Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Oversight Review
Unauthorized Practice of Medicine
at a VA Medical Center

Report No. 11-04130-192

May 29, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an oversight inspection to determine the validity of allegations of the unauthorized practice of medicine.

A complainant alleged that a non-physician staff (subject staff) at a VA Medical Center (the facility) Emergency Department (ED) engaged in the unauthorized practice of medicine by representing himself as a doctor, and that the ED nurse manager was aware of this behavior but did not take action to correct it. The complainant also alleged that the subject staff intubated a patient during an emergency resuscitation causing the patient's death and that, in another instance, the subject staff pronounced a patient dead.

The facility conducted an internal investigation and took corrective actions. The investigation found that the subject staff acted outside the scope of his duties by responding to and participating in a "code blue" event. The facility did not find that the subject staff engaged in the unauthorized practice of medicine.

We reviewed all documents produced during the facility's investigation, pertinent medical records, and other administrative records, and interviewed facility staff. We concurred with the findings of the facility and found the corrective actions to be appropriate.

We made no recommendations.

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

TO: Director, VA Healthcare System

SUBJECT: Healthcare Inspection – Healthcare Inspection – Oversight Review, Unauthorized Practice of Medicine at a VA Medical Center

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine if allegations of unauthorized practice of medicine had merit and whether the facility properly addressed the allegations.

Background

The facility is a tertiary care facility that provides comprehensive healthcare through inpatient and outpatient services in medicine, surgery, mental health, and rehabilitation medicine.

The complainant alleged that:

- A non-physician staff (the subject staff) at the facility Emergency Department (ED) "misrepresented himself as a doctor" during his tour of duty by wearing a tee-shirt with his last name preceded by the word "Doc" on the front of the shirt, introducing himself as a doctor to patients, providing diagnoses, and instructing patients about which medications should be prescribed and which tests should be ordered.
- The nurse manager was aware of this behavior but did not take action to correct it.
- When a patient died at a VA Community Living Center and was transported to the facility, the subject staff officially pronounced the patient dead.
- A patient died after being intubated by the subject staff.

Scope and Methodology

Prior to OIG receiving the allegations, the facility had performed an internal review and taken corrective actions. We conducted a site visit and followed-up on the facility's investigation. The OIG reviewed all documents produced during the facility's investigation, reviewed pertinent medical records, and other administrative records, and interviewed staff.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Unauthorized practice of medicine

We did not substantiate this allegation. Adequate staff and resources must be available to evaluate all individuals presenting to the ED. Because of the unscheduled and episodic nature of health emergencies and acute illnesses, experienced and qualified physician, nursing, and ancillary personnel must be available during all hours of operation.[1] The overriding principle for proper ED care is that evaluation, management, and treatment of patients must be appropriate and expedient. It is recognized that additional staff, such as health care technicians, paramedics, licensed practical nurses, nurses' aides, patient support assistants, pharmacists, and clerical staff, provide important supportive roles in the ED.

The subject staff is a medical specialist in the United States military reserves who had been called to active duty and deployed in support of Operation Iraqi Freedom. The subject staff reported that he wore a tee-shirt with his scrubs and that the tee-shirt had a military insignia on it and the word "Doc." The subject staff denied representing himself as a physician and denied making diagnoses and treatment recommendations for patients.

Controlling State law prohibits unlicensed persons from using the words or letters "Dr." or "Doctor" in connection with a person's name in any way that represents the person as engaged in the practice of medicine. This includes oral communication indicating an examination or diagnosis of a patient, which includes recommendation of a drug or medicine or treatment for any wound, infirmity, or disease. Additionally, the law prohibits the use of words, letters, or titles to induce the belief that the person who uses them engages in the practice of medicine.

On one occasion when the subject staff was called "Doctor" by a patient, the subject staff informed the patient of his status and that he was not a physician. On another occasion,

[1] VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing*, March 2, 2010.

the subject staff was called "Doc" by a patient who had been a military medical specialist and knew that the subject staff held the same position.

It is a long-standing practice of the military to call non-professional enlisted hospital personnel "Doc." Army and Air Force medics and Navy corpsmen are trained to be independent medical personnel and perform many healthcare functions and procedures in military settings. Many of the functions and procedures of military clinical personnel would, if performed in a civilian setting, be reserved for licensed, privileged, professional healthcare providers.

Issue 2: Failure of supervisor to take corrective action

We did not substantiate this allegation. We reviewed documentation that the nurse manager counseled the subject staff that his tee-shirt could be misleading and could not be worn to work.

Issue 3: Improper pronouncement of death

We did not substantiate that the subject staff pronounced a patient dead.

Under controlling State law, only a physician can pronounce a person dead. A physician may pronounce a person dead without personally examining the body of the deceased only if a competent observer has recited the facts of the deceased person's present medical condition to the physician and the physician is satisfied that death has occurred. A competent observer could be a duly licensed nurse, emergency medical technician, paramedic, physician assistant, chiropractor, or coroner's investigator.

Veterans Health Administration (VHA) policy provides that an appropriately trained nurse or physician assistant assigned to a community nursing home may perform the death pronouncement only if a responsible physician is not immediately available on-site for a veteran who has a valid Do Not Resuscitate order on record and dies of cardiopulmonary arrest due to apparent natural causes.[2]

A veteran died at a local VA Community Living Center[3] (CLC), was pronounced dead by the physician on-site, and was transferred to the facility morgue. The ambulance service stopped at the ED entrance to get directions to the morgue. A question arose as to whether or not the patient had been officially pronounced dead. While the subject staff gave the ambulance crew directions to the morgue, the ED physician went outside to the

[2] VHA Directive 2011-016, *Pronouncement of Death and Request for Autopsy by a Registered Nurse, Advanced Practice Nurse or Physician Assistant in VA Community Living Centers,* March 16, 2011.
[3] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

ambulance and learned that the nursing home physician had already made an official pronouncement of death.

We reviewed the deceased's medical records, which showed the patient was pronounced dead by the CLC physician, not the subject staff.

Issue 4: Patient death

We did not substantiate that the subject staff had intubated[4] a patient causing death. However, we found that the subject staff did act outside the scope of his duties by participating in a "code blue" response.

Emergency codes are used in hospitals to alert staff to various emergency situations and to convey essential information quickly while preventing stress or panic among visitors to the hospital. "Code blue" is used to indicate a patient requiring resuscitation or otherwise in need of immediate medical attention, most often as the result of a respiratory or cardiac arrest. When announced by a public address system, the notice takes the form of "code blue, (floor), (room)" to alert the resuscitation team where to respond. Every hospital sets a policy to determine which personnel are to provide code coverage. Code teams are typically comprised of staff with Advanced Cardiac Life Support or equivalent resuscitation training. Frequently, these teams are staffed by ED and/or intensive care unit physicians, respiratory therapists, and nurses. At least one attending physician must be present on any code team; this individual is responsible for directing the resuscitation effort and is said to "run the code." The facility policy identifies specific members of its code team.

The subject staff was working as a transporter (someone who provides medical escort services to patients) in the facility when he responded to a "code blue," accompanied medical residents to the cardiac catheterization laboratory, and assisted with chest compressions. During this time, a provider was unsuccessful in an attempt to intubate the patient. The subject staff then moved to the head of the table and began to insert an oral speculum into the patient's mouth in preparation for intubation. A nurse told him to stop since an Anesthesia provider had arrived to perform the intubation.

The subject staff was not assigned to the code team. The facility policy states that individuals not assigned to the code team are to stay away from the code area. Attendance at the code and attempts to insert an airway speculum without a physician's order or supervision is beyond the scope of the subject staff's duties.

[4] Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea), through the mouth or the nose. In most emergency situations it is placed through the mouth.

The facility took appropriate action in response to this incident.

Conclusion

We concurred with the facility's finding that the subject staff did not engage in the unauthorized practice of medicine

We found that managers properly addressed issues raised in response to complaints about the subject staff.

In summary, the facility was notified of concerns surrounding the subject staff and took timely and appropriate actions.

We made no recommendations.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the report. No further action is required.

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 30, 2012

From: Director, VA Healthcare System

Subject: **Healthcare Inspection – Unauthorized Practice of Medicine, VA Medical Center**

To: Director, Washington DC Office of Healthcare Inspections (54DC)

Thru: Director, VHA Management Review Service (10A4A4)

I have reviewed and concur with this inspection report. Thank you for this comprehensive and thoughtful review.

Should you have any questions or need any additional information please feel free to contact the Deputy Quality Management Officer.

(original signed by:)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: 4/26/2012

From: Director, VA Medical Center

Subject: **Healthcare Inspection – Unauthorized Practice of Medicine, VA Medical Center**

To: Director, Healthcare System

1. I have reviewed the report and concur. We appreciate the comprehensive review the Office of Inspector General conducted regarding this allegations.

2. If further information is required, please contact the Accreditation Specialist.

(original signed by:)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Randall G. Snow, JD Bruce Barnes, Team Leader Jerry Herbers, MD George Wesley, MD Natalie Sadow-Colón, MBA, Program Support Assistant

Appendix D

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