ORAL STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"SCHEDULING MANIPULATION AND VETERAN DEATHS IN PHOENIX: EXAMINATION OF THE OIG'S FINAL REPORT"
SEPTEMBER 17, 2014

Mr. Chairman, Ranking Member Michaud, and Members of the Committee, thank you for the opportunity to discuss the results of the Office of Inspector General's extensive work at the Phoenix VA Health Care System. Our August 26, 2014, report expands upon information previously provided in our May 2014 interim report and includes the results of the reviews by OIG clinical staff of patient medical records.

We initiated our review in response to allegations first reported through the OIG Hotline on October 24, 2013, from Dr. Samuel Foote, who alleged gross mismanagement of VA resources, criminal misconduct by VA senior hospital leadership, systemic patient safety issues, and possible wrongful deaths at Phoenix. The transcript of our interview with Dr. Foote has been provided to the Committee and I request that it be included in the record.

We would like to thank all the individuals who brought forward their allegations about issues occurring at Phoenix and other VA medical facilities to the attention of the OIG, the Congress, and the Nation.

On August 19, 2014, the Chairman, Subcommittee on Oversight and Investigations, sent a letter to the OIG requesting the original copy of our draft report, prior to VA's comments and adopted changes to the report. On September 2, 2014, a Committee staff member made a similar request for a written copy of the original unaltered draft as first provided to VA on behalf of the Chairman. Their concerns seem to come from our inclusion of the following sentence in a subsequent draft report that was not in the first draft report we submitted to VA.

> *"While the case reviews in this report document poor quality of care, we are unable to conclusively assert that the absence of timely care caused the deaths of these veterans."*

This sentence was inserted for clarity to summarize the results of our clinical case reviews that were performed by our board-certified physicians. It replaced the sentence *"The death of a veteran on a wait list does not demonstrate causality,"* which appeared

in a prior draft. This change was made by the OIG strictly on our own initiative; neither the language nor the concept was suggested by anyone at VA.

In the course of our many internal reviews of the content of our draft report, on July 22nd one of our senior executives wrote this question: *"Did we identify any deaths attributed to significant delays? If we can't attribute any deaths to the wait list problems, we should say so and explain why. After all, the exact wording in the draft report was "Were the deaths of any of these veterans related to delays in care?"* This type of deliberation to ensure clarity continued after the initial draft was sent to the Department.

In the last 6 years, we have issued more than 1,700 reports. This same draft review and comment process has been used effectively throughout OIG history to provide the VA Secretary and Members of Congress with independent, unbiased, fact-based program reviews to correct identified deficiencies and improve VA programs. These reports have served as the basis for 67 congressional oversight hearings, including 48 hearings before the U.S. House Committee on Veterans' Affairs. During these same 6 years our work has been recognized by the IG community with 25 Awards for Excellence. We are "scrupulous" about our independence and take pride in the performance of our mission to ensure veterans receive the care, support, and recognition they have earned through their service to our country.

The VA Secretary has acknowledged the Department is in the midst of a serious crisis and has concurred with all 24 recommendations and submitted acceptable corrective action plans.

Our recent report cannot capture the personal disappointment, frustration, and loss of faith of individual veterans and their family members with a health care system that often could not respond to their physical and mental health needs in a timely manner. Although, we did not apply the standards for determining medical negligence during our review, our findings and conclusions in no way affect the right of a veteran or his or her family, from filing a complaint under the Federal Tort Claims Act with VA. Decisions regarding VA's potential liability in these matters lie with VA, the Department of Justice, and the judicial system under the Federal Tort Claims Act.

Mr. Chairman, this concludes our statement and we would be happy to answer any questions you or other Members of the Committee may have.