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Dirty and Dangerous Conditions at VA Medical Center in Mississippi

By Captain Samuel F. Wright, JAGC, USN (Ret.)

9.0--Miscellaneous

The United States Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency, created by the Civil Service Reform Act of 1978. OSC also has authority under the Whistleblower Protection Act and the Uniformed Services Employment and Reemployment Rights Act. OSC's primary mission is to safeguard the merit system by protecting federal employees and applicants from prohibited personnel practices, especially reprisal for whistleblowing. OSC's Disclosure Unit serves as a safe channel for federal employees (whistleblowers) to make allegations of wrongdoing within Executive Branch agencies.

The Special Counsel of the United States heads OSC. The Special Counsel is appointed by the President, with Senate confirmation, for a five-year term. The Honorable Carolyn Lerner has served as Special Counsel since June 2011.

The work of OSC is of great interest to me. I worked for OSC, as an attorney, in 2007-08. In 1996-97, I served (as an active duty Navy Captain) as the Director of the Hotline Investigations Division of the Office of the Naval Inspector General.

I know that many people (especially those who are in authority in federal agencies) consider whistleblowers to be a nuisance or worse. I have exactly the opposite opinion of them. From my own military and civilian service, I am well aware that it is only through disclosures by federal insiders (military and civilian) that fraud, waste, and abuse in federal agencies can be brought to the attention of inspectors general so that these abuses can be corrected. Whistleblowers often show great courage in disregarding the risks to their own careers in order to bring to light serious abuses.

In a March 18, 2013 letter to the President and Congress, Special Counsel Carolyn Lerner raised concerns about the G.V. (Sonny) Montgomery VA Medical Center (VAMC) in Jackson, Mississippi. The letter summarizes whistleblower disclosures brought by five VAMC employees and physicians. According to Ms. Lerner, the whistleblowers' allegations met the high "substantial likelihood" standard required by OSC to refer cases to the Secretary of Veterans Affairs, who is then required by law to conduct an investigation and report the findings back to OSC. The VA has completed its investigations into the first three cases described below; the fourth and fifth cases are currently under investigation by the VA. The five cases include:

- First, in 2009, in response to a whistleblower disclosure to OSC, the VA confirmed that "dirty, rust-stained instruments" and other unsterilized medical devices were sent to VAMC clinics and operating rooms in violation of VA policy. The VA outlined a series of steps to correct longstanding problems within the VAMC Sterile Processing Department.

- Second, in 2011, a whistleblower alleged that employees continued to follow incorrect procedures in the Sterile Processing Department, placing the safety of employees and patients at risk. The VA investigated and did not substantiate the allegations. However, OSC determined that the VA's findings were unreasonable, in part because they were made without interviewing the whistleblower, who disputed much of the VA's response.

- Third, in 2011, a whistleblower disclosed that Jackson VAMC public affairs employees were told to issue false statements that mischaracterized the findings in the 2009 case involving unsterilized medical equipment. A VA investigation confirmed that the VAMC made inaccurate statements to the public and

Congress. However, the VA concluded that the inaccurate statements were not intentional because VAMC management was never informed by the VA that violations were found in 2009. OSC determined that the VA's findings were unreasonable, and the VA should have informed the VAMC about violations of agency policy.

- Fourth, in 2012, a whistleblower alleged that chronic understaffing in the Primary Care Unit threatens patient safety. Specifically, the physician alleged that narcotics are prescribed to veterans by nurse practitioners who are not legally permitted to do so. Physicians are pressured to prescribe narcotics to veterans they have not seen. Veterans are routinely scheduled for appointment times when no physician is on duty, leaving patients to arrive at unstaffed clinics, only to be turned away. Nurse practitioners operate in the facility in violation of VA rules and state licensing requirements. Moreover, inadequate physician staffing levels result in numerous fraudulently completed Medicare Home Health Certifications. On February 28, 2013, OSC referred this case to the VA Secretary for an investigation, which is pending.

- Fifth, in 2013, a whistleblower alleged that a VAMC radiologist failed to read properly thousands of radiology images, leading to missed diagnoses of serious and in some cases fatal illnesses. Court documents demonstrate that VAMC management was aware of this but did not take corrective action, including notifying the affected patients. On March 5, 2013, OSC referred this case to the VA Secretary for an investigation, which is pending.

"The VA whistleblowers raise serious questions about the ability of this facility to care for the veterans it serves," Lerner said. "We urge the VA to carefully investigate and take corrective action."