Administrative Closure
Increased Surgical Mortality and Falsification of Documents
Louis Stokes VA Medical Center, Cleveland, Ohio
MCI Number: 2011-02865-HI-0169

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant that a surgeon (subject surgeon) at the Louis Stokes VA Medical Center (facility) in Cleveland, Ohio, had a high mortality rate and falsified documents.

We did not substantiate the allegation that the subject surgeon had a patient mortality rate of 10 to 15 patients over a one-year period. However, we did identify that surgical documentation and the peer review process need improvement.

The complainant sent 4 faxes with 17 patient names over a 6-week period to support the allegation of a high patient mortality rate. We reviewed all 17 patients' electronic health records (EHRs); eight of the patient were deceased. The eight deaths occurred between October 2009 and June 2011. While 5 of the 17 identified patients died within 30 days of surgery, the patients were all high-risk surgical cases and expected mortality was high.

We found inconsistent documentation of the pre-anesthesia evaluation and American Society of Anesthesiologists (ASA) assignment in the 44 surgical cases involving the 17 named patients. Eleven (25 percent) of the surgical procedures were missing pre-anesthesia notes and 19 (43 percent) were missing ASA classification in the pre-anesthesia notes.

We reviewed peer review data from October 2009 to August 2011 and found (b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

The facility self-identified inconsistencies in internal peer reviews of supervisory providers and changed their medical center policy in March 2011 to externally peer review all supervisory providers.[1]

While we substantiated that the surgeon's mortality rate was averaged with the other facility surgeons of the same specialty, we did not substantiate that this was done to improve the appearance of the subject surgeon's mortality rate. We reviewed surgical data from quarter 4 of fiscal year (FY) 2010 through FY 2011 and found that the facility monitored and reviewed surgical data through occurrence screens, peer reviews, and Veterans Affairs Surgical Quality Improvement Program (VASQIP) data.[2] Based on the allegation, facility managers reviewed both averaged surgical data and the subject surgeon's specific data.

We did not substantiate the allegation that the subject surgeon had falsified surgical dictations. We reviewed EHRs of patients named by the complainant and conducted interviews with OR nurses and technicians, anesthesiology staff, surgeons, and surgical residents. Prior to being interviewed, OR staff were asked to read operative reports of cases with which they assisted. During interviews, staff commented on the accuracy of the reports and, in all cases, stated that (to the best of their recollection) the operative reports contained no falsifications.

We received written notification on June 14, 2012, from the facility director that the subject surgeon has resigned and accepted a position outside of the VA medical system effective (b)(6) (b)(6)

We discussed with the facility director the need to monitor the peer review process to ensure compliance with VHA policies and the amended peer review process regarding chief of service physicians, and review the pre-operative risk assessment practices to ensure that all required elements are completed and documented prior to a surgical procedure.

John D. Daigh, Jr., M.D.
Assistant Inspector General
For Healthcare Inspections
7/25/12

NB old cases

[1] Louis Stokes VA Medical Center, MCP 011-067, *Peer Review for Quality Management*, July 19, 2011.
[2] VASQIP is responsible for VHA's measurement and reporting of surgery outcomes and is overseen by the National Director of Surgery.