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BY ELECTRONIC and FIRST CLASS MAIL

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1730 M Street, N.W.
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Re: OSC File No. DI-13-4505

Dear Mr. Young:

On behalf of Dr. Mohit Pawan Chopra, thank you for the opportunity to submit the following comments on the July 22, 2014 letter from Acting Principal Deputy Under Secretary ("Acting PDUS") James Tuchs Schmidt of the Department of Veterans Affairs to Ms. Lerner.

The above-referenced letter (hereinafter "the VA's July 22 letter") purports to provide OSC with additional information regarding the care received by Veterans 1 and 2 at the Brockton Community Living Center ("CLC"). It is clear that July 22 letter aims to convey the message that these two Veterans got good care and to refute any assertion that these veterans were neglected. Dr. Chopra disagrees and reasserts here that the care provided to Veterans 1 and 2 reflected negligent care and gross mismanagement by the VA Boston Healthcare System ("VABHS").

In addition, the VA's July 22 letter cunningly seeks to undermine Dr. Chopra's credibility and/or integrity by implying that he did not report his concerns about patient care while still employed. (See next to last paragraph of the VA's July 22 letter.) That is patently false. In fact, Dr. Chopra reported his concerns regarding patient care to both his immediate supervisor, Ronald Gurrera, M.D. and, subsequently, to John Bradley, M.D., Chief of Psychiatry for VABHS who was immediately above Dr. Gurrera in the line of supervision. Unfortunately, Dr. Chopra's reports did not meet with the kind of response by VA management that he had hoped for and expected, quite the contrary.

As a preliminary matter, it is important to note that the VA's July 22 letter does not in any way refute or disprove the essential factual findings of its Office of Medical Inspector's ("OMI") original report, dated January 2, 2014: Veteran 1 went for more than eight (8) years, and Veteran 2 went for more than seven (7) years, without receiving comprehensive psychiatric evaluations. The additional

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information provided in the VA's July 22 letter is confusing and misleading, and includes information that is immaterial.

Dr. Chopra finds the VA's July 22 letter, unfortunately, to be characteristic of the institutional denial that led to the neglect in the first place, symptomatic of the disregard that caused it to persist even after he sounded the alarm (by reporting it to his VABHS supervisors) while still employed, and consistent with the dismissive conclusion of the VA's own OMI (in its May 1, 2014 supplemental report) that, despite its substantiation of Dr. Chopra's allegations, no laws were violated, not even the laws that give these Veterans rights as patients.

I. The VA's July 22 letter is confusing and misleading.

The July 22 letter provides confusing information about Veteran 1.

With regard to Veteran 1, the VA's July 22 letter is confusing. It seems to describe a different individual than the person described by OMI's report. OMI's January 2, 2014 report described Veteran 1 as follows:

Veteran 1 is a 65-year-old male, Army combat Veteran of Vietnam who is 100 percent service-connected for major depression with psychotic features. He has a history of multiple suicide attempts, including stabbing himself in the stomach and overdosing on medications. He was first admitted to the CLC in March of 2003 due to suicidal ideation, and has been a resident there since that time.

(See OMI's January 2, 2014 report at p. 4) The VA's July 22 letter, on the other hand, paints a much more pleasant picture:

The Veteran was admitted to the CLC in 2003 with longstanding stable PTSD and chronic pain.

The VA's July 22 letter repeatedly glosses over, and avoids mentioning seemingly important, albeit disturbing, facts found and reported by OMI such as the fact that that Veteran 1 was first admitted to the CLC "due to suicidal ideation." (See January 2, 2014 OMI report at p. 4, quoted above). (Emphasis added).

The VA's July 22 letter asserts as to Veteran 1, "There was a full evaluation by a psychiatrist at the time of admission." Although the July 22 letter does not anywhere assert that the OMI site visit team erred in its fact-finding, this

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statement by the VA would appear to be a direct and material contradiction of a finding by OMI. OMI's report states, "His first comprehensive psychiatric evaluation did not occur until June 17, 2011." (See OMI January 2, 2014 report at p. ii.) OMI further noted, "His first contact with a psychiatrist in the CLC was on September 19, 2003, whose note in the EHR refers to an extensive assessment by a psychology intern on September 12, 2003." (Emphasis added).

Dr. Chopra submits that, if there had been a "full evaluation by a psychiatrist at the time of admission," as the VA's July 22 letter claims, it is implausible, that no fewer than five (5) medical professionals who were actively searching to ascertain when the first full psychiatric evaluation was performed on Veteran 1 – Dr. Chopra, who is board certified in geriatric psychiatry, and the four-person OMI site visit team consisting of the Medical Inspector John R. Pierce, M.D., Medical Inspector, OMI, Bernard Winkel, Ed.D, Clinical Psychologist, OMI, Jorge Cortina, M.D., board certified in geriatric psychiatry, and Lisa Minor, Registered Nurse (RN), Chief, Facility Based CLC Programs, Veterans Affairs Administration - were unable to find it.

Dr. Chopra notes that, even if it turns out to be true that Veteran 1 did receive a full evaluation by a psychiatrist in 2003 upon admission in the CLC and, therefore, OMI's factual findings were erroneous, it does not alter the fundamental truth: This Veteran did not receive another full psychiatric evaluation until Dr. Chopra performed one more than eight (8) years later on June 17, 2011.

Statistics without context are misleading

The July 22 letter gives statistics with regard to the number of "notes" in the "chart" of the two Veterans. (A "chart" in this context is also known as a medical record or "electronic health record" or EHR.) Without context, these numbers sound impressive. By introducing some context, they actually underscore the neglect.

As to Veteran 1, the letter asserts, "The Patient's care team wrote more than 3000 notes in his chart during his stay at the CLC."¹ Assuming that the total number of notes represents the total since Veteran 1 was admitted to the CLC, and does not count notes entered in his chart by VA personnel prior to his admission to the CLC, 3000 is an inadequate number. Dr. Chopra submits that it

¹ Dr. Chopra points out that, unless something has changed since the Office of Medical Inspector conducted its site visit, Veteran 1 is still alive and living at the CLC. Thus, presumably, his care team continues to enter notes in his chart to this day. The opportunity to enter notes in the chart of Veteran 2 ended with his death in May of 2013.

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is reasonable to expect that the aggregate total of all notes from the many members of the Veterans' treating "team" at the CLC - physicians, physician assistants, nurse practitioners, social workers, psychologists, pharmacists, physical therapists, and recreational therapists - would average out to at least one note per day for the duration of Veteran 1's stay at the CLC. Therefore, it follows that, from the Veteran's admission in March 2003 through December 2013 (10 years, 9 months), when the OMI made its site visit, there should have been at least 3,920 notes in his chart. Further, the number of expected notes increases to more than 4,160 if, in fact, the VA's July 22 letter attempted to include a count of all notes until around the date of the letter (11 years, 4 months).

As to Veteran 2, who resided at the CLC from his admission in June of 2005 until his death eight (8) years later in May of 2013, Dr. Chopra submits that the bare minimum number of chart notes should have been 2,895 to reflect at least an average of one note per day during his life in the CLC. In other words, it is reasonable to expect far more than 2,000 notes in the chart of Veteran 2, if in fact notes entered by all the members of his care team at the CLC were included in the count, as the VA's July 22 letter implies.

The VA's July 22 letter cites large numbers in an apparent effort to support its underlying claim - that these Veterans received good, not neglectful, care at the Brockton CLC. For example, regarding Veteran 1, it further glosses, without providing specific details concerning dates, "Over the next several months [after his March 2003 admission to the CLC], there were multiple evaluations by psychology, including a 3,853-word, extraordinarily detailed mental health evaluation." Presumably, this "extraordinarily detailed mental health evaluation" is the "extensive assessment" that OMI reported, which was done by a psychology intern on September 12, 2003. (See January 2, 2014 OMI report at p. 4) Dr. Chopra notes that a "psychology intern" is someone who has completed his or her Masters level education and is the junior most trainee in the VA's psychology service.

The facts found by OMI concerning Veteran 1 comport with Dr. Chopra's recollection of the facts.

Dr. Chopra's recollection is consistent with the facts summarized in OMI's January 2, 2014 report:

- a) the chart (EHR) showed that Veteran 1 had been paid one extremely brief visit by one junior (first or second year) Harvard South Shore (HSS) psychiatry resident while on-call at the Brockton Urgent Care

(UC) during the nighttime (off-duty) hours in April 2009 as the Veteran had been agitated and had expressed strong suicidal ideation earlier in the evening. By the time this HSS resident had been able to extricate himself from what is otherwise a fairly busy UC, the Veteran had settled down and was determined to be not in need of any urgent intervention. In fact, Dr. Chopra remembers this note from April 2009 was brief, about half a page, as can be expected from any resident attending to a busy UC), and not co-signed by a VABHS Staff psychiatrist. As such, this note should be considered an unsupervised visit by a psychiatry trainee.

- b) the chart showed that the first comprehensive psychiatric evaluation was performed on Veteran 1 by Dr. Chopra on June 17, 2011 (as mentioned in the OMI's report) along with a final-year psychiatry resident from the HSS psychiatry program. Dr. Chopra personally spent a good amount of time with this Veteran and was able to convince him that he needed to have blood tests that had not been done during his eight-year stay and that he needed to take antidepressant medications, which he had not taken so far. This quality time with the Veteran paid off, as he was amenable to the suggestions, did undertake the laboratory tests, started taking antidepressant medications for the first time, and showed some rapid and dramatic improvement once his low Vitamin D and testosterone levels were replaced. As Dr. Chopra has described before, about a month later, he was able to get up and walk to the nurses station to ask for his medications, something the CLC Psychologist told Dr. Chopra this Veteran had not done in eight (8) years.
- c) The OMI's report correctly points out that a follow-up visit was made "by another psychiatrist" after the lab test results for Veteran 1 were available. This "psychiatrist" was the final-year HSS resident who had been present with Dr. Chopra during the initial comprehensive evaluation of Veteran 1 a couple of weeks earlier. (See January 2, 2014 OMI report at p. 5) Dr. Chopra recalls that the Veteran's vitamin D and testosterone levels were both abnormally low when they were checked at his urging for the first time in June 2011. This note had been co-signed by Dr. Chopra and almost certainly (would have) contained an addendum that he had personally supervised the resident physician during this encounter, or words to that effect.
- d) Subsequently, Dr. Chopra was consulted concerning Veteran 1 again in November 2012 for an entirely different question, viz. to assess his

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decision-making capacity. By this time, Dr. Chopra had made his disclosures concerning patient neglect internally (not only to Dr. Gurrera, but also to Dr. Bradley) and he was being given ever-decreasing amounts of time to assess Veterans. During this 2012 visit, he was allowed only one hour to see the Veteran, whereas it had previously been customary to allow him up to 1.5 hours.

- e) Dr. Chopra notes that it was customary at the VABHS for the Psychology trainees and Staff Psychologist to assess Veterans' decision-making capacity (DMC). However, the psychiatrist should be called upon to make that assessment if the decision-making pertains to a specific medication or treatment where the psychiatrist is the content expert.
- f) During this second assessment in November 2012, Dr. Chopra recalls having the impression that the Veteran, unfortunately, had returned to his previous severely depressed state to the point of nihilism, and was refusing any and all kinds of treatment, including for his medical problems. He had indicated that in so doing, he had hoped to speed up his dying process and it was his hope to die as soon as possible. (Bear in mind, this Veteran was only 65 years of age.) It was Dr. Chopra's assessment, in the time allocated to him for this subsequent evaluation of Veteran 1, that the severity of his depression was likely impairing his decision-making so globally that it was not specific to any psychiatric medication in particular, but to treatment as a whole. As a result, Dr. Chopra's recommendation in November 2012 had included a more formal assessment of the Veteran's DMC to refuse all treatment, and not just psychotropic meds, and that this would have to be performed by the psychologist.

Dr. Chopra's note from November 2, 2012 should have cast some serious doubts as to whether this Veteran did in fact have intact DMC and that question needed additional assessment.

In short, despite the VA's efforts in its July 22 letter to downplay the psychiatric problems of Veteran 1, the fact that he had serious psychiatric problems is not open to debate. Unfortunately, the foregoing list summarizes, in quantity and quality, the sum total of the encounters between staff psychiatrists or psychiatry residents and Veteran 1 in the CLC over the nine (9) years nine (9) months from his March, 2003 admission to December, 2012 when Dr. Chopra's was no longer there.

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Veteran 1 had been determined to be 100 percent service-connected for major depressive disorder (MDD) with psychotic features. Both times that Dr. Chopra saw this man, it was his impression that his standing diagnosis was accurate, and that his severe depression was interfering with his ability to accept treatment. Severe MDD with psychotic symptoms is not a condition that would have gotten better without medications or treatment. The VA's July 22 letter seeks to emphasize the "stable" nature of Veteran 1's condition, using the word three (3) times in the space of two (2) consecutive paragraphs. While stability might be considered desirable in a vacuum, remaining "stable" in a severely depressed and strongly suicidal state is bad, not good.

Further glossing and obfuscation with regard to Veteran 2.

As, with Veteran 1, the VA's July 22 letter does not contain an affirmative assertion that the OMI's factual findings were in any way erroneous. Rather, the VA's July 22 letter seeks to emphasize certain facts and de-emphasize or avoid other facts in order to paint the VABHS in a better light.

The VA's July 22 letter continues its theme of "stability" in its discussion of Veteran 2, noting that, "he had been on a stable medication regimen for his mental health problems for some time." This was precisely the problem. Dr. Chopra notes that this Veteran was admitted to the CLC on multiple major psychotropic medications. In other words, the medications that Veteran 2 was on at the time of his admission to the CLC in 2005 came with black-box cautionary warnings and serious potential adverse effects. Specifically, he was on high doses of quetiapine (Seroquel®) and sodium valproate (Depakote®). Dr. Chopra submits that it would constitute negligent care if the Veteran's medications were not closely monitored or evaluated, per the VABHS's own policy, at least every six (6) months.

Because Veteran 2 passed away in May of 2013, neither the OMI site visit team nor Dr. Tuchsmidt were eye-witnesses to his condition. Dr. Chopra, however, vividly remembers this 66-year-old Veteran 2. Dr. Chopra recalls arriving in his room in August of 2012, finding him in a reclining chair. The Veteran was stooped forward, unable to lean back and relax, as sometimes happens in Parkinson's patients. In addition, he had a blank, mask-like face and unblinking gaze. He was drooling, as a result of hyper-salivation/sialhorrea, which is a common side-effect of anti-psychotic medications, and he was unable to wipe away the saliva himself.

While he seemed to register Dr. Chopra's arrival, he was unable to make any meaningful responses to Dr. Chopra's questions and was largely quiet. Dr.

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Chopra does not recall Veteran 2 being able to engage in any communication. He would not have been able to communicate by writing given his stiffness, and given all this (inability to talk/communicate), Dr. Chopra's assessment included performing a physical examination, which revealed significant rigidity. It was Dr. Chopra's assessment that Veteran 2's rigidity was an indication that he was on too much anti-psychotic medication and very likely not enough medication to treat his Parkinson's disease (e.g. Sinemet). Dr. Chopra recalls seeing in Veteran 2's chart that he had been seen by a neurologist previously, but not for quite some time, and he further recalls recommending during the August 2012 assessment that a neurologist re-evaluate both the Veteran's illness and his Parkinson's-related medications.

Regarding the claim in the VA's July 22 letter that Veteran 2 had "periodic consultations with neurologists," Dr. Chopra believes that the use of the term "periodic" tends to cloud rather than clarify the facts. Dr. Chopra recalls the following: Neurology coverage at the Brockton campus was limited, where in fact neurologists were present at the Brockton campus only on two days of the week, and did not perform in-patient consultations even though many Veterans at the CLC, especially those in the LTC units, have dementia and other neuropsychiatric disorders, like Parkinson's disease. So, in Veteran 2's case, the team waited until an out-patient appointment became available in the clinic of Dr. Raymond Durso, whose neurology clinic operated once a week (on Thursdays). Dr. Chopra believes that Veteran 2 was subsequently seen at Dr. Durso's clinic, but does not recall that Veteran 2 had multiple (as the term "periodic" implies) evaluations by neurologists as asserted by the VA's July 22 letter.

Please note that, while the VA's July 22 letter admits that Veteran 2 had an "... inability to communicate," the letter omits any mention of the high doses of unmonitored psychotropic medications, including the anti-psychotic, quetiapine, and the mood-stabilizer, sodium valproate, as contributors to his most unfortunate condition, which ended with his death at the age of 66.

The gratitude of family members in this context is immaterial because it is not illuminating.

While it is certainly plausible that Veteran 2's wife was "very grateful" and "felt the patient received extraordinary care," as reported in the VA's July 22 letter, Dr. Chopra wonders if she was aware that her husband was receiving high doses of medications that could be sedating and likely contributed to his inability to communicate with her? Was she aware that the psychotropic medications he was given regularly, year after year, had not been reviewed for over seven year since his readmission to the CLC in 2005? If she were fully informed concerning

the care he received at the Brockton CLC, would she remain "very grateful?" (Note that the VA's July 22 letter contains a back-handed admission that psychotropic drugs were being used unnecessarily at the Brockton CLC to control patient behaviors: "Since OMI's site visit, nursing personnel have undergone additional training in behavior measures to reduce the need for psychotropic medications.")

The cases of Veterans 1 and 2 were particularly shocking to Dr. Chopra because, based on his training and prior experience, both of these human beings could have experienced (and in the case of Veteran 1, could experience) a much better quality of life if their psychiatric disorders had been adequately and appropriately addressed, treated, and monitored. The fact that this level of neglect of the psychiatric care of these Veterans took place in spite of the "team" of medical professionals charged with their care makes it that much more shocking.

II. The July 22 letter's insinuation that Dr. Chopra did not blow the whistle while employed is false.

As noted above, Dr. Chopra did make the disclosures internally while still employed by VABHS, both to his immediate supervisor, Dr. Ronald Gurrera, and then up the chain of command to the next-level supervisor, the Chief of Psychiatry, Dr. John Bradley. At the time of submission of the OSC Form-11 to the US Office of Special Counsel, on the top of page 6 in Section A, it was noted that Dr. Chopra disclosed cases of long-standing Veteran neglect to Dr. Ronald Gurrera, and when he brushed off Dr. Chopra's complaints on more than one occasion, he (Dr. Chopra) disclosed the information to Dr. (Col.) John Bradley.

The sequence of events was as follows: Soon after Dr. Chopra became aware of Veteran 1 in June of 2011, he discussed the case with Dr. Gurrera, the Associate Chief of Staff (ACOS) in Psychiatry and his immediate supervisor.

Dr. Chopra distinctly recalls that, after reviewing all the information that Dr. Chopra shared with him (including the EHR), Dr. Gurrera asked Chopra to "... appreciate my [Dr. Gurrera's] hands-off attitude" with regards to the "problems in that building," referring to Building 4, where the CLC was located on the Brockton campus.

Subsequently, when Dr Chopra became aware of Veteran 2 (August of 2012), he recalls that his immediate reaction was that he could not continue to stay there (at the VABHS) and watch this happening in front of him. He considered resigning with immediate effect, but decided against it, and instead

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created a document on the VA's Network (N:), a cloud-based, drive and made a note of both Veterans 1 and 2 where long periods of time had gone by without any psychiatric assessments. With the discovery of Veteran 2, he feared he had discovered signs of a pattern of neglect in the Brockton CLC.

Once again, soon after Dr. Chopra discovered the neglect in the psychiatric care of Veteran 2, he brought it to Dr. Gurrera's attention and presented the information he had discovered. At this meeting, Dr. Gurrera's responded, "If you (Dr. Chopra) stop bothering me (Dr. Gurrera) with the problems in that building, then I (Dr. Gurrera) will leave you (Dr. Chopra) alone," or words to that effect.

At this time, it became abundantly clear to Dr. Chopra that his immediate supervisor, Dr. Gurrera, was not going to take his complaints and internal disclosures seriously, but Dr. Chopra kept a running list of Veterans where extensive periods had elapsed before or between psychiatric assessments. By the end of August 2012, he recalls adding Veteran 3 to the list after his follow-up evaluation of this Veteran indicated that more than two and a half (2.5) years had gone by between his initial evaluation and subsequent re-consultation.

Later, on a day in the month of September 2012, Dr. Chopra was at the VABHS West Roxbury (WX) campus with Dr. John Bradley, the Chief of Psychiatry, immediately above Dr. Gurrera in the supervisory line. Dr. Chopra was providing care the WX campus that day at his (Dr. Bradley's) request. He recalls this meeting with Dr. Bradley took place on a Wednesday afternoon in mid- to late September. They were in the Psychiatry/Mental Health conference room on 1 G (Building 1, Ground floor).

During this meeting, Dr. Chopra went to his N: drive on the VA computer system (from WX), opened the document where he had been keeping a list of the neglected Veterans and showed the list to Dr. Bradley. Thereafter, Dr. Chopra recalls logging into the CPRS electronic health record (EHR) and reviewing the EHR of these Veterans with Dr. Bradley. Dr. Bradley gave the appearance of being greatly concerned by what Dr. Chopra was showing him during this September 2012 meeting.

Over the next two months (October and November of 2012), Dr. Bradley shared with Dr. Chopra on more than one occasion that he had communicated the disclosure Dr. Chopra made further up the chain of command to the "higher ups" at VABHS. He made specific reference to Chief of Staff Michael Charness.

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Unfortunately, Dr. Chopra witnessed no sign of change or reform following his September 2012 disclosure to Dr. Bradley, and, within approximately three (3) months of that disclosure, his previously promising career with the VABHS was summarily terminated.

III. Conclusion

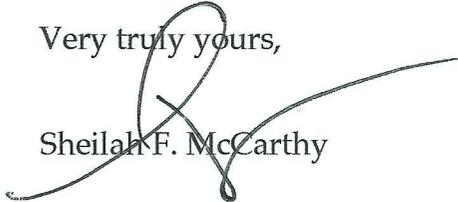
Dr. Chopra submits that the VA's July 22 letter reflects an institutional attitude that is analogous to a person who would boast that they have fed their dependent parent three square meals every single day while failing to mention that they have not taken their parent to all their doctor's appointments thereby depriving the parent of some quality of life in their remaining days.

Dr. Chopra submits that the VA had a duty to provide these Veterans with the appropriate level of psychiatric care. Psychiatric care is as essential to the health of these Veterans as the other kinds of care they were receiving, especially since each of the three Veterans were 100-percent service connected for psychiatric disorders. Unfortunately, the VA failed to provide the appropriate level of psychiatric care to the Veterans in the Brockton CLC.

Dr. Chopra notes that the VA's July 22 letter does not alter OMI's January 2, 2014 findings, which supported his whistleblower allegations and he maintains that, by the neglect he reported with respect to Veterans 1 and 2,² the Brockton CLC violated its own (VABHS) policies as well as other laws, rule, and regulations. Dr. Chopra reiterates that the rights of these Veterans as patients were violated. Finally, Dr. Chopra reaffirms that he disclosed, through appropriate channels of communication at VABHS and later at OSC, his belief that the wrongdoing he reported constituted violations of the law, rule, or regulation; gross mismanagement; and a specific danger to public health and safety.

As always, Dr. Chopra appreciates your attention to this matter.

Very truly yours,


Sheilah F. McCarthy

² For the reasons explained in our July 2, 2014 letter, Dr. Chopra reasserts that his whistleblowing allegations concerning Veteran 3 should have been substantiated by OMI.