Administrative Closure
Review of Surgical Care for Select Patients
With Gastrointestinal Surgery
Gulf Coast Veterans Health Care System (520/00)
Biloxi, Mississippi
MCI# 2014-01088-HI-0411

The VA Office of Inspector General Office of Healthcare Inspections received allegations from an anonymous complainant questioning the competency of (b)(6), a surgeon at the Gulf Coast Veterans Health Care System (facility), Biloxi, MS.

The complainant provided the names of 12 of (b)(6) patients who had postoperative complications. A majority of the 12 patients had undergone multiple surgeries. The complainant alleged that (b)(6) provided questionable care including delayed diagnosis and treatment, and that the patients had poor outcomes due to complications from surgery, including death.

We reviewed the electronic health records (EHRs) of 53 individual patients: 12 identified by the complainant, 33 patients who underwent elective surgical procedures performed by (b)(6) during July 2012 through December 2013, and all 13 surgical cases involving (b)(6) that had a mortality review during the review period. The facility had a total of 205 elective procedures performed by various surgeons during the July 2012 through December 2013 period.

We were provided a list of 25 peer review cases that involved (b)(6) during the same period. The list included the 13 mortality cases for which we reviewed the corresponding EHRs. The complainant's list identified 7 of the 25 peer review cases. (b)(6) was (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705.

Of the 13 mortality reviews, (b)(3):38 U.S.C. 5705.(b)(6) (b)(3):38 U.S.C. 5705.(b)(6)

We reviewed (b)(6) last two ongoing professional practice evaluations in VetPro, the facility surgical quality data for (b)(6), and the National Surgery Office (NSO) reports on surgical quality data for fiscal year 2013. Despite facility outlier data during fiscal year 2013 for surgical site infections and 30-day morbidity in general, vascular, and thoracic surgery, this data did not result in an elevated ranking of concern from the NSO. This facility had only (b)(6); therefore, the NSO data reflected the complication rates of (b)(6) and one other surgeon.

The facility reported there were no tort claims against (b)(6) during the review period. Additionally, he was not the only attending for the complainant's identified 12 cases.

We substantiated that some of (b)(6) patients developed post-operative complications that were common for the types of surgery performed. However, we did not find that (b)(6) (b)(6) patients had a complication rate higher than expected.

Based on our review, I am administratively closing this case.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections
2/24/14