

WRITTEN TESTIMONY OF DR. KATHERINE L. MITCHELL

for submission to

113th HOUSE COMMITTEE ON VETERANS AFFAIRS

July 2014

Written testimony submitted 7/3/14

(Oral testimony to be presented 7/8/14)

Dedication

This written testimony is respectfully submitted in memory of my uncles:

Capt. Jay Anderson Mitchell, a good-natured, red-haired, blue-eyed, freckle-faced young Marine, husband, and father who lost his life & crew in 1967 when his helicopter shook apart over the South China Sea because the U.S. government failed to timely investigate the safety deficiencies of that aircraft type, and

Phillip V. Mitchell, a former Institute of Defense Analyses employee and Army Veteran who moved heaven & earth within the Pentagon to ground and repair the remaining faulty helicopters in the days that followed Uncle Jay's death so other young Marines would have a chance of returning home alive to their families.

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SECTION I: Introduction & Background

My name is Dr. Katherine Mitchell. I am an internist who is fellowship trained in geriatrics. My various positions caring for the Phoenix VA Veteran population have given me a great sense of personal pride during my 5 years as a registered nurse on the hospital wards, my 9.5 years as a physician within the Emergency Department, and my 1.5 years as medical director of the Post Deployment Clinic.

I greatly admire my fellow VA employees, past and present, who have spent years trying to meet the VA mission despite facility politics, low pay, lack of resources, and the barrage of negative publicity that often overshadows the vast amounts of amazing care we have provided to countless Veterans through millions of high quality patient encounters.

Like other Phoenix VA employees, I have diligently worked within the system to identify and resolve numerous care issues and system deficiencies slowing the provision of care to Veterans. I have rewritten policies, served on committees, developed action plans, participated in Lean Teams, and composed endless e-mails in the pursuit of better care. Along with a huge number of other VA personnel, I have spent untold hours each pay period trying to meet work responsibilities which cannot be humanly completed within the space of the designated 40 hour workweek.

It is a great honor and pleasure to work with the many experienced VA employees who, though they could find private sector jobs with better working conditions, remain dedicated to providing and enhancing the quality of Veteran health care. Their combined expertise is vital to advancing the future of the Department of Veterans Affairs.

It is imperative for us to join together and address the long-standing series of crises within our VA that are currently threatening the viability of our institution and undermining its ability to meet and exceed our obligations to the nation's current and future Veterans.

SECTION II: Executive Summary

In the last 75 years, the VA institutional culture has descended into a breeding ground for horizontal violence within the workplace. While overt acts of physical aggression are extreme examples, VA horizontal workplace violence includes, but is not limited to, open ridicule, shouting, failure to promote for merit, inappropriate down-grading of proficiencies, unfair distribution of workload, political back-biting, and formation of, as well as exclusion from, influential workplace cliques.

Such horizontal violence has propagated in response to high stress levels, unequal distribution of power, disparate advancement opportunities, and unreasonable performance expectations. The destructive phenomenon of this internal violence has greatly eroded the quality of patient care throughout the VA system to the point that the VA has been unable to fulfill its mission to “care for him who has borne the battle...” for hundreds of thousands of Veterans.

In unscrupulous VA health care administrators’ hands, horizontal violence has been wielded as a specific tool to advance the administrators’ personal and financial goals to the detriment of quality Veteran care and system efficiency. By directly propagating horizontal violence or by ignoring the presence of it among employee ranks, VA administration has betrayed the VA core values of integrity, commitment, advocacy, respect, and excellence.

As a 16 year Phoenix VA employee who has routinely advocated for patient care improvements, I have been the recipient of horizontal violence at my facility for years. I have personally witnessed the devastating consequences such horizontal violence has wreaked on the quality of patient care within the Emergency Department.

The purpose of this written testimony is to clearly describe the details of those experiences and provide a description of administrators’ tactics of retaliation against others within the Phoenix VA Medical Center and elsewhere at sister facilities.

Although improvements in overall care have propelled the Phoenix VA to a level of care significantly greater than what I observed in 1989 when I first jointed the facility, regretfully there has been no significant change in the dysfunctional institutional culture of the Phoenix VA Medical Center. Employees today still risk backlash for bringing up patient care problems, identifying misuse of facility resources, and questioning the presence of prohibited personnel practices.

Quite simply, a problem isn’t allowed to exist within the Phoenix VA care system unless senior administrators officially allow it to be recognized. No matter how critical the issue is to patient care or safety, senior officials will deliberately avoid the problem by covering up any evidence of deficiency. This routinely is accomplished by ignoring legitimate requests for resources, manipulating statistics, hiding objective reports critical of the local VA’s operations, and providing misleading information to outside official inquiries. Most pointedly, certain employees systematically intimidate any fellow employee who dares advocate for Veterans in a manner inconsistent with the Phoenix VA administration’s party line.

Ethics have never been made an official VA performance measure, and thus do not appear to be a clear administrative goal. There seems to be no perceived financial advantage to pursuing ethical conduct. Administrative repercussions are lacking for unethical behaviors that are so routinely practiced among senior executive service employees. Unfortunately, Phoenix administration has had a financial incentive to artificially maintain a positive public image using retaliation tactics even if such a facade comes at the expense of quality patient care provision and the inability to attract and/or retain quality employees.

The most serious retaliation against me occurred during my last 3 years as the sole ER medical co-director. During that time, our ER remained greatly understaffed in terms of nurses, physicians, and ancillary employees. New graduate nurses were filling in for seasoned triage nurses. There were insufficient personnel to wash beds, answer phones, transport patients or labs, and perform other tasks. The ER physicians and nursing staff continually were pulled away from direct patient care to absorb those extra duties in order to keep the ER flowing.

As the number of patient ER visits greatly increased beginning in 2010, deficiencies in our ability to meet high standards of health care became readily apparent. In our tiny 8-room ER, even the most experienced triage nurses could not have kept up with the dangerous flood of patients diluting triage time. The number of actual or potential misses in nursing triage skyrocketed. Internal head bleeding, strokes, heart attacks, pneumonias, and dehydration were examples of cases missed by either inexperienced triage nurses or seasoned nurses overwhelmed by the glut of patients engulfing the ER.

Without targeting any nurse, I began reporting actual or potential misses to the nursing chain of command. As backlash from a few nurses became evident, I had to ask all physicians to give me their cases to report. I knew I had to be the only backlash target. Any large scale adversarial relationship between physicians and nurses would grind patient care to a halt during a time when we were already gasping from insufficient resources.

After reporting hundreds of cases, eventually about 20% of the ER nurses actively began to impede care of my own ER patients. Those nurses stopped initiating protocol orders for me, providing me with verbal patient reports, handing me EKGs, and answering basic questions I asked.

Although my immediate supervisor provided support to the degree the VA culture allowed, senior executives chose not to intervene to stop or investigate the horizontal violence against me. I was accused of poor communication skills. I was banned from submitting cases to the risk manager. I worked 2 years of unlimited scheduled shifts without compensation in order to keep my position as medical co-director and provide even bare bones physician staffing. My yearly proficiencies dropped. I was subjected to verbal abuse from senior executives. Human Resources failed to expedite requests for physician hiring. Eventually I would be involuntarily transferred to a medical director position in a defunct medical clinic without receiving a valid reason for such a transfer.

Staffing was increased after I was removed from the ER. Additional resources were provided including additional patient rooms. Triage was expanded. However, the intense, recurring nurse triage training for which I advocated would never be instituted.

With few avenues for change left open to me, in 2013 I submitted a 30+ page confidential OIG report through my senator's office outlining a variety of patient safety concerns & facility deficiencies. I was subsequently placed on administrative leave for a month, investigated for improper conduct, and eventually received a written counseling for violating a patient privacy policy which the Phoenix HR department still declines to name.

I remain very concerned for the future of our Veterans and the Phoenix VAMC.

The Veterans who present in Arizona for VA care have survived campaigns like D-Day, Iwo Jima, Heartbreak Ridge, Pork Chop Hill, Chosin Reservoir, Inchon Landing, multiple Tet Offensives and Counter-Offensives, Desert Storm, Kosovo, Croatia, Ethiopia, the Battle of Fallujah, and dismal years in Helmand Province. It is a bitter irony that our VA cannot guarantee their high quality health care and safety inside our medical facility in the middle of cosmopolitan Phoenix. This tragedy is no doubt mirrored in other VA facilities across the country.

This country's founding fathers organized government into 3 branches so that no one department would possess the majority of power. Eventually cabinets and departments would be created to help fulfill the obligations of the federal government to its citizens. President Lincoln conceived the VA mission eloquently as "to care for him who have born the battle and his widow and his orphan". Sometime in the last 75 years, the Department of the VA has evolved into a powerful, narcissistic, unethical bureaucracy which at times openly defies the laws of the land including federal employment law, flouts congressional authority by ignoring requests for information, and jeopardizes the health of Veterans by statistical indiscretions.

There must be swift congressional bipartisan effort to address the gross misconduct within the VA. Congress must ensure those unscrupulous administrators who ignored ethical standards and sacrificed patient well-being for financial gain or personal prestige face consequences for unethical and/or illegal behaviors. In addition, steps must be taken to protect those employees truly devoted to patient care who found themselves in the untenable position of following orders or risk losing their livelihoods and their ability to provide any services to Veterans within the system.

With proper reforms, the horizontal violence within the VA can be stopped. VA employees will then be free to voice concerns without fear of retaliation. It is only with the combined efforts and voices of our current dedicated VA employees that the Department of Veterans Affairs will be able to evolve from a bureaucratic institution today into a dynamic health care model for tomorrow.

Most importantly, in this process, the ability to positively influence patient care & safety should not be misconstrued as being a specific Democratic or Republican platform, a pro-union or anti-union choice, or even a uniquely American problem. The ability to freely advocate for the health and safety of any patient is a human issue with ethical implications for all societies

SECTION III

Phoenix VA Administrative Retaliation: Personal Experiences and Clinical Implications

NOTE: Because whistle-blowing retaliation in my facility is currently being investigated, I cannot include the names of the employees or the specific documents to which I refer. These omissions are necessary to maintain the integrity of the whistle-blower investigation and also prevent potential retaliation against my co-workers.

In the last 75 years, the VA institutional culture has descended into a breeding ground for horizontal violence within the workplace. While overt acts of physical aggression are extreme examples, VA horizontal workplace violence includes, but is not limited to, open ridicule, failure to promote for merit, inappropriate down-grading of proficiencies, unfair distribution of workload, dangerous work hour requirements, political back-biting, and formation of, as well as exclusion from, influential workplace cliques. Such horizontal violence has propagated in response to high stress levels, unequal distribution of power, disparate advancement opportunities, and unreasonable performance expectations.

In unscrupulous VA health care administrators' hands, horizontal violence has been wielded as a specific tool to advance the administrators' personal and financial goals to the detriment of quality Veteran care and VA efficiency. Horizontal violence is commonly used by many supervisors to ensure compliance with their personal agendas which are disconnected from the mission and stated values of the Department of Veterans Affairs. Administrators' retaliatory tactics essentially debase employees and suppress any identification of system deficiencies that would make the administration look unfavorable if the deficiency was openly identified.

As a 16 year Phoenix VA employee, I have seen what happens to personnel who advocate for patient safety and welfare in a manner that challenges the administrative status quo. The devastation of the individual's career is usually the end result and likely is the only transparent process that exists within the Phoenix VA Medical Center today.

During the last 3 years that I served as the sole medical co-director of the Phoenix VA Emergency Department, I routinely suffered negative workplace consequences for persistently reporting issues related to drastically inadequate staffing, lack of sufficient training, and lack of ancillary resources. After I was involuntarily transferred to the Post-Deployment medical director position in December 2012, the administration's retaliation tactics against me persisted into 2014.

Because I am a practicing physician, such retaliation greatly impeded my ability to provide high quality care for patients presenting to the ER and crippled my ability to serve as an advocate for patient health and safety throughout the VA system. The following details some instances of administrative retaliation toward me during the timeframe from 2009-2014 and the consequences to patient care.

1. Phoenix VA ER background.

I was a Phoenix VA emergency department staff physician from 2003 to approximately 2006 and then promoted to medical co-director of the ER from 2006 - 2009. After administration failed to fill the co-director position when my fellow co-director resigned to attend fellowship training, I remained as the sole co-director from 2009 - 12/10/12. Because the co-director position was never filled, I was referred to as the ER medical director by default even though the position was technically designated for two medical co-directors.

2. Despite spending 3 years repeatedly alerting senior administration to the dangerous clinical situations in the Phoenix VA Emergency Department, my concerns were ignored repeatedly by Phoenix senior administration.

Since 2009, I had been very vocal about the escalating danger to patient care in the ER because of physician shortages, nurse short-staffing, and lack of formal training for triage nurses. As a matter of habit, I notified the nursing chain of command with concerns as well as communicated the issues to staff in the physician chain of command.

When reporting morbidity (illness) and mortality (death) related to lack of quality triage, I never targeted a specific nurse. Instead, cases were used to emphasize the need for formal, ongoing nursing triage training as well as additional nursing staff.

From 2010 to 2011, I was involved in two “lean teams” (system redesign teams) to exam ER process issues affecting the quality and efficiency of the Emergency Department. Both teams concluded that the influx of new resources including additional manpower and formal nurse triage training were necessary to help resolve care issues and correct serious flow inefficiencies.

Unfortunately, although the Phoenix VA administration did make some changes in availability of ancillary/non-medical staff, senior administration did not directly address those poor quality triage issues nor quickly resolve the ER nursing/physician shortage. Although a few nurses were sent for formal triage training in early 2012, there was never any comprehensive nurse triage training implemented despite repeated episodes of the same nursing triage patient care mistakes being made.

While on paper there were some gains in ER nursing staffing, those gains were offset by the loss of extremely experienced nurses who chose to leave the ER because of the unsafe working conditions. An increase in full-time physician manpower (above 6 full time physician positions) was extremely slow in coming. The significant understaffing of physicians in the Phoenix ER was not corrected until early 2013

Although senior officials may contend the Emergency Severity Index (ESI) was the “standard training” required for nursing triage training, ESI is only a classification system based on ER resources used. It is not a nursing-based assessment of potential complaints presenting to the

Emergency Department. It does not teach nurses how to stratify potential symptoms to determine the patient's proper level of acuity (severity of health impairment).

Senior Phoenix VA administration has claimed the quality of nursing triage has significantly improved since 2012 after hiring of experienced triage nurses from the community. However, VA staff members continue to tell me anecdotally the triage process is still extremely variable. This variability increases the risk of mistakes and near-misses in ER triage.

During the years I was in the ER, there were countless instances when the lives of Veterans were needlessly placed in jeopardy because of Phoenix VA administration's lack of response to clearly identified deficiencies within the ER including lack of sufficient triage training and resources. The following cases are a few examples when appropriate care was not expedited for Veterans:

- a) A patient with homicidal thoughts and potential gastrointestinal bleeding was put in a room for 49 minutes with no report given to a physician. A patient like this is at risk for extreme violence as well as severe blood loss.
- b) Two patients were discovered to have bleeding inside their heads after sitting in the lobby for several hours. They had to be transferred out immediately for stat neurosurgery.
- c) An elderly patient with an elevated pulse rate of 119, nausea/vomiting, and abdominal pain was deemed stable for the lobby even though his presentation indicated severe illness.
- d) A patient on a blood thinner who reported dark red blood in stool was deemed stable for the lobby. This patient was potentially at risk for severe blood loss.
- e) An obviously ill, immunosuppressed patient was neglected for 5 hours before report was given to a physician.
- f) A patient with possible heart attack had no mandatory protocol orders initiated by nursing staff.
- g) No protocol lab orders initiated for an immunosuppressed patient on a blood thinner who had fallen and reported feeling lightheaded and weak.
- h) A diabetic patient with a fast heart rate of 110 who was breathing rapidly was placed in the lobby instead of being brought to the attention of the physician on duty.
- i) A patient with low blood pressure and a heart rate of 130 at rest was left to wait in the lobby for 10 hours before a physician was notified. This patient was very ill.

3. I was verbally banned from submitting cases to the Risk Manager/Patient Safety Office by a former Senior Executive Service administrator and well as by others who remain at the Phoenix VAMC.

Frustrated by the nursing service's inability to stem the issues related to nursing triage and understaffing, I submitted several concerning cases to the Risk Management department in 2011. When I checked on the status of those cases, I was informed that the cases would not be investigated. I learned the department had been told by Phoenix senior executives not to investigate my cases nor accept any future cases from me. This is contrary to both local and national VA policies which were designed to identify and address potential health and safety issues through the use of risk management reviews.

4. In 2011 & 2012 I was forced to work unlimited scheduled shifts to prevent job loss and to provide at least minimal physician staffing coverage in the ER.

When jobs were offered to ER physician candidates, Human Resources was so slow at credentialing them that those ER physicians eventually obtained employment elsewhere. Phoenix VA administrators then developed a plan to compensate for the VA's unsuccessful attempts at ER physician recruiting efforts. This plan involved having salaried ER physicians work without compensation to fill any open, scheduled shifts.

To remain a salaried medical co-director, I was informed I would have to work all scheduled, unfilled shifts myself or convince my colleagues to work the shifts without compensation. I believed forcing ER physicians to work additional scheduled shifts was not safe or ethical unless there was a facility-wide emergency declared. I stated I legally couldn't schedule any physicians for more than 80 hours per 2 week pay period. In response, I was informed that the Human Resources department had investigated and determined current physician contracts allowed the unlimited scheduling of any physician.

I had no choice but to work open unlimited shifts in order to keep my position and provide at least minimum physician staffing coverage in the ER. I knew if I refused to work those open shifts, my work environment would become more hostile from senior management. I hoped HR would expedite ER physician hiring as I was promised it would during that meeting.

Unfortunately, HR never expedited the recruitment or hiring of additional ER physicians until late 2012/early 2013. Because I worked so many open shifts, the amount spent on fee basis (hourly) ER physicians in 2011 and 2012 significantly dropped prior to hiring any full-time physicians. At one point, I was physically present working various hours in the ER for 18+ days in a row to cover open shifts/short staffing. The physical and emotional strain on me was tremendous. Although administration seemed indifferent to the consequences of forced excessive work hours, I knew being forced to work abnormally long workweeks greatly increased the risk of patient care mistakes.

5. I was ordered to cut fee basis (hourly) physicians even though insufficient ER physician staffing still existed and open shifts were covered only when I worked excessive hours.

I was informed a senior administrator refused to approve any additional fee basis physicians until I cut the number of fee basis physicians. I was forced to fire several fee-basis (hourly wage) physicians who couldn't commit to the number of monthly shifts the senior administration was requiring. After cutting those fee basis physicians, additional approvals/hires for more fee basis physicians did not come/were not processed in a timely manner by HR. Thus I was forced to work even more hours above my scheduled workweek.

In my opinion, I believe this was a deliberate attempt by senior executive service members to make my working conditions so intolerable that I would choose to resign.

6. Because senior administrators ignored the growing problem in the Phoenix ER, short staffing and inadequate quality triage became routine within the ER in 2011 and 2012.

The quality of triage in general was extremely inconsistent depending up on the skill set of the triage nurse assigned and the number of patients presenting for triage.

At one point, I identified 3 full-time nurses who were considered extremely unreliable triage nurses by all full-time staff because of the inappropriate triaging of seriously ill patients and the frequency of mistakes made by those nurses on all shifts. However, I was told nursing staffing in the ER was too short-staffed to prevent the inexperienced and/or inadequately trained nurses from being placed in triage.

One of these nurses actually sent a seriously ill patient to the Eligibility Clinic instead of performing triage because the patient had never been registered at the Phoenix VA before. Triaging of the patient's problem should always be done before any patient is diverted away from the ER.

New grads were allowed to do triage only after a very short period of triage training. Some of them were even trained by nursing staff who previously had demonstrated inadequate triage nursing skills.

The Phoenix ER patient flow rapidly increased and the inexperienced nurses could not keep up nor were they given sufficient time to be mentored in triage. By late 2011 and early 2012 the triage mistakes or near misses were so prevalent it was impossible for the physicians to monitor all the misses/mistakes on an hourly basis.

Although senior administrators may state that the ER usually met the minimum requirements for nursing staffing, in truth many times the "ER nurses" were float nurses from other parts of the hospital with no ER experience or specialty training. In addition, the minimum nursing staffing was inadequate because it didn't allow an increase based on the sheer number of patients presenting for triage nor make adjustments for the high acuity of patients presenting.

Phoenix senior administration declined to institute formal nursing triage training on a recurrent basis even when the lack of nursing knowledge contributed to significant morbidity and some instances of mortality.

7. Despite my well-articulated concerns regarding the number of nursing triage mistakes and the difficulty physicians would have addressing those mistakes quickly without paper print-outs of triage notes, Phoenix senior officials ordered the cessation of all paper-based triage note print-outs.

The VA goal nationally was to move away from paper-based processing of triage notes.

However, I felt this move could not be done safely at the Phoenix VA in 2011. I repeatedly explained in meetings that the majority of triage nursing notes as of 6/2011 were still inadequate with significant concerns regarding the quality of triage. Paper based print-outs allowed the physicians on duty to rapidly determine if there were serious symptoms/vital signs documented within the note that the triage nurse did not realize indicated seriously ill/potentially unstable patients. I opposed the loss of backup printed triage nurse notes because it meant the physician on duty could not quickly monitor the triage notes/vital signs/patient complaints to reassign the patient's acuity level to the proper category.

The need for close physician monitoring was quite evident based on the admission data present during that timeframe. There continued to be a high number of patients who were inappropriately designated as low-acuity (indicating non-urgent condition) in triage. These Veterans were actually high-acuity and were subsequently admitted to the hospital.

Multiple ER physicians reported to me that nursing triage quality was extremely unreliable. I repeatedly communicated those concerns to both the nursing chain of command and my physician chain of command. Senior executives still did not respond.

8. I was exposed to ongoing extremely hostile working conditions in the ER from a small percentage of nursing staff whom senior administration refused to investigate.

Beginning in approximately 2010, I became more vocal regarding the need for nurse triage training and the understaffing of triage. Shortly thereafter, a few nurses began intermittently ignoring my orders, not answering my questions in the nurses' station, not giving me verbal reports on patients, and not expediting the discharge of my patients. As a result, I asked that all ED physicians direct any concerns regarding nursing triage outcomes to me for submission in order to avoid having other physicians be the recipient of nursing backlash which could grind patient care to a halt in the ER.

By late 2011, approximately 20% of nurses were consistently ignoring my orders, failing to give me verbal report on patients, declining to notify me of ekgs, and refusing to initiate protocol orders for serious complaints like as chest pain in my patients. Patient assignments would be changed to my name in the computer without telling me. Those nurses were intermittently verbally aggressive toward me when I was in the ER nurses' station.

From 2011-2012, the aggressiveness towards me from those few nurses was so open that it was frequently observed by fee basis ER physicians, full-time ER physicians, other nursing staff, front desk staff, Phoenix VA police officers, and even housekeepers.

Although I communicated my concerns through the nursing chain of command, there was no significant change in the level of hostile work environment for me. I was told by the nursing chain of command that the nursing department could not stop such behavior.

When I spoke to my physician chain of command, senior administration refused to intervene on my behalf. I was told not create any problems for nursing staff which I believed included not completing formal write-ups.

9. By late February 2012, ER conditions were so dangerous that I told the on-coming medical center director, Ms. Helman, the ER should be shut down completely unless additional staffing, resources, and triage nurse training were provided.

I mentioned the multiple actual negative outcomes and potential near-misses that had been ignored by prior administrators for several years. I cited both acute and long-term short staffing shortages in the ER. I told her the last 3 days had been so dangerous for patient care that I believed the ER should be completely shut down unless there was an immediate influx of resources.

I reported conditions had been dangerous during the prior 3 days for a variety of reasons including nurses unable to write orders during shift because the current nursing protocols could not be found within the facility, extremely high flow of patient walk-ins, inadequate availability of nursing staffing, multiple instances of poor quality of nursing triage, inadequate physician staffing, and lack of ancillary services. I stated current policy for nursing order protocols was not available despite 2 months of me asking for the protocols to be located.

10. After reporting to Ms. Helman the dangerous conditions in the ED at the end of February 2012, I was subsequently told by senior administrators that the only problem in the ER was my lack of communication skills.

Within 1.5 weeks of telling Ms. Helman that the ER was grossly unsafe, I was called into a meeting with senior executives and told the only problem in the ER was my lack of communication skills.

After emphatically stating the issue was not my communication skills, I gave the group a stack of 20+ cases of actual patients with negative outcomes related to triage. I also provided additional cases for the senior executives to review after the meeting.

11. After I reported the dangerous conditions in the ER and discussing staffing shortages, no action was taken by senior executives for another 5-6+ weeks.

Despite my statements describing life-threatening situations within the ER to S. Helman at the end of February 2012 as well as my description of dangerous ER conditions at the early March 2012 meeting where I was accused of poor communication skills, no formal action or investigation was taken by the senior executives at the Phoenix VA to investigate or address the grave concerns I had verbalized.

I sent additional emails to administration emphasizing the dire conditions within the ER. In my April 2012 email to my physician chain of command I wrote "...I continue to be extremely concerned about the safety of our veterans who are presenting to the ED (Emergency Department) for care when the ED is saturated. Based on the events of [omitted] & [omitted] as well as numerous events over the last 24 months that have been reported on ongoing basis, I believe the potential for patient mortality in our ED is incredibly high during periods of ED saturation...The number of near-misses is so high during peak flow/high acuity days that multiple occurrences of significant nosocomial morbidity & mortality are inevitable...I have tried multiple avenues to alert this facility to the issues vital to our ED & improve provision of care in the ED despite being faced with incredibly toxic circumstances & political backbiting. This facility must not delay focusing immediate resources to reduce the risk of needless suffering and loss of life in our ED..."

Unfortunately, even that email would not generate any significant response for 3+ weeks from management.

Finally, in late April 2012, my chain of command agreed to meet with ER physicians to corroborate my statements. During that meeting all the ER physicians confirmed the significant care issues, staffing shortages, and nursing backlash against me.

A formal action plan was written by senior executives to address many of the issues outlined in the meeting. However, I was informed the nursing backlash against me would not be investigated. I was also told not to cause any problems for nursing staff. I was devastated to learn senior executives were ignoring nurses who had jeopardized ER patient care. I was very fearful for my patients in the ER because I knew it would be a continual struggle for me to provide quality care for ER patients in the face of continual backlash from a small group of nurses.

There should have been an immediate internal response/action plan developed after I informed former Director Helman of the severe internal crisis state existing in the ER. Inquiring into the issues including interviewing the other ER physicians should not have been delayed for almost 2 months.

12. My care for patients remained impeded by a small group of ER nursing staff throughout 2012.

The following are a few of the many episodes when my ability to care for ER patient was impeded by a small group of nurses in 2012 while I was on duty. (None of the delays were related to short-staffing issues.)

- a) Patient with an elevated heart rate of 112 was placed alone in an exam room for 2 hours and 40 minutes before I was notified. (Such a resting heart rate can indicate significant illness requiring the patient to be seen much sooner.)
- b) Nursing staff refused to draw blood on a patient because I had put a patient in a room they didn't like. (It was the only available bed and the care needed to be expedited for the patient.)
- c) A nurse did not give me report or the ekg on a patient with recent chest pain who had a history of prior heart attack.
- d) A hypertensive patient with a bad headache was put in a room for 20 minutes without ever telling me. This delayed care for a patient with a potential hypertensive emergency.
- e) On one shift, four patients were placed in rooms without giving me any type of report.
- f) An obviously ill patient with fast heartbeat was placed in a room without giving me any type of report on the patient.
- g) A nurse refused my request to respond to telemetry alarm monitors on my patient even though the nurse was assigned to the room and was not otherwise occupied.
- h) Labs I had ordered on an ill patient were still not drawn 3 hours after I ordered them.
- i) My chest x-ray order for a patient with shortness of breath was ignored for 3 hours despite my asking the nurse twice to have it completed.
- j) A stat ekg I ordered on a patient was not done for 2.5+ hours and my other orders were delayed including orthostatic vital signs.
- k) IV fluid administration was significantly delayed because a nurse didn't want to restart a hepllock on my patient.
- l) Care was delayed when the pregnancy test and other tests I ordered were not done.

I continued to communicate my concerns to the physician and nursing chains of command without any success.

13. In December 2012, I was notified unexpectedly that I was being laterally transferred out of the ER to the Post-Deployment Clinic because of a “critical need” which management would not specify.

I was told this administratively-driven lateral transfer was necessary to meet a critical need in the Post-Deployment Clinic. However, that clinic had been a defunct medical clinic for 1.5 years prior to my transfer. It only contained a social work program working with returning combat Vets and a part-time polytrauma case manager. There was one physician assistant who performed basic registry exams for traumatic brain injury. These types of exams do not require a physician to complete.

My chain of command declined to specify the critical need in the Post-Deployment clinic that I was supposed to address. It took over a month for senior administrators to grant me clinical privileges to see any Veterans.

My transfer to the Post-Deployment Clinic left the ER critically short-staffed. At management’s request, I returned for a few shifts over the Christmas holiday to provide emergency coverage for open shifts.

Despite the circumstances of the transfer to the Post-Deployment Clinic, I eventually discovered a way to make my position an important adjunct to the OEF/OIF/OND Transition Services social work team.

14. I chose to submit a confidential OIG report to address multiple health and safety concerns within the Phoenix VA that were being ignored by administration.

In 2013, I was working on a project to reduce the risk of suicides among Veterans. Despite phenomenal attempts by the Suicide Prevention Team to work within the confines of grossly inadequate resources, the rates of suicide at the Phoenix VA increased over a very short time span. I inadvertently became aware of long-standing Phoenix VA system inadequacies that were placing our Veterans at higher risk of successful suicide completion. Senior administration’s lack of response heightened my concerns.

I decided to initiate an OIG complaint and submit it through my senator’s office. Our nation, has lost too many Veterans from all eras to suicide. While no one factor will prevent a suicide, as health care providers we are obligated to make the safety net as tight as possible in our attempt to do outreach to those who are considering taking their own lives.

When I chose to initiate the OIG complaint, I was aware of previous inadequate OIG investigations at the Phoenix VAMC and failures to maintain confidentiality of those making the complaint. I could not submit the complaint anonymously because that would have severely limited the scope of the pending OIG investigation.

I organized my complaint so it would address as many patient care and safety issues as possible. I hoped this would increase the likelihood that my OIG complaint would result in significant positive changes within the Phoenix VA.

I went to my fellow Phoenix VA employees with whom I had developed a trusted relationship and asked them to provide me with information regarding the most serious issues within the VA facility. The problems must be easily proven and be urgent enough that the issues could not wait for resolution by the normally ponderous VA process of change. It was equally important the information could not be traced back by management to my “sources”. I wanted only me to be the only target if my name was not kept confidential by the OIG. The Phoenix VA couldn’t afford to lose any more good employees if management chose to retaliate against anyone else whose name might be associated with the report.

As the result of the information collected as well as my first-hand knowledge of facility issues and overt backlash, I wrote a lengthy complaint detailing the various problems. When I presented my written OIG complaint to staff at Senator McCain’s office, the seriousness of the VA situation was evident to even those staff who had no health care background. I was informed the most serious safety issues listed in my complaint would be forwarded with a request for an expedited investigation performed by an outside OIG team to address the issues and maintain the confidentiality of my name.

Some of the issues in my complaint included disturbing system issues involving suicides, statistical manipulation of the wait list, failure to prioritize appointments according to national VA policy, and improper distribution of complex patients.

15. My confidential 2013 OIG complaint regarding multiple safety concerns within the facility resulted in overt retaliation against me.

My plan to address system deficiencies failed almost completely. My name was not kept confidential by the OIG. Shortly after the national VA acknowledged receipt of my complaint, I was placed on administrative leave for about a month and investigated for alleged wrong-doing for including truncated patient information in the confidential OIG complaint submitted through approved channels.

I was told I acted outside the scope of my duties as Post-Deployment medical director and “may have” violated privacy policy by including patient information to support my allegations regarding the disturbing suicide trends at the facility.

I eventually would receive a written counseling in January 2014 for violating privacy policy and for working outside the scope of my duties as purportedly evidenced by the content of the OIG complaint submitted for me by Senator McCain’s office. There was no information in the written counseling specifying exactly what policy I had violated or how it was concluded I was working outside the scope of my duties. I was not given access to the investigative file. Instead, I was told the investigative file had been “shredded for my protection”.

I sent a formal request outlining my concerns and requesting to have the investigative file re-created. I also asked to be informed of which patient privacy policy I violated. I subsequently was told that HR determined it did not need to respond because written counseling did not rise to the level of disciplinary action that Title 38 employees were allowed to challenge.

My senior physician chain of command did not intervene on my behalf, and thus clearly supported HR's decision. The written counseling was never rescinded even though HR declined to tell me the name of the policy I supposedly violated.

16. The 2013 OIG report of my complaint was never officially provided to me and can't be found on the OIG website. I was forwarded a brief email received by the senator's office indicating the investigative findings were benign. Of note, the investigation found no significant problems with scheduling issues.

I have never seen the official OIG report on my 2013 complaint and do not know if one exists. Senator McCain's office made attempts to locate the report for me without success. There is no indication of the investigation on an OIG website search.

I subsequently learned the OIG has complete discretion as to which reports it puts on its website. I was told anecdotally the VA OIG often doesn't list any reports which are critical to senior administrators. Recently I was sent an OIG report critical to senior administrators at another VA. That report issued in 2014 and was assigned an OIG case number. However, this report cannot be located on the OIG website and was obtained only by FOIA request.

SECTION IV:

VA Horizontal Violence: Specific Retaliation Tactics against Title 38 Health Care Providers (Physicians, Surgeons, Dentists)*

**Note: Variations of some tactics are commonly used against wage grade employees & Title 38-hybrid employees. The implications may differ (depending on the skill set) but the outcomes are similar.*

Overview Summary

A. Types of Retaliation:

1. Sham peer review.
2. Malicious down-grading of proficiencies.
3. Deliberate understaffing of Title 38 provider positions.
4. Deliberate understaffing of necessary ancillary personnel.
5. Inequitable distribution of extremely challenging patients to overburden provider.
6. Faulty clinical profile to overwhelm provider.
7. Unjustified written counseling.
8. Lateral transfer for factitious reasons.
9. Exploitation of “24/7” work contract.
10. False accusations of patient privacy violations in retaliation for whistle-blowing.
11. Unreasonable timeframes assigned for completion of nonessential training requirements or extraneous tasks.
12. Removal of teaching privileges to ostracize provider.

B. Clinical Implications (in numerical order based on retaliation type):

1. Veterans are denied the skills of talented, qualified providers who are fired due to unjustified accusations of poor medical skills.
2. Qualified candidates for direct patient care positions or supervising administrative positions are not promoted to positions where they can use their skills sets to fulfill the VA’s mission for quality health care.
3. Provision of direct patient care services is greatly slowed.
4. Direct patient care time is diminished due to additional, excessive daily tasks.
5. Punitive and dangerous system is used for managing care of complex Veterans.
6. Delays occur in necessary follow-up required for labs, studies, and consults.
7. Ineffective disciplinary system doesn’t support high quality care for Veterans.
8. Potentially dangerous health and safety problems perpetuate when advocates for quality care are removed from clinical settings.
9. The risk of patient care mistakes increases when providers are physically/mentally exhausted.

10. Malicious administrative conduct stifles the reporting of future legitimate patient care concerns and perpetuates unsafe situations.
11. Delays occur in completion of important administrative tasks related to patient care.
12. Increased potential for patient health care mistakes occur when there is loss of talented attending physicians who normally would guide students/new doctors to consistently deliver high quality medical care.

C. Professional Implications (aggregate):

In an unethical and unprofessional institutional culture, providers quickly develop high stress, low morale, and physical/mental exhaustion. Providers who advocate for patient care and safety against the local administration's status quo are isolated in their work environments, demoralized, and professionally impeded in their careers. In some cases, providers are exposed to extreme retaliation that can effectively ruin their medical careers in both the VA system and the private sector.

D. Outcomes (aggregate):

1. Administrators have extremely effective methods to ensure compliance with their personal agendas which are disconnected from the mission and stated values of the Department of Veterans Affairs.
2. The VA system is unable to effectively retain and/or recruit well-qualified providers who have been/would be effective advocates for patient health and safety.
3. Veterans are denied the highest quality, efficient medical services within the VA despite VA administration having access to a talented pool of dedicated patient care providers already employed within the system.
4. The U.S. government loses money compensating for high staff turn-over and defending administrators' inappropriate personnel decisions.
5. The horizontal violence within the VA institutional culture propagates.
6. Outcomes 1 through 5 above threaten the viability of the VA and undermine its ability to meet and exceed our obligations to the nation's current and future Veterans.

Detailed Explanation of Retaliation Tactics Against Title 38 Employees

1. Sham peer review.*

Note: In contrast to a sham peer review, a professional peer review is a formal, lengthy review done of a physician's cases by his/her peers and is initiated only when there is legitimate concern the physician may not be following medical standards of care. The outcomes are based on objective findings, not subjective opinion.

Tactic: A well-orchestrated attempt to sabotage a physician's credibility/professional reputation via organizing a sham review of cases by the administrator's associates/cronies. Even though there is no objective evidence of improper care, the predetermined written "findings" imply the physician has, at a minimum, subjective deficiencies in professional or personnel qualities. (The practice of sham peer review is not considered a prohibited personnel practice. The Office of Special Counsel doesn't accept sham peer review cases.)

Clinical implications: Veterans are denied the skills of talented, well-qualified physicians when those providers are relieved of patient care duties or fired due to unjustified accusations of poor medical skills.

Professional implications: Professionally and personally devastating to the provider. The physician has to fight the sham findings at great financial expense in civil court or via the Merit Protections Board. For the rest of his/her professional career, the physician has to report on job applications and license renewals that he or she was the subject of a peer review.

Outcome:

- a. Management can effectively and permanently sabotage a physician's ability to be gainfully employed anywhere as a physician inside or outside of the VA system.
- b. Threat of a sham peer review can effectively stifle physicians who want to voice serious concerns about patient safety.
- c. Fighting a sham peer review can financially devastate a physician who is pitted against the unlimited legal resources of the U.S. Dept. of Veterans Affairs.
- d. Patient care is delayed as yet another VA physician chooses to resign or retire instead of facing a sham peer review.

2. Maliciously down-grading proficiencies.

Tactic: Deliberately reducing the accuracy of a provider's yearly written performance evaluation on the whim of the administrator instead of completing the evaluation based on objective criteria normally used to judge accomplishments of providers.

Clinical implications: Qualified candidates for direct patient care positions or supervising administrative positions are not promoted to positions where they can use their skills sets to fulfill the VA's mission for quality health care.

Professional implications: Physicians and other providers are not allowed to expand their professional careers. If the provider decides to obtain a position at another VA or in an outside institution, the unfairly downgraded proficiencies make the provider less apt to be selected for the new position.

Outcomes:

- a. Patients are denied the benefits of having the most qualified personnel in supervisory/other positions who would normally work toward efficient/high quality care.
- b. Management has a direct/efficient method of sabotaging the professional reputation of a provider who verbalizes concerns about patient safety, fiscal irresponsibility, or prohibited personnel practices.
- c. Management saves money on bonuses associated with providers who earn "outstanding" ratings on yearly proficiencies.
- d. Management wields significant power to create compliance with administrative edicts by granting monetary awards to providers based on whim instead of merit.
- e. Rank and file staff member burn-out.
- f. Impedance of a provider's ability to be employed in the private sector or at another VA.

3. Deliberate understaffing of provider/Title 38 provider positions.

Tactic: Vacancies or identified needs for staffing increases are ignored by administrators so that remaining Title 38 employees have to manage ever-increasing patient loads.

Clinical implications: Provision of direct patient care services is greatly slowed. Providers are routinely managing complex patient loads that are 10% -50% above the VA's predetermined safe levels for provider patient panels. The risk of overlooking key patient needs is very high. There is often slowed clinical response to mountains of patient requests flooding provider's clinic.

Professional implications: Providers frequently worry about meeting the complex needs of huge patient panels that outstrip the available resources. Providers are also penalized on their yearly performance appraisals because they can't keep up with the unwieldy patient flow.*

**Note: Unlike wage-grade, non-supervisory positions, Title 38 employees can be penalized on performance appraisals even if deficiencies in care are directly related to chronic understaffing/excessive patient workloads.*

Outcomes:

- a. Patient appointments/consults are difficult to schedule because the provider is booked so far into the future.
- b. Delays in patient care and interpretation/communication of testing results/future needs.
- c. Senior administrators save money/reap potential bonuses for avoiding salary expenditures.
- d. Rank and file staff member burn-out as workweeks extend far beyond 50-60 hours and their yearly proficiencies drop despite every attempt by the provider to meet the needs of the vast patient load.

4. Deliberate understaffing/failing to post positions for necessary ancillary personnel.

Tactic: Vacancies or identified staffing needs are unanswered by managers so that basic clerical/ancillary functions of clinic are not addressed.

Clinical implications: Direct patient care time is diminished due to additional, excessive daily tasks. Providers have to absorb those tasks in order to keep the clinic running. This pulls providers away from direct patient care time.

Professional implications: Providers have their administrative & clinical time stretched so incredibly thin that they are often unable to fully meet the needs of their patients during any given day. Providers have to use off-duty time to meet their ethical and medical obligations to patients. They are also faulted for failing to meet clinical requirements or performance measurements in a timely fashion.

Outcomes:

- a. Provision of direct patient care is slowed.
- b. Patient frustration because they don't understand why phones aren't answered, lab results aren't timely communicated, and messages aren't returned promptly.

- c. Management can reap bonuses for keeping labor costs low by avoiding the salary expenditures for hiring/replacing basic staff members.
- d. Management is able to wring more time out of salaried rank and file employees.
- e. Rank and file staff member burn-out as workweeks extend far beyond 50 hours and impossible standards of achievement are mandated.

5. Inequitable distribution of extremely complex patients to overburden provider.

Tactic: Extremely complex patients are “dumped” onto a provider’s panel en masse without allowing the provider additional clinical time to address the patient needs at each visit. These patients are time-consuming in terms of physical/clinical interactions needed to address multiple physical problems and approach the psychological issues inherent to the patient’s ability to engage in the health care process.

Clinical implications: Punitive and dangerous system used for managing care of complex Veterans. The provider is chronically “running behind” in clinic trying to meet the pertinent needs of each Veteran within an appointment timeframe that is too short for such a complex patient.

Professional implications: Although the provider tries to give quality patient care to each Veteran, the provider is penalized on proficiencies and in meetings for “taking too long” with his/her patients despite the complexity of the patients. The provider is rated negatively by administrators because the provider cannot process the complex panel of patients as fast as fellow providers who have lighter/less complex patient panels.

Outcomes:

- a. Management easily creates burdensome working conditions to harass staff member.
- b. Managers who have patient panels quickly can reduce their own work load/improve their own efficiency ratings by dumping complex patients onto other provider panels.
- c. Patient frustration because his/her assigned provider is chronically late starting appointments or only has time to deal with 1-2 active problems during the appointment.
- d. A greater number of patients can be neglected when provider time is routinely monopolized by fewer but much more complex patients.
- e. Rank and file staff member burn-out.

6. Faulty clinical profile to overwhelm provider.

Tactic: Providers are given inadequate administrative time to follow-up on electronic alerts* and other administrative tasks. The clinic appointment time is reduced to a bare minimum in order to give the appearance of adequate provider staffing in the entire clinic.

**Note: Electronic alerts are computer notifications of various information of which the provider must be aware. Examples of electronic alerts include requests to co-sign chart notes or the receipt of results from labs, radiology studies, consults, or pharmacy actions. Although some alerts can be cleared in seconds, other alerts can take from 5-15 minutes each because follow-up action is required. At the Phoenix VA, primary care providers average 85 electronic alerts per day.*

Clinical implications: Delays occur in necessary follow-up required for labs, studies, and consults because providers are inundated with administrative tasks.

Professional implications: Providers feel chronically overwhelmed and stressed. His or her yearly proficiency is downgraded because the provider is unfairly labeled as being “inefficient” even though the provider has been assigned tasks that no human being reasonably could meet within a 40-50 hour workweek.

Outcomes:

- a. Management is able to wring more time out of salaried employees.
- b. Management can save money on proficiency bonuses for staff by reducing the number of providers labeled as “outstanding” on yearly proficiencies.
- c. Rank and file staff member burn-out as workweeks extend far beyond 50-60 hours.

7. Unjustified written counseling.

Tactic: Written counseling is used only as a punitive stepping stone for unjustified disciplinary actions and as false justification for penalizing employee proficiencies.

Clinical implications: Ineffective disciplinary system is created which doesn't ensure high quality care for Veterans. Providers who perform appropriately are penalized unjustly. Providers who demonstrate inappropriate behaviors are not issued written counseling as long as those providers are pleasing the administrative chain of command.

Professional implications: Providers are helpless to defend themselves because written counseling doesn't rise to the level of disciplinary action that Title 38 employees are allowed to challenge.

Outcomes:

- a. Administrators have an easy tool to discipline providers without being challenged.
- b. Written counseling is never used to correct inappropriate behaviors of providers who are favored by administrators.
- c. Rank and file staff member burn-out.

8. Lateral transfer for factitious reasons.*

**Note: Lateral transfers are allowed in only 3 situations: an employee requests the change and a vacancy is open in the new workstation; an employee faces a disciplinary action and management believes a new workstation would be a better fit for the employee's skill set; or there is a true "critical need" in another area which management must meet by transferring the employee to the new location even if the employee doesn't desire the transfer. Declining a "critical need" lateral transfer can result in disciplinary action against the employee.*

Tactic: An employee is laterally transferred to a less favorable work site based on a factitious "critical need" in the new area. Often the employee will then be penalized on his/her proficiencies for not performing well in the new area.

Clinical implications: Potentially dangerous health and safety problems perpetuate when advocates for quality care are removed from clinical settings.

Professional implications: Providers become hesitant to verbalize concerns for patient health and safety in any work station.

Outcomes:

- a. Management has a powerful tool to punish employees who persistently advocate for patient care/other issues against administration's party line.
- b. Effective, dedicated professionals are essentially "moth-balled" to areas where they have less of an ability to effect positive change within the work-environment.

9. Exploitation of "24/7" work contract.*

**Note: A full-time federal Title 38 employee at one agency cannot work for another federal agency simultaneously even if the second agency's work hours fall within the federal employee's off-duty work hours from the first agency. In my limited understanding, I believe that the salaried Title 38 employee contract has been interpreted in recent years to mean the employee can only be scheduled for 80 hours per 2 week pay period even if*

the actual work day extends far longer. When a Title 38 employee's workday inadvertently lasts more than the usual timeframe, the employee does not get paid overtime or comp time. A VA Title 38 employee may be scheduled to work more than 80 hours per 2 week pay period if the VA facility director declares an emergency at the VA facility. The true interpretation/implication of the 24/7 work contract needs to be officially clarified in writing by senior VA officials.

Tactic: Clinics are set up with faulty administrative time/odd hours that routinely extend the usual 8 hour/day (40 hours/workweek) to 10-12 hours per day (50-70 hours/workweek).

Clinical implications: The risk of patient care mistakes increases when providers are physically/mentally exhausted during any given workweek.

Professional implications: Even if actual mistakes are not made, providers are physically/mentally exhausted and greatly fear making a critical mistake or overlooking important health care needs of their patients.

Outcomes:

- a. Management is able to wring more time out of salaried employees.
- b. Providers are quickly burnt out as their personal/family time is steadily eroded.

10. False accusations of patient privacy violations in retaliation for whistle-blowing.

Tactic: Even though the employee uses the approved administrative channels of VA oversight, any provider who includes the necessary patient care information to support the allegations of wrong-doing is subsequently disciplined for violating patient privacy. * In extreme cases of administrator wrath, the practitioner will be reported to his/her credentialing board for privacy violations.

**Note: Disclosure of pertinent patient care information in support of whistle-blower activity through approved channels of VA oversight is not a patient privacy violation. Unfortunately, the Office of Inspector General has declined thus far to put that opinion in writing. With lengthy legal efforts, these inaccurate disciplinary actions can be overturned, but the process may take years.*

Clinical implications: Malicious administrative conduct stifles the reporting of future legitimate patient care concerns and perpetuates unsafe clinical situations. Patient care cannot rise to the high level of quality care needed by our Veterans until health and safety issues are reported and corrected.

Professional implications: Fear of retaliation can silence providers or reduce their ability to effectively advocate for patients.

Outcomes:

- a. Administrators have a powerful tool to suppress any information that may be contrary to a positive public image of the VA facility.
- b. The quality of patient care in the VA can never reach its full potential.
- c. The U.S. taxpayers foot the bill for legal wrangling between the VA who supports the disciplinary action and the Office of Special Counsel which is trying to overturn the disciplinary action.

11. Assigning unreasonable timeframes for completion of excessive training requirements/tasks to penalize the provider.

Tactic: Mandatory training requirements/task assignments, often assigned at the last minute, are required to be done within a short time frame without allowing any flexibility in administrative time. If requirements/tasks are not completed, the provider is penalized on proficiencies or in write-ups.

Clinical implications: Delays occur in the completion of important administrative tasks related to patient care. Administrative time for most providers is filled with daily tasks including reviewing mandatory electronic alerts. Being given additional tasks without additional time allowance means the providers may have to ignore administrative tasks related to patient care during allotted timeframes to complete the extraneous or nonessential tasks. This tactic erodes the Title 38 employee's ability to complete other/more pressing administrative tasks within the course of daily duties.

Professional implications: Staff frustration/burn-out because unreasonable time demands force the employees to use lunch breaks, weekends, or other off-duty hours to either complete training criteria/extra duties or follow-up on patient care administrative duties.

Outcomes:

- a. Management is able to wring more time out of salaried employees.
- b. Rank and file staff member burn-out as workweeks extend far beyond 50-60 hours.

12. Removal of teaching privileges to ostracize provider.

Tactic: An administrator will exclude the physician from teaching privileges, an inherently renewing professional activity.

Clinical implications: Increased potential for patient health care mistakes occur when there is loss of talented attending physicians who normally would guide students/new doctors to consistently deliver high quality medical care.

Professional implications: Involuntary removal of teaching privileges isolates/ostracizes the professional provider within the workplace.

Outcomes:

- a. Management is able to effectively isolate “trouble-makers” within the work environment who threaten administrator’s status quo.
- b. Quality of training in the facility is reduced by the loss of an effective educator.

SECTION V

VA Horizontal Violence: General Retaliation Tactics against all VA Employees

Overview Summary

A. Types of Retaliation:

1. Open ridicule in meetings.
2. Anonymous “report of contact” writing campaigns to sabotage employee’s credibility and justify malicious disciplinary actions.
3. Deliberate exclusion of employee from participation in projects necessary for promotion/career advancement.
4. Failure to promote on merit by willfully denying promotions to the best qualified candidate.
5. Reassignment/relocation in the workplace in order to debase an employee.
6. Abrupt firing of probationary employees who report patient care concerns, identify misuse of facility resources, and/or question violations of human resource policy.

B. Clinical Implications (in numerical order based on retaliation type):

1. Legitimate hazards to patient care and safety remain unaddressed due to perpetuation of hostile work environment.
2. The firing, resignation, or failure to promote competent and dedicated employees impairs the quality of direct and/or indirect Veteran services.
3. The available staffing expertise is not utilized for the maximum benefit of the patients.
4. Because less qualified employees do not possess the mandatory traits/skills required for their new positions, the quality of all direct and/or indirect care is compromised.
5. An employee who feels debased often cannot perform new duties to meet the standards and requirements of the VA system.
6. Potential health and safety concerns are not addressed appropriately.

C. Staff Implications (aggregate):

In a system where there is disparate advancement opportunities, unequal balance of power, and emphasis on retaliation, qualified employees dedicated to the care of Veterans and the VA mission are subjected to horizontal violence that prevents them from achieving their full career potential and encourages them to seek career opportunities elsewhere. Less qualified employees are allowed to fill direct and indirect care positions which results in a lower standard of care throughout the VA system.

D. Outcomes (aggregate):

1. Administrators can employ a variety of retaliatory methods to debase employees and to suppress identification of system deficiencies that may make the administration look unfavorable.
2. The system is unable to effectively retain and/or recruit employees who have been/would be effective advocates of health and safety in all aspects of the VA health care system.
3. Veterans are denied high quality, efficient medical services within the VA despite administration having access to a talented pool of dedicated employees already working within the system.
4. The U.S. government spends inordinate amounts of money trying to legally defend administrators' retaliation against employees and also compensate for high staff turn-over.
5. The horizontal violence within the VA institutional culture propagates.
6. Outcomes 1 through 5 above threaten the viability of the VA and undermine its ability to meet and exceed our obligations to the nation's current and future Veterans.

Detailed Explanation of Retaliation Tactics Against all VA Employees

1. Open ridicule in meetings.

Tactic: In meetings and other personal interactions that don't leave a paper trail, administrators use verbal behavior such as raising voice, profanity, sarcasm, and interruption in response to an employee verbalizing concerns about safety or care. Nonverbal behaviors such as crossing arms, rolling eyes, and scowling are done while the employee is speaking about his/her concerns.

Clinical implications: Legitimate hazards to patient care and safety remain unaddressed due to perpetuation of hostile work environment.

Staff implications: The employee immediately becomes aware he/she is displeasing administrators and is often humiliated in front of co-workers. Thereafter, employees remain silent to avoid becoming targets for administrative abuse.

Outcomes:

- a. Management has a method of discouraging employees from voicing concerns about safety.
- b. Management can later claim "no knowledge" of the problem if the deficiency/issue later comes to the surface in another manner.
- c. Lines of facility communication are impaired because rank-and-file staff avoid meetings.

2. Anonymous "report of contact" writing campaigns to sabotage employee's credibility and justify malicious disciplinary actions.

Tactic: Administrators orchestrate a "write-up" campaign against an employee wherein the employee is the subject of falsified or exaggerated reports of contact from employee's co-workers. The employee is never told who composed each "report of contact" write-up. The employee is then penalized/disciplined within the workplace based on these write-ups against which the employee cannot easily mount a defense.

In a variation of this tactic, an administrator will pressure co-workers into writing up reports of contact on incidents, even if those incidents are outdated and/or insignificant. The co-workers are forced to write up the employee or face retaliation themselves from the administrator. Co-workers who refuse are viewed as "not being team players" or are told they are "unprofessional". These derogatory labels will negatively affect future proficiencies for the co-workers.

Clinical implications: The firing, resignation, or failure to promote competent and dedicated employees impairs the quality of direct and/or indirect Veteran services.

Staff implications: An employee feels attacked by unseen enemies or by his/her own co-workers.

Outcomes:

- a. Administrators have a tool to easily justify disciplining employees on trumped-up charges or minor infractions.
- b. Administrators have a divisive tool to isolate an employee or break up a cohesive team of employees.
- c. Employees have significant distrust of each other.

3. Deliberate exclusion of employee from participation in projects necessary for promotion/career advancement.

Tactic: Administrators avoid assigning an otherwise qualified employee to participate in projects that are needed to advance the employee's VA career. This is done because the administrators view the employee as a threat to the current status quo.

Clinical implications: The VA doesn't utilize its staffing expertise to the maximum benefit of its operational goals.

Staff implications: An employee's potential remains undeveloped even though the employee otherwise is truly capable of expanding his/her role within the VA.

Outcomes:

- a. Administrators have an easy way to prevent employees who are vocal on patient care issues from ever being given opportunities to achieve career fulfillment or advance into supervisory roles.
- b. Inappropriate utilization of staffing resources.
- c. Overall staff productivity is decreased.

4. Failure to promote on merit by willfully denying promotions to the best qualified candidate.

Tactic: Administrators deliberately overlook qualified candidates in favor of the administrators' friends/co-workers who conform to the unethical administrative power structure.

Clinical implications: Because less qualified employees do not possess the mandatory traits/skills required for their new positions, the quality of all direct and/or indirect care is compromised.

Staff implications: Employees with desired expertise are extremely frustrated because they are unable to apply those skills to the maximum extent possible within their own department. Positions are filled with candidates who do not possess the preferred expertise and qualifications for the job.

Outcomes:

- a. An administrator has now filled positions of responsibility with unqualified individuals who continue to promote an unethical and unsafe work environment.
- b. Government monies are wasted on avoidable legal proceedings between the VA that supports the administrator and the Office of Special Counsel/EEOC which is trying to overturn the prohibited personnel action.

5. Reassignment/relocation in the workplace in order to debase employee.

Tactic: An experienced employee is transferred to an entry level position/other position that doesn't effectively use employee's skill set while the employee is being "investigated" for an alleged infraction.

Clinical implications: An employee who feels debased often cannot perform new duties to the standards and requirements of the VA system.

Staff implications: An employee's dignity is reduced when removed from a role that he/she had great personal pride in fulfilling.

Outcomes:

- a. Administrators have an effective tool to isolate an employee or break-up a cohesive group of workers who verbalize health/safety concerns.
- b. Inappropriate use of experienced staff member.
- c. Loss of productivity.

6. Abrupt firing of probationary employees who report patient care concerns, identify misuse of facility resources, and/or question violations of human resource policy.*

*Note: Administrators have the ability to fire any probationary employee without cause during a period of probation that can last up to 2 years. This ability is supposed to be judiciously applied only in situations where the employee is not a good fit for the VA.

Tactic: As a way of filtering out new employees who express health/safety concerns or violations of other policies/procedures, an administrator unjustly/abruptly terminates these

probationary employees simply because they are viewed as a threat to the administrator's power base.

Clinical implications: Potential health and safety concerns are not addressed appropriately within the work environment.

Staff implications: Probationary employees are afraid to vocalize health and safety concerns because they fear unjustified job loss.

Outcomes:

- a. Administrators have an effective leverage over probationary employees to suppress any identification of system deficiencies that may make the administration look unfavorable.
- b. In order to meet administrators' personal goals, there can be coercion of probationary employees to do activities that are not in keeping with VA official standards of conduct.