Administrative Closure Summary 11/30/05
November 9, 2005
Hotline Inspection MCI # 2005-03285-HI-0326
West Palm Beach VA Medical Center, FL

This case, involving a neurosurgeon who is practicing at the West Palm Beach VA Medical Center (VAMC), was referred to the Office of Inspector General's Office of Healthcare Inspections by the Department of Justice (DOJ). The DOJ told us that their investigation had found that the surgeon had been "booted out" of private practice because she was uninsurable as a result of malpractice suits that resulted in payments of $3 million or more. They also found that the surgeon "...performed non-emergency procedures on multiple patients during a 24 to 48-hour time period and that there were multiple complications...performed multiple procedures on the same patient over a period of days and that these patients had a high infection rate." On September 1, 2005, we made an unannounced site visit to the West Palm Beach VAMC

Our review of the surgeon's VAMC employment application, VA Form 10-2850 dated 10/10/03, found the following:

- The surgeon had been named in only two malpractice cases over the last ten years, and no monetary judgments had been awarded to either plaintiff.

- A July 21, 2003, letter from the private medical center where the surgeon had last been employed indicated the surgeon had been a member in good standing on the medical staff from July 1997 to July 1, 2003, with a specialty of Neurosurgery and no disciplinary actions. The letter also noted that the surgeon had performed 1,082 procedures during the period October 2000 thru May 2003.

- The National Practitioner Data Base query dated July 11, 2003 came back with no matches.

- Recommendation letters from three physician obtained on 8/18/2003 all recommended the surgeon without reservation.

We also reviewed the Professional Standards Board Minutes dated October 10, 2003. The minutes show that the Board made a recommendation to approve the surgeon for initial clinical privileges pending six month proctorships for all special procedures and approval of the Clinical Executive Board.

We interviewed the Chief of Quality Management and the NSQIP Nurse Reviewer. The Chief of Quality Management was not aware of any practice variations or quality of care issues concerning the surgeon. The NSQIP nurse

reviewer told us that 8 of the 91 procedures that the surgeon performed at the VAMC had occurrences that were reported in the National Surgery Quality Improvement Program (NSQIP) data base. All of the occurrences were resolved. She told us that the NSQIP data did not indicate any unusual trends in morbidity or mortality. .

During our site visit we were told that the surgeon was in the process of being re-privileged, and the process would be completed in November 2005. Therefore we delayed our report until this process was completed.

On inquiry regarding the result of the re-privileging, the Chief of Quality Management told us that the surgeon's temporary appointment at the VAMC expired on November 4, 2005. She told us that the surgeon elected not to extend her appointment and therefore, she will not be re-privileged.

We did not substantiate any of the allegations or find any problems with the surgeons practice patterns during her appointment at the VAMC. Therefore we did not make any recommendations.