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RE: Special Counsel OSC File Numbers DI-16-5687, DI-16-5688, DI-16-5690

Dear Attorney Young:

Thank you very much for providing me with a copy of the recent report to the Special Counsel OSC File Numbers DI-16-5687, DI-16-5688, DI-16-5690, dated June 9, 2017.

I have had the opportunity to review this document and, unfortunately, find many errors, partially correct statements, substandard investigation and overall unsatisfactory job performed by the investigation committee assigned by the OMI to the Whistleblower complaints that I filed on behalf of my clients, all currently employed physicians at the Manchester Medical Center.

As you know, this investigation was initiated by your office due to a referral from US Senator Jeanne Shaheen, wherein she forwarded my letter to Carolyn Lerner, Esq., the previous Special Counsel. Attached to my letter to Senator Shaheen was a letter from Dr. Chima Ohaegbulam, a neurosurgeon at New England Baptist Hospital in Boston.

Both of these submissions documented the serious concerns of the Whistleblowers as it pertained to patient care of our Veterans who were treated at both the Manchester and the Boston VA facilities.

I have had the opportunity to review the report and with regard to Allegation 1, their findings were:

1. They were unable to substantiate that patients with spinal cord conditions do not receive proper medical care at the VA, and that the neurosurgical care providers of Veteran 1 and 2 were evaluated and deemed appropriate.

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2. They did not substantiate that a neurosurgeon must make the diagnosis of myelopathy. (This was not our complaint and the committee did not understand the actual problem laid out by the physicians, which I will address herein below.)

3. They were unable to substantiate that there was a rate of worsening neurological function related to myelopathy patients at the Medical Center and that this was indicative of clinical neglect resulting from delayed referrals and surgical intervention.

4. They were unable to substantiate a process of referring patients from the Medical Center to the Boston SC created undue delays in care.

5. They were able to confirm that the medical center leadership is authorizing care to eligible veterans under the Veterans Choice Program.

Firstly, the committee contacted the administration of the Medical Center to ascertain the names of the people that they should interview who had knowledge of the Whistleblowers' complaints. This immediately allowed the administration to line up interviews with those who were cherry-picked and was contrary to your office's interest for an independent inquiry. The physician who had collected the data on the 96 patients with untreated myelopathy not only was excluded from the interview process, but learned that Dr. Schlosser, the Chief of Staff, had submitted his name as the Director of the Spinal Cord Clinic and was to be interviewed about the myelopathy situation.

Dr. Kois, to his credit, approached the committee as they were walking down the hallway outside of his office and identified himself as the doctor in charge of the Spinal Cord Clinic. As a result, he was allocated 45 minutes of their time. Given the fact that there were 96 patients to discuss, this averaged out to around 18.75 second per patient. The amount of time required to discuss each of these cases in the depth required by the serious nature of their disease would have constituted days, not minutes. As a result of the short time period, Dr. Kois was only able to discuss 10 to 15 patient cases, but not in the depth necessitated for a proper and thorough investigation.

In addition to the problem with the interview process, Dr. Kois was not asked any questions in follow-up, which is striking in light of the serious and ongoing nature of this problem at the Medical Center.

Also of concern is the fact that the committee only reviewed the charts of two of the 96 patients revealed to them by Dr. Kois. Although Dr. Kois disagrees with both the factual content of these two patients electronic medical records as well as the conclusions reached as to the appropriateness of their care, given that the committee also recommended further evaluation of 30 patients, with no mention of the remaining 64 patients, I am baffled that they could form a conclusion that there was no harm or problems associated with the care provided to the 96 patients who developed myelopathy during their course of treatment at the Medical Center.

Although Dr. Kois specifically reiterated his findings that the electronic medical records for these 96 patients were inaccurate, at best, due to the cut and paste practice of Dr. Huq, his predecessor in the spine clinic, they failed to consider that in their investigation. To have based their review of these two patients solely on the medical charts, which they have found to have been cut and pasted, is beyond the pale. They did not independently verify anything in the chart with Dr. Kois or the patients. In addition, there were frequent discrepancies with what patients discussed with the physician and what was charted, which brings me to my next point. How could they determine which part of the medical records were reliable and accurate and worthy of reliance, and which were cut and pasted from a prior note?

Furthermore, they found that there was no substantial relationship between worsening function and clinical neglect; however, I would point you to the list of durable medical goods that were prescribed for patients on the list. Dr. Kois noted that there were a significant amount of assistive devices given to these patients, including canes, Lofstrand crutches, walkers, wheelchairs, electric wheelchairs, hospital beds and adaptive equipment, up to and including diapers. This period of time when their function declined was during the same time that the electronic medical records were being cut and pasted. There appears to be no recognition by the committee of the connection between these two occurrences, i.e. the evidence of the increased use of adaptive equipment by patients and the cut and paste of Dr. Huq's records. The committee has reached conclusions in a vacuum and without connecting the dots!

If the committee had reviewed each individual patient's durable medical supply list, they would have seen a clear progression in their disability as it progressed from straight canes through crutches, walkers, wheelchairs, electric wheelchairs, etc.

Another important omission of the committee report is their failure to reference Dr. Ohaegbulam's letter, where he concluded that had these significantly disabled patients been properly treated earlier in the course of this progressive disease their conditions would have been more successfully treated. His letter went on to state that the diagnosis of myelopathy is a clinical one rather than radiographic, and that the trigger for surgical intervention comes from both a history and a physical exam of the patient. Both of these elements were missing from the Medical Center's care. The remainder of his letter speaks for itself.

Given the strength of this letter, it is concerning that there appears to have been no attempt to interview or discuss this further with Dr. Ohaegbulam.

To further delve into the body of the findings, specifically with Patient #1, they presented him as very disabled and feeble, but it must be noted that he had worked full time as a box truck operator right up until his admission to the Boston VA. He drove himself to their Emergency Room, and within a few short days of being there, he was comatose, and eventually died. The committee states that the chart showed no evidence of any clinical signs of infection; however, they omitted findings from the CSF, which on multiple occasions after his becoming comatose showed elevated proteins in the 450 range, when normal is 15; demonstrated white cells too numerous to count, with 98-99% of the type associated with an acute infection. In addition, the CSF was known to be cloudy or turbid when normal should be clear. Of note, that there was no bacteria found; however, almost all of the CSF samples occurred after the patient had already been started on IV vancomycin, thus rendering the culture and gram stains done on his blood suspect. Another important clinical sign that they failed to mention was the development of bilateral frontal hematoma that occurred between the two CTs of his head shortly after he became comatose. These types of hematomas can be frequently seen when a patient is dropped or through a blunt trauma; however, the patient had been comatose and immobile, so it is unlikely that he suffered a blunt trauma and the conclusion can be drawn that he was dropped!

With regard to Patient #2, as a result of his infection, he has become significantly compromised and still continues to be so. Contrary to the committees finding, this is a bad outcome. Dr. Kois recently saw this patient who was still having significant difficulties and wondered whether he would ever be normal again... Unfortunately, the answer is 'No'.

In addition to these two (2) patients, it appears that they did not bother to review or interview other patients, such as the one who had a screw placed through his nerve, who developed intractable leg pain who was seen at least ten times over five months post-surgery until Dr. Kois ordered a CT scan of his surgical site on his spine and found the screw! This patient was sent to Dr. Ohaegbulam to repair this botched surgery. In addition there is the case of the patient who had a spinal cord tumor only partially resected in 1995 in Boston, where his phrenic nerve was negligently severed by the neurosurgeon and he received no follow-up for the tumor until Dr. Kois repeated a scan in 2015. This demonstrated a return of the tumor, now inoperable, as well as two (2) levels of cervical stenosis at 3 mm. This has resulted in him progressing from being ambulatory and able to travel inside and outside of this Country, to now being predominately wheelchair bound and in diapers.

The lack of follow-up with patients is a glaring weakness in this report not only because patients would have had a lot to offer in terms of how they felt they were treated, but, also, what their actual interaction with the provider was like.

Finally as to Allegation #1, the committee's opinion that there were no problems associated with the Whistleblowers' complaints is disingenuous, and, at this point, I believe that outside evaluation needs to be initiated.

With regard to Allegation #2, and the cut and paste of medical records from the prior spinal cord physician, it must be noted that they only reviewed the charts from 2008 to 2012. However, the physician in question was in place guiding the spinal cord unit from 2002 until 2012. This amounts to a six year gap in their knowledge base, and again it is troubling that they felt comfortable concluding that there were no adverse patient outcomes from this practice. Of note, these records are easily retrievable, and a progression can be seen in many of the patients in the list of 96 myelopathy patients, which showed discrepancies between the office notes and the progression of ordered adaptive equipment. Again, it is incongruous that they could state that there was no clinical decline in patients as a result. The interrelationship between Allegation 1 and 2 is hard to ignore, although the committee seems to have done so, in that Dr. Huq was the spinal cord provider for many of these 96 patients and hence the inadequate follow up care.

Finally, with regard to the flies in the OR, the committee concludes that there was no delay in care, but Dr. Levenson testified differently to the committee and they ignored his testimony. Dr. Levenson's testimony was that there were cancellations of GI procedures for colonoscopes. As I had previously written you, as an attorney representing these doctors, I was appalled at the obvious bias that I witnessed while sitting in with Dr. Levenson. Dr. Kois had reported the same to me from his vantage point during his interview. He perceived that the committee was attempting to blame him for the lack of proper care and follow up, by questioning why he didn't refer these patients to the Boston hub SCI clinic. The committee chair argued with Dr. Levenson about his testimony that the flies in the OR delayed patient procedures, specifically colonoscopies. She didn't allow him to expand his testimony about other ways the Center had manipulated records and data about delays in the OR by blaming lack of anesthesia or other such OR problems, when in fact he had been present at meetings where the surgeons and nurses complained about shutting down ORs due to flies.

I tried to intercede and point out that there were other Whistleblowers who had issues that they would like to discuss with the committee and I offered to name them, but the committee chair declined my assistance. I gave examples of dirty and rusted surgical instruments, the lack of a nuclear camera for cardiology, and other problems raised in my filings with the OSC, but was rejected by the chair each time.

The chair turned the tables on Dr. Levenson on the cut and paste charge against Dr. Huq, and asked him why he transferred him to primary care from spinal cord clinic if he was so bad, and Dr. Levenson had to remind her two times that it was not his job to do that since he was not the Chief of Staff, and had no authority over Dr. Huq.

Dr. Kois was not going to be interviewed by the OMI group if Dr. Schlosser and Danielle Ocker had had their way. If Dr. Kois had not confronted them in the hallway and introduced himself as the spine clinic doctor, they would have left the Manchester VA only having interviewed Dr. Schlosser and Ms. Ocker, the two subjects of the Whistleblowers' complaints!

The Quadrad had briefed the staff on talking points to give the OMI investigators before their arrival. In addition, Dr. Schlosser had telephoned one of Dr. Kois's patients the night before the OMI members arrived on campus, to try to smooth things over with him so that he wouldn't respond negatively if he was contacted as part of the investigation. This patient had never met Dr. Schlosser, nor had he ever spoken to him; he thought that it was very odd to receive this call, and he was upset about it and reported it to Dr. Kois.

All in all, the behavior of the so-called independent reviewing committee was far from neutral or independent. From my actually witnessing their interview with Dr. Levenson and hearing from Dr. Kois about his interview, it is clear that they had no interest in a fair and impartial and complete investigation into the systemic problems that directly impacted patient care in Manchester.

Please let me know if you require anything else from my clients in regard to these three issues that were the subject of this investigation.

Thank you for your courtesy in this matter,

Sincerely,

Andrea Amodeo-Vickery

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