Ms. Catherine McMullen

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Dear Ms. McMullen:

What follows are my OSC Whistleblower Comments on the November 12, 2013 interim report from the Department of Veterans Affairs regarding the investigation of Primary Care at the G.V. (Sonny ) Montgomery VA Medical Center in Jackson, Mississippi (OSC File DI-12-3816).

One only has to read the second paragraph of the VA interim report to get an unhealthy inoculum of the VA philosophy on medical ethics. The report states that all the violations of state and Federal laws and agency policies "uniformly stem from the VA medical

center's (VAMC) institutional failure to adhere to/or enforce current Federal laws and VA policies, regulations, and policies". It is a difficult maneuver to get one's mind around such verbiage. Wait—no *person* did anything wrong—it was all the *institution's* doing. But—just in case someone in "the leadership under which the institutional failure occurred" might be culpable the report states *such people* "have already left the facility and, in some cases are no longer employed by the VA". So—looking into what *they* might have done "would not be feasible". Besides—neither the original complaint nor the VA's report *required* that *anyone* "investigate the past/historical actions that may have led to such institutional failure", or even "identify any disciplinary action(s) that need to be taken". And finally, *everyone* can just take a long deep breath and relax, because the facility has "new leadership".

Here I must share what several coworkers (including some Veterans) at the VA have said about the "verbal diarrhea" of VA leadership: *"A LIE!"*

The VA's talent for such brain gymnastics and contortionist syntax is of Olympian- athlete quality. But as once was said of President Richard Nixon, the VA also "has a dislocated relationship with the truth". And the particular untruths in thispeculiar "VA-Gate" are easy to delineate.

1.) The Jackson VAMC does *not* have "new leadership"—it still has Joe Battle, Center Director, who has been at the facility for two years and participated with full knowledge of the legal and professional violations from the beginning of his tenure.

2.) The Jackson VAMC *still* has the same key physician lawbreakers—Drs. Kent Kirchner and Jessie Spencer. And Dr. James Lockyer, the other key physician miscreant, may have left the Jackson VAMC but he *still* works for the VA—at the Mountain Home VAMC.

3.) The VISN 16 leadership in Jackson still has three of the *same* people who "contributed to, or directed violation of state and Federal laws and agency policies"—Rica Lewis-Payton, Dorothy White-Taylor, and Dr. Greg Parker.

4.) The VA's investigative report did not mandate any disciplinary actions or review of "historical actions that may have led to such institutional failure" because *no one* in the VA ever appears to be held accountable for breaking laws and codes of ethics in medicine. Thus—why bother to look when "we" don't really care? No conscience—no consequences.

5.) It's wholly ridiculous to "disembody" the bad players in this VA scheme and blame it all on "institutional failure". *The building did it. The building hurt Veterans. The building breaks laws. (And the Devil's dog made me eat my homework).* But—physicians and nurse practitioners are human beings with *individual* licenses and requirements for professionalism as they do the sacred work of medicine. And administrators have *individual* names—and clear duties to the Veterans they profess to serve.

The VA rubric is what the VA problems "uniformly stem from"—and its need to cover up its mistakes and crimes is the same dishonorable premise that has led politicians and priests to break the law and injure other human beings. *The rules don't apply to us; we're different.* The VA flies the flag of "Federal supremacy", and then hoists the "that person no longer works for the VA" banner as needed—and as the rest of the interim report shows, the VA "will develop", and "monitor", and "review", and "encourage" the *same people* (physicians, nurse practitioners, and administrators) who broke the rules and suffered *no* penalties. But VA slogans and mottos will continue to be bandied about like candy.

The Medical Center has corrected the practice-designations of nurse practitioners according to their state licensure requirements, and defined scope of practice for individual nurse practitioners; I obtained a copy of once such document. The memorandum notifies the nurse practitioner that "Your supervisor will remain the same, and you will continue to be monitored using the Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE) under established medical guidelines." What is *not* verifiable at present is whether and/or who is now evaluating, monitoring, and documenting issues for individual nurse practitioners, as it is unclear just *who* has the personnel folders of the nurse practitioners. Historically, no matter what department the NP worked in, the Department of Nursing (run by Dorothy White-Taylor) did *all* the nursing employees' evaluations and promotions. I believe it is critical that OSC receive documentation regarding exactly *who* the supervisor is for *each* nurse practitioner at the Medical Center—and verify that the proper schedule is being followed for how often such evaluations are being done. The interim report states "The Medical Center will continually update and maintain an in-depth spreadsheet to track NP-specific information…"—which, of course, should have been *de rigueur* from the inception of the Medical Center having *any* NPs in the facility seeing Veterans. Obviously, the track record of the Medical Center in voluntarily following regulations, laws, and policies on its own shows an arrogant lack of respect for such systems and concepts, and there is no reason to believe that the "institution" has had a change of heart or soul. There is good reason to suspect that once the spotlight is off the facility will revert to form and fail to *maintain* and continue proper practices. For the Jackson VAMC's creed has not been one of willing apostles to honesty.

The Medical Center has made the proper changes to the Medical Staff Bylaws; I attended a meeting of a subcommittee of the medical staff where the wording of the changes was discussed, and reviewed with the group (which included Mr. Battle, Center Director) what the VA investigative report on my OSC Whistleblower complaint had mandated—and why. I reiterated that the Jackson VAMC (and VA Central Office) should obtain, from the licensing boards of *each state* that allows NPs to practice as LIPs, a clear *letter of policy* from each board regarding when an NP practicing out of that state needs a physician collaborator—e.g. if the NP

works in a VA facility in an NP/MD collaborating state. The interim report does not address that issue, and it is of particular concern at the Jackson VAMC as a very large number of Mississippi-licensed NPs at that facility quickly obtained Iowa licenses in order to evade the need for collaborative agreements (CAs). And even though the Iowa State Board of Nursing sent a letter to Ms. Charlene Taylor, of the Credentialing and Privileges Department at the Jackson VAMC, stating that its regulations require an Iowa-licensed NP who practices *outside Iowa* in a state that requires CAs to then *have* a collaborating physician, the Jackson VAMC memorandum to NPs cleverly sidesteps that point of law by stating "Per the Nurse Practice Act of the State of Iowa, you are not required to have a collaborative/consultative relationship with a physician." This is the same kind of sneaky approach to the law—and the overall care of Veterans—that is the hallmark of the Medical Center.

The interim report states the Medical Center "has complied with the individual state requirements for collaborative agreement ratios", but then goes on to state that the states of Arkansas and Mississippi do not have set maximum NP-to-MD collaborative ratio guidelines. That is definitely not my reading of current Mississippi nursing and medical licensing board regulations; my understanding is that the maximum ration is 4:1. (I have not been able to fully check for Arkansas ratio guidelines.) In addition, the interim report states "The current maximum ratio of assigned collaborative NPs-to-physicians at the Medical Center is 4:1"—but it is well known that Dr. Jessie Spencer, who continues as Chief of Medicine despite violating Federal narcotic laws and instructing physicians-in-training in writing to break the law, continues to have at least ten NPs with whom she "collaborates". Joe Battle has admitted publicly that she definitely has more than four NPs assigned to her. Dr. Spencer also does not follow the law regarding collaborating: there is no evidence she is reviewing the proper percentage of each NP's charts each month, and keeping a log of each chart reviewed and the outcome, nor is she meeting quarterly face-to-face with each NP and documenting such events. Dr. Spencer—and other physician collaborators at Jackson, and the respective NPs—should be asked to provide documentation of their compliance with state law, and also now the Medical Staff Bylaws of the Jackson VAMC. Whether the physician collaborator is actually in the same medical discipline as

the NP should be checked; Dr. Kirchner, a nephrologist, has signed an agreement with an NP who does only women's health. The interim report states that "The Medical Center's clinical service chiefs monitor physician collaborator requirements, and report compliance to leadership during the Quarterly Service Performance Dashboard Report." But with *all* the "acting-chiefs" of clinical services that the Jackson VAMC continues to have (all continuing over the now more than two year tenure of Joe Battle), exactly *who* is monitoring *whom*, and *when?* It's like an old Abbott and Costello routine—except it's about the lives of the human beings who are Veterans. And it's not funny. It's sick. And if the Chief of Medicine—Jessie Spencer—is herself in violation of the law, can she be trusted to monitor anyone else?

We do a thorough medical record review in the Compensation and Pension department, and I recently saw a Veteran making an original claim for diabetes due to Agent Orange exposure. The date of onset of the disease is a key question for the claim—and the Veteran told me he felt he had been ill for a long time before the "doctors" told him he had diabetes. The Veteran was right: the labs clearly showed new and definite diabetes *three* years before he was told and "diagnosed". But—the Veteran had not been seen by doctors; he saw unlawfully unsupervised NPs for years. Another Veteran came in for a cardiac disease Compensation & Pension claim, and in reviewing his records I saw that for the past two years he had become diabetic—and *no* mention of the abnormal labs or proper interpretation, or treatment, or monitoring, or communication of any of this to the Veteran had been done. I was the one who told him of his serious additional diagnosis, including the fact that the proper urine test screening for diabetic kidney disease—which of course had never been done—now showed he had developed renal damage. But adding to the miserable situation was that Dr. Spencer had cosigned the NP note in the medical chart—and Dr. Spencer had *not* addressed the abnormal labs, or made the diagnosis, or done any of the appropriate medical steps as a physician. I presume she did not read the chart. This clearly is not how a collaborating doctor is supposed to act.

Tellingly, the interim report states that the Medical Center maintains copies of all NP collaborative agreements, but "VA is not required to forward collaborative agreements to the state for approval". But—my reading of the nursing and medical board licensing regulations in the states of Mississippi and Arkansas is that both the NP and the physician involved will sign the specialty-specific collaborating agreement, and both will notify their respective boards of their status, and send a copy of the CA. Once again, the wording of the interim report and the "VA" is clever and obfuscating. And the need to evade full disclosure once again reflects the need for the "VA" to do whatever it wants. (Here I am reminded of what so many Veterans asked me about Medical Center leadership when as patients they were caught in the chaos of Primary Care—*"What is wrong with these people?"*)

The interim reporte goes on to note that the VA investigation team recommended that "Locum tenens physicians should not be physician collaborators"; the interim report "Resolution" is that "The Medical Center has a made a commitment to avoid, if at all possible, using locum tenens as collaborative physicians if any are hired in the future." Why not—the Medical Center will *not* ever do it again as it is against the law?

As of mid-December 2013, the last of several new physicians finally joined the Primary Care Service, bringing the doctor total to ten; there are still fourteen to fifteen nurse practitioners in the department, as another nurse practitioner was also hired. It should be noted that now all of the Primary Care physicians are women; and the *only* male provider available to the Veterans is one nurse practitioner. This means a Veteran desiring a male physician cannot be accommodated; and this situation is in contrast to all the time I spent in Primary Care, as well as when *locum tenens* doctors rotated through the department.

The interim report states the investigative team recommended that "Once an adequate number of physicians are hired, the Medical Center will ensure that NP panel sizes are

reduced to meet VHA guidelines." Which brings us to the central question of how safe are unsupervised NPs in the care of the extremely and ever more complicated American patient, and especially the American Veteran, who has more medical conditions (including psychiatric and chronic pain) at a younger age than the average citizen and then goes on to develop additional chronic diseases? Why do the NPs need their panel sizes lower than physicians if they are the *same* kind of clinicians and equally qualified to see the *same* kind of patients?

Where is VHA going with this? As I made clear in my testimony before the O & I Subcommittee of the House Veterans Affairs Committee at a hearing in Washington, DC in September, VHA is attempting to change its nursing handbook guidelines—and make *all* NPs in the VA system nationwide, *regardless* of state nursing licensing board requirements—entirely independent practitioners. We already have laws flouted—and we already have Veterans at the Jackson VAMC who have cardiac conditions and *never* see a primary care doctor once, never mind a cardiologist (or a lung specialist with a serious pulmonary condition; or a diabetic specialist when they have out of control diabetes, etc.). If the NP does not properly identify and emphasize the urgent facts pointing to the Veteran's new and persistent fatigue as a sign of underlying and escalating heart disease, the consult request to Cardiology only results in a note in the medical chart telling the NP what to prescribe next, and not an appointment with the doctor to discuss a cardiac catheterization. And the killer disease that is still number one on the American "hit parade" later declares itself as sudden death.

On the other hand, I see much "routine" *misdiagnosis* by nurse practitioners, when careful details and precise thinking, and the habit of discipline to practice that way, would mean the right medical and human actions occur. The habits of the mind must be honed to ensure we can give our best to the patient—the Veteran. Just this week at work I have seen two cases where Veterans were diagnosed with diabetes when they *are not* diabetic—and one has erroneously been receiving compensation for this disease as service-connected due to his Vietnam/Agent Orange exposure. The lab tests clearly and unmistakably show that these Veterans are "pre-

diabetic", an important distinction both medically and for service-connection ratings. (This also highlights why nurse practitioners should not be doing Compensation and Pension exams; too much money and fairness to other Veterans hinges on these exams being done correctly.) And I have seen multiple cases of Veterans labeled with the diagnosis of "COPD"—when a third-year medical student doing a proper history and physical would come to the conclusion that the Veteran has adult-onset asthma. Again—a vital difference for compensation purposes, but of even weightier consequence is that the Veteran has continued to suffer from "losing his wind" when he tries to do anything at home for over a year, with coughing fits, because he wasn't diagnosed or treated correctly. As I said to one Veteran and his wife, "Does it make sense to you that you would get COPD, worsening over the last two years, when you stopped smoking ten years ago?" You don't have to go to medical school to understand that; but the NP never stopped to clearly think it through.

OSC, OMI, and I believe the House Veterans Affairs Committee should all understand that at the Jackson VAMC "chart consults" are being done by specialists, who are not seeing the patients but reading what the NP has written in the note and making recommendations. This compounds the risks to the Veterans when an NP has made the wrong diagnosis, and done a poor exam. Wheezing when a patient breathes out will be missed if the patient isn't taking truly deep breaths and moving enough air; I learned that as a medical student and have emphasized it when I taught students. This *means* something. If the pulmonary consultant "goes" by the less than proper clinical information given by a nurse practitioner, then the simple and necessary subtleties of medical practice will be overlooked to the detriment of a human being's life. And now the idea of "tele-consults" is being introduced by the VA system; this means that the consultant specialist won't even be in the same geographic area as the patient, and will never see that Veteran. I don't know what other VAMCs think of this, but perhaps it does not upset the leadership at the Jackson VAMC too much as the "standard of care" for years has been having nurse practitioners alone take care of most of the Veterans.

My previous House Veterans Affairs Committee testimonies and OSC Whistleblower comments make clear the absolute hierarchy in clinical competencies between physicians and nurse practitioners. Besides the markedly different initial education and training

regimens, the substantial divide in ongoing educational requirements again recently came to my attention. My specialty board (American Board of Family Medicine) requires a recertification (eight hour) exam every 7 years; and standard state medical licensing boards require at least 50 hours of continuing medical education (CME) per year for physicians for licensure (and specialty society membership and certification). Per the American Academy of NPs Certification Program, those NPs who chose to be certified "re-certify every five years *either* by sitting for the appropriate examination or by meeting the clinical practice and continuing education requirements established for recertification. These requirements include a minimum of 1000 hours of clinical practice as a nurse practitioner in the population focus and 75 contact hours of continuing education relevant to the nurse practitioner's population focus"—that's 15 hours (CEUs—continuing education units) per year. Quite a clinical divide. What will the VHA "require" of its unsupervised NPs? Something akin to "ENT Basics for the Nurse Practitioner" (a course an NP at the Jackson VAMC took), which awards 0.40 CEUs, and is taught not by an ENT physician but by another nurse practitioner?

The interim report notes that the VHA's "Office of Nursing Service's Advanced Practice Nursing Advisory Group will develop an IL (information letter) that will detail the process to ensure compliance with advanced practice nursing requirements and issues of regulatory control." As with all the "word salad" in the report, this IL must be carefully watched.

Remember: The OSC complaint proceeded to investigation because it was felt the whistleblower issues constituted a "substantial and specific danger to public health and safety at the Medical Center". Does the VHA truly believe that completely unsupervised NPs, across the United States, are a safe way to treat the Veterans? My previous comments document that NPs were designed to see patients *after* a physician had made the diagnoses, and only continue to see the patient when the patient's medical condition remained stable (which at some point it will not be). The *Wall Street Journal* recently noted that "diagnostic problems are more common than other medical mistakes—and more likely to harm patients"—and also the "leading cause of malpractice claims." All those years at the Jackson VAMC, tens of thousands of Veterans'

medical visits with unsupervised NPs (some of them just out of school); there is no way to tell how many diagnoses were delayed or never made, or how much malpractice went under the radar because no one ever traced events back in the chart.

The interim report states that there are no more "ghost clinics", and that "All providers have been assigned to appropriate clinics." What the Medical Center carefully did was eliminate the specific names of any providers in primary care clinics, and now only refers to them as "PC Blue Clinic Provider 1", or PC Green Clinic Provider 2" etc. so one cannot tell in the computerized medical record who the Veteran was supposed to see for that scheduled appointment, and especially whether it is an MD or an NP. One also cannot tell if the "provider" the Veteran thought he or she would be seeing is the same one in that clinic now. My previous clinic ("PC Blue 1 Hollenbeck") has had nine doctors and one NP rotate through since I left in August 2012; for several months (September to November) there were temporarily three physicians dividing up my old schedule, without a daily plan. And the report states that "As the Medical Center recruits new physicians and establishes teams under the PACT model they anticipate the need for overbooked appointments will decline. The Medical Center reviewed appointment grids for all providers". But the single physician now left in my previous clinic is finding the promises made to her as to how many patients she would have to see each day, as well as a limit on walk-ins, are not being kept. She had 12 patients scheduled one day recently (all slots filled), and 9 walk-ins—that's still "double-booking".

The interim report notes that VISN 16 is in the process of implementing a tool for the recommended clinical quality care review "in light of the fact that electronic View Alerts are often not being reviewed by physicians in a timely fashion and NPs were practicing outside the scope of their licensure." But the VA system has a bigger nationwide problem: A survey of VA primary care practitioners reported in March 2013 (Journal of the American Medical Association—JAMA) that more than two-thirds reported receiving more alerts than they could effectively manage. This volume issue is multiplied when a physician is overbooked, and their

panel size is too high—and these are the points I heard the new physician currently in my previous clinic stating at the medical staff meeting in December. So what is that physician now doing in order to survive? Calling Veterans who have not had any continuity of care for over a year and telling them not to come in again for several months, and informing the nurses the current acting chief of primary care has OK'ed this manipulation of her schedule.

This same physician was also told she had to supervise an NP, and she spoke up at the December medical staff meeting asking when will she be given the time to review the NP charts, meet with the NP etc…all because she wants to obey the law. But no time for compliance "ideas" like this have been put into her schedule.

And with so many of the NPs at the Jackson VAMC now with Iowa licenses, and no longer in "legal" need of supervision, why is the leadership at Jackson still "punishing" those physicians unwilling to put his or her medical license on the line for an NP? Those doctors who do not obtain a Mississippi medical license, and then sign up to supervise an NP who requires a collaborating physician are still prohibited from 50% of any possible performance pay. Once again, this is part of a nationwide VHA problem, for a recent GAO report showed the VHA has *no* standardized guidelines for physician performance pay. Quality of clinical care plays *no* role. I would certainly ask that those overseeing the Jackson VAMC review whether the physicians who broke the law while working at the Jackson VAMC—Drs. Kirchner, Spencer, and Lockyer—received any bonuses, and if so to rescind those awards.

In addition, has a pay panel been held on Dr. Kirchner, as it should have been once he was forced out as Chief of Staff in later 2012, or is he still being paid the same salary? Who at VISN 16 gave him the position of overseeing "physician productivity"? Have Drs. Spencer, Kirchner, Parker, and Lockyer been reported to their respective medical licensing boards for their ethical and legal violations regarding Federal narcotic laws, and if not, why not? Why was

Dr. Lockyer given another VA job as a head of another primary care service? Who gave him recommendations? Why has Dr. Spencer not been removed as Chief of Medicine, and any appointment she has at the University Medical Center (as well as any appointment of Dr. Kirchner's) not been revoked, due to her assigning physicians-in-training to break Federal laws? These were young doctors at her mercy for their recommendations. Have the nurse practitioners who knowingly ignored state nursing board licensing laws and DEA regulations had appropriate disciplinary actions put in their personnel records?

If we finally get a permanent Chief of Staff at Jackson, that physician needs to be fully informed by OMI about the history of issues, and the ongoing investigations. A new culture of competence needs to be birthed.

My understanding is that the Office of Medical Inspector (OMI) and the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) are now involved and overseeing the "implementation of action plans" at the Medical Center, and "will continue to monitor the progress and sustainability of recommendations." Such bloodless language for problems that affected the bodies and hearts of so many Veterans, and still do. Most certainly, DUSHOM and OMI must be hyper-vigilant—just as the wounded souls with PTSD are—watching the Jackson VAMC and the "VISN 16 Accreditation Specialist". The battle cannot be assumed to have been won even in simple things. Even though Medicare Home Health Certifications have always been as direct as moonlight (in the instructions on the lower right side of the page) that a physician signing the form must have the patient under "continuing care", medical and administrative leadership at the Jackson VAMC didn't take that seriously. So even more certainly, OMI and DUSHOM must ride herd on the Medical Center to make sure that the beyond-serious review of NP patient care records where controlled substances were prescribed is completed. And find out *who* at Jackson is involved in reviewing the records—it cannot be the same old "gang" of physician leaders—and it must *not* be done by nurse practitioners! All aspects of the review, from how charts are picked to what criteria are used for

review must be scrutinized under a high-suspicion microscope. As it is the Jackson VAMC "institution" that "failed", no internal "institutional" compliance review of any of the VA investigative report recommendations can be trusted.

I also believe a message *must* be sent to the VHA system: Incompetent and unethical physicians, and other leadership, *cannot* see the VA healthcare network as a place to hide until he or she is ready for retirement. What Drs. Kirchner, Spencer, and Lockyer did are fireable offenses anywhere else in the reputable medical world.

A breach of duty in the VA healthcare system must be taken as seriously as a breach of duty is for a Veteran. Again—the Jackson VAMC leadership, in particular Joe Battle—had *no* intention of changing anything until the DEA began to force the issue after narcotic laws were flagrantly broken, and then he and others were repeatedly publicly shamed by the Office of Special Counsel and the House Veterans Affairs Committee, with the help of national media. Without these things, Joe Battle and Rica Lewis-Payton and Dr. Greg Parker would have kept Dr. Kirchner as Chief of Staff and Dr. Lockyer as Chief of Primary Care; indeed, they still have Dr. Spencer as Chief of Medicine. And Rica Lewis-Payton has Dot Taylor sitting in her VISN office building, still with access to everything that is happening at the Medical Center. They have all acted dishonorably.

"Institutional failure"—such a smug phrase. The institution is not just real estate, but real people. And the Jackson VAMC has a culture of smugness in its leadership—they trumpet how the Medical Center is "one of the best" in the country, when Medicare hospital ratings for chronic diseases readmissions and mortality show that the Biloxi Gulf Coast VA System scores significantly better, never mind local private hospitals.

The leadership at Jackson will do it again if no one is punished—as will misbehavers at other VAMCs, as ongoing scandals across the country play out like reruns.

Finally—what keeps coming back to me is the same mind-sickness that infects all major scandals. Institutions need to be held accountable, but of course, institutions are run by individuals. The *Financial Times* recently published an article on the Vatican Bank's (called The Institute for Religious Works) many year cover-up of how it "took care of" its money. After the worldwide financial crisis started in 2008 JP Morgan Chase would tell Vatican officials "we answer to the regulators", and they would say "we answer to God". Pope Benedict set up the Financial Information Authority, but this regulator lacked the legal powers and independence to monitor and sanction the Vatican's financial institutions. Only when a completely new kind of leader came—Pope Francis, who is now in charge—were investigators allowed in and the Vatican bank was found to be compliant or largely compliant on only nine out of 16 core standards. Sound familiar?

We need a new "Pope" in the VHA. An entirely new approach so that the simple and clear "religion" of caring for the Veteran is brought back front and center, to the feet of those we serve—and the arrogance of power has no place.