Veterans Affairs Whistleblower Coalition
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U.S. Senator Daniel Kahikina Akaka
Chairman of the Veterans' Affairs Committee
United States Senate
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Washington, D.C. 20510
Fax: (202) 224-2126

March 16, 2007

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Senator Akaka,

I write this letter to you today as Director and Founder of the VA Whistleblowers Coalition (VAWBC, www.vawbc.com) in the interest of veteran safety and concern for Veterans Affairs employees. As a group, we wish to share serious concerns with you, especially in light of recent media attention given to the deplorable conditions at the Walter Reed medical facility. We are hopeful that you will take heed of our warnings and insist that our concerns be thoughtfully investigated.

By way of one local example, last year Mr. Paul Kornak was sentenced to 6 years in prison as a result of a 48- count manslaughter charge for violations of conducting research on veterans at the Stratton VA Medical Center in Albany NY. Several of our members publicly voiced concerns that although we believe Mr. Kornak should have received maximum punishment for killing patients, falsifying documents and practicing medicine without a license, he was simply being used as a scapegoat for a much larger problem. Among those concerns are previous research violations, which surely predated Mr. Kornak. Until an investigation is performed we have no way of knowing the extent of criminal activity in unauthorized experimentation on veterans, illegal diversion of money, and administrative abuse of personnel.

Additionally, administrators and licensed professionals that spent a decade retaliating against employees attempting to bring the abuses of Kornak and others to light, should be held to account for their actions. These people are far more dangerous than a dozen Kornaks, since they have taken up various posts across the country and threaten to undermine accountability at a number of VA institutions. The actions of these people caused the deaths of veterans, and there seems to be few people interested in discovering the truth and preventing a repeat of the Stratton catastrophe at other VA facilities.

Several of the signers below have agreed to provide you with the names of suspected persons involved in similar wrongdoing at their respective VA institutions, the current VA locations of offenders, and their professional licenses and current positions within the Department of Veterans Affairs.

Locally, we have supportive documentation in the form of patient records, many of which have been filed with several VA Offices of Inspector General (VA-OIG), the Albany FBI field office, US Attorney, Office of Special Counsel (OSC), and Merit Systems Protection Board (MSPB). Other of our members have congruent stories, with supporting documents, of patient abuse whereby fierce retaliation against the whistleblower was condoned and encouraged at VA facilities throughout the United States. The nature of these matters are such that they require intervention by Congress to further efforts at a comprehensive, and much needed, investigation of systemic misbehavior in the VA.

The following is a summary list of immediate concerns. Each day that ticks by without action is another day that puts veterans needlessly in danger.

The lapses and malfeasance of the Stratton facility at Albany represent <u>just one</u> example of abuse, mismanagement, and cover-ups that are prevalent throughout the VA system nationwide. While Stratton was especially egregious in violating veterans' rights and compromising the safety of patients, these practices exist <u>throughout the VA system</u>. The extent of this abuse calls for immediate investigation and remediation.

- Investigations of unauthorized experimentation, malfeasance in health care provision, and medical corruption are difficult and expensive to investigate. The FBI and other agencies tasked with investigative responsibilities seem unprepared for investigations in the settings presented by VA and are reticent to start investigations; perhaps out of fear of what may be found, perhaps because of reticence to attack another government agency, or perhaps because the victims of these crimes are poor and sick and have few resources at their disposal. The FBI needs to be prompted to develop an investigative protocol for the VA and to remember that the people being harmed are those who risked their lives to keep this country free. And, unfortunately, they are often vulnerable and too ill or feeble to advocate for themselves.

- The Stratton VA (and other facilities nationwide) should be investigated thoroughly for past and current abuses. There are two reasons to do this. First, obviously, to find out the truth and determine the extent of criminal activity. Second, the events at Stratton constitute a sort of "national laboratory" for VA misbehavior and provide a model that investigative techniques and protocols may be built around.

- Public congressional hearings should be convened to determine the prevalence nationwide of activities similar to those discovered at Stratton. You may start with a large list of VAWBC members!

- The systemic and persistent lawbreaking by OSC regarding its primary function - protecting federal employees from prohibited personnel practices, namely retaliation, enabling lawbreaking at the Merit Systems Protection Board (MSPB) must be halted in the name of veteran safety.

Because of the breadth of this problem, we have engaged other Veterans Affairs whistleblowers by forming a national Veterans Affairs Whistleblower Coalition. The coalition consists of Veterans Affairs employees (past or present) who agree to actively lobby Congress to end government retaliation against those who expose veteran patient harm and abuse and major ethical breaches. We have partnered with several organized concerned colleagues, some of whom include the National Security Whistleblowers Coalition, the Liberty Coalition, the Semmelweis Society, and the Patient Quality Care Project. These concerned citizens and groups share our position and concerns for veterans and the system which was put in place to care for them.

Our membership of VA whistleblowers spans the entire nation including California, Arizona, Colorado, New Mexico, Iowa, Indiana, Missouri, New York, Pennsylvania, Alabama, Tennessee, Florida, and Texas, as you can see from the signatories below. This in and of itself should serve as a very telling wakeup call. Most of these members are medical professionals that reported direct patient abuse causing imminent harm or death to our nation's veterans. Others include a police officer, engineer, supply clerk, and more. Each of these members was punished [most often] for exposing patient abuses or hastened deaths, but several have concomitantly exposed government waste, fraud, and abuse. The current system in place to purportedly protect federal whistleblowers clearly has served as a covert system to abuse the innocent and protect the guilty.

Although injury to our whistleblower members remains an important issue, we are most concerned about the permissive attitude toward shabby performance at all levels of VA management and the priority to obscure criticism to provide protection from embarrassment. Perhaps replacing top management will correct the situation, but there is little confidence that this action will be successful unless oversight agencies are investigated and their leadership similarly questioned and prosecuted where necessary. At a minimum, there must be a change in leadership at multiple levels and poor past behavior should be investigated. Criminal behavior should be prosecuted. The virtue and honor of the VA should be re-established and protected as a means of repairing the patriotism of all Americans but, mostly, to pay appropriate homage and respect to the soldiers who have given so much to protect our democracy.

In a recent press release regarding the Walter Reed Hospital you stated "I am deeply concerned about this situation, both as a member of the Senate Armed Services Committee, and, given that many of these wounded troops will soon be classified as veterans, as Chairman of the Senate Veterans Affairs Committee."

Please help our group to educate you on the malfeasance that exists among our VA hospital administrators, the VA-OIG, the OSC, and the MSPB. Help us to uphold

excellent quality care to veterans without having to fear for our safety, our jobs, our families, and our professional careers. Most importantly, please help us to expose these travesties and bring subversive government employees to justice in advance of another Walter Reed expose'.

As a matter of clarification, the signatures included below are in two separate categories. The first includes some of our VAWBC members. Their current or former VA affiliations are included so that you may see the breadth of this national problem. They are not signing in their official capacity as government employees, nor does their signature constitute the opinion, agreement, or disagreement of any government agency. The second block of signatures includes those officers representing certain of our concerned partner groups. Copies of this letter will be sent to select government officials including but not limited to select congressmen/congresswomen and senators. This letter will be sent to you via U.S. mail, faxed to both offices listed above, and e-mailed through your official government website.

All of my contact information appears below my signature block. You may view my professional credentials and curriculum vitae' at www.NOVAPAIN.net. Other important website addresses, including documents and media links are included below. I am hopeful that you will contact me directly.

03-16-2007

Jeffrey Fudin, B.S., PharmD, DAAPM
Diplomate, American Academy of Pain Management
Clinical Pharmacy Specialist, Pain Management (VAMC-Albany NY)
Adjunct Associate Professor of Pharmacy Practice (Albany College of Pharmacy)

Executive Director/Founder, Veterans Affairs Whistleblower Coalition (www.VAWBC.com)
CEO, NovaPain (Located at www.PainDr.com or www.NOVAPAIN.net)

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VAMC Office: 518-626-5706 (gov't business only)
VAMC Fax: 518-626-6328 (gov't business only)
Digital Pager: 518-342-3084 (gov't business only)

VAWBC Member signatures (past or present VA professionals):

1) Lewis Baxter, MD (Psychiatrist)
   Previously employed as a Psychiatrist at
   Malcom Randall **VA Medical Center, Gainesville FL**

2) Saundra J. Counce, RN (Nurse)
   Previously employed as a Nurse-Post Coronary Telemetry ICU at
   Tennessee Valley Health Care System, VA Medical Center, Nashville TN

3) Viola Davis, BSN, RN (Nurse)
   Previously employed as a Critical care ICU Nurse at
   Atlanta VA Medical Center, Atlanta GA

4) Louis A. Fontana, MD (Physician)
   Previously employed as a Director, Pain Clinic at
   Jerry L. Pettis Memorial **VA Medical Center, Loma Linda CA**

5) Jeffrey Fudin, BS, PharmD, DAAPM (Clinical Pharmacist)
   Clinical Pharmacy Specialist
   Stratton VA Medical Center, Albany NY

6) Scott Harrington, PharmD (Pharmacist)
   Previously employed as a Pharmacist at
   Southern Arizona VA Healthcare System, Tucson AZ

7) Jeffrey Holst (Police Officer)
   Previously employed as a Police Officer/now demoted to Housekeeping pending review **Iowa City VA Medical Center, Iowa City IA**

8) Laura Holst, BS, RN (Nurse)
   Staff Nurse, Intensive Care Unit at
   Iowa City VA Medical Center, Iowa City IA

9) David Hornick, MD (Physician)
   Previously employed as a Medical Director, Hospital Based Home Care at
   Stratton VA Medical Center, Albany NY

10) Kevin Kuritzky (Medical Student)
    The Student Health Integrity Project
    Previously employed as a Medical Student at
    Atlanta VA Medical Center, Atlanta GA

11) Diane King, BS, JD, ASCP (Medical Technologist)
    Previously employed as ASCP Medical Technologist at
    Central Alabama Veterans Healthcare System, Montgomery AL

12) Soa Yuc Lee, MD (Psychiatrist)
Psychiatrist
VA Nebraska Western Iowa Health Care System, Lincoln NE

13) Anthony Mariano, BS, RPh (Pharmacist)
Previously employed as Chief of Pharmacy Service at
Stratton VA Medical Center, Albany NY

14) John J. Morykwas, Jr., BS, BSMT, ASCP (Medical Technologist)
Previously employed as ASCP Medical Technologist at
Central Alabama Veterans Healthcare System, Montgomery AL

15) Roberta Miller, MD (Physician)
Previously employed as Medical Director, Hospital Based Primary Care at
Stratton VA Medical Center, Albany NY

16) James Murtagh, MD (Physician)
President, Doctors for Open Government (DFOG) and Semmelweis Society
Previously employed as Physician at
Atlanta VA Medical Center, Atlanta GA

17) Catherine Pacilli RN (Nurse)
Previously employed as a Nurse at
VA Central California Health Care System, Fresno CA

18) Laura Raymo, BS, PharmD, BCPS (Clinical Pharmacist)
Previously employed as a Clinical Pharmacy Specialist at
Stratton VA Medical Center, Albany NY

19) David A Shaller, MD (Physician)
Previously employed as Chief, Rheumatology and Chief, Nursing Home Care Unit at **Wilkes-Barre VA, in Wilkes-Barre PA**

20) Carla Rae Thieben, BSN, MA, RN (Nurse)
Previously employed as Nurse at
New Mexico VA Health Care System, Albuquerque NM

Organization Signatures:

21) George Anderson
Ethics in Government Group (EGG), manderson358@comcast.net

22) Ralph Bard
Vice President, Semmelweis Society, rmbard@charter.net

23) Dane von Breichenruchardt
President, U.S. Bill of Rights Foundation, usbor@aol.com
Chairman, PQCP of the Liberty Coalition

24) Henry Butler
Past President, Semmelweis Society International, hbutler@pol.net

25) Roland M Chalifoux
The Health Integrity Project, neuroswbs@yahoo.com

26) Sibel Edmonds- Director
National Security Whistleblowers Coalition (NSWBC), www.nswbc.org

27) William Hinnant, MD
President, Semmelweis Society International, NETDOC37@aol.com

28) Gwen Marshall
Georgians for Open Government, rgnm3@bellsouth.net

29) Ron Marshall
Chairman, The New Grady Coalition, rgnm3@bellsouth.net

30) Michael Ostrolenk
National Director, Liberty Coalition, www.libertycoalition.net

Via e-mail, copied to:
Copies of this letter will be sent to select government officials including but not limited to select congressmen/congresswomen and senators.

Congressman Bob Filner
Chairman, House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
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