Ryan Honl Statement

Tomah Congressional Field Hearing

I am the one who blew the whistle on the alarming irregularities concerning unethical practices at the Tomah Veterans Affairs Medical Center. I am also a disabled combat veteran who received care at the VA for 15 years up until last year. I enlisted as a combat engineer after high school, served in Desert Storm, earned an appointment to West Point, then became a commissioned infantry officer before being medically discharged with, among other things, PTSD. It is important to note that I was only the spark to set off years of employees raising concerns about the dangerous prescription and distribution of narcotics as well as the resulting retaliation. The results were to the detriment of the health of veterans and in some cases the deaths of veterans. The system was slow to respond but quick to silence those who raised concerns. I just wish the whistle I blew would resurrect those who have died due to mistreatment. There are three areas where the system broke down.

One, there is a widespread failure of leadership across the VA. That, in the words of the Rob Nabors White House report issued last year, leads to a corrosive culture that protects corrupt officials from top to bottom and ultimately leads to the harm of veterans. Initially, my complaints to the VA Office of Inspector General mainly centered on a hostile work environment that tolerated fraud and abuse. I only briefly mentioned that although I wasn't a witness to the over prescription of narcotics, there was a widespread concern among my coworkers. I simply stated in my complaint that it should be looked into. The failure in leadership within the Tomah facility centered mainly around Dr David Houlihan and a facility director, Mario Desanctis, who was quite simply a rubber stamp. It is a culture where cronyism runs rampant leaving incompetence in charge at all levels that tolerates unethical practices. In a nutshell, I was asked and made aware of unethical behaviors centering on falsely recording time & attendance of a doctor, the loss of personel files, and tolerance of sending up false reports of the Talent Management System. Once I came out publicly blowing the whistle, I had current and former employees contact me with information about other unethical activities up to and including patient harm and death. There is a lack of accountability in VA leadership. There were years of complaints concerning a retaliatory environment and patient harm, yet both VA leadership and the VA Office of Inspector General ignored or handed off complaints back to the Tomah facility so it could investigate itself. There is a culture in the VA of admitting no wrongdoing and covering it up. Pain management and wait times are simply a symptom of a

far larger lack of accountability. Tomah is not an island unto itself. Dr Houlihan should have been held to account years ago, yet the system protected him and not our nation's veterans.

Two, the VA Inspector General's office is broken. If it weren't for a FOIA request done by Senator Baldwin's office last summer, no one would have known about the issues in Tomah. We wouldn't be sitting here today if it had been public. It took an investigative journalist at the non-profit Center for Investigative Reporting to do the job that the VA Inspector General was incompetent to do. When I received that report through a former colleague whose friend was simply wondering what had happened to their complaints, it was shocking. Everything people had been talking to me about since I blew the whistle was in that report black and white. Excessive prescribing of narcotics. Drug diversion. Patients not using their narcotics. A physician in 2009, Dr Chris Kirkpatrick, who raised concerns about Dr Houlihan's prescribing practices, was terminated, and went home and committed suicide. Tomah municipal police reports of veterans using and selling their medication. Retaliation against those who spoke up concerned about their licenses, such as the 5, let me say again, 5 pharmacists who spoke with investigators about the dangerous levels and early filling of narcotics and resigned or were terminated. Most incredible to me was the statement about the perception of retaliation, implying that it didn't really exist, yet numerous people in the report had been forced out of the facility for simply raising concerns. Perception? No, reality. It doesn't take a rocket scientist or a medical degree to see that something doesn't smell right. Recently, Inspector General Griffin said that he wouldn't have done anything different and no one else would have either. Let me raise my hand with every elected official and whistleblower that something needed to happen far differently. Ms Gromek stated that it couldn't be released because of personally identifiable information. The report received through the FOIA request was redacted. I'll give you two personal examples of retaliation even after resigning from the VA. After requesting a patient access report of my medical records, I discovered that a half dozen Tomah employees had accessed my electronic medical records after I left the facility over a supposed mix up in Secretary McDonald's office concerning a complaint about my prescriptions. Although I had never received care or prescriptions from the Tomah VA, there were half dozen Tomah non pharmacy employees in my records. I had originally informed my supervisor, Lisa Noe, that I had a PTSD diagnosis since I was in vocational rehabilitation and my counselor in Indiana needed to know information about my employment at the Tomah VA. I asked that this remain in confidence. However, as soon as I blew the whistle, I started hearing about my instability from other employees. Ultimately, the most troubling occurred since everything came out in the media in January. Dr Houlihan's attorney sent a letter to me threatening a lawsuit for defamation. In an interview with the Milwaukee Journal Sentinel, his attorney alluded to my mental health status. Shortly after while VA investigators were in the Tomah VA, Police Chief Huffman directed that a police report be done on me by my former supervisor, Lisa Noe, and two coworkers, Leesha Dukes and Rachel Fleming, four months after I resigned over a supposed

“threatening incident” that took place while I was an employee before I resigned. You can see the police report that someone leaked to me in my submitted documents. In one part of the police report, I’m accused of acting “crazy.” Clearly, my mental health diagnoses are being used by those I reported in order to discredit me.

Three, of greatest concern are the harmed and dead veterans. The VA has become one of the biggest drug dealers in the nation. It is disheartening to see numerous Dr Houlihan and Deb Frasher patients singing his praises. If you were an addict receiving free narcotics, with some even selling them on the streets, would you be happy that the supply has been cut off? I encourage you to look beyond the fanatical support of those two clinicians and understand why their patients want them prescribing again. Pain medication is necessary. The tragedy is you have two clinicians wildly prescribing and no one within the VA willing to care enough to hold them accountable which is only going to cause the responsible clinicians out there to be more restrictive with those patients that really need that pain medication. I have PTSD. If I were ever prescribed a narcotic to manage it, I'd ask a lot of questions. However, if I had just gotten out of the service and was more vulnerable, I'd trust a physician more. If through that trust I became an addict who knows what would have happened.

In conclusion, there are several things that need to happen. First the good. I believe as do most of the others who are or have raised concerns, that Secretary McDonald is the right guy to tackle the VA's accountability problem. If it weren't for Bob McDonald, none of what has been going on in Tomah for these many years would have been exposed. It was well known within the facility that Bob had published his cell phone number. When I called it, he answered. We didn't talk in any detail about the problems in Tomah, but he listened to what we did talk about. I'm not the only one. Others have had a similar experience. When you have rotten leaders from the bottom to the top, communication becomes the greatest obstacle to changing a culture. By opening up the lines of communication, Bob McDonald has a clearer picture of the problems in the VA than any previous secretary. And that puts the fear of God into the corrupt leaders that would love to see him go and return things to the status quo. The last thing the VA needs is yet another new VA secretary. The greater problem in the VA is an incompetent Inspector General. Until the Secretary is brought up to speed on serious problems, how can he fix what he doens't know? As both Senator Baldwin and Senator Johnson have done, ask the President to nominate a permanent Inspector General. Finally, elected offices need to make sure that when they hear of serious problems in a facility, they direct those concerns far higher than the facility level. When, as in Tomah, unethical practices go all the way up to the facility director, sending those concerns back to that facility director only leaves the fox to guard the hen house. As Congressman Kind stated, when he came to the Tomah facility last summer, there wasn't a peep from Mario Desanctis that there were any problems whatsoever. Nothing. A VA Inspector general should at minimum provide a summary

of problems in a facility. In the case of Tomah, when someone from Congress comes calling, they should already have a topline of any issues concerning investigations. This Inspector General's office didn't even keep senior leadership informed. Carolyn Clancy who will testify today, only found out about the report late last year. Get the President to nominate a new Inspector General and let Bob McDonald continue to clean up and get rid of those who serve themselves instead of veterans. I and others are very encouraged by the efforts of our elected officials to introduce legislation to hold the VA accountable.