Administrative Closure
Alleged Quality of Care Concerns
Oklahoma City VA Medical Center, Oklahoma City, OK
MCI# 2012-02655-HI-0395

On April 26, 2012, the Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received allegations regarding the quality of patient care at the Oklahoma City VA Medical Center, Oklahoma City, OK.

An anonymous complainant alleged that:

- Facility administration was aware of concerns regarding a surgeon's competency; however, the surgeon was still allowed to perform [redacted] surgical procedures alone.
- The surgeon had completed only two [redacted] operations without assistance.
- A patient died unexpectedly three hours after a [redacted] surgery [redacted] and a "near miss" was identified when the surgeon [redacted] in another surgical case.

The complainant contacted the OIG Hotline Division on April 20, 2012. OHI contacted the facility on May 1, 2012, to discuss the allegations. The facility provided the following documents to OHI: Professional Standards Board (PSB) minutes, operative reports, initial Focused Professional Practice Evaluation (FPPE) for the surgeon, and the surgical peer review.

The facility's PSB initially approved the surgeon's credentials and privileges and an FPPE was presented after 3 months that identified no issues. Over a period of 9 months, the surgeon was the attending provider for a total of 46 surgical cases and all 46 cases were successful.

The unexpected death was immediately reported to Quality Management and a surgical peer review was promptly initiated and presented to the Peer Review Committee. The surgeon called for assistance during a separate case where [redacted] There was no negative outcome to the patient, but the case was identified as a "close call." The surgeon volunteered to cease performing surgeries until an additional FPPE and review was completed by the PSB. [redacted]

The facility acted promptly in initiating a thorough case review and took appropriate follow-up actions.

I concur with recommendation for administrative closure of this inspection.

Approved by: _____
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

5/23/12