

Testimony of  
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before the Senate Committee on Veterans' Affairs  
Legislative Hearing (Health and Benefits)  
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Chairman Isakson, thank you for inviting me to testify today, and thank you Senator Kirk for your continued leadership on whistleblower protections at the Department of Veterans Affairs and for introducing the Veterans Affairs Patient Protection Act. I am Liz Hempowicz, the Public Policy Associate at the Project On Government Oversight (POGO). Founded in 1981, POGO is a nonpartisan independent watchdog that champions good government reforms. POGO's investigations into corruption, misconduct, and conflicts of interest achieve a more effective, accountable, open, and ethical federal government.

**Fear and Retaliation at the Department of Veterans Affairs**

None of us would be aware of the extent of the problems at the Department of Veterans Affairs if not for whistleblowers. Early last year, whistleblowers came forward to expose that managers at the Phoenix, Arizona, VA facility were falsifying records of extensive wait times in order to get bonuses.<sup>1</sup> Quickly, news of similar wrongdoing at VA facilities began to pop up in other parts of the country. Although POGO had never investigated the operations of the VA before, we were deeply concerned about what we were seeing in these reports. Last year, POGO held a joint press conference with Iraq and Afghanistan Veterans of America asking whistleblowers within the VA to share with us their inside perspective in order to help us better understand the issues the Department was facing.

In POGO's 34-year history, we have never received as many submissions from a single agency. In little over a month, nearly 800 current and former VA employees and veterans contacted us. We received credible submissions from 35 states and the District of Columbia.<sup>2</sup> A recurring and fundamental theme became clear: VA employees across the country feared they would face repercussions if they dared to raise a dissenting voice.

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<sup>1</sup> Scott Bronstein, Drew Griffin, and Nelli Black, "Phoenix VA officials put on leave after denial of secret wait list," CNN, May 1, 2014, <http://www.cnn.com/2014/05/01/health/veterans-dying-health-care-delays/> (Downloaded July 27, 2015)

<sup>2</sup> Statement for the Record, Project On Government Oversight (POGO), for the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations Hearing on "Addressing Continued Whistleblower Retaliation Within VA," April 13, 2015. <http://www.pogo.org/our-work/testimony/2015/pogo-provides-statement-for-house-hearing-on-va-whistleblowers.html>

Based on what POGO learned from these whistleblowers, we wrote a letter to Acting VA Secretary Sloan Gibson in July last year, highlighting three specific cases of current or former employees who agreed to share details about their personal experiences of retaliation after they had raised concerns about wrongdoing.<sup>3</sup>

In California, a VA inpatient pharmacy supervisor was placed on administrative leave and ordered not to speak out after raising concerns with his supervisors about “inordinate delays” in delivering medication to patients and “refusal to comply with VHA [Veterans Health Administration] regulations.”<sup>4</sup> In one case, he said, a veteran’s epidural drip of pain control medication ran dry, and in another case, a veteran developed a high fever after he was administered a chemotherapy drug after its expiration point.

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 POGO. This action occurred after he reported to his supervisors that, in medical emergencies, physicians who were supposed to be on call were failing or refusing to report to the hospital. The Office of Special Counsel (OSC) shared his concerns, writing “[w]e have concluded that there is a substantial likelihood that the information that you provided to OSC discloses a substantial and specific danger to public health and safety.”<sup>5</sup>

In Appalachia, a former VA nurse was intimidated by management and forced out of her job after she raised concerns that patients with serious injuries were being neglected, she told POGO. In one case she was reprimanded for referring a patient to the VA’s patient advocate after weeks of being unable to arrange transportation for a medical test to determine if he was in danger of sudden death. “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. She also pointed out that there is “a culture of bullying employees....It’s just a culture of harassment that goes on if you report wrongdoing.”

That culture clearly isn’t limited to just one or two VA clinics. 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, but 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.”

This kind of fear and suppression of whistleblowers who report wrongdoing often culminates in larger problems, as the VA has been experiencing.

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<sup>3</sup> Letter from Project On Government Oversight to Sloan D. Gibson, then-Acting Secretary of the Department of Veterans Affairs, about Fear and Retaliation in the VA, July 21, 2014. <http://www.pogo.org/our-work/letters/2014/pogo-letter-to-va-secretary-about-va-employees-claims.html>

<sup>4</sup> 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.

<sup>5</sup> 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.

## **Veterans Affairs Patient Protection Act**

Current laws have failed to adequately protect whistleblowers. Shifting the VA's culture to identify and correct risks to veterans' health and well-being cannot be accomplished without legislation that codifies accountability for those who retaliate against whistleblowers. This is why legislation such as that introduced by Senator Kirk is so incredibly important. The Veterans Affairs Patient Protection Act includes many necessary improvements to how whistleblower complaints are addressed, and perhaps more importantly, how those who retaliate against whistleblowers are punished. Accountability for illegal retaliation has been missing in other pending VA legislation, and is one of the strongest aspects of Chairman Kirk's legislation.

Managers at the VA have abused their discretionary authority and chosen not to punish those who retaliate. This bill would put in place a minimum 12-day, unpaid suspension when a complaint that a supervisor has retaliated against a whistleblower is substantiated. This combination of due process and mandatory punishment for retaliators is the right way to send and enforce the message that retaliating against whistleblowers will not be tolerated. This bill also expands the definition of prohibited personnel practice to include peer reviews and retaliatory investigations—two common forms of retaliation that have not previously been prohibited.

Additionally, the misconduct committed at the VA in Phoenix has shown how important bonuses and evaluations are in motivating supervisors' behavior. We are happy to see that this bill makes how supervisors handle whistleblower complaints part of the criteria for annual reviews, and further, that bonuses will not be awarded to those employees who have been found to have retaliated against whistleblowers.

Both POGO's investigation and the work of Congress have shown that working under a supervisor or alongside a colleague on whom you have blown the whistle often prompts future retaliation or simply a hostile work environment for everyone involved. This is why it is encouraging to see that this legislation includes a provision that would give preference to a whistleblower's request to transfer to another office within the VA. This provision could make the difference between a whistleblower feeling comfortable enough to come forward or being too worried about rocking the boat to speak up.

We are also pleased to see that the Veterans Affairs Patient Protection Act requires annual training for all VA employees on prohibited personnel actions, which includes retaliating against whistleblowers as a prohibited action. Further, VA employees will receive an explanation of all the methods they can use to report wrongdoing.

### **Recommendations**

It is POGO's hope that the Veterans Affairs Patient Protection Act will ensure that whistleblowers can expose wrongdoing, confident that coming forward will not result in retaliation. This bill is a great starting place for necessary reforms in the VA; however there are a few changes that we would like to see before it becomes law, in order to make sure the bill doesn't inadvertently weaken whistleblower protections.

First, stating that whistleblowers have the ability to report wrongdoing to a direct supervisor is a good clarification, but it should not be a required step for a whistleblower complaint. We are

worried that the legislation appears to make it mandatory for whistleblowers to go to their supervisors, which would narrow their ability to report wrongdoing to less than what is currently available under the law. Most whistleblowers already try to solve problems by directly going to their supervisors. But there are many scenarios where an employee would not want to disclose concerns to his or her direct supervisor, and those are not limited to the three provided in this legislation. Therefore, we respectfully suggest that you amend this section to *allow* a whistleblower to go to his or her direct supervisor to make a protected disclosure, but not *require* them to do so.

In addition, we are concerned about the creation of a Central Whistleblower Office within the VA. While it is clear that more resources are necessary to address the influx of whistleblower complaints, we believe that this office would not be sufficiently independent to investigate whistleblower complaints. Without proper independence, we worry this office could become an internal clearinghouse that helps agency officials identify and retaliate against whistleblowers. Moreover, we worry that this lack of independence will hurt the ability to attract the necessary expert personnel and will divert resources from offices already filling that role—like the Office of Special Counsel. Our concern is that a new office would create duplication and confusion instead of streamlining the process as intended.

OSC has been working to investigate claims of retaliation and get favorable actions for many of the VA whistleblowers who have come forward. In 2014 and 2015 alone, the OSC has achieved favorable actions for 116 VA whistleblowers. But the OSC still has nearly 100 pending VA reprisal cases for disclosing concerns about patient care or safety, among the highest of any government agency, according to Special Counsel Carolyn Lerner. Therefore, POGO recommends that you consider appropriating additional funds to this agency to help with the increased workload rather than creating a new, less independent office to do largely the same thing.

Finally, we urge Congress to extend whistleblower protections to contractors and veterans who raise concerns about medical care provided by the VA. POGO's investigation found that both of these groups also fear retaliation, which prevents them from coming forward. Contractors are only currently protected under a pilot program, but need permanent statutory protections. In addition, a veteran who is receiving poor care should be able to speak to his or her patient advocate without fear of retaliation, including a reduction in the quality of health care. A veteran should not fear that they would lose access to their medications for blowing the whistle on problems they've experienced at VA hospitals or clinics. Without this reassurance, there is a disincentive to report poor care, allowing it to continue uncorrected.

The VA and Congress must work together to end the culture of fear and retaliation. Whistleblowers who report concerns that affect veteran health must be lauded, not shunned. And the law must protect them. It is POGO's hope that the Veterans Affairs Patient Protection Act will ensure that whistleblowers can step forward to expose wrongdoing, confident that it will not result in retaliation.