

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON SCIENCE AND TECHNOLOGY

SUITE 2320 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6301
(202) 225-6375
TTY: (202) 226-4410
<http://science.house.gov>

May 15, 2009

General Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear General Shinseki:

I do not ordinarily regard a personnel matter in the Executive branch as a proper subject of Congressional oversight. However, the pending matter of Dr. Anna Chacko, who has been placed on administrative leave and prohibited from her workplace without a police escort, raises serious questions about the management of the Veterans Affairs Pittsburgh Health System (VAPHS), as well as rudimentary procedural fairness.

Last year, this Subcommittee held a hearing to consider actions by Dr. Mona Melham, a high-ranking official at VAPHS. The Subcommittee's investigation resulted in harsh criticisms of the management at VAPHS, and especially of Dr. Melham's conduct. The Subcommittee concluded that Dr. Melham ordered the destruction of a 30-year research collection of *legionella* bacteria that represented the life's work of two world-renowned researchers. The subcommittee concluded that Dr. Melham ordered the collection destroyed out of personal animosity for the two researchers, and that her explanation of her conduct to the system's chief of staff was knowingly false. The Subcommittee also concluded that VAPHS officials violated the Department's published disciplinary procedures in firing one researcher and attempting to fire the other, including conducting a blatantly biased Administrative Board of Investigation. (See, "Biobanking: How the Lack of a Coherent Policy Allowed the Veterans Administration to Destroy an Irreplacable Collection of *Legionella* Samples," Staff Report, Subcommittee on Investigations and Oversight Committee on Science and Technology, U.S. House of Representatives, Sept 8, 2008.)

After that hearing, Department officials assured Subcommittee staff that the Department would take steps to address the Subcommittee's criticisms. It appears that the Department has taken no such steps. There has been no investigation by VAPHS of the conduct at issue, and no official has been disciplined or reprimanded.

Dr. Chacko, who was brought in as the fourth chief of the VAPHS radiology department in five years in September of 2008, complained to superiors about Dr. Melham's conduct in the radiology department: Dr. Chacko alleged that it was improper and had potentially compromised patient care, including ordering an x-ray for an employee who Dr. Chacko believed not to be eligible for VA care, purchasing unsuitable radiology equipment and materials. Subsequent to those complaints, Dr. Chacko received notice of an Administrative Board of Investigation (ABI) hearing into "allegations of impropriety" in the radiology department which she believed to be directed toward Dr. Melhem.

At the ABI hearing, it became evident that Dr. Chacko's supervisory skills were the primary subject of the investigation, even though ABIs are not normally convened for management issues that do not rise to the level of alleged criminal behavior or serious misconduct. Despite this focus on Dr. Chacko, she was denied the right to submit documentary evidence or a written statement after the hearing and was not provided a transcript of her oral testimony to review, correct and/or supplement, all in violation of the Department's published ABI procedures. The ABI report concluded that the radiology department's performance had "recently begun to suffer under Chacko's leadership." Certainly any change in the department's performance under Dr. Chacko's leadership would have been recent, given Dr. Chacko's brief tenure and no evidence of such deterioration was revealed in the ABI report.

Dr. Chacko is the fourth head of the radiology department in the last five years. She was new to the VA system and had received minimal orientation or supervisory training. Her probationary evaluations were to be measured against an initial performance plan, but that plan was not received until after the ABI was convened. There is something very wrong in the management of VAPHS.

Currently, the VAPHS appears to be using every possible procedure to remove Dr. Chacko from her position. Although the VAPHS director has not issued a final decision on what action will be taken in response to the ABI report, VAPHS management has already taken other steps to remove Dr. Chacko. In addition to banning her from her office, it has convened a Professional Standards Board (PSB) review, scheduled for Thursday, May 21. No documents necessary to prepare for this review were provided to Dr. Chacko until eight days before the scheduled meeting, and the PSB procedures have not yet been provided.

A Summary Board to review her work as a probationary employee has also been convened, although no date for that has yet been set. Dr. Chacko also has not received a copy of the procedures for that Board. These failures are evidence of basic unfairness in the VAPHS' disciplinary procedures and smack of the same "rush to judgment" actions the Subcommittee saw in its earlier investigation.

Again, were it not for the similarity of the events surrounding Dr. Chacko's employment with VAPHS to the conduct that was the subject of this Subcommittee's

earlier investigation and for the Department's failure to take any corrective action, this Subcommittee would be strongly disinclined to intrude into this matter. VAPHS has already suffered the irreparable loss of what had been a nationally acclaimed special pathogens laboratory as a result of similar conduct in the recent past, and patient care may now be affected by the failings of the VAPHS management.

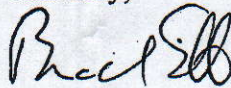
Therefore, by this letter, we ask that the PSB meeting and any other action concerning Dr. Chacko's employment be postponed until there has been a thorough investigation by the Department's Inspector General of the following: (1) the appropriateness of the use of the Administrative Board of Investigation of Dr. Melhem to recommend the removal of Dr. Chacko on , including the process by which witnesses were selected, and documents obtained; (2) the supervision and management of Dr. Chacko by Dr. Melhem and Dr. Jain from the initiation of the offer of employment to Dr. Chacko until the present, including a review of all documents informing Dr. Chacko of her probationary period and the performance plan and evaluations that would take place during that period; (3) events that have led up to four radiology chiefs at VAPHS in five years, including a review of the contracting procedures and the reporting lines and performance evaluation system for radiology employees, and whether they impact the authority of the radiology chief; (4) the use of restricting persons on non-duty administrative leave from VA facilities without a police escort when there has been no evidence of violent or physically disruptive behavior on the part of that individual; (5) quality of care issues at the VAPHS involving the proposed use of certain radiology equipment and materials on patients that may have increased their doses of radiation; and (6) a review of the purchasing regulations and guidelines at the VAPHS, including a discussion of the role of department chiefs in purchasing equipment for their departments.

Because the meeting of the PSB is now scheduled for Thursday, May 21, I am requesting a response to this letter by Tuesday, May 19.

If your staff has any questions or need additional information, please have them contact Dr. Dan Pearson, Subcommittee staff director, at (202) 225-4494 or Edith Holleman, Subcommittee counsel, at (202) 225-8459.

Your attention to this matter is greatly appreciated.

Sincerely,



BRAD MILLER

Chairman

Subcommittee on Investigations and Oversight