United States Senate
WASHINGTON, DC 20510

July 13, 2017

VIA ELECTRONIC DELIVERY

The Honorable David Shulkin, M.D.
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shulkin:

We are writing to request an urgent meeting with you to discuss our serious concern with the lack of progress in improving patient care and safety at the Marion Veterans Affairs (VA) Medical Center in Illinois.

We have received multiple whistleblower complaints alleging mismanagement and deficient care at the facility. These reports detail alleged incidents of prohibited personnel practices, including whistleblower retaliation, nepotism, unfair labor practices and mistreatment and abuse of employees. Simply put, the Marion VA Medical Center appears to be plagued by a hostile work environment that makes it difficult to recruit, hire, and retain talented medical professionals and clinical staff.

We are most troubled by allegations that this mismanagement is negatively impacting quality of care and jeopardizing patient safety. In a series of disturbing disclosures, whistleblowers from a number of departments detailed specific allegations of clinical errors, patient record falsification and manipulation, or hiding wait time data. Individuals stated that when they reported concerns to superiors, including errors that could result in a patient's death, these complaints were not responded to or addressed. To protect whistleblowers at Marion VA Medical Center, we are refraining from including identifying details of the specific incidents in this letter, and prefer to discuss the specific allegations during the meeting we are urgently requesting with you.

The whistleblower reports do not appear to be isolated incidents. These disturbing disclosures appear to be consistent with Marion VA Medical Center's troubling performance in annual VA All Employee Surveys and biennial Culture Surveys. They are also consistent with deficiencies and problems identified by the VA's National Center for Patient Safety (NCPS), which visited Marion VA Medical Center in 2015 following multiple staff complaints to NCPS.

Following that visit, a NCPS program manager found that "realignment of patient safety and quality management was paramount" at Marion and urged Veterans Integrated Service Network (VISN) 15 leadership to: "...intervene to assure staff complaints were fully investigated and addressed." However, NCPS has not observed progress in implementing these recommendations. According to a May 31, 2017 memorandum authored by the NCPS program manager, "...after that visit in 2015, it appears that no transparent action was implemented," and Marion VA Medical Center is "now likely to have a less healthy patient safety culture than the VHA norm." That same memorandum noted that in 2016 and 2017, 26 employees at the facility contacted NCPS to request additional site visits to address patient safety concerns.

The VA Office of Inspector General (OIG) is aware of concerns at the Marion VA Medical Center and the U.S. Office of Special Counsel has received employee complaints. In fact, on May 26, 2017, we requested VA OIG initiate an immediate investigation into the most alarming whistleblower allegations. However, any ongoing investigative work by VA OIG is limited to only examining the specific incidents. The VA OIG has also informed us that it will wait before considering any investigation until any current work by other VA departments, such as the Office of Medical Inspector or the Administrative Board of Inquiries, has concluded. However, it is our understanding the scope of any current work may be limited to singular departments or issues.

In light of the gravity of the whistleblower allegations (which continue to be received by our offices), combined with the non-responsiveness of leaders at Marion and VISN 15 to the NCPS findings, we believe direct and immediate intervention is warranted by Department leaders to fix any quality of care and access problems at Marion facility-wide, while protecting whistleblowers against retaliation in all forms.

Accordingly, in addition to meeting with us at the earliest possible date, we are requesting the Veterans Health Administration (VHA) designate a team of experts and investigators from its National Center for Organizational Development immediately commence a fully-resourced, top-to-bottom review of Marion VA Medical Center operations and VISN 15 leadership. This comprehensive investigation should examine allegations of mismanagement and poor patient care, and if validated, result in swift, effective and sustained intervention to transform the leadership, culture and performance. We look forward to discussing in detail the specific issues that we believe any review must address.

Marion VA Medical Center's long-standing problems must be fixed. We are bringing this matter to your personal attention to demonstrate our level of alarm and outrage over the whistleblower allegations and apparent indifference to reform among local management. It also expresses our confidence in your leadership and commitment to achieving a VA that delivers world-class care across-the-board. As a clinician with extensive administrative experience managing hospitals, you are uniquely positioned to hold the Marion VA Medical Center accountable for implementing true management reforms that enhance quality of care and improve workforce morale. We must make sure that the brave men and women who served our country receive the level of care and access to services they deserve. Thank you for your prompt attention to this matter. We look forward to meeting as soon as possible to discuss our concerns and request.

Sincerely,

Tammy Duckworth
United States Senator

Richard Durbin
United States Senator