

United States Senate

January 9, 2015

Richard J. Griffin
Acting Inspector General
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Acting Inspector General Griffin,

I request the Veteran Affairs (VA) Office of Inspector General (OIG) appoint new inspectors to investigate complaints at the Edward Hines, Jr. VA Hospital (Hines), Hines, Illinois, to provide fresh perspective and unbiased insight into the allegations first reported by cardiologist, Dr. Lisa Nee, and received by the OIG as a congressional inquiry on February 27, 2013. Dr. Lisa Nee disclosed to the VA OIG allegations of deficiencies in cardiovascular care that resulted in unnecessary invasive coronary procedures, life-threatening delays in treatment, and disturbing falsification of patient records and manipulation of physician productivity data. It has come to my attention that the VA failed to fully investigate these cases.

These allegations were disclosed to the VA OIG in 2013 and a subsequent investigation was completed. However, this initial investigation was incomplete. According to a statement by the Office of Special Counsel (OSC) on September 17, 2014, it “failed to fully investigate all cases of alleged unnecessary coronary surgeries...failed to investigate and address the root cause of these repeated diagnostic errors...failed to fully investigate allegations of deficiencies in echocardiogram imaging and processing...and failed to investigate falsely recorded procedures performed by a VA physician.” In September 2014, OSC directed the VA OIG to conduct another investigation into Dr. Nee’s disclosures of:

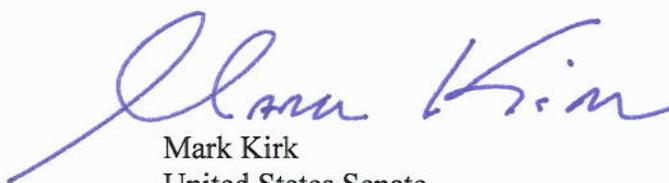
- Deficiencies in cardiovascular care at Hines resulting in unnecessary coronary surgeries and procedures performed on patients due to diagnostic errors.
- The root cause of the diagnostic errors and notification to patients who underwent unnecessary surgeries due to serious medical mistakes.
- Deficiencies in echocardiogram imaging and processing resulting in hundreds of useless studies and, a significant backlog of unread echocardiogram studies that caused life-threatening delays in treatment to patients; and
- Claims at least one physician, Dr. Robert Dieter, recorded an inflated number of procedures he performed to falsely boost the appearance of his productivity.

The same VA OIG investigator who failed to properly investigate these allegations the first time is assigned to investigate the Hines VA again, according to Dr. Nee. Therefore, I request the VA OIG appoint a different lead investigator and investigative team to this matter to ensure an unbiased inquiry into these allegations. In July 2014, I wrote Secretary McDonald detailing my concerns about the mounting evidence my office uncovered of delayed and negligent care, secret wait lists, and appointment scheduling manipulation at Hines VA. Additionally, I shared my

concerns that a pervasive culture of corruption and systematic retaliation against whistleblowers existed at the Hines VA and was being perpetuated by the Hines leadership. Yet again, I write about egregious allegations regarding patient care at the Hines VA and the disturbing lack of due diligence displayed by your office when investigating these allegations.

We cannot begin to fix the VA if we do not know what the exact problems are, and without effective instigative efforts of the VA OIG that task is impossible. Our veterans, who bravely served our country, deserve the best medical care available and at the very least deserve their leaders' attention to people and systems that obstruct them from receiving that care.

Sincerely,

A handwritten signature in blue ink that reads "Mark Kirk". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

Mark Kirk
United States Senate

cc: Robert A. McDonald, Secretary Department of Veterans Affairs