



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Credentialing and Privileging
Irregularities at the
South Texas Veterans Health Care System
San Antonio, Texas**

Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to determine the validity of allegations regarding the malpractice history, quality of care, and credentialing and privileging (C&P) irregularities of a surgeon currently employed at South Texas Veterans Health Care System (STVHCS).

We could not substantiate the anonymous complainant's allegation of 300 malpractice claims pending against the physician, but did find several C&P irregularities related to evaluation of the physician's malpractice history. Both the facility and the Veterans Integrated Service Network (VISN) considered claims found in the National Practitioner Data Bank (NPDB) in their decision to approve this physician's initial appointment, but failed to document that they had considered claims still pending or dismissed in their initial C&P evaluation of the physician or during the reappointment process. The provisions of Veterans Health Administration (VHA) Handbook 1100.19 specifically require that a facility attempt to obtain malpractice information from sources other than the NPDB for use during the credentialing, privileging and reappointment processes. The facility did not document attempts to obtain primary verification from insurance companies, courts, or attorneys of circumstances surrounding the eight malpractice claims disclosed on the physician's initial application for employment. Reports from the physician's previous place of employment are not primary source verification for purposes of malpractice claim information per VHA Handbook 1100.19. The physician's initial appointment was contingent on a 3-month period of proctoring but the physician was appropriately proctored in less than 10 percent of cases he performed during the first 3 months of his employment. Since beginning VA employment, no evidence exists that the physician has given inadequate care to his patients. We found no evidence of patient complaints or additional claims against the physician.

The following recommendations were made to improve management attention in the area of C&P:

- Ensure provider appointments with provisions for proctoring are completed and clinical competence is adequately demonstrated to support granting requested privileges in accordance with VHA Handbook 1100.19.
- Ensure credentialing and privileging staff attempt to verify all malpractice claims with the primary source in accordance with VHA policy and document these attempts in the provider's C&P file.
- Ensure peer reviews of cases are completed and Peer Review Panel (PRP) meetings are held in accordance with VHA, VISN, and local policies.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N17)

SUBJECT: Credentialing and Privileging Irregularities at the South Texas Veterans Health Care System, San Antonio, TX

Purpose

The VA OIG Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding the malpractice history, quality of care, and C&P irregularities of a surgeon currently employed at STVHCS.

Background

The OIG Hotline Division received the above allegations from a former patient who wishes to remain anonymous. The complainant underwent surgery by the named physician in the private sector in 2001.

The complainant alleged the physician in question provided negligent medical care in the private sector prior to his employment with the Department of Veterans Affairs, resulting in over 300 malpractice claims against him. The complainant further alleged the physician had a poor bedside manner when he cared for the complainant. Finally, the complainant questioned how the VA could hire a physician with this malpractice history, indirectly alleging C&P irregularities. While we cannot address the allegations resulting from events which occurred in the private sector, this report does evaluate both the physician's quality of care and bedside manner since his employment with the VA. We conducted a review of the physician's malpractice claim history and application of VA's C&P process to this physician hire.

Scope and Methodology

To address the allegations, OHI inspectors conducted a phone interview with the complainant and visited the facility from January 23–25, 2006. The OHI inspectors and a VA OIG consultant physician interviewed 20 employees including nurses, physicians, management, and C&P personnel. We discussed the physician's appointment to the medical staff with the Medical Center Director, Chief of Staff, and Chief of Surgery and conducted a telephone interview with a VISN official.

We reviewed policies and procedures, medical records, performance improvement, morbidity and mortality data, risk management documents, operative reports, and the physician's C&P files. We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results

Issue 1: Alleged Malpractice Claim History and Credentialing and Privileging Irregularities

We could not substantiate the allegation of 300 malpractice claims in the private sector, but did substantiate certain C&P irregularities related to determining the physician's malpractice claims history. The complainant alleged the physician in question had over 300 malpractice claims filed against him prior to his appointment with the VA. The physician's C&P file contained evidence of a total of eleven malpractice claims, three of which were reported to the NPDB. Of the remaining eight claims, five were dismissed and three were pending at the time of this review. Two of the three pending claims were filed after the physician received an initial appointment to the facility, but prior to the reappointment of the physician in August 2005. Our inspection revealed an additional claim filed in May 2005, during the term of the physician's VA employment, against a mid-level provider as an agent of the physician in question. Therefore, we found evidence of a total of 12 malpractice claims.

The NPDB, a database containing malpractice actions resulting in a settlement or judgment against a practitioner, is "intended to augment, not replace, traditional forms of credentials review."¹ VHA Handbook 1100.19, the handbook describing VA's policies pertaining to C&P, requires primary source verification of information contained within the NPDB. VHA Handbook 1100.19 requires that the C&P file contain (1) a statement by the practitioner explaining any malpractice claims, (2) evidence that the facility evaluated the facts regarding resolution of the malpractice case(s), and (3) a "statement of adjudication by an insurance company, court of jurisdiction or statement of claim status from the attorney."²

Practitioner Explanatory Statements

The C&P file contains explanatory statements from the physician regarding the eight malpractice claims filed prior to his initial C&P application. We found no deficiencies in the submission of explanatory statements by the practitioner during the initial C&P process.

Two years after the physician's employment with the VA began, he submitted an application for renewal of privileges (reappointment) as required by VHA Handbook

¹ National Practitioner Databank, "About the Databanks" www.npdb-hipdb.com.

² VHA Handbook 1100.19, 5.k.(3).

1100.19. The physician included explanatory statements pertaining to three additional malpractice claims filed since the date of his initial appointment. All three of these claims arose from incidents that occurred in the private sector, prior to his employment with the VA.

The C&P file does not contain any statement concerning the case naming a mid-level provider as an agent of the physician. This event occurred at the VA prior to the physician's application for reappointment. VHA Handbook 1100.19 requires that an employee undergoing reappointment be asked to "list any involvement in administrative, professional or judicial proceedings, including Tort claims, and to provide a written explanation of the circumstances."³ The handbook does not specify what circumstances, if any, would require a physician to write an explanatory statement if he or she is not specifically named in the action as a defendant.

Facility and VISN Evaluation of Malpractice Cases

The C&P file contains evidence that the Professional Standards Board (PSB) reviewed the malpractice claims identified through NPDB and sought the opinion of a regional risk management official and VA Central Office (VACO). The VACO C&P Director recommended consultation with the VISN Director. A July 2003 memorandum from the facility Chief of Staff to the VISN Chief Medical Officer presented a brief synopsis of the three cases found in NPDB, adding that the facility reviewing personnel "judged that these suits did not represent significant ongoing quality of care or liability concerns." However, in an August 2003 e-mail, a PSB member addressing the facility's chief of staff makes the following statement: "I presented him back to the PSB last Thursday which I chaired for you and everyone was in agreement that the candidate was risky. . . ."

We interviewed a VISN official by phone regarding approval of the physician's initial appointment. He did not recall what information he specifically reviewed but recalled that there were some malpractice claims. He did not indicate whether he knew about all claims against the physician or only those contained in the memorandum of July 2003. The official stated there were no records kept by the VISN concerning VISN approval of the appointment. In August 2003, the PSB approved the physician's application for appointment with the provision he be proctored for a period of 3 months. Two days later a memorandum from the VISN to VACO's C&P Office endorsed the appointment.

VHA Handbook 1100.19 requires "consideration of any information related to medical malpractice allegations or judgments"⁴ in the initial privileging of a physician. There is ample evidence of consideration in the initial appointment process and review of the three malpractice cases identified through NPDB. The facility's C&P files did not contain documentation that claims not listed in the NPDB, but disclosed by the physician, were considered during initial C&P. During the reappointment process, claims discussed in a letter from the physician's attorney were considered. Nothing in the facility's C&P

³ VHA Handbook 1100.19, k(2), p. 10-11.

⁴ VHA Handbook 1100.19, (1)(a)4, p. 16.

file suggests that the claim against the mid-level provider, as an agent of the physician in question, was considered during the physician's reappointment process.

However, when endorsing the initial appointment, the VISN did request that special attention be given to assessing the surgeon's skills during the proctoring period established by the PSB. Operative reports for the first 3 months of his appointment (October–December 2003) do not support consistent proctoring of the physician. Of the 41 surgeries the physician performed during his first 3 months of employment, only four were proctored as required by the provision of his appointment. Ten cases were assisted by a surgeon of the same specialty who had been appointed on the same date and also required proctoring. The remaining cases had either physician assistants and/or residents assisting the surgeries, with no other physicians recorded as present.

On November 2003, a memorandum submitted by a senior physician to the Chief of Staff indicates both physicians under the proctoring provision were now able to work independently. He also recommends the physician in question be made service chief of his specialty.

Primary Source Verification of Malpractice Claims

VHA Handbook 1100.19 also requires the facility attempt to obtain primary source verification of the malpractice cases. Primary sources specifically listed by the handbook include statements from insurance companies, courts or attorneys. Only three of the eleven claims contained within the C&P file were referenced by a document from an attorney. The remaining eight claims were referenced in statements from the physician and the physician's previous place of employment, but not from one of the individuals or institutions described in VHA Handbook 1100.19. The C&P file does not contain documentation that the facility attempted to contact other sources for primary verification of malpractice claims filed against the physician.

Issue 2: Alleged Inadequate Care and Poor Bedside Manner

We can neither substantiate nor repudiate allegations of poor quality of care and bedside manner prior to the surgeon's employment at the facility. We did not substantiate the allegation of poor care and bedside manner during the surgeon's employment with VA.

The complainant alleged a poor outcome from his surgery performed by the physician in 2001. The complainant also described the physician's bedside manner as "terrible." While we cannot address the quality of care provided to the complainant in the private sector, we did examine the quality of care that the physician has provided since beginning his VA employment in 2003. Part of the evaluation included analysis of National Surgical Quality Improvement Program (NSQIP) data. NSQIP is a database created in response to Public Law 99-166, which mandated the VA to report its surgical outcomes annually on a risk-adjusted basis, factoring in the overall health status of the patient comparing them to national averages.

We compared morbidity and mortality data from the date of employment through May 31, 2005, to morbidity and mortality statistics from surgeons of the same specialty who had previously worked for the facility. Neither the physician's morbidity or mortality rates departed from those of other surgeons previously practicing in the same specialty at the facility. The surgeon's mortality rate also met NSQIP benchmarks for the year 2004, although his morbidity rate was somewhat higher. However, morbidity rates for the facility were not risk adjusted, meaning that they did not take into account the overall health status of the individuals undergoing the procedures. This prevents a valid comparison between the surgeon's morbidity rate and NSQIP benchmarks.

We reviewed C&P documents pertaining to quality of care, including recommendations written on behalf of the physician as well as peer review documents. While all recommendations within the C&P file were uniformly positive, we found that the facility failed to conduct adequate peer review of the surgeon as defined by VHA and the facility's own policies and procedures.

Peer review standards applicable to the facility are set forth in VHA Directive 2004-054, "Peer Review for Quality Management." This directive requires that individuals with similar training and privileges complete an initial peer review then refer all cases determined to be a Level 2 or Level 3 to the peer review committee. Level 2 cases are those in which most practitioners might have managed the case differently, while Level 3 denotes a case in which most practitioners would have managed the case differently. The initial review must be completed in 45 days, with the final review of each case occurring within 120 days from the determination that a peer review was necessary. In addition, the directive requires facilities to produce policies that establish "time frames for protected peer review activities, including when reviews are to be conducted and when results are to be reported to all parties concerned, including providers whose care is under review and VISN leadership."⁵

A local policy was established with the purpose of outlining membership, responsibilities, and functions of the PRP for the facility. The policy states the PRP will meet monthly or at the call of the chairperson, as needed. It establishes no time frame in which a case will be presented to the PRP following recommendation by the initial reviewer. The meeting minutes provided reflect the PRP met in June 2005, August 2005, and January 2006. The physician in question had two cases which the initial reviewer assigned as a Level 2. The first incident involved a patient admitted in April 2005, but the initial reviewer did not assign a level to this incident until January 2006. The second incident involved a patient admitted in July 2005, whose individual peer review was completed in September 2005. The PRP had not reviewed either case by the date of our site inspection in January 2006. Therefore, the facility is not in compliance with time limitations as outlined in VHA Directive 2004-054 nor is it in compliance with its own policy requiring monthly meetings. This resulted in peer reviews being unavailable both

⁵ VHA Directive 2004-054, September 29, 2004, p. 8.

for consideration during the reprivileging process and for purposes of our assessment of the quality of care provided by the physician.

Inspectors found no documentation of any complaint against the physician pertaining to inadequate care or poor bedside manner at VA. We interviewed nursing staff, mid-level providers, and other physicians and operating room personnel who worked closely with the physician. None expressed awareness of complaints against the physician or had witnessed incidents that caused them to doubt the quality of care provided by the physician. We also interviewed a patient advocate and quality management personnel, none of whom expressed awareness of complaints or concerns regarding the quality of care provided by the physician. We questioned all 20 individuals interviewed regarding incidents of poor bedside manner or inappropriate behavior. No one had knowledge of complaints made by patients during the physician's VA employment alleging any problems with his bedside manner.

We found no evidence that the physician has provided poor care or expressed an inappropriate bedside manner since being employed by the VA. We nevertheless recognize that both the absence of adequate peer review and proctoring of the physician during his first 3 months of employment limit the quality of evidence available to us for purposes of making this determination.

Conclusion

We could not substantiate the complainant's allegation of 300 malpractice claims pending against the physician, but did find several C&P irregularities related to evaluation of the physician's malpractice history. Both the facility and the VISN considered claims found in the NPDB in their decision to approve this physician's initial appointment, but failed to document that they had considered claims still pending or dismissed in their initial C&P evaluation of the physician or during the reappointment process. The VISN maintained no pertinent documentation to its role in the approval of this appointment. While recognizing that many malpractice claims are groundless, the provisions of VHA Handbook 1100.19 do not limit consideration of malpractice claims to only those resulting in monetary settlements or verdicts against the physician.

This handbook also specifically requires that a facility attempt to obtain malpractice information from sources other than the NPDB for use during the credentialing, privileging and reappointment processes. The facility did not document any attempts to obtain primary verification from insurance companies, courts, or attorneys of circumstances surrounding the eight malpractice claims disclosed on the physician's initial application for employment. Instead, there are reports from the physician's previous place of employment, which is not listed as a primary source for purposes of malpractice claim information in VHA Handbook 1100.19.

Finally, after both the VISN and the PSB approved the physician's appointment contingent on a three month period of proctoring, the physician was appropriately proctored in less than ten percent of cases he performed during the first 3 months of his employment. In addition, two cases identified as needing additional peer review were not reviewed in accordance with VHA and facility policies and procedures, further limiting the facility's ability to monitor quality of care administered by the physician.

Since beginning employment with the VA, however, no evidence exists that the physician has given inadequate care to his patients. Morbidity and mortality data for this physician are not different than other physicians in the same specialty who previously worked at this facility. We found no evidence of patient complaints or additional claims against the physician, with the exception of one malpractice case filed against a mid-level provider acting as an agent of the physician.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that provider appointments with provisions for proctoring are completed and clinical competence is adequately demonstrated to support the PSB in granting requested privileges, as prescribed by the VHA Handbook 1100.19, VISN, and local policies.

Recommendation 2. We recommended that the Medical Center Director ensure that credentialing and privileging staff attempt to verify all malpractice claims with the primary source in accordance with VHA policy, and document these attempts in the provider's C&P file.

Recommendation 3. We recommended that the Chief of Staff and Medical Center Director ensure peer reviews of cases are completed and PRP meetings are held in accordance with VHA, VISN, and local policies.

VISN and Medical Center Director Comments

The VISN Director and Medical Center Director concurred with the results of this inspection and have taken actions to implement the recommendations in this report (See Appendix A, B, C, and D, page 9-20, for VISN and Medical Center Director comments).

Assistant Inspector General for Healthcare Inspections Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 21, 2006

From: VISN Director

Subject: **Credentialing and Privileging Irregularities at the South Texas Veterans Health Care System**

To: John D. Daigh, Jr., MD, Assistant Inspector General for Healthcare Inspections

VISN 17 submits the attached response to the Draft Report of the Healthcare Inspection of the South Texas Veterans Healthcare System.

VISN Director's Comments to Office of Inspector General's Report

The following VISN Director's comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that provider appointments with provisions for proctoring are completed and clinical competence is adequately demonstrated to support the PSB in granting requested privileges, as prescribed by the VHA Handbook 1100.19, VISN, and local policies.

Concur **Target Completion Date:** May 1, 2006

Service Chiefs will be required to ensure that all proctored providers are monitored directly by another credentialed provider who is present during the examination or operative procedure and that records are reviewed for each patient and co-signed. The Professional Standards Board (PSB) will identify the number and type of cases and duration of proctoring to be completed. (Appendix C).

Recommendation 2. We recommended that the Medical Center Director ensure that credentialing and privileging staff attempt to verify all malpractice claims with the primary source in accordance with VHA policy, and document these attempts in the provider's C&P file.

Concur **Target Completion Date:** April 10, 2006

A malpractice checklist has been initiated that will be included in each provider's application (at initial appointment and repriviliging) to detail all malpractice information. The credentialers will ensure that each malpractice case is fully documented to include a detailed statement regarding malpractice; copies of court documents or letters from the provider's attorney detailing each case along with final settlements or outcomes or a letter from the hospital or university where malpractice occurred with final outcomes for review by the Professional Standards Board (PSB); and signature by the credentialer responsible for that record. PSB physician reviewers will initial off on malpractice case reviews and document actions required (Appendix D).

Recommendation 3. We recommended that the Chief of Staff and Medical Center Director ensure peer reviews of cases are completed and PRP meetings are held in accordance with VHA, VISN, and local policies.

Concur **Target Completion Date:** May 30, 2006

Peer Review Committee: The STVHSCS Peer Review Committee met on January 5, February 24, March 7, and April 4, 2006 to conduct a secondary review of all Level 2 and Level 3 Protected Peer Reviews and a sample of Level 1 Protected Peer Reviews. Peer Review Committee meetings for CY 06 are scheduled for the first Tuesday monthly from 1300 to 1400. To prevent potential schedule conflicts and ensure maximum attendance the meeting has been placed on the outlook calendar of all committee members and coordinated with their direct secretarial support staff. Committee members are provided with an agenda approximately 1 week prior to the meeting to ensure attendance and member readiness related to cases to be presented.

To ensure secondary review by providers with similar training QM staff ensures attendance by specialties related to cases scheduled for review. STVHCS will review and revise the current STVHCS Peer Review Policy to ensure and enhance compliance with VHA Directive 2004-054, Peer Review for Quality Management. Protected Peer Reviews will not be sent for consideration during the reprivileging process and for purposes of assessment of the quality of care provided by the physician IAW VHA Directive 2004-054, Peer Review for Quality Management. Administrative Board of Investigation Reports conducted based on the recommendation of initial reviewer and/or the Peer Review Committee that relate to quality of care and potential negligence will be sent for consideration during the reprivileging process and for purposes of assessment of the quality of care provided by the physician.

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 21, 2006

From: Medical Center Director

Subject: **Credentialing and Privileging Irregularities at the South Texas Veterans Health Care System**

To: John D. Daigh, Jr., MD, Assistant Inspector General for Healthcare Inspections

The South Texas Veterans Health Care System submits the attached response to the Draft Report of the Healthcare Inspection of the Central Texas Veterans Healthcare System.

Medical Center Director's Comments to Office of Inspector General's Report

The following Medical Center Director's comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that provider appointments with provisions for proctoring are completed and clinical competence is adequately demonstrated to support the PSB in granting requested privileges, as prescribed by the VHA Handbook 1100.19, VISN, and local policies.

Concur **Target Completion Date:** May 1, 2006

Service Chiefs will be required to ensure that all proctored providers be monitored as an ongoing process by ensuring that another credentialed provider be present during the examination, operative procedure, etc. and/or that records are reviewed for each patient and co-signed. The PSB will identify the number and type of cases, and duration of proctoring to be completed. (Attachment A).

Recommendation 2. We recommended that the Medical Center Director ensure that credentialing and privileging staff attempt to verify all malpractice claims with the primary source in accordance with VHA policy, and document these attempts in the provider's C&P file.

Concur **Target Completion Date:** April 10, 2006

Malpractice Checklist has been initiated that will be included in each providers' file which will include all malpractice information. The credentialers will list each action to include provider's detailed statement regarding malpractice; copy of court document, letter from provider's attorney detailing each case along with final settlements/outcomes or letter from Hospital/University where malpractice occurred with final outcomes for review by PSB; and signed off by credentialer responsible for that record. PSB physician reviewers will initial off on malpractice case and document action required.

Recommendation 3. We recommend that the Chief of Staff and Medical Center Director ensure peer reviews of cases are completed and PRP meetings are held in accordance with VHA, VISN, and local policies.

Concur **Target Completion Date:** May 30, 2006

Peer Review Committee: The STVHSCS Peer Review Committee met on January 5, February 24, March 7, and April 4, 2006 to conduct a secondary review of all Level 2 and Level 3 Protected Peer Reviews and a sample of Level 1 Protected Peer Reviews. Peer Review Committee meetings for CY 06 are scheduled for the first Tuesday monthly from 1300 to 1400. To prevent potential schedule conflicts and ensure maximum attendance the meeting has been placed on the outlook calendar of all committee members and coordinated with their direct secretarial support staff. Committee members are provided with an agenda approximately 1 week prior to the meeting to ensure attendance and member readiness related to cases to be presented.

To ensure secondary review by providers with similar training QM staff ensures attendance by specialties related to cases scheduled for review. STVHCS will review and revise the current STVHCS Peer Review Policy to ensure and enhance compliance with VHA Directive 2004-054, Peer Review for Quality Management. Protected Peer Reviews will not be sent for consideration during the reprivileging process and for purposes of assessment of the quality of care provided by the physician IAW VHA Directive 2004-054, Peer Review for Quality Management. Administrative Board

of Investigation Reports conducted based on the recommendation of initial reviewer and/or the Peer Review Committee that relate to quality of care and potential negligence will be sent for consideration during the reprivileging process and for purposes of assessment of the quality of care provided by the physician.

DEPARTMENT OF VETERANS AFFAIRS

Professional Service

South Texas Veterans Health Care System
San Antonio, Texas 78229-4404

Memorandum xx-xx
April 10, 2006

DRAFT

PROCTORING OF PRACTITIONERS

1. **PURPOSE:** The South Texas Veterans Health Care System (STVHCS) establishes this policy to ensure that licensed independent practitioners are competent to provide services requested in their credential applications.

2. **POLICY:** It is the policy of the STVHCS that practitioners applying for privileges as licensed independent practitioners show evidence of competence for credentials requested in their medical staff application packets. This evidence will include but not be restricted to peer reviews, a service chief appraisal, documentation of training and experience, and appropriate licensure. If the professional standards board's (PSB's) review of this or any other information pertaining to the quality of practice provides insufficient information to make a determination that the practitioner can practice requested privileges independently, the PSB may require a period of proctoring of the clinical practice prior to making a final determination of privileges.

3. **ACTION:**

a. The PSB will be responsible for determining if documents presented during initial application or reprivileging indicate competence of the practitioner to perform, execute, or manage the privileges requested.

b. The PSB may request a period of proctoring of the practitioner to ascertain competence for requested privileges.

c. The PSB will define the privilege in question and the required oversight to ascertain competence.

(1) The PSB will communicate to the service chief and practitioner the privilege to be reviewed and the oversight required in this review including requirements for the clinical characteristics of patients for whom care needs to be proctored and the number of patients or duration of oversight that should occur.

(2) Proctoring will be accomplished only by licensed independent practitioners with approved privileges for the areas under review.

(3) The service chief will assure that the applicant's practice in the areas under review is restricted from those areas except under the supervision of the proctor.

PROFESSIONAL SERVICE

MEMORANDUM – XX-XXX

*****DRAFT*****

(4) Upon satisfactory completion of the proctoring requirements, the service chief will submit recommendations to the PSB based on assessments of the proctors as to the advisability of granting privileges to the applicant as an independent licensed practitioner.

4. **REFERENCES**: Medical Staff Bylaws, Rules, and Regulations 2006.

5. **RESPONSIBILITY**: Chief of Staff

6. **RECISSIONS**: NONE

7. **RECERTIFICATION**: April 2009

RICHARD BAUER, MD
Chief of Staff

SOUTH TEXAS VETERANS HEALTH CARE SYSTEM

MALPRACTICE CLAIM/SUIT INFORMATION

The Medical-Dental Staff Bylaws require the practitioner to provide information on any professional liability claims, complaints or causes of action that have been lodged against him/her and the status of such matters.

Please complete one of these forms for each incident in which you have been involved.

REGARDING: _____ **VS** _____

Please provide a chronological narrative of the case provided to the alleged injured party during the time of the alleged injury.

State current status of claim:

<input type="checkbox"/> Claim filed	Date: _____
<input type="checkbox"/> Claim settled	Date: _____
<input type="checkbox"/> Lawsuit filed	Date: _____
<input type="checkbox"/> Schedule Court Trial	Date: _____
<input type="checkbox"/> Disposition at Trial	Date: _____

Case against you was: Dismissed Removed Dropped

NAME OF INSURANCE COMPANY: _____

NAME OF ATTORNEY: _____

NAME OF INSTITUTION: _____

Brief Statement explaining your involvement:

Applicant's Signature

Date

For STVHCS Use:

Court Document: _____

Insurance Company: _____

Attorney's Statement: _____

Other: _____

Credentialer

PSB Reviewer's Initials

OIG Contact and Staff Acknowledgments

OIG Contact	Wilma Reyes, Healthcare Inspector, Dallas Office of Healthcare Inspections, (214) 253-3334
Acknowledgments	Linda DeLong, Director Karen Moore, Associate Director Andrea Buck, M.D., J.D.

Report Distribution

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