Reader Feedback

Blowing the Whistle on Veteran Harm

This letter is prompted by the article "Former VA Employee Convicted in Research Abuse Trial," which appeared in Federal Health Matters on page 33 of the March 2005 issue. It outlined an incident at the Stratton VA Medical Center (SVAMC) in Albany, NY after the *New York Times* reported that Paul H. Kornak pled guilty to charges of fraud and criminally negligent homicide on January 18, 2005.[1] I write this letter as a follow-up and to remind practitioners of their obligation to report ethical misconduct.

On November 21, 2005, a federal judge sentenced Mr. Kornak to the maximum prison term of six years. According to a local report, "At least one veteran died and 64 others suffered unduly or were harmed by the forgeries, which involved manipulating their medical backgrounds so they would qualify for drug studies…."[2] A decade earlier, two pharmacists working at the SVAMC had warned VA officials and authorities that patients were placed at risk or had died as a result of unethical experimentation. Both pharmacists, myself and a colleague, reported that they suffered retaliation from senior administrators as a result of their disclosures.[2]

Health care providers should be encouraged to disclose alleged flaws primarily through appropriate internal channels. Administrators should embrace disclosures that foster quality improvement. It is problematic, however, if those who expose ethical flaws are harassed, intimidated, shamed, or labeled as troublemakers.

The Office of Special Counsel (OSC) is empowered by the government executive branch to aid federal employees faced with whistleblower retaliation. Their "primary mission is to safeguard the merit system by protecting federal employees from prohibited personnel practices, especially reprisal for whistleblowing."[3]

In 1999, Terry Everett, (R-AL) chairman of the House VA Subcommittee on Oversight and Investigations told a congressional panel that retaliation against VA whistleblowers was common and goes unpunished.[4] A year later, Mr. Everett released a study of the VA's compliance with the Whistleblower Protection Act (WPA). He said, "The VA's failure to follow the law has created an atmosphere of fear and reluctance of its employees to come forward with reports of wrongdoing."[4] A 2001 congressional report specific to whistleblower reprisal complaints indicates that, of 700 total submissions, only 0.57% of agency officials were held accountable for their retaliatory actions.[5] In February 2005, the *New York Times* reported that the VA health care system is, "…fraught with persistent complaints about abuse of power, cronyism, and reprisals against whistleblowers."[1]

Since whistleblower retaliation has been pervasive across several federal agencies, President Bush signed new legislation into law, effective October 2003. Under the Notification and Federal Anti-Discrimination and Retaliation Act of 2002, "agencies must pay for settlements, awards, or judgments against them in whistleblower and discrimination cases out of their own budgets. The OSC is responsible for ensuring that agencies meet their obligations to inform and educate their employees of the WPA."[6]

From my perspective (and from that of many other whistleblowers), the current system is a government facade that is cumbersome, time consuming, expensive, and presents a governmental conflict of interest. While limited cases reviewed by the OSC have indeed yielded positive outcomes for whistleblowers, many neglected cases require further scrutiny.[7]

Possibly, thoughtful new legislation to protect federal whistleblowers—enforced by a nongovernment entity—could benefit veteran patients and their caregivers. Individuals, not just "individual institutions," should be punished for retaliation.

As someone who "blew the whistle," the most common question posed to me is, "If placed in the same situation, would you do it again?" You bet I would! Whether or not to blow the whistle is a decision dictated by your conscious and ethical standards; how to blow it is a matter of preference.

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Treating PTSD When the Patient Has Committed Criminal Acts

The article "Treating Combat PTSD Through Cognitive Processing Therapy," which is found on page 75 of the October 2005 issue, addresses some important topics regarding the treatment of combat posttraumatic stress disorder (PTSD). Seldom do either patient or provider discuss the notion that the act of violence can be emotionally problematic. And for patients who had no intention of committing an atrocity, the authors' suggestions for cognitive reprocessing are noteworthy. The tougher question, however, which is discussed even less frequently but is of equal clinical pertinence, is how to help those who committed criminal acts that clearly were beyond the boundaries of war—such as murder; assault; or rape of innocent civilians, including children. As this is an uncomfortable and politically sensitive subject, the tendency is to include these acts under the rubric of war, though this fails to account for situations in which patients are fully aware of their intent at the time—situations that can lead to patient guilt and remorse after the fact. From a treatment perspective, psychotherapeutic and psychopharmacologic interventions often are futile in such cases as the pertinent issues are not addressed. Do the authors have any thoughts about the psychological differences between the patients who committed atrocities while in the combat realm and those who did not?

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The authors respond:

Dr. Benjamin's comments raise a particularly important question for the treatment of combat-related PTSD: How do we help those patients who have "clearly committed criminal acts that were beyond the boundaries of war?" We use the broader term perpetration, rather than atrocity, to encompass a wider range of violent acts ranging from those that may be questionable to those that are clearly beyond the rules of engagement in a combat situation.

With regard to perpetration, we consider the most important elements to be the individual's intentionality when committing the violence and the context surrounding the violence. Consistent with one of the primary goals of cognitive processing therapy (CPT), we encourage patients to accept the reality of their perpetration and to express the naturally occuring emotions they feel about the events (including shame, embarrassment, guilt, and horror). To facilitate greater acceptance and expression of these emotions, Socratic questioning can focus on the differences between responsibility and blame, which is more fully outlined in the CPT manual.[1] In essence, patients are responsible for their own behavior, and this responsibility is not to be disavowed. Rather, the emphasis should be on the patient's degree of blameworthiness, which, again, is based on the intentionality at the time of perpetration and the situational context in which the intent was formed. We also recommend Socratic questioning to help patients recognize the strength involved in taking responsibility for one's actions and moving forward versus self-condemnation and self-loathing. Moreover, pursuing a spiritual path to forgiveness or redemption is consistent with the religious or moral beliefs of some patients.

In addition, patients can exhibit over-accommodation, that is, extremes in their judgments about themselves and others based on their traumatic experiences. More specifically, perpetration can result in extreme beliefs about the enduring, global, and defining nature of these events and about the perpetrator's character that disregard contrary information. Examples of such maladaptive and extreme beliefs include, "I must be evil, a sociopath," or "I can't be redeemed." Cognitive restructuring aimed at these beliefs includes a review of the patient's history of criminal violence across many different contexts, not just combat, and questioning whether a true sociopath would feel remorse. Ultimately, the patient needs to achieve a more balanced view of these events without making extreme characterological judgments.

Consider the following case example: A veteran who was shot during the peace keeping mission in Somalia presented for PTSD treatment. During his service, after having recovered from the gunshot wound, he returned to duty, but subsequently became overzealous in his use of lethal force for crowd maintenance.

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In treatment, his most severe traumas were related to killing civilians. He felt ashamed and believed that he was "definitely going to hell" and "must be a psychopath." For each belief, cognitive strategies were used to determine whether there were more balanced and realistic beliefs. For example, his Christian belief that forgiveness of one's sins is possible through confession aided his ability to come to a more balanced perspective that, though he believes he committed a sin, he could be redeemed. His belief that he was a psychopath also was causing elevated fearfulness and anxiety in his day to day life because of his concern that he might easily be induced to kill others if he felt threatened in any way. Thus, Socratic questions about the characteristics of psychopaths, in conjunction with an examination of his ability to regulate emotions, including anger, were used to confront the distorted belief. Changes in these beliefs led to decreased anxiety and fearfulness in his daily life.

With regard to Dr. Benjamin's question about "the psychological differences between patients who committed atrocities in the combat realm and those who did not," there has been minimal longitudinal research about premilitary factors associated with perpetration. There is, however, evidence that perpetration is associated with more severe PTSD symptoms.[2–4] This highlights the need for clinicians to address specifically the topic of perpetration in order to achieve successful PTSD treatment.

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