U.S. House of Representatives, Committee on Veterans' Affairs (HVAC)
Subcommittee on Oversight and Investigations (O&I)
"Correcting 'Kerfuffles' – Analyzing Prohibited Practices and Preventable Patient Deaths at Jackson VAMC"
For the O&I hearing on November 13, 2013 at 10:00; 334 Cannon House Office Building, Washington, DC
Written Comments for the Record by Erik Hearon, CPA and Maj Gen (USAF) (Ret.)

Honor Veterans with a Much Improved VA Health Administration and Central Office

Committee members and staff, thank you for your commitment to ensuring proper care for and treatment of our precious veterans. This hearing focuses on the VA Medical Center in Jackson, MS and is one in a long line of hearings you have held to focus on issues at many VA Medical Centers. This does not excuse Jackson. Instead, the pattern of ongoing but uncorrected errors lasting a decade or more proves many critical points about the systemic VA failures of leadership nationwide.

The dictionary defines kerfuffle as fuss, commotion, to disorder, confuse – all perfect descriptions for some aspects of the Jackson and nationwide VA operations.

In addition to these written comments, I have provided the Subcommittee with two copies of a videodisk of the April 3, 2013 "town hall meeting" in Jackson.

Panel 1 represents over two hundred people in the Jackson, MS area who are very interested in the VA providing the best professional, timely and organized health care to our veterans. Our group is composed of veterans, past and current employees of the VA and concerned citizens. We do not have an official name or a budget. One thing we do have is a strong ongoing commitment to exposing areas for improvement in Jackson and nationally until the issues are fixed.

We thank and support all VA employees who provide professional, caring health care to our veterans. Those who consistently follow the I CARE core values of Integrity, Commitment, Advocacy, Respect and Excellence should be emulated by the others. We wish there was no need for negative discussion, media coverage or Congressional inquiries. We also thank the Office of Special Counsel and every veterans' organization, each investing significant time and resources into improving the VA's management and health care.

One of the members testifying today in the other panel gave me the title "Chief Instigator." I wish that our group's work was no longer needed but there is no sign that we have succeeded in our pursuit for improved management. Transfers to the VISN (Veterans Integrated Service Network) office and to another VISN have not improved health for veterans overall.

During my forty years of military service I heard many stories about deficiencies in the operation of the Jackson VA Medical Center, which is named for G. V. "Sonny" Montgomery. Sonny served in World War II, earned the Bronze Star with Valor and the Combat Infantry Badge, served in the Mississippi House for ten years and

served in the US House from 1967 to 1997, including chairing your committee from 1985 to 1997. The Montgomery GI Bill is named for Sonny, as are a C-17 cargo aircraft, the conference room at the VA's Central Office and many other VA and non-VA facilities. Sonny also received the Presidential Medal of Freedom.

Whenever Sonny was asked "Are you red or blue?" his consistent answer was "I am red, white and blue." Supporting issues to protect national security and Veterans were at the top of his priorities. These issues have normally enjoyed broad bipartisan support and we trust that this pattern will continue. We are sure that the current committee has the same dedication to veterans as did Sonny.

We celebrated Veterans Day two days ago, honoring and thanking the millions of men and women, as well as their families, of all races and faiths who have defended our many freedoms. Their dedication and sacrifice have always protected our freedoms and us for centuries. Chairman Coffman's service in the Army and Marine Corps and during the Gulf War and the Iraq War are extremely laudable. We also thank Rep. Tim Walz for his twenty-four years of military service.

We must remember President Lincoln's commitment in his second inaugural address "to care for him who shall have borne the battle and for his widow and his orphan." The Department of Veterans Affairs has been responsible for fulfilling President Lincoln's commitment. I believe that the spirit with which Sonny served Veterans has been displayed in several management actions of the current VA administration.

The VA has more than 1,700 facilities, employs over 200,000 people and cares for over 6.3 million Veterans each year. The VA's Health Administration (VHA) expenditures are over $53.4 billion or about $8,500 per patient per year on average.

A House Veterans' Affairs Committee (HVAC) hearing in April 2013 included a commitment by a Congressman to the VA that he would introduce legislation to privatize the benefits process if the claims backlog has not been resolved by 2015. I ask that a similar challenge and commitment should be made now if some significant aspects of health care aren't dramatically improved. The replacement to the VHA should provide the same level of coverage and care through insurance from the private sector and would, I estimate, save at least $4.6 billion annually. The calculations for my estimate for this are at the end of these comments but the primary reason for the suggestion to change to insurance would be to provide better, safer and more appropriately monitored care.

While very many of the VAMCs' physicians and other health care professionals provide excellent care to the patients, management has a much more mixed record. The VA management's failures result in cancelled and delayed appointments, interim and occupants of what should be permanent employees, reduced continuity of care, failure to enforce standards due to the shortages and other issues leading to decreased patient safety and care.

The HVAC has been diligent in pursuing improvements at the VA, holding a hearing in Pittsburgh, PA on September 9 that focused on lack of accountability, ques-

tionable bonuses, preventable deaths and patient safety issues. Five VAMCs were in the spotlight: Pittsburgh, Buffalo, Atlanta, Jackson and Dallas.

Dr. Petzel was the lead representative in Pittsburgh from the VA. He has been the Under Secretary for Health for the VA since February 18, 2010 but is "retiring" some time in 2014. I attended the Pittsburgh hearing and am convinced that the U.S. Representatives conducting the hearing were skeptical initially because of prior events but seemed insulted by some of the VA's responses that day and many failures to respond to the Committee before.

After the Pittsburgh hearing, an incredibly misleading and incomplete press release was published on behalf of Robert A. Petzel, MD, by the VA Central Office in Washington. The press release was a blurred snapshot with so much "photo-shopping" that the actual event was hard to visualize.

The most significant omission or kerfuffle in the press release is that virtually every medical treatment error relates to ongoing poor management over many years but no errors were mentioned. This includes management in some VAMCs, networks (a group of about ten VAMCs) and the VA's Central Office, from chiefs in hospital departments to the Secretary.

An ongoing lack of accountability by VA management personnel was one focus of the hearing. The Pittsburgh VA had five patients die and others sickened (all veterans) recently from Legionella, after multiple warnings about improper maintenance of the water system, going back to 2010. A simple fix had been recommended and ignored, resulting in the unnecessary deaths.

The Pittsburgh VAMC had a world-class research lab to study Legionella but it was closed several years ago by the hospital's director, Michael Moreland, and the samples were destroyed. However, Mr. Moreland was promoted to director over ten VAMCs as well as forty-three outpatient clinics and awarded a Presidential award for a "lifetime of service", based on the recommendation of Dr. Petzel. The award included a $63,000 bonus. The HVAC hearing focused on this as well. Dr. Petzel said "yes" when asked whether or not he would still nominate Mr. Moreland knowing all of the events leading up to the hearing and the deaths. Mr. Moreland's retirement was announced October 4 and his replacement was announced October 24, effective November 2. He was asked to return the $63,000 award during the HVAC hearing in Pittsburgh. The VA said that they do not have a mechanism to "claw back" bonuses. How do the circumstances around Mr. Moreland's promotion, bonus, etc. exemplify any standard of integrity, transparency, leadership, care, etc.?

Bonuses to "leaders" at facilities and networks with serious and well-known problems were another focus of the hearing but were not mentioned in the VA's press release. The criteria and calculations for bonuses are closely guarded secrets but the HVAC and some in the media have worked to crack the wall of secrecy. Some people directly or indirectly in charge of VAMCs which had, and often still have, significant medical errors received bonuses anyway as investigated by your committee.

Bonuses of over $408 million in a recent fiscal year show that bonuses are treated as an entitlement to some rather than for service over and above normal. If an employee cannot consistently follow the I CARE core values, they should be reprimanded, receive no bonus for that year and their appraisal should reflect this. An investigative story titled "Death and Dishonor: Crisis at the VA" aired two days ago on CNBC and highlighted the bonus issue in Jackson, as have other media reports.

Several families testified about suicides and other deaths resulting from VA errors and management issues, including under-staffing. Dr. Petzel's attempt at apologizing to the families was enough to make about 90% of the audience groan.

The VA's culture of tolerating a certain level of unnecessary patient deaths and injury should never have existed and must be immediately stopped, with disciplinary action for those who accepted it. Suicides and other unnecessary deaths have not received a proper and forceful response.

A culture of not removing problem employees exists in Jackson. Transfers from a VAMC to another VAMC or network have been considered as corrective but keep them on the VA payroll without taking real action.

The Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency. The OSC has received proportionately more complaints about the VA than any other US Government agency. Everyone who wants better performance at the VA at all levels appreciates the OSC's diligent work to make this happen. If the VA would pursue corrective actions on substantiated complaints we might not need this hearing. Secretary Shinseki has signed many reports to the OSC, including about Jackson, but no leadership personnel have received noticeable adverse actions.

Considering the reports to the OSC and the many reports of needed corrections from the VA's Office of the Inspector General, the number of repetitive problems should have been a huge wakeup call long ago.

Many issues have also been brought to the VA's attention by House and Senate Veterans' Affairs Committees. It seems like an extremely sad and expensive whac-a-mole game wherein the same problem occurs in a new location when the VA says it has resolved the same issue in recent but different locations.

Problems have existed in some VAMCs about improper narcotic prescriptions. The management of the VAMC in Jackson, MS has fought with the MS Boards of Medical Licensure and Nursing, as well as the DEA, about some Nurse Practitioners operating beyond their license. Some nurse practitioners at Jackson have even obtained a license from Iowa, although Mississippi has been their source before, because Iowa does not require collaboration or supervision of them by a physician. Ultimately patient health and safety are at risk as illustrated by a tragic situation described below.

Allowing employees who have been previously licensed in their state of residence and the VA facility at which they work to change to another state for licensing should not be allowed. It allows people to seek the path of least resistance

(demonstrated professional knowledge). If they can not pass the test in their home state, move to Iowa or a similar state of lax licensing requirements. Patient safety is compromised now.

Patients around the country rely on state Boards of Health, Medical Licensure and Nursing as a critical link in assuring that only competent medical professionals are allowed to practice. Mississippi is no different. However, the "federal supremacy" concept precludes those state agencies from performing their normal monitoring duties to protect patient safety. The agencies cannot improve the attitude of a small percentage of those in Jackson who apparently feel that the patients are an inconvenience but they can more diligently make normal inquiries as well as investigate complaints.

The legal concept of "federal supremacy" adversely impacts the health of VA patients. The state agencies already perform inspections in almost all hospitals, nursing homes, etc. to ensure the quality of patient care. They have been stiff-armed in Jackson and federal facilities throughout the country. The "federal supremacy" concept should be abandoned immediately for the entire VA system.

Effective initial and continuing training for VA supervisors and "leaders" does not exist. If the training were effective, the same or very similar problems would not keep appearing. Most VAMCs and networks are run safely and effectively but others do not have management with a sense of dedication, service and integrity. When the OSC investigated errors in prescribing narcotics and the VA promised they had changed, within one week the Jackson VA was again telling physicians to prescribe narcotics for patients they had not examined.

Many critical management practices must be corrected. The VA claims to follow core values as described in their I CARE posters: Integrity, Commitment, Advocacy, Respect and Excellence. If the VA lived by the I CARE values, job openings for medical professionals would be few and easily filled, "leadership" positions would be filled by permanent employees instead of having so many "acting service chiefs" (the Jackson VAMC has spent a year with 15-17 acting chiefs), continuity of care and management would be greatly improved with resulting increases in quality of care and employee morale, employee appraisals would be accurate, inspections would be routine, media and Congressional inquiries would not be feared, and VA press releases would be much more truthful.

Your full Committee held a hearing on May 3, 2011 in this same room. The subject was "Sacred Obligation: Restoring Veteran Trust and Patient Safety", a laudable and reasonable expectation. Chairman Jeff Miller's remarks included "After these incidents [of serious patient safety violations] the VA assured Congress and the country that it was aggressively addressing patient safety issues and never again would a veteran's trust be compromised by lapses in quality care at a VA medical facility and, yet, each patient safety incident has seemingly led the way for the next lessons learned and the unacceptable and inexcusable revelation that the patient safety culture in VA is fractured and accountability and leadership at the helm are lacking. The time for talk is over." (page 4) Legionella in Pittsburgh and a significant turnover and lack of physicians, at least in Jackson, are clear signs that the VA's assurances on May 3, 2011 have not been fulfilled. The subject for that

hearing should have been easily understood and attained by the VA but it has not been in too many situations.

The culture that has grown over the last decade or more in Jackson has not improved the trust of veterans. Mr. Joe Battle, the center director, has been in Jackson for one year and ten months. In my view, Mr. Battle is a fine person and has tried hard to improve health care but has been hampered and constrained by the apparent lack of information and support by his staff, VISN 16 and the VA Central Office.

At the urging of U.S. Senators Cochran and Wicker from Mississippi, a "town hall" meeting was held in Jackson April 3, 2013. Robert Petzel, MD, Under Secretary of Health for the VA, was the key speaker, accompanied by Gregg Parker, MD, Ms. Rica Lewis-Payton from VISN16 and others. An opportunity to restore communications and trust between the VA and over 200 veterans in attendance was completely wasted and actually fueled the frustration. The third relatively recent article in the New York Times about the Jackson VA's challenges was in the next day's issue and was about one-half page with a photograph.

The ratio of physicians and nurse practitioners in primary care in Jackson has been skewed for years. The ratio has been three nurse practitioners (NPs) per physician but is now said by the VA to be approaching two to one. The 3:1 ratio evolving from the direct efforts of a former Chief of Nursing Services who resisted the hiring of physicians. She was arrested on narcotic charges May 23, 2012 and returned to work about thirteen (13) months later after criminal charges were dropped. She received her pay of about $170,000 annually throughout that absence. The New York Times reported in a September 9, 2013 article that she "received $61,250 in performance bonuses between 2003 and 2011". I personally had a DEA agent tell me that they would not be able to pursue the case against her "due to political pressure". She has been assigned to VISN16.

Another factor in some lapses in quality care is that the professional judgment and medical orders of some physicians were overridden by a nurse practitioner. While the large majority of NPs in Jackson provide caring and professional care, some appear to feel that they are qualified to make better decisions than the physicians. When this situation arises and particularly when it is allowed to stand, the insult to physicians is dramatic and well known among the staff.

Just this past Wednesday, one week ago today, I was told about and interviewed a veteran of over twenty years who also happened to be an employee of the Jackson VAMC. He and his wife told me that he had been seen for almost two years only by nurse practitioners and could not see a physician. They went back for his appointments each three to four months complaining of increasing levels of pain. Each time he was given medicine just above the level of aspirin and given another appointment. They said the VA drew his blood for a routine test on each visit but never ran a CA-125 test to check for cancer, although a CT scan had disclosed "something". He finally and totally lost faith in the VA's health care and obtained non-VA medical care, which discovered this past April that he had adenocarcinoma in the stomach. His private oncologist wrote him an excuse to miss work indefinitely while he received chemotherapy but the VA Human Resources department

would only accept the document for six months. At the end of that time and while still receiving chemotherapy he had to argue with a physician in primary care and she finally extended the excused absence for three days, yes, three days. The physician also all but told him he was being a slacker, based on her view of other patients' actions. His entire stomach was removed about two months ago. Some of his small intestines were made into a stomach and he continues chemotherapy. He missed an entire month's pay, has not received it yet, is out of the VA pay system, receives Social Security Disability and $230 monthly from the VA. He also lost about $5,000 out-of-pocket on insurance deductibles since he could not get his earned but insufficient care at the VA for his illness. He has not received an institutional disclosure from the VA, not to mention an apology for misdiagnosis. He has a wife and six children. The spirits of the parents are much better due to their faith than I expected but their upcoming financial and health situations are of great concern. In my view, he should immediately receive a personal apology from the primary care physician, his full pay for the month or so gap created when paperwork was not properly handled, reimbursement of the full amount of his insurance deductibles and an institutional disclosure to help him understand his legal alternatives with the VA. He is the second veteran I have talked to in the last five months with a very similar story.

The horrific situation described above comes after the well-publicized April 1, 2011 death of a veteran within a very few hours of surgery. Johnnie Lee bled to death in recovery because no one checked on him for hours. Before Mr. Lee's death, the FDA issued warnings in 2009 and February 2011. The medical procedure required checking the patient about every fifteen minutes. The VA claims that The Joint Commission (also known as JACO) investigated the case of Mr. Lee's death and decided that nothing was done wrong. In my mind, the quality of the investigation by JACO in this case was substandard and disqualifies JACO inspections as qualifying as any comfort about the quality of care at Jackson and nationwide.

At the Jackson VAMC, there are no orthopedic surgeons or podiatrists. It is obvious that those specialties and many others are needed for the patient population. Those services have been contracted to outside facilities. However, several if not all of the best local orthopedic practices have discontinued accepting referrals from the VA due to non-payment from the VA for extended periods. After relying on outside practices and being unable to staff the specialty themselves, the VA's Central Fiscal Office should be examined and reprimanded, if appropriate, with firings due to the impact on patient care of their delay in paying legitimate bills. The slow payments to vendors also came up in the April 3, 2013 "town hall" meeting.

There should absolutely not be funds for bonuses to VA "leadership" if the health care providers cannot be paid on time.

The terror faced by some veterans after medical errors has been exacerbated by the VA and US Attorneys. A World War II veteran in Jackson who drove other veterans to the hospital was blinded in both eyes after an undiluted solution was put in both eyes for cataract surgery. The covering to both eyes boiled away. His whole life turned upside down. Very limited help was offered by the VA. The VA and US attorneys fought him tooth and nail in court and lost. If his situation could have

been made worse, the VA and US attorneys found a way to do so in this and other cases.

Accountability, highlighted at the Pittsburgh hearing as a critical factor, has been partially shown in two instances. A physician who was Chief of Staff in Jackson instructed physicians to prescribe narcotics to patients who had not been examined by that physician, which risked the medical license of physicians who followed his instructions. He was ultimately removed from his "leadership" position where he saw very few if any patients but he remains in the Jackson VA medical center as a physician, creating "kerfuffle" or confusion among other employees as to his true role. Additionally, the Chief of Primary Care received enough encouragement to get him out of the Jackson VA but he transferred to a VA in Mountain Home, TN, in another VISN.

The VA website states that they are "the nation's largest integrated health care system …". Some financial institutions were said to be too large to fail. I suggest that it is past time to consider whether the VA is too big to succeed.

What is the solution? Any solution must include the immediate retirement or termination of all "leaders" who knew or should have known of the practices which led to patient deaths or serious injury or who condoned lapses of ethics and integrity. The changes must be transparent and decisive to restore trust among the Veterans. Actions by people in "leadership" positions, as well as their lack of actions, send messages to employees and the veterans. The message so far has often been "no matter what you do or how much you ignore the I CARE core values, we will not fire you." To paraphrase General Colin Powell's first rule of leadership, "Being responsible sometimes means making some people very mad."

The solution to ongoing VA problems must also include the retirement of Secretary Eric Shinseki. While he had a distinguished military career, Secretary Shinseki has failed to acknowledge and correct leadership deficiencies or serious and well-known problems affecting many Veterans.

Secretary Shinseki has signed so many reports to the Congress and OSC acknowledging deficiencies that he has no plausible deniability about knowing of serious problems in VISN16, Jackson and elsewhere. Leadership starts at the top and he is directly and personally responsible for his failure to lead the VA or to hold his staff accountable. The responsible action is for Secretary Shinseki to resign, along with Dr. Petzel, Mr. Moreland and others. Those willing and able to perform for the veterans should be encouraged and the others should leave the VA. Only a clean house, with the windows wide open, will restore the lost trust of the Veterans and show that the VA truly cares.

Again we thank the Oversight and Investigations Subcommittee, the full Committee and your staffs for continuing to focus the VA on accountability, responsibility, transparency, transformation and fully pursuing their core values of I CARE. Thank you for the Accountability Watch featured on your website. We also thank the Office of Special Counsel and the media in Jackson and around the country for covering the shortcomings, as well as the successes, of the VA.

We especially thank those current and former VA employees who care for our veterans appropriately and who have shared information to improve the medical care.

We look forward to continuing work with the Committee in the future to support your critical oversight. Thank you and God Bless America.

Veterans Health Administration (VHA)	
Comparison of Providing Insurance v. VHA Costs; Estimated	
152 Medical Centers, 817 Community-Based Outpatient Clinics	
Money spent in Veterans Health Administration, FY12, per VA	
Performance and Accountability Report, unaudited ($ in millions)	
Budgetary; Part IV, page 4; Note (1)	
Personnel compensation and benefits	$ 27,529
Other contractual services	11,580
Supplies and materials	8,784
Land and structures	3,231
Equipment	2,058
Rent, communications and utilities	1,869
Grants, subsidies and contributions	1,300
Other	1,040
Less VA Community Living Centers / Nursing Home; Note (2)	(4,250)
Plus FY13 VHA construction request; Note (3)	1,024
Total	54,165
Note: FY13 discretionary funding for Medical Care $55,672 million	
$417 million for General Administration and $1,271 million for	
construction and grants; Note (4)	
2013 premium example; standard option for veteran only; includes	
monthly gov't + employee premiums; Note (5)	600
times number of months to annualize	12
premium per patient per year; estimated	7,200
times number of unique patients in VA system; FY12 estimate;	
Note (6); in millions	6.2547
Estimated premiums for veterans only; in millions $	45,034
Estimated additional amount for covered family -- 10%	4,503
Total estimated premiums (in millions)	49,537
Estimated savings to close VHA portion of VA (millions per year)	$ 4,628
Notes:	
(1) www.va.gov/budget/docs/report/PartIV/2012-VAPAR_Part_IV.pdf	
(2) VA 2013 Congressional Submission; page 1A-5; FY12 estimated	
(3) VA FY13 Budget Request, Vol IV, page 1-1	
(4) www.va.gov/budget/docs/summary/Fy2013_Fast_Facts_VAs_ Budget_Highlights.pdf	
(5) as an example, 2013 Blue Cross and Blue Shield Service Benefit Plan; non-Postal premium; page 150 of printed brochure; www.fepblue.org	
(6) www.va.gov/budget/docs/report/PartI/2012-VAPAR_Part_I.pdf; page I-31	

Some articles (links where available) to some media stories about Jackson's VA and the VA system:

Title	Author; source; link
Death at VA hospital probed; Employee found dead in room after routine leg surgery	Jerry Mitchell; Clarion Ledger; published May 8, 2011
Jackson VA Hospital official (Dorothy White-Taylor) charged with drug fraud	Clarion Ledger; published May 24, 2012
Rep. Bennie Thompson asks probe of VA staffing, patient care	Clarion Ledger; published June 13, 2012
Documents link deaths to improper VA staffing	Jerry Mitchell; Clarion Ledger; published August 25, 2012
Narcotic scripts focus of VA probe	Jerry Mitchell; Clarion Ledger; published August 25, 2012
Congressional Investigation of Jackson VA in order	Charles "Todd" Sherwood; op-ed in Clarion Ledger; published September 12, 2012
Federal probe: VA hospital in Jackson subject of scathing report	Robert Burns (AP); Clarion Ledger; published March 20, 2013; clarionledger.com/viewart/20130320/NEWS01/303200028/Federal-probe-VA-hospital-Jackson-subject-scathing-report
Town hall opportunity to discuss veteran care at Jackson VA	Senator Roger Wicker; op-ed in Clarion Ledger; published March 24, 2013
Questions welcome at VA town hall meeting	Jerry Mitchell; Clarion Ledger; published March 30, 2013; clarionledger.com/apps/pbcs.dll/article?AID=2013303300025
VA's appalling failure in MS are not recent problems	Sid Salter; op-ed; Clarion Ledger; published March 31, 2013; clarionledger.com/apps/pbcs.dll/article?AID= 2013303 310030
Some VA nurses went out of state for needed certification; certification from Iowa seen as way to skirt MS Boards	Jerry Mitchell; Clarion Ledger; published April 3, 2013; clarionledger.com/apps/pbcs.dll/article?AID=2013304030012
Some vets frustrated by one-sided format at VA town hall meeting; Officials say hospital one of best in nation	Jerry Mitchell; Clarion Ledger; published April 4, 2013; clarionledger.com/apps/pbcs.dll/article?AID=2013304040047
Meeting didn't give veterans chance to speak on issues	Clarion Ledger editorial; published April 5, 2013; clarionledger.com/article/20130405/OPINION01/304050015/Meeting-didn-t-give-veterans-chance-speak-issues
VA can't get worse, must get better	Bob Slater, Madison, MS letter to the editor; Clarion Ledger; published September 19, 2013; clarionledger.com/apps/pbcs.dll/article?AID=/201309201635/OPINION02/309200320
Counsel: VA deficient in care, responding to problems	Jerry Mitchell; Clarion Ledger; published September 22, 2013
Veterans no longer trust VA hospital for care; mentions numerous names	Fred Lucas (veteran); op-ed; Clarion Ledger; published October 12, 2013; clarionledger.com/apps/pbcs.dll/article?AID=2013310120035

A Pattern of Problems at a Hospital for Veterans	James Dao; New York Times; published March 19, 2013; nytimes.com/2013/03/19/us/whistle-blower-complaints-at-veterans-hospital-in-mississippi.html?emc=eta1&_r=0
Veterans Affairs Officials Offer Reassurance About Troubled Hospital	James Dao; New York Times; published April 4, 2013; nytimes.com/2013/04/04/us/veterans-affairs-officials-offer-reassurance-about-troubled-hospital.html?_r=0
V.A. Inquiry Finds Inadequate Staffing of Doctors at Mississippi Hospital; re accusations by Dr. Phyllis Hollenbeck	James Dao; New York Times; published September 9, 2013; nytimes.com/2013/09/09/us/inquiry-finds-inadequate-staffing-at-mississippi-veterans-hospital.html?_r=0
Death and Dishonor: Crisis at the VA	Dina Gusovsky; CNBC documentary; cnbc.com/id/10001293?_source=vty%7Cinvestigationsinc%7C&par=vty
20 Buffalo VA patients test positive for hepatitis	Jerry Zremski; Buffalo News; printed May 9, 2013; buffalonews.com/apps/pbcs.dll/article?AID=/20130509/CITYANDREGION/130509231