TESTIMONY OF JEFFERY DETTBARN,

DEPARTMENT OF VETERANS AFFAIRS FEDERAL EMPLOYEE

before the

HOUSE COMMITTEE ON VETERANS' AFFAIRS,

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

on

LEARNING FROM WHISTLEBLOWERS AT THE DEPARTMENT OF VETERANS AFFAIRS

June 25, 2019

Chairman Pappas, Congressman Bergman, and distinguished members of the Subcommittee, it is my honor to appear before you today to testify about my experience as an employee and whistleblower at the Department of Veterans Affairs. My name is Jeffery Dettbarn, I have been employed for over 14 years at the Iowa City VA Medical Center, with an unblemished record before blowing the whistle on the improper mass cancellation of what turned out to be tens of thousands of radiology orders. I have been a Registered Radiologic Technologist for over 29 years. After receiving the Mallinckrodt award for the highest achievement in my radiology school class, I went on to my first job as an X-ray Technologist, learning general ultrasound, echo cardiography and carotid doppler sonography. I took a position approximately 2 years later doing Mobil Computerized Tomography which also allowed me the opportunity to learn to drive a Semi truck and trailer. I later worked at the University of Iowa working as a Cardiac Cath laboratory technologist and in Orlando Florida, where I spent 11 years working in many facets of radiology as a supervisor. In 2005, I returned to Iowa, taking the position of Radiology Supervisor at the VAMC Iowa City. After 3 ½ years as a supervisor, I stepped down to the role of CAT Scan Technologist and that was what I did and loved every work day until I blew the whistle two years ago and was quickly banished to non-patient care duties, where I have remained to the present date.

Over the years I have developed a strong rapport with many of my patients, but NEVER have I had such an over whelming feeling of loyalty as I do to our Veterans. The comradery, compassion, and loyalty these men and women have to their Family, Flag and Freedom is phenomenal. It is also infectious. In my heart, the Veterans and I are family because of the relationships I have cultivated over the past 14 years of caring for them. I have been called "Brother," by countless numbers of our Veterans, which to me shows their confidence, faith, and trust in me. I have not served but I SERVE them, and they are my extended family.

I came forward and became a whistleblower out of concern that Veterans were being placed AT RISK of not receiving the care, and follow-up care, they desperately needed, and because of the unnecessary risk to patient care presented by non-medical personnel practicing as physicians. Since then, the VA has banished me from the hospital for two years, away from the greatest job ever—taking care of Veterans, cut my pay by a third, targeted me with an Administrative Investigation Board, proposed my removal, and subjected me to unbelievable physical and emotional stress,

My present saga began in early to mid-2016, when the CT area began experiencing issues with management's implementation and attempted implementation of bogus policies and Standard Operating Procedures that did not undergo the proper approval and implementation process. These "policies"

included email instructions for technologists to "protocol" exams and to fill out, and complete with the Veteran the required Patient Consent forms. Protocol sheets are forms used to specify EXACTLY what type of scan a Veteran is to receive based on a diagnosis. For example, a chest CT may require the use of intravenous contrast, resulting in the need for a kidney function test, when ruling out cancer, or it may be done without contrast when looking for a calcification of the lung. Instructing a technologist to "protocol" an exam was entirely beyond the technologist's "scope of practice," and something that only a physician should do.

Another bogus policy involved the execution of the Patient Consent form—normally only executed by the Veteran together with the RADIOLOGIST when the use of intravenous contrast is necessary, yet the Veteran has some contraindication for NOT being a perfect candidate for contrast. All risk factors would be discussed by the radiologist and the Veteran, and the Veteran's informed consent would be obtained. This consent must include a consult with the radiologist for it to be effective, and instructing the technologist to execute the Patient Consent form was also out of the technologist's "scope of practice."

Upon my questioning of many of these "new" rules, I was met with great hostility and anger. No matter who I tried to contact locally for assistance, someone in a higher position seemed to be blocking anyone who was willing to help me with the issues I had reported. The hostility I was met with paved the way

for the barrage of retaliation I have endured since making my disclosures to numerous agencies, such as, OIG, OAWP, OSC, and including Senators Grassley and Ernst.

The big reveal of the impact of improper cancellations of radiology orders came on February 22, 2017, when a Veteran presented for a CT of the chest for a LUNG CANCER screening. There was a history of smoking since age 13. That cancelled order would eventually be found to have been improperly cancelled by the Radiology Service Secretary—only the Physician who ordered it should have cancelled it. This order had been cancelled 19 days prior to the appointment, meaning that the mysterious cancellation had not been adequately reviewed for nearly three weeks and suggesting that it had been part of a "block" or "mass" cancellation.

The lead technologist at the time, when attempting to register what should have been an active order, inquired "why can't I register this, there is no order." Upon investigation, I realized there was an issue due to the original order having been cancelled by the Service Secretary, who is not a licensed practitioner. This violation of policy was magnified when the lead technologist then took it upon himself to "Reorder" the Veteran's exam, in effect acting as the Veterans care provider. This is completely beyond the Scope of Practice of a Radiologic Technologist. Orders are only valid when initiated by a Licensed Independent

Practitioner. The lead technologist went on to hide what had been done by destroying the "New" order and passing off the paperwork for the cancelled order as bona fide, stating to a co-worker, "This one is ready," and implying that the Veteran was ready for a valid exam, properly ordered by a Licensed Independent Practitioner. This is when I knew something was wrong.

I informed my co-worker of the issues and specifically instructed him to "hang on to that paperwork, this is going to come back around." I had no knowledge at the time this was anything other than an Iowa City issue, but it has since become an ongoing national investigation of improper radiology cancellations by the VA Inspector General. Some 12,660 orders were cancelled at the Iowa City VA Medical Center alone, according to the sworn testimony of our Administrative Officer.

My co-worker at the time voiced his concerns of these unprecedented actions to management, and I voiced mine to Patient Safety. In no realm of healthcare is this practice of cancelling a physician's order acceptable. Normally, only the physician who placed the order would cancel the order. Every day for the months to follow, my co-worker and I would uncover multiple scheduled patients with their orders cancelled by management and ancillary staff. In the weeks to follow I would again contact patient safety officers, compliance officers, AFGE,

and the Joint Commission (JACHO) Readiness Manager with my concerns of the mass cancellations we were seeing in radiology.

Anyone trying to assist me or make their own disclosures was met with every roadblock you can imagine, from sham Administrative Investigation Board investigations, to blatant retaliation by not only management, but other employees recruited by management. The harassment caused a co-worker to leave the VA entirely.

By June of that same year, I was informed that one of the staff radiologists was now complaining of my job performance. This complaint came at approximately the same time of my first disclosure to Senator Grassley. Months later, as I reviewed the testimony and documents used by the Administrative Investigation Board to justify my removal, I became aware that just days after I submitted an Electronic Patient Safety Report on June 22, 2017, the Administrative Officer solicited others in the department to forward to her any adverse reports on me that they could come up with. These false allegations were exactly the pretext upon which the VA proposed my removal six months later, and included, "Failure to follow hospital Policy and procedure, failure to follow standard operating procedure, failure to assist a radiologist during a contrast reaction, and failure to follow physician instruction on patient positioning."

During that same timeframe, ironically, I was also nominated for and awarded a "Good Catch Award," submitted to the agency by a co-worker for my actions regarding a Veteran's poor renal function. After discovering the potential for complications due to an order for intravenous contrast, I alerted the proper staff to ensure the Veteran's care and treatment were NOT jeopardized by the contrast. Only by accident was I made aware of this award the day after I was to have received it at the All Employee Forum from our Medical Center Director, Judith Johnson Mekota. After that, it would take me almost four months of continually asking the director and her aid, before finally receiving my pin and certificate via interoffice mail. Because I was later banished from the main facility, the award was forwarded to me by a co-worker; it had been sent to the Radiology department and placed in my mailbox which had been stripped of my name.

On July 12, 2017, while a Joint Commission Survey Consultant was at the facility reviewing numerous processes in the CT area, my co-worker and I disclosed to the consultant many of our concerns, including technologists being instructed to act outside the scope of their practice. The consultant later confirmed that the ordering and "protocoling" of exams by CT technologists was improper and must cease. Yet, as I have heard from others to scared to come forward, the cancellations have continued.

During this entire time while I was questioning the improper cancellation of orders, management at the Iowa City VA consistently referenced the "DUSHOM directive," Outpatient Radiology Scheduling Policy and Interim Guidance, VAIQ 7722255, of August 12, 2016, as justification. This directive begins with the declaration that "orders can be placed as much as 390 days in advance," yet management was cancelling orders as "expired" that were within days of the date the Veteran was scheduled to appear for care. This is but one example of management's flawed and twisted interpretation of this directive.

Later, after the VA detailed me out of the main facility, I learned from others to afraid to speak up that numerous specialty clinics where keeping secret lists of Veterans who would present for their appointments and NOT have received the prior imaging required for that appointment. A case manager of the Urology clinic informed me of this practice, and upon investigation and questioning, other case managers and Nurse Practitioners from Urology, Pulmonary, Ear, Nose and Throat (ENT) Hematology and Oncology all admitted to having similar lists. Upon learning of these lists, I contacted OIG, with the permission of the case managers and Nurse Practitioners to release their names, and reported that "they would gladly speak with an OIG official," should they be asked. To my knowledge, there has been no follow up from OIG regarding my complaint.

On July 27, 2017 I was summoned to the Chief of Imaging Service office. This was to be the beginning of my "Banishment," from the hospital setting. I was given a "not to exceed 120 days" detail letter and told to immediately report to the Federal Building. No specifics of why I was being detailed were given. I was handed a piece of scratch paper with "Post Office," and "Find Savanah," written on it. Upon my arrival at the partially abandoned post office building in downtown Iowa City, I found the building locked with an access control system and I had not been given the code. There were no signs or identifiers to guide me once inside the building, but this was just an introduction to the types of retaliation I have encountered over the past 2 ½ years of being a whistleblower by the Agency.

Following my detail to the partially abandoned federal building, I was targeted by a sham AIB investigation. In August 2017 I was told to appear for testimony before the AIB, but I was not given a charge letter, only informed that the AIB was addressing "issues in radiology." Soon after I began to testify, it became clear from the accusatory nature of the questions, that I was the target.

At that same time I had again contacted Senator Grassley, and I continued to contact Senator Ernst, whose office got me in contact with the OSC disclosure unit. I then began the tedious process of filing Forms 11 and 12 with OSC. I was also given contact information for OAWP and in December of 2017, I formally filed with them after a telephonic conversation with a triage case manager. This would

lead to my sending hundreds of emails and skype messages to OAWP, attempting to get any information or progress reports about my case. I do not recollect ever being contacted by OAWP, I had to initiate all communication. In the meantime my detail was extended—"not to exceed" 120 days, again.

In November 2017, prior to the release of the AIB report, and after my initial contact with the intake and the retaliation unit lawyers of OSC, I was made aware that I had been the target of a patient abuse allegation which is what prompted my removal from direct patient care. On December 28, 2017, the Chief of Staff, Stanley L. Parker, proposed my termination. It was at this time that I was given the testimony and exhibits from the sham AIB investigation. After reviewing the entire 4000 plus pages and prompted by the amount of false testimony it contained and the apparent attempt by management to cover up the wrongdoings at the VA Medical Center Iowa City, I sought assistance with the process of "Blowing the Whistle." I had been referred to as being "Toxic," and "Bi-Polar" by the JACHO Readiness Manager and Administrative Officer of Imaging Services, and it had been reported to me that the Imaging Supervisor had warned co-workers, "not to let Jeff get his hooks into them."

It wasn't until I reviewed the testimony and exhibits that I became aware of the numerous Reports of Contact aimed at me and submitted by the recently assigned Cat Scan Supervisor who had been promoted twice with a year, likely

rewarding him for his willingness to retaliate against me. It is my belief that I was targeted for this barrage of Reports of Contact because of my whistleblowing and part of the effort to have me dismissed from my position. That Cat Scan Supervisor also made several attempts to discipline me for bogus and unfounded allegations, alter the scope of my duties, or simply harass me only to be blocked or reversed with help from AFGE.

Beginning in July 2017, VA employees retaliated against me by filing multiple bogus complaints with the Iowa Department of Public Health and the American Registry of Radiologic Technologists, the national association that maintains my certifications. All of these allegations have been investigated and dismissed as having no merit and no action is needed but this particular retaliation is incredibly hurtful and could result in the loss of my livelihood.

The process of seeking assistance as a whistleblower was truly confounding. Do you file with EEO, OSC, OAWP, OIG, ORM, or JACHO? How would anyone know who to contact? Sometimes you contact the wrong agency, not knowing which way to go with no guidance or assistance. Although I was lucky enough to have two good intake lawyers at OSC, not everyone is that fortunate. For every person who gets to this point of being a whistleblower there are 1000 that have spoken up only to be removed, demoted, or intimidated into silence. After finally getting in touch with some of these remedial agencies, I was occasionally

confronted with downright hostility, making the whistleblower feel as if "they" are the problem, or that their disclosure is not relevant or important. After that, I sat for months before finally prodding a response from OAWP, or subsisting on the minimal correspondence from OSC and OIG. During this ongoing two years of exile away from my patients, the VA has forced me to forego about one-third of my salary, shutting me off from "on-call" pay.

I have endured both physical and mental stress over the past 2 ½ years of retaliation and whistleblowing, including Major Depressive Disorder and Social Anxiety Disorder. I have sought psychiatric counselling and started on medication for both disorders. I have had to endure multiple regimes of different drug combinations to find one that will afford me enough relief to allow me to function despite the depression. I also have had to start on medication for chronic stomach pain and discomfort caused by stress and nervousness. I am reluctant to attend any type of function outside of my home, because of the risk of a panic attack—I was forced to leave my nephew's wedding because of one. My social life has become non-existent and the headaches, nausea, stomach cramps, and diarrhea are at times debilitating.

My current professional situation, after 22 months, is unbearable. The VA has placed me in a fabricated position as a "records requester." I am NOT receiving approximately $20,000-$30,000 per year of "on-call" pay which is

specifically stated in my job description and represented about one-third of my annual income. I have not had a performance appraisal for over three years. The mobbing and harassment continues, ranging from fabricated allegations against me, to the clothing I wear to my detailed position in the partially abandoned federal building.

A truly accountable upper-level management would have easily rectified the mass cancellation problem in its earliest stages by admitting there was a problem and mustering all-hands to correct it. But instead, they chose to blatantly fabricate excuses and present incorrect DUSHOM directives, trying to pass them off as permission to continue illegal activity. They then fabricated and pursued egregious accusations against me, the person who spoke up for the core VA values and our Veterans. Some of my co-workers who were similarly committed to high-quality patient care chose to leave the VA rather than endure the toxic leadership.

There is a culture of fear and retaliation that the VA uses as the weapon to silence the whistleblower. I am the prime example that the Iowa City VA has made to silence all employees. I have heard everything from "look at the trouble Jeff is in," to "you don't want to end up like Jeff," but I feel the worst is to have been asked "what did you do?" And the answer is, "I TOLD THE TRUTH.'' Other employees can see what happened to me, the VA destroyed my career because I told the truth. They will not speak up.

I am concerned about the lack of accountability for those responsible for the mass cancellations. I have been banished for 2 years, away from patient care, with no end in sight, while the Administrative Officer who was responsible for the cancellations and the direction to cancel the orders for those needed exams has faced no repercussions. Likewise, the Cat Scan Supervisor, implicated in the cancellations and the retaliation was returned to duty promptly after a 120-day detail. There has been absolutely NO discipline for those who broke the rules and retaliated against me for speaking the truth. Where is our SPEED OF TRUST, I CARE, and NO FEAR that is constantly touted by management? Where is the accountability preached by OAWP, where is the TRANSPARENCY everyone speaks of? The only information I received on OAWP was an email from the AFGE president stating that one particularly sensitive email that I provided to OAWP was forwarded to hospital management and then thrown in the union representative's face to be used against me as evidence of my not being a team player.

One of the most important questions I have for the committee is who will stand up for the best quality CARE our Veterans need and deserve? If not for the VETERAN, I would not be a whistleblower, I would not be needed. When I think of why I am doing all of this, I think of my brother, a medically retired Chief Warrant Officer 4, who served 20 years before a life-threatening accident in Iraq

that took him out of the military. The thought of him needing any type of care and it being jeopardized by individuals who are not qualified to cancel, alter, or order a life-altering test is unfathomable to me. I have other immediate family members, father and uncles, that also receive their care at the VAMC. The Veterans I am trying to protect and help have become an extended family to me. I know hundreds of them by name, their histories, their family scenarios, and their loved ones. As I have continually stated in this process: This is someone's Mother, Father, Son, Daughter, Husband or Wife.

Taking care of my patients and ensuring the best possible care for our Veterans is why I am here and it is what I love. At this point and time in my life I haven't much to lose or anything to gain. I am 51 years old, and my life has been very good. However, the Veterans that I am here for, to stand up for, and be a voice for, DO have a lot to lose. THEIR LIVES.

Thank you.