North Detroit General Hospital

3105 CARPENTER AVENUE
DETROIT, MICHIGAN 48212

TELEPHONE (313) 369-3000

September 28, 1990

Nuclear Regulatory Commission
799 Roosevelt Road
Glen Elly, Illinois 60137

ATTENTION: Mr. A. Bert Davis
Regional Administrator

RE: License No.: 21-10578-02
Docket No.: 030-12467

Dear Mr. Davis:

Enclosed please find our confirmatory action letter as you have requested. We have made arrangements for our on site visit to be held on Friday, October 5, 1990 to discuss and review the matter further with you and your staff.

If you have any questions prior to our visit concerning this report please do not hesitate to contact myself or Dr. Cola personally and we will be happy to assist you.

Sincerely,

Jerry A. Frohlich

Jerry A. Frohlich
President

JAF/bjp

Enclosure

North Detroit General Hospital

3105 CARPENTER AVENUE
DETROIT, MICHIGAN 48212

TELEPHONE: (313) 369-3000

INVESTIGATIVE REPORT

RE: ACTIVITIES AND OCCURRENCES IN THE NUCLEAR MEDICINE DEPARTMENT BETWEEN 7-19-90 AND 7-27-90

A summation of the background information and activities during and immediately after detection of the fraudulent activities of Leonard Williams is provided in the "Report of Emergency Radiation Safety Committee Meeting" dated 8/9 and 8/10/90 and, "Director of Radiology Report" dated 8/13/90 (attachments A & B).

To briefly review, Nurses, Inc.(a temporary service provider) was contracted by the hospital to provide a nuclear medicine technician to fill in on an emergency basis due to the sudden illness of our permanent and long term technician, Gloria Hasten. Expedition of our selection and orientation process was necessitated by the immediacy of our need. Leonard Williams was referred to us by the agency, and presented himself both on personal interview with our department director and by way of his resume as an experienced, competent, certified nuclear medicine technician. His reported experience and prior satisfactory performance at a noted local institution (verified by phone conversation with the department director at that institution) provided him with much credibility. After the interview and background check, the hospital agreed to accept Leonard Williams as a temporary nuclear medicine technician.

Upon his arrival for work, Mr. Williams was provided with a morning of introduction to our Nuclear Medicine Department by Mary Ann Nowak, (long term part time nuclear medicine technician). During this period, she familiarized Leonard with the department's procedures and equipment. A computer is utilized for some studies (i.e., MUGA, biliary, stress thallium), and she reviewed the computer's operation with Leonard. Some written instructions related to the computer's operation, as well as intensity settings for various studies were left with Leonard. He was also shown the location of the Procedure Manual. Mr. Williams reportedly took some notes of his own during this period. Mary Ann supervised the performance of one study with Mr. Williams during this morning (Case #205169). In addition to the written instructions, Mary Ann left Leonard with the telephone numbers of herself and Gloria Hasten, and was instructed to call one of them if he encountered difficulty of any kind. At that time, he reportedly indicated no problem or difficulty functioning in the department.

During Leonard's first day of employment, the Director of Radiology informed the RSO of Leonard Williams activities as well as his reported background, verified his references, and orientation. During the remainder of the first day, Mr. Williams was observed apparently performing his normal duties and submitted studies without voicing any difficulty or apprehension.

In a word, we feel the major contributor and explanation for such an unfortunate and likely unavoidable series of events is trust. To the various radiologists and staff, Leonard Williams conducted himself for the most part in a professional and very courteous manner during his stay. Leonard was viewed several times each day by the various radiologists including the RSO, and the Director of Radiology. He provided quick responses to queries, provided additional views when requested, and appeared to be performing normal duties.

The RSO, upon reviewing some of the studies Leonard submitted during this first day, noticed that Leonard was not completing our patient history forms (attachment C). The RSO then instructed the Director of Radiology to instruct Leonard to correct this deficiency. After being reminded to do so during his second day, Leonard Williams began submitting completed forms. This form includes information which closely duplicates the data which is normally entered in the formal dose log records found in the Nuclear Medicine Department. Completion of the formal dose log records is a normal daily function of the nuclear medicine technician in every nuclear medicine department. In view of Leonard Williams past work experience, recommendations, and outwardly dedicated manner, we assumed he was completing these records, particularly since he was providing similar data on the history sheet.

At no time during Leonard Williams employment did he report any difficulty with the equipment, work load, etc. He provided what, without suspicious and close retrospective scrutiny, appeared to be adequate studies of diagnostic quality in a timely fashion. As a reportedly certified, experienced professional, we placed our trust in Leonard, and had no concrete reason to doubt his virtue. Of course, as we all now regrettably know, nothing could have been further from the truth.

The physician of each patient studied during the time of Leonard Williams employment was notified of the unreliablity of the diagnostic reports. Notification was made both in writing and by follow up phone conversation. The department offered to repeat all studies if the patient would return, and if the patient's physician deemed it appropriate (representative letters of notification are provided in Attachment D, E and F). Also, notices (sample Attachment G) of unreliability were attached to all reports and to the patients film jackets (sample H).

All available information concerning each individual case including follow up care has been analyzed. Dose log and Syncor dose slips during this period were also reviewed. A summary of this various data is provided in table form below.

			HISTORY SHEET &/OR REQUISITION SLIP INFORMATION + = info. provided - = info. not provided									
ID#	DATE	STUDY	HISTORY SHEET	DOSE mCi	ISOTOPE	TIME OF INJECT	TECH INITIAL	FRAUD **	MATCH ***	NAME APPEARS ON DOSE SLIP	PTS' EXAM Y/N	DOCTOR REQUESTS TO BE REDONE DATE
2046	7/19	V/Q	-	req 10.6 req 5.1	Xe TcMaa	-	req. +	A		+	N	
90948	7/19	Hida	-	on film 5.1	-	-	-	VS			N	
9159	7/19	Tc Thyroid	-	req. 23.8	-	-	req +	I			N	
795	7/19	Bone	-	req. 26.1	TcMDP		req. +	C	+		Y	8/28
0341	7/20	V/Q	-	-	-	-	-	V - C Q - I			N	
7437 *	7/20	Bone	-	-	-	-	-	C			Y	8/29
7545	7/20	St TL	+	2.9	-	+	+	C			Y	8/31
8818	7/20	Muga	+	20	Tc	+	+	C			N	
5999 *	7/20	Muga	+	20	-	+	+	C	+		N	
5999 *	7/23	V/Q	+	10 4.5	Xe TcMaa	+	+	C			N	
0252	7/23	Muga	+	on film 21.5	Tc + PYP	-	-	C		+	N	
1155	7/23	Bone	+	20	TcMDP	+	-	C		+	N	
1069	7/23	Q only	+	4.5	TcMAA	+	+	C			N	
7268 *	7/23	Liver	+	5.4	TcSC	+	+	C			N	
3552	7/23	Muga	+	17.9	Tc + PYP	+	+	C	+		N	
0471	7/23	St TL	-	req. 3,0	-	-	-	C			Y	Sched.for 10/8
9719	7/24	Bone	+	20	TcMDP	+	+	C	+		N	
5621 *	7/24	Bone	+	20	TcMDP	+	+	I			N	
1025	7/24	Muga	+	20	Tc + PYP	+	+	C			Pt. refuses	

* = Pt had more than one study

** = On review of films, fraud is:

*** Match with old study of another patient

			HISTORY SHEET &/OR REQUISITION SLIP INFORMATION									
ID#	DATE	STUDY	HISTORY SHEET	DOSE mCi	ISOTOPE	TIME OF INJECT	TECH INITIAL	FRAUD[1]	MATCH[1,3]	NAME APPEARS ON DOSE SLIP	I.S' EXAM Y/N	DOCTOR REQUESTS TO BE REDONE DATE
)7331	7/25	Liver	+	4.9	TcSC	+	+	C	+	+	Y	9/10
)5053	7/25	Bone	+	20	TcMDP	+	+	C			Y	8/21
1145 *	7/25	Muga	+	20	Tc + PYP	+	+	C		+[1]	Y	8/28
1175	7/25	Hida	+	5.5	Tc Choletec	+	+	C	+		N	
)0072	7/25	St TL	+	2.5	TL	+	+	C		.[2]	Y	8/20
1171 *	7/25	Bone	+	20	TcMDP	+	+	C			N	
6884	7/26	Muga	+	21.2	Tc + PYP	+	+	C	+	+	Y	8/15
1162	7/26	Bone	+	25.1	TcMDP	+	+	C	+		N	
5621 *	7/26	Bone	-	req. 19.4	TcMDP	-	-	C	+	+	N	
)0442	7/26	Muga	+	20	Tc + PYP	+	+	C			Y	8/24
1840 *	7/26	Muga	+	20	Tc + PYP	+	+	C	+	+	N	
7268 *	7/26	Muga	+	12.1	Tc + PYP	+	+	C	+	+	Dr. unable to contact pt.	
9369	7/26	Hida	+	6	Tc Choletec	+	+	I		+	N	
1171 *	7/27	V/Q	+	6.4 4.4	Xe TcMaa	+	+	C		+ Tc	N	
9321	7/27	St TL	+	3	TL	+	+	C		+[3]	N	
1145 *	7/27	St TL	+	3	TL	+	+	C	+	+[3]	Y	8/28
1840 *	7/27	V/Q	+	7.5 5.3	Xe TcMAA	+	+	C			Y	8/16
7437	7/27	Q only	+	4.4	TcMAA	+	+	VS			N	
)5169	7/27	Muga	+	17.6	Tc + PYP	+	+	C			Recovered from comp. disk	

& 3 Two copies of the same dose slip each with a different name.

2 Pt. name on Tc MDP slip. Mr. Williams states was clerical error. Appropriate dose and isotope are indicated on history sheet.

The information provided on the history sheets and/or the requisition slip in all cases where this information is available, states the appropriate radiopharmaceutical and dosage for the examination ordered. In one case, 190072, the information on the history sheets is appropriate for the Stress Thallium study ordered, however, the patient's name appears on a Syncor dose Tc labeled MDP, rather than thallium. NRC inspectors have reported to us that Leonard states the name on the Syncor slip is a clerical error. He states that he administered the appropriate isotope and dose as stated on the history sheet. While the dose log records during this period are substantially incomplete and many are completely missing, the Syncor slips having names, otherwise appear appropriate for the study ordered.

The films that Mr. Williams submitted for patient #205167 interpretation were fraudulent. However, we were able to retrieve diagnostic data from a computer floppy disc. The recovered image indicates the appropriate radiopharmaceutical was administered, and the image was interpreted. The results were immediately forwarded to the requesting physician.

On case #190072, images were present on a floppy disc labeled as this patient which were not of diagnostic quality, and no conclusion is possible.

Patient #231840 reports no recollection of a mask being applied for Xenon ventilation scan. This suggests the study was not performed and no dose was administered in this case.

Patient #202046 was performed under the supervision of Mary Ann Nowak and appears to be accurate.

A few studies are indeterminate for fraudulent activity. These studies are Perfusion scan 240341, Bone scan 185621, Biliary scan 239369, and Thyroid scan 239159. On these studies, the images are consistent with appropriate radiopharmaceutical administration for the study ordered, however, it is impossible to be certain that the images belong to the patient stated. All other studies performed during this period appear to be fraudulent.

Syncor dose slips during this period were also evaluated. An analysis of the slips indicates several more doses were ordered during this period than were utilized. This is easily explained, as orders were placed at the end of each day for the following days expected needs based on out-patients scheduled and appointment book and In-patient exam request slips for the

following day. The orders seemed to correspond fairly closely with the records of our expected need. However, for various reasons, some of the studies scheduled were not performed or were rescheduled (ie: due to poor patient condition, other diagnostic studies taking precedence, out-patients not showing up, etc.) It does appear that for each day, doses were available to provide the proper patient with the prescribed radiopharmaceutical and dose.

We have no way of knowing whether each patient did or did not receieve a radiopharmaceutical injection. However, if administration did take place, information currently available, suggests appropriate radiopharmaceutical and dose was given. To date, we have no information to indicate misadministration.

An individual who is sufficiently intent upon and devious enough to perpetrate a fraudulent act can be extremely difficult to detect and stop, even with diligent screening and monitoring procedures. It it our intent, however, through enhancements and/or additions to our policies and procedures to minimize the risk and hopefully prevent and/or speed the detection of any similar reoccurrence. Our comprehensive program includes procedures which will be followed governing hiring, orientation and long term supervision of individuals who use and administer radioactive material including both permanent and temporary employees.

Our program is as follows:

A. Guidelines for selection of new employees (either permanent or temporary)

1. Perspective employee to provide resume including curriculum vitae, previous employers including address, at least 3 references including addresses and proof of certification by N.M.T.C.B.

2. Director of Radiology to verify directly by phone and/or writing:
   a. N.M.T.C.B. certification
   b. References (at least 2)
   c. Previous employers (speak directly with supervisor and/or RSO), and make detailed inquiry as to candidates previous duties, responsibilities, work ethics, competency level and patient care skills.

3. Personal interview with director of Radiology and one of the Radiologists (preferrably RSO). Include review of above date, and detailed discussion of candidates prior duties, responsibilities, knowledge of Nuclear Safety procedures and regulations.

B. Orientation Program

1. Tour of entire Department of Radiology and introduction to the Radiology Department personnel including radiologist, technical, and clerical staff. Familiarize with phone and intercom system including emergency procedures for patient arrest, fire, etc.

2. Orientation to the Nuclear Medicine Department and procedures with documentation of completion via check sheet and signatures of employee, director of Radiology, and RSO. Check sheet to include:

   a. Familiarity and competency to operate required equipment (dose calibrator, survey meters,cameras , computers, etc.)

   b. Location and knowledge of procedure manual,license, emergency procedures, safety procedures, emergency phone numbers.

   c. Procedures for ordering, receiving and disposing of radiopharmaceuticals.

   d. Location, knowledge and completion of dose log, wipe and survey records, quality assurance records.

3. Two day close direct supervision of new employee by Director of Radiology and RSO to include:

   a. Watching performance of at least two entire procedures from dose calibration through logging the dose, kit preparation, administration scanning, imaging and film development.
   b. Multiple random inspections during the day by Director or Radiology and RSO. Check for proper completion of dose log.
   c. Review all necessary documentation for completeness at beginning and end of each day.
   d. Make inquiry regarding employees comfort with equipment, work load, etc. and if there are any questions or concerns on the employees part.

C. Continuing Supervision of Individuals who use and administer Radioactive Materials.

1. During first week, all required documentation will be checked daily for completeness,then at longer but frequent intervals.Complete review of this information will take place at least quarterly.

2. Emphasis will be placed on frequent active supervision and inspection of department activities by the RSO for purpose of insuring continued compliance with radiation safety procedures, completeness of documentation, quality of studies and patient care.

3. Continuing Education.

   a. Emphasis will be placed on increasing length and educational content of quarterly radiation safety committee meetings to include review of :

      i) Hospital Nuclear License and its various conditions and committments.
      ii) Review of Radiation Safety Procedures.
      iii) NRC rules and regulations particularly any recent revisions or additions.
      iv) Interesting journal articles, literature, NRC Newsletter (NMSS).

4. Technicians and Radiologist will be encouraged to pursue self study (ie: journals, videos, seminars, etc).

5. Basic education of other (non nuclear), department and hospital personnel coming into contact with nuclear medicine department. Any employee noticing behavior not complying with safety regulations (such as eating, smoking or drinking in the Nuclear Medicine Department) unusual or abnormal behavior is to report such to the Director of Radiology and/or the RSO. Such a finding will be immediately brought before the Radiation Safety Committee and appropriate corrective action taken.

It is our sincere desire to have a quality safe Nuclear Medicine Department which complies with Nuclear Regulatory Commission regulations. We are committed to achieve this end.

Respectfully submitted,

J. David Cole, MD

J.David Cole, M.D., R.S.O.

North Detroit General Hospital

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TELEPHONE: (313) 369-3000

ATTACHMENT A

REPORT OF EMERGENCY RADIATION SAFETY COMMITTEE MEETING AND SUBSEQUENT IMMEDIATE ACTIONS

August 9 & 10, 1990

In attendance: David Cole, M.D. (RSO), Raymond Sneider,D.O.(Dept. Chairman), Richard Varterasian, (rep. admin.- Dir. of Radiology), Gloria Hasten (Nuc. Med. Tech)

RE: Validity of Nuclear Medicine studies during the employment of Leonard Williams, temporary Nuclear Medicine Tech. July 19-July 27, 1990.

Meeting was convened following discovery of strong evidence that some of the exams during the above period may have been tampered with or otherwise invalid. The suspcious findings consisted of mismatched dates on films (labeled and handwritten vs. computer digital display) as well as unusual markings suggestive of tampering (faint underlying and overwritten letters and numbers). The evidence was reviewed and discussed by the parties in attendance, and was concluded to be highly suggestive of fraudulent activity on the part of Leonard Williams.

The committee members recommended rapid thorough investigation. Major concerns of the committee and goals of the investigation were to: 1) confirm and determine the extent of any fraudulent activity, 2) determine the validity and/or reliability of the diagnostic studies and their reports, 3) evaluate radiopharmaceutical usage and appropriateness during the period in question, 4)assess the impact on patient care, 5) notify as soon as possible the ordering physician of the patients for whom accurate diagnosis is in doubt, 6/ notify top level hospital administration, dept, physicist, and any governmental and/or regulatory agency requiring such information.

All nuclear medicine cases performed during the period of L. Williams employment (7/19 - 7/27/90) were assembled and reviewed by various committee members during the remainder of the day of 8/9/90 and morning of 8/10/90. After review, it was concluded that fraudulent nuclear diagnostic exams were submitted by L. Williams, and the results of these exams were not reliable for diagnostic purposes. A list of all questionable exams including patient name, study type, and physicians name, was compiled.

The following immediate actions were recommended and instituted by the committee members: 1) notify Jerry Frohlich, Pres. N.D.G.H., of committee findings, 2) inform patient physicians that the exams are not reliable for diagnosis, and the patient should return for accurate study if clinically warranted, 3) inform Dept. Physicist and NRC as soon as possible.

The complete evaluation of this matter continues to be of great concern and is ongoing.

Respectfully submitted,

J. David Cole, M.D.
Radiologist -RSO

JDC/mlk

August 13, 1990

ATTACHMENT B

SUBJECT OF REPORT: Leonard Williams
Temporary Nuclear Medicine technologist, employed from Thursday July 19, 1990 through Friday July 27, 1990.

During the period of time from Thursday July 19, 1990 through Friday July 27, 1990, the Department of Radiology at North Detroit General Hospital contracted for Leonard Williams who is a certified nuclear medicine technologist to perform the nuclear studies within the department. Leonard was an agency technologist from Nurses Incorporated.

Prior to Leonard Williams startup date, I contacted the Department of Radiology Director at Hutzel Hospital where Leonard Williams had previously been employed and received very positive reference from a Mr. George Samm.

During the period of time when Mr. Williams worked within the Department of Radiology, he functioned in an independent role as the sole nuclear medicine technologist. During the 7 day period in which he worked, I personally walked over the nuclear medicine suite on several occasions each day to check on Leonard. During each visit, Leonard informed me that things were under control and running smoothly.

Mr. Williams completed his assignment on Friday July 27, 1990 as our full-time nuclear medicine technologist was to return to work the following Monday. During the week of August 6, 1990, it was discovered that a few of the cases that Mr. Williams had performed looked suspicious with evidence of tampering. A full scale audit was performed with every examination that Leonard was to have performed being pulled and inspected by myself, the chief radiologist, Dr. Ray Sneider and the Radiation Safety Officer, Dr. David Cole.

During our investigation, it was learned conclusively that Leonard Williams had doctored and provided fraudulent nuclear medicine studies for interpretation. Mr. Williams had submitted nuclear medicine studies on patients who had previously been imaged within the Department during the past 2 years and altered the names on those images and placed the names of the patients he was to have performed studies on in their place.

Conclusive proof of his doctoring and fraudulent activity was made by examining computer printed dates on several of the studies that do not coincide with the dates the studies were to have been performed.

During the 7 day period in which Leonard Williams was employed, he performed 30 nuclear medicine examinations. Following our investigation, on Friday August 10, 1990 the Department of Radiology contacted the physicians who had ordered the studies that Mr. Williams was to have performed and informed them that the reports that were submitted may not be correct. The physicians were informed that due to technical difficulties, the accuracy of the studies was in question and that the Department of Radiology would, at no additional cost to the patient, repeat the studies if the doctor who ordered the study deemed it appropriate.

As of today, Monday August 13, 1990, 7 studies have been requested to be repeated.

On Friday August 10, 1990 I personally contacted the Administrator at Nurses Incorporated, Gail Brewer, and informed her of the fraudulent activity that her employee, Mr. Leonard Williams, had performed within our Department. I strongly recommended that she contact the institutions where Mr. Williams had previously been employed to warn them of possible fraudulent activity. Ms. Brewer assured me that their agency, Nurses Incorporated, performs extensive background checks on the people that they employ and she seemed very, very surprised and concerned about this activity. Ms. Brewer indicated that she would be in immediate contact with her corporate office out of the state of Michigan and inform them of what had happened. Our conversation ended with me indicating that her agency would be hearing from our institution in the near future.

The following patients were to have nuclear medicine studies performed by Leonard Smith during the period of time he worked within the department:

IN-PATIENTS:

1. ı ICU-6, Hosp. #288231-4, date of service

2. Rm 532-2, Hosp.# 288190, date of service

3. 437-2, Hosp.# 288212-4, dates of service

4. -844566-0, date of service 7-25-90.

5. , Rm 556-2, Hosp# 288173-8, date of

6. 307-1, Hosp# 287967-4, date of service

7. Rm 555-1, Hosp# 288168-3, date of service
8. Rm 536-1, Hosp# 288238-9, date of service
9. 457-2, Hosp# 288109-2, date of service
10. Rm 538-2, Hosp# 288167-0, date of service
11. ski, Rm ICU-9, Hosp# 288221-5, date of
12. J-8, hosp# 288243, date of service 7-27-90.
13. osp# I-844569-4, date of service 7-27-90.
14. m 554-1, hosp# 28. 7-2, date of service
15. p# 288164-7, date of service 7-23-90.

The following were out-patients that Leonard Williams was to perform nuclear medicine tests on:

1. opd# O-844721-1, date of service 7-25-90.
2. opd# 0-844766-6, date of service 7-26-90.
3. s, opd# 0-900185-0, date of service 7-24-90.
4. # 0-900203-1, date of service 7-27-90.
5. 0-844608-0, date of service 7-23-90.
6. pd# 0-900182-7, date of service 7-23-90.
7. 900166, date of service 7-20-90.
8. pd# 0-900154-6, date of service 7-19-90.
9. 0-900197-5, date of service 7-26-90.
10. -844712-0, date of service 7-25-90.
11. # 0-900192-6, date of service 7-25-90.
12.

Additional evidence is available which supports the fraudulent activities that Mr. Leonard Williams has performed within the Department of Radiology. It is the position of the Department of Radiology that Mr. Leonard Williams is fully guilty of improper and fraudulent behavior and activity, and has placed at risk the health and welfare of the patients whom he was to have performed studies on during his employment.

Respectfully submitted,

Richard A. Varterasian

Richard A. Varterasian
Director of Radiology
August 13, 1990

ATTACHMENT C

DATE

NAME

AGE

WEIGHT

ENV. #

DOCTOR

TYPE OF SCAN

REASON FOR SCAN

RADIOACTIVE MATERIAL

DOSE

TIME OF INJECTION

TECHNOLOGIST

CAMERA SCOPE INTENSITY

TIME EXAM COMPLETED

COMMENTS

North Detroit General Hospital

3105 CARPENTER AVENUE
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TELEPHONE: (313) 369-3000

ATTACHMENT D

8/20/90

Dr.
3120 Carpenter
Suite 207
Hamtramck, MI. 48212

Dear Doctor,

The Department of Radiology recently spoke with you concerning several of your patients who had undergone nuclear medicine testing.

The department since the time of exam completion on each has learned that the results of each test are inaccurate and would like to reschedule the testing at no cost to your patients.

Your response was that you together with Dr. Ray Sneider would review each of the cases in question and determine whether or not you'd like the department to have them repeated.

The specific patients involved are as follows:

1. - bone scan 7/24/90
2. - stress thallium 7/27/90
3. - muga 7/23/90
4. - muga 7/20/90
5. - thyroid 7/19/90
6. - biliary 7/26/90
7. - biliary 7/25/90
8. - biliary

The Department of Radiology shall wait to hear from your office before rescheduling any of the above listed patients.

Sincerely,

Richard A. Varterasian

Richard A. Varterasian
Director Radiology

North Detroit General Hospital

TELEPHONE: (313) 369-3000

3105 CARPENTER AVENUE
DETROIT, MICHIGAN 48212

ATTACHMENT E

August 15, 1990

Dr.
9801 Conant
Hamtramck, MI 48212

Dear Dr. [redacted],

The Department of Radiology recently contacted you concerning one of your patients, [redacted], who had a MUGA examination performed on July 23, 1990. The Department informed you that we have recently learned that the results of that MUGA examination are questionable and that if you deemed it appropriate, we would be happy to repeat this study.

It was your decision, Dr. [redacted], to not have the study repeated, should you feel it appropriate in the near future to have the study repeated, the Department of Radiology shall be glad to in a timely and efficient manner do so.

Sincerely,

Richard A. Vartanian
Director of Radiology

RAV/mak

North Detroit General Hospital
TELEPHONE: (313) 369-3000
3105 CARPENTER AVENUE
DETROIT, MICHIGAN 48212

ATTACHMENT F

August 15, 1990

Dr.
11470 Joseph Campau
Hamtramck, MI 48212

Dear Dr.

On Tuesday, August 14, 1990, I contacted you concerning three of your patients, , and , who had had nuclear medicine examinations performed in our department. It was mentioned to you, Dr. , that the results of those three examinations we have determined to be in question due to technical difficulties which occurred during their completion, and should you deem it appropriate we would be happy to repeat those studies at no cost to the patients.

It was your decision to have all three studies repeated. Therefore the Department of Radiology shall contact those three patients and arrange for repeat study.

The Department shall of course provide to your office complete written report in a timely and efficient manner following the completion of the studies.

Sincerely,

Richard A. Varterasian
Director of Radiology

RAV/mak

North Detroit General Hospital

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DETROIT, MICHIGAN 48212

TELEPHONE: (313) 369-3000

ATTACHMENT G

8/10/90

The results and dictated report of this Nuclear Medicine procedure have been determined to be inaccurate.

Do not use the information contained within this typewritten report for purposes pertaining to the continuance of patient care.

The examination carried out in this report shall be scheduled for repeat during August 1990 and September 1990. Please refer to the results contained within the repeated test report.

ATTACHMENT H

DAY YEAR

I II III IV V

NORTH DETROI

OF

DETROIT,

REPORTS

VIATION

EMARKS

DIAGNOSIS

Results of Reports of 7-24-90
MUGA SCAN INACCURATE

DATE OUT