

July 21, 2014

Richard J. Griffin
Acting Inspector General
U.S. Department of Veterans Affairs
Office of Inspector General (50)
801 Vermont Avenue, NW
Washington, D.C. 20420

Dear Mr. Griffin:

The Department of Veterans Affairs (VA) has emphasized its commitment to providing high-quality, safe and effective health care for our nation's veterans. With more than 1,700 medical facilities located across the country, the VA health care system is the the largest medical education and health professions training program in the United States. It employs approximately 250,000 doctors, nurses, and support staff who are responsible for treating and rehabilitating the millions of veterans who return home after enduring significant sacrifices in serving our country. While I appreciate the Department's continued commitment to providing and improving these essential services, I remain concerned that veterans are not receiving the quality levels of care they deserve from the Oklahoma City Veterans Affairs Medical Center (OKC VAMC).

I am troubled by a number of allegations against OKC VAMC staff and leadership brought by veterans, and current and past employees—particularly as Oklahoma's veterans are being subjected to overall sub-standard care at OKC VAMC, which is one of VA's five one-star rated medical facilities nationwide.¹

Recently, on June 11, 2014, I was alerted that OKC VAMC decided to close its thoracic surgery program following the death of a patient. Following the patient's death, *NewsOK* discovered there had been a total of five patient deaths following heart surgeries since October 2014 at OKC VAMC.²

I was also informed of a patient death in 2012 which resulted in a previous closing of OKC VAMC's thoracic surgery program—not disclosed by OKC VAMC in a June 2014 inquiry from my office. I am particularly concerned with events and circumstances surrounding the tragic death of veteran Paul Thompson, who died following heart surgery at OKC VAMC in March 2012. Also, if there were potentially warnings from current or former OKC VAMC staff who

¹ Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," *Wall Street Journal*, June 3, 2014; <http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437>

² Jaclyn Cosgrove "VA heart program in Oklahoma City temporarily closed after five deaths since October" *NewsOK*, June 24, 2014; <http://newsok.com/va-heart-program-in-oklahoma-city-temporarily-closed-after-five-deaths-since-october/article/4952506>

sought to alert current or former OKC VAMC leadership about poor care in OKC VAMC's thoracic surgery program.

I am also concerned with senior management at OKC VAMC, which may have exacerbated these problems at the facility through poor management and intimidation of its employees. According to White House Deputy Chief of Staff, Rob Nabors, VA suffers from "a corrosive culture" which has led to personnel problems across the department that seriously impacting morale and timeliness of health care.³ Mr. Nabors also found that problems at VA "are exacerbated by poor management and communications structures, distrust between VA employees and management, a history of retaliation toward employees raising issues, and a lack of accountability across all grade levels."⁴

Often times, instead of acknowledging these problems and increasing efforts to restore adequate health care management, the VA has been known to reward medical providers and administrators responsible for failing conditions and preventable deaths with bonuses and promotions. For example, CNN recently reported that last year, Sharon Helman, the director of the Phoenix VA Health Care System, received a \$9,345 bonus, despite all the patients who died under her watch.⁵

According to the VA Office of Inspector General (OIG), there are a number of facilities nationwide that will require additional scrutiny following initial inspector general efforts to investigative secret waiting lists at VA facilities. There may be senior leaders at OKC VAMC who have harmed our veterans through mismanagement at other VA facilities around the country—VA should immediately hold these employees accountable for past mismanagement if the IG's findings supported such action.

As the Ranking Member of the Homeland Security and Governmental Affairs Committee, I have a responsibility to ensure our nation lives up to the promises it has made to its veterans. In an effort to gain a better understanding of the quality of care our veterans receive from OKC VAMC employees, potential employee intimidation by senior leaders, protect whistleblowers, and to ensure effective management at all levels within the facility, I request the VA OIG immediately conduct a thorough investigation of the care and management within the following areas at OKC VAMC: all surgery clinics, podiatry, primary care, scheduling, customer service, GI clinic, internal medicine, pharmacy, hospital administration, and facility security.

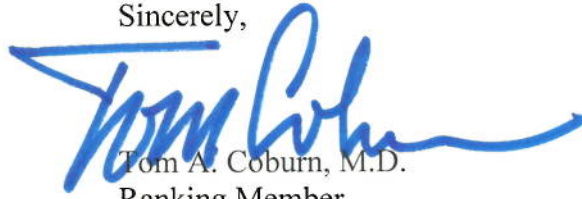
Thank you for your attention to this important matter. A written response is requested by no later than July 30, 2014. If you have any questions concerning this request, please contact my staff via Jabari White at (202) 224-5754.

³ Steven Dennis, "Rob Nabors Cites "Corrosive Culture" in VA Scandal" June 27, 2014, Roll Call; <http://blogs.rollcall.com/white-house/rob-nabors-va-report-scandal-corrosive-culture/?dcz=>

⁴ Steven Dennis, "Rob Nabors Cites "Corrosive Culture" in VA Scandal" June 27, 2014, Roll Call; <http://blogs.rollcall.com/white-house/rob-nabors-va-report-scandal-corrosive-culture/?dcz=>

⁵ CJ Ciaramella, "VA Director at Phoenix Hospital Got \$9K Bonus," Washington Free Beacon, April 24, 2014, <http://freebeacon.com/issues/va-director-at-phoenix-hospital-got-9k-bonus/>.

Sincerely,

A handwritten signature in blue ink that reads "Tom Coburn". The signature is written in a cursive style with a large, sweeping initial "T" and a long, horizontal flourish at the end.

Tom A. Coburn, M.D.

Ranking Member

Senate Committee on Homeland
Security and Governmental Affairs