", but the concept has been abused. It should not mean that the VAMC can operate as if it is "another country", or that state medical and nursing licensing boards cannot have access to what physicians or nurse practitioners do in the VA system. How else can true quality of care be assured and monitored—and why else do we have strict licensing requirements for medical professionals? In any other medical group, if a physician in leadership breached ethics and the law, and also asked other physicians to break the law (and especially did that to physicians in training), that physician would lose his or her job and have their

medical license under investigation. Working in the VA system should not mean you can escape this reality.

All year long the Jackson VAMC has "operated" with an average of fifteen "Acting Chiefs" of departments (services)—and as of the week of August 26th, seventeen acting chiefs. Can this really be considered to be a fully operational medical center? The overwhelming entirety of the substantiated findings in this report is sickening, and concrete. One comes back again to how could this kind of constellation of "symptoms" and mismanagement "disease" come to pass? Whoever thought that the type of "leadership" seen at the Jackson VAMC (and apparently at other VAMCs to greater or lesser degrees) could ever be deemed appropriate? Many times in the morning my primary care team and I—after voicing prayers and hope for the day for our Veterans and our staff—looked at each other and repeated "Laugh or go crazy." In a truly very sad/funny way, the situation at the Jackson VAMC reminds one of the famous quote from Casey Stengel about the 1962 Mets—"You look up and down the bench and you have to say to yourself, 'Can't anybody here play this game?'" But the truth is, yes, a lot of people at the Jackson VAMC, and seemingly at other VAMCs, know how to "play the game"—the *wrong one*, where you gamble with the lives of Veterans who put their lives in your hands.

And so how does one finally make an impression on those who have the power to make the medical care given to the Veterans the best healthcare possible? To aim to make it the best in the world? To take all of the work that goes on at a VAMC dead seriously? I will end with the words of one of America's vital playwrights, Arthur Miller.

In “Death of A Salesman”, Miller has a character say this: “But he's a human being, and a terrible thing is happening to him. So attention must be paid. He's not to be allowed to fall in his grave like an old dog. Attention, attention must finally be paid to such a person.” So many, many Veterans and the fine, committed staff at VAMCs, feel that no attention is being paid. This cannot be allowed to stand as it is. And one simple change to make is to not have VA Medical Centers directed by non-medical people; they simply do not understand what happens on the front lines, any more than someone who has not been a soldier can know what truly happens in the trench.

Arthur Miller also wrote a play called “All My Sons”, in which the son of a manufacturer of defective airplane parts in World War II goes to war, and when he finds out the role his father played in the death of fellow soldiers, crashes his own plane and kills himself in response to the family responsibility and shame. The father learns the truth and says “Then what is this if it isn’t telling me? Sure, [Larry] was my son. But I think to him [the pilots killed] were all my sons. And I guess they were, I guess they were.”

Just so. I look at a Veteran, and I can see one of my sons who fought in the Army in Iraq. But that Veteran reminds me of so many more. For they are *All Our Sons, All Our Daughters*—and they deserve the very best the United States can give them. Nothing less.

We cannot fail them.