Subcommittee on Oversight and Investigations Hearing: Broken Promises – Assessing VA's Systems for Protecting Veterans from Clinical Harm

Congressman Bruce Westerman (AR-04)
Statement for the Record

Chairman Pappas and Ranking Member Bergman, distinguished Members of the Committee, and today's witnesses, thank you for hosting today's hearing and allowing me to submit a statement for the record.

As many of you now know, the Veterans Health Care System of the Ozarks (VHSO) suffered a catastrophic failure to hold one of their highest-ranking providers accountable, Chief Pathologist Dr. Robert Morris Levy.

Since his firing in 2018, only after he was arrested for a DUI, it has been uncovered that his malpractice resulted in the death of 15 of our nation's veterans and 15 others whose health was irreparably harmed.

An additional 3,007 errors and misdiagnosis date back to 2005. It's now been uncovered that Dr. Levy had a misdiagnosis rate of 9%. Over twelve times the average pathology error rate.

In total, Dr. Levy diagnosed over 21,000 individuals and viewed 33,902 total cases during his tenure.

We may never know the true extent of the damage he caused, but the systemic problems that allowed it to occur in the first place must be addressed, and that starts with leadership.

When I first learned of the issues with Dr. Levy in May of 2018, I immediately requested more information on how veterans and their families would be notified of the lookback process, and what resources would be made available to those seeking more information.

The VA did set up a dedicated phone line for patients, but when my staff tested it, they sat on hold for over 22 minutes.

Imagine learning from a televised press conference that you may have had your cancer misdiagnosed, and you call a number to learn more about what you can do, only to wait almost half an hour before you can talk to anyone.

That's simply unacceptable, and the problems didn't end there.

We requested for months that the VHSO put together an Administrative Investigative Board (AIB) to internally review the processes and problems that enabled this to happen, but it wasn't completed until September 17, 2018, almost four months after first learning of the problems with Dr. Levy.

At that time, many of the senior leadership staff had retired or quit, limiting the ability for the Board to conduct a substantive investigation.

Furthermore, we were told that the AIB was limited to assessing the validity of the allegations against Dr. Levy related to quality of care, and that they could not investigate the quality of care and oversight because the Office of the Inspector General (OIG) was investigating these issues.

My staff inquired with the OIG's office to assess if this was in fact true, and we were told the OIG does not believe they would have directed the VHSO to avoid those topics.

I would like to know why the AIB took so long to be commenced and completed and why, or if, it was limited in scope per the VHSO's communication to my office?

I also have concerns regarding the VHSO's decision to first only conduct a short retrospective review of Dr. Levy's cases.

It took the VA Inspector General requesting a full, comprehensive review to be done instead of the VA making this decision on their own – potentially harming the health of veterans who received care from Dr. Levy at other stages of his career.

The lookback process seems as if it was made up as it went along without any proven and tested systems in place to ensure each and every case was reviewed in depth and in a timely manner.

Does the VA have a standard lookback or review process for cases involving medical malpractice, and if so, was it properly followed?

Additionally, why was Dr. Levy allowed to immediately return to a position of authority after rehabilitating from substance abuse?

This allowed Dr. Levy to conceal misdiagnosis that may have been caused by his substance abuse. He was able to remove and delete cases that may have shown evidence of misdiagnosing patients, and even falsely claim a second physician had reviewed his cases for quality control.

The VA must look at the processes and procedures for reinstating physicians after substance abuse issues to ensure they do not relapse or hide medical mistakes without proper oversight.

Another issue we discovered was the length of time it took for VISN Director Skye McDougall to put a permanent Medical Center Director in place following the retirement of Dr. Worley in June of 2018, the previous Medical Center Director and supervisor to Dr. Levy.

From communications my staff had with Director McDougall, she stated that a replacement candidate had been submitted for approval in May of 2018 – yet this makes no sense because Dr. Worley was still there at the time.

That candidate, Mr. Kelvin Parks, was not formally approved until the end of November 2018.

Why did it take 6 months to hire a permanent director, one who had been serving as an Interim Medical Center Director the whole time, during a time when strong leadership was needed?

And was a proper interview process followed that included other candidates to assess who may serve the VHSO best?

Additionally, what processes are in place to ensure a timely and efficient hiring process is in place, and what can be done, whether administratively or legislatively, to ensure the hiring process can be improved?

Although more issues were uncovered, the examples I present here today show a pattern of leadership failures when problems arise, and we need to ensure these failures don't happen again.

The members of America's Armed Forces are promised care for life due to the sacrifice they make to serve our nation. We owe it to them to ensure that promise is kept, and that the care they receive is of a high quality.

The men and women that work at the VA are honorable, hard-working and highly qualified medical personnel who provide our nation's veterans with great care, but that care can always be improved.

And when malpractice like this happens, it's imperative we do everything we can to ensure it's made right and corrected so it may never happen again.

As Members of Congress, how can we support the VA, and are there legislative changes we need to make to help stem leadership and accountability failures and ensure our veterans get the best care possible?

Again, thank you Chairman Pappas and Ranking Member Bergman for allowing me this opportunity, and I trust that we will all work together to ensure this may never happen again.