Statement of Dr. Gary R. Lammert to the Committee on Veteran's Affairs, Sub Committee on Oversight and Investigations for the 23 July 2019 hearing entitled "Learning from Whistleblowers at the Department of Veterans Affairs."

21 July 2019

Dear Members of the Subcommittee on Oversight and Investigations:

My name is Dr. Gary Lammert, Captain United States Navy Retired. I was commissioned in 1973 as an ensign in United States Medical Corps and was the third emergency medicine residency trained physician in the Navy. I served with the Seabee's in Diego Garcia in 1978 and with the 1st Marine Expeditionary Force at Camp Commando during the OIF invasion in 2003. I have earned two Navy Meritorious Service Medals. I served as the Emergency Medicine Department Head at Camp Pendleton Naval Hospital and at Jacksonville Naval Hospital for a total of nearly 15 years and served as the Emergency Medicine Residency Program Director at Naval Hospital San Diego for over 9 years, training some 80 physicians in emergency medicine. After retiring from the Navy at the rank of Captain in 2005, I served at a position as a contract emergency physician at Naval Hospital Jacksonville and then accepted a position as the section chief of the emergency physicians at West Palm Beach VAMC in January 2006. I served as section chief until April 2018 when my section chief position was replaced with a service chief position, which was filled by management with their preferred candidate, a non-veteran physician who was not board certified or residency trained in emergency medicine. The other major difference between me and my replacement is that he is not a whistleblower, whereas I am not only a whistleblower, I am a whistleblower who has filed complaints of whistleblower retaliation. Since my removal as section chief, I have been transferred from the Emergency Department to Primary Care, where I am no longer able to practice my Board Certified specialty of Emergency Medicine. Currently, my credentials to practice medicine at the WPB VAMC are being threatened.

My Whistleblowing and the Retaliation Which I Experienced

Out of concerns for my fellow veterans, preventing waste in the government, and adhering to laws, regulations and policies, I have reported a number of whistleblower issues dealing with all of these concerns. In particular, I reported to the VA OIG and Secretary McDonald in September 2017 about an issue of physicians in the VA on compressed tours receiving excess leave due to leave being defined in days rather than hours. I also pointed out to Secretary McDonald that the WPB management was trying to mandate a reduction in compressed tours from 12 hours to 10 hours in an effort to reduce the excessive leave. (WPB management was deliberately short staffing the ED to invoke Rule 7422 to mandate the change after the compressed tour physicians refused to voluntarily reduce the length of their tours.) Although my reporting of this issue was a personal disaster for me from the retaliation that it started, my effort was a success for the VA as my recommendation to have leave designated in hours, rather than days, was eventually implemented in the summer of 2018. The retaliation that I received following my reporting of this issue is described in detail in the reports my advisor sent to the OSC and VA OIG, which will be provided to any member of the subcommittee upon request.

I doubt that the Subcommittee has much interest in individual whistleblower retaliation cases so I will just provide a few highlights of the tactics that were used by VA management to punish my whistleblowing:

1. I received downgraded FY2016 ECF performance review (and bonus) in November 2016 based on four false statements including a reference to my whistleblowing that stated that I did not "*utilize appropriate chain of command while providing reasonable timeliness and attempts to address areas of concern/ interest*". My immediate reply to management was that the downgraded performance review (and bonus) represented whistleblower retaliation, and false statements represented an initial step to remove me from my leadership position as section chief of the ED. I was promised that an independent investigation would be initiated for my claim of whistleblower retaliation, but received no results of an investigation.
2. WPB management initiated a second site review of the ED within an 11 month period in November 2017, even though the first site review in December 2016 had been very favorable to my leadership, organization, and work ethic and to staff morale. While the second site reviewer made more than 10 recommendations for improving the operation of the ED, the only significant one implemented by WPB management was to move the leadership position of the ED from my section chief position to a service chief position. (The site reviewer was the Medical Center Director of a VA hospital, but the physicians in the ED in his hospital were led by a section chief, not his recommended service chief.)
3. In February 2018 WPB management posted the position of service chief to replace my section chief position on "usajobs" for only a two week period just days after I left on six weeks of sick leave, yet they failed to inform me of this posting. (I did find the posting while at home and did apply.)
4. During 2017 and through January 2018 the ED was understaffed by management failing to offer salaries to attract highly qualified candidates in a timely manner. I was not only working 60-70 hours per week to partially alleviate this understaffing, I was subjected to numerous harassing events (such as management created short deadlines) in an attempt by management to establish performance deficiencies, which they were unable to accomplish. The short staffing did cause disharmony among the physicians, particularly between a group of physicians having to work rotating shifts and a part time physicians who had an established tour (for more than 10 years) of weekday only day shifts to accommodate her family needs.
5. WPB management was faced with a serious dilemma. They had already arranged for their chosen candidate to come to WPB as the new service chief, but they unexpectedly had my application in hand for that position. Their solution to the problem was to convene an AIB to investigate my leadership of the ED with the intent to use the AIB findings to disqualify me from competing for the service chief position. The problem with convening the AIB was that it violated the conflict of interest policy of VA Handbook 0700 for both self investigation and bias.
6. The primary allegation on the AIB agenda was a charge that named me as the RMO (management official alleged to have discriminated against the complainant) in an EEO claim. This EEO claim started from the part time physician (discussed above in #4) submitting a complaint of intimidating and disruptive behavior against one of the more vocal physicians having to work rotating shifts, who insisted that she also be required to work her fair share of rotating shifts. By the complaint using the term "hostile work

environment" in her complaint against the vocal physician, but with no claim of discrimination in the complaint, WPB management in collusion with an ORM district manager was able to manufacture a fraudulent and false gender based discriminatory claim of sexual harassment against me citing a specific date of 3/27/2018 of an EEO occurrence. Furthermore, the ORM district manager failed to initiate the informal investigative procedure defined in the ORM EEO VA Handbook 5977 deferring to the AIB to investigate the EEO claim, thereby depriving me of my due process rights guaranteed by that Handbook, and depriving me the ability to resolve the false claim essentially immediately.

7. In addition to this false issue on the AIB agenda and the conflict of interest of the convening of the AIB, there were at least three other violations of VA Handbook 0700 in the convening of the AIB, including the purposeful violation of my Privacy Act rights.

8. My supervisory duties were suspended just days prior to being offered a phone interview for the supervisory position of service chief. (My reply was that I was not in a position to compete for the service chief position until the OSC resolved my claims of whistleblower retaliation, obstruction, and violations of VA policies.)

9. In October 2018 I was subjected to a psychiatric examination just a day and a half after I reported to the DAS for Resolution Management the wrongdoing of the ORM district manager in his failing to follow the procedures of VA Handbook 5977 in investigating the EEO claim. The next week I was threatened by a local VA manager for reporting this claim.

10. In early March 2019 I was transferred out of the Emergency Department and into Primary Care Urgent Care Clinic based on a verbal statement that the transfer was the result of the AIB investigation, rather than receiving an "advanced written notice" as required by VA Handbook 5021.

11. My credentials to practice medicine at the VA are currently being threatened.

Dealing with Whistleblower Protection Agencies

Not only have I been subjected to extreme emotional distress from the actions of WPB management in their efforts to remove me from my leadership position in the ED (and then not allowing me to practice medicine in the ED), I have been subjected to the stress caused by the inactions of those in government agencies, including the VA OIG, the OSC and the OAWP, from whom I have sought to investigate my claims of whistleblower retaliation, of obstruction of my ability to compete for a position that replaced my section chief position, and of violations of numerous VA policies and federal statutes. My interactions with these agencies have been as follows:

<u>VA OIG</u>

I have made several submissions to the VA OIG, including submissions for whistleblower retaliation, detailed lists of VA policy and federal statute violations, and abuse of authority. I have never received a reply from the VA OIG other than the automated response statement following the submission stating that each of my five repetitive submissions over a six month time period was received.

<u>OSC</u>

I began compiling a complaint of whistleblower retaliation in January 2018 with the first submission in about April 2018, followed by more submissions as I was subjected to more retaliatory events. In the initial response from the OSC on 27 November 2018 the

investigator made numerous misstatements of facts and claims and failed to address (totally ignored) many of my key claims, including all allegations of policy and statute violations. Although these errors were pointed out in my rebuttal to the investigator's initial report, the investigator's final report of 14 February 2019 still contained numerous misstatements and ignored most allegations. My advisor, Michael Lammert, sent a letter on 4 April 2019 to the Special Counsel complaining of the investigator's poor performance in the investigation and the report in which he identified 10 misstatements of facts and claims, 3 misstatements of law and 5 ignored allegations. The Special Counsel immediately replied that he would investigate the handling of my case. While the errors in the initial report might be dismissed as poor communication between the investigator and me, the final report failed to address the clarifications I provided, including my re-statement of ignored allegations. The final report goes far beyond incompetence.

When I determined that the PPP Unit of the OSC was not going to address any allegations of federal statute or VA policy violations I submitted a claim to the OSC's Disclosure Unit identifying those violations, but not including any PPP violations. I was told by the Disclosure Unit that since those statute and policy violations were associated with PPP claims, it was the PPP Unit's job to investigate this claim. They closed my case without any investigation.

I initially thought that the OSC's handling of my case was an aberration, but then I received a "Reconsideration Report" from a very senior OSC official. This report contained more than 20 misstatements/obfuscations of fact and VA policy with my claims being addressed to those misstatements. One of the more egregious misstatements was the statement that the Disclosure Unit had investigated my claims of statute and policy violations and then closed my case, when in actuality the DU had done no investigation! My advisor just sent another letter to the Special Counsel informing him of the misstatements and the essentially nonexistent investigation done by the senior OSC official and asking him about which unit of the OSC has responsibility for investigating statute and policy violations when those violations are associated with PPPs. Perhaps the Subcommittee could also ask the Special Counsel to answer this question, and why OSC reports on their investigations of PPPs contain so many deliberate misstatements.

<u>OAWP</u>

The claims of the VA policy and statute violations were also reported to the OAWP. I answered a number of questions regarding these violations which were submitted to me by the designated OAWP triage case manager. The triage case manager closed my case on 15 February 2019, one day after the OSC closed their case, stating: "*The VISN POC certified that appropriate follow-up occurred*". There are two problems with this statement. First, the VISN POC would not have been in a position to address the VA policies and the federal statutes which I alleged were violated by an ORM district manager. Second, if the VISN had addressed all claims, my claims of VA policy violations in the convening of an AIB would have had to be addressed. These claims should have resulted in all findings of the AIB being declared null and void. However, I was told just a few weeks later in early March 2019 that I was being transferred out of ED as a result of this AIB investigation (not why, just as a result of). It is apparent that the OAWP did no independent investigation other than ask a few good questions of me. When the OSC closed their case without addressing a single VA policy or statute

violation, the OAWP followed. I am requesting the Subcommittee investigate the OAWP's handling of my allegations of VA policy and federal statute violations.

Recommendations for the Subcommittee

1. See that the OSC is held accountable for performing proper investigations of allegations of whistleblower retaliation and other PPPs, and that OSC final reports accurately respond to those allegations.
2. Have the Special Counsel explain how the OSC handles PPP cases when there are serious policy and federal statute violations associated with the PPP claims.
3. Determine if the OAWP is providing any useful function to protect whistleblowers. If the OAWP is not providing a useful function, move the investigative assets of the OAWP to the VA OIG and eliminate OAWP managers and administrators.
4. If the VA OIG, the OAWP, and the OSC will not insure the discipline of federal employees that libel and slander other employees or persons, or that make false statements and writings in violation of 18 U.S.C. 1001, modify the Federal Tort Claims Act to allow those individuals to be sued for their wrongdoing in civil court.
5. Federal statute 5 U.S.C. 2302 could be strengthened if Congress would add a new "Personnel Action" to Section (a)(2)(A) to the 12 items already listed. This new personnel action would be: (xiii) exposure to a pattern of harassing and intimidating behavior, examples of which include such actions as yelling at the employee, making false accusations against the employee, creating artificial deadlines, deliberately causing physician staffing shortages which jeopardizes veteran care, assigning work with a very short deadline when that work could have been assigned much earlier, assigning work of no value to the agency, etc. (More items can be specified by Congress.)
6. Although VA Handbook 0700 is quite clear as to what constitutes a conflict of interest in an AIB investigation, Congress should see that the VA makes the conflict of interest rule more explicit for any attempt to convene an AIB to investigate a whistleblower, especially a whistleblower who has also made a claim he/she is experiencing retaliation. My recommendation is that if an agency manager wants to investigate a whistleblower with an AIB, then that the manager should be required to have the AIB convened by the Secretary of the VA and the investigation performed by an independent investigative group that reports directly to the Secretary.
7. Allegations of wrongdoing by higher level VA management must be investigated by an independent group. A VISN leader has no desire to find that one of his direct reports violated a policy or statute. Findings of wrongdoing would make the VISN leader look bad for not watching over his/her employees more closely. Reporting wrongdoings back to the VA or doing an "investigation" by just contacting the wrongdoers, as it appears the OSC PPP Unit is doing, will never be an effective way of removing bad actors from the VA.

Sincerely,

Gary R. Lammert MD
Fellow of the American College of Emergency Medicine
Captain United States Navy Retired
OIF Service Connected Veteran