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U.S. House of Representatives  
Committee on Veterans Affairs  
One Hundred Thirteenth Congress  
335 Cannon House Office Building  
Washington, DC 20515

RE: Hearing on the Narcotics Problem within the VA system

## ***BACKGROUND INFORMATION***

As a Board-Certified Family Physician for over twenty years and having worked in the medical field wearing various hats for over forty years, I feel more than qualified to enter an opinion on the current state of affairs regarding the narcotic situation at the VA primary care clinics. For the last 3½ years I have been a traveling primary care physician for the VA Interim Staffing Program. During this time, I worked as a physician directly providing medical care to veterans at thirteen different VA facilities. Additionally, I am a physician acupuncturist, a licensed physical therapist, and more importantly, I am a disabled veteran who also is a consumer of care at the VA.

## ***SUMMARY***

***Although the VA can demonstrate they have guidelines and resources for the prescription of narcotics, on the grassroots level the primary care providers are struggling to stay afloat in a system flawed with errors, lacking oversight at all levels, and burdened by policies and politics that make it difficult to***

*monitor and manage veterans with pain. These veterans, through the VA's own emphasis on pain, come to expect and demand narcotics, see pain control with narcotics as their "right," and bristle at attempts to limit use of these potent, addictive, and potentially lethal medications.*

**DISCUSSION:**

The problem with narcotics is but the tip of the iceberg and the VA the Titanic headed full speed ahead for catastrophe. To quote a fellow physician, even a garbage dump looks good when you're flying at 50,000 feet.

Perhaps the narcotic fiasco run amuck will serve as the impetus to revamp a system steeped in tradition and run by a good ole boys club that protects its members even under legitimate fire. Take the recent hearings in Pittsburgh and the Legionnaire's problem. The VSN (division) director Mr. Moreland was rewarded with a \$63,000 bonus, which his superior Dr. Petzel found no problem with authorizing. An administrator from the Jackson, Mississippi VAMC when faced with serious charges is allowed to step down from his position and continue to see patients. Another administrator involved in Jackson narcotic disaster was reportedly transferred to a similar position at an unsuspecting VA in Tennessee. These are but a few recent examples of an administrative "shell game" played by those at the helm of the VA Health Care System.

Then there's the case of a physician assistant in Maine who was so unreliable and had so many complaints from staff and veterans that in an ordinary medical practice would have discharged him long ago. Around February of this year the VSN decided to investigate and place the man on paid administrative leave. He had been missing work on a regular basis, absent during working

hours and no one knew his whereabouts (it was rumored that he was teaching an unauthorized course at a local college over lunch and saw no problem making vets wait 1 ½ hours until he returned), and veterans were regularly requesting they be transferred to another provider.

This physician assistant would not obtain his own DEA license (drug enforcement agency) to prescribe narcotics (he told me he refused to pay for it, insisting the VA should pay for this license), instead, asked the physician in the adjacent office to write narcotic prescriptions on patients he had never met or examined (a violation of DEA prescribing policies). Then it was discovered that the physician assistant had been documenting that he had been doing extensive physical examinations on many vets who later complained to staff (and myself) that he never touched them (since most of the vets are also of Medicare age, this constitutes Medicare fraud). As far as I could ascertain, when I later covered his panel of vets, the only part of the physical exam for which he reliably performed per the veteran's admissions was the rectal exam.

As I worked with his former patient panel, it became obvious that not only had he not examined patients, he had ignored their complaints, in many cases had misdiagnosed veterans, and in some cases there was a potentially life-threatening delay in diagnosis. He had month after month seen to their narcotic prescriptions, yet never had examined the body part(s) for which they had a pain complaint. I discovered that the problems lists were incomplete or inaccurate, the medications lists were often not updated or accurate, and his notes worthless and unreliable.

As of about eight months later, this physician assistant was still on administrative leave, still getting paid, and the investigating committee could not make a determination as to his disposition. When a system cannot dispose of their own dead

wood, how can one expect that system to effectively monitor and police itself?

This is but one example of failure to provide veterans with the high quality of care the VA likes to list on their flyers. In particular, the provision of veterans with narcotics in a rather cavalier fashion appears to be a systemic problem. I have been in thirteen VA facilities in the last 3 ½ years while employed as a traveling physician with what initially was known as the VA Physician Locums Program and now is the VA Interim Staffing Program. The program in its hayday, employed ninety physicians who also traveled around to other VA facilities throughout the country. How easy would it have been to survey these grassroots physicians, asking about the narcotics situation, particularly after many of us complained to our administration. I requested that our comments and concerns be passed along, but nothing was done. When our staff had telephone group conferences (few and far between), the problems we were experiencing with being expected to sign-off on narcotic prescriptions was brought up during at least two conferences. Again, nothing was done.

Suggestions were made to alert the facilities to the need to address our responsibilities as interim staffing and the facility expectations regarding continuing to write for narcotics, particularly when never having seen the veteran. We were all concerned that this violated the DEA policies and was a potential threat to the veterans and could result in DEA action against us. These comments never went any further, were not passed along to VACO (VA Central Office) who in their ignorance used us as a bunch of narcotic prostitutes.

This sounds rather far-fetched, but when the sparks hit the fan at Jackson, and it came out that the nurse practitioners were illegally writing narcotic prescriptions, VACO begged the VA locums staff to find physicians to immediately fly to Jackson to help with the situation. The only catch was that we were never

informed that upon arrival we were going to be the narcotic pushers, and not do primary care, but get the drugs rolling.

The staff physicians had refused to write prescriptions for narcotics on patients they had never seen and the ER docs felt the same way. As one of the first two volunteers for this assignment, we were met by the administrator who informed us that even with his administrative duties he could manage reviewing thirty charts per day. He instructed us to simply look the chart over, see if the vet was "stable", and knock out the narcotic prescriptions that his veterans were clammering for since the nurse practitioners lost their ability to write due to DEA action. He saw no reason to do a physical examination and said we needed only a "face to face" visit to satisfy the DEA. When I pointed out that not only could I not physically or ethically be able to push through 30 vets on narcotics, but I needed sufficient time and space to perform examinations.

I was stuck in a section at Jackson, not far from the airport type screening at the front door (equipped with guards, metal detectors, and an X-ray screening device), and assigned my own swash-buckling narcotics police nurse, a male clerk, and had the angry vets lined-up at my gates on a daily basis. I insisted on drug screens on every one prior to my even seeing them, and when they came back positive for illicit substances, or not positive for substances they should have been on, they were cut-off.

It was obvious that the administration was not in favor of my examining each vet, or reviewing each chart in a methodical fashion. My request from day one for an examination table was met with questions as to what purpose would I require an examination table for. To examine the vet properly was the response, yet my request went unanswered for one week until I threatened to climb back on the plane that very day if I didn't get the exam table. I got my table.

What I discovered at Jackson, by reviewing charts from a vast assortment of nurse practitioners, was typical of many of the VA facilities in which I have worked. Jackson perhaps was the worse example. I discovered that narcotic prescriptions were rubber-stamped month after month, sometimes for two years on end, without a reexamination of the body part(s) in pain. Sure, the veterans were seen by the provider, but the pain was addressed by merely asking if the vet had pain and to rate it using the infamous 1/10 rating scheme. This violates not only the standards the VA itself has posted (that is, if you can find these web-sites easily in the heat of battle), but the dictates of the DEA and ethical practice standards. Nearly every facility I have gone to for providing emergency coverage has the same recurring problems. Notes that are incomplete, poorly typed, difficult to read, and are rushed off to completion to satisfy time constraints administrators place on providers, so that billing can be completed immediately. No one seems to remember how to write a note, listing in order of importance the problems in a logical, clearly documented fashion. The art of note-writing had a purpose, that of assuring continuity of care is possible and reflecting the thoughts and impressions of the provider. If you compare the VA notes to those of outside physicians, our notes are a shameful disgrace. And yes, it does impact on the quality of care when I cannot pick up a chart and look at the last note or two and figure out what the veterans problems are, what the provider was thinking or planned. You would think this would be one of the measures of quality. It is not.

It became obvious that no one was supervising the nurse practitioners at Jackson, who essentially were practicing independently. As I reviewed the charts, I discovered notes that were incomplete regarding major health issues, conditions that were misdiagnosed, problem lists that were not up-to-date, medicine lists that were not current, tests were not being done,

and in general, it appeared that they had fallen into a pattern of habit regarding the knee-jerk response to automatically refilling narcotic prescriptions. Often there were no recent consultations to specialists, no updated tests such as MRI's, and a lack of inquisitive investigation of pain complaints. Many times positive urine tox screens were ignored as well as drug screens that should have been negative. Drug screening was infrequent and if performed, was announced or anticipated by the routines of testing. There was no attention to the potential impact on poly-pharmacy on the health of veterans.

The same problems noted at Jackson were also noted at other VA facilities. Administrators expected that temporary or new providers would jump right into the mix, continue what the prior providers had started, and keep the veterans happy. After all, a happy vet is one that doesn't write damning letters to his Congressman about how the VA ignores his pain. These letters reportedly adversely affect that VSN's (division's) money flow from above.

Many facilities now shuffle the narcotic renewals from provider to provider when a position is left vacant, sometimes having administrators temporarily cover the narcotic prescriptions until a provider is replaced or returns. Again, these veterans are not seen in an actual face to face encounter, their charts are superficially scanned, and out pops a narcotic prescription ready to churn out of the VA pill mill.

The same problems exist at other VA facilities regarding documenting not only a veteran's pain complaints, but the medical encounter itself. Providers notes often are pages and pages of cut and paste, including a record of the exam using a repetitive template of basic findings, but little in the way of a pain-directed physical exam.

Notes are shamefully difficult to read, have incomplete listings of problems in the assessment section, and have sketchy plans outlined. The providers often are forced for the sake of time to address scores of pop-up "reminders" that have been triggered by the computer in order to appear as if they are providing what some administrator has identified as an indicator of quality care. These type of notes are conducive to mistakes. Several times I have seen a diagnose drop-off the radar because the medication expired for the problem and the provider doesn't have the time to review the scores of notations littering the path to discovery of all medical issues.

The one medication that never seems to be lost is the prescription for narcotics. Unfortunately, substance abuse may be listed on the main problem list, but it is often ignored when dealing with a pain complaint. Another factor that is often ignored is the potential interaction of multiple psychiatric medications prescribed. It is sort of the 'go ask Alice when she's ten feet tall' culture. There are pills for everything, and pushing pills is one thing the VA is good at - so good that the VA had been cited as being the biggest supplier of on-street legal drugs in the United States, and the largest consumer of narcotics in the world.

How did it get that way? It appears that about ten years ago the VA decided that pain was the fifth vital sign (after temperature, pulse, respiration and blood pressure). It became so ingrained that staff members were chastised if they did not ask about pain, even if the veteran had presented with no intention of discussing pain, they would be flagged. Now, not only do they ask about pain, but they must ask if you want something done about it that very day. It is no wonder medical problems fail to get addressed or are missed.

Pain management has become a double edged sword for the medical providers. You are damned if you don't prescribe narcotics and damned when you do and someone has an adverse outcome. Both cases result in complaints, and depending on how well placed the veteran is, those complaints can generate considerable aggravation for administration. Often I watched as a vet I had denied giving a prescription of narcotics to, although I had documented in great detail the rationale, as the vet would present to administration to have the non-clinical administrators order another provider to write for the medication (Jackson VAMC was quite good at this). The other scenario was the vets would go to the VA emergency room, and often just to get them out quickly, the prescription would be written.

Facilities encourage prescriptions of narcotics by denying alternative forms of treatment such as chiropractic (most facilities do not have a chiropractor or enough of them), massage, or acupuncture. The VA's vocational rehabilitation department spent \$8000 sending me to a physician acupuncture course two years ago, and I have yet to find a facility that will credential me so I can provide this service to vets. They give the excuse of having no one to supervise me. It makes no sense when acupuncture is less invasive than performing minor surgical procedures, cutting someone with a scalpel, or poking holes in skin to drain abscesses, all of which I am credentialed to do. The true issue is that they don't want to open a can of worms, ie., be faced with having the vets demanding more of the same service. It is infinitely cheaper to dole out narcotics than it is to have veterans deal with pain through alternative measures. That is the bottom line.

Furthermore, the pharmacy gestapo controls the formulary, which is dictated in turn by the bonus a manager might receive if the costs are kept down. For instance, if you want to provide the

non-formulary drug Lyrica for pain modulation, it typically is not approved by the pharmacist that oversees physician drug prescribing. You are instructed to use the older, less effective drug gabapentin first, document its lack of effect, then try a concoction of other pharmaceuticals all with central nervous system depressing effects first. If the veteran lives through the experimentation with chemicals coming at him from all directions and types of providers, maybe at some point they will relent and allow you to provide the drug.

Another example is Voltaren gel, a topical anti-inflammatory drug that can be rubbed into painful joints to control pain. It works and unfortunately for the veterans, it's non-formulary. Many vets are on so many drugs they should be putting omeprazole (Prilosec) in the water to counter the effects on their stomachs. Non-steroidal anti-inflammatory medications (NSAID's) are notorious for causing stomach ulcers, gastrointestinal bleeds, and even heart problems, yet these are the preferred first-line drugs that we are supposed to push - if one doesn't work, try another and another. Just add the omeprazole, the H2 blocker (like Zantac), or Cytotec that causes uncontrollable sudden bursts of diarrhea. Give them any number and combination of narcotics and mental health drugs, but don't allow the vet to use a topical substance, even on a trial basis, because it costs too much. Tell me, what is the cost of hospitalization for a GI bleed? Or the cost to society when a vet dies of a drug overdose?

No, the pharmacy is a dynasty, run by the new Ph.D.'s on the block, the Pharm.D. The pharmacists control the formulary, which is kept a secret and never, never published (the National formulary is published, however, each VSN can decide on what drugs to include or not include), since people might start to realize how few drugs and how old the drugs are that the VA allows on the formulary (and this is somehow up-to-date, high quality care?).

Not only do the pharmacists control the drugs, they now tell us how to practice medicine. It appears the VA has condoned such practices - pharmacists are cheaper than docs, maybe know the drugs' theoretical advantages, and are loving the increased responsibility. Unfortunately, the VA leaders pushed us to this slippery slope in the name of cost-savings. When you think of it, why even have physicians when pharmacists take over management of hypertension, hyperlipidemia, diabetes in their "clinics," - clinics in which they are given an entire block of time to deal with a few targeted medical disorders. Perhaps if the providers had such luxury there would be better control of chronic diseases, including pain management.

To cite an example, recently I had two pharmacists tell me they wouldn't authorize the use of Voltaren gel for a vet who had numerous failures with other meds, stomach issues, and problems with narcotics. They instructed me, the physician, that I should have the veteran lose weight (as if that will happen magically overnight), exercise (which he couldn't do much of due to his severe knee problem), refer him to physical therapy (which would do nothing for severe degenerative arthritis), and I should treat his "gout" because that might be causing his aches and pains. Twice I wrote back that the vet does not have gout (he had several joint aspirations proving this) and that an increase in uric acid (hyperuricemia) does not equate necessarily to a diagnosis of gout. Not only are the pharmacists telling us how to practice medicine, they are now diagnosing veterans.

What about the returning heroes coming back from the sandboxes in the Middle East? Often they are started on narcotics while deployed, just to keep them in the field. They arrive at our doors on medications for depression (who wouldn't be depressed with the ridiculous number of back-to-back deployments), medications for anxiety such as Xanax, a medication to prevent

the nightmares of PTSD, one or two pills to make them sleep (like zolpidem that makes them do things like sleep walking, night driving while asleep, asleep eating, or making crazy purchases on-line, none of which they remember upon waking), another anti-depressant when the first one isn't quite performing the chemical lobotomy, perhaps a drug for attention deficit (it's no wonder they can't stay focused considering the drug soup bathing their brains), and to round off the cocktail they have been prescribed a narcotic or maybe even two for that ubiquitous pain complaint.

They present to facilities, young men typically, strung out on prescription cocktails, mentally shattered, and desperate for help. The VA dictates that, rightfully so, they need to be priority patients. However, they haven't figured out how to assimilate another body into the mix when they can't even accommodate the veterans currently on the roles. So administration begins another "shell game," moving patients out of a provider's panel into the officially unassigned category. The slot created on a panel allows them to put in the new OEF/OIF (Operation Enduring Freedom and Operation Iraqi Freedom) veteran for his initial appointment. Therefore, the providers panels are bulging, current veterans cannot get timely appointments, and if someone is sick and doesn't have the luxury of having an outside physician, they are out of luck.

What happens when these hurting vets, soldiers with PTSD driving their miseries, are told there are no appointments even though there is a mandate (which they are aware of) directing facilities to get them in within so many days? One poor hero, desperate to get his PTSD treated, after too many rejections by the Wilmington VAMC, reportedly shot himself in the parking lot of the facility.

Walk-ins are definitely not welcome, nor is the system even user friendly if the providers do make room. Patients are expected to be "squeezed-in", which only serves to make the provider run

late (bad, a ding against the provider and the facility). Since time can't be created, then the other veterans with appointments get short-changed in their face-to-face, now hurried appointments.

It would be too logical to pre-schedule slots that are reserved for sick visits. Even if that were done, the veterans cannot get through to their assigned offices on the telephone. Yes, the telephone system that links the VA facilities is archaic, inefficient, and contributes to the large number of vets getting frustrated after repetitively calling a VA answering service in Colorado (or some such place that might as well be on the moon) and be asked to leave a message - a message that some busy clinic clerk might get to some time that day. I have not found one VA facility in nearly four years of traveling as a gypsy doc for the VA who has a direct phone number to their assigned clinic that their patients can call in a normal fashion in order to be seen. So the response the VA has to this is to insist walk-ins must be seen that day. How this can be achieved is up to the staff who have no power to alter schedules, block-out time slots, or do anything creative without first going through levels of supervisors or one of the infamous, omni-present and omnipotent, sacred VA committees.

Oh, the VA has a solution. The pressure now is not to bring the vets in for a real appointment, providers are encouraged to try to do telephone appointments - a scheduled phone call of 15 minutes to do the same thing you would normally do in 30 minutes, sans the physical exam, without eyes on the patient, with minimal prep time, and no scheduled time to write notes. It's no wonder sloppy is the norm. The providers end up staying later and later to catch-up, becoming more and more dissatisfied, and it is not rocket science to recognize that the providers mutate to the point of being pill-pushing automatons. VA survival tactics 101 - an ideal setting conducive to narcotics being passed merrily along with the rest of the mind-altering medications.

Is it going to get any better regarding the monitoring of narcotics? Probably it will until all the heat dies down, the newspapers get tired of the same story with a different twist, and the pressure returns to keep costs low. There are problems inherent in the system that impact on the way the narcotics are being prescribed. The providers are saddled with stifling paperwork, regulations and rules generated by persons who never treat patients, a computer system that is cumbersome and not user friendly, and no ability to control decisions that impact negatively on productivity.

Who ever heard of having a provider assigned to one exam room which also functions as a medical office? When a provider wants to see the next vet, he has to first change the paper of the exam table (maybe even wipe it down first), and then walk down to hall to fetch the patient. Five minutes wasted. The provider has to be a typist, a transcriptionist, the person who enters each and every drug a veteran receives from an outside physician in a labor-intensive fashion (it would be too logical to have the screening nurse do this chore), the one who enters each lab tests one by one (no clicking on panels for our docs), the person who enters a detailed consult to specialists (specialist who can decide to deny a consult based on how busy or motivated they are), or perform the lengthy questionnaire prior to entering an MRI (which a clerk could easily do).

The specialists also are the ones that are so pampered that they can agree to a consult only if the provider enters the testing that the specialist wants, that they will review, yet the provider has to take time to enter tests as if they were the specialist's secretary. Then it is up to the provider to make sure the vet attends the appointment. If they don't make the appointment, it's still the provider's burden of responsibility.

From the other side of the coin, as a disabled veteran I get medical care from the Lebanon VAMC in Pennsylvania. Recently, I went to see an ENT specialist for an ear infection causing hearing loss to the point I couldn't hear with my stethoscope. The surgeon was rude, refused to let me explain my problem in a succinct fashion, and instead insisted that he first wanted to read my chart (perhaps he should have done that before I entered the room for my 30 minute consult time slot he insisted on having since I hadn't been seen in over a year by ENT). After several minutes he rolled his chair over to the ENT (barber-like) chair where I sat, spun the examination chair rapidly, reached up and began to examine my right ear without having listened to what my new complaint was. He inquired, "So what is wrong with your right ear?" I explained that had he let me provide a history he might know I had a recurring problem with both ears. The treatment as I already knew from several such bouts, was to suction the residual debris from my ear canals. As he rapidly and vigorously moved the suction device in my ears he repetitively hurt me (he got too close to the ear drum). Every time I would reflexively flinch and every time he would chastise me for moving, regardless of the pain his less than gentle approach was creating. The final insult was when he berated me for waiting so long to come in (over a year), when in reality the problem have begun abruptly over the prior week.

Prior to that episode, I went to a VA doc for a complaint of feeling ill for a month, having symptoms of a kidney infection, and being concerned about my health. This fill-in ex-Navy physician, sat flipping through my thick paper chart (thick because the VA had all sorts of records from the illnesses caused by Anthrax immunizations), reached over and patted my hand, and asked, "Did you ever think of seeing a psychiatrist?"

A week later I was in the hospital with a mild stroke and a kidney infection.

Another VA surgeon performed a colonoscopy on me, never explained the procedure (doesn't matter than I am a physician), had me sign the consent, and then never bothered to tell me after the procedure what he did or didn't find. He just instructed the nurse to show me the photos from the colonoscopy and tell me the results. He was much too important as the Chief of Surgery to bother with mundane details.

Now if specialists treats me, a physician that way, how do they treat the run of the mill veterans? I hear complaints like this all the time about the insensitivity, the rushed consults, and the non-professional behaviors of specialists on the VA payroll. Being the sacred cows of the VA, they are untouchables.

Meanwhile, the provider is inundated with useless, repetitive computer messages known as "view alerts." No one seems to know how to stop messages that tell us an appointment was made (we only need to know if one wasn't made and why). Labs pop up as view alerts over and over again, the same labs, multiple labs presented separately in multiple view alerts, hundreds of view alerts. Then there are the mandatory staff meetings, time wasted that could be addressed through memos or e-mails. RN's aren't even allowed to enter unsigned orders to assist providers in performing duties, or are not allowed to do tasks within their scope of practice that could simplify the office procedures (like entering the orders for the endless medication renewal requests so that after reviewing the chart, the provider could more quickly sign the orders) and free up the provider to see patients.

Some nurses refuse to help providers with phone calls. Some nurses, like at Durham refused to do much to help the veterans. If I would ask them to flush a veterans ears (a facility that actually allowed the nurses to do this), they would answer that they needed to schedule an appointment. It didn't matter that it was an elderly veteran who lived a distance away. They were out of the office 12:00 sharp and out the door at 4:30 come hell or high water, which the provider usually was overcome by at the end of the day.

Don't expect that blood pressures listed in the charts are correct. For a matter of convenience the VA purchased all these expensive electronic BP machines that typically register higher than the true resting BP. You will never find the BP entered for both arms as you would in private practice, which is standard operating procedure for a patient with hypertension. A difference in pressure could indicate a blockage in one of the main arteries coming off the heart (this isn't fantasy, I am a prime example of a subclavian blockage diagnosed only because I insisted the BP be taken in both arms). The machines automatically send the single BP to the electronic medical records, but apparently they aren't set-up to manage two BP's. Therefore, if the busy doctor wants a true reading he has to first scrounge around to find a manual cuff, find one that actually works or has all the parts, and then try to find a large cuff for the big arms. . . More wasted time that physicians' could be using to think, to prevent disaster.

Yes, the VA physicians, nurse practitioners, and physician assistants are expected to be the supermen and women of the VA, yet have little input as to things that impact their day to day activities. Yes, the providers are not properly screening veterans taking narcotics, simply as a matter of sheer survival and keeping one's head above water. Of course, it is their fault for putting up with the system, not trying to change it, but be

forewarned that those who do speak up are likely to lose their jobs. People are rewarded for keeping their opinions under the radar, their hands hog-tied, and their jaws wired shut. Welcome to the world of the VA.

## **RECOMMENDATIONS REGARDING NARCOTIC PRESCRIPTION**

1. ***Provide an intensive training course for prescribers of narcotics*** that is done in-house, not on a video monitor that providers can wander in and out of the training session ad lib (this was witnessed at a recent Tele-training course held by Wilmington VAMC). Provide written materials and references to all physicians, not merely the ones who were able to attend the live training. The course should be at the physician level, not watered down to include all personnel. Separate training should be done for nurses and staff having roles that intersect the provision of narcotics to veterans.

2. ***Educate the veterans on options for and benefits of pain control with an emphasis on non-narcotic solutions.***

- a. For veterans currently on regular large doses of narcotics, require mandatory attendance at educational seminars.
- b. For veterans inappropriately prescribed or taking large amounts of narcotics concurrently with or without other central nervous system depressants, for veterans with a history of current or past substance abuse, provide an in-patient residence program. This program should promote healthy living concepts, introduce non-narcotic alternatives, provide an independent medical examination

(a second opinion) of their pain complaints, and result in designing a comprehensive pain control program with minimal narcotic usage.

c. Acknowledge alternative forms of care by making a dedicated effort to provide such services.

1) Allow providers trained in alternative forms of care to deliver these services (for instance, I am a licensed physician acupuncturist and have not been allowed (in the last two years that I have been licensed) by any VSN credentialing board to provide this service to veterans in lieu of prescribing narcotics).

2) Pay for chiropractic services on a "fee-basis" program if a chiropractor is not on staff. If not on staff, advertise and hire enough necessary to deliver these services.

3) Allow the VA physical therapists (who now are required to have Ph.D. degrees) to function as part of the pain management team and do more than simply sending the veteran out the door with a list of home exercises (Note: I also have been a licensed physical therapist for 40 years, with a Master's Degree as well!)

**3. VA Pain Services should be directed by a full-time physician with special training in Pain Management.**

a. Physician Assistants (PA's) and Nurse Practitioners

(NP's) should not be the primary source of care in the Pain Management service when a veteran is referred by other providers for evaluation of a difficult pain management case.

- b. Veterans managed by PA's and NP's should be evaluated on a regular basis by the Pain Management physician
- c. Veterans placed on significant doses of narcotics by the Pain Service should not be allowed to transfer the prescription of these narcotics to primary care providers simply because it is beneath the dignity of the Pain Service to perform such mundane activities (this is the role their extended care providers can address).

**4. Physicians and extended care providers need to be responsible** for obtaining a complete pain history, performing a thorough examination pertaining to each body part in pain, ordering appropriate lab tests, studies (eg., X-rays, MRI's, CT's) and consultations.

- a. Adequate time needs to be dedicated to the investigation of the pain complaint. This process is necessarily time-intensive and requires an appointment not riddled with other issues or concerns. That is, the session should not be part of a routine check-up for multiple medical issues, during which time multiple medication prescriptions need to be addressed and written, or when time is spent coordinating care with multiple outside physicians (as is commonplace).

- b. Measures need to be taken to assure that the persons prescribing narcotics have proper training in physical assessment of musculoskeletal conditions. Perhaps giving providers extra training with the orthopedic service or on the pain service might be indicated.
- c. Charts of veterans receiving narcotics should be randomly reviewed by peers, or the pain service if requested, to determine appropriateness of narcotic prescription.
- d. Clinical Pharmacologists (Pharm D level) should also review narcotic prescriptions for appropriateness, likelihood of drug interactions (particularly in the presence of other mind-altering drugs).

5. ***Dedicated monitoring should be required*** of all persons taking narcotics (other than for a brief episode).

- a. The urine drug (tox) screening process needs to be revised:
  - 1) Veterans are familiar with criteria that military screening entails (witnessed drug screens, emptying pockets, leaving personal belongings out of the room)
  - 2) Urine drugs screens needs to be both announced and unannounced, regardless of suspicion for diversion or abuse.
  - 3) The screening needs to be taken seriously by both the staff and veteran. No excuses can be accepted when a request is made for providing a specimen.

- 4) The specimen needs to be collected in a manner consistent with accepted protocol, such as is used in pre-employment screening or post-accident screening by industry. For example, the veteran shall not have access to running water, the toilet water is dyed with a chemical designed to foil surreptitious dippers, and specimen containers should be specially designed for urine tox screening (such as to monitor pH and temperature). The veteran must empty their pockets, leave belongings outside the room, and preferably be monitored.
- 5) The issue of insufficient staffing must be addressed. This makes another case for the prescription of narcotics to be managed by providers at a facility equipped to properly monitor for drug misuse and other substance abuse.
  - b. Unannounced pill counts need to be performed, even in veterans not suspected of diversions or abuse, since no one can predict who will be the guilty culprit.
  - c. Although signing of Pain Contracts is not proven to be much of a deterrent, its use may serve to provide the veteran with the rules of engagement and serve as a warning that certain behaviors will not be tolerated.
  - d. The "lost prescription" story needs to be addressed up front. Veterans need to know they are responsible for keeping their controlled substances in a safe place.

- e. The business of providing 'bogus' police reports as evidence of theft should be addressed initially upon signing the pain contract.
- f. The practice of allowing veterans to "slip-up" and have a dirty urine should not be tolerated. These veterans should immediately be referred to Pain Management or a Suboxone program.

**6. Safety issues need to be addressed regarding veterans who are prescribed narcotics**, particularly when in combination with other centrally acting depressants or mind-altering drugs.

- a. Veterans who are on other mind-altering drugs are at increased risk of accidental overdose and unwanted side effects.
- b. Psychiatry should be responsible for assessing the appropriateness of all the mental health medications, particularly if narcotics are being prescribed.
- c. Veterans should be offered alternative treatments for mental health disorders, including sleep problems and PTSD, such as intensive counseling programs and holistic approaches (relaxation exercises, melatonin, Herbals, acupuncture).
- d. Pharm.D. pharmacists should also routinely earmark cases involving potentially interacting or additive medications for review on an on-going list.
- e. A master list of each provider's narcotic patients should be maintained and accessible to both provider and those engaged in monitoring.

- f. The state's narcotic data banks should be routinely accessed by either the provider or preferably the Pharm. D. This practice should be encouraged, since it is infrequently performed by busy providers who are currently expected to be a revolving door for veteran health care. By querying the data bank, veterans who doctor shop for narcotics can easily be spotted. For instance, earlier this year I discovered a vet that had been to 10 different providers who had written for narcotics for this vet between January and June.
- g. There should be a nationwide central clearing house to which states be mandated to report all persons obtaining narcotic prescriptions. This data bank should be accessible to anyone providing an ongoing regimen of narcotics to an individual.

***7. Safety issues need to be addressed regarding the persons who prescribe, interact and provide services related to the prescriptions of drugs.***

- a. Security at Community Based Outpatient Clinics (CBOC's) is non-existent. Some CBOC's have a system to silently alert the staff to a situation, but the keyboard must be accessible. Some CBOC's have silent alarms under the provider's desks, that go to the central office's police station. By the time local police are notified and arrive, the situations has either resolved or had an adverse outcome.
- b. Providers and staff are at increased risk of harm by

disgruntled veterans - veterans who have problems with anger management, PTSD, anxiety, depression, and whose thought processes are chemically challenged by a cocktail of prescribed and possibly unprescribed substances. These veterans who have suffered unimaginable situations during their service to our country often lack the coping mechanisms, the internal restraints, or even the normal problem solving capabilities a non-medicated, mentally together individual would normally display.

c. Staff members have been assaulted, some killed, by veterans angry with care, whose demands are not met, or have been refused narcotic prescriptions.

- 1) In Jackson, Mississippi about 10 years ago a physician was shot and killed by a veteran who was denied pain medication.
- 2) Again in Jackson, two or three years ago a doctor had acid thrown in her face because a veteran was dissatisfied.
- 3) In Maine, a veteran reportedly became angry recently with not getting narcotics and ran his car into the side of their new CBOC building.
- 4) Another veteran angry about not getting his narcotics presented to the 'mother ship' in Maine reportedly hunting for the administrator to shoot. Instead, he was confronted by the police and a "suicide by cop" incident occurred.

- 5) Not long ago in Delaware two psychiatrists were reportedly attacked by a patient (it is rumored that both physicians have left the system)
- 5) I was told by a Phoenix VAMC staff member at the VA Intermin Staffing Program when I complained about concerns as to my safety while at Jackson, that this is not uncommon and a provider had been shot at the Phoenix VAMC.
- 6) The magnitude of the risk cannot be assessed since these statistics, if kept, are not available to staff.
- 7) Staff are not allowed to carry or have access to any type of protective device, such as a TASER or Mace. Instead, we are given silly little learning modules instructing us how to speak, act, or move to theoretically defuse volatile situations. One time I was forced to suggest that the all-female staff might grab the fire extinguisher to spray any violent perpetrator.
- 8) When potentially violent veterans or those who are known to have a history of violence or aggressive behavior directed against staff are identified, little effort on the part of administration is made to ensure the safety of staff. A complaint must be made to the "Disruptive Behavior Committee" after the fact, who will then decide on the final disposition of the complaint. The perception of the staff who were threatened or

attacked seems to be overshadowed by the veterans "rights", of which there seem to be more of than the staff's rights when it comes to safety.

- 9) Often the vet will simply be reassigned to another provider at the facility, even though the vet will be coming into contact with the disparaged staff members.
- 10) The most potentially violent vets are as a last resort required to present for care at a VA hospital where a guard must be assigned to the veteran. In a remote CBOC this is not an option.
- 11) Even the provider asking the staff to call the local Police to stand-by during an encounter is met with administrative objections and this action has to be approved by someone who has no medical background, direct knowledge of the situation, and nothing to suffer if a veteran loses control.
- 12) In summary, the staff's concerns about potentially violent persons in the workplace needs to be honored with swift action designed to lessen the risk to staff.

9. ***One life lost is too many on either side of the coin.***

## **GENERAL RECOMMENDATIONS**

1. **Complete reorganization of the VA Health Care System**, eliminating the "top heavy" emphasis of the current organizational scheme.
2. **Elimination of bonuses paid to administrators at various levels that provide incentive to provide the cheapest medical care**, and **NOT** provide the most effective strategies for medical services, including pain management
3. **Across the board "retirement" of administrators who have been shuffled to other facilities in the face of controversy, as pawns in a real life "shell game"** that merely transposes problem administrators, and whitewashes solutions to problems that threaten the health of veterans.
4. **Return the baton of health care administration to the realm of those trained in medicine** - the physicians, nurses, extended care providers, and personnel in other medical specialties. Eliminate policies that allow non-medical personnel, including those without college education and no medical background, to oversee and implement policies that directly impact medical professionals.
5. **Identify, address, and eliminate the rules and regulations that have restricted the ability of medical professionals to practice** their profession according to the highest (not the cheapest) standards, including making medical decisions that impact upon the quality of health care, within the scope of their medical licenses.
6. **Upgrade the computer system** used by the VA - the sacred tail that wags the dog. Implement user-friendly touch screens on portable lap-tops, making the providers more efficient and mobile. Field-test programs and changes with users/providers who don't live in a world of techno-gobblygook, instead of just adding layers of patches and illogical, inefficient steps

designed by IT (information technology) geeks that do not consult or care to consult with the providers who are slowed by laborious and unnecessary steps in documentation. The system should be provider-driven for purposes of accurate, efficient note-keeping to direct medical care with the least amount of burden, not administrator-focused for the purposes of forcing provision of data to be used for purposes that shed a positive light on the top dogs and their potential bonuses.

**7. Return the provision of medical care to the realm of physicians,** who by nature of their extensive education and training, are the ones who not only know what constitutes quality care, but should be allowed to see to it that this care is provided to our veterans. Do not mistake the concept of quality medical care as being the cheapest care that can be provided to the masses.

**8. Analyze the VA sanctioned indicators of quality care** and determine if the measures used are merely ways to polish statistics to make the upper echelon appear to be the shining knights of the VA dynasty.

**9. Allow extended care providers, nurse practitioners and physician assistants, to practice according to their own practice acts.** Do not allow the VA to rewrite their job descriptions based on administrators' perceived ability to provide equivalent primary care, which equates to merely "adequate" health care (most of the time for non-complex cases) at a cheaper cost. Allow the physicians to follow the more medically complex cases, including oversight of all the pain management cases, and allow the extended care providers to do the routine nuts and bolts daily medical services. Currently the system is flip-flopped, with the NP's and PA's having smaller panels of patients than the physicians, who are expected to manage much larger panels, thus having less time to contemplate or effectively manage their clients complicated medical issues. Consequently, there is not even time to supervise or consult of the cases handled by extended care providers who largely function independently at the VA. Basically, the simpler cases

should be handled by extended care providers and the more complex ones managed by physicians who should be given more time with these difficult cases.

10. **Reverse the trend to replace physicians with cheaper extended care providers.** Realign the team units to be directed by a physician who oversees that team's nurses and extended care providers along with ancillary staff. Currently the physicians are powerless due to the dictates of the administrative burdens. Implement methods to simplify and expedite day to day practices which historically have to pass through several layers of administration who jockey for control.

11. **Recognize that the heart and soul of the medical team is composed of the providers** of medical care. The current PACT approach (Patient Aligned Care Team) is based on a belief that the patient sits atop the health care team pyramid, when, in fact, the veterans are partners with the providers of medical care. The back to basics approach is based on the notion that the health care team is there to provide the best and most efficient care to the veteran, but the veteran does not have ownership of that team. The concept promulgated by the VA known as "Pain as the 5<sup>th</sup> Vital Sign" and that pain must be addressed regardless of other medical issues, is evidence of how terribly wrong a well-meaning system can become when care is driven by administrative demands and unreasonable expectations.

12. **Return specialty care to the domain of physician specialists.** Currently, many nurse practitioners and physician assistants perform specialty consults without physician intervention. The extended caregivers do not have equivalent training, their specialty training being largely on-the-job training. If there are not enough specialists, such as dermatologists and ENT physicians, contract the services out to medical experts and don't rely on cheap substitutes.

13. **Address the problem with the National VA Formulary** being so restrictive, loaded with cheap generics and limited drug choices in various categories. Currently each VSN's pharmacy decides

which drugs they will supply, which is based on cost-saving practices that allow chiefs to obtain monetary rewards for limiting costs. Pharmacists are the persons currently making decisions about medical necessity of non-formulary medications, often basing their decisions on studies that they are instructed to quote to justify their sometimes inappropriate denials or decisions. Return physicians to the front-line of drug-prescribing. Make the facilities publish the medication lists on-line so the providers of medical care will know what drugs are available per category and veterans will know the limitations of the formulary. Currently, it is impossible to get the VSN pharmacy to print a list of drugs they authorize as "formulary" - their rationale being the list changes daily, which in this day and age of computers is a particularly feeble excuse. This practice really equates to a veiled attempt by cost-cutters to maintain a wall of secrecy and whose practices are designed to exert control over providers.

14. ***Emphasize non-medicinal oriented approach*** to health care instead of focusing on which little pill can relieve a problem, and address what the veteran can do to help himself.

- a. Do group visits for problems such as weight loss or chronic medical problems requiring education such as diabetes, hypertension, and hyperlipidemia - the 'Big Three' problems making up the nemesis of the VA.
- b. Introduce alternative medicine approaches to be realistic options to facilities, such as acupuncture, chiropractic, massage, Tai Chi, and other such "mindfulness" oriented care.
- c. Allow physical therapists to return to hands-on activities, not being forced by time constraints to be mere machine jockeys or mere distributors of exercises

to do at home.

- d. Allow physicians who are trained or to be trained in acupuncture and to utilize it according to the principles of established practice within their daily practices.

15. **Address Poly-Pharmacy** as a real problem with potentially real-life serious consequences. Realize the current system of "medicine reconciliation," no matter how well-intentioned, just isn't working. People are over-medicated because medication is cheaper than alternatives, less labor-intensive than a provider explaining rationale and alternatives (which are currently limited), and reinforced by the revolving door mentality (get them in and out as quickly as possible). Acknowledge that by farming out much care to inaccessible specialists (often due to limitation of training and experience by extended care providers), there is no one who truly is "Captain of the Ship" - the role primary care physicians were designed to fulfill. Medications are added to already long lists of medications willy-nilly, with computer-generated reminders of "poly-pharmacy" and warnings of potentially serious interactions often being ignored.

16. **Identify true measures of quality care** instead of relying on surrogates that are designed to make an administrator's fiscal bottom line look good and perhaps contribute to his bonus. For instance, the current system rewards a provider based on whether they complete the computer-generated "Reminders" on-time or if they do the billing correctly and promptly, or do the endless and repetitive computer education modules on time (assigned by some well-intentioned administrator at the top who is far-removed from patient care). This says nothing about quality. Ignoring the fact that the veterans complaints have not been completely addressed, or all the interacting medical conditions were not taken into consideration, or that the physicians' documentations of encounters are worse than a beginning medical student's. These are examples of practices destined to result in harm to a veteran in the form of mistakes,

misdiagnoses, delay of care, and adverse reactions, any of which could be life-threatening.

17. **Return to Basics**, providing all aspects of primary care at offices and eliminating unnecessary consultations of specialists and stopping the practice of making veterans travel distances for care within the boundaries of primary care.

A. *Allow offices to perform simple point of care testing:*

1. Ability to perform finger stick blood sugars (a test which is readily done in the home by patients but is not allowed in offices due to lack of common sense by the administrators and lack of guidelines defining these simple office procedures).
2. Ability to perform finger stick INR's in the office to facilitate in-office management of anticoagulation
3. Ability to do simple hemocult testing (stool for Blood) in the office (CLIA waved testing) by nurses and providers without being subjected to onerous & ridiculous regulations that defy common sense.
4. Ability to use specially designed urine tox screen containers when obtaining specimens (for example, Monitor pH and temperature of urine)

B. *Allow physicians, NP's and PA's to practice according to their training:*

1. *Provide necessary supplies for performing simple procedures, such as performing biopsies of suspicious skin lesions, minor laceration repair so that veterans do not have to wait unnecessarily long times*

for appointments with specialists and have to travel unnecessarily for procedures that can be office-based.

2. *Train and accommodate providers* who desire to do Joint injections, trigger point injections, or other simple procedures
3. *Permit physicians who are trained in alternative medicine techniques to practice their skills* (such as herbal therapy, acupuncture, manipulation). Develop an environment of support for providers who chose to use non-pharmacological approaches as part of their practices. Provide additional funding for training in alternative medicine.

C. *Allow nurses to perform simple procedures they are trained to do* without being hog-tied by regulations.

For example:

1. Perform screening and removal of cerumen (ear wax) from veterans to eliminate referral to specialists and not make the veteran wait for care or have to travel long distances to the VA hospitals.
2. *Allow nurses to follow a predetermined policy for monitoring INR test results* to facilitate anti-coagulation (which many elderly vets are on).
3. *Allow nurses to remove sutures* so vets do not have to unnecessarily travel long distances to specialists
4. *Allow RN's to function as valuable team members*, and

provide medical technologists for drawing blood and obtaining and recording vital signs.

Do not put LPN's in medical technologist positions or fail to recognize their training prepares them to do more than most facilities are allowing (the problem is that there appears to be an emphasis on hiring more highly paid RN's and not using less expensive LPN's who can do most of what an out-patient office requires of nurses). Encourage the RN's to do more patient-oriented services, such as patient education.

18. **Encourage providers to attend outside the VA medical education courses** to learn the most up-to-date practices:

- a. Provide ample education funds sufficient to attend at least one extensive medical review course per year (currently the VA only pays \$1000 per provider per year, which is a fraction of what non-VA providers are offered and does not cover the cost of a decent course).
- b. Take the funding from the reported lavish junkets the administrators have sent themselves on in recent years and subsidize education, which will ultimately benefit veterans.

19. **Eliminate waste at all levels.** For example:

- a. VSN administrator being paid a \$63,000 bonus for quality care when the facility had a Legionnaire's outbreak.
- b. The Department of Veterans Affairs purchased pictures to spend leftover fiscal year dollars for \$562,000 (per

the Washington Post) when the veterans themselves would gladly have contributed veteran-made artwork for free (Washington Post).

- c. One facility purchased about 8 large flat-screen new televisions that were hung in the cafeteria which were not used as TV's but to flash a display of photos scanned repetitively, which supposedly were designed to calm the staff.
- d. Eliminate blocking out an hour each week for an entire staff meeting, which takes providers away from patient care, and inefficiently transmitting information that could be passed-on by e-mail memos.
- e. Eliminate indiscriminate purchase of expensive tele-health monitoring equipment which appears to be a priority over basic essentials such as decent suture removal kits, cerumen removal supplies, glucometers, point of care INR testing devices, minor surgical equipment, and liquid nitrogen.
- f. One facility purchased off-brand wall mounted otoscopes for their new office (which likely were deemed more cost-effective by a bean-counter), but failed to realize that the standard otoscope tips don't fit the cheap knock-offs. To use them, the provider has to perform an exercise in finger dexterity, which slows the examination process.
- g. One New Jersey new CBOC facility was supposed to have a

temperature-controlled room to store medications (which was never set-up as planned). Consequently, when temperatures soared in the office above the safe level, several thousand dollars' worth of medications had to be destroyed. When the nurse manager returned these to the pharmacy, a non-clinical administrative worker (with no medical training) berated the nurse for doing her job and attempting to prevent veterans from being given compromised medications.

- h. Employees from multiple facilities complain about the inefficient and wasteful system for obtaining ID badges. This usually amounts to each employee making multiple trips to the VSN headquarters (aka the 'mother ship') information technology (IT) department when getting an ID badge. These appointments are tightly controlled by the IT staff, who make appointments for their convenience and not necessarily the convenience or needs of employees.

Furthermore, often the system is "down", or if working, it can take hours of waiting to print one ID card. This process occurs after the employee is again finger printed (if it has been more than 3-6 months since the last badge was issued) - another time-consuming and expensive proposition). Several employees report driving 4-5 hours one-way from their CBOC (Community Based Out-Patient Clinic) only to be told they must return again and again-

some as often as 5 times to obtain the sacred "PIV" ID badge. This badge designed is to travel with the employee from facility to facility, yet the various IT departments inappropriately inactivate the badges. This can become a costly process. For example, for each of the 70 doctors and extended care providers now in the VA Interim Staffing locums department, that means with each of 3-4 assignments per year there is a good likelihood that this process of wasted work days and IT employee hours will be repeated over and over again at a cost not even factored in to the scheme of things. No one is counting lost productivity, the cost of travel back and forth, and how this contributes to waste and interruption of care.

Curiously, this inept system has found me going to five different IT departments, making several trips at each facility resulting in a significant amount of time away from treating veterans.

This also means that five times I've been fingerprinted and my fingerprints run through the FBI system (or whoever checks our status). At what cost is this?

Does anyone do anything? Does anyone care?

- i. Another gross waste is the time and money spent by each VA facility's credentialing department. Of the now seventy physicians (previously ninety) who are part of the VA traveling physician corps (now called VA Interim

Staffing), each physician has to be "re-credentialed" for each VA assignment. If each physician does three assignments per year that is 210 times per year references have to be contacted, 210 times per year the National Practitioner Data Bank is queried (not an insignificant cost for each query), and 210 times a huge number of staff have to track down the same information (all physicians and extended care providers) are initially credentialed upon hire).

The simple solution is for the VA Central Office (VACO) to issue a mandate that physicians or other 'providers' employed by the VA can be credentialed on a temporary basis at a facility that has an emergency need for staffing based on credentials from the parent facility. This loss of money had been going on during the over four years of this program's existence in spite of numerous complaints by providers.

20. ***Make it easier to remove employees who are consistently not performing*** according to job standards.

- a. Do not allow the practice of moving administrators around the VA system, relocating them in a secret "shell game" to other VSN's (divisions) when performance has come into question.
- b. Do not allow investigations to drag on through committee inertia or inability to take a stand on cases of abuse, or fraud.

One noteworthy case in New England involved a physician

assistant accused of fraudulent medical records, poor work ethic, failure physically examine patients, and failure to monitor narcotics (some of the reported charges). At last report, the investigation was now into at least the 8<sup>th</sup> month, while the provider received full pay while on administrative leave (and reportedly also working in an ER at a local hospital outside the VA).

**21. The VA is experiencing shortages of provider, which is at the core of the problems surrounding the VA, yet a program that was helping short-staffed facilities is in serious jeopardy.**

- a. The VA has its own corps of traveling physicians (some PA's), initially a great idea for getting temporary emergency medical coverage for VA facilities that needed providers to help deliver medical care to veterans who would otherwise go untreated.
- b. Now due to micromanaging by the upper echelon and an emphasis on cost containment, the number of providers dropped from 90 to about 70, the focus is on cost-cutting, and the program now hires only part-time people who do not get benefits.
- c. The VA Intermin Staffing Program now charges facilities, so there was a dramatic drop in the number of facilities requesting a VA locums provider (from well over a hundred facilities to about twenty).

- d. So what happens to the vets because facilities do not have it budgeted to supply providers when short-staffed? They don't get care, or they are shuffled to another on-staff provider who already doesn't have the time to manage his/her panel. This contributes to the problem with failure to adequately manage pain medications.
- e. What does the VACO offer as a solution to our program? Of course, hire another supervisor, an expensive Director of the VA Intermin Staffing Program. Great credentials, but did he ever do locums work? The program can't afford to keep trained, readily available physicians on their payroll, but they can add another layer of administration. As I mentioned previously, the system is far too top heavy and bogged down with committees that govern committees, and rules that sustain committees.

***God Save Our Veterans! Apparently, no one else can.***