

October 10, 2013

At the outset I would like to thank the members of this committee on Veterans Affairs for offering me an opportunity to share my first hand experiences as a physician at a Veterans Hospital located in Hampton, Virginia.

I am presenting to you a letter I wrote to my State Senator in March 2010. The thoughts and observations in the letter were recorded with great clarity. I have included the names of individuals as in the original letter. As the truth was documented originally, so I chose to let it stand.

I beg of you to hear these words and act decisively to improve the healthcare delivery system for our deserving veterans.

Thanking you in advance for your attention.

Respectfully submitted,

Pamela J. Gray, M.D.

Dear Senator Webb,

I am writing to you to report my experiences with the delivery of medical care at the Hampton VAMC. My observations from April 2008 to March 2010 note the level of care is not consistent with community standards. As a physician working at the Hampton VA during that time period, I witnessed an abuse of authority which is a potential danger to public health and safety, specifically the overprescribing of opioids providing opportunity for diversion into the Hampton Community. As a result of reporting this information I have been terminated as of March 26, 2010. I am seeking whistleblower protection. The first contact via telephone to your office in Norfolk was December 2009. I am also asking you to contact the Office of the Inspector General on my behalf. I was initially contacted by Special Agent Molly Morgan on February 1, 2010, however, I am asking for further investigation as I feel my termination is reprisal for my concerns regarding prescribing of Schedule II narcotics.

I have been employed as a physician at the VAMC since April 28, 2008. I was hired in the capacity of 30% Rheumatology, 70% Primary Care. I have been informed by fellow physicians that in the six months prior to my arrival in multiple Primary Care Staff meetings, I was identified as a "pain specialist." I have no specialized training as a pain specialist nor did I ever identify myself as such. After my arrival, I was informed I would manage difficult pain patients with musculoskeletal diagnoses being treated with large doses of Schedule II narcotics. As this is not a standard of care in the community, I sought to give a more appropriate level of care. I encountered resistance on the part of my service chiefs, clinic nurses, telecare nurses and nursing supervisors. My concern at this point was the overprescribing of opioids with the potential for diversion into the Hampton/Newport News communities. It is well documented that 10-20% of opioid users become addicted. The opportunity for diversion was of concern as this had been documented at the V.A. in Beckley, West Virginia. This was also well known by my service chiefs and the Chief of Staff as we had discussed it in full. I received no support for my efforts. I was told by the Chief of Medicine to "think twice before refusing to write narcotics in a time of economic downturn."

I served on the Pain Committee upon appointment by the Director of the VAMC, Ms. Mims. There are multiple instances when I have been coerced or even ordered to write for Schedule II narcotics when it was against my medical judgment. Ms. Mims called me directly out of a Pain Committee meeting, ordering me to write opioids for a patient who had no objective findings to support a musculoskeletal diagnosis requiring such treatment. He was a thirty-eight (38) year old male with knee pain with normal exam and x-rays. Non-medical personnel tried to influence me to write for opioids, again for incorrect purposes. A patient care advocate, Mr. Waylon Murphy, and an Administrative Assistant, Roger Barkers, tried to persuade me to do so. This was documented in my medical notes. I was ordered to alter my notes by Dr. Karin Soobert, Chief of Primary Care. As I had documented factual truth, I

refused. It is illegal to alter notes in a medical record; an addendum may be added but notes cannot be deleted. My note was deleted under the orders of Dr. Soobert, who is also Chair of Medical Records. I continued to lobby on behalf of the patients for a better level of care as well as improved work environment for the physicians, physician's assistants and nurse practitioners who also felt pressure to write Schedule II narcotics against their better judgment. This was reported to Ruth November, J.D, Office of Regional Counsel, McGuire VAMC, Richmond, VA in April, 2009 (See email of same date).

Although pain management was not an area I wished to pursue, I served on the Pain Committee, represented our Medical Center at a National Pain Conference for VISN 1-11 and wrote the standard operating procedure for VAMC that is now in current use. I did everything which was asked of me by my two Service Chiefs and the Director. I brought all information back from the National Pain Conference to Dr. Soobert, Service Chief, and Dr. Arul, Chief of Staff. No change was implemented in one year.

As an advocate for a patient who was sent out of the Hampton V.A. Medical Center Emergency Room while he was having a CVA (cardiovascular accident or stroke), I sought neurologic consultation for the patient in July of 2009. The consult was refused three times. As a result of trying to protect the community image of the VAMC and care for the patient, I was threatened in writing that further such action "may result in disciplinary action to include removal" by Dr. Soobert. I have appealed her action and have been denied. The patient has filed suit against the VAMC Hampton.

In trying to improve patient care, I have received death threats from patients, coercion to practice poor medicine by non-medical personnel, have been found guilty of an ethics violation committed by another physician and now face a Professional Standards Board Review without being allowed to review any documents to be used against me. My service line chief who initiated the PSB denied knowing anything about the Board meeting. I am informed by Ms. Ruby Sheperd in Human Resources this originated directly as a result of Dr. Soobert's request. Dr. Soobert denied knowledge of this and denied me access to my records for review prior to the Board.

In the twenty-three (23) months of my employment: 1) I have been forced to do work in which I have no professional training, 2) been ordered by supervisors and the Director to write large amounts of Schedule II narcotics in inappropriate medical circumstances, 3) have had my medical records altered to hide factual documentation, 4) have received sexual harassment by a male nurse, again, regarding opioids, 5) been reprimanded for advocating for a stroke victim's right to care from the VAMC Hampton who, as a Marine veteran, was sent

out of the Hampton VAMC Emergency Room as he was having a stroke, resulting in permanent brain injury, 6) been threatened to be reported to the National Data Bank for a non-reportable Level I Peer Review and 7) been subjected to situations involving entrapment by supervisors to "not stop writing for opioids in a time of economic downturn"/say defamatory remarks about ethnicity/say defamatory remarks about the Director, all of which I resisted as I found these actions reprehensible. I now am being asked to cover another physician's clinic in Hampton in the clinic where I received the death threats and had a male nurse scream at me for refusal to overprescribe opioids to hide the actions of a married doctor who has had a sexual relationship with a married nurse. Both have had their jobs protected. I am asked to participate in the cover up of a crime.

A Probationary Review Board to decide whether to terminate me was called on February 4, 2010. As of today, March 24, 2010, I have never been notified of its findings. One of the three physician members of the Committee referred a patient to me for ongoing care on March 10, 2010. I received a letter from the Union attorney on March 8, 2010 stating he had no knowledge of the outcome of the Board. The February 23, 2010 minutes of the Virginia Beach VAMC clinic where I had seen patients indicated I was to return to Virginia Beach April 2010. At 4:15, March 12, 2010 I received notification to come to Dr. Karin Soobert's office at the conclusion of my work. When I did not appear by 4:30, I received a second call telling me "not to forget to come to Dr. Soobert's office." When I arrived at 4:45 p.m. I was informed I was terminated. No cause was given. I was denied Union representation. I was told to sign the document placed in front of me. I asked to review it with a Union attorney. I was told to sign it "right now" and "turn in your badge." As it was then after close of business, I had no one to turn to for questions. In the termination note to follow, I was given Kellie Franks as the Human Resources person to contact. I called, leaving my cell phone number as a contact. I received no return call for one week. When she called she wanted to know what my questions were and she would call me back. Upon return call, I was given another contact name and number. When Evelyn Stephenson was contacted she informed me she did not know the answers to my questions (Cobra coverage, retirement funds, continuing Union dues, etc.) and that I should "go to the liberry [sic] and look it up." I have no answers to date. I was denied a written response.

Physicians in Primary Care at Hampton VAMC have three choices when prescribing large amounts of opioids. They may resign (3 excellent physicians did so in the past 12 months - Drs. Pagador, Hilland and Wozniak), do as they are told, or be terminated. Dr. Jamal Al-Zhara was terminated when he refused to alter records to hide emergency room errors. Dr. Soobert fired him and then prevented him from working at other VA Hospitals.

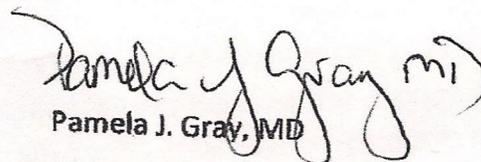
The Primary Care Physicians have no support from Administration including at the Director level. Examples of excess opioids includes:

- 55 year old male received Morphine MS Contin 30 mg twice daily, Tramadol 300 mg daily, Percocet 4 times daily, 1 Fentanyl patch 25 mg every 3 days for carpal tunnel since 2004, was not seen since 2004, had no labs checked since 2004, and had the opioids mailed to him.
- 64 year old, 102 pound female hospitalized for morphine/vodka overdose receiving 1800 tabs hydrocodone monthly concurrently with morphine sulphate (MS Contin) 100 mg tabs, 360 tabs monthly, and has received as many as 3,600 5 mg Oxycodone at monthly intervals
- 38 year old male, normal exam, normal x-rays ordered by Director Mims to continue filling his Percocet. Had been receiving 360 tabs every month.
- 39 year old male, working full time as farmer in Suffolk, VA receiving MS Contin, Duragesic patches, Percocet and Tramadol simultaneously for neck pain. Evidence of receiving Percocet from an outside, private primary physician and VAMC, never went to pain management consult but meds continued.
- 50 year old male, diagnosed with "low back pain" 10 years ago, last x-ray in 2004, wants more than Tylenol #3 (codeine) 4 per day, Tramadol 4 per day. Refused labs and x-rays, wants pain meds refilled.
- 55 year old male on morphine for "low back pain" 30 mg tabs 3 times per day, 240 tabs monthly mailed and Oxycodone 40 mg daily, 240 tabs monthly.
- 56 year old male wants Percocet for "chronic generalized pain." He wants 10 Percocet daily. I refuse. He reports me to administration. I am ordered by Dr. Karin Soobert to write the prescription. When I explain, she reports me for failure to follow orders. Contacted by Mr. Roger Barkers, Administrative Assistant, to write prescriptions.
- 52 year old male on morphine 300 mg CR, 2 tabs 3 times daily for Lupus. He does not have Lupus. He reported me to Roger Barkers who had Dr. Mowery see the patient and write the opioids. Patient on 1080 mg of morphine daily, 4 Oxycodone 80 mg twice daily for disease he does not have.
- 55 year old male demands morphine and Oxycodone because "I want them and you have to give them to me." Abusive. Police called. Another provider gives the meds the same day.
- 56 year old sleeps through appointment with me. I feel he is over-medicated. He is diagnosed with rheumatoid arthritis with no DMARD since 2000. On morphine 90 mg daily, Oxycodone 10 mg daily, receiving 180 tabs morphine and 100 tabs Oxycodone monthly. I begin to taper on October 8, 2008, wife calls for in for more meds within 1 week. I was reported.
- 52 year old on Fentanyl patches. No CBC (complete blood count) since 2004, no LFT (liver function test) since 2007 and last urine drug screen 2008. Patches are mailed to him monthly for mild osteoarthritis. I alert Dr. Soobert this is not standard practice. I am terminated the following day.

Tens of thousands of examples exist. I have repeatedly alerted Dr. Karin Soobert, Chief of Primary care, Dr. Mary Kim Voss, Chief of Medicine and Dr. Arul, Chief of Staff that, due to fear of administrative reprisal, these are the rules, not the exception. The doctors are afraid to refuse the patients' demands. The amounts of Schedule II narcotics prescribed indicate diversion into the community is occurring.

I have consistently seen more patient than the other physicians. I am the only primary care physician to be over 100% booked in the history of the Primary Care at the VAMC Hampton. I have received the praise of my fellow physicians and nurses. It is my fondest desire to return to my position as a physician at the VAMC. There are fine physicians who wish to improve the level of care given to our veterans if given the opportunity and administrative support. Please assist me in bringing about the necessary changes to make this happen. I understand fully the gravity of these accusations and factual documentation exists for all.

Respectfully,

Handwritten signature of Pamela J. Gray, MD in black ink.

Pamela J. Gray, MD