



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Leadership Failures Related
to Training, Performance,
and Productivity Deficits of a
Provider at a Veterans
Integrated Service Network
10 Medical Facility



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a concern from the U.S. Office of Special Counsel about allegations of mismanagement, waste of funds, and safety risks at a Veterans Integrated Service Network 10 medical facility (facility). Specifically, a complainant alleged that an ophthalmologist (surgeon) lacked adequate training, provided substandard care to patients, and failed to meet productivity expectations. The complainant also alleged that although numerous staff members reported the surgeon's deficient surgical skills, excessive operative times, and substandard care, the chief of staff (COS) intended to reappoint the surgeon following an initial probationary period. The purpose of this review was to evaluate the merit of the allegations and determine if facility leaders responded to the concerns brought to their attention.

Reportedly, while recruiting an otolaryngologist (ear, nose, and throat specialist) in 2016, the facility's chief of surgery learned that the otolaryngologist's spouse was an ophthalmologist, and therefore a potential candidate for a vacant ophthalmology position.¹ The surgeon entered on duty the same day as the otolaryngologist.

The OIG substantiated that the surgeon lacked adequate training to perform cataract and laser surgery as the surgeon did not satisfactorily complete an approved residency training program.² The surgeon attended a foreign medical school and was a licensed physician in Kentucky. However, the surgeon was ineligible for board certification in ophthalmology. Because the surgeon was not board-eligible, the surgeon did not meet the facility's requirements for hire as an ophthalmologist.³

The OIG found several credentialing and privileging activities that did not comply with Veterans Health Administration (VHA) requirements. Specifically, the credentialing and privileging coordinator did not explain to the OIG why primary source verification was not obtained from all of the foreign educational institutions the surgeon listed in VetPro and did not document when attempts to do so were unsuccessful.⁴ Additionally, the references provided by the surgeon and accepted by the facility were insufficient to determine the surgeon's suitability to perform cataract surgeries. Nonetheless, the COS, who relied on the chief of surgery's judgment that the

¹ Facility leadership approved the hiring of a full-time ophthalmologist in mid-October 2016.

² VHA requires accredited ophthalmology training by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Board of Ophthalmology.

³ VHA Directive 1132, *Performance of Therapeutic Laser Eye Procedures in Veterans Health Administration Facilities*, May 5, 2015.

⁴ VetPro is the Veterans Health Administration's electronic credentialing system and must be used for credentialing all practitioners who are granted clinical privileges.

surgeon was an appropriate candidate to be the facility's sole ophthalmologist, endorsed the professional standards board recommendation to initially appoint the surgeon with privileges to perform cataract surgery in late November 2016.

The surgeon did not consistently demonstrate surgical skills necessary to assure good outcomes, and the surgeon often required significantly more time to perform cataract surgeries than other (contract) ophthalmologists. For example, the COS was told in early March 2018 that, on average, it took the surgeon from one–two hours to complete a single cataract surgery as compared to the VHA average of 26 minutes. Additionally, the surgeon's demeanor in the operating room was described as timid, which potentially contributed to the prolonged surgical times that increased risk of surgical complications.

Staff concerns about the surgeon's productivity, competency, and technical skills began within months of hire and continued throughout the surgeon's tenure. Seven months after the surgeon performed the first cataract surgery, and as part of the ongoing professional practice evaluation (OPPE) process, the chief of surgery requested one of the contract ophthalmologists directly observe the surgeon performing cataract surgery. Although the results of the OPPE indicated that the observed cases were within community standards, the criteria used and documented on the OPPE did not address the concerns brought to facility leaders' attention. For example, the criteria did not include the type or complexity of the cases or reference surgical times. The chief of surgery did not appear to question the shortcomings of the OPPE, and the surgeon continued to independently perform cataract surgery.

The COS also requested independent and retrospective clinical reviews by two Veterans Integrated Service Network ophthalmologists. Both reviews reflected deficits. One physician reviewer identified prolonged cataract surgery times and inadequate or missing clinical documentation. Based on the surgeon's documentation, the second physician reviewer told the OIG that it appeared the surgeon did not give "good care." The COS acknowledged the reviewer's comments, describing them as "significant for concerns about the surgeon's judgment, techniques and laser procedure management." However, the COS did not timely terminate the surgeon, suspend surgical privileges to perform cataract surgery or laser procedures, or implement a performance improvement plan.⁵

The OIG substantiated that the surgeon was unable to meet the facility's expectation for surgical productivity and that surgery times exceeded norms. The surgeon was expected to perform six or more cataract surgeries during a scheduled operating room day. However, after a year, the surgeon was only able to consistently complete two cataract surgeries during an operating room day and never reached the required productivity. Attempts to increase the surgeon's productivity

⁵ In late October 2018, the COS was considering either terminating the subject surgeon for unacceptable performance or developing a short-term performance improvement plan. However, the subject surgeon was allowed to stop performing cataract surgeries and no further action was pursued. The COS did not provide the OIG with an explanation for this decision.

were unsuccessful, resulting in an increase in “suboptimal outcomes” identified during routine audits of cataract cases in August 2017. Specifically, after the surgeon performed ophthalmologic procedures, several patients were referred to community providers with “suboptimal outcomes” including increased swelling, and less-than-expected improvement in vision following cataract surgery. The surgeon was subsequently assigned less complex cataract surgery cases. In November 2018, the COS allowed the surgeon to voluntarily relinquish surgical privileges to perform cataract surgery but continued to perform clinic laser procedures.

The facility likely incurred expenses for ophthalmology care that it intended to avoid. The COS told the OIG team that hiring the surgeon provided an opportunity for the facility to reduce the cost of purchased eye care (by providing those services in the facility). However, due to the surgeon’s limited skills to perform the full range and volume of surgeries, patients requiring more complex cataract surgery and specialty care continued to be referred to other ophthalmologists. The team found that the facility’s decision to continue referring some surgical eye procedures to community care and contract providers was appropriate to ensure safe patient care.

Despite the ongoing concerns regarding surgical skills and productivity and the objections of two members of the professional standards board, the COS endorsed the surgeon’s reappointment as a member of the facility medical staff and sole ophthalmologist. Although the COS denied being influenced to overlook the surgeon’s deficient practices for fear the spouse (also a surgeon) would quit, the COS did acknowledge that it was a consideration. While the reappointment appropriately did not include cataract surgery privileges, laser procedure privileges were granted in conflict with VHA guidelines. The surgeon performed laser procedures through February 2019. In March, the OIG was notified that the surgeon’s employment had been terminated.

The OIG team concluded that multiple system and leadership failures allowed a surgeon to perform cataract surgery and clinic laser procedures without the required training and competency to do so. Once the surgeon’s deficits were identified, facility leaders were slow to respond. As a result, over a two-year period, patients were placed at unnecessary risk for potential surgical complications. Although the OIG team was not told about, nor did it identify, patients that experienced permanent vision loss directly resulting from the surgeon’s practice, some patients required referral to community providers for additional surgeries or other treatment to resolve post-operative complications.

The OIG made five recommendations related to credentialing and privileging, focused professional evaluation, actions of the facility COS, and resources to support providers with performance deficits.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans. (See appendixes B and C, pages 19–23.) The OIG will follow up on the planned actions until they are completed.



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Abbreviations

C&P	credentialing and privileging
COS	chief of staff
FPPE	focused professional practice evaluation
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
PSB	professional standards board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a concern from the U.S. Office of Special Counsel about allegations of mismanagement, waste of funds, and safety risks at a Veterans Integrated Service Network (VISN) 10 Medical Facility (facility).⁶ Specifically, a complainant alleged that an ophthalmologist (surgeon) lacked adequate training, provided substandard care to patients, and failed to meet productivity expectations. The complainant also alleged that although numerous staff members reported concerns about the surgeon's practice, the chief of staff (COS) intended to reappoint the surgeon following an initial probationary period.⁷

On January 8, 2019, the OIG learned that the COS was aware of the concerns, but described the surgeon's practice, and the COS's actions related to professional oversight activities, in a substantially better light than was reported by the complainant. The purpose of this review was to evaluate the merit of the allegations and determine if facility leaders responded to concerns brought to their attention.

Background

The facility offers primary and secondary medical and surgical services. Primary care clinics are available at the facility and its community based outpatient clinics.

Veterans Health Administration Eye Care Program

The Veterans Health Administration (VHA) Office of Specialty Care Services has established guidelines for the provision of eye care. At the facility level, the director is responsible for ensuring there is a full-time clinical ophthalmologist able to provide eye care services for 1,300 to 1,800 unique patients and to perform surgery and laser procedures.⁸ Additionally, a full-time optometrist is expected to provide care for 1,200 to 1,700 unique patients per year. However, VHA also acknowledges that this productivity standard is dependent upon the availability of support personnel, operating room time, and the number of part-time or contract ophthalmologists and optometrists.

⁶ The U.S Office of Special Counsel is an independent federal investigative agency whose primary mission is to safeguard federal employees from prohibited personnel practices, especially reprisal for whistleblowing.

⁷ The term "appointment" refers to the medical staff. After the credentialing and privileging process is complete, medical staff are allowed to provide patient care services. This process is referred to as being "appointed" as a member of the facility medical staff.

⁸ VHA requires that only ophthalmologists who have completed an approved and accredited ophthalmology residency program or are certified by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology, may perform laser eye procedures.

Credentialing and Privileging

All VHA health care professionals, who are permitted by law and the facility to provide patient care services independently, must be credentialed and privileged. Credentialing refers to the process of screening and evaluating qualifications, while privileging refers to granting a provider's request to independently perform specific medical, surgical, or other patient care services that are within the scope of the provider's license and clinical competence. Clinical privileges are granted for a period not to exceed two years.

After being granted permission to provide patient care, VHA requires periodic individual provider performance evaluations. This requirement is accomplished in two ways:

- Focused professional practice evaluation (FPPE) refers to the evaluation of a provider's specific competence. FPPE occurs at the time of initial appointment and prior to granting new or additional privileges. FPPE may also be used when a question arises regarding a currently privileged provider's ability to deliver safe, high-quality patient care.⁹ The process may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.
- Ongoing professional practice evaluation (OPPE) refers to the monitoring of providers to confirm the quality of care delivered and to ensure patient safety. Activities such as direct observation, clinical discussions, and clinical pertinence reviews can be incorporated into this process.

VHA requires ophthalmology- and optometry-specific FPPE and OPPE at least every six months to evaluate care delivered to patients diagnosed with macular degeneration, diabetic retinopathy, and glaucoma.¹⁰ These focused and ongoing professional practice reviews are to be used by the respective section or service chiefs of ophthalmology and optometry and the Executive Committee of the Medical Staff for initial privileging and re-privileging decisions. Facilities with a single eye care provider are to make arrangements with the respective VISN Eye Care lead or another VHA medical facility with a comparable eye care professional to conduct the reviews.

The facility professional standards board (PSB) is responsible for reviewing and making recommendations on whether a physician applicant meets the requirements as established by VHA standards. Whenever possible, the PSB will be composed of employees from the same

⁹ For example, an FPPE for cause is used when a privileged provider is given an opportunity to improve through a structured process and is similar to a performance improvement plan for non-privileged providers.

¹⁰ Macular degeneration is caused by the deterioration of the central portion of the retina, the inside back layer of the eye that records the images we see and sends them via the optic nerve from the eye to the brain; it is the leading cause of vision loss and is considered an incurable eye disease. Diabetic retinopathy is an eye condition that occurs in people with diabetes and is caused by high blood sugar levels that damaged blood vessels in the eye. Glaucoma is a disease where the pressure from fluid buildup in the eye damages the optic nerve.

occupation as the individual being considered, however qualified individuals from other occupations may participate.

Allegations

On December 26, 2018, the U.S. Office of Special Counsel notified the VA OIG of a complainant's allegations:

- The surgeon lacked adequate training.
- The surgeon provided substandard care—specifically noted were deficient surgical skills and excessive operating room times—that increased patients' risks for complications.
- The surgeon's substandard performance resulted in diminished productivity and increased expenses for the facility as certain procedures and complex cases had to be referred to other ophthalmology providers.
- Despite the surgeon's substandard care being reported to facility leaders, the COS intended to reappoint the surgeon in early 2019 at the completion of the probationary period.¹¹

Scope and Methodology

The OIG initiated the inspection on January 7, 2019, and conducted a site visit March 5–8, 2019.

Prior to the onsite inspection, the OIG team interviewed the complainant, Facility Director, COS, and the current and previous risk managers. During the onsite inspection, the OIG team interviewed the surgeon, ophthalmology and optometry providers, staff from the operating room and eye clinic, credentialing and privileging (C&P) staff, and others with knowledge of the allegations and the facility's response. Additionally, following the onsite visit, the OIG team interviewed the previous VISN surgical consultant and the program director for medical staff affairs.

The OIG team's data review included electronic health records for patients who underwent laser eye procedures from February 7, 2017, through February 27, 2019, and patients who had cataract surgeries performed by the surgeon from February 28, 2017, through November 7, 2018.¹²

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the

¹¹ The probationary period allows a federal employer an opportunity to evaluate a new employee's conduct and performance before an appointment becomes final.

¹² The surgeon was hired in January and started performing cataract surgery February 28, 2017. There was a delay while the facility obtained equipment and instruments the surgeon requested.

available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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

Table 1. Timeline of Key Events

	Month	Event or Activity
2017	February	The surgeon began to perform cataract surgeries and clinic laser procedures.
	March	Ten cataract surgeries were completed during the initial FPPE period from January through April 2017.
	April	The chief of surgery developed a plan to increase productivity.
	May	The chief of optometry and clinical optometry staff raised concerns to the chief of surgery about referring patients to the surgeon for cataract surgery.
	July	The chief of optometry requested review of surgeon's cataract surgery complications.
	August	During the initial OPPE period, four of the surgeon's cataract surgery cases were sent for peer review. ¹³ The surgeon requested privileges to perform intravitreal injections (medical retina procedures). ¹⁴
	September	Fifty-three cataract surgeries were completed during the initial OPPE period from April through September 2017. The chief of surgery requested a contract ophthalmologist to directly observe the surgeon performing cataract surgery.
	October	The chief of optometry raised concerns about the increase in complications associated with attempts to increase the surgeon's productivity.
2018	Month	Event or Activity
	March	The acting chief of surgery raised concerns about the surgeon's competency. The COS requested a VISN ophthalmologist perform a retrospective review of cataract surgery and laser procedures.
	April	The surgeon's request to perform medical retina procedures was denied. ¹⁵
	July	The acting chief of surgery requested FPPE for cause due to the surgeon's prohibited use of cut and paste documentation and recommended the surgeon no longer perform cataract surgeries.

¹³ Peer review is an organized process to evaluate the performance of other professionals (peers) and is intended to promote confidential and non-punitive processes that consistently contribute to quality management efforts at the individual provider level.

¹⁴ Intravitreal injection is a procedure used to put medication directly into the back of the eye. The procedure is used to treat a variety of medical conditions such as age-related macular degeneration, diabetic retinopathy, and retinal vein occlusion. <https://www.asrs.org/patients/retinal-diseases/33/intravitreal-injections>. (The website was accessed on May 19, 2019.)

¹⁵ Medical retina is a specialty that uses medication injections to treat certain conditions of the eye. As the result of a failed FPPE, the surgeon's request for privileges to perform intravitreal injections was denied.

	October	The COS considered termination of the surgeon for substandard performance.
	November	The COS requested a second VISN ophthalmologist review selected cataract and laser procedures. The reappointment decision was postponed pending the VISN review results. The surgeon voluntarily relinquished operative privileges and was not performing cataract surgery.
	December	Reappointment of the surgeon was approved with modification of privileges to exclude cataract surgery but allow clinic-based laser procedures.
2019	February	The surgeon continued to perform clinic laser procedures until late February.
	March	The OIG was notified that the surgeon's employment had been terminated.

Source: VA OIG analysis

**This timeline illustrates key events following the surgeon's appointment as the facility's sole staff ophthalmologist.*

Inspection Results

1. Inadequate Training

The OIG substantiated that the surgeon lacked adequate training to perform cataract surgery as required by VHA.¹⁶ The surgeon did not complete an approved U.S. residency program in ophthalmology but was hired anyway. The OIG subsequently determined that the surgeon was unable to perform the range or volume of surgeries expected while maintaining quality care and good outcomes. Additionally, and despite requirements to do so, facility staff did not document unsuccessful attempts to verify the surgeon's foreign education and training.

Verification of Physician Education and Training

Ophthalmologists are physicians specializing in the comprehensive care of the eyes and visual system. Following medical school, ophthalmologists complete four years of specialized training that includes a three-year residency in ophthalmology and a one-year internship. Optometrists are health care providers who examine, diagnose, and treat conditions of the eye. Optometrists complete four years of optometry training, one year of residency training, and one to two years of fellowship training.

VHA requires physician applicants to have a degree in medicine from a school accredited by the Liaison Committee on Medical Education leading to a full and unrestricted license to practice medicine in any U.S. state or territory.¹⁷ Medical education received by foreign graduates must be verified by the Educational Commission for Foreign Medical Graduates.¹⁸ The OIG team found that the surgeon attended a foreign medical school, and the required Educational Commission for Foreign Medical Graduates certificate to verify the school's credentials had been obtained by the C&P coordinator and was part of the C&P file. Additionally, the OIG team confirmed that the surgeon was a licensed physician in the state of Kentucky.

VHA also requires physician applicants to have completed an approved and accredited residency training program leading to eligibility for board certification in the physician applicant's individual specialty area.¹⁹ In addition, VHA requires that only ophthalmologists who have completed an accredited ophthalmology residency program perform laser eye procedures. The OIG team determined that the surgeon had not completed an approved residency program in ophthalmology, and the C&P file presented to the PSB in late November 2016 accurately

¹⁶ VHA Handbook 5005/85. *Staffing*. December 17, 2015, appendix G2.

¹⁷ The Liaison Committee on Medical Education is the U.S. Department of Education recognized body that accredits programs leading to the MD degree in the United States.

¹⁸ Educational Commission for Foreign Medical Graduates Certification ensures that international medical graduates in patient care situations have met minimum standards.

¹⁹ The Accreditation Council for Graduate Medical Education and the American Osteopathic Association are the only approved accrediting bodies accepted by the Secretary of Veterans Affairs. Their accreditation only applies to U.S. residency programs; VHA Handbook 5005/85. *Staffing*. December 17, 2015, appendix G2.

reflected that information. Nonetheless, the COS, who relied on the chief of surgery's judgment that the surgeon was an appropriate candidate to be the facility's sole ophthalmologist, endorsed the PSB recommendation to initially appoint the surgeon with privileges to perform cataract surgery.

PSB approved the surgeon's request for surgical privileges without consulting an ophthalmologist of equal or higher qualifications than the subject surgeon, nor did the facility consult with the VISN or other resources to support the decision to hire.

Primary Source Verification

Primary source verification is documentation from the original source of a qualification reported by an individual health care provider. For healthcare professionals requesting clinical privileges, primary source verification of all residences and other clinical training programs is required. When verification from a foreign country is not possible, full documentation of efforts and circumstances should be filed in the C&P file in lieu of the document sought.

The C&P staff are responsible for verifying the education and training claimed by a physician applicant. The OIG team noted that the surgeon's application listed additional post-medical school education and training; however, the C&P coordinator did not obtain primary source verification from the additional institutions the surgeon provided. The C&P coordinator told the OIG team that although letters were sent to all the post-graduate educational institutions the surgeon listed in VetPro, no replies were received and that non-U.S. educational institutions typically do not respond to requests to verify an applicant's education.²⁰ However, the C&P coordinator was unable to provide documentation of the unsuccessful attempts to obtain primary source verification as VHA requires.

References

In addition to documentation to support claims of education and training, VHA requires physician applicants to provide the names of references with knowledge of the applicant's ability to perform the work for which they are being hired. The references should contain specific information about the individual's level of performance, number and type of procedures performed, appropriateness, and outcomes of care provided. Additionally, the former VISN surgical consultant told the OIG team that a reasonable expectation when hiring a surgeon would be to obtain information, from someone other than the applicant, on surgical case volume, complication rates, and surgical procedure outcome data. The OIG team reviewed the four references the surgeon provided and noted that two of the four individuals providing references had no direct knowledge of the surgeon's ability to perform cataract surgeries and were therefore unable to provide information on the types of surgeries performed, outcomes, or complication rates. A third reference, from the director of an ophthalmology fellowship program,

²⁰ VetPro is VHA's electronic credentialing system and must be used for credentialing all practitioners who are granted clinical privileges.

described the surgeon as “meeting or exceeding program requirements,” but did not provide the actual numbers or types of procedures the surgeon completed or describe the quality of surgical outcomes. The fourth reference described the surgeon’s satisfactory performance of 17 cataract surgeries in one country and 30 in another country. However, this individual was also unable to describe the surgeon’s technical performance of these surgeries. The OIG concluded that the references accepted by the facility were insufficient to determine the surgeon’s suitability to perform cataract surgeries. (Details of references, education, and training can be found in appendix A.)

Functional Statement

Applicants for healthcare positions with VHA agree to accept the professional obligations as defined in their individual specialty position description or functional statement. The facility’s functional statement for a staff ophthalmologist required the incumbent to be a licensed, full-time, board-certified ophthalmology surgeon who had completed an accredited ophthalmology residency.²¹ The OIG determined that the surgeon held an active state medical license. However, the surgeon was not board certified in ophthalmology and had not completed an ophthalmology residency program in the United States.

The OIG team concluded that facility leaders hired the surgeon to be the sole staff ophthalmologist knowing that the applicant lacked the residency training required to perform the full spectrum of ophthalmology services as outlined in the functional statement.²² Nevertheless, the surgeon started work at the facility on January 23, 2017.

2. Substandard Care

The OIG substantiated through interviews and document reviews that the surgeon did not consistently demonstrate surgical skills necessary to assure good outcomes. Further, the OIG substantiated that the surgeon often spent more time to complete cataract surgeries than other ophthalmologists who cared for facility patients. For example, the COS was told in early March 2018 that, on average, it took the surgeon from one–two hours to complete a single cataract surgery as compared to the VHA average of 26 minutes. Additionally, the surgeon’s demeanor in the operating room was described as timid, which potentially contributed to the prolonged surgical times and increased risk of surgical complications.

²¹ Board certification is a voluntary process that indicates a practicing physician’s mastery of the core body of knowledge and skills in his or her chosen specialty at a specific time.

²² As the sole ophthalmologist, the subject surgeon would be the primary person responsible for providing eye care services during times when the contract ophthalmologists were not present in the facility. Therefore, in the event of any unanticipated emergency, the subject surgeon would be expected to perform the full spectrum of ophthalmology services needed.

The OIG team found that leaders were slow to evaluate reports related to the surgeon's clinical deficiencies.

Whenever there are concerns that a provider has demonstrated "substandard care, professional (clinical) misconduct or professional (clinical) incompetence," the facility is required to gather information to either confirm or refute the legitimacy of the concerns.²³ When sufficient evidence exists that a provider may have demonstrated substandard care, the COS "will appoint one or more impartial clinical reviewers to complete a comprehensive focused clinical care review of the concerns." The clinical care reviewers may be from other VHA healthcare facilities and should have the same specialty and similar privileges to ensure an objective review.

The surgeon began performing cataract surgery in late February 2017. Interviewees told the OIG team that within a few months, facility leaders were told that during surgery, the surgeon appeared to "lack confidence" and the surgical times were excessively long. However, it was not until September 2017, seven months later, that the chief of surgery requested one of the contract ophthalmologists to observe the surgeon performing cataract surgery. Although the results of the observed cataract surgery cases indicated that the care was "within community standards," the OIG found the criteria used to evaluate the surgeon, as documented on the OPPE form, did not address the issues and concerns brought to the facility leaders' attention. For example, the criteria did not describe the complexity of cases, document the time it took to complete the cataract surgeries, or reference the number of cases observed. The chief of surgery did not appear to question the shortcomings of the review process and results.

The COS told the OIG team that for a period of several months, it appeared that the surgeon's surgical times were improving. However, concerns raised in March 2018 by one of the acting chiefs of surgery prompted the request for an ophthalmologist within the VISN to review the documentation of several of the surgeon's cataract surgeries and clinic laser procedures. The VISN ophthalmologist reviewed nine cataract surgeries and six laser procedures and determined that, in general, surgical outcomes "were good." However, the VISN ophthalmologist also noted concerns about "inappropriate or premature procedures [being completed] and insufficient documentation of patient education and understanding." No apparent action was taken to further evaluate or address the VISN ophthalmologist's concerns.

In November 2018, and in preparation for renewing the surgeon's privileges, the COS requested a second VISN ophthalmologist review the documentation for a sample of cataract surgeries and laser procedures performed by the surgeon from April 2018 through November 2018. This VISN ophthalmologist identified similar issues with the cataract surgeries as previously noted by other reviewers that included surgical times longer than expected for routine cases, and inadequate or missing clinical documentation. In addition, the second VISN ophthalmologist described the surgeon's documentation for the five laser procedures as "maybe" demonstrating a lack of clinical judgment; and told the OIG team that it did not appear that good care was provided. In a

²³ Facility, *Medical Staff Bylaws and Rules*, January 17, 2018.

follow-up email to the second VISN ophthalmologist, the COS acknowledged “significant concerns regarding the surgeon’s judgment, technique and management of these veterans’ conditions [laser cases].” Despite this concern, the COS did not timely terminate the surgeon, suspend surgical privileges to perform cataract surgery or laser procedures, or implement a performance improvement plan. Instead, the COS allowed the surgeon to continue to perform laser procedures until February 2019.

3. Productivity and Cost

The OIG substantiated that the surgeon was unable to meet the facility’s expectation for surgical productivity and that clinical staff continued to refer surgical ophthalmology cases to community providers. Although the OIG substantiated that the facility incurred expenses for ophthalmology care referred to other providers, the OIG team did not attempt to quantify the cost.

Productivity

A member of the Surgery Service told the OIG team that the expected productivity for the surgeon was six to eight cataract surgeries during a scheduled operating room day. However, after a year, the surgeon was not able to reach that number and was only able to complete two cataract surgeries during a scheduled operating room day.²⁴ This contrasted with the facility’s contract ophthalmologists, who generally performed between six and eight cataract surgeries during their individual scheduled operating room times, with the average cataract surgery taking between 15–20 minutes to complete.

In April 2017, the chief of surgery proposed a plan to improve the surgeon’s productivity. Specifically, the surgeon would start performing three cataract surgeries per week, increasing the number by one each month until reaching six completed cataract surgeries during a scheduled operating room day. However, in October 2017, the chief of optometry told the acting chief of surgery that increasing the surgeon’s productivity had resulted in increased complications and suboptimal outcomes.²⁵ Specifically, after the surgeon performed ophthalmologic procedures, several patients were referred to community providers with increased swelling and less-than-expected improvement in vision following cataract surgery. The surgeon was subsequently assigned less complex cataract surgery cases.

The COS told the OIG team that although concerns regarding the surgeon’s cataract surgery times continued, the chief of surgery said that surgical times had decreased and there were no confirmed cases with negative outcomes. In early March 2018, the acting chief of surgery told the COS that the surgeon’s productivity had not improved, surgical times were still outside of VHA norms, there was an increase in intraoperative complications, and complex surgeries were still being sent out to community providers. While the surgeon was still performing cataract

²⁴ The surgeon, on average, took one to two hours to perform a cataract surgery.

²⁵ The permanent chief of surgery was temporarily removed from administrative responsibilities and a series of acting chiefs continued to manage the surgery program.

surgeries until November 2018, contract and community ophthalmologists were performing a majority of cataract surgeries to meet patient care needs.

Increased Costs

The COS justified hiring the surgeon as a way to reduce the cost of purchased eye care (by providing those services in the facility). However, due to the surgeon's limited skills to perform the full range and volume of surgeries, patients requiring more complex cataract surgery and specialty care were routinely referred to other ophthalmologists, which resulted in costs the facility intended to avoid. Because it is difficult to determine retrospectively and with certainty the appropriateness of a specific patient's referral to a community provider on a given day in the past, the OIG team did not attempt to isolate and quantify eye care costs incurred by the facility for these services.

The OIG team noted that, given the circumstances surrounding the surgeon's performance, the decision to refer some surgical eye procedures to other providers was appropriate to ensure safe patient care.

4. 2019 Reappointment

The OIG substantiated that the surgeon was reappointed in early January 2019 at the completion of the probationary employment period.²⁶

In November 2018, the surgeon's C&P file was presented to the facility PSB for review and approval. Because a second VISN ophthalmologist's review of the surgeon's cataract and laser procedures was pending, the PSB requested to delay the reappointment decision until late December. After receiving the results from the second VISN ophthalmologist's review, and despite the concerns surrounding the surgeon's ability to perform laser procedures, the PSB recommended reappointment with laser procedure privileges in conflict with VHA guidelines.

Two members of the PSB told the OIG team that because of the ongoing concerns about competency, they were opposed to the surgeon's reappointment. The COS told the OIG team of being aware of staff concerns; however, the COS felt the surgeon was making progress with surgical productivity. Given the data provided to the COS on three separate occasions describing the surgeon's technical skills deficits, intraoperative complications, and failed attempts to improve surgical productivity, as well as the results of two external reviews, the OIG team found the COS's statements to be inconsistent with the facts. Despite ample evidence that the surgeon was not meeting expectations, the COS approved reappointment.

²⁶ New VHA employees are required to complete a two-year probationary period. The probationary period allows the supervisor to observe an employee's on-the-job performance and determine suitability for continued employment.

Leaders' Awareness and Response

Clinical leaders knew prior to hire that the surgeon had not completed the required residency training and knew within months of the surgeon being hired that performance and productivity deficits existed.

Specifically, the COS knew that the surgeon did not have the required residency training. The lack of required training, coupled with “weak” references, should have prompted a more proactive, real-time evaluation of the surgeon’s skills and competence during the initial FPPE. The former chief of surgery; however, elected to complete the initial FPPE via a retrospective chart review, which may not have been sufficient to proactively identify deficits in the surgeon’s technical skills to perform cataract surgeries.

In early 2017, staff began to voice concerns to facility leaders about the surgeon’s prolonged surgery times, lack of confidence, and other concerning surgical practices. Reportedly, one staff member personally informed the Facility Director of issues concerning the surgeon’s operative skills. Although staff continued to raise concerns about the surgeon’s general competency, clinical knowledge, and cataract surgery complications during the initial two-year probationary period, the chief of surgery continued to describe the surgeon as having good [surgical] outcomes and that the primary issue was productivity. In March and July 2018, additional performance concerns were reported.

In early October 2018, the COS was considering terminating the surgeon, who was still a probationary employee.²⁷ Instead, a month later, the COS elected to seek another peer evaluation of the surgeon’s performance, the results of which reinforced previous assessments of the surgeon’s skills and competence. Although the COS considered initiating a remedial plan to assist the surgeon to be successful and also considered suspending surgical privileges, the COS did neither.²⁸ Instead, prior to reappointment, the surgeon was allowed to voluntarily stop performing cataract surgery. The surgeon performed cataract surgery for nearly two years before relinquishing surgical privileges.

Interviewees told the OIG team that they believed that the COS and chief of surgery did not take their concerns about the surgeon’s surgical practices seriously because facility leaders needed the services of the surgeon’s spouse, who was also a surgeon. Both the surgeon and the spouse were hired by the facility in January 2017. During interviews with the OIG, staff frequently referred to the hiring of the two surgeons as a “package deal,” and implied that leaders’ decision to hire the surgeon was influenced by a desire to hire the spouse.

²⁷ VHA facilities may terminate an employee during the probationary period when performance does not demonstrate a fitness for continued employment. Employment is terminated once the employee is notified in writing the reasons for the termination and the effective date. When a probationary employee is terminated for unsatisfactory performance, appeal rights are limited.

²⁸ The OIG found no evidence that the performance plan considered by the COS was ever implemented.

The COS characterized the hiring of the two surgeons as a “package set” which provided the organization an opportunity to fill two positions. Although the COS denied being influenced to overlook the surgeon’s deficient practices for fear the spouse would quit, the COS did acknowledge that it was a consideration. However, the COS also stated that if the spouse should decide to leave because of actions initiated against the surgeon, it would not deter the facility from “doing what needed to be done.”

Overall, the OIG concluded that facility leaders repeatedly failed to respond timely and proactively to the surgeon’s surgical skill and clinical knowledge deficits. Those actions, or lack thereof, from the time of hire until termination, did not provide the surgeon with opportunities to gain additional knowledge and experience and ultimately placed patients at risk for surgical complications.

Conclusion

The OIG team substantiated that the surgeon lacked adequate training to perform cataract surgery and laser procedures as required by VHA. The surgeon did not complete an approved U.S. residency program in ophthalmology and was not board certified as required by the facility functional statement. In addition, C&P activities to verify physician education and training did not comply with VHA requirements, and the references attesting to the surgeon’s abilities to perform the work were insufficient. The surgeon was hired as the sole ophthalmologist and given privileges to perform cataract surgery and laser procedures.

The team substantiated that the surgeon did not consistently demonstrate surgical skills necessary to assure good outcomes and that the surgeon often spent more time performing cataract surgeries than other (contract) ophthalmologists. The OIG team identified deficient surgical skills and excessive operating room times which had the potential to increase patients’ risks for complications. The OIG team found that leaders were slow to evaluate reports related to the surgeon’s clinical deficiencies.

Staff concerns about the surgeon’s productivity, competency, and technical skills began within months of hire and continued throughout the surgeon’s tenure. The COS requested independent and retrospective reviews by VISN ophthalmologists. Both reviews reflected deficits. However, the COS did not timely terminate the surgeon, suspend surgical privileges to perform cataract surgery or laser procedures, or implement a performance improvement plan.

The surgeon was unable to meet the facility’s expectation for surgical productivity, surgery times exceeded norms, and attempts to increase productivity resulted in an increase in surgical complications. Although the OIG team was not told about, nor did it identify, patients that experienced permanent vision loss directly resulting from the surgeon’s practice, some patients required referral to community providers for additional surgeries or other treatment to resolve post-operative complications. The team found, though, that referring some surgical eye procedures to community care and contract providers was appropriate to ensure safe patient care.

Prior to the surgeon's reappointment, the COS acknowledged concerns about the surgeon's judgment, techniques, and laser procedure management. Further, two members of the PSB reported being opposed to reappointment. Despite this, the COS approved the PSB recommendation to allow the surgeon to continue to perform clinic laser procedures. Although the COS denied being influenced to overlook the surgeon's deficient practices for fear the spouse (also a surgeon) would quit, the COS did acknowledge that it was a consideration. The surgeon was reappointed in early January 2019 at the completion of the probationary period. The reappointment appropriately did not include privileges for cataract surgery; however, the privileges to perform clinic laser procedures were granted despite a VHA requirement that only ophthalmologists who have completed an accredited ophthalmology residency program perform laser eye procedures. The OIG team was subsequently notified that as of March 29, 2019, the surgeon was no longer employed by the facility.

The OIG team concluded that multiple system and leadership failures allowed the surgeon to perform cataract surgery and clinic laser procedures without the required training and competency to do so. Once the surgeon's deficits were identified, facility leaders were slow to respond. As a result, over a two-year period, patients were placed at unnecessary risk for surgical complications.

Recommendations 1–5

1. The Veteran Integrated Service Network 10 Medical Facility Director ensures the Credentialing and Privileging process for primary source verification of foreign education is performed and documented in accordance with Veterans Health Administration requirements.
2. The Veteran Integrated Service Network 10 Medical Facility Director ensures that the Credentialing and Privileging process for verifying and accepting professional references meets sufficiency standards in accordance with Veterans Health Administration guidance.
3. The Veteran Integrated Service Network 10 Medical Facility Director ensures that the Focused Professional Practice Evaluation process used to determine technical competence and skills meets Veterans Health Administration requirements.
4. The Veteran Integrated Service Network 10 Director evaluates whether the decision to reappoint the surgeon referenced in this report was improperly influenced by the Chief of Staff's resolve to retain the services of the surgeon's spouse in a sub-specialty position, and take action, if indicated.
5. The Veteran Integrated Service Network 10 Medical Facility Director coordinates with Veterans Integrated Service Network 10 or other resources to assist and support sole providers with performance deficits.

Appendix A: Surgeon’s References, Education, and Training

Table A.1. Surgeon’s References

Ref.	Practice Type	Comments in Reference Letter
1	Private Practice 1	<p>A physician wrote, “In response to your request, I wanted to reiterate that I believe that the [subject surgeon]²⁹ is an extremely conscientious and ethical clinician. [He/She] is a competent ophthalmologist who cares very much for all of [his/her] patients. While I have not directly observed [his/her] ability to operate or perform procedures directly to any significant degree, I am sure that [he/she] has operated with someone who could give you a better understanding of those skills.³⁰</p> <p>I was recently made aware that [he/she] has been keeping [his/her] surgery skills up to date by performing eye surgery in [a non-U.S. country] and on a recent mission trip in [another non-U.S. country], I reviewed those records and did see that [he/she] performed several eye surgeries successfully and without complication. My original comment in past reference letter that you consider to have a preceptor observe [his/her] first several cases, was only, if you were unable to get comments from someone with direct experience with [his/her] surgery skills, which I believe [he/she] should be able to provide. Otherwise, I fully support [him/her] as physician in your department.”</p>
	OIG Analysis	<p>This physician did not directly observe the subject surgeon and was unable to provide information on the number or type of surgeries performed, surgical outcomes, or complication rates.</p>
2	Private Practice 2	<p>A physician wrote, “...[T]he extent of my surgical experience with the subject surgeon was a one-week mission trip with [him/her] to [a non-U.S. country]. I did not directly observe [his/her] surgical skills, but I don't believe any of [his/her] patients had any complications and they all had good outcomes. In regard to [his/her] clinic work, my main experience has been taking over management of [his/her] patients while [he/she] has been gone. All of [his/her] patients were, in my opinion, managed well. I haven't had to make any significant changes in their management. The only negative thing I could say is that [he/she] was a little overly cautious in their follow-up schedules. The main basis for my recommendation without reservation is simply because of my limited direct observation of [him/her] in the OR [operating room] and/or the clinic. All of evidence and experience confers that [he/she] will make a good addition to your house staff.”</p>
	OIG Analysis	<p>This physician did not directly observe the subject surgeon and was unable to provide information on the number or type of surgeries performed, surgical outcomes, or complication rates.</p>

²⁹ For the purposes of confidentiality, the subject surgeon’s name was removed and gender deidentified from the references. Additional changes were made for the purpose of de-identifying other physicians and university personnel.

³⁰ **Bolded text** in the third column was added by the OIG for emphasis.

Ref.	Practice Type	Comments in Reference Letter
3	University Fellowship	A physician wrote, "The fellowship director from the time of the subject surgeon attended a fellowship at [a U.S. university] is no longer with the [institution]. This evaluation is based on a review of [the subject surgeon's] file at [the U.S. university]. The [subject surgeon] successfully completed and graduated as a glaucoma fellow from 07/01/10 to 06/30/11. [His/Her] case log submitted at the exit survey demonstrates a surgical volume that meets or exceeds the recommendations by the Association of University Professors in Ophthalmology Fellowship Compliance Committee. At the completion of [his/her] fellowship the [subject surgeon] was evaluated by two clinical and one research faculty. [His/Her] clinical competence and skill were deemed to be good by both clinical reviewers at the end of [his/her] fellowship. [His/Her] professional judgement was rated as good by all three reviewers. [He/She] was recommended as qualified and competent for independent practice at the end of the fellowship."
	OIG Analysis	This physician's reference relied on a retrospective review of documents and did not provide specific numbers associated with a surgical case volume, types of surgeries performed, or other data to support clinical competence. The subject surgeon completed a one-year, non-accredited, pre-residency fellowship as a glaucoma fellow in the Department of Ophthalmology at a U.S. university. Postgraduate training was not accredited by the Accreditation Council for Graduate Education.
4	Private Practice 3	A physician at a private eye care practice wrote, "The subject surgeon has worked in my practice for about two years, doing general ophthalmology with emphasis on management of glaucoma. [He/She] has done numerous minor surgeries in the office, but due to the local hospitals requiring certification by the American Board of Ophthalmology, [he/she] has been unable to get hospital surgical privileges. [He/She] is Board Certified in a non-U.S. country. [He/She] participated in [an international] cataract mission with me in [another non-U.S. country] in February 2016 and performed 17 cataract surgeries satisfactorily. In order to keep up [his/her] surgical skills, [he/she] spent a month in [a non-U.S. country] in October 2015 doing 30 cataract surgeries. I reviewed the reports from that hospital, and [his/her] results were all good. [He/She] is very good with patients and staff and I can recommend [him/her] for staff privileges at your facility."
	OIG Analysis	This physician described cataract surgical case volume (17 and 30). However, this reference did not provide surgical outcome data to support the interpretation that surgeries were performed "satisfactorily."

Source: *OIG review and analysis*

Table A.2. Surgeon’s Education and Training

Institution/Certifier	Education and Training Submitted to Vet Pro
Non-U.S. Medical Academy	Years attended: 7; Graduated June 1995; Degree: MD
Ophthalmology Institute	Non-U.S. country; Specialty Ophthalmology; Post Graduate levels 1 and 2; Completed September 2000; 24 months
Non-U.S. Hospital	Non-U.S. country; Specialty Ophthalmology; Post Graduate levels 3 and 4; Completed January 2003; 24 months
Certification by other than an American Specialty Board	Diplomate of National Board of Examiners–non-U.S. country Diploma of Ophthalmology–non-U.S. country
U.S. University	Glaucoma Fellow from July 1, 2010, to June 30, 2011

Source: OIG review and analysis

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 16, 2019

From: Acting Network Director, VISN 10 VA Healthcare System (10N10)

Subj: Healthcare Inspection—Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a VISN 10 Facility

To: Director, Office of Healthcare Inspections Rapid Response Team (54RR)
Director, GAO/OIG Accountability Liaison GOAL Office (VHA 10EG GOAL Action)

1. Thank you for this comprehensive investigation. I concur with the facility's response and appreciate the thoroughness of this report.
2. Thank you for the opportunity to respond.

(Original signed by:)

Ronald E. Stertzbach *for* Shella Stovall, MSN, RN
Acting Network Director, VISN 10

Comments to OIG's Report

Recommendation 4

The Veteran Integrated Service Network 10 Director evaluates whether the decision to reappoint the surgeon referenced in this report was improperly influenced by the Chief of Staff's resolve to retain the services of the surgeon's spouse in a sub-specialty position, and take action, if indicated.

Concur.

Target date for completion: Completed

Director Comments

The Veterans Integrated Service Network 10 Director is unable to determine whether the decision to reappoint the surgeon referenced in this report was improperly influenced by the Chief of Staff's resolve to retain the services of the surgeon's spouse in a sub-specialty position. The Chief of Staff has been detailed from [the] position and is on leave with a tentative retirement date. The surgeon's spouse is in the process of transferring to another Veterans Affairs facility.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 8, 2019

From: Director, VISN 10 Medical Facility

Subj: Healthcare Inspection—Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a VISN 10 Facility

To: Acting Network Director, VISN 10 VA Healthcare System (10N10)

1. I concur with the VISN 10 Medical Facility response and action plan as detailed within this report for Recommendations 1, 2, 3 and 5.

(Original signed by:)

Director, VISN 10 Medical Facility

Comments to OIG's Report

Recommendation 1

The Veteran Integrated Service Network 10 Medical Facility Director ensures the Credentialing and Privileging process for primary source verification of foreign education is performed and documented in accordance with Veterans Health Administration requirements.

Concur.

Target date for completion: September 10, 2019

Director Comments

The VISN 10 Medical Facility will review and confirm all foreign education on file contains prime source verification in accordance with VHA requirements. The VISN 10 Chief Medical Officer (CMO) will complete a site visit on September 9-10, 2019 to conduct a thorough review of the VISN 10 Medical Facility primary source verification process.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Veteran Integrated Service Network 10 Medical Facility Director ensures that the Credentialing and Privileging process for verifying and accepting professional references meets sufficiency standards in accordance with Veterans Health Administration guidance.

Concur.

Target date for completion: September 10, 2019

Director Comments

VISN 10 Medical Facility will develop a comprehensive reference checklist. Also, a protocol will be developed that Service Chiefs will use when contacting Provider candidates to review references prior to making any recommendations to hire a Provider. The checklist will be kept in the departmental folder. Quality Management will monitor completion of the checklist until at least a 90% compliance rate is sustained for 3 consecutive months.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The Veteran Integrated Service Network 10 Medical Facility Director ensures that the Focused Professional Practice Evaluation process used to determine technical competence and skills meets Veterans Health Administration requirements.

Concur.

Target date for completion: January 2, 2020

Director Comments

VISN 10 Medical Facility will review and revise our Focused Professional Practice Evaluation (FPPE)/Ongoing Professional Practice Evaluation (OPPE) policy to include actual observations of technical skills and record reviews observed by the service chiefs of all surgical and clinical cases. The FPPE/OPPE forms will be revised to include complications/readmissions and other areas specific to the individual service-line and/or individual provider. Trended information will be presented to the Clinical Executive Board/Professional Standards Board by name on a bi-annual basis with a two-year collective review.

Recommendation 5

The Veteran Integrated Service Network 10 Medical Facility Director coordinates with Veterans Integrated Service Network 10 or other resources to assist and support sole providers with performance deficits.

Concur.

Target date for completion: January 2, 2020

Director Comments

The VISN 10 Medical Facility will ensure the process for solo/duo Providers have OPPE/FPPE's performed by Subject Matter Experts (SME) within VISN 10. Standardized audits will be completed and reported to Clinical Executive Board (CEB)/Professional Standards Board (PSB) every six months.

OIG Contact and Staff Acknowledgments

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