July 12, 2015

The Honorable Carolyn N. Lerner
U.S. Office of Special Counsel
1730 M Street, N. W., Suite 218
Washington, D.C. 20036-450

Re: OSC File No. DI-14-2754

Dear Ms. Lerner:

I have reviewed the copy of the supplemental report dated May 5, 2015 from the Department of Veterans Affairs (VA) which purportedly investigated my allegations of life-threatening deficiencies in patient care and patient access issues at the Carl T. Hayden VA Medical Center (VAMC) in Phoenix, Arizona. As per that supplemental report, the VA conducted a second site visit to the medical center on January 27-29, 2015 to address outstanding issues I had raised after reviewing the VA's initial report.

Unfortunately, after reading the report, I believe the VA left most issues unresolved including the adequacy of Emergency Department (ED) and Mental Health (MH) nurse triage training, the quality of Ambulatory Care triage, the inappropriate referral of unenrolled veterans to Eligibility Clinic prior to a medical evaluation in the ED or MH, and presence of retaliation against me by select nursing staff during my ED tenure.

Specifically, as outlined in the attached document, the investigative technique is so flawed as to render the investigators' supplemental report conclusions invalid in most key areas.

In its supplemental report, the VA states it "...completed additional interviews to determine whether there had been a general failure of the nursing staff to provide verbal reports to the whistleblower and other ED physicians." It concluded it could find no evidence of withholding of those verbal reports.

However, according to multiple witnesses who were interviewed by the team during its site visits, the team never actually asked ED physicians, Administrative Officers of the Day (AODs), or front-line ED nurses specific questions about retaliation toward me during my tenure in the ED.

During the September 2014 site visit, the VA investigators failed to ask any pertinent questions of the Emergency Department (ED) physicians with whom I had worked closely for 3+ years and who had first-hand knowledge of the retaliation I experienced. Although the original investigative team spoke with 4 of these physicians during that September 2014 trip, I was informed by some of those witnesses that no questions were asked about specific retaliatory actions toward me. On the second site visit, none of these physicians were interviewed even

though locating these ED physicians should have been a very simple task -- all of them are still currently employed within the Phoenix VA Emergency Department.

Based upon the team's witness lists and contrary to its own written statements in the body of the report, during the both site visits the VA team did not interview ED front-line nursing staff including any of the nurses with whom I worked for up to 10 years prior to my involuntary transfer. Many of those nurses are still employed by the Phoenix VAMC. They, too, were witnesses to the retaliatory actions of a select group of ED nurses.

In stark contrast, the VA investigators did take the time to interview 6 nursing administrators and executives, all of whom were part of the nursing chain of command that repeatedly failed to halt the overt retaliation against me that was impeding the care of ill patients in the Emergency Department. Those nursing administrators have a strong motive to deny that such retaliation occurred. The team also accommodated interviewing 3 other VA executives who were directly responsible for retaliatory actions against me through the chain-of-command in Medicine and in Human Resources.

While the ED nursing retaliation against me is not a pressing issue by virtue of my transfer from the area, it remains very disconcerting that several nurses who compromised patient safety via retaliation against me are still actively working within the Phoenix ED. Their willingness to jeopardize patient care poses an inherent danger to all future Phoenix ED patients if those nurses choose to penalize a particular physician for identifying ED safety issues. In addition, lack of accountability for their retaliatory actions has a chilling effect on physician willingness to call attention to those ED nursing care problems which are still present today.

While the team did interview two ambulatory care physicians about outpatient triage problems, I am not surprised that those physicians did not speak of difficulty with the ambulatory care triage process. Those were not the physicians who spoke to me about grave concerns involving outpatient triage.

When pursuing the practice of sending unenrolled patients to Eligibility Clinic during day shifts from the ED or mental health prior to a clinician exam, the investigative team asked two AODs who had no knowledge of the process because either they don't work the day shift or were not present during the time the practice was in full force. I am keenly aware of the process that started after my transfer from the ED in 2013 because the delay in care contributed to a series of events that resulted in one suicide.

Although it is possible that all members of the investigative team truly lacked the competence to conduct a thorough investigation, I believe the investigative team deliberately chose to obscure the facts by not interviewing the key physicians and front-line nurses about retaliation against me on any site visit. In either case, the team's conclusion that it could not substantiate allegations of retaliation against me has no merit and indeed appears to be more evidence of VA retaliation against whistleblowers. If the VA truly had desired to uncover the truth, it would have sent an impartial investigative team that was willing to ask the difficult questions. This team did not meet that criteria.

While the team did uncover dangerous patient care practices, it again failed to realize the depth and breadth of the overwhelming direct and indirect issues threatening patient safety at the Phoenix VAMC.

Unfortunately, this investigation devolved into yet another blatant attempt by the VA to deliberately ignore the presence of overt whistleblower retaliation among its ranks while sabotaging the credibility of the whistleblower.

Sincerely,
Katherine L. Mitchell, M.D.

Whistleblower's Limited Comments on VA Supplemental Report Dated 5/5/15

1. Comment on VA Answer #1, #2 & #5: **After conducting a sham investigation where it did not specifically ask my Emergency Department (ED) front-line colleagues/ED front-line nursing co-workers about retaliation against me, the team inexplicably concluded that it could not substantiate retaliation against me in the form of withholding verbal reports or EKGs.**

   An understanding of the VA's investigative tactics on both site visits is necessary to comprehend the extreme deceptiveness of the VA's response and its inability to conduct impartial investigation. The initial site investigators did conduct interviews with 4 Phoenix VA Emergency Department (ED) physicians with whom I worked for years. However, according to the anecdotal reports from witnesses with whom I have spoken, the investigators failed to ask those staff any specific questions about the retaliation against me by ED nursing staff. The initial team apparently focused only on general questions about the ED and didn't delve into retaliatory actions against me.

   When the second site visit was done, the investigative team chose not to interview these ED physician witnesses who possess in-depth, detailed, first-hand knowledge of the retaliation I experienced from a select group of ED nurses. Locating those physicians with whom I worked would have been a simple task – they all remain full-time employees of the Phoenix VA ED. They were the ones who described in unison to the senior physician chain of command the retaliatory nursing behaviors including failure to provide nursing reports, withholding EKGs, unwillingness to answer my basic questions, and slow completion of my patient medical orders.

   On each site visit, based upon names included on the witness lists in both reports, the VA investigative team also failed to interview any front-line Phoenix VA ED nursing staff. Those ED nurses could have easily attested to the nursing retaliatory behaviors against me. Instead, the VA investigators chose to interview 6 nursing administrators and nursing executives, all of whom were part of the nursing chain of command that repeatedly failed to halt the overt retaliation against me that was impeding the care of ill patients in the Emergency Department. Those nursing administrators and executives have a strong motive to deny that such retaliation occurred.

2. Comment on VA Answer #1 & #3: **After referring to ED & Mental Health (MH) triage as a "danger to patient health and safety", the investigative team recommendations were too weak to ensure adequate triage nurse training at a level recognized by the national Emergency Nurses Association and/or the accrediting body for mental health nurses.**

   Acknowledging the ED and MH triage practices "constitute a significant risk to public health and safety", the investigative team admits that those additional 110 clinical scenarios I provided supported allegations of improper triage and delays in care. However, the team stated it was "unable to find evidence of any adverse outcomes. In

each case, Veterans received appropriate and thorough medical care by the whistleblower following her initial evaluation. None of the Veterans suffered morbidity or mortality as the result of the nursing triage."

The team should have viewed those 110 episodes as serious "near misses"/sentinel events -- incidents were a patient could have been harmed but wasn't because an ED physician such as myself intervened. Such a high number of nursing triage delays in care and inappropriate evaluations should have resulted in an urgent recommendation for triage nurses to receive appropriate triage training and enact triage nursing protocols to prevent recurrent mistakes. That training should involve symptom detection.

Instead, the VA's response merely emphasized training of the ED nursing staff on the Emergency Severity Index (ESI). The ESI is only a basic classification method that assigns a severity number or "score" of 1 to 5 based on vital signs and the number of resources such as x-ray, IV fluids, or lab draws that a patient might require. The ESI score serves as a simple indicator of the urgency with which a patient should be seen.

The ESI does not help a nurse identify subtle symptoms that may indicate significant urgency/severe emergency even though the patient doesn't initially appear to require an intense number of medical resources. For example, if the patient presents with subtle/early signs and symptoms commonly associated with a potential stroke, blood infection, or intracranial bleeding, the nurse may not recognize that these symptoms require more resources & a more urgent medical evaluation. Without significant triage training in symptom recognition, the patient would be assigned an inappropriate score and thus may wait needless hours while his/her medical condition deteriorates. Countless Phoenix ED patients have been left in the waiting room by triage nurses who weren't trained well enough to identify these subtle presentations of life-threatening conditions.

The ESI is not a substitute for nursing judgement or triage skills in evaluating a patient's presenting symptoms. Triage nursing skills are complex and require significant ED experience and supplemental training to master.

The Emergency Nurses Association, a nationally recognized professional body, has specific recommendations regarding the training/experience required for a nurse to function in the ED nursing triage role. Across the country, many VA ED triage nurses do not meet those requirements.

It is extremely important for the VA to develop standardized ED triage nursing protocols so that nurses consistently address symptoms in a similar and appropriate fashion in all VA Emergency Departments.

In addition, the VA response fails to address how the inadequate MH triage would be improved. That inadequate MH triage resulted in multiple issues including having a self-identified homicidal veteran leave the waiting room without notification of any psychiatrist. That veteran was subsequently arrested by community police who were investigating a rash of unexplained gunshots within city limits.

3. Comment on VA Answer #6: **The investigative team failed to ask the appropriate individuals about the process of referring unenrolled patients coming to the ED to Eligibility Clinic prior to being medically evaluated in the ED.**

   The VA's response is grossly inadequate because its investigative technique was severely flawed. The investigative team interviewed two Administrative Officers of the Day (AOD) who would be unfamiliar with the practice of sending unenrolled veterans to the Eligibility Clinic. One AOD who was moved into that position apparently after the practice of sending unenrolled patients to Eligibility Clinic waned. The other AOD never worked day shift so would have been unaware of the practice. If I had been contacted at any time by the second investigative team, I would have gladly provided the names of the long term AODs and other staff who could confirm the practice and the length of time it remained in place. Based on that practice there were at least two severe patient outcomes of which I am aware, one of which was suicide.

   According to my sources, questions regarding the diversion of patients to enrollment were apparently not asked during the first site visit.

4. Comment on VA Answer #7: **The VA's response is vague and sidesteps the immediate issue of the current lack of adequate telemetry monitoring in the Phoenix Emergency Department (ED) and the absence of a contingency plan to obtain additional telemetry monitoring if needed in the ED.**

   The total number of telemetry ("heart monitoring") beds in the Phoenix VA ED remains unchanged at 8. There are many times when the capacity for telemetry monitoring beds exceeds the Phoenix ED's capacity to provide it. While the new ED will almost triple the number of monitored beds, the new ED isn't built yet*. The current ED needs to have a written contingency plan to safely monitor patients on telemetry whenever the telemetry monitoring need exceeds the ED's capacity of only 8 monitored beds. To my knowledge, there no written contingency plans in place to address an acute shortage of telemetry beds in the Phoenix ED as well as a lack of basic protocol for monitoring of ED telemetry.**

   **I have previously reported to the OIG and the Phoenix VA Medical Center administration that the plans for the new ED are grossly inadequate and unsafe. Although some minor changes have been made, the new ED remains obsolete even before it has been built.*

   ***There also needs to be a standardized method of monitoring telemetry in the ED. During my tenure, the nursing staff would often ignore telemetry alarms. There was no person assigned to watch the telemetry monitors. The results of the ED telemetry monitoring were rarely placed in the electronic medical chart. There were no print-outs of telemetry strips done. Those conditions remain unchanged even today.*