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Comment on the report by the Office of Medical Inspector

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The report addresses two allegations.

Allegation 1. Staffing deficiencies

Comment: The Office of Medical Inspector did an excellent job evaluating this concern and their recommendations are sound.

Allegation 2. False and misleading medical records

Comment: OMI concluded that I did not provide adequate documentation to support this allegation. That is correct. I shredded all the supporting documents. Those reviewing this report deserve an explanation of why this happened and how it is directly relevant to the allegation.

I expected to be on the staff of the Martinsburg VA Medical Center with full and legitimate access to those records when the review by OMI took place. Reprisals against me started after I reported Allegation 1 to the VA's Office of Inspector General. I was warned in mid-July of a serious attempt on my professional reputation and licensure and left the VA in haste days later. From Dr. Kathrine Mitchell in Phoenix I learned that the VA could find creative ways to invoke the Privacy Act to initiate criminal prosecution against me in retaliation. I shredded everything.

Given this lack of proof, it was quite generous of OMI to take my second allegation seriously and to make recommendations. As they were not given adequate documentation, they cannot be expected to arrive at the correct conclusions. Their report suggests that this is an isolated problem caused by a few individuals not doing what they were told. In fact the doctors are doing exactly what they are expected to do. The problem I allege is similar to the wait time scandal. That problem did not originate with a few rogue clerks but with a corrupt leadership. The cause of this problem is the same: unrealistic goals and strong incentives to cheat. The necessary condition for both is whistleblower retaliation; without it cheating is impossible. This has implications far beyond the medical record.

Before joining the Martinsburg VA I served at the St Cloud VA in Minnesota. The Chief of Staff and indeed the entire medical staff were highly ethical. Falsification of medical records was unthinkable there. Sadly that was not the case in Martinsburg. Deceitful medical leadership has

a direct effect on the quality of the medical staff and the care they provide. Recruiting quality primary care physicians in a remote Midwestern town with few job openings for spouses is a challenge. In contrast medical positions in this area are highly competitive. At one of the urgent care centers in our town, every doctor trained at Johns Hopkins. The staffs of the private hospitals in Frederick and Hagerstown are all MD or DO as are those at the St Cloud VA and the Army clinic at Detrick adjoining the VA CBOC. You will not find the MBBS degree among any of the urgent care or hospital staffs in this area. The pay for physicians in VA primary care is quite competitive. So why is there not a single MD on the staff at Frederick or Hagerstown CBOC's? All are MBBS. Why does the VA primary care staff in a remote area look like the private hospitals and clinics here? I will explain how record falsifications lead to this striking anomaly.

The issue of the quality of care is harder to document, but I picked up on this immediately after I began working with Veterans in the Martinsburg system. In St Cloud, Veterans would thank me by telling me I was as good as their previous doctor and I sincerely hoped that I was. During my entire time with Martinsburg VA I had the extraordinary experience of Veterans telling me I was the first doctor they had seen in the VA who ever: listened to them, explained things, did more than a superficial clothed exam, controlled their blood pressure, or talked to them like they were a person. I had not encountered such unmet need and gratitude since I worked at the Albert Schweitzer hospital in Haiti.

How can this be? The medical records document thorough exams, complete care, and lengthy patient discussions. Every day I encountered disparities between what I saw and learned from the patient and what I read in the medical record. The chart notes could not be trusted. Fortunately there was a mechanism for correcting this, our ongoing medical record peer review. We each reviewed another physician's charts every month. When I found obviously false items in the patient record, I noted that in my written report. My service chief phoned and told me to resubmit the report without those comments. He told me I had better keep quiet in the future and just check the boxes on the form. The boxes do not indicate whether the notes are pertinent or accurate, only if they contain the required elements. They always do because those required elements form part of the note template and go into the note automatically.

It is deeply troubling to work with untrustworthy medical notes of Veterans so I repeatedly brought this up. One opportunity was a request from the Ethics Committee for important ethical issues the medical center should address. I submitted the problem of false patient records as a serious ethical concern and suggested that calling attention to the problem might reduce occurrences such as documentation of a normal extremity exam on an amputee. My submission was ignored but the committee did find that the lack of **infant** resuscitation equipment in this Veterans Medical Center warranted attention.

I had mentioned my Ethics Committee submission during a hastily assembled exit interview. After I left and as more reports of reprisals toward others at my clinic came out, I wrote the VISN 5 Director, asking if public statements that the VA would not tolerate retaliation were true. I described what was done to me and this was the only topic mentioned in the letter. His

reply ignored my question, but assured me that the issue of accurate medical records was always carefully monitored and the Ethics Committee was consulted on an ongoing basis.

Why were my questions about retaliation evaded? It is far easier and more certain to meet institutional goals by cheating. That only works if it is kept hidden. I witnessed how this approach leads to deceptive records. Our administration learned that advanced directives are a hot topic. Our service chief sent us written instructions to include documentation of advanced directive counseling in our note templates. Now every visit note will have that documentation. The administration anticipated recognition for such an outstanding result. Few doctors will find sufficient time in a full schedule to actually do this consistently, but once the text is in the template, no time is required to add it to the note. Administration cares only that the text is in the note. They are not concerned that the activity described actually occurred. I never encountered false information in the part of any note that was typed or dictated, but most of the text in medical records here is imported by clicks of templates. Administration strongly encourages template use because it produces massive amounts of text containing all the elements to meet all of the goals of the administration in the note. Any additional text that may be typed is the only part of the note that is trustworthy.

I have also personally observed how this affects the composition of the staff and the care provided Veterans. Often newly hired doctors leave quickly, or never start, realizing that it is simply not possible to actually do all the tasks the charting mandates imposed and take care of the patient's needs as well. Those with good credentials leave for other opportunities. Doctors with limited options adapt and learn that so long as the notes have in them what administration wants, no one in authority cares if the documentation reflects what really happened. They will have minimal involvement with the Veteran, just as my patients observed, but their notes will have all the required entries. On the measures that count for the administration, they will excel.

Some physicians will stay on, trying to both meet mandates and care for Veterans. I frequently heard stories of others who had shared my concerns about these issues and also were forced out. Because so much is at stake for the administration, retaliation is essential to keep this quiet. It is hard to convey just how bad this has become. Standing under an official poster proclaiming that it is safe to bring up legitimate concerns I was told quite bluntly that if I see anything wrong and say something about it again, I will be fired. Whistleblower retaliation is the keystone. Without it the whole structure falls.

OMI Specific Recommendations for Allegation 2:

10 and 11. Focused review of the providers in my previous CBOC. This is both unfair and inappropriate. Although I provided a specific example from my previous clinic, I worked in other Martinsburg CBOC clinics and have reviewed records from all clinics. This is a system wide problem. The physicians mentioned have been with Martinsburg for some time and their charts reviewed countless times previously. When I came here my service chief specifically held up

their medical records as an example I should emulate. They are doing what the administration expects them to do. Focused review may allow the administration to use them as scapegoats but that would do nothing to improve documentation.

12. Provide additional training per VA Handbook 1907.01 Medical providers are smart. They know the difference between what is formally stated and what is expected. They would even memorize VA handbook 1907.01 if required but they will continue to do what their leadership expects of them.

13. Address Copy/Paste This is a useful tool in CPRS and like other tools in medicine can be misused. There is no technical fix to insure that it is used properly. The already mandated peer review of charts would be quite adequate to identify and correct any misuse if that review were done honestly. If the only goal is meeting formal requirements, no technical fix will work. In fact the larger problem is the misuse of templates, which can place all required information into a note with one or two clicks. That text may not be accurate but it is there. Because it is so burdensome to type out notes, there is a strong incentive to use this. The VA is moving forward with an excellent technical solution for this problem, the Enterprise speech to text program. For the honest production of chart notes, this method is far superior to anything else. For the deceitful production of notes that game the system, the template method remains superior. Unless the ongoing corruption is eliminated, all the money and effort spent on this Enterprise software will not improve clinical notes.

In place of these 4 recommendations I have 3.

1. Honor the promises already made to take action against those who participate in whistleblower retaliation. The usual solutions to prevent cheating are to create more metrics and do more monitoring. This is unnecessary and could be gamed. The intensity and viciousness of retaliation by dishonest administrators shows how threatened they are by those calling attention to this. Without active intervention, physicians who insist on honest clinical work will advocate for it. Unless silenced through intimidation, they will prevail. No program will do more for our Veterans than removing the most powerful tool corrupt officials have for maintaining deceit in the VA. Recall the question I posed the VISN 5 Director: Is what the VA said about not tolerating whistleblower retaliation true? Is there any evidence whatsoever to contradict his implied answer?

2. Change from a phony to a real peer review of records with the sole criteria whether or not the records accurately convey the status of the Veteran and the clinic visit. This will have to be monitored by someone outside of VISN 5 or it will quickly revert back to perfunctory.

3. Just as unrealistic scheduling expectations invited the wait list scandal, so do unrealistic charting requirements invite chart note falsification. Mandates and extraneous charting requirements have a time cost that should be measured and noted. In the review of allegation 1, OMI referred to PCMM which is a precise quantitative system for optimal panel size. This tool has been a major factor in improving the care Veterans receive. A similar calculus of the amount of time spent charting for the visit with the Veteran is needed. Just as excessive panel size in PCMM will predict poor care, so will excessive charting burden.

The farsighted decision to provide Dragon Medical 360 in an Enterprise configuration to all VA clinicians has the potential to produce the finest medical record system ever seen, with accurate and highly useful clinical information. The only barrier is lack of integrity. So long as the VA fails to keep its promise that whistleblower retaliation will not be tolerated, dishonesty will prevail. Our nation's Veterans served us honorably. We should serve them honorably.

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