

Statement of Dr. Minu Aghevli
Coordinator, Opioid Agonist Treatment Program at VA Maryland Health Care System
Before the Subcommittee on Oversight and Investigations
United States House of Representatives
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Thank you for having me today. It's an honor to be here.

I am the program coordinator of the opioid agonist treatment program at the VA Maryland Health Care system in Baltimore, Maryland. We provide medication assisted treatment for over 400 opioid dependent veterans. I've been with the VA almost twenty years, and in this role for over ten. Throughout my career, I have consistently received outstanding ratings on my performance evaluations, and I have been awarded multiple Gold VA Pins for excellent customer service. Our program treats one of the most vulnerable and stigmatized group of veterans in the VA system, who are at an extremely high risk for overdose, suicide and other deaths. Many are indigent. I love my job and the veterans that I treat. I have spent years developing relationships with my patients and have earned their trust and respect. I can't imagine any job I'd rather do. But for the past five years, the VA has consistently impeded my ability to provide care to veterans who need it the most, at the expense of those veterans, and in order to prevent me from speaking out about patient care issues.

Most recently, on April 24, 2019, the Chief of Staff and Medical Center Director summarily suspended my clinical privileges under circumstances which could only lead to the conclusion that they were revoked because I blew the whistle. I have not been able to provide care to veterans since then and there is no available recourse for me.

By way of background, for approximately five years, the VA has engaged in continuous retaliation against me, in what appears to be a concerted, systematic effort to oust me from the Agency. The retaliation started when I first reported concerns about the improper practices for maintaining a waitlist for veterans waiting to receive care for opioid treatment. Specifically, in the spring of 2014, following a nationwide Agency scandal concerning lengthy patient wait times, VA management began to convey to me that our waitlist was too long and they were concerned the waitlist would draw scrutiny from VA leadership and Congress. In order to reduce the waitlist, I was instructed to improperly remove veterans from the electronic waitlist by scheduling fake appointments for them in an imaginary clinic. This clinic was not tied to any provider or location, nor did it actually correspond to any real visits and accordingly, the veterans scheduled for these fictitious appointments were not actually receiving VA care.

The VA also pressured me to artificially reduce the number of patients on the waitlist through other improper means. This included making minimal efforts to contact indigent patients and then coding them as "care no longer needed" without confirming that care was, in fact, no longer needed; as well as scheduling patients for appointments without telling them, and then coding them as "no show" when they did not appear for the appointments about which they had not been notified. I was repeatedly pressured to make these changes, and I protested. I went through my chain of command including the

Deputy Director and Director of Mental Health, the head of my facility and ultimately to the Secretary of the VA. I also repeatedly communicated my concerns to Office of Inspector General (“OIG”) and to this Committee. For example, in September 2015, the VA received a Congressional suspense asking about wait times for treatment. Due to our inappropriate removal of patients from the electronic waitlist, the official numbers were significantly less than the actual numbers of veterans waiting to receive care. When the VA deliberately sent these incorrect numbers to Congress, I again contacted OIG and also got in touch with this Committee.

For the past five years, VA management has made my life a nightmare and interfered with my ability to perform my duties but the Office of Special Counsel (“OSC”) has repeatedly told me that the VA’s actions are just not bad enough for them to take any action. Approximately one month after I complained of the improper waitlist practices, I was told that I would be summarily transferred out of my coordinator role and moved to an entirely different area of the hospital, where I would be performing work unrelated to substance abuse treatment or the area in which I had expertise. I filed with both OIG and OSC, and the transfer was rescinded at the last possible minute before it became effective. During the month that I was awaiting that transfer, I lost twenty pounds and almost had a nervous breakdown. However, OSC told me that since the VA had reversed the transfer, there was no adverse personnel action for them to address. Since then, I have been routinely reprimanded and subjected to fact findings about various frivolous and inappropriate things. I have been excluded from meetings, subjected to scrutiny and oversight that my colleagues are not, my functional statement has changed, and I have been stripped of many duties which I previously performed. In June 2016, I was informed that I would be detailed to work in the Mental Health Executive Suite and prohibited from engaging in patient care. The VA did not provide any legitimate justification for its decision. I retained counsel and was ultimately reinstated to my position. I was again unable to obtain redress through OSC, who closed my case earlier this year, finding that the details did not constitute a prohibited personnel action.

Most recently, shortly after OSC closed out my earlier case, VA management again removed me from clinical care, this time also formally suspending my privileges. As a result, I am currently not able to provide care to veterans and am instead assigned to perform basic, data entry work. The letter that I received from the Medical Center Director stated that the suspension was because I visited one of our high-risk veterans at a community hospital after he had overdosed and then subsequently attempted to commit suicide. This reason is simply nonsensical and cannot be the true reason for the suspension of privileges. I had visited the veteran with the approval and authorization of the attending physician and the Director of the ICU at the hospital where the veteran was located. I have contacted the Maryland Psychological Association’s Ethics Committee, and numerous other highly respected psychologists and physicians, all of whom agree that there are no concerns with my conduct. According to a Maryland Psychological Association Ethical Consult, the only ethical issue is the fact that the VA is forcing me to me abandon my patients. My actions were also in line with the VA’s policies on assessment and follow up of suicide risk and providing mental health care to high risk veterans, an issue I am grateful this Committee has devoted a lot of attention to.

Since the suspension, I haven't been allowed to speak to any of my patients, plan for coverage of the program, or even sign my chart notes from the day that my privileges were suspended.

Despite the fact that I have been unnecessarily unable to provide care to high-risk veterans for two months, OSC has again proven to be a futile option. On June 4, 2019, OSC issued a preliminary determination letter stating that “[t]he suspension of privileges is not a personnel action covered by 5 U.S.C. § 2302.”

In sum, the VA has been relentless in threatening me with action, taking limited action against me, and then evading any liability by reversing course. The constant harassment has ruined my life and impeded my ability to provide care to veterans. When I turned to it for help, OSC refused to take action and left me vulnerable to the Agency’s sanctioned retaliatory actions.

Ultimately, the way the VA treats whistleblowers affects veteran care. I have taken care of some of my patients for close to twenty years. I see many of them every single day and as their therapist and the program coordinator, I am often one of the few constants in their lives. Every time I've abruptly disappeared, it is traumatic for them as well. After my suspension, I was not even allowed to visit a patient dying from cancer in our hospice unit to say goodbye, or call his family to offer my condolences after his death. These are certainly adverse outcomes. I've been punished for speaking up for a group of people who are often stigmatized, and that isn't right. They deserve better. Many of the veterans we treat, especially in substance abuse, don't have a lot of support in their lives or people who are advocating for them and letting them know they are worth fighting for. It's important to me to speak up when they are not receiving the treatment they deserve, because we need to convey a message that our veterans, and their treatment, are worth standing up for. I ask you to please join me in standing up for these underserved veterans and expand protections for whistleblowers so that we can continue ensure that these veterans receive the care to which they are entitled, without the VA undermining us by circumventing current law.