Rejoinder – Sham OMI investigation report on Dr. Kevin McGuire, WVAMC @ Elsmere, Delaware

File No DI-14-2175 report dated 10 April 2015 received on 13 April 2015.

Let me start by expressing my profound appreciation to the Office of Special Counsel (OSC) for assigning Ms. Tracy Biggs, an indefatigable attorney to this disclosure since 2013, she has been absolutely phenomenal in every ramification. It is just not enough that when few Federal government agencies like OSC are demonstrating probity and accountability in ensuring the safety of Americans and preventing waste, fraud and abuse at the taxpayers' expense; other disingenuous and corrupt agencies like the Veterans Administration (VA) laden with very wicked and unpatriotic so-called 'professionals' and 'administrators' (albeit, mal-administrators) remain the cog in the wheel of efficiency and meaningful progress.

The report submitted in the light of the allegation/s against Dr. Kevin McGuire can best be described as egregious and pretty distasteful that really did not come as a surprise owing to known culture of manipulation of facts and data in a system designed to cater to our Heroes (American Veterans) of which I will be a part sometimes in the near future with huge ambivalence and intense palpitations should this present culture of disdain for Veterans' lives go unabated.

Here are some of the reasons I fault this report in its entirety;

- The accompanying letter signed by VA Chief of Staff Jose D. Riojas dated 3 April 2015 was inaccurate as it contained the erroneous statement "The whistleblower alleged that psychiatrists at the Medical Center were failing to follow local standard operating procedures (SOP) in the treatment of opioid use disorder". The whistleblower only alleged that Dr. Kevin McGuire was not following the local SOP that was adapted from other VA Medical Centers across the country. The other prescribing psychiatrists have never had issues with the SOP as they each contributed to the SOP during its formative phase. Only Dr. McGuire has not followed the SOP.
- As a valued team member of the healthcare team, rather than doing a true peer review to analyze my complaints, the medical center management came after me evidenced by being detailed under controversial circumstances more than 6 months now at the instance of Dr. McGuire over trumped-up charges. The local SOP is the operating instruction at any given time whether it subsists elsewhere or not according to the Joint Commission and as long as the OMI attested to Dr. McGuire's violation of the SOP as is and treatment agreement violation by the referenced patients, the standard of care was breached. Another clinical specialist Patricia Frick, CARN-AP, MSN was threatened and attacked by the same practitioner as a result of voicing her concerns then, she was forced into retirement
- The OMI had given a pre-investigation knowledge of almost 7 days to the Medical Center Director which was summarily relayed to Dr. McGuire so, whatever defenses proffered were pre-arranged and the references to VA/DoD guidelines in the conclusion lack merit. They are only mere theories that do not translate to safe practice. Why will the OMI notify the psychiatrist being investigated ahead of the investigation? It is like a teacher leaking the examination questions to his or her students
- The investigation confirmed whistleblower's allegation that there was continued prescription of buprenorphine/naloxone in higher doses when more than 4 patients that were sampled

continue to use illicit substances and alcohol when the literature is quite succinct that use of benzodiazepines, alcohol, opioids and other illicit substances while receiving buprenorphine/naloxone can produce fatal outcomes. The fact that none of our patients died (based on assumption due to lack of follow-up) does not negate the known risk of death in association with the concomitant administration of buprenorphine/naloxone and other depressants such as alcohol or other opioids.

- Out of the many Veteran names that were provided, why were only 4 reviewed? Why did the Wilmington VAMC develop a center memorandum (now referred to as SOP) when violating practitioners will not be held to that standard but instead, when management wants to go after perceived troublesome employees who have done nothing but showed concern for patient safety, they readily and conveniently reference such local policies like this SOP in question?
- VHA is supposed to be reputable for standardization of its processes, if the argument that the VA/DoD guideline is to hold any weight, why was this not streamlined for the purpose of eliminating any ambiguities across the VA Medical Centers nationally? Dr. McGuire has never worked with the VA or DoD; this is his first employment with the VA, why was this never raised as his argument for his questionable practice when the whistleblower brought up his concerns many times through the chain and nothing was ever done to address this issue despite calling for true peer review a number of times?
- Comparing the subsisting SOP with the so-called revised version found at the link below, there is no significant differences so, what argument is being advanced here?

https://vaww.visn4.portal.va.gov/networks/Wilmington/BHS/Shared%20Documents/Standard%20Operating%20Procedures/0000-0999%20BHS/BHS%20SOP%200009%20Buprenorphine%20Naloxone%20induction%20maintenance%20treatment.pdf

- With specificity, did the OMI determine what Dr. McGuire's treatment success rate was versus the other providers and not just providing a cumulative statistical data? A Veteran who once worked with Dr. Yacoub but self-terminated after years of being on buprenorphine/naloxone for personal reasons, later resumed with Dr. McGuire when the former had maxed out his DATAS 2000 numbers. This male Veteran stated when he was unable to attain sobriety with Dr. McGuire and eventually dropped out of the program that "I did much better with Dr. Yacoub, if I continue with Dr. McGuire, I doubt if I will ever get better."
- How do the VHA and OMI respond to real-life occurrences at places like Tomah that are making news headlines "Veterans at the hospital told a reporter that distribution was so rampant, they nicknamed the place "Candy Land." Last Aug. 30, a 35-year-old Marine Corps veteran, Jason Simcakoski, died of an overdose while in the inpatient psychiatric ward and 32 other unanticipated deaths have occurred at the facility in the past few years.Simcakoski died while under the care of Houlihan and another physician. He had checked himself in for anxiety and was scheduled for release that day, but having been put on a new medication, Suboxone, in addition to the 14 other medications he was taking — tranquilizers, an antipsychotic medication and tramadol — could not move, according to his father Marvin Simcakoski.

- Overall, I saw the entire report as a charade and an attempt to mislead the public while as usual, painting whistleblowers as ill-informed and disgruntled employees. It is rather scary that people like me who will be in the Veterans' shoes in few years will grapple with these levels of dishonest, sham investigations meant only for cosmetic purposes at the expense of our precious lives. It is unconscionable; and until third-party, neutral agencies preferably non-government entities are tasked with investigating issues in government agencies like the VA, we cannot get anywhere. I rest my case. Thanks.