

Opening Statement of Samuel Henry Foote M.D.

My name is Dr. Sam Foote. I started my Internal Medicine training in 1981 at the combined Good Samaritan/Phoenix VA program. I finished in 1984 and became Board Certified in Internal Medicine. I went to work full time in East Mesa, AZ as an emergency physician and I returned to the VA in 1990, the same year that I earned my Boards in Emergency Medicine. I ran the VA's Emergency Department from 1990 to 1998. I was a Medical Service teaching attending from 1991 to 2003 and I became an outpatient Clinic Director in December of 1994, a position which I held until my retirement in December of 2013.

While I have views on many aspects of what has come to be known as the VA scandal, I would like to use this statement to comment on what I view as the foot-dragging, downplaying and frankly, inadequacy of the Inspector General's Office. This continues in the report issued August 26, 2014 which I fear is designed to minimize the scandal and protect its perpetrators rather than to provide the truth along with closure to the many Veterans and families that have been affected by it.

All VA employees receive mandatory recurrent training on their duty to report waste, fraud and abuse to the Inspector General whose job it is to investigate these allegations. I first did this in February of 2011 which resulted in then Director Gabriel Perez being placed on leave within two weeks of the IG receiving my letter and a few months later, his resignation in lieu of termination.

I sent a second letter to the IG in April of 2013 where I made allegations against the Chief of Health Administrative Services Brad Curry for creating a hostile workplace, engaging in prohibited personnel actions and discrimination against certain classes of employees. As far as I can tell, the IG never investigated this complaint and it appears that they turned it over to the Veterans Integrated Service Network Director Susan Bowers who was both Helman's and Curry's superior. Susan Bowers could not take action against him without running the risk that the entire waiting list scandal would be exposed.

In late October of 2013 I sent a third letter to the IG informing them of the existence of a secret waiting list where 10 patients on the list had died while awaiting for appointments. I also included additional allegations of prohibited personnel actions by senior staff. Furthermore, I advised them of a second hidden backlog of patients contained in the Schedule an Appointment with Primary Care Consult lists and that an unknown number of Veterans had perished on it. I also detailed other methods that were in use to lower the apparent backlog for new patients and I implored the IG to come to Phoenix to investigate all of the above.

I got a response from the San Diego IG office on December 3, 2013 to join a conference call with them on December 6, 2013. Their team came out to investigate the week of December 16-20. At that time, I and others told them about the unaddressed Schedule an Appointment Consults and showed them the Northwest Electronic Holding Clinic which was being used as were prior holding clinics to mask the true demand for return patient appointments. We updated them that the secret EWL summary report was showing that 22 patients had been removed from it because they had died. We only had the names of two of the deceased because none of the employees who were working with me had the electronic keys

to print the names of the deceased. We asked the IG Inspectors if they could do it, but they responded that they could not.

The last e-mail response that I had from them was on 12-21-13 when I received an Out of the Office until Tuesday, December 31, 2013 reply. I had offered to fax or mail the names we had at that time, but they were unable to give me a working fax number or address to mail it to. Fax and standard mail (but not unencrypted e-mail) are considered appropriate methods to transmitted HIPPA sensitive material. I sent four more e-mails in early January again asking if they would like me to fax or mail the patients names but I got no response. I also got no response when I advised them that several more Veterans had died.

Finally on February 2, 2014 out of frustration with the lack of action by the IG even though we were informing them of more and more deaths, I sent out IG letter number four with copies to everyone who I could think of that might be able to help. The only response that I got from the IG was a confirmation that they had received my letter. A friend suggested that I contact the House Veterans Affairs Committee and there I found the help I needed. During this process I was advised by several people that the only way that I could get the IG's Office to investigate my allegations was to make them public which reluctantly I did.

In my opinion, this was a conspiracy, possibly criminal, perpetrated by Senior Phoenix Leaders. Of the many scandalous aspects – from the performance bonuses paid to top administrators for supposedly meeting waiting time goals to the harassment of employees trying to rectify the situation to the destruction of documents and electronic records to the very real harm done to the health of thousands of Veterans unable to receive timely medical care – nothing is more scandalous than the fact – the fact – that 293 Veterans died in Phoenix.

Yet, even now, right here in this report, the Inspector General tries to minimize the damage done and the culpability of those involved by stating that none of the deaths can conclusively be tied to treatment delays.

I have read the report many times and several things bother me about it. Throughout the case reports, the authors appeared to have downplayed facts and minimized the harm. This was absolutely true in cases 6 and 7 where I have direct knowledge. After reading those two cases, it leaves me wondering what really happened in all the rest. For example, in case number 29, how could anyone conclude that the death was not related to the delay when a patient who needed an implanted defibrillator to avoid sudden death did not get one in time? And why was a cardiac death case excluded from the IG review?

In addition, a critical element to proving that this was a conspiracy was the potential tampering with the reporting software of the EWL. From the beginning, the IG's own data showed that there was a difference between the numbers reported to Washington and what the numbers actually were on the secret EWL. The IG clearly minimized the significance of this crucial point, treating it as a trivial clerical error and touting how quickly the IT department corrected it rather than exploring who tampered with it in the first place.

Adding it up, the IG report states that 4,900 Veterans were waiting for new patient appointments at the Phoenix VA. 3,500 were not on any official list and 1,400 were on the non-reporting secret EWL. 293 of these Veterans are now deceased. This vastly exceeds my original allegation that up to 40 Veterans may have died while waiting for care.

The IG says it is not charged with determining criminal conduct. True. But neither is it charged with producing reports designed to downplay potentially criminal conduct, designed to defuse and discourage potential criminal investigations, or to diminish the quite appropriate public outrage.

At its best, this report is a whitewash. At its worst, it is a feeble attempt at a cover-up. The report deliberately uses confusing language and math, invents new unrealistic standards of proof, ignores why the EWL was not reporting accurate data and makes misleading statements. In addition, the attempts to minimize bad outcomes by downplaying damaging information and thereby protecting the VA officials who were responsible for this scandal just reinforces the VA's long standing culture of circling the wagons to delay, deny and let the claim, story or patient die that the Veteran's community has had to suffer with for years. In this regard, the way the report was released speaks volumes. First, the "good news" that "we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans," was leaked. Then the full report was released a day ahead of schedule in order to coincide with Arizona's Primary Election Day when the Washington Administrators knew full well that the Arizona media would be too busy to react. This leaves no doubt about what the true intent was.

Secretary McDonald said that he was going to try to increase the transparency of the agency and that he would not tolerate Whistleblower retaliation. Apparently, senior Washington VA administrators did not get that memo. This report fails miserably in those areas with a transparency equivalent to a lead lined four foot thick concrete wall. On behalf of all of the Veterans and their families who were affected by this scandal, I respectfully request that a full independent outside review of all the cases where deaths occurred be conducted including the 77 suicides and that those case reports be made public.

If the VA is really serious about restoring the Veterans trust in the organization, this would be a giant first step in that direction. I would like to take this opportunity to thank the Committee for allowing me to speak before you today on behalf of our Nation's Veterans.

Samuel H. Foote M.D.