



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection Quality of Care Issues at a VA Healthcare System

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Executive Summary

The purpose of the inspection was to determine the validity of an anonymous allegation that “a number of patients” died while under the care of a board certified surgeon employed by a VA healthcare system. We concluded that the system took appropriate actions to ensure patient safety and to review the provider’s quality of care prior to and during the Office of Inspector General’s review of the allegations. We also concluded that the system’s Regional Counsel needed to determine whether reporting the provider to the NPDB and to appropriate licensing boards was warranted

We recommended that Regional Counsel review all pertinent documentation and actions taken by the system and determine whether the system had a legal obligation to report the provider to the National Practitioner Data Bank and/or the appropriate state licensing boards. The VISN and System Directors agreed with the findings and recommendation.



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

TO: Director, Veterans Integrated Service Network

SUBJECT: Healthcare Inspection – Quality of Care Issues at a VA Healthcare System

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed allegations regarding quality of care issues at a VA healthcare system (the system). The purpose of this inspection was to determine the validity of the allegations.

Background

On March 6, 2008, OIG received an anonymous complaint alleging that “a number of patients” died while under the care of a board certified surgeon employed by the system. However, the complainant identified only one patient who had recently died intra-operatively.

Scope and Methodology

We reviewed the credentialing and privileging folder of the provider and interviewed appropriate senior managers during a site visit in March 2008. We also evaluated results of reviews of the provider’s care conducted through the system’s internal processes and the results of case reviews conducted by a panel of surgeons independent of Veterans Health Administration (VHA). We reviewed VHA regulations governing credentialing and privileging,¹ reporting to the National Practitioner Data Bank (NPDB),² and reporting to state licensing boards.³ Additionally, we reviewed pertinent Joint

¹ VHA Handbook, 1100.19, *Credentialing and Privileging*, October 2, 2007.

² VHA Handbook 1100.17, *National Practitioner Data Bank Reports*, November 13, 2002.

³ VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, February 17, 2004.

Commission (JC) standards⁴ and made a second site visit in May. Because the complainant was anonymous, we were unable to interview that individual or get any further information. We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

We found that system clinical managers took appropriate actions to ensure patient safety and to review the surgeon's clinical care prior to our March visit. Clinical managers took the following actions:

- Consulted Regional Counsel and notified the surgeon in writing of plans to review cases for quality of care issues and to have a second surgeon assist on all major procedures during the period of the review.
- Completed an internal review of the surgeon's cases from September 1, 2006 – August 9, 2007. That review showed that the surgeon's post-operative mortality and morbidity rates were lower than the national averages.⁵
- Arranged for an independent review of a select number of the provider's mortality cases (seven) during the period of January 2006 to January 2008. Two of these cases were intra-operative deaths (the third intra-operative death identified by the complainant had not occurred at the time this external review was arranged). Surgeons from a community medical facility functioned as an independent review panel and completed the review.
- Planned to arrange for a second independent review of the same cases, including the third intra-operative death.

The independent panel's conclusions were available while we were onsite in March. The panel concluded that all seven patients were challenging and that five of the seven patients had severe co-morbidities that directly contributed to their fatal outcomes. In four of these cases, the review showed that the families requested only comfort measures be provided because of the patients' critical medical conditions. The remaining two patients suffered from advanced cancer. While the panel did not criticize the provider's clinical decisions, it made several recommendations designed to improve overall care for patients requiring surgery. The system either implemented or was in the process of implementing the recommendations at the time of the May site visit. The following is a summary of the recommendations.

- Patient selection should involve a multi-disciplinary review of cases by a tumor board comprised of Medical Oncology, Radiation Oncology, and Surgery.

⁴ The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, September 2007.

⁵ Information from the system's National Surgical Quality Improvement Program data, FY 2007.

- Deconditioned patients should be exposed to preoperative conditioning programs in an effort to decrease postoperative complications.
- Two surgeons should perform high-risk resections.
- Postoperative care must involve nursing and resident staff experienced in respiratory care and high risk pulmonary patients.
- Administratively, the panel offered the option of a designation of first assistant for the surgeon for a period of 6–12 months that would allow for ongoing technical assessments and weekly morbidity and mortality reviews.

The panel also had the opportunity to review the third intra-operative death that occurred after it completed its initial case reviews. The results of that review and the result from the second independent review were available at the time of our May site visit. Based on the panel's recommendations and the conclusions from the second independent review, clinical managers implemented the following action plan.

- The surgeon would continue to see patients in the clinic, care for patients in the hospital, consult on cases, and share in emergency call including performing necessary emergency surgeries.
- Specific cases would be presented at the multi-disciplinary weekly conference, and tumor cases would be presented to the tumor board.
- Assistance by a second surgeon would be required on all procedures deemed major and/or high-risk surgeries.
- The surgeon's technical skills and intra-operative judgment would be monitored and evaluated weekly for 6 months. If satisfactory, the surgeon could perform major cases with a surgical fellow or the chief surgical resident.
- The surgeon could perform non-major cases with surgical residents.

The JC Medical Staff standard (MS.4.30) allows the medical staff to define the circumstances requiring monitoring and evaluation of a practitioner's professional performance and states that a decision to assign a period of performance monitoring should not affect other existing privileges in good standing.

VHA Handbook (HB) 1100.19 (page 40) also allows for the restriction of performance of selected specific procedures, if the restriction is time limited and restoration is contingent upon on particular conditions or criteria. However, the HB also states (*italicized note on pages 39–40*) that “any situation that results in a practitioner being proctored, where the proctor is assigned to do more than just observe, but rather exercise control or impart knowledge, skill, or attitudes to another practitioner...may constitute supervision. If this occurs after initial privileges have been granted, it is considered a restriction on the practitioner's privileges and as such is a reduction of privileges and is reportable to the NPDB if proctorship lasts longer than 30 days....”

The system's position was that the surgeon was not restricted from performing major surgeries because he could function as primary operative surgeon, could do non-major procedures that did not require a second surgeon, and could fulfill all other duties in accordance with granted privileges including emergency call. Therefore, the system believed that the surgeon's privileges were not restricted or reduced; and the system was not obligated to report the surgeon to the NPDB or the State Licensing Board. Ultimately, the decision to report a practitioner is a legal decision; and the system's Regional Counsel needed to make that determination.

Conclusions

We concluded that the system took appropriate actions to ensure patient safety and to review the provider's quality of care prior to and during OIG's review of the allegations. Regional Counsel needed to determine whether reporting the provider to the NPDB and to appropriate licensing boards was warranted

Recommendation

We recommended that the VISN Director ensure that the System Director requires that Regional Counsel review all pertinent documentation and actions taken and determine whether the system has a legal obligation to report the provider to the NPDB and/or the appropriate state licensing boards.

OIG Comments

The VISN and System Directors agreed with the findings and recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 5–7, for the full text of the Directors' comments.)

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 12, 2008

From: Director, Veterans Integrated Service Network

**Subject: Healthcare Inspection – Quality of Care Issues at a VA
Healthcare System**

To: Regional Director, Office of Healthcare Inspections

The Network Director concurs with the findings of the Healthcare Inspection.

Network Director

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 12, 2008

From: Director, Healthcare System

**Subject: Healthcare Inspection – Quality of Care Issues at a VA
Healthcare System**

To: Regional Director, Office of Healthcare Inspections

We concur with findings of the Healthcare Inspection review of the VA
Healthcare System

System Director

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

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

OIG Recommendations

We recommended that the VISN Director ensure that the System Director requires that Regional Counsel review all pertinent documentation and actions taken and determine whether the system has a legal obligation to report the provider to the NPDB and/or the appropriate state licensing boards.

Concur

The documents and actions taken have been referred to Regional Counsel to determine whether the System has a legal obligation to report the provider to the NPDB and/or the appropriate state licensing boards.

OIG Contact and Staff Acknowledgments

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|-----------------|---|
| OIG Contact | Katherine Owens, MSN Regional Director, Office of Healthcare Inspections (603) 222-5871 |
| Acknowledgments | Jerome Herbers, M.D. George Wesley, M.D. |

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