Phoenix VA Medical System is Failing Veterans

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The national commander of the Veterans of Foreign Wars of the United States is calling for the full accountability of the leadership at a Department of Veterans Affairs health care system in Phoenix after it was reported that at least 40 veterans have died while awaiting care.

"Leadership, management and accountability is all we have ever required of the VA," said William A. Thien, a Vietnam veteran from Georgetown, Ind., who leads the 1.9 million-member VFW and its Auxiliaries. "When you deal with lives, there should be no leniency granted to anyone with any knowledge of this alleged cover-up, to include everyone in Phoenix who knew but didn't tell, and those in oversight positions at the VA network and VA headquarters in Washington who knew but didn't care," he said.

Phoenix allegedly kept two sets of waiting lists, only one of which is official and used to report average patient appointment waiting times to Washington. The VA requires its medical facilities to provide care to patients typically within 14 to 30 days, depending on the availability and specialty required. The alleged secret waiting list tracks real appointment waiting times, which span far beyond 14 to 30 days; precious time seriously ill patients cannot afford.

"The VFW fully supports the ongoing VA Inspector General's investigation and closer congressional oversight, especially to uncover whether other VA medical centers are also cooking their books," he said.

"Regarding VA leadership in Phoenix, there is zero trust in their ability to lead, much less to properly care for America's heroes. If the allegations of veterans dying as a result of this internal process are true, then the individuals responsible should be prosecuted criminally to the fullest extent of the law. The Secretary of Veterans Affairs needs to fire them all, then let the lawyers sort it out."

NATIONAL HEADQUARTERS

406 W. 34th Street
Kansas City, MO 64111
Office 816.756.3390
Fax 816.968.1157

WASHINGTON OFFICE

200 Maryland Ave., N.E.
Washington, D.C. 20002
Office 202.543.2239
Fax 202.543.6719
info@vfw.org
www.vfw.org

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