New revelations of neglect and coverup at US veterans health care facilities

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Recent days have seen new exposures of the neglect of US veterans at Veterans Affairs (VA) medical facilities across the country. These include psychiatric patients who languished for years without treatment at a Massachusetts facility, as well as new whistleblower allegations that "deceased" records were removed from files in Phoenix, Arizona, so veterans would not be counted as having died while waiting for care.

The new revelations come in the wake of the scandal that rocked the veterans' agency after whistleblowers at the VA hospital in Phoenix came forward with information on falsifications of wait times for appointments. VA administrators pressured staff to falsify records in an effort to receive bonuses for delivering timely care.

Doctors at the Phoenix facility charged that delays in treatment had been responsible for at least 40 preventable deaths, while an earlier internal VA review found that long wait times at VA hospitals in multiple states were linked to 23 deaths.

VA director Eric Shinseki resigned over the scandal May 30, after presenting President Obama with preliminary department findings and ordering a system-wide audit of VA health services. Various bills are working their way through Congress to "fix" the VA system. While none provide significant additional funding for the agency, all of them include provisions to at least partially privatize veterans' health care services.

On Monday, the US Office of Special Counsel (OSC) sent a letter and report to the White House on its examination of whistleblower allegations at 10 VA hospitals. In addition to finding numerous instances of egregious treatment of VA patients, the report also criticized the VA's medical review agency, the Office of the Medical Inspector (OMI), for its refusal to admit that this poor care had detrimentally affected veterans' health.

The OSC, an independent federal investigative and prosecutorial agency, is tasked with investigating the allegations of whistleblowers in the civil service and other federal departments. The agency is still investigating more than 50 whistleblower disclosures involving VA patient health and safety.

OSC investigated the allegations of seven whistleblowers at the Veterans Affairs Medical Center in Jackson, Mississippi (Jackson VAMC), which the VA had substantiated. These disclosures included "improper credentialing of providers, inadequate review of radiology images, unlawful prescriptions for narcotics, noncompliant pharmacy equipment used to compound chemotherapy drugs, and unsterile medical equipment," according to the OSC.

In an effort to work around the issue of chronic staffing shortages in the Jackson VAMC's Primary Care Unit, the facility developed "ghost clinics," in which "veterans were scheduled for appointments in clinics with no assigned provider, resulting in excessive wait times and veterans leaving the facility without receiving treatment." Despite confirming these problems, "the VA routinely suggests that the problems do not affect patient care," the OSC writes.

In response to a disclosure from a VA employee in Fort Collins, Colorado, OSC received a report from the VA's OMI confirming severe scheduling and wait-time problems at the VA facility. Patients' appointments had been "blind scheduled," meaning patients were not consulted when they were rescheduled.

If a veteran then called to change the date, schedulers were instructed to record the appointment canceled at their request, so the records would no longer indicate that the initial appointed had actually been canceled by the facility. The OMI reported that nearly 3,000 veterans in Fort Collins were unable to reschedule canceled appointments.

The OSC notes: "Schedulers were placed on a 'bad

boy' list if their scheduled appointments were greater than 14 days from the recorded 'desired dates' for veterans." The OSC is currently investigating allegations by two schedulers in Fort Collins that they were removed from their positions and reassigned to a Wyoming facility for not complying with instructions to "zero out" wait times.

The OSC letter also refers to allegations of the mistreatment of two veterans at a long-term VA mental health facility in Brockton, Massachusetts. One veteran with a psychiatric condition "100 percent service-connected" was a resident of the facility from 2005 to 2013. His first examination—by the whistleblower, a staff psychiatrist—did not take place until 2012.

The second veteran was admitted to the Brockton facility in 2003 "with significant and chronic mental health issues," according to an OMI investigation. No medication assessments or modifications occurred until a medical consultation eight years later—in 2011. Despite these horrific findings of patient mistreatment at the facility, the VA concluded: "OMI feels that in some areas care could have been better but OMI does not feel that their patient's rights were violated."

The OSC letter refers to numerous examples of deficient care at facilities nationwide brought to light by whistleblowers. An incomplete list includes the following:

* Montgomery, Alabama: A pulmonologist copied prior provider notes to represent current readings in more than 1,200 patient records.

* Grand Junction, Colorado: Drinking water had elevated levels of *Legionella* bacteria, and standard maintenance and cleaning procedures required to prevent bacterial growth were not undertaken.

* Harlingen, Texas: The VA facility did not comply with rules on credentialing and privileging of surgeons.

* San Juan, Puerto Rico: The VA substantiated a whistleblower's allegations that "nursing staff neglected elderly residents by failing to assist with essential daily activities, such as bathing, eating, and drinking."

In the latest whistleblower revelation, Pauline DeWenter, a scheduling clerk at the Phoenix VA hospital, told CNN that records of dead veterans were changed or altered to hide how many people died waiting for an appointment.

DeWenter, one of the two main sources of information on mistreatment and falsification at the VA's Phoenix facility, says she was ordered by supervisors for the better part of a year to manage the "secret waiting list" where the names of veterans seeking care were left often for months—stuffed in a drawer—without receiving appointments or treatment.

She said "deceased" notes on files were removed to improve patient statistics. "By doing that, that placed [the veterans] back on the wait list," DeWenter said, for what she believes was the purpose of "bringing them back to life" in the paperwork to hide the fact that they had died waiting for care.

DeWenter said the stress became unbearable as she received calls from doctors, nurses and emergency room providers seeking appointments for individual patients who were particularly at risk.

In one case, she said she made a call to a Navy veteran in early December last year to say she finally had an appointment available for him. "I called the family," she told CNN, "And that's when I found out that he was dead." She said hearing the anger of the veteran's daughter-in-law was a turning point. "And I promised her that I would do everything in my power to never have this happen to another veteran again."

These and other horrific stories continue to come to light of the mistreatment of patients in the VA health system. The soldiers sent to fight the endless stream of wars prosecuted by the US ruling elite are subsequently chewed up and spit out by an underfunded and mismanaged system.

Veterans from the wars in Iraq and Afghanistan return with brain injuries, amputations, post-traumatic stress disorder and other debilitating injuries. Aging veterans of the Vietnam War make up a significant proportion of the homeless population and still seek treatment for exposure to Agent Orange and other conditions at VA facilities.

The political representatives who feign sympathy for the veterans' plight are responsible for the permanent state of war that reaps this human suffering. They seek to exploit the scandal at the VA, not as the occasion for an infusion of new spending to improve conditions, but as a pretext to target the agency for privatization.