Whistle-Blower Accuses VA Inspector General of a "Whitewash"

Yesterday, Dr. Sam Foote, the initial whistle-blower at the Phoenix VA, criticized the Department of Veterans Affairs inspector general's (VAOIG) report on delays in healthcare at the Phoenix VA at a hearing before the House Committee of Veterans Affairs (1,2). Foote accused the VAOIG of minimizing bad patient outcomes and deliberately confusing readers, downplaying the impact of delayed health care at Phoenix VA facilities. "At its best, this report is a whitewash. At its worst, it is a feeble attempt at a cover-up," said Foote. Foote earlier this year revealed that as many as 40 Phoenix patients died while awaiting care and that the Phoenix VA maintained secret waiting lists while under-reporting patient wait times for appointments. His disclosures triggered the national VA scandal.

Richard Griffin, the acting VAOIG, said that nearly 300 patients died while on backlogged wait lists in the Phoenix VA Health Care System, a much higher number than the 40 listed in his August 26 investigative report (1). However, he defended his office's report and conclusion that the VAOIG could not "conclusively assert" that any veteran deaths were "caused by" untimely care. Dr. John Daigh, Griffin's assistant inspector general, seemed to disagree saying that excessive wait times not only negatively affected veterans, but helped lead to deaths.

Griffin's office has also been accused of allowing VA personnel to "soften" the report-a charge which he denied. Griffin was taken to task by the committee for not providing the original (unaltered) copy of the report which had been requested.

Robert McDonald, the recently appointed VA Secretary also testified. McDonald had come under fire the day before in a letter from Arizona senators John McCain and Jeff Flake for inaction against senior VA officials (3). McCain and Flake said, "Senior VA leaders have ... not been held accountable for delaying and denying patient care, silencing and intimidating whistle-blowers, and enriching themselves by manipulating wait-time statistics to receive undeserved performance bonuses." McDonald and Griffin replied that 19 disciplinary actions are in process and OIG investigators are working with the FBI and Justice Department on possible prosecutions.

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References

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2. C Span. Phoenix VA Inspector General's Report. House Committee of Veterans Affairs. September 17, 2014. Available at: http://www.c-span.org/video/?321497-1/hearing-veterans-affairs-inspector-generals-report (accessed 9/18/14).

3. Wagner D. Inspector general: care delay may be factor in VA deaths. USA Today. September 18, 2014. Available at: http://www.usatoday.com/story/news/nation/2014/09/18/inspector-general-care-delay-may-be-factor-in-va-deaths/15814065/ (accessed 9/18/14).