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Whistleblower Comments OSC File No. DI-14-4305

“My VA”

It has been a type of visceral torture—a water-boarding of the soul—to write yet another set of comments on yet another VA response to another whistleblower complaint. I filed this complaint in 2015 with the Office of Special Counsel (OSC—the Federal whistleblower protection agency) in the Department of Justice; I filed my first in July 2012. My second one came about because illegal, dangerous, and unethical—and let me stipulate sinful— events were still

occurring in primary care at my VA medical center. These events are the same kind as the ones I brought forward the first time. As my Irish mother would say "*If it isn't one thing, it's the same thing.*" The same "ugly chaos". So now my mortal being toggles back and forth between frustration that wants to become fury, and sadness that has become despair. Fury at seeing the same litany of excuses and lies and doublespeak in VA reports and investigations; despair because four years after I first filed with OSC as a whistleblower the landscape I see for the care of the Veterans is as bleak and dangerous as the one I try to envision Veterans face in the theaters of war. Reading the VA's current report on my whistleblower complaint I try to stay sane by thinking of a quote from Edward Tufte (celebrated Princeton professor, statistician, and artist): "*If your words aren't truthful, the finest optically letter-spaced typography won't help.*"

I worked at a naval hospital some years ago, and when the precursor to the current computerized medical record that the VA now uses came on board we had to choose a personal phrase as our login ID. The one that floated into my mind was "Laugh or Go Crazy". It worked—and not just on the computer.

I now practice my profession as a physician at a VA hospital, and I think it's clear to all that the VA system is "sick". So in the spirit of all of the above, here are a few sick jokes regarding the VA:

1.) We found Elvis, and he's alive but not well. He's been sitting in a VA medical center waiting room all these years trying to get an appointment

2.) Do you know what the difference between the Mafia and the VA is? The Mafia knows who they killed, how it happened, and where they are buried.

3.) Why is the VA like the Roman Catholic Church? They both excel at cover-ups of nauseating scandals, and the hierarchy and perpetrators never get fired—just skimmed to another job (even promotion) within the organization. The VA Central Office is like The Vatican; moving to D.C. is akin to transferring to Rome. If one is accused, a common interim *modus operandi* used is “administrative leave”. (Check out the movie “Spotlight” to hear the Boston Globe reporters recite this time after time for how the Catholic Archdiocese classified the pedophiles.) But confession forgives all sins: The VA OIG investigates the cases, finds the charges “substantiated” but no one is punished. All the VA has to do is repetitively mouth like a “Hail Mary” the phrase “taking care of the Veterans is a solemn duty that we take seriously”.

4.) What’s the difference between the Oxford English Dictionary (OED) and the VA? They exist in two different dimensions: OED follows centuries of English language words and definitions, and the VA has its own native tongue and meanings for what it says. Deputy Secretary of the VA Sloan Gibson told

Congress in December 2015 that the term ‘accountability’ should mean “providing a record or explanation of one’s conduct”. OED sees it as “liable to be called to account; answer for to persons for things; to be counted on; be responsible for the death etc. of”. In the VA accountability just means count up the problems—it doesn’t mean anyone is going to be held accountable for fixing them, or guilty. Or God forbid—fired. (The VA also has its own math “accounting” system. It keeps “renumbering” how many VA employees have actually been fired.)

5.) Compare and contrast TSA and the VA: Both have long waiting lines, but unlike the San Diego airport the VA didn’t hire circus entertainers to distract upset customers. (Although the VA Secretary did recently reference Disney. And some might say the clowns are already at the VA.) But the head of TSA resigned when the recent “waiting time” scandal hit the news—unlike in the current VA leadership. And as far as we know no one died waiting at the airports. Of course, someone *could* die on a roller coaster at DisneyWorld...

6.) Why is the VA like quantum mechanics? It partakes in “spooky action at a distance”. That is what Einstein called the idea of “entanglement”, when two particles interact even if they are at opposite ends of the universe. It is the guiding principle of how VA leadership communicates with frontline employees.

7.) Why is the VA an example of a tenet well known in medical, law, and business schools? It is a case study in what professors will tell you: "You can't mandate ethics. You have to find the right people." So you can't make the leadership in civil service be a moral service. They have to have a moral compass carved into their bone marrow.

8.) Do you know the name of the organization that has scored as the "Tops in Customer Service" according to J.D. Power and Associates for the last six years? The VA's National Cemetery Administration. Imagine if we all lived by their motto: "We only get one chance at the Veteran!"

No, wait--that last one isn't a joke. It was actually told to us, straight-faced, by the prior medical center director where I work. I have also heard it touted several times by the VA Secretary, and as employees we have received multiple emails trumpeting this as part of the excellence of the VA. One of our mandatory training videos shows a VA employee cutting the grass over graves. It reminds me of the old "Irish Mother's Letter to Her Son": "Your father has a new and important job where he has hundreds of people under him. He's the groundskeeper at the cemetery."

Did I mention laugh or go crazy?

The VA Secretary has also publicized his new initiative that was launched in September 2014 called "My VA"; it is part of the cultural change he wants to enact at the VA, making it more "Veteran-Centric". Those of us who signed on thinking that was always the mission continue to operate that way—and the ones still here that don't work that way have no intention of pivoting their focus. We all know who they are. They don't smile back, or even lift their heads, when you say "Good Morning" to them. It's draining to be near one of them.

9.) Why is the VA like Steve Jobs? Both aim (or aimed) for "reality distortion fields" in order to sell their products. However, the VA needs to extend the connection: "MyVA" should be "iVA".

When I was interviewed by the New York Times in early 2014, as a federally-protected VA whistleblower who had also testified twice before Congress in 2013, the reporter captured the most telling part about working in primary care at the VA. I had reported the dangerous shortage of doctors, illegal narcotic prescriptions by nurse practitioners who were also not supervised as their licenses required, and what I called "ghost clinics"—scheduled clinics with the name of a doctor or a nurse practitioner who no longer worked in primary care. When the Veteran came in for a long-awaited appointment they were told someone else would have to see them and they were escorted to a clinic to wait (also a protracted

delay) as a walk-in. Often, they left, but it looked like *they* cancelled their “requested appointment”.

The woman writer from the New York Times summarized my feelings about trying to take care of Veterans this way in the first paragraph of the story: "*It breaks your heart.*" In over three decades in medicine I had never seen anything like what I witnessed in my VA job; and I kept remembering and telling leadership that what we're talking about is people's lives. But it was either stand up or give up--and I couldn't give up.

Back then, as more and more whistleblowers came forward, we had hope for change. We watched the House Veterans Affairs Committee have hearing after hearing documenting the beyond belief systemic symptoms of disseminated disease at the VA, and then heard the VA leadership respond with the static that these events "do not reflect our values" and "a plan is being implemented to correct these problems". The Deputy Secretary of the VA came to my hospital and did a town hall meeting saying that the VA wanted to "celebrate whistleblowers"—I was sitting 10 feet from him but did not get introduced even privately just for a moment. This was the same week my picture went up on the Office of Special Counsel website; it was kind of hard to miss, and I was already notorious by that time.

Another year went by, and as employees we received emails, and mandatory online training—and buttons— about living the core values of ICARE: Integrity, Commitment, Advocacy, Respect, and Excellence. At the end of 2014 three of us received "Public Servant of The Year" awards as VA whistleblower physicians from the Office of Special Counsel in Washington, DC. Carolyn Lerner, *the* Special Counsel, called us “patriots”, bringing tears to our eyes. The same Deputy Secretary sat at the head table with us and spoke about how whistleblowers need to be rewarded and encouraged. When I gave my acceptance speech I spoke about being blessed to be a Boston girl who had stood on the same ground where the Minuteman fired "the shot heard round the world" and that I had inhaled the sea smell from the harbor that hosted a tea party. I noted that without Washington’s Army—and the men and women who have continued to serve in our military—none of us would be here that day in his namesake city. I said I thought the tradition of fighting for what was right was "in our American bones". Still, when I went to work at the VA Medical Center in Jackson, Mississippi I wasn’t looking for a fight. It came to me.

I mentioned that being a whistleblower landed me on the “feces roster” at my VA. I asked that VA leadership “bring the physicians back in close”, instead of marginalizing us. And at the end I mentioned what my Irish mother

always said about a problematic human "*Leave him to God; He gets around to everyone.*" I looked the Deputy Secretary in the eye and asked that with regard to the VA miscreants that the VA leadership not wait for God. Make the changes now. Please.

So what happened? When the head of communications for the VA in DC called each of us to do a piece on our winning of awards, it was squashed. Those VA employees committing a kind of daily malpractice continued to violate the "ICARE" core values even as we all got emails telling us we had to reaffirm our commitments to this motto. The same supervisors who had not listened to the whistleblowers or other good employees were the ones responsible for letting the VA Secretary know that everyone at the VA facilities had signed on. We got an email when a VA employee in Seattle told an acutely injured Veteran to call 911 from the parking lot in front of the hospital instead of getting him a wheelchair—and were reminded that "this doesn't represent our core values or who we are". But other episodes and scandals akin to those in a TV comedy show became almost daily TV news highlights. And ongoing OIG investigations show that waiting times are actually longer. The VA still says it can't "prove" that any Veteran suffered or died as a result of long waits for care. But as a congressman asked a

VA official at one hearing I attended, “Is there ever anything good about delayed care?”

A few more doctors were hired in primary care at my VA after my initial whistleblower complaint, but then several left (and are still leaving) for the same reasons that kept my heart in my mouth all the time I worked in that department: no way to keep up with the care of the Veterans getting sicker and sicker, younger and younger, who were all walking chemistry experiments with their suitcases of medications. Patients had an average of 30 chronic medical problems, and then a new one—or a known one went sideways. In a sneaky way that required all the hard-won scientific and intuitive skills of a doctor and a human being. No one stays stable. Excellent doctors across the country contacted me, filed whistleblower complaints, and were brave warriors as long as they could hang on. But these physicians were attacked and left to save themselves and their families. No one can keep working in a war zone forever. However, as employees we did get a memo from VA Central Office leadership in Washington, DC stating that “...intimidation or retaliation against whistleblowers is absolutely unacceptable” and “Protecting employees from reprisal is a moral obligation of VA leaders, a statutory obligation, and a priority for this Department” and “We will take prompt action to hold accountable”—*(there’s that pesky word again)*—“those engaged in

conduct identified as reprisal for whistleblowing...”. Maybe “identifying” that conduct is where the VA executives got mired—or they forgot to look up the OED definition of that word.

What I am going to say next will not make me popular with some in the VA, and nursing, but it is the truth. George Washington thanked one of his generals for being “a fountain of candor”, so I will carry on that tradition. *Nurse practitioners are not the answer to the Veterans’ prayers for care.* In a previous set of OSC comments I presented the incontrovertible data: tens of thousands of hours of difference in education and training between doctors and nurse practitioners, as well as being taught and evaluated by physicians (for MDs) or nurses (for NPs). No standard board certification criteria or exams for NPs vs. ongoing certification and recertification for MDs. And as I said in my OSC award speech “it is an humbling honor to have a Veteran say ‘Help me’ and put his or her life in my hands ...the ‘laying on’ of our hands, and brains, and hearts is how medicine happens and we are the laser line to what is happening, or not happening, to our patients. We understand the processes of life and death, and know where the snipers are.” In the military no junior officer would be put in charge of the battle; the VA needs to acknowledge that credo.

Nurse practitioners who thanked me for being a whistleblower told me they did not want to be doctors—they wanted to be part of a physician-led healthcare team. The entity of nurse practitioner came into being when I was a young doctor; it was designed to take care of uncomplicated wellness exams, and to be part of a medical care group with doctors. As I have told Congress and as I told this latest VA investigative team I have a file cabinet full of mistakes, poor care, and missed diagnoses by NPs. A cocky third year medical student is scary but at least he or she is watched over and corrected by a senior doctor; even cardiology fellows five years out of medical school have their notes cosigned by an attending physician. Not so with a cocky nurse practitioner. An NP interviewed in The Seattle Times said, “We don’t practice medicine. We practice nursing.” Exactly. (And note: the newly designed “Doctor of Nursing Practice”, or DNP, is a nursing administrative leadership degree—*not* a clinical degree—most of which can be earned online.)

In the Compensation & Pension (C & P) department, where I now work, we do disability exams and see every type of medical record including those of private physicians, VA, and Dept. of Defense clinicians. The “cut and paste” function of the VA electronic medical record gets browbeaten and used fanatically by nurse practitioners in particular. Veterans come in to C & P for a “Heart”

disability exam, with a history of coronary artery bypass surgery, a heart attack, and a pacemaker—and a review of records shows that for years no mention of coronary artery disease is noted on the problem list at each visit. The NP does not ask (although they order the medicine refill) “Why are you on this blood thinner?” or other heart rhythm medication—which would lead to the missing diagnosis. But the “URI” (upper respiratory infection) diagnosis is repeated in each note (as the eternal cold), with its billing code. So the medical record does not function as both a communication and legal tool—it makes it extremely hard for another clinician to tease out what really is going on. It is entertaining in a sick way. I have numerous examples, but my favorite is the NP who listed “Pine Oil Cyst” as a historical and chronic problem for the patient. This diagnosis persisted into perpetuity. The closest thing I can come up with is that she meant a “pilonidal cyst”. But what does it say when a clinician can even write down “Pine Oil”, like in a commercial? What kind of medical professional would do that? Someone who has a bachelor’s degree in nursing, and 18 months of nurse practitioner training (taught by other nurses), and then—at the age of ~ 24-25—wants to go out and take people’s lives in his or her hands all alone. With no supervision. If an NP thinks they are as knowledgeable as an MD, then pass the same ongoing board certification exams as physicians do. Or go to medical school, and through

residency, for medicine is not getting less complicated over time—it is getting more detailed and complex and takes more time to learn. Risking the lives of patients is dishonorable and criminal.

Right now the VA wants to make it official policy that all NPs who work in the VA system (including those who administer anesthesia) will be allowed to practice independently, without supervision, regardless of their state licensing laws. This VHA Handbook proposal change is out for public comment at The Federal Register until July 25th. It is a frightening thought, and it will make the VA system the best place for incompetent and inexperienced NPs to hide. The current OSC whistleblower complaint I am commenting on is a star-studded example. Medical groups are fighting this proposal—but if Secretary McDonald (who does not have medical training and perhaps does not have only an NP for his medical care) wants to push it through then he *must* be honest with the Veterans. I believe the Veterans deserve doctors. Many of the Veterans go for years now not realizing they are not seeing a doctor (and not being clearly informed of credentials by some NPs, in violation of law). The Veterans have no idea what may be being missed in their medical care until something truly sad and catastrophic happens—like the Veteran who went ten years with diabetes relentlessly progressively damaging his kidneys, and didn't find out until he came into the ER in kidney

failure, needing dialysis. He was sent to C &P for a new “Diabetes” exam—he will get more money now that he has more diabetic complications—and asked me if something could have been done to prevent his ending up dependent on a machine three times a week in order to live.

So it *does matter* who you see; the kind of brain power, commitment, experience, and professionalism of the person who walks into your room in a white coat can mean the difference between life and death. Patients assume competence when they come to a medical office; the Veterans deserve the truth. At the Jackson VA right now a Veteran may never ever see a doctor—the subspecialists, if consulted, will read the NP’s chart notes and make recommendations. But what if the NP hasn’t asked the right questions of the patient? No one will ever trace the trail of suffering and death back.

Having the Veterans taken care of primarily, and often solely, by NPs will amount to a two-tiered medical care system. After almost 40 years as a primary care physician I know more than ever that primary care is the hardest job in medicine to consistently do well. As cardiologist Dr. Sandeep Jauhar has noted it is about “finding the extraordinary in what may appear to be routine”. Otherwise another human being may slip through your hands.

At my VA the Veterans Choice Program goes something like this:

“Dear..., Thank you for your interest in receiving your Primary Care at the G.V. (Sonny) Montgomery VA Medical Center...we are unable to schedule your appointment within 30 days....I have added you to the Veterans Choice list and submitted the documentation to the Veterans Choice Program...please call 1-866-...it is your responsibility to call to schedule your appointment.” It is your responsibility to call whether you are chronically ill or in pain or almost deaf or have had a stroke or a traumatic brain injury or are thinking of killing yourself. If you need “health care services that are not available at VA” you have 14 calendar days to contact the Veterans Choice Program at 1-866... or “the approval for these services will be discontinued”. Even if the “services not available at VA” are obstetrics, which is a 24/7 kind of condition. And you’re out of luck if the VA isn’t paying the private medical groups who want to help our Veterans but still have to pay their bills to keep the doors open, because there won’t be many “choices” from which to pick.

Bruce Springsteen has the following line in one of his songs:

“Wherever this flag’s flown, we take care of our own.” So the only way to do this now for our Veterans is to follow the recommendations of the “independent blue-ribbon panel of experts” (per the New England Journal of Medicine 9/30/15)

commissioned by Congress who presented their report that September to Secretary McDonald and also publicly released it. The report states the VA should reconsider whether to be the “comprehensive provider for all veterans’ health needs or should emphasize more limited centers providing specialized care”. The “aging” Veteran population as well as those younger in age are also suffering from the same “All-American” diseases of coronary artery disease, hypertension, and diabetes; the VA was never set up to be all things to everyone and can’t do it well. So the report means outsource chronic care (closer to where the patient lives) and establish VA specialty care with centers of excellence in PTSD, amputations, and spinal cord and traumatic brain injuries. And I would add this change also means giving the jobs in those premier facilities to the excellent employees you now have working, above and beyond, across the VA despite its dysfunction—many of them Veterans themselves.

When you join the VA as part of a medical team, you go through the classic five stages of grief: denial, anger, bargaining, depression, and acceptance. You can’t believe it’s as bad as it seems to be, then you’re angry and try to help make changes, then you’re broken down and worn out, and finally you give up. But every day at my VA, like a morning religious devotion (or Orwellian mind-messaging) the overhead system comes on, highlights one of the VA’s

achievements, and then tells us all to “have a great VA day”. No one knows what that means.

For this Memorial Day, we received an email noting three “MyVA” stories about employees honoring Veterans at the end of their lives. I know and work with these kinds of employees and reading the stories brought forward my tears and enlarged my heart. And when the phrase “A Sacred Trust” was used as to why we honor the legacy of our Veterans, I’m in full agreement: The book I wrote in 2005 is called “Sacred Trust: The Ten Rules of Life, Death, and Medicine”. But then we got another email listing “Five Things About MyVA” that we should answer if “asked about the VA and what the Department is up to”. The first point is that “despite the coverage you may have seen, Secretary McDonald is by no means taking his eye off the ball when it comes to wait times for care”; others include “we are transforming the Department” by things such as working towards “improving the Veteran experience; improving the employee experience; achieving support services excellence; establishing a culture of continuous improvement; enhancing strategic partnerships”. And at the end of the email it invited us to “take a few hours to visit one of our beautiful cemeteries”... (*wait for it*)...“our number one-rated customer service offerings from NCA” (National Cemetery Administration). The cemeteries and what and who they represent are beyond

honor and glory—but number one in customer service in the VA should be occurring above ground.

That email also proclaimed the decline in processing time for disability claims. But I work in the Compensation & Pension service at my VA, and what we are now seeing are the mistakes made by rushing claims through outside contractors who never read the Veterans' medical records. So now there is a bigger backlog of appeals on decisions—holding up benefits to Veterans.

I started this by saying we can all agree that the VA is sick. In May 2015 The Brown Political Review (at my alma mater for both undergraduate and medical studies) published an article entitled “The VA Still Needs A Trip To The ER”. At one point I thought the VA could change, and then had to accept that it might be too big to fix. But if we look at the VA as a patient it is now what we doctors would call “*too sick to save*”. The VA is a patient in the ICU who has multi-organ failure: the kidneys can't filter the toxins circulating in the body so waste is building up in the lifeblood of the VA; the lungs can't ventilate out all the hot air because there is airway resistance to whistleblowing; the GI tract is backed up and full of feces; the heart is constricted and can't beat in a regular, reliable pattern; and the brain has multi-infarct dementia but also traumatic injuries. The

VA Central Office can't clear the body of its terminal disease, and the patient lies mute and paralyzed.

Right now at “my VA” primary care doctors continue to leave for the same reasons of overload that still prevent conscientious care. Once again the word on the local medical streets is that the VA hasn't changed. So the VA as a patient is also still bleeding, and the same kinds of infections continue to travel in its arteries and have become overwhelming sepsis. The “Code Blue” for the VA was initiated in 2014, but it's now time to “call the code”—meaning pronounce the time of death for what we couldn't save. So many great people have done all they can, but they can't undo this much bodily, systemic damage. So we must take care of our own in a different way.

Before it got to this state, the sick VA as a patient needed the kind of medical savior described by the Scottish philosopher and economist Adam Smith in 1759: *“He is a bold surgeon, they say, whose hand does not tremble when he performs an operation upon his own person; and he is often equally bold who does not hesitate to pull off the mysterious veil of self-delusion, which covers from his view the deformities of his own conduct.”* But I do not see any such man or woman right now in my VA—one who will cut out the tentacles of self-satisfaction and security and look at himself or herself clearly in the mirror.

10.) Why is the VA like/unlike “death and taxes”? The VA does take more and more government money each year—but the dysfunctional VA leadership is stronger than death. It plans to wait out eternity, like a congealed McDonald’s (no pun intended) French fry under the seat of your sedan.

So here I will quote the humorist S.J. Perelman on a fantasy correspondence from a man to a recidivist laundry owner who keeps putting too much starch and bleach in his shirts: “*With every good wish and the certainty that nothing I have said has made the slightest possible impression on a brain addled by steam, I am compassionately...*”. I fear I am talking to VA executives without medical understanding whose brains—and hearts—have been addled by too much power and insulation. As one Veteran put it when describing “people who ‘don’t care’”: they who are “slow of heart”.

Laugh or go crazy.

I will reach for something to wipe a tear away, remembering what I tell a Veteran, with a fellow-traveler smile, when he or she starts to cry in my office and I hand them the tissue box. “Take more than one—no extra charge. It’s your tax dollars at work.” For just as I felt years ago when I spoke to the New York Times reporter, my VA—and what happens to the Veterans who come there, asking for help—is still breaking my heart.

But I also tell the Veteran this when I walk him or her back to the waiting room and they thank me for treating them with respect: “Everyone should treat you that way. Your mission meant signing up to put your life on the line. Our mission is to take care of the Veteran—much simpler and safer than yours. It’s what we can do for you now.” And just as the US Army can say in a commercial I love that shows barbecues and parades and fireworks— “Enjoy your Fourth of July. Brought to you continuously by the United States Army since 1775.”—I remind the Veteran: “You’re why we’re here.”

Let me now specifically eviscerate the VA’s response to:

OSC File Nos. DI-14-3209, 4305, and 5078.

And let me repeat once more, as it applies so well to the VA’s investigative report(s) this quote from Edward Tufte: “*If your words aren’t truthful, the finest optically letter-spaced typography won’t help.*”

The VA report (in the fine print at the bottom of page 4) interestingly states that “The previous ACos, PC and top leadership at the Medical Center from 2009 to 2013 no longer work at the Medical Center, and were not available for questioning.” This is as untrue as the VA stating in its report on my original

whistleblower complaint that the employees involved in the primary care problems no longer worked for the facility or the VA. All of them still did work at the Jackson VA or in the VA system in 2013; and the “top leadership” from 2009-2013 at the Jackson VA either still worked at Jackson (e.g. prior chief of staff, and now current nephrologist Dr. Kent Kirchner, and current acting chief of staff and prior chief of medicine, Dr. Jessie Spencer), or at other VAs (e.g. prior primary care chief Dr. James Lockyer, currently at a VA in Tennessee)—and all the other acting chiefs of primary care we had before ACos, PC (Associate Chief of Staff, Primary Care) Dr. Burnett were “imported” from other VAs. I believe that the VA has nationwide telephone service and the investigative team could have done interviews that way with these people, just as the team notes they did using teleconference for interviews with whistleblower Kim Washington and ACoS Dr. Andree Burnett.

The VA report does begin by reviewing that after the VA substantiated my first OSC complaint, two site visits were conducted in 2013 at the Jackson VAMC and an “action plan” was put in place. In October of 2013 the VA Office of Medical Investigation conducted a follow-up visit to “oversee implementation”; one recommendation was to conduct a “clinical quality of care review” of a “representative sample” of patient electronic records for all NPs, as

well as all physicians” who worked in primary care. The Jackson Medical Center also “established” that they would review charts and “OPPE data”; OPPE being ongoing monitoring of clinical providers who have current staff privileges.

The VA report does substantiate that an NP (Hubbard) in primary care “regularly failed to provide sufficient care to patients”, and that “patient health was placed in jeopardy” as a result. This “jeopardy” included two delays in diagnosis of advanced cancer as well as other Veterans suffering “adverse events” due to “improper” management of chronic conditions or abnormal test results. The report noted that NP Hubbard was initially granted clinical privileges at the Jackson VA in July 2009. It also noted that this NP’s lack of “sufficient care” was identified in March 2014 and a 90 day “unprotected clinical review” was done by June 2014; the NP resigned in July 2014.

The evidence shows that in March of 2014 a chart note by Dr. Burnett stated “Chart reviews done. Abn. labs identified...Mr. G contacted...states he has never been called on abn. labs.” I serendipitously found out this information when the same patient came to Compensation & Pension to see me in 2015 for a new “Diabetes” disability exam, and I reviewed his records. He remembered getting a call from a “woman doctor who seemed pretty upset”. The Veteran did follow-up with his outside physician for repeat labs and found out indeed that he had

developed diabetes. The evidence I submitted also showed that another NP (Denson) failed to act on or properly diagnose new diabetes in the same Veteran when she saw him in 9/2010. This definitive lab evidence was clearly visible to the chief of primary care when she reviewed the other NP's chart work in March 2014. Yet she did not act on that information to review the first NP.

Part of my job as a disability examiner is to find the date of onset of the condition or disease, and a simple review of this man's records showed that he had developed diabetes by his *first* Jackson VAMC visit in September of 2010. That is over three years before Dr. Burnett's phone call to the Veteran in 2014, and the same labs were as available and visible to her as they were to me. And *two* different NPs had not followed up on or notified the Veteran since 2010 about his new diabetes. Just looking at the labs in 3/2014 when she called the patient should have triggered an immediate response from Dr. Burnett to check into both NP Hubbard's and NP Denson's work quality—and to make sure that all OPPEs and other credentialing were being handled per VA regulations and state licensure guidelines. But Dr. Burnett did none of these things; instead, she carefully worded her chart note to cover up any issues—notably, by leaving out the blood sugar result of 382 and the diagnosis of “diabetes”.

This improper, unethical, and weak approach to the job of Associate Chief of Staff, Primary Care (ACoS, PC) is detailed in other sections of the VA report. When interviewed by teleconference in June 2013 Dr. Burnett told the investigative team that she assessed the quality of care provided to Veterans by primary care nurse practitioners and physicians through the OPPE and the FPPE processes (FPPE is done for initial privileging and if a change of privileging occurs). Dr. Burnett “admitted that she was behind in documenting OPPEs, and that the OPPE process did not take place every 6 months, as required.” The report also makes clear that NP Hubbard only had OPPEs dating back to 2011 (two years after joining the clinical staff); that between 2011 and 2013 one OPPE “raised concerns about deficiencies in care”; and the May 2013 OPPE “documented “marginally acceptable performance evaluations ‘based on concerns regarding clinical care’.” Then suddenly an FPPE (and why was this done instead of ongoing OPPEs) rated the NP as fully satisfactory and remained so “until VISN 16 external clinical reviews” (mandated by the plan required after my first OSC complaint) were completed with an unprotected clinical review in March 2014.

In December 2013 Dr. Burnett was officially appointed ACoS, PC after having served for several months as acting ACoS. However, it should also be noted that Dr. Burnett has been a member of the Jackson VA medical staff for

decades—and knew about the serious issues I raised in my OSC complaint starting in July 2012. In fact, Dr. Burnett worked in primary care at Jackson until the end of 2008 (when I took over her patients, as well as those of another physician). We talked about the well-known issues of quality, use of NPs, losing MDs etc. long before December 2013. In addition: NP Hubbard’s “approach” to patients was commented upon in the hospital “grapevine”—this VA is a “small town”—and not a secret. When a patient of his came in feeling weak, had a very quick visit, and went out to the parking lot only to be found many hours later essentially “cooked” in his car in the Mississippi heat, we all heard about it.

Dr. Burnett “admitted that she did not review the NP’s EHRs” (electronic medical records) when NP Hubbard was re-privileged again after a December 2013 OPPE; she also admitted that “in recommending continuation of his privileges she had relied on the review of other PC physician providers”. (Is there documentation of who these providers were, and what they did?) Dr. Burnett then said “she was unaware of any issues with his care delivery or of his patient chart deficiencies until notified by VISN 16 in early 2014.”

But the number of clinical “alerts” (messages and results in the EHR) has been monitored for years, and it was well known (and trumpeted by NP Hubbard) that he had over 1000 unanswered alerts at all times. This fact alone

should have been enough information for the ACoS, PC to have suspicions about the quality of his care. And damningly, the VA report concludes that “issues regarding this NP’s clinical care should have been identified through the OPPE process.” The report also found that “current OPPEs were not completed in accordance with VHA Directive 2010-025. Accountability actions are warranted since clinical leadership is responsible for ensuring the timely, thorough completion of OPPEs.”

The VA report notes that “unaddressed clinical alerts pose a risk for delays in care”; sounds a lot like my previous documentation and testimonies asserting that no one in primary care can fully keep up with the volume of work that comes at them 24/7. The alerts come in continuously all weekend, so when a physician or NP comes in Monday morning they can already be 200+ alerts behind. And then the full schedule starts, and walk-ins come in, and the laws of physics of the current universe that MDs and NPs work in (unlike the apparently parallel universe that VA administrators live in) dictate that you can only see one human patient at a time. The constant fear of missing something vital is what haunts all conscientious clinicians; it remains the single highest reason that we continue to lose excellent doctors in primary care. And although this VA report recommends “provide protected administrative time for NPs, as well as all PC

providers” (I guess that means MDs, who do not get overtime as NPs do) “in accordance with VHA Handbook 1101-10 (Patient Aligned Care Team Handbook)’, none of this has happened to date.

Finally the VA report recommends that the “Chief of Staff (CoS) continue to review the Medical Center’s FPPE and OPPE processes and take action to ensure that they are completely timely by the ACoS, PC”.

What does all this mean? It means that Dr. Burnett did not fulfill the duties of her leadership position in primary care. It means that Dr. Burnett did not take the duty (moral, ethical, and professional) seriously of making sure that Veterans were not harmed by personally reviewing privileging files of providers. What occurred on her watch is that she did not “keep up” with making sure that everyone who saw patients in her department was clinically competent. It means that if she had done her job fully she *would* have known in December 2013 about the “discrepancies” in NP Hubbard’s file. She would have known about the issues documented in his VA credentialing file about two Mississippi Board of Nursing fines—one for “writing notes before he saw the patient”, eerily similar to issues raised in this VA report in interviews with other PC staff.

Dr. Burnett was as aware as I was of the “push” to increase the numbers of NPs in primary care, done under the aegis of Dot Taylor (documented

in my first OSC complaint), and the concomitant drive to get physicians out of primary care. She knew that NP Hubbard was hired in 2009, a time when that push was on. NP Hubbard was hired then and under the regime of Dot Taylor, and overseen by Dr. Kent Kirchner, the proper review of NPs clinical work was not done.

And just as in my previous OSC complaint, the question remains: When an NP was “reviewed” was that review done by another NP or an MD? For if NPs feel they can do the same type of clinical care as physicians, then their work should be reviewed by physicians—as the work of other physicians is. If, as the VA report notes, NPs at the Jackson VA applied for and obtained Iowa NP licenses just in order to avoid the need for MD supervision, does that suddenly increase his or her individual competence? Does the brain and the heart and the work ethic of the NP change? (The Iowa Board of Nursing apparently had no ethical qualms about taking money for licenses for NPs who had no intention of working in that state.) And also as in my previous OSC complaint, this second VA report has to once again reiterate to the Jackson VA that it must “Ensure that all advanced practice registered nurses [APRNs—another term for NPs] are working in accordance with the rules and regulations of their state licensure”. The report specifically states that regarding NP Hubbard “During the time period that he

practiced at the Medical Center under his Mississippi license, the NP never worked under a scope of practice or with a collaborating physician.” As my first OSC complaint makes clear, he was not the only one seeing patients in violation of law.

This recent VA report also notes that Dr. Burnett did not follow VHA Handbook 1100.18 regarding “Reporting and Responding to State Licensing Boards”—and that “leadership accountability” must be determined. The report states that as of June 4, 2014 “the standard for taking a summary suspension of privileges” was met for this NP as the unprotected 90 day clinical review had been completed and showed 30 of 60 charts to be “deficient”. But it was not until June 19, 2014 that Dr. Burnett acted upon this “imminent danger to the health of any individual” and recommended summary suspension of the NP’s privileges; and “The ACoS, PC was unable to explain the reason for the 2-week delay.” When the NP resigned and voluntarily surrendered his privileges on July 7, 2014 the Jackson VA did not initiate a clinical review of his care until 7/29/14—“one month after concerns regarding his practice were identified” when the unprotected clinical review had been completed in June 2014. Again—Dr. Burnett should have been at the forefront of initiating this review. That is her duty. The VA report notes that VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards, “requires the initiation of a review within 7 calendar days” if information is

received indicating concern for the safety of patients. This VA report goes on to say that “Following the May 2015 site visit the proper “mandatory” procedures were initiated—but that makes it almost one year from June 2014, when it should have been done.

No mention is made of also notifying the National Practitioner Data Bank (NPDB); VHA policy regarding this should be reviewed. However, a local newspaper investigation (The Clarion-Ledger) has documented that this VA also has two physicians currently on its staff that cannot either see patients or operate due to quality concerns, and it also unclear whether these situations have been reported to NPDB.

This VA report also soft-pedals what happened when Dr. Burnett devised her plan, announced in an email on July 29, 2104, to review the NP’s charts for quality of care. She directed all of the NPs and MDs in primary care to review charts (*a total of 718*) “thoroughly. If there are (sic) any symptomatology or any abnormal studies (labs, xrays, procedures, biopsies, etc.) that haven’t been addressed this should be documented and appropriate work up initiated. You will receive a spread sheet to document each review. On the spread sheet there will be a question asking, if there was any harm done to the veteran? If the answer is yes, please give an explanation and notify Admin.”

One does not have to go to medical—or law—or seminary school to believe this plan is illegal and unethical. The (less than 10 total) physicians refused; Dr. Burnett threatened each one individually with a letter for their personnel file for insubordination if they refused. (Documentation of this done by third whistleblower for this complaint, who wished to remain anonymous.) The VA report called this “appropriate” since it was conducted by the NP’s professional peers (and again, why is the standard of care for NPs not to be reviewed by doctors?). The VA report states “several physician providers said they did not wish to participate in the chart reviews...Some reported that they were uncomfortable recommending follow up care when they had not examined the patients face-to-face. Eventually, all PC providers completed the review process after several additional directives from the ACoS, PC.”

Read those “several additional directives from the ACoS, PC” as more invective. But mood swings arose. An email from Dr. Burnett on July 30, 2014 to the PC staff stated “I wanted to thank you all for the **EXCELLENT** job you have done and continue to do in managing your alerts. You are an **AMAZING** group of professionals! It is showing in your alerts, in the number of compliments we have been receiving, and in the upswing of performance measures...**YOUR EFFORTS ARE GREATLY APPRECIATED!!!!!!**” But then one charming email to the PC

staff on August 5, 2014 was about “Civility”: “ALL, There has been a GREAT concern for the growing lack of respect and common courtesy within Primary Care.” The email listed nine “costly effects” on workers who have been the recipients of incivility, by percentages, including 80% who lost work time worrying about the incident; 66% said their performance declined; 78% said their commitment to the organization declined; and 63% lost work time avoiding the offender. It referred the readers to the attachment *Employee Responsibility and Conduct Policy*, and to “adhere to it accordingly”. The email ends with ‘Every action done in company ought to be with some sign of respect to those that are present.’—George Washington.” The irony of the chief of primary care not treating other professionals with respect—or the Veterans at risk—and what it felt like to have a leader so different from our first President was apparently lost on Dr. Burnett.

A telling example of what occurred due to this review of 718 charts was an NP from the Women’s Clinic writing a September 2014 letter to a man stating “UPON REVIEW OF YOUR EMERGENCY ROOM VISIT 6-13-14 I HAVE REQUESTED HOLTER MONITOR AND ECHOCARDIOGRAM TO FURTHER EVALUATE YOUR DIZZINESS AND LOW HEART RATE. I HAVE SENT YOU A BP MONITOR. WRITE DOWN YOUR BLOOD

PRESSURE AND HEART RATE AND BRING WITH YOUR TO YOUR PC

BLUE VISIT FOR YOUR PROVIDER TO REVIEW.” Just think about this:

Three months after your emergency room visit for a possible heart problem you get a letter, as a man, from someone at the VA who works in the Women’s Health Clinic—a woman you have never met, and don’t expect to meet—who tells you to do some things you probably don’t understand. Then the next letter states “SEE ENCLOSED NORMAL ECHOCARDIOGRAM. HOLTER HAS NOT BEEN READ YET. CONTACT YOUR PRIMARY CARE BLUE 3 PROVIDER MS.NP FOR ANY QUESTIONS. PLEASURE TO SERVE YOU.”

But the last you knew NP Hubbard was your “primary care provider” in PC Blue 3; and no one has notified you to the contrary. So you walk into PC Blue and ask for Ms.....NP but it turns out she is no longer there but in another color clinic covering for a provider who isn’t being allowed to see patients (due to a “credentialing issue”) and besides you’ve never met her either. Then a nurse in PC Blue gives the walk-in sheet about you to a conscientious NP who has just been thrown into PC Blue, who knows she has to see you and examine you and does so in the midst of a more-than-full schedule...and calms you (after more than three months) about your dizziness and low blood pressure because she actually reviews your medicines and dosages and sees that one is probably too high and changes the

order. And thank God you landed where they put her—and thank God you didn't die before that.

This same excellent NP then writes to the Mississippi Board of Nursing asking “Should I order test/procedures on patients of whom I have never seen or examined” (such as our Women’s Clinic NP did). The answer from the Executive Director of the Mississippi Board of Nursing (an NP who used to work at the Jackson VA) is (bold lettering hers): **“No. You cannot order a test/procedure on patients that you do not have an established provider/patient relationship.”** Our excellent NP also asks “Should the VA provide me with clearly established guidelines or protocols to follow regarding residents at a remote site?” The answer comes back **“You should not be ordering consults on patients you have not evaluated. There would be no good guidelines and/or protocols that would make this work.”** And the final question from our NP is “Should a face to face visit occur prior to placing any type of order?” And the answer is **“Yes, you must have an established provider/patient relationship before placing any order. This would include a face to face encounter.”**

Our excellent and conscientious and ethical NP sends a copy of the Mississippi Board of Nursing information “respectfully” to Dr. Burnett, but no reply. But I bet you could have guessed that one.

To his credit, as issues became unavoidably evident regarding the lack of oversight, proper procedures, and respectful leadership with Dr. Burnett in her role as ACoS, Dr. David Walker (Chief of Staff at the time, and now Medical Center Director) appointed another physician (Dr. Jo Harbour) as Deputy Chief of Primary Care. This VA report repeatedly mentions that the “Deputy ACoS, PC” is “continuing to review, monitor, and track all patient cases of concern to determine the quality of care provided by NPs” and “overall practice for all providers to ensure clinical competency.” The VA report acknowledges that all of the “14 examples of suboptimal patient care” that I provided demonstrated “poor control and progression of chronic diseases”—and all were placed in the group that the Deputy ACoS, PC is now following. (As I told the investigative team and stated earlier in my comments, I have a lot more than 14 examples of inadequate NP care.) The investigative team states that they “concur with Dr. Hollenbeck that the NP’s failure to provide adequate care placed patients in jeopardy.” It should be clear from all of the above that the Deputy, ACoS, PC is doing the work of both a clinical physician and an administrator—to her deep and honorable credit.

So here I sit, after writing another set of comments for OSC on the VA, getting heartsick again but also so heart- proud of my colleagues who have also stood up, and tried to always do the right thing as far as humanly possible. But where does this leave the Veterans—who are the reason we are all here? All I can do now is pray until my knees wear out, speak up like this and state my case—and continue to do all I can for one Veteran’s life at a time. Because it should be “*Their VA*”.

I will remain a “Boston Girl” for whom the tradition of fighting for what is right and just is instilled in my DNA. The last rule in my book, “Sacred Trust: The Ten Rules of Life, Death, and Medicine” is “Don’t Break Your Own Rules”—and I won’t. My Irish mother would tell you that each of us is entrusted with the stewardship of our own soul; as a physician I am imbued with the surety that I am the steward of the bodies and souls of my patients. “*My VA*” will always be the images (smiles and grimaces and blood and tears) and sounds (heartbeats and song and laughter and crying) of the men and women who have trusted me with all they are. I can always put my arms around these men and women as long as my brain works. They will outlast eternity.