The VA's troubled history

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Who's to blame for VA scandal? 02:00

Story highlights

Allegations that veterans died waiting for care is the latest in a long line of VA scandals

Scandal, controversy and veterans care in the United States have gone hand-in-hand for virtually as long as there's been a republic.

After the Revolutionary War, for instance, payments promised by Congress to disabled veterans were left up to the states, and only a few thousand of those who served ever received

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Controversy in veterans care is as old as the country

Scandals have rocked veterans agencies every decade since at least the 1930s.

NEW: VA Secretary Eric Shinseki resigns in veterans’ care.

1932 -- Thousands of World War I veterans and their families march on Washington to demand payment of promised war bonuses. In an embarrassing spectacle, federal troops forcibly remove veterans who refuse to end their protest.

In 1932, 10,000 WWI veterans, many unemployed, protest over pay.

1945 -- President Harry Truman accepts the resignation of VA Administrator Frank Hines after a series of news reports detailing shoddy care in VA-run hospitals, according to a 2010 history produced by the Independent Institute.

1946 -- The American Legion leads the charge seeking the ouster of VA Administrator Gen. Omar Bradley, citing an ongoing lack of facilities, troubles faced by hundreds of thousands of veterans in getting services and a proposal to limit access to services for some combat veterans, according to the 2010 history.

1947 -- A government commission on reforming government uncovers enormous waste, duplication and inadequate care in the VA system and calls for wholesale changes in the agency’s structure.

1955 -- A second government reform commission again finds widespread instances of waste and poor care in the VA system, according to the Independent Institute.

1970s -- Veterans grow increasingly frustrated with the VA for failing to better fund treatment and assistance programs, and later to recognize exposure to the herbicide Agent Orange by troops in Vietnam as the cause for numerous medical problems among veterans.

1972 -- Vietnam veteran Ron Kovic, the subject of the book and movie, “Born on the Fouth of July,” interrupts Richard Nixon’s GOP presidential nomination acceptance speech, saying, according to his biography, “I’m a Vietnam veteran. I gave America my all, and the leaders of this government threw me and others away to rot in their VA hospitals.”
for the creation of VA Medical Corps.

A VA patient wheeled into an outpatient clinic in Boston in 1961. The American Medical Association said vets should be treated in private hospitals.

President Jimmy Carter after signing the 1980 Veterans Rehabilitation and Education Amendment, which increased job training and educational benefits for vets.

1974 -- Kovic leads a 19-day hunger strike at a federal building in Los Angeles to protest poor treatment of veterans in VA hospitals. He and fellow veterans demand to meet with VA Director Donald Johnson. The embattled director eventually flies to California to meet with the activists, but leaves after they reject his demand to meet in the VA's office in the building, according to Johnson's 1999 Los Angeles Times obituary. The ensuing uproar results in widespread criticism of Johnson. A few weeks later, Johnson resigns after President Richard Nixon announces an investigation into VA operations.

1976 -- A General Accounting Office investigation into Denver's VA hospital finds numerous shortcomings in patient care, including veterans whose surgical dressings are rarely changed. The GAO also looked at the New Orleans VA hospital, and found ever-increasing patient loads were contributing to a decline in the quality of care there, as well.

1981 -- Veterans camp out in front of the Wadsworth Veterans Medical Center in Los Angeles after the suicide of a former Marine who had rammed the hospital's lobby with his Jeep and fired shots into the wall after claiming the VA had failed to attend to his service-related disabilities, the New York Times reported at the time.

1982 -- Controversial VA director Robert Nimmo, who once described symptoms of exposure to the herbicide Agent Orange during the Vietnam war as little more than "teenage acne," resigns under pressure from veteran's groups. Nimmo was criticized for wasteful spending, including use of a chauffeured car and an expensive office redecorating project, according to a 1983 GAO investigation. The same year, the agency issues a report supporting veterans' claims that the VA had failed to provide them with enough information and assistance about Agent Orange exposure.

1984 -- Congressional investigators find evidence that VA officials had diverted or refused to spend more than $40 million that Congress approved to help Vietnam veterans with readjustment problems, the Washington Post reports at the time.

1986 -- The VA's Inspector General's office finds 93 physicians working for the agency have sanctions against their medical licenses, including suspensions and revocations, according to a 1988 GAO report.

1989 -- President Ronald Reagan signs legislation elevating the Veterans Administration to Cabinet status, creating the Department of Veterans Affairs.
Air Force veteran Joseph Parnell Sr., visits the grave of his son, Joseph Parnell Jr., at Fort Logan National Cemetery.

1991 -- The Chicago Tribune reports that doctors at the VA's North Chicago hospital sometimes ignored test results, failed to treat patients in a timely manner and conducted unnecessary surgery. The agency later takes responsibility for the deaths of eight patients, leading to the suspension of most surgery at the center, the newspaper reported.

1993 -- VA Deputy Undersecretary of Benefits R.J. Vogel testifies to Congress that a growing backlog of appeals from veterans denied benefits is due to a federal court established in 1988 to oversee the claims process, the Washington Post reports. The VA, Vogel tells the lawmakers, is "reeling under this judicial review thing."

1999 -- Lawmakers open an investigation into widespread problems with clinical research procedures at the VA West Los Angeles Healthcare Center. The investigation followed years of problems at the hospital, including ethical violations by hospital researchers that included failing to get consent from some patients before conducting research involving them, according to the Los Angeles Times.

2000 -- The GAO finds "substantial problems" with the VA's handling of research trials involving human subjects.

2001 -- Despite a 1995 goal to reduce waiting times for primary care and specialty appointments to less than 30 days, the GAO finds that veterans still often wait more than two months for appointments.

2003 -- A commission appointed by President George W. Bush reports that as of January 2003, some 236,000 veterans had been waiting six months or more for initial or follow-up visits, "a clear indication," the commission said, "of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care."

Walter Reed Army Medical Center was consolidated with another facility in 2005 and renamed Walter Reed National Medical Center.

2005 -- An anonymous tip leads to revelations of "significant problems with the quality of care" for surgical patients at the VA's Salisbury, North Carolina, hospital, according to congressional testimony. One veteran who sought treatment for a toenail injury died of heart failure after doctors failed to take account of his enlarged heart, according to testimony.

2006 -- Sensitive records containing the names, Social Security numbers and birth dates of 26.5 million veterans are stolen from the home of a VA employee who did not have authority to take the materials. VA officials think the incident was a random burglary and not a targeted theft.

2007 -- Outrage erupts after documents released to CNN show some senior VA officials received bonuses of up to $33,000 despite a backlog of hundreds of thousands of benefits cases and an internal review that found numerous problems, some of them critical, at VA facilities across the nation.
2009 -- The VA discloses that than 10,000 veterans who underwent colonoscopies in Tennessee, Georgia and Florida were exposed to potential viral infections due to poorly disinfected equipment. Thirty-seven tested positive for two forms of hepatitis and six tested positive for HIV. VA Director Eric Shinseki initiates disciplinary actions and requires hospital directors to provide written verification of compliance with VA operating procedures. The head of the Miami VA hospital is removed as a result, the Miami Herald reports.

2011 -- Nine Ohio veterans test positive for hepatitis after routine dental work at a VA clinic in Dayton, Ohio. A dentist at the VA medical center there acknowledged not washing his hands or even changing gloves between patients for 18 years.

2011 -- An outbreak of Legionnaires’ Disease begins at the VA hospital in Oakland, Pennsylvania, according to the Pittsburgh Tribune-Review. At least five veterans die of the disease over the next two years. In 2013, the newspaper discloses VA records showed evidence of widespread contamination of the facility dating back to 2007.

2012 -- The VA finds that the graves of at least 120 veterans in agency-run cemeteries are misidentified. The audit comes in the wake of a scandal at the Army's Arlington National Cemetery involving unmarked graves and incorrectly placed burials.

2013 -- The former director of Veteran Affairs facilities in Ohio, William Montague, is indicted on charges he took bribes and kickbacks to steer VA contracts to a company that does business with the agency nationwide.

Double amputee Bradley Walker goes through physical therapy to get used to a computerized prosthetic leg.

January 2014 -- CNN reports that at least 19 veterans died at VA hospitals in 2010 and 2011 because of delays in diagnosis and treatment.

April 9 -- Lawmakers excoriate VA officials at a hearing. "This is an outrage! This is an American disaster!" says Rep. Jackie Walorski.

April 23 -- At least 40 veterans died while waiting for appointments to see a doctor at the Phoenix Veterans Affairs Health Care system, CNN reports. The patients were on a secret list designed to hide lengthy delays from VA officials in Washington, according to a recently retired VA doctor and several high-level sources.

April 28 -- President Barack Obama calls for an investigation into the situation in Phoenix.

April 30 -- Top officials at the Phoenix VA deny the existence of a secret appointment waiting list.

May 1 -- Shinseki places the director of the Phoenix VA and two aides on administrative leave pending the investigation into the veterans' deaths.

May 5 -- Veterans groups call for Shinseki's resignation. American Legion National Commander Daniel Dillinger says the deaths reported by CNN appear to be part of a "pattern of scandals that has infected the entire system."

May 6 -- Despite the clamor for Shinseki’s ouster, White House spokesman Jay Carney says Obama "remains confident in Secretary Shinseki’s ability to lead the department and take appropriate action." Shinseki tells the Wall Street Journal he will not resign.

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May 8 -- The House Veterans Affairs Committee votes to subpoena Shinseki and others in relation to the Phoenix scandal.

May 9 -- The scheduling scandal widens as a Cheyenne, Wyoming, VA employee is placed on administrative leave after an email surfaces in which the employee discusses "gaming the system a bit" to manipulate waiting times. The suspension comes a day after a scheduling clerk in San Antonio admitted to "cooking the books" to shorten apparent waiting times. Three days later, two employees in Durham, North Carolina, are placed on leave over similar allegations.

May 15 -- Shinseki testifies before the Senate Veterans Affairs Committee. "Any allegation, any adverse incident like this makes me mad as hell," he says. At the same hearing, acting Inspector General Richard Griffin tells lawmakers that federal prosecutors are working with his office looking into allegations veterans died while waiting for appointments.

May 19 -- Three supervisors at the Gainesville, Florida, VA hospital are placed on paid leave after investigators find a list of patients requiring follow-up care kept on paper, not in the VA's computerized scheduling system.

May 20 -- The VA's Office of Inspector General says it is investigating 26 agency facilities for allegations of doctored waiting times.

May 21 -- Obama says he "will not stand" for misconduct at VA hospitals, but asks for time to allow the investigation to run its course. The same day, Shinseki rescinds Phoenix VA director Sharon Helman's $8,495 bonus. Helman got the bonus in April, even as agency investigators were looking into allegations at the facility.

May 22 -- The chairman of the House Veteran Affairs Committee says his group has received information "that will make what has already come out look like kindergarten stuff." He does not elaborate.

May 28 -- A preliminary report from the VA inspector general's office finds systemic problems at health facilities nationwide, and serious management and scheduling issues in Phoenix.

May 29 -- Political pressure mounts from Senate Democrats and others for Shinseki to go.

May 30 -- President Barack Obama accepts Eric Shinseki's resignation. Obama says he did so with regret, and said that Shinseki offered to step down at a White House meeting with the President so as not to be a distraction going forward. Obama said that Deputy VA Secretary Sloan Gibson will temporarily fill Shinseki's role as the search is launched for a permanent replacement.

Document: VA audit report released