

**Testimony of Lisa M. Nee, MD
Interventional Cardiologist**

Senate Veterans Affairs Committee

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Dear Committee members, thank you for the opportunity to provide written testimony for the record in support of Senator Kirk's VA Patient Protection Act. I wish to extend my gratitude to Senator Kirk and his staff for the continued attention to the alarming matter of whistleblower retaliation and for moving forward with this important legislation. Although there is significant rhetoric from various branches of government that this type of behavior is detrimental to the care of the veteran, there seems to be no end in sight for those who continue to face retribution for taking the courageous step of coming forward. A September 2015 report from the Committee on Homeland Security and Governmental Affairs stated the Office of Special Counsel has received 35% of its entire retaliation caseload from VA employees. Despite its efforts to prioritize investigations, Special Counsel Carolyn Lerner testified before Congress in August of this year that the volume of incoming VA complaints remains overwhelming. This clearly demonstrates the severe, dysfunctional culture within the VA that encourages retaliation against the very individuals who expose harm to the veteran and attempt to improve the health care delivery process.

There are many journeys we all participate in during the course of our lifetime. Some are arduous, many are attainable, but none has been more agonizing and unfulfilling than the current process of obtaining justice for the men and women who have fought for our freedom. I realize that not every complex situation in life presents itself with moral clarity, however this is not one of them. Caring for our veterans should be elementary. There should never be a single instance where a physician must choose between self-preservation and the life of a patient. Or suffer an assault to their character in order to obtain accountability for criminal and inhumane acts against patients and fraudulent behavior towards the taxpayer. The amount of bureaucratic gymnastics coupled with agency corruption can render the strongest individual forlorn and exhausted. Knowing when to lose with grace is an honorable skill and one that requires precise timing- this is not that time. Armed with voracity for equity, an insatiable appetite for the truth and a colossal amount of evidence, I am prepared to continue this battle until there is responsibility from leadership and transformative action which will hold those at fault accountable.

My personal journey began over 4 and half years ago with exposure to the corruption at Hines VAMC regarding patients who died of cardiac complications while awaiting their cardiac ultrasound to be read. Unfortunately for them the tests were hidden in bankers boxes and left unread for a year. The mere questioning of such an egregious act resulted in significant retaliation, which went unabated the entire two years I was employed at Hines. But hell hath no fury like a VA administration scorned, and the retaliation

continued even after I resigned, with the Office of Inspector General (OIG) and its pervasive culture of disparaging the truth teller. Multiple allegations regarding deficiencies in cardiovascular care were made including, but not limited to: patient's having their chest sawed open for unnecessary procedures, disparities in care based on ethnicity, procedural diagnostic errors resulting in harm and pervasive billing fraud. These allegations have resulted in an initial deficient OIG investigation, a subsequent OSC investigation, a second contemptible OIG investigation, insistence from the OSC for an authentic and thorough investigation, and culminating with an ongoing Office of Medical Inspector's (OMI) investigation. It is a mind numbing process to not only keep track of the endless agency acronyms, but also calculating the amount of wasted taxpayer dollars consumed by these ineffectual inquiries. They are not true investigations for they lack experienced subject matter experts and have a pre-determined conclusion, which maintains the status quo.

The path this case has taken over the last four years has been objectively obfuscated, and its bureaucratic oscillations can only be the result of stunning deficiencies at all levels of the VHA leadership. The task has become the exercise within itself. To engage in multiple investigations by varying internal agencies which have substantiated patient harm as well as criminal activity, and to never mention one, single word regarding accountability- one can only conclude this maladjusted behavior is designed to serve the agency itself, and not the veterans. It is the VHA leadership attempting to gain credit for oversight that the agency has failed to provide. Duplicitous. No other word describes it.

The OMI report from July 2015 substantiated some of my allegations regarding deficiencies in cardiovascular care, deficiencies in echocardiogram processing, failure to disclose deficiencies in care and harm to patients, inflated productivity measures by cardiologists and evidence that Veterans were inappropriately charged copayments for care they never received, otherwise known as billing fraud. In regards to this billing fraud, the report states, "We found that these actions possibly violate 18 US Code 208-Acts affecting a personal financial interest". The OMI referred this criminal matter to the OIG who has **declined** to open a criminal investigation.

Interestingly the bulk of the report is dedicated to the fraudulent billing practices, including in depth statistical analysis, diagrammatic explanations and extensive billing pattern documentation. This provides a glaring contrast to the lack of investigative fervor and expertise when dealing with patient morbidity and mortality. However all this effort is for naught as the end result once again allows the documented criminal activity to go unpunished. For the agency to demand an OMI investigation yet deny the credibility of criminal findings is administrative misconduct. The OIG must adhere to the Quality Standards for Investigations issued by Council of Inspector General on Integrity and Ethics (CIGIE) and the Attorney General Guidelines for OIG with Statutory Law Enforcement Authority. You don't get to be above the law just because you work for the VHA. Or do you? An equally compelling question is, if the OMI substantiated findings and then those are ignored, why do we need any of these investigative arms within the VA? They are redundant and wasteful and should be restructured.

To sum up the totality of all the reports to date is to call them a mismatch between words and deeds. A failed promise to treat and protect the veterans, while instead protecting hundreds of useless report generators who will then retire with benefits. The investigators have gone so far out of their way to protect the VHA leadership that it has rendered every investigator impotent and every investigative finding ineffectual. They are highly skilled at one part of their job, generating a paper trail designed to justify their professional existence. But they have failed at their original mission statement and severely compromised the health care of the men and women who have fought for our freedom.

In order for any type of transformative action to begin to take shape and halt systemic corruption, there must be protection for truth tellers, accountability for those who fail at their duties and transparency to illuminate both operational deficiencies but also properly analyze collected data. These are far from novel concepts and are most certainly codified in policy and procedure. Chairman Kirk's VA Patient Protection Act will demand accountability for those who retaliate against truth tellers and empower those who can begin to make a positive impact on the outcomes of patient care. Preventing retaliation in the current defective culture of the VA requires deterrents, which should be timely, formidable and indelible. This bill would properly punish VA supervisors who have been found to take retaliatory actions against whistleblowers. There can be no saving of an agency as large as the VHA if the employees operate from a constant position of fear, rather than conviction and collaboration.

An additional step towards agency accountability, which should be addressed by Congress, is extending legislative authority to the OSC in two arenas. 1. Allow the agency to embark on a criminal investigation or partner with the Department of Justice if the preponderance of evidence suggests illegal activity and 2. Grant the OSC the necessary authority to determine the corrective action and punishment once the allegations are substantiated. They have independent authority to determine if conduct constitutes a violation of law, rule, gross mismanagement and a substantial and specific danger to public health. If they can determine the crime, they should be allowed to determine the punishment.

Many people have asked me why I continue to fight for the veterans even though I have left the VA. "What can you do?" I want the American public to contemplate that question for a moment and then consider an alternative perspective, and perceive it as "What should I do?" With that, the only acceptable response would be to strive for social justice and search for the truth.

Which brings us to the truth. A glorious, unadulterated supreme reality, holding the ultimate meaning and value of existence, corroborated by evidence. It does not change over time, as it never has to rely on anybody else's interpretation. As a nation, we can achieve this goal for the genuine protectors of truth, our veterans.