WASHINGTON PRIMARY CARE PHYSICIANS

Peter Basch, M.D.
Laurie Brien Bond, FNP
Deborah Edge, M.D.
Yasmin Panahy, M.D.
Daniel H. Waterman, M.D., F.A.C.P.

666 Pennsylvania Ave., SE Suite 100
Washington, D.C. 20003
(202) 546-4504 Fax: (202) 544-6136

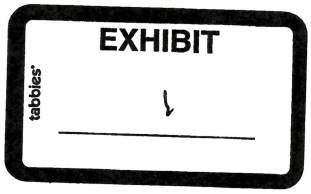
June 9, 2000

To Whom It May Concern:

I have written this medical evaluation of Leonard Peltier, at the request of his attorneys, in preparation for his parole hearing on June 12, 2000. I have never met Mr. Peltier, nor have I examined him. I have read the medical records sent to Mr. Peltier's attorneys, which are supposed to be his complete medical records for the past three years.

I was born in Hartford, Connecticut and am a citizen of the United States of America. I reside in Washington, D.C. I am a general internist licensed to practice medicine in the District of Columbia and the State of Maryland. I have been licensed to practice medicine since 1980, and have been on the clinical faculty of the George Washington University School of Medicine since 1981.

I received my undergraduate training at Trinity College (Hartford, Connecticut), graduating with a B.A. in psychology in 1974. I received my M.D. from the George Washington University School of Medicine in 1978. My post-graduate residency training took place at the George Washington University Hospital. Academic honors include Phi Beta Kappa (1974) and Alpha Omega Alpha (1978). My current faculty appointment is as an Assistant Clinical Professor of Medicine and Health Care Sciences at the George Washington University. In addition to a full time private practice of medicine, I regularly teach medical students. I have provided expert medical testimony previously in United States District Court and the Superior Court of the District of Columbia in matters regarding personal injury and physical abuse. I am also a volunteer physician examiner with Physicians for Human Rights, a non-profit organization based in Boston, Massachusetts, and three organizations based in Washington, DC; Ayuda, The Jacob Burns Community Legal Clinic of the George Washington University Law School, and The Center for Applied Legal Studies of the Georgetown University Law School.



My review of Mr. Peltier's records reveals that he has the following chronic medical conditions:

Hypertension
Obesity
Hyperlipidemia
Diabetes mellitus (non-insulin dependent)
Central retinal venous occlusion of the left eye
Stroke
+PPD/with normal chest x-ray
Bilateral TMJ ankylosis (status post multiple surgeries)

There is an episode of herpes zoster (shingles) in September of 1998. There is also an episode of a possible kidney stone in February of 2000.

Hypertension, or high blood pressure, is a chronic disorder, which untreated, or inadequately treated, can lead to stroke, heart disease, and kidney failure.
Obesity is a medical term used to describe someone more than 20-30% above their ideal weight. Obesity is associated with hypertension, diabetes, hyperlipidemia, and arthritis.
Hyperlipidemia, or high cholesterol, is a chronic disorder, which untreated, or inadequately treated, can lead to stroke and heart disease.
Diabetes mellitus is also a chronic lifelong disorder, and if untreated, or inadequately treated, can lead to stroke, heart disease, kidney disease, blindness, kidney failure, and nerve damage.
Central retinal vein occlusion can occur from a variety of factors, both local and systemic. It leads to sudden visual loss. It is strongly associated with diabetes, hypertension, and hyperlipidemia.
Stroke is a term which refers to a sudden and permanent central nervous system defect, caused either by hemorrhage or vascular occlusion.
+PPD, refers to a positive tuberculosis skin test. A negative chest x-ray, rules out active pulmonary tuberculosis, and treatment with isoniazid for 6 months, is adequate for chemoprophylaxis against the development of future "reactivation" tuberculosis.

Mr. Peltier has had multiple surgeries for his jaw, and my understanding is that since his last surgery, he is finally doing well

Assuming that I have been sent a complete set of medical records on Mr. Peltier for the past three years, my review reveals that certain of his health problems have been treated appropriately, and that several have not. There are enough serious deficiencies, in particular with his diabetic management, that provide cause for concern for Mr. Peltier's current and future health.

1. Mr. Peltier was diagnosed in September of 1998 as having herpes zoster. He was treated with acyclovir 200mg three times a day for 10 days. This dosage of acyclovir is used for prevention of recurrent herpes simplex, and is inadequate for the proper treatment of herpes zoster. The correct dosage is 800mg five times a day for ten days.
2. Mr. Peltier was diagnosed with a possible kidney stone in February of 2000. There is no

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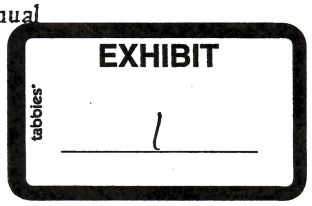
record of follow-up of this one incident, nor is there record of a work-up to see if there were multiple stones remaining in the urinary tract. Appropriate management (particularly in a diabetic) should have included a sonogram or IVP x-ray. As I only have limited records, I don't know if Mr. Peltier has had previous kidney stones. If so, then he should have additionally have had filtering of his urine to try to catch and then analyze the stone, with appropriate measure to prevent recurrent stones in the future.

3. It appears that after multiple surgeries, and in particular his most recent surgery at the Mayo Clinic, that his jaws condition is finally appropriately treated.
4. Mr. Peltier has had appropriate diagnosis, treatment, and follow-up for his +PPD (the skin test for tuberculosis)
5. Mr. Peltier's records contain several instances where diet and weight loss have been discussed, and it appears that attempts have been made to get him to lose weight.
6. Mr. Peltier has evidence of good treatment of his hyperlipidemia, with an excellent medication, and regular follow-up care.
7. Mr. Peltier has evidence of fair treatment of his hypertension, with an excellent choice of medication, but with multiple moderate to severe readings mentioned in his records, without note thereafter of change or increase in medication, to attempt to bring high readings under better control. Appropriate treatment of high blood pressure should include an assessment and plan, or change or increase in medication, in response to multiple elevated readings.
8. Mr. Peltier's records for the past three years show only one retinal examination. There is no notation in his record of the etiology of the central retinal venous occlusion, nor is there mention of any work-up being done to rule out treatable risk factors. Proper care dictates that a retinal exam be done at least annually.
9. There is sporadic mention of the term "stroke" in the record, but no detail. There is also no notation of a complete neurologic exam to document what if any neurologic deficits Mr. Peltier might have. I do note that he is on a daily dose of aspirin, which is often used for future stroke prevention.
10. Mr. Peltier's records intermittently mention diabetes. Several notations mention that it was diagnosed in 1986, and that he has the non-insulin dependent type, which is well controlled by diet. Mr. Peltier's records show spotty management, and a lack of following even the advise provided by his physicians at the prison. Proper care of a diabetic includes an annual foot exam, dilated retinal exam, endocrinologist or diabetologist evaluation, as well as monitoring the urine for microalbumin annually, and regular determinations of blood sugar and kidney functions. Mr Peltier's records indicate one visit in the past three years for diabetic education, and one visit for diet education. There is no record of a endocrinologist/ diabetologist evaluation. As mentioned in #8 above, his records show only one retinal exam (8/7/97), and not annual exams. His records state that the Bureau of Prisons recommends HgbA1C blood tests every six months, as well as regular diabetic care. He was also recommended on 4/11/97 to have fingerstick blood sugars done twice a week. These are not being done.

I am most concerned about his diabetic care, and the fact that it does not seem to follow standard accepted diabetic protocols, nor does it seem to follow the Bureau of Prison guidelines as presented to Mr. Peltier. Mr. Peltier unfortunately now has several potential causes of visual problems (including blindness), as well as kidney failure. Proper diabetic care, including annual diabetic diet and general instructional counseling, regular podiatric, endocrinologic, and



ophthalmologic consultation, as well as regular monitoring of blood sugars, kidney functions, urinalysis for microalbumin, and HgbA1C. Suboptimal care, and in particular suboptimal care combined with spotty blood pressure control, can lead to serious complications, including: recurrent central retinal vein occlusion, stroke, heart disease, and kidney failure.

In conclusion, from my review of Mr. Peltier's most recent three years of prison medical records, it is my opinion that his care for two acute medical problems, and two of his chronic medical conditions, was below a reasonable standard of care, and thus may predispose him to an unnecessary risk of serious and or life-threatening complications.

Sincerely,

Peter Basch, M.D.

Addendum to the Medical Records Review of Leonard Peltier

October 15, 2015

To Whom It May Concern:

Please accept this addendum to my initial report on Leonard Peltier, dated June 9, 2000. I was recently contacted by his attorney to update my review and opinion of his medical care and medication condition, based on receipt of new records.

As stated in my original report, I have never met Mr. Peltier, nor have I examined him. I did review his medical records, as stated in my initial report dated June 9, 2000; and I additionally reviewed updated records, forwarded to me for review, by his attorneys.

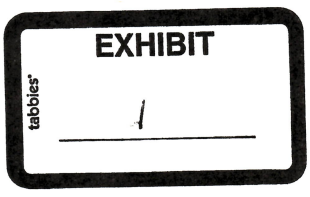
As an update to my credentials, I am still a practicing board certified general internist, and still practicing with Washington Primary Care Physicians – which is now owned by MedStar Medical Group. Our updated address is 660 Pennsylvania Ave., SE, Suite #100, Washington, DC 20003. Our phone number is still 202-546-4504.

In addition to clinical practice, I am currently the medical director for MedStar Health's ambulatory Electronic Health Record, as well as MedStar's medical director for Health Information Technology Policy. I am additionally a Visiting Scholar with the Center for Health Reform at the Brookings Institution, and a Senior Fellow in Health IT Policy for the Center for American Progress. Since my last letter, I have been awarded a Mastership from the American College of Physicians.

I received approximately 430 pages of medical records on Mr. Peltier, which I was advised was his complete medical record from 2000 – current. These records begin in 2008 and appear to be up to date as of the fall of 2015. I was not given any records between 2000 and 2008.

Mr. Peltier's medical problems are as mentioned in my initial report, and include several new issues and conditions, including:
1) Iron deficiency anemia
2) Blood in the urine
3) Undiagnosed chest pain
4) Absence of documentation of the standard of care for routine adult vaccinations, as well as absence of documentation of the standard of care for management of diabetes.

Iron deficiency anemia
There is mention on multiple occasions of him being iron deficient, as well as laboratory evidence supporting iron deficiency anemia (low blood count with a low MCV – or low mean corpuscular volume). Further, his regular medications include

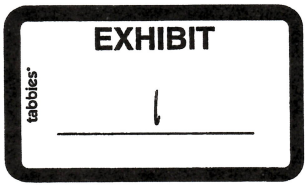


over the counter iron. While there is a normal biologic reason for iron deficiency anemia in a woman (menstrual cycles, and in particular – heavy menstrual cycles), this is obviously not the case in a man. In a man, iron deficiency almost always comes from blood loss, and again most commonly from blood loss from the gastrointestinal tract (stomach and/or intestines). While his blood count is followed periodically and he appears to be stable on iron – aside from one test (a negative test for blood in the stool), there is no evidence that this problem was ever put through a medical workup that would be routinely accepted as meeting the standard of care. That workup would include at a minimum, a colonoscopy and an upper endoscopy, as well as a consultation with a gastroenterologist and a hematologist. There is mention in his record of him needing to get a colonoscopy – though no record that this was ever done.
Undiagnosed iron deficiency could be masking a serious and potentially life threatening disorder, such as cancer.

Blood in the urine
There is mention of him being seen by a urologist, and having a cystoscopy (insertion of a tube thru the penis to examine the urethra and bladder), and that the results were normal. As he has a history of an enlarged prostate and a possible kidney stone, there are at least two possibilities for having blood in the urine. That said, his episode of blood in the urine was without pain, which makes it more likely to be associated with a malignancy; and while the cystoscopy was appropriate for ruling out cancers in the bladder and urethra; there was an insufficient workup of his upper urinary system (ureters and kidneys) – and again his treatment did not meet a reasonable standard of care – at least as I can determine by the documentation presented to me.
Undiagnosed painless hematuria can be the only early symptom of kidney cancer – and there is no documentary evidence that this was looked for.

Undiagnosed chest pain
There is at least one mention of chest pain and pressure, which by documentation in his medical record sounded potentially worrisome for cardiac disease. While it was noted that the chest pain subsided – there is no evidence that he was seen thereafter by a cardiologist to have more complete diagnostic testing. This is particularly necessary in people with diabetes, and cardiac disease does not always present classically in diabetics. His workup for chest pain did thus also not meet a minimal standard of care.
Undiagnosed chest pain in a diabetic can be a sign of a minor heart attack. It is already known that Mr. Peltier has previously had a stroke – which is also more common in diabetics. Undiagnosed and thus untreated heart disease can be fatal in diabetics.

Chronic care for diabetes
Mr. Peltier appears to be on appropriate medication, and has regular medical exams, which include appropriate monitoring tests for diabetes and its complications, with the exception of annual eye exams. My review of his records shows two eye exams –



these should be done annually.
His diabetic eye care is thus substandard, and he is thus at increased risk for undiagnosed and untreated diabetic eye disease – which can lead to blindness.

Substandard preventive care

All peoples 50+ should have colon cancer screening, and if done with colonoscopy, at least every ten years. And where there is reason to look further, such as for blood in the stool or anemia, screening protocols are accelerated such that appropriate diagnostic tests are done more frequently. There is no evidence in the record that Mr. Peltier has had anything other than a stool test for occult blood – and even then, I can only find one instance. When stool testing for occult blood is used in place of colonoscopies – these should be done annually.
His colon cancer screening does thus not meet the standard of care.

There is evidence of regular depression and substance abuse screening, which is commendable. Further, there is evidence that he is getting annual flu shots – which is also commendable. However, there is no evidence that he was ever vaccinated for shingles (herpes zoster) or for pneumonia. The CDC and the ACIP (the American College for Immunization Practices) recommends a single shingles vaccination for everyone at 60 (barring a contraindication), even when there is a history of shingles – as is the case with Mr. Peltier. There is also no documentation that he ever received the PPS23 vaccine for pneumonia, or the newer PCV13 vaccine. People over the age of 65 are particularly susceptible to contracting and dying from pneumonia, and being a diabetic and being incarcerated further increases Mr. Peltier's risk.
His preventive vaccines are thus not in keeping with the standard of care.

As an internist practicing in an area of Washington DC that includes extreme poverty; I am aware that what should be done in theory cannot always occur. I am also aware of the limitations on prison budgets, and am thus not criticizing his providers in the prison who have I assumed have done their best, given what must be very challenging circumstances. That said, from what I can determine by the medical records provided to me, Mr. Peltier's care is now substandard to what would be offer in the community; and that with his advancing age and chronic and perhaps undiagnosed conditions, the limited ability to provide the care that he needs is putting his health in jeopardy. I also note that the level of care he needs is considered a standard in most communities, and is not extraordinary outside of a prison.

Sincerely,

Peter Basch, MD, MACP