

**DI-14-1588**  
**Revised Whistleblower Comments**

July 12, 2015

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-14-1588

Dear Ms. Lerner:

I have received and reviewed the 6/1/15 VA response to my request for documents critical to exposing deeper flaws in the original Office of Medical Investigation (OMI) investigative report on my allegations.

I was incredibly disturbed to read that the OMI/VA now claims that I consented to the release of my name during the investigation. This is patently untrue. I did not want to have my name released because I did not want the investigation to be biased by those VA employees who have already enacted a variety of retaliatory acts against me. Just as I feared, the investigation's focus turned away from looking at the patient care issues including adequacy of surgical resident skills/supervision. Instead, the team began to "investigate" me with a pre-determined goal of discrediting my surgical skills and teaching competence. Unfortunately, this manner of discrediting the whistleblower is a well-known, standard technique within VA investigations.

I am deeply disappointed that the majority of documents I requested either were not made available to me by the VA or were so heavily redacted in a non-standard manner as to render their usefulness negligible. In addition, because only 5 disclosure reports (Exhibit 1) were released to me for the timeframe 2012-2014, I remain quite concerned that the VA either declined to release the true number of reports or failed to make adequate institutional disclosures.

My surgical technique and standards are so advanced that there has never been a "Disclosure of Adverse Event" note needed on any of my patients. Unfortunately this is not true for the other surgeons at the facility. As reported in my 5/10/15 letter/formal response, I am aware of at least four cases that should have mandated institutional disclosures which were not described in the Disclosure of Adverse Event notes released to me.

While Quality Assurance (QA) documents are protected, the generic trends reflected in those documents would have proven that the investigative team's summary conclusions were flawed in regards to the overall competence of surgical resident skills and inadequate resident supervision. The investigative team, in its function of oversight, would have had the capacity to review such documents but chose not to do so in keeping with its deliberate tactics of denial and minimizing problems.

I believe the only useful document was the email string (Exhibit 2) between Dr. Joehl and myself between 4/9/13 & 4/10/13. In my email of 4/9/13 I clearly outlined my concerns regarding the surgical residents (doctors-in-training) skills in terms of "suturing, hand tying, and use of the laparoscope and laparoscopic techniques...[because] I have witnessed several of our junior residents and interns struggling with these tasks during procedures..." I proposed a plan to help those residents improve their

skills while not exceeding the mandatory limits on resident work hours. Dr. Joehl's response of 4/10/13 not only dismissed my plan but also failed to address the serious deficits in resident skills that I described.

Those emails were important because the VA erroneously used Dr. Joehl's email as evidence to support his claims that my teaching style was inadequate. The content of Dr. Joehl's email did not comment on my teaching style or purported need to alter my approach to support training requirements of graduated responsibility. Instead, Dr. Joehl's response revealed his own indifference to my concerns about inadequate resident skills and failed to suggest an alternative plan.

The investigative team declined to provide its notes by claiming that all notes were deliberative in nature. Standard interview notes are not deliberative in nature – they are a recording of facts/details as described by the witness. Those notes should not have been withheld. I believe the VA's unwillingness to provide such notes is indicative of many things including its attempt to obscure the poor quality of its investigation and hide facts vital to substantiating my claims.

Claiming that they had no "control" over the information, the VA declined to provide the documents to me related to resident evaluations and in-service scores. The VA is part of a joint surgical residency program and should have been freely able to access this information had it made any effort to do so. This important information was never accessed by the original investigating team even though the results would have supported some of my allegations.

For the reasons outlined above as well as those provided in my lengthy 5/10/15 letter/document to you, I do not believe the VA made a good faith effort to investigate the very serious allegations that I made.

Sincerely,

[REDACTED]



NOTE DATED: [REDACTED] 012 17:23

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

VISIT: [REDACTED] 2012 17:23 REPORT OF CONTACTS-X

DATE, TIME, AND PLACE OF DISCUSSION: [REDACTED] 2012 at 12:30 pm in room [REDACTED]  
[REDACTED]

NAMES OF THOSE PRESENT:

[REDACTED]  
[REDACTED]  
[REDACTED]  
Sarah Nelson, Patient Advocate  
Susan Hall, Acting EA to the COS  
Darren G. Deering, D.O., COS

DISCUSSION POINTS OF THE ADVERSE EVENT:

I explained to the patient the events that surrounded this event which included an unexpected loss of power to the Operating Room while he was under general anesthesia while having an [REDACTED] completed. The procedure was approximately 80-90% complete but had to be aborted when power was lost. The procedure was terminate (without completing the [REDACTED] and the patient was recovered by anesthesia.

[REDACTED] hospital course was otherwise uneventful.  
[REDACTED] underwent [REDACTED] during this admission and had an [REDACTED] during that time.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT:

- \* details of case explained to patient
- \* apology was made on behalf of the PVAHCS
- \* patient given information regarding claims process but declined to take any of the paperwork - [REDACTED] expressed [REDACTED] sincere appreciation for what [REDACTED] perceived as excellent care here.
- \* [REDACTED] was offered the opportunity to ask questions

QUESTIONS ADDRESSED IN THE DISCUSSION:

the patient had no specific questions for the team.

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM:

as above. this was offered to the patient but [REDACTED] refused to take the paperwork. [REDACTED] was given the contact info for the COS and Risk Management office should [REDACTED] change his mind.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

none

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Progress Notes  
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[REDACTED] 2012 17:23

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Signed by: /es/ DARREN G DEERING, DO  
CHIEF OF STAFF

[REDACTED]/2012 17:39

NOTE DATED: [REDACTED]/2012 11:45

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

ADMITTED: [REDACTED] 2012 10:00 2CM

Late entry. Patient initially visited with [REDACTED] on [REDACTED] 2012 at 11:45 a.m.

Pt was sitting up in a chair but was mildly sedated 2' to analgesics and had no next-of-kin present.

I introduced myself and quickly decided that the timing was not right to complete the institutional disclosure.

DATE, TIME, AND PLACE OF DISCUSSION: [REDACTED] 12 at 11:45 am in the patient's room in the [REDACTED].

NAMES OF THOSE PRESENT: [REDACTED] and myself initially.

DISCUSSION POINTS OF THE ADVERSE EVENT: See above.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT: See above.

QUESTIONS ADDRESSED IN THE DISCUSSION: See above.

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM: not completed, see above.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:  
will need to revisit patient when [REDACTED] is more coherent and [REDACTED] next-of-kin is present (hopefully [REDACTED]).

Signed by: /es/ DARREN G DEERING, DO

CHIEF OF STAFF

[REDACTED] /2012 06:56

[REDACTED] 2012 06:57 ADDENDUM STATUS: COMPLETED

Follow-up visit conducted today.

Pt is much more alert and coherent and doing well.

DATE, TIME, AND PLACE OF DISCUSSION: [REDACTED] 12 @ 3:00 pm.

NAMES OF THOSE PRESENT: [REDACTED] Terri Elsholz (Risk Management) and myself.

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[REDACTED] PHOENIX VAMC

Printed: 04/03/2015 16:32

Pt Loc: OUTPATIENT

Ph [REDACTED]

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[REDACTED]/2012 11:45

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DISCUSSION POINTS OF THE ADVERSE EVENT:

Discussed the events leading up to [REDACTED] admission which included the [REDACTED] with resulting [REDACTED] early recognition, nearly immediate surgical intervention and suspected [REDACTED]. We also discussed [REDACTED] treatment course immediately afterwards, in the [REDACTED] and the medical ward afterwards. An apology was made on behalf of the facility.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT: Pt was informed that [REDACTED] would not incur charges relating to the procedure or the hospitalization or follow-up care for this event.

QUESTIONS ADDRESSED IN THE DISCUSSION:

Patient had general questions about [REDACTED] care - follow up needs, when [REDACTED] could return to work, etc. This were addressed in detail.

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM: SF95 claim form provided to the patient.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

None at this point.

[REDACTED] was given our contact information in the event [REDACTED] has questions or needs assistance completing the SF-95.

Signed by: /es/ DARREN G DEERING, DO

CHIEF OF STAFF

[REDACTED] 2012 19:18

NOTE DATED: [REDACTED]/2012 08:38

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

ADMITTED: [REDACTED] 2012 18:20 [REDACTED]

DATE, TIME, AND PLACE OF DISCUSSION:

[REDACTED] 2012 3pm

NAMES OF THOSE PRESENT:

[REDACTED] operating room nursing staff

DISCUSSION POINTS OF THE ADVERSE EVENT:

a [REDACTED] of the pop off suture and remained in the wound  
a final post op xray was taken revealing the [REDACTED] in the subcutaneous layer  
the patient had the very minimal top portion of the skin and subcutaneous layer  
opened and [REDACTED] removed with no adverse effect to the success of the  
operative intervention

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT:

discussed with the patient the night of surgery and the morning after the  
surgery and the event with full disclosure of the event

QUESTIONS ADDRESSED IN THE DISCUSSION:

discussed that the final out come of the operation was not effected at all the  
minor opening and retrieval of the [REDACTED]

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE  
TORT CLAIM:

discussed the willingness to be open with any and all parties the patient might  
bring into the discussion or further legal status

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

discussed that we will see the patient post op this week with new xrays so that  
[REDACTED] can see no adverse event is still in place

Signed by: /es/ [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED] /2012 08:45

Digital Pager: 602-779-0431

NOTE DATED: [REDACTED] 2014 12:28

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

VISIT: [REDACTED] 2014 12:28 [REDACTED]

DATE, TIME, AND PLACE OF DISCUSSION:

[REDACTED] 2014 at 11:30 a.m. in Deputy Chief of Staff's office

NAMES OF THOSE PRESENT:

[REDACTED] Risk Manager, [REDACTED]  
Chief of Surgery, Sylvia Vela Deputy Chief of Staff

DISCUSSION POINTS OF THE ADVERSE EVENT:

[REDACTED] release was performed instead of [REDACTED] (wrong procedure). Time out procedure failed in this case. Pt was very upset that surgeon consented [REDACTED] for a [REDACTED] release instead of the [REDACTED] must have forgotten or [REDACTED] didn't read [REDACTED] notes". We apologized on behalf of the facility and let [REDACTED] know how seriously we view this mishap. We will be looking into why our timeout processes failed to make a determination what can be done to prevent this in the future.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT:

[REDACTED] would prefer that [REDACTED] be performed in the community which will be arranged for [REDACTED] also requests that a new PCP be assigned to [REDACTED] here at the facility.

QUESTIONS ADDRESSED IN THE DISCUSSION:

How could this have happened? (We will be looking into this with an RCA). Who can help fill out [REDACTED] disability form? [REDACTED] primary care provider). How much time does [REDACTED] have to fill out the tort claims form? (2 years)

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM:

Jill Friend discussed with [REDACTED] right to file a tort claim and handed [REDACTED] the tort claim forms.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

Contact information for [REDACTED] and Jill Friend were given to the patient who was very grateful that we took the time to talk with [REDACTED]

Signed by: /es/ B SYLVIA VELA

Deputy Chief of Staff

[REDACTED] 014 12:43

Digital Pager: 602 910 1306

NOTE DATED: [REDACTED] 09:40

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

ADMITTED: [REDACTED] 2013 17:21 3BS

DATE, TIME, AND PLACE OF DISCUSSION:

[REDACTED] at 9:10 a.m. at [REDACTED]

NAMES OF THOSE PRESENT:

[REDACTED]  
Terri Monisteri, Risk Management  
Darren Deering, D.O., Chief of Staff

DISCUSSION POINTS OF THE ADVERSE EVENT:

I reviewed the course of events with the veteran including [REDACTED] initial [REDACTED] surgery, the unexpected [REDACTED] bleeding and the subsequent events [REDACTED] leading to [REDACTED] (code arrest, etc.).

[REDACTED] remembers feeling [REDACTED] at home and returning to the hospital, but events following that are not clear to [REDACTED]

[REDACTED] has been recovering well slowly and is now planning to transfer to an [REDACTED] [REDACTED] is excited about this as [REDACTED] is looking forward to playing in [REDACTED]

[REDACTED] is appreciative of the care [REDACTED] has received and feels no one did anything wrong.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT:

I informed him that we would review [REDACTED] case further and if there were concerns about [REDACTED] care (none of which have been identified thus far), that I would contact [REDACTED] for a follow up meeting.

While it is not clear that this event was avoidable, I still apologized on behalf of the PVAHCS.

QUESTIONS ADDRESSED IN THE DISCUSSION:

[REDACTED] had no specific questions for me and expressed [REDACTED] appreciation for the staff caring for [REDACTED].

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM:

SF-95 provided to veteran along with contact information for the Risk Manager/COS.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

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[REDACTED] PHOENIX VAMC

Printed: 04/03/2015 18:34

Pt Loc: OUTPATIENT

Ph: [REDACTED]

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[REDACTED] 2013 09:40

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I will f/u with the veteran in 2-3 weeks.

Other than that, I don't believe there are any further issues to address at this time.

Signed by: /es/ DARREN G DEERING, DO  
CHIEF OF STAFF

[REDACTED] /2013 09:54

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[REDACTED] PHOENIX VAMC

Printed: 04/03/2015 18:34

Pt Loc: OUTPATIENT [REDACTED]

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**Email to Dr. Joel dated 4/9/2013**

**From:** [REDACTED]  
**Sent:** Tuesday, April 09, 2013 2:16 PM  
**To:** Joehl, Raymond J.  
**Subject:** office space

Dear Dr. Joehl,

I wanted to follow up with you on our previous conversations last fall regarding procuring an office space or other area which would provide me with a better environment for instructing the residents on suturing, hand tying, and use of the laparoscope and laparoscopic techniques. As I mentioned previously, my request is out of concern that although we are now in our tenth month of residency I have witnessed several of our junior residents and interns struggling with these tasks during procedures. I feel that taking the time to reinforce these basic techniques during actual procedures (especially when the patients are awake) will only serve to increase the anxiety of both the patient and the residents, hinder their learning, and prolong operative time. I understand that there are several unoccupied office spaces throughout the department which I hope may be utilized for this purpose until a more suitable location might be found. I realize there is a simulator lab available for resident use at the Banner facility which could conceivably be used for this purpose. However, I was advised by Dr. Johnson after I volunteered to teach a class there covering these subjects to our residents during the weekend that this would not be possible due to resident work hour regulations. Therefore, I think it would be ideal to teach and reinforce these skills with the residents during their down time in a suitable area as I have suggested within our own facility if available. I certainly appreciate your support in this matter and look forward to any guidance you might be able to give in establishing such a teaching area for our residents.

Kindly,  
[REDACTED]

**Email from Dr. Joehl dated 4/10/2013**

**From:** Joehl, Raymond J  
**Sent:** Wednesday, April 10, 2013 10:27 AM  
**To:** [REDACTED]  
**Cc:** Deering, Darren; 'Johnson, Steven B'  
**Subject:** RE: office space

[REDACTED]  
VA Resources including office space are scarce. Dedicating office space for impromptu and occasional simulation exercises-technical skills practice is not possible currently. As we have discussed, conducting simulation training exercises must be done in concert with the Residency Program's goals and objectives, and with the full support of the Residency Program Director.

Thanks,

RJJ