

## VA Public Hearings Urged

10-23-04

In response to the October 8, 2004 Times Union newspaper article titled Stratton Medical Chief to Quit Post (listed on this website under "Related News Reports, 10-09-2004 Medical chief to quit post"), I applaud the medical staff at the VA Medical Center for their courageous actions urging the removal of the Chief of Staff. I also applaud Assemblyman Ronald Tocci for his concern and involvement in improving conditions for employees and the veterans they serve.

As a past employee of the Stratton VA, I experienced first hand the type of strong-armed management practices that the Chief of Staff dealt to employees under her supervision. Although I was not supervised by Chief of Staff, the management at Stratton VA has for ten plus years has displayed a pattern of retribution for people who speak out, retaliation for those who stand up for veterans care and have forced employees to keep their mouths shut in order to keep their jobs.

Dr. Roberta Miller, an acclaimed physician, who was a primary care giver for many veterans who were home bound, was one of those employees who could not stay silent when she saw problems in veterans care. But, by speaking out, Dr. Miller became the next in a long line of victims who were forced from VA employment for caring too much.

Assemblyman Tocci's involvement should be used as a first step in putting Stratton VA under the microscope. Management at the top and mid level needs to hear the concerns of employees, patients and patient's families.

Congress, in the summer of 2003, passed legislation that removed research oversight from the VA based on what occurred in Albany. However, this reform does not go far enough to hold VA officials accountable for the patients who were harmed over the many years as a result of gross mismanagement practices in Albany. It is a well-known fact that VA officials made every attempt to cover up patient care violations for the entire decade of the 90's. Officials from the Quality Assurance office followed orders to remove patient medical records from peer review. Such removal was to prevent any validation of the patient harm or death stemming from research and gross mismanagement practices at the facility.

Oversight of VA mismanagement is delegated to the VA's own Office of Inspector General. As VA employees, they are responsible for investigating the same officials who provide their income and their training. How can one be assured that anyone asking for an inside VA investigation would get a fair shot? This typical "fox guarding the hen house" situation has to be stopped.

Previous calls to the Office of Inspector General's Office to investigate wrongdoing and mismanagement have gone unanswered. It appears they pick and choose what complaints they want to investigate and which officials they want to protect. As in the case of the indicted research violations, they targeted an employee who was a technician but ignored the responsibility of those above him. Why wasn't top management held accountable for allowing this to happen? Why weren't Dr. Fudin's calls for an investigation several years earlier heeded? Public records show that Dr. Fudin warned all higher levels of Stratton VA management at the time, so they clearly knew of the research irregularities? Could it be that the financial gain of the program outweighed any concern they had for patient care?

On October 21, 2004 the Times Union newspaper reported that VA Officials once again retaliated against Dr. Jeffrey Fudin who was to speak at a national pharmacy conference on various topics, one of which included whistle-blowing. Dr. Fudin has become an "expert" on how to document,

defend, and survive the outcomes of blowing the whistle. All VA employees and any healthcare professional outside the VA need to know how to handle this type situation should they become a target for whistle-blowing.

By refusing to validate and allow Dr. Fudin administrative time to attend and speak at this conference, VA Officials once again show that they truly do not care about patient care and the betterment of VA programs. If they did, they would welcome Dr. Fudin's comments on how to be a stand-up ethical employee and not fear to report wrongdoing.

What is suspect in these two articles is that Assemblyman Tocci's call for hearings on VA care was announced just one day before Dr. Fudin was denied official attendance at the conference. What does the VA fear? Are they fearful that Dr. Fudin knows their long-standing policy of cover-ups? Do they realize that he has become so knowledgeable about the process that they fear others will no longer be intimidated as previous?

I urge Assemblyman Tocci to go forward with hearings on VA care. There needs to be a forum for all those who care deeply about veterans and their families. For those employees, veterans and families of veterans who wish to testify, I urge you to contact the office of Assemblyman Ronald Tocci at 518-455-4897.

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