July 21, 2014

Sloan D. Gibson
Acting Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Acting Secretary Gibson:

In California, a Department of Veterans Affairs inpatient pharmacy supervisor was placed on administrative leave and ordered not to speak out after protesting what he described as errors and delays in the delivery of medications to patients.

In Pennsylvania, a former VA doctor was removed from clinical work and forced to spend his days in an office with nothing to do, he told the Project On Government Oversight (POGO). This action occurred after he complained that, in medical emergencies, physicians who were supposed to be on call were failing or refusing to report to the hospital.

In Appalachia, a former VA nurse was bullied by management and forced out of her job after complaining that patients with serious injuries were being neglected, she told POGO. “Such an upsetting thing for a nurse just to see this blatant neglect occur almost on a daily basis. It was not only overlooked but appeared to be embraced,” she said. “There’s a culture of bullying employees….It’s just a culture of harassment that goes on if you report wrongdoing,” she said.

These people are among the hundreds who contacted POGO over the past several weeks after we joined forces with Iraq and Afghanistan Veterans of America (IAVA) to seek inside perspectives on the Department of Veterans Affairs. Together, we and IAVA created the website VAOversight.org and asked people within the VA system to share their stories.

In its 33-year history, POGO has never received as many submissions on a single issue—nearly 800 current and former VA employees and veterans contacted us. POGO reviewed each of the submissions, and the comments indicate that concerns about the VA go far beyond long or falsified wait times for medical appointments; they extend to the quality of health care services veterans receive.

POGO received allegations of wrongdoing from 35 states and the District of Columbia, and in the limited time we have had thus far to analyze the information, a recurring and fundamental theme has become clear: VA employees across the country fear they will face repercussions if they dare to raise a dissenting voice.

Without direct action by you and the incoming Secretary to counteract the widespread climate of fear and whistleblower intimidation, the VA’s toxic culture will persist and the care of our veterans will continue to suffer. There are various reforms being considered by Congress, but in
addition, you and the incoming Secretary must immediately demonstrate that whistleblowers will be protected and their contributions respected, and that those responsible for shortcomings will be held accountable.

Hundreds of the individuals who came to POGO had similar stories, just a few of which should give you insights into how this institutional collapse happened, as well as a greater sense of urgency to tackle the challenges VA leadership must confront.

Some people, including former employees who are now beyond the reach of VA management, were willing to be interviewed by POGO and to be quoted by name. Others said they contacted us anonymously because they are still employed at the VA and are worried about retaliation. One put it this way: “Management is extremely good at keeping things quiet and employees are very afraid to come forward.”

**Afraid to Be Identified**

An anonymous contact from Illinois wrote to POGO, “I can’t reveal my name as I fear retribution from my supervisors and other staff members.”

An anonymous commenter from Florida wrote, “The working environment is [so] full of fear and intimidation that very few employees will advocate for the Veteran. I have and so I am treated very badly.”

Another from Florida wrote, “Current employees appear to be afraid of losing jobs, and family members of patients have stated there is fear of not being able to continue receiving services, if they complain, or make concerns known.”

A third from Florida wrote: “[W]hile everyone knows about the shady practices and procedures, everyone is too afraid to talk….I have dared in the recent past to raise my voice and of course I am a marked employee.”

An anonymous commenter from Kansas said, “I know my job is in jeopardy if they become aware that I have reported any information.”

An anonymous commenter from Texas wrote, “I have been told not to bring things up about the doctors because ‘they don’t like it’, and my evaluation was threatened to be marked lower next time, if I continued. I am very afraid for my job at this point.”

From Pennsylvania, an anonymous commenter wrote, “Have not spoken out for fear of retribution. A recently hired…manager who was very qualified and tried to be proactive to effect changes to improve the OR was quickly removed from his position and demoted when he approached administration about this and other issues that they did not wish to acknowledge were occurring.”

Another from Pennsylvania: “I’d rather remain anonymous. I’ve already suffered retaliation for trying to help….I don’t want this to be about me but the consequences of trying to help were profound!”
A tipster from the Southeast cautioned: “I do not wish to be contacted because I fear for my job.”

And another from the Southeast echoed the sentiment. “[I]f they find out it is me reporting this…I’ll be fired.”

When VA insiders contacted POGO anonymously, it was impossible to look into their claims. However, when their accounts are combined with stories from former employees and current employees who did provide contact information, a disturbing picture begins to form.

**Medication Errors and Delays in Palo Alto**

Consider the case of Stuart Kallio, an inpatient pharmacy technician supervisor at the VA Palo Alto Health Care System in Palo Alto, California. Like many VA employees, Kallio is also a veteran; he served nine years in the Navy.

In emails Kallio shared with POGO, he complained to superiors at the VA hospital about what he described as incompetent, uncaring management and inefficiencies in the delivery of medicine to patients.

“In summation, patients are experiencing inordinate delays in their healthcare as a result of your failure and refusal to comply with VHA regulations,” he said in an email to a superior dated February 5.

“In essence, after all these years of suffering under gross mismanagement and wonton [sic] violation of VHA regulations, the processes utilized by the Pharmacy Service have steadily deteriorated and atrophied to the point that the Inpatient Pharmacy is in reality in a perpetual state of failure, failing to provide timely, quality care to veterans,” he said in an email dated February 26.

He addressed his criticisms up the chain of command as far as Elizabeth Joyce Freeman, director of the Palo Alto VA Health Care System.

On April 7, the chief of the pharmacy service sent Kallio a letter threatening to suspend him. His offenses: sending a dozen listed emails “that contained disrespectful and inappropriate statements about your Service Chief” and others at the hospital, including “VA Palo Alto Health Care System Leadership,” the letter said.¹

Three weeks later, in a letter defending himself to the chief of the pharmacy service, Kallio said patients were suffering from “missed doses, late doses, wrong doses.” He quoted hospital records of medication errors and cc’d his letter to congressional overseers.

The hospital administration was unmoved by his defense. In a letter dated May 29, the chief of the pharmacy service, Kelly Robertson, informed Kallio that he would be suspended from June 8 through June 21.²

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¹ Letter from Kelly Robertson, Pharmacy Service Chief at Palo Alto VA Health Care System, to Earl Stuart Kallio, Pharmacy Service, about Proposed Suspension, April 7, 2014.
² Letter from Kelly Robertson, Pharmacy Service Chief at Palo Alto VA Health Care System, to Earl Stuart Kallio, Pharmacy Service, about Suspension, May 29, 2014.
On the first day of his suspension, Kallio emailed Freeman reiterating his complaints. “For almost two years now, I have been communicating my concerns regarding the VAPAHCS Palo Alto Division Inpatient Pharmacy up the chain of command up to and including your office,” Kallio wrote. “Your response has been to unlawfully retaliate against me...,” he continued.

He cited additional medication errors, including a case in which a veteran’s epidural drip of pain control medication ran dry, and another in which a chemotherapy drug that requires refrigeration was administered two-and-a-half hours after its expiration point and the patient subsequently developed a high fever.

The hospital administration wasn’t done with Kallio. On June 20, the day before his suspension was scheduled to conclude, Freeman sent Kallio a notice placing him on paid administrative leave pending an investigation. The same day, Robertson sent him a letter with the heading “Direct Order” restricting his communication. “Do not discuss this matter with anyone inquiring outside of official representational role or management investigative capacity and who does not have a need to know,” the order said.3

In an interview with POGO, Kallio made it clear that he would not be silenced. “As far as I am concerned, this is a public safety issue and the public has a need to know.”

This month, Freeman became interim director of the VA’s troubled Southwest Health Care Network based in Arizona. She has been in the news recently for other reasons. On February 28, she was awarded a bonus of $12,579 for the last fiscal year, according to information provided by the House Committee on Veterans’ Affairs.4 In addition, an audit of VA scheduling practices released July 3 flagged one of the facilities in the Palo Alto system she headed, the Livermore facility, for further review.5

The order attempting to gag Kallio and the expansion of Freeman’s responsibilities seem directly at odds with a message you sent to all VA employees last month emphasizing the importance of whistleblower protection.

“I want to make clear that intimidation or retaliation against whistleblowers—or any employee who raises a hand to identify a legitimate problem, make a suggestion, or report what may be a violation of law, policy, or our core values—is absolutely unacceptable. I will not tolerate it,” you said in your June 13 message.

Kallio’s criticisms of management at the Palo Alto VA may come across as intemperate. But whether he is right or wrong, punishing and trying to silence him sends precisely the wrong

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3 Letter from Kelly Robertson, Pharmacy Service Chief at Palo Alto VA Health Care System, to Earl Stuart Kallio, Pharmacy Service, about Direct Order—Restricted Communication, June 20, 2014.
message for the VA. Furthermore, the gag order was placed on Kallio after his VA superiors could see that he was copying Congress on correspondence; it is against the law to attempt to interfere with a person’s communications with Congress.

Kallio told POGO that the VA’s actions have taken a toll on him financially and emotionally. He said he lives paycheck to paycheck. He told us that the suspension—which he said was unpaid—and the threat to his employment plunged him into such a state that a congressional aide with whom he spoke arranged for a counselor from a veterans’ crisis hotline to call him.

Patient Neglect in Appalachia

Consider, too, the account given by the nurse in Appalachia referenced above who participated in a series of interviews but asked that we not identify her or the facility where she worked. As the nurse told it, she complained that profoundly injured patients were suffering from neglect and long delays in getting needed services. She spoke up for veterans who were afraid to speak for themselves; they told her they feared that, if they complained, their benefits or pain medication would be taken away.

The nurse told POGO that she thought the veterans’ fear of retribution was unfounded until she herself became a victim of retribution.

For example, the nurse said that in a 2012 episode she was faulted for referring a patient with an unresolved complaint to the hospital’s patient advocate. The veteran’s complaint was that for weeks he had been unable to reach the VA employee responsible for arranging his transportation for a medical test to determine if he was in danger of sudden death. The nurse said her supervisor chastised her for referring the veteran to the patient advocate because that meant the hospital director would learn about the complaint.

The nurse said that, ultimately, despite having received highly favorable performance reviews, she was falsely accused of misconduct and was told that if she did not resign, the VA would report her to the board of nursing. To preserve her nursing license and her livelihood, she said, she left the VA last year. She lost her retirement benefits and her health insurance and is now working three jobs to make ends meet, she said.

“I felt that everything that meant anything to me was taken away for nothing—because I didn’t look the other way and ‘wink, wink’ when patients made these complaints to me,” she told POGO.

On-Call Physicians Phoning It in at a VA Hospital in Wilkes-Barre

Thomas Tomasco, a doctor who worked at the Wilkes-Barre VA Medical Center in Pennsylvania, said that he “was made to quit [his] position under duress” after he raised concerns about the hospital’s on-call policy. He complained that on-call physicians refusing or failing to come to the hospital in emergency situations—and instead providing consults by telephone—delayed care to patients requiring immediate assistance.
Speaking of himself and some VA colleagues, Tomasco wrote in an August 27, 2012, email to an attorney with the VA’s Philadelphia Office of Regional Counsel: “I am writing to tell you that the issue continues to occur multiple times with multiple physicians in this facility….We have notified our supervisors of this issue and nothing is done.”

An August 28, 2012, email that Tomasco provided to POGO from a member of the hospital’s leadership to hospital personnel showed that the hospital allowed specialists on call to literally phone it in. “It is the consultants [sic] prerogative to either come in or not and they have the legal responsibility for their decision thereafter,” the email said.

Much later, the VA’s Office of the Medical Inspector (OMI) reviewed Tomasco’s allegations and determined that the Medical Center’s on-call policy was legitimate. “On-call policies are a local issue and vary from facility to facility depending on the staffing available. Many facilities, both private and VA have limited physician resources and their on-call practices are shaped by their available resources and transfer agreements.” Due to limited staffing at the VA’s Wilkes-Barre hospital, “physician call is sometimes limited to ‘telephone only,’” the Office of the Medical Inspector reported.6

Soon after Tomasco raised concerns, he faced a series of adverse actions. Tomasco was suspended for a day without pay in 2012 for allegedly unprofessional conduct, according to notices related to the suspension. Tomasco contested the disciplinary action. A VA appeals board eventually ruled “the charge was not sufficient to support the penalty” and the action was overturned.7 The doctor said that, after the suspension, he was removed from clinical service twice and each time was forced to sit in an empty office with nothing to do for weeks at a time.

An advocate who helped Tomasco contest his suspension, Ray Mazzarella, argued that Tomasco’s story fit a broader pattern. In a letter to the Medical Center’s Director on September 17, 2012, Mazzarella referenced other clients who had problems with this hospital’s management: “[S]everal other physicians and non-physicians have left Wilkes-Barre under circumstances similar to my current clients’….This is another of those VA Wilkes-Barre ‘coincidences’ where employees who express their honest, well supported opinions find unrelated allegations just around the corner.”8

Tomasco’s concerns were reviewed by the Office of Special Counsel (OSC), an agency empowered to investigate whistleblower complaints and allegations of reprisal against federal employees. In a March 2013 letter to Tomasco, the OSC said: “We have concluded that there is a

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7 Letter from Robert Jesse, Department of Veterans Affairs Principal Deputy Under Secretary for Health, to Dr. Thomas Tomasco, about Disciplinary Appeals Board Decision, July 24, 2013.
8 Letter from Ray Mazzarella, to Wilkes-Barre VA Medical Center Director, about Thomas Tomasco, MD—Response to proposed Suspension, September 17, 2012.
substantial likelihood that the information that you provided to OSC discloses a substantial and specific danger to public health and safety.”¹⁹

It was at this point that the OSC referred Tomasco’s information to OMI for further investigation. Tomasco recounted that he was contacted by VA inspectors but felt they were more interested in attacking him than in looking into his allegations.

“The inspector told me, if you don’t like it here so much why don’t you just quit? You don’t like it here, you hate this place. Why don’t you just quit?” Tomasco told POGO.

Still sidelined from medical duties, Tomasco did just that. In an April 12, 2013, resignation letter, Tomasco wrote that he would have preferred to continue working at the hospital but the work environment was too hostile. “I have been suspended, removed from clinical duties, and treated like a pariah with no justification….Due to this ongoing harassment I feel management has given me no recourse but to resign from my position as hospitalist at VAMC Wilkes Barre,” he wrote.

It wasn’t until after Tomasco’s resignation that the VA’s OMI released its findings: “OMI’s investigation and review of its findings did not reveal any evidence of gross mismanagement or substantial and specific danger to public health and safety.”¹⁰ The OSC then declared that “the findings of the agency head appear reasonable.”¹¹

Nonetheless, in a February 10, 2014, letter to President Obama, OSC head Carolyn N. Lerner said Tomasco “raised a reasonable concern about whether it is the best medical practice to permit on-call physicians to use their medical judgment in determining how they provide consultations, by telephone or in person.”¹²

This case demonstrates a fundamental weakness in the broader system: When probing cases of alleged wrongdoing at federal agencies—including alleged threats to public health and safety—the OSC must depend on the agencies accused of wrongdoing to investigate themselves.

Adding fuel to questions about OMI’s conclusions in this case, the OMI is currently being restructured after the OSC sent a letter to the President on June 23, 2014, describing “a troubling pattern of deficient patient care at VA facilities nationwide, and the continued resistance by the

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⁹ Letter from Karen Gorman, Deputy Chief, Disclosure Unit Office of Special Counsel, to Dr. Thomas Tomasco, about Dr. Tomasco’s allegations OSC File No. DI-13-0416, March 21, 2013.

¹⁰ In its June 4, 2013 report, the Office of the Medical Inspector said other doctors also related that there had been “issues” involving on-call physicians, but it described those as in the past. Tomasco originally made his complaints a year before the report was written, and it appears that the past issues referenced by OMI were consistent with Tomasco’s account. The OMI report said: “Although, a couple of the hospitalists reported that in the past there had been issues with orthopedic and urology specialists on-call, currently they all, except the whistleblower, described a collaborative relationship with the on-call specialty physicians, and reported that they do not have a problem getting them to come in when needed....” OMI’s Report of Investigation On-Call Physicians at Wilkes-Barre VA Medical Center, pp. 2, 10.


¹² February 10, 2014, Letter from Carolyn Lerner regarding Dr. Tomasco
VA, and OMI in most cases, to recognize and address the impact on the health and safety of veterans.\textsuperscript{13}

As of July 8, the OSC had 67 active investigations into retaliation complaints from VA employees from 45 facilities in 28 states. About 30 of those investigations had passed the initial review stage and were in the OSC’s investigation and prosecution unit, Lerner said in testimony to Congress.\textsuperscript{14} In a recent letter, Lerner wrote: “I remain concerned about the Department’s willingness to acknowledge and address the impact these problems may have on the health and safety of veterans.”\textsuperscript{15}

**First Essential Steps Towards Solving the VA’s Problems**

Although former VA Secretary Shinseki resigned shortly after the media began reporting these issues in May, his exit will not solve the VA’s problems. Indeed, even your statement saying retaliation against any employee would not be tolerated will not be enough.

POGO recommends that you and the new Secretary take concrete steps to demonstrate an agency-wide commitment to changing this culture of fear, bullying, and retaliation. First, the VA and its Office of Inspector General must both complete the OSC’s certification program. Now mandated by the second Open Government National Action Plan, the OSC certifies agencies that take five relatively simple steps to educate their employees and managers about whistleblower rights and protections.\textsuperscript{16} The OSC can offer insights into whistleblower best practices and even provide training for employees and managers.

Just as importantly, you and the new Secretary need to make a concrete and meaningful gesture to support those whistleblowers who have been trying to fix the VA from the inside. POGO recommends that once the OSC has identified meritorious cases, you both personally meet with those whistleblowers and elevate their status from villain to hero. These employees should be publicly celebrated for their courage, and should receive positive recognition in their personnel files, including possibly receiving the types of bonuses that have been provided to wrongdoers in the past. Retaliation against whistleblowers is already a prohibited personnel practice, but it will be up to the senior-most VA leadership to ensure that this rule is enforced by the agency. This should not be an isolated event done in response to recent criticisms but an ongoing effort. Whistleblowing must be encouraged and celebrated or wrongdoing will continue.

Lastly, where the evidence warrants, the wrongdoers—whether those who retaliated against whistleblowers or those who engaged in the practices raised in the whistleblowing—should be


\textsuperscript{14} Testimony of Carolyn Lerner, Special Counsel, before the House Committee on Veterans’ Affairs, on VA Whistleblowers, July 8, 2014. https://veterans.house.gov/witness-testimony/the-honorable-carolyn-lerner (Downloaded July 17, 2014)

\textsuperscript{15} June 23, 2014, Letter from Carolyn Lerner about VA Deficiencies

\textsuperscript{16} Office of Special Counsel, “Outreach and Training: Overview of OSC’s 2302(c) Certification Program.” https://www.osc.gov/Pages/Outreach-2302Cert.aspx (Downloaded July 16, 2014)
held accountable and not simply transferred—or even promoted, as we have repeatedly seen done.

The Project On Government Oversight and Iraq and Afghanistan Veterans of America would like to meet with you at your earliest convenience, and with the new Secretary if he or she has been appointed at the time of the meeting, to discuss these recommendations in detail.

Sincerely,

Danielle Brian  
Executive Director

cc:  Department of Veterans Affairs Office of the Inspector General  
Members of the House Committee on Veterans Affairs  
Members of the Senate Committee on Veterans Affairs