

A) I started working at the Tomah VAMC as a Clinical Pharmacy Specialist on August 4th 2008. I officially started on the pay roll July 6th, 2008 and my service computation date was July 2nd, 2007. From August through November I was warned by many pharmacists including the previous Chief of Pharmacy Dr. Jim Due, Staff Pharmacist Kaleen Larson RPh, Virginia Schroeder RPh, Dan Hanson RPh, Dave Dettle RPh, and Clinical Pharmacists Dr. Richard Schroeder and Dr. Laureen Savage-Chambers that if I questioned Chief of Staff Dr. David Houlihan's MD prescriptions that I would be fired. They gave me many examples of previous employees that were forced to resign or have been fired for questioning one of Dr. Houlihan's prescriptions. I was warned by all that if he did not fire me, then he would make my life very difficult at the VA. I cannot recall specific names of employees that they mentioned, however my clinical colleague Dr. Laureen Savage-Chambers and Clinical Coordinator Dr. Richard Schroeder gave the most specific examples. I did witness one of the out-patient providers Dr. Zakia Siddiqi MD be forced to resign for refusing to write a narcotic order for a chronic pain patient who's urine drug screen did not test positive for oxycodone on more than one occasion.

During this time frame I was nominated by Performance Improvement Leader Tracey Lane to be the chair of the Tomah VAMC pain committee due to my background working in a pharmacist run pain clinic in conjunction with a board certified pain specialist while in my residency at Chalmers P. Wylie VA Ambulatory Care Clinic in Columbus, OH. The interim Chief of Pharmacy at that time was Dr. Erin Narus who decided the pharmacy was too short staffed for me to spend the time necessary to be the chair of the pain committee; however, she decided I would be the pharmacy representative for the committee. (See attachment A).

B) Friday 11/21/08 I was the "hot seat" pharmacist. This pharmacist fills the window prescriptions for the patients that are waiting at the pharmacy. I received a prescription for Morphine Sulfate IR (i.e. immediate release) 15mg 7 tabs every 4 hours, 2 tablets three times daily prn (i.e. as needed) #1080 for a 30 day supply written by Dr. Houlihan. I quickly reviewed the patient profile in his medical record CPRS (i.e. computerized patient record system) to get a better assessment of what the indication for the short acting narcotic pain medication was for and to assess the type of pain being treated as well as other medications the patient had previously failed. This patient has somatic pain from a fracture of the T12, in addition to neuropathic pain with radiculopathy. After this brief assessment of the patient my initial clinical judgment was to question the short acting agent of choice and the quantity that was prescribed. After having experience working as a clinical pharmacist in a pain clinic at the VA in Columbus OH, I clinically felt this patient's pain was not being properly treated. Strictly treating a patient with only short acting medication is not the standard of care. I felt this patient would benefit from a long acting narcotic, a NSAID (i.e. non-steroidal anti-inflammatory drug), and a medication to appropriately treat his neuropathic (i.e. nerve pain) pain. I felt the short acting immediate release morphine was inappropriate monotherapy. The prescription was due to be filled on 11/24/08. The prescription was early, so I felt I had time to look into the patient's medical records to better formulate a recommendation for the provider.

I asked many of my colleagues including Clinical Pharmacists Dr. Lauren Savage-Chambers, Dr. Richard Schroeder, Dr. Margaret Hyde, and Dr. Erin Narus, and they felt the prescription was inappropriate as well. I was told not to question the order; however because it was from Dr. Houlihan and he doesn't like pharmacists questioning his orders. I was told by multiple clinical and staff pharmacists if I question the order and try to make recommendations he did not agree with, then he would try to fire me or at least make work unpleasant for me. I discussed the prescription with multiple pharmacists and I asked how the prescription had been getting filled thus far. The responses I received were statements such as, "I'm sick of fighting with Dr. Houlihan," or "I'm not calling Dr. Houlihan, I don't want to have to fight with him about anything today...good luck with that...I'm glad I'm not you." or "Last time I called and questioned an order, Dr. Houlihan called the previous Chief of Pharmacy Dr. Jim Due and told him I was trying to cause a problem."

I took the prescription to the new Chief of Pharmacy Dr. Erin Narus to review the prescription. She agreed the patient needed to be on a long acting narcotic medication as well as possibly an NSAID and a medication to treat the neuropathic pain. While I was in Dr. Naus's office I received a call from Dr. Locker MD who wanted to know if a pill identification had been done as he believed this particular patient had brought his own immediate release morphine sulfate from home and was taking this in addition to the immediate release morphine we were giving him while he was admitted to the VAMC. This would have been a direct violation of the patient's pain contract. Dr. Locher wanted to let Dr. Houlihan be aware of this violation before Dr. Houlihan wrote a new prescription for immediate release morphine upon discharge 11/21/08. The medication should have been taken away from the patient and locked up in inpatient pharmacy as this is standard protocol. This however did not happen. Dr. Locker spoke with Dr. Houlihan about his concerns with the patient and his over use of this short acting pain medication. I spoke with Dr. Locker and Berry Emerk PA-C about the pill identification. While on inpatient unit 400 observation, I showed the two providers the prescription. Both providers said, "We are glad our name isn't on the prescription." This in addition, added to my concerns about the appropriateness and safety of the prescription. The patient has built a large tolerance to this medication, which happens very quickly with short acting analgesics, and is now taking more than prescribed. This patient will likely continue to require more and more medication as he builds tolerance and dependence. Is this a case of pseudoaddiction because the patient's pain is not properly treated? Due to the fact the patient had been an inpatient for a few days and was receiving immediate release morphine in the hospital and was requesting the prescription early the patient should have had enough medication to cover through the weekend and therefore was not going to be without any medication.

My plan which was discussed and agreed upon with Dr. Narus was to go through the patients medical record more in depth and devise a plan to help convert the patient over to a long acting narcotic medication and start to taper the short acting immediate release morphine. I consulted with the Board Certified Pain Specialist, Dr. Sanhaj and Clinical Pain Pharmacist, Dr. Staci Jackson that I previously worked with in my residency to

reinforce the decision to request this patient be converted to a long acting narcotic and how to safely go about converting someone on such a large unsafe dose.

I did not have time to thoroughly go through the patients chart until Monday morning 11/24/08. All weekend long I dreaded having to make this phone call. I was afraid to call Dr. Houlihan to discuss this case after everything my colleagues had told me. I even lost sleep over it. I woke up multiple times and went over my game plan how I could tactfully and professionally approach this situation and make a recommendation to Dr. Houlihan to help him treat this patient without upsetting him, but that would safely and effectively treat the Veteran. First thing Monday morning I met with Dr. Narus and reviewed my plan with her. I asked her how to approach Dr. Houlihan knowing it was going to be a tough situation. She gave me some advice on how I could broach the subject. I had to give myself a pep talk just to pick up the phone. I have never been afraid to contact a provider to question an order or provide a recommendation before because that is my job and I know it is in the best interest of the patient. I called Dr. Houlihan's nurse Susan Schmitt and she told me he was with a patient. I told her I had a question in regards to an order, but it was an in depth question so he could call me back at his earliest convenience. The nurse ended up transferring me to Dr. Houlihan. I told Dr. Houlihan that my name was Noelle I was one of the pharmacist and I had a question in regards to the immediate release morphine order for this particular patient. I asked if Dr. Locker had spoke with him in regards to this patient taking his own morphine while admitted to the VA as an inpatient. Dr. Houlihan said he spoke with Dr. Locher. Dr. Houlihan said, "This patient did not take his own morphine while he was here." I told him I had looked through the patient's medical record and saw that he had somatic pain as well as neuropathic pain with radiculopathy. The patient had been on long acting morphine in the past. Dr. Houlihan said, "He wasn't tolerating the medication." I said, I read in the chart he was taking more than prescribed, not that he wasn't tolerating the medication." I then said I think this patient would benefit from a long acting pain medication would you consider starting him on another long acting narcotic medication. I was thinking methadone. It is a good medication for patients with somatic and neuropathic pain. This is where Dr. Houlihan began to get upset. He started to get very stern and short with his answers and he starting raising his voice. He said, "The patient has addictive properties so methadone would cross the lines to addictive treatment which would need a special license." (Methadone for addiction requires a special license. Methadone for chronic pain management does not). Dr. Houlihan then asked me, "What is the bottom line, what are you really trying to say?" I said, "I clinically don't feel comfortable filling this prescription. I really feel the patient needs a long acting medication. Where are you going to go with this patient's medication regimen? The patient is going to just keep building up tolerance and greater dependence. Are you just going to keep increasing the dose?" Dr. Houlihan responded by yelling, "I'm sick of you pharmacist questioning my prescriptions. By questioning my prescription you are questioning my clinical judgment and my authority, thus by doing so are putting my license in jeopardy!" I said, "I am not trying to question your clinical judgment; I am trying to help the patient and you come up with the best way to safely and adequately treat this patient's pain." Dr. Houlihan said "Yes you are, you are questing my clinical judgment and how I treat my patients. Some one has to see these patients and it is me." I said, "I was told you are the only one who

sees the chronic pain patients.” Dr. Houlihan said, “Yes, I am the only one who can. If you don’t want to fill this prescription and you want to question me all the time than you can be the one to find these patients a new Dr. to see them. How are you going to do that? No one else is going to see them! Are you going to see them?” I said, “I would like to work with you to help find the right pain regimen to treat this patient.” Dr. Houlihan responded by telling me what needed to be done was, the prescription needed to be filled. I replied by telling him, “I do not feel comfortable filling the prescription and I will not do so. I would find you another pharmacist to fill the prescription, but my name will not be on the prescription because it is not in the best interest of the patient.” Dr. Houlihan said he would be speaking to Dr. Narus about this situation. I told Dr. Houlihan that was fine Dr. Narus was aware of the situation. Dr. Houlihan hung up the phone.

I instantly starting crying after hanging up the phone. I felt very attacked. I as well as the other pharmacists do not deserve to be treated like that. I as well as my colleagues deserve to be treated with respect, dignity, and civility. I believe Dr. Houlihan behaved in an unprofessional and threatening manner. I now know what the other pharmacists were talking about and why everyone is afraid to recommend any changes to Dr. Houlihan. I don’t feel I should have to be afraid. I feel that I did what was right. I stood up for patient safety, my ethics, and protected my license. Filling that prescription was not clinically in the best interest of the patient. I feel I had every right to question the prescription and not fill it based on my clinical judgment. (See attachment B1, B2, B3).

The technician Mrs. Toni Johnson was standing next to me filling narcotic prescriptions during my phone conversation with Dr. Houlihan. Mrs. Johnson wrote a statement to attest to my professionalism. (See attachment B4).

I tried to give the prescription to another pharmacist so they may have the opportunity to fill the prescription if they chose to do so based on their own clinical judgment. The other staff pharmacists refused to fill the prescription as well once I had questioned the order. The prescription was filled by Dr. Narus.

After the phone call I went to the clinical pharmacy office for support from my fellow colleagues. They also agreed the prescription was inappropriate and that Dr. Houlihan acted in an unprofessional manner. I called Dr. Narus to tell her the conversation did not go well and she should expect a call from Dr. Houlihan. She asked if I would like to discuss what happened. I decided to contact a union representative first.

I had multiple treatment recommendations planned for this patient, but due to Dr. Houlihan's demeanor I did not have the option to discuss all of them with him.

- 1) Convert to methadone...methadone is a good option for patients who do have addictive problems because it is so long acting you do not get a "high feeling from it," it is great for somatic and neuropathic pain. We would have been using this to treat this patient's chronic pain, not an active addiction problem that I am aware of. I still believe this is a good therapeutic option for this patient. (All long acting meds are going to be hard to convert to because pt is on such a large dose of short acting morphine 720mg/d). Start to taper short acting morphine.
- 2) Pt would likely benefit from a chronic NSAID such as Etodolac since fracture of T12
- 3) Could consider retrial of long acting morphine or trial of Oxycotin or fentanyl
- 4) Could consider retrial of gabapentin. Patient had reported muscle cramps at low dose. This would be beneficial for neuropathic pain. Could consider other agent such as pregabalin or duloxetine if unable to tolerate gabapentin.
- 5) Could consider SNRI...reported ADR to venlafaxine...unknown

I then filed a grievance with the union in regards to this matter. The Inspector General was contacted in regards to a different matter. (See attachment B5). Shortly after this incident Labor and Management had a meeting. In this meeting Dr. Houlihan stated, "A pharmacist turned me into the Inspector General." I never at any point in time contacted the Inspector General.

He told the Union Steward, Diane Streeter that I acted unprofessional in regards to this specific patient matter. Diane stated, "She was not unprofessional and she has a witness who wrote a statement stating she maintained her professionalism." At this time Ms. Streeter stated she had tried to bring up the issue of starting a pain clinic and using me as an integral provider in the clinic. Per Ms. Streeter, Dr. Houlihan stated there will never be a pain clinic in this facility and if pharmacy takes over pain management then patients will start dying. If this happens patients will bring their guns to pharmacy and start shooting.

After this incident I was told by Dr. Narus and Service Line Manager, Jeff Evanson that I was no longer to call Dr. Houlihan. I was instructed to fax him my recommendations because he is unable to control his temper and faxing was Dr. Houlihan's preferred method of contact.

C) On 12/12/08 I received a prescription for a Controlled Schedule II (CII) narcotic printed on a white piece of paper from Dr. Houlihan. This prescription was a work order copy. Any employee that had computer access could have printed this prescription off CPRS. At this time the Tomah VA required all CII prescriptions to be hand written by the provider on the green prescription pad assigned to each individual provider. Some VA's were transitioning to using the computerized form of a CII prescription. This prescription was printed as a work order, not a computerized CII prescription. As far as I and the other pharmacists were aware we were still requiring the green prescription copy. I tried paging Dr. Narus multiple times and did not get a response. The patient was waiting for the prescription to be filled and was irritated it was taking so long. I decided to go to Dr. Houlihan's office to ask his secretary to have Dr. Houlihan rewrite the CII on the green copy. Dr. Houlihan's office door was open and he heard me talking to his secretary. Dr. Houlihan came running out of his office yelling at me. He said, "This is a legitimate prescription and I will not rewrite the prescription. He yelled I am so sick of you F...ing pharmacist! I want to speak to Erin Narus immediately!" He marched down to out-patient pharmacy and I paged Dr. Narus again to come to the pharmacy. Dr. Narus and Jeff Evanson came to the pharmacy and had a meeting with Dr. Houlihan in the back. I went back to filling prescriptions and I could hear Dr. Houlihan maligning me. I was never brought into the discussion to defend myself. As it turned out Dr. Narus and Dr. Houlihan had made a prior agreement that Dr. Houlihan would start to write the CII prescription on the computerized form due to a previous confrontation he had a week prior with another pharmacist in regards to misspelling a patients name 3 times. This change was not communicated with any of the pharmacists. The prescription still had to be rewritten as requested due to the fact it was a work order, not a prescription written and printed correctly from CPRS. On 12/15/08 Dr. Narus handed out a new hard copy guideline exclusively for Dr. Houlihan. (See attachment C New Schedule II order Entry in CPRS for Out-Patient-Pharmacy).

D) February 2009: New Chief of Pharmacy Dr. Tom Jaeger and Dr. Savage-Chambers attend a Medical Executive Meeting. In this meeting Dr. Houlihan again told everyone that I turned him into the Inspector General. Both parties told Dr. Houlihan that I did not turn him into the Inspector General.

E) February 6th I had a meeting with Dr. Jaeger and Union Steward Diane Streeter. This meeting was to discuss the verbal threat Dr. Houlihan made in the Labor and Management meeting. In this meeting Dr. Jaeger gave me suggestions of agencies to contact with my concerns. He gave me the paper work for the Inspector General and JACHO. Dr. Jaeger explained, he thought JACHO was the best avenue to pursue for reporting the unsafe practices of Dr. Houlihan.

At this point Dr. Jaeger assigned me to the VISN 12 (regional level) Pain Committee. I was also assigned as the leader of the Opioid Work Group by Tracey Lane from performance improvement.

F) On March 9th, 2009 I received a prescription from Dr. Houlihan for Methylphenidate Sustained Release 120mg/day. The max dose of this narcotic stimulant medication is 60mg daily. I reviewed the patient's medical record and discovered the patient had previously been on this dose. I also noted the patient had a strong cardiac history. I did not feel this was a safe dose for the patient. This medication is a lipid soluble medication. If given too high of a dose the medication could over saturate the enzymes used to break the medication down and therefore build up in the patients system and potentially cause harm such as a cardiac arrhythmia due to the stimulant properties. I faxed Dr. Houlihan and asked if the dose could be reduced or if the medication was not beneficial at a lower dose if he could choose an alternative agent for the patient. Within a couple of days Dr. Houlihan wrote a new order for the same dosage and commented on the prescription, "Pt is a large man, fill as is." This medication is not weight based for adults. Dr. Savage-Chambers and I resourced with colleagues at the VA in Madison to see if any doses greater than 60mg have ever been filled. One prescription had been filled for 70mg, other than that dose above 60mg had not been filled. I consulted with many of the clinical and staff pharmacists and they all felt the medication dose was unsafe. I gave the prescription to my previous Interim Chief of Pharmacy, now Out-Patient Supervisor Dr. Narus who also agreed the medication dose was unsafe. Dr. Narus was going to talk to Dr. Houlihan. A few days had gone by and nothing had been done with the prescription. Dr. Narus was called away from work for personal reasons. I received a call in clinic from one of the out-patient staff pharmacist Kaleen Larson, RPh. She stated, "The patient is coming to pick up his Methylphenidate and Erin would like the prescription to be partialled (see definition below) until further clarification from Dr. Houlihan. I want nothing to do with this prescription you need to come over to out-patient and fill this prescription." Dr. Narus had written directions on the prescription to give a 7 day supply. There was also a yellow note stuck to the prescription that stated I was to tell the patient to only take 2 tablets twice daily until further clarification from Dr. Houlihan. There were two separate problems at hand. It is illegal to partial a CII narcotic prescription unless you do not have sufficient quantity to dispense the total and then you only have 72 hours to dispense the remaining or the rest of the prescription is null and void. (See attachment F1). It is also illegal and unsafe to tell the patient to take different directions than what is written on the bottle or what the provider has prescribed. (See attachment F2).

I was not going to illegally partial a prescription and I was not going to tell the patient to take different directions than what the Dr. had prescribed. Dr. Jaeger was out of the office and now so was Dr. Narus. I brought the prescription to my Service Line Manager, Mr. Jeff Evanson who is not a pharmacist or licensed professional. Mr. Evanson's response was, "Why are you trying to cause trouble?" I explained that I wasn't trying to cause trouble, that this was an unsafe dose for the patient and I was not going to illegally fill the prescription as I had been asked to do. He stated, "Why are you trying to throw Erin under the bus?" I again explained that was not my intention, but the patient was coming to get the prescription at the pharmacy and neither Dr. Narus nor Dr. Jaeger were available. I was not going to fill the prescription at the unsafe dose. I was unwilling to fill it illegally and the other pharmacists were not going to fill the prescription either. Mr. Evanson responded by saying, "If Dr. Houlihan said to fill the prescription you will fill it. You have no right not to!" I responded by saying, "I am an individually licensed

pharmacist. I am 50% liable for anything that happens to that patient. I in good conscience cannot fill that prescription just because a provider thinks that I should. It is my job to make sure that prescription is safe for the patient to take. If something were to happen to this patient I am liable and I am not willing to compromise patient safety and my ethics. Mr. Evanson and I continued to debate the issue for over an hour. Mr. Evanson stated, "How dare you claim to be an expert! He asked, why have the other pharmacist filled the medication so far?" I explained that the other pharmacists told me they were told not to question Dr. Houlihan's prescriptions and they were afraid they would be fired if they made a recommendation he did not agree with. I then told Mr. Evanson that Dr. Houlihan could fire me, but I was going to stand up and do what was right and safe for the patient. I was not, and will never be willing to compromise patient safety and my ethics. Mr. Evanson responded by saying, "Houlihan doesn't have the authority to fire you, only I can make that decision." The conversation ended by Mr. Evanson asking to speak with my Clinical Coordinator Dr. Schroeder. Dr. Schroeder, Dr. Savage-Chambers and Union Steward Peggy Burke attend a meeting with Mr. Evanson. Both clinical pharmacist supported and clinically agreed with my decision. Dr. Savage-Chambers wrote the error up in our good catch log. This is a log of provider errors that are kept track of. The patient did not receive the medication that day. When Dr. Narus returned she spoke with Dr. Houlihan and the order was changed to 60mg total daily dose. (Documentation of prescription and note to partial the prescription and change directions is on file with the Tomah VA Union Office).

G) After this incident Dr. Jaeger asked me to write a standard operating procedure (SOP). He wanted me to write a procedure that stated if the provider disagreed with the clinical recommendation that we had to fill the prescription as is. If the pharmacist documented they clarified the prescription then the liability was no longer placed on the pharmacist. I disagreed with this and did not feel comfortable making the SOP without legal advice. I called the Iowa Board of Pharmacy. They advised me that the pharmacist is still liable for those prescriptions even if there is documentation of clarification. They advised me to not fill anything that was unsafe for the patient. They also recommended I contact Inspector General as it seemed we had a problem in the Tomah VAMC. I gave Dr. Jaeger this information and wrote the SOP accordingly. (See attachment G).

H) March 30th, 2009 Janice Waldstein a NP from the Wausau Community Based Out-Patient Clinic (CBOC) emailed Dr. Jaeger to compliment my professional abilities and report our positive interactions over the previous 5 months she had worked in the CBOC. Dr. Jaeger responded by saying, "Thank you for the feedback. I agree that Noelle is an exceptional pharmacist. It is always nice to get this sort of feedback to assure her that her work is appreciated. Thanks." (See attachment H)

I) May 12th, 2009 I attended the Tomah VAMC pain committee meeting. While in this meeting the new chair of the committee Dr. Whiteway MD told us that some key stakeholders would be having a meeting in regards to a proposal for starting a pain clinic. He named some of the key stakeholders which included himself, Deb Frasher co-chair, Dr. Houlihan, Associate Chief of Staff, Dr. Picca MD and then he said, "And your colleague Dr. Margaret Hyde. I don't know her. Why would she be asked to attend?" I

didn't explain the situation at the current time as there were many people around and it was not the appropriate time or the place. After the meeting I explained to Dr. Whiteway that Dr. Houlihan and I didn't exactly see eye to eye. I gave him some of the examples of the prescriptions I felt were unsafe for the patient and consequently refused to fill, as well as some other examples of questionable practices. I also explained that another clinical pharmacist Dr. Margaret Hyde had been consulting with Dr. Houlihan on some of his pain patients. Dr. Whiteway told me he received an email that said I was not to attend the meeting and that he was to find another pharmacist. At this time Dr. Houlihan named Dr. Hyde. At this time I told Dr. Whiteway and Deb Frasher NP that if Dr. Houlihan is unwilling to work with me that it might be in the best interest of the patients and the committee if I step down. They agreed and Deb Frasher told me that I could work from behind the scene to help the patients and Dr. Hyde. Approximately seven months prior Dr. Hyde approached me in front of Dr. Savage-Chambers and asked me to teach and guide her in relation to managing diabetic and chronic pain patients.

May 15th, 2009 I then set up a meeting with Dr. Jaeger and Dr. Hyde. At this time we all agreed for consistency purposes it needed to be the same person on all committees and clinics. I told Dr. Jaeger and Dr. Hyde that if the support wasn't there from the Chief of Staff to be on the pain committee and in the pain clinic, then I didn't feel I should be following the individual pain patients that I had been making recommendations on. They both agreed and Dr. Jaeger assigned Dr. Hyde to all the committees in my place. I then gave Dr. Hyde a list of the few patients I was still following for specific providers. She agreed to take over the monitoring of these patients. Most of these patients were now stable so they could have been sent back to primary care.

J) May 27th, 2009 I received a prescription from Dr. Houlihan for a prescription that was written for 1,447mg of Morphine equivalent. This was a 100% increase in dose for this patient. I knew this patient was a difficult patient and that Dr. Hyde was working on this patient with Dr. Houlihan. I reviewed the medical record with Dr. Savage-Chambers and there was no documentation at the time as to why Dr. Houlihan was increasing the dose 100% or that the plan was to admit the patient for observation on June 1st. Dr. Hyde did not have a pager at the time and was in an infectious disease meeting. The patient again was waiting so I called Dr. Hyde in her meeting. I asked Dr. Hyde why they were doing 100% increase. I said, "In most cases a 100% increase at such a high dose is contraindicated. Why would Dr. Houlihan do a 100% increase if a 25% increase would have been beneficial. Dr. Hyde then raised her voice at me and said, "You don't know what you are talking about, I have been in practice a lot longer than you. Just because you worked in a pain clinic doesn't mean you have seen everything. The patient increased the dose 100% on his own!" The prescription was then filled. Five minutes later I saw Dr. Hyde in the hallway. She stated, "They are going to admit that patient for observation on Monday." I then asked her why we gave him a 30 day supply of a narcotic medication at that dangerous dose if he was going to be admitted as an inpatient in 4 days, especially if he was self escalating his dose. I also told her after looking back at his refill history that even at the 100% increase he should still have enough medication to last until Monday. Dr. Hyde then walked away. The patient was not admitted on Monday June 1st.

K) The first week of June I asked Dr. Jaeger if I could be taken off the 9-5:30pm shift. I rotated this shift with two other pharmacists. I was hired on as a Clinical Staff Pharmacist. I worked two days a week in out-patient pharmacy and three days a week in the out-patient clinic. When I was hired I was told the intention was to hire me as a full time clinical pharmacist, however that is not the position that had open and they would be back filling a staffing position. I then became 60% clinical and 40% staffing. When I was hired I was told my tour of duty would be a temporary shift and the least senior and last person hired would have to work the 9-5:30pm shift. Beginning of June and July two new staff pharmacist were hired. This shift started to interfere with my clinic time as my colleagues in the clinic would start at 8am and I would then be an hour behind on my work and I was putting in overtime to catch up. I set up a meeting with Dr. Jaeger and asked what the possibilities would be if I could be taken off the shift since the two new pharmacists were going to be starting and I was told it was a temporary shift. Dr. Jaeger responded, I don't know I will have to look into it since this shift was made before I got here. I then told Dr. Jaeger and Dr. Narus that I would volunteer to stay on this shift until the two new pharmacists were trained. I also told this to the Inpatient Clinical Staff Pharmacist, Dr. Heather Ashmus that was making out the new schedule. A few days later I received a call from Dr. Jaeger and he said, "Effective immediately you are no longer on the 9-5:30pm shift." I then again told Dr. Jaeger and Dr. Narus that I would be willing to work the shift until the two new pharmacists were trained. Dr. Narus said, "Forget it; it is too much of a hassle."

Dr. Ashmus was then sent an email telling her, she was to pick up most of my shifts. No one volunteered to take the shifts like the report of contact stated, and I never refused to work the shift. Dr. Jaeger then told Dr. Ashmus that this was an unapproved shift and it never went through the union so if I wanted to I could cause a problem and that someone had turned him into the union in regards to unapproved shifts. (See attachment N3).

I never filed a grievance or even discussed the matter with the union in regards to this shift.

L) Beginning of June I was contacted by Drug Enforcement Administration; DEA investigator Thomas Hill and asked to comply with his investigation regarding Dr. Houlihan. I agreed to meet with Mr. Hill (414-839-5682) and did so on June 19th, 2009. I met with Mr. Hill and my parents at my apartment in Tomah for about 2 hours. I gave Mr. Hill examples of about 10 of Dr. Houlihan's patients and the unsafe narcotic prescriptions he was prescribing. The examples included the unsafe doses, duration, and quantities of these narcotics which are listed in this report, in addition to examples I was not specifically involved with. We also discussed the 3 unexplained suicides at the VA over the last couple of months. All of which were Dr. Houlihan's patients. I gave Mr. Hill the names of another pharmacist and private physician who wished to help in Mr. Hill's investigation. Mr. Hill informed me the Attorney General would likely be speaking with me. He said he would be asking for an immediate suspension of Dr. Houlihan's DEA License. I was advised not to fill anything I did not feel was safe for the patient or anything that was outside of the normal scope. Mr. Hill informed me he would be in contact.

M) June 8th, 2009 I received a prescription from Dr. Houlihan for the narcotic Dextromethamphetamine Sustained Release 30mg three times daily. This is usually a once daily medication. It could at times be a twice daily medication if it wasn't lasting long enough, however it should not be used three times a day. The short acting medication is used three times daily instead. Like the Methylphenidate prescription the max dose was 60mg/day. It has very similar pharmacokinetic properties. I again felt uncomfortable with the dosage and the duration. I initially filled the prescription because I was so sick of fighting. By the time the prescription got to the front of pharmacy I felt so guilty and afraid it may harm the patient. I took the prescription back and discontinued the computer order because my name was on the prescription. I kept the hard copy intact. I brought the prescription to the attention of Dr. Savage-Chambers for advice. She agreed the prescription was not appropriate. At this time I went back to the pharmacy to speak with the patient. The patient said he was taking the medication because he could not focus. This patient had a diagnosis of schizophrenia and that was the indication listed in his medical record. This medication is cautioned in such patients especially at high doses. It can cause hallucinations and mania and the studied dose was listed as 10mg daily per multiple drug references. The patient presented with both of these symptoms. The patient had enough medication to last until the 11th so I told the patient I did not feel comfortable dispensing this medication and there was a question in regards to the safety of his dose. I wanted to look into more research before making a decision. The patient was in agreement with this plan, however his wife got very upset and called Dr. Houlihan's nurse Susan Schmitt. In the mean time, Dr. Savage-Chambers had sent an email to Dr. Jaeger asking if the medication could be reviewed by Dr. Picca who is the head of Pharmacy and Therapeutics Committee as Dr. Houlihan was out of the office. In the mean time Dr. Houlihan's nurse called me and told me I was to fill that prescription and that Dr. Houlihan was not available for consultation. I told her I was aware, and the prescription was going to be reviewed by Dr. Picca. She said, "Dr. Houlihan would not be happy about this and you should just fill the medication as the patient has been on this dose before." I explained to her again, I was not going to fill the medication until I could look into the toxicology further to make sure it was safe for the patient.

I asked Dr. Narus if she would fill the prescription, she declined. She agreed it should go to Dr. Picca for review.

The next day I started looking into the toxicology information and more in depth in the patient's medical record. I observed a note scanned into this patient's chart from an outside physician. This physician claimed to be following this patient for his chronic pain. The outside physician was prescribing long acting narcotic Oxycontin **twice** daily for the patient. The patient had a recent drug test and he tested positive for methadone, another long acting pain medication. This patient claimed that he was on methadone a long time ago. The patient never received methadone from any VA. The medication is very long acting, however it should not show up in a urine drug test after about 3-9 days after discontinuation depending on length of therapy and varying references. (See attachment M). The patient also claimed he was taking his amphetamine "prn" (i.e. as needed) The provider asked the patient to come back and do another drug test. The patient did not have one done, so the outside provider was discontinuing his Oxycontin.

Dr. Houlihan wrote Oxycontin for this patient **three** times daily. I started to look at the refill dates listed in the letter scanned from the outside provider and the dates the patient was getting Oxycontin from the VA. The refill dates were only a week or two apart for a 30 day supply. The patient was again in violation of his pain contract and this allowed me to believe the patient was diverting the narcotics and taking other narcotic prescriptions illegally. In addition, a while back this same patient left his cell phone in pharmacy by accident. The Staff Pharmacist, Dave Dettle, RPh picked up the phone and on the other end a man was trying to buy medication from this patient's phone.

I printed this information and highlighted it and gave it to Dr. Jaeger who decided to still fill the prescription as is per Dr. Picca's request on June 12th. When I gave the information to Dr. Jaeger, he just looked at me and said, "Whatever!"

N) June 16th, 2009 at 4:10pm Dr. Jaeger took me in his office and said, "You are going to be fired as of 4:30pm today. They were going to fire you on Friday June 19th, but for some reason they are going to fire you today instead." He proceeded to tell me he thought that I was a wonderful pharmacist and I was just too progressive for this place. I was going to make a great clinical pharmacist for some other facility. He stated, "I will write you a letter of recommendation and I will stand up for you. I will defend you." He proceeded to give me his cell phone number and his personal email. Dr. Jaeger then told me, "If you let them fire you than you will be deemed unfit for federal employment and I don't want to see that happen so I hope you will resign. You have to make a decision by 4:30pm today." I asked, "Why am I being fired." Dr. Jaeger told me there were some reports of contact. I asked, "From whom?" He stated, "I was one of them. I didn't mean it, and I tried to take it back, but it was too late. I wanted to take the report of contact back, but it was taken off of the Interim Service Line Manager Susan Robinson's desk." He then proceeded to explain that neither Susan Robinson nor he knew that I was going to be fired. Dr. Jaeger stated, "I thought there was going to be a performance improvement plan made." Dr. Jaeger then stated, "Please don't let them fire you." Dr. Jaeger then asked if I wanted him to write my letter of resignation. I agreed, and he wrote my letter of resignation on his computer. He replaced his information on a pre-written letter of resignation with my information, he then stated, "I'm resigning as of June 26th. I am not going to put up with this. What happened to you was wrong. I don't want to work for an organization like this. I am done with the Federal Government forever." I then went to Susan Robinson's office to hand in my resignation and she told me I needed to go to Dave Dechant's office in human resources.

I proceeded to Dave Dechant's office accompanied by Union Stewards Diane Streeter and Peggy Burke. I gave Dave Dechant my resignation form. Dave then said, "You do not have to make this decision to resign or be terminated until June 30th" I then took my resignation form back. He proceeded to give me a memo of separation (See attachment N1). I asked Dave for an explanation of why I was being terminated. He stated, I was in my probationary period and based on "performance issues" I was not going to become a permanent employee. Dave gave me copies of two reports of contact. One was from Dr. Margaret Hyde and the other was from Dr. Tom Jaeger (See attachment N2 and N3). I asked Dave how this could be done. I was never given a verbal or written warning on

anything and both of my performance evaluations were fully successful (See attachment N4). The reports of contact were not verified and were not truthful. Dave responded by saying, "It doesn't matter they didn't have to warn you because you are still in your probationary period." I later discovered my probationary period end date was July 6th 2009. At that point in time I was to return to work the next day. Peggy Burke and Diane Streeter asked for me to be given one day of authorized absence to pull myself together before returning to work.

I then proceeded to the union office where I received a call from Dave Dechant. I was then granted authorized absence until June 30th and I had to hand in my keys and badge. At this point all of my computer access was terminated. I was not given the opportunity to obtain my personal files and literature documents that I had brought with me from the previous VA I had transferred from.

Later that evening I had a 2 hour phone conversation with Dr. Jaeger. Dr. Jaeger told Dr. Ashmus, my mother MAJ Johnson, and I that he felt coerced into writing the report of contact and if he could, he would take it back. He agreed to write a retraction statement.

O) June 17th MAJ Johnson, Dr. Jaeger, Union Steward Diane Streeter and I had a meeting. Dr. Jaeger again stated he did not know who fired me. He stated, "Neither Susan Robinson or I fired you." He also stated again, "I felt coerced into writing the report of contact and if I could, I would take it back." He said, "I will be glad to write a retraction statement." Dr. Jaeger also stated at this meeting Dr. Houlihan still thinks I turned him into the Inspector General. At this time Dr. Jaeger also reported, "I think Dr. Houlihan acts like he is on a cocaine high."

P) June 17th I had a meeting with Human Resource Coordinator Dave Dechant, MAJ Johnson, and Union Steward Diane Streeter. Dave Dechant told us that I turned Dr. Houlihan into the Inspector General. I again told him I never turned Dr. Houlihan into IG. Dave Dechant said, "You were fired based on a committee decision compiled of upper management." He would not say who made up this committee or divulge who made the actual decision for termination. He did report it was not Susan Robinson who brought him the reports of contact. I also asked for the VHA directive that states a probationary employee can be fired with out any verbal or written warning. Mr. Dechant was unable to provide such a VHA directive for probationary employees. Mr. Dechant stated he contacted Milwaukee Human Resource department who was also unable to provide such documentation or any directive related to termination of a probationary employee.

Q) June 17th, Dr. Houlihan called a meeting with the two least senior pharmacists. This included Dr. Heather Ashmus and Out-Patient Staff Pharmacist Rebecca Bell. In this meeting he professionally slandered me by discussing the terms and conditions of my termination as well as the differences we incurred. He fabricated information by telling them I threw papers in his face and that he was a Board Certified Pain Specialist. He told them he was not the one who "pulled the trigger" on me. These were interesting choices for words considering Dr. Houlihan threatened about patients shooting the pharmacist

who took over pain management while in a labor management meeting with Union Steward Diane Streeter. (See attachment Q).

R) June 18th Dr. Jaeger resigned from the Tomah VA. Dr. Jaeger had Dr. Ashmus help him clean out his office prior to leaving June 17th. Per Dr. Ashmus, Dr. Jaeger stated I'm done with this place, I'm not ever coming back. I will not stand around and take the fall for Noelle's termination. On the 18th I attempted to contact Dr. Jaeger on his cell phone to ask for the retraction statement he said he would write. Dr. Jaeger did not answer or return my message. I have not contacted him since.

S) June 23rd I had a meeting with Associate Director Sandra Gregor, Human Resource Coordinator Dave Dechant, and Union Steward Kurt Hass. Sandra Gregor reported I was fired based on the reports of contact and the recommendation from Chief of Pharmacy Dr. Tom Jaeger. Dave then gave me a copy of a new report of contact that Dr. Jaeger had written. This stated he would not retract his previous report of contact. He stood by his decision that my performance was considered unsatisfactory due to refusing to fill multiple prescriptions. (See attachment S1).

I told Sandra Gregor I would like to write a report of contact on the professional slander Dr. Houlihan had made. She responded by saying, "That is your word against his and the other pharmacist." I said exactly! I was fired for reports of contact that were falsified and never verified. I was never given verbal or written warning, or the chance to defend my position. She then stated, "I stand by the decision for termination." Immediately after my termination and Dr. Jaeger's departure the pharmacist who wrote one of the reports of contact Dr. Hyde was appointed to the position of Acting Chief of Pharmacy. (See attachment S2 and S3).

Attachments:

- A) Nomination for Tomah Pain Committee Chair from Performance Improvement Tracey Lane.

- B) 1) Clinical Practice Guidelines for the use of Chronic Opioid Therapy in Chronic Non Cancer Pain. Journal of Pain, Vol 10, No 2. February, 2009: pp 113-130

2) VA/DOD Clinical Practice Guidelines for the Management of Opioid Therapy for Chronic Pain. Medication Pocket Guide. <http://www.qmo.amedd.army.mil>

3) Methadone Dosing Recommendations for Treatment of Chronic Pain. <http://www.vapbm.org>

4) Technician Toni Johnson Statement

5) Questions for Leadership from the American Federation of Government Employees; Presented to Inspector General

- C) New Schedule II Order Entry In CPRS for Out-Patient-Pharmacy

- F) 1) Iowa Board of Pharmacy Controlled Substance Law on partial filling a CII

2) Drug Enforcement Agency Diversion Control Program laws regarding what changes a pharmacist can make on a CII prescription.

- G) Standard Operating Procedure: Prescriptions Under Clarification

- H) Email from Nurse Practitioner Janice Waldstein

- M) Urine Drug Screen Practical for Clinicians. Mayo Clin Proc. 2008;83(1)66-76 www.mayoclinicproceedings.com

- N) 1) Memo of Separation

2) Report of Contact from Margaret Hyde

3) Report of Contact from Tom Jaeger

4) Noelle Johnson Performance Evaluation

- Q) Statement of Professional Slander from Heather Ashmus and Rebecca Bell

S) 1) Tom Jaeger's second Report of Contact

2) Medical Center Bulletin

3) Department of Veteran Affairs Memorandum

T) Character References (1-12) from Clinical Pharmacists, Staff Pharmacists, Pharmacy Technicians, and Providers.

U) State of Wisconsin Department of Workforce Development, Division of Unemployment Insurance