US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Clinical Care and Behavior Concerns about Two Surgeons at the Martinsburg VA Medical Center in West Virginia

Healthcare Inspection | **25-01013-135** | **June 11, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection of the Martinsburg VA Medical Center to evaluate leaders' response to clinical care and behavioral concerns involving two surgeons. The inspection was initiated on June 30, 2025, following receipt of multiple staff complaints regarding the two surgeons' surgical competency, outcomes, and behavior. The OIG performed an on-site visit in August 2025, conducted virtual interviews through October 2025, and reviewed documentation through February 2026.

Facility Leaders' Response to Clinical Care Concerns

The OIG determined that facility leaders generally complied with Veterans Health Administration (VHA) requirements for managing clinical care concerns for the two surgeons (Surgeon A and Surgeon B). Leaders implemented privileging actions, conducted peer reviews, and completed institutional disclosures.

Privileging Actions

In accordance with VHA Directive 1100.21(1), *Privileging*, facility leaders took privileging actions in response to clinical care concerns regarding Surgeons A and B.[1]

- Surgeon A: Privileges were summarily suspended in early spring 2025 after a potential patient safety concern was identified. A fact-finding review concluded care met standards, and privileges were restored in the following month.
- Surgeon B: A focused clinical care review initiated in spring 2024 identified substandard care, leading to suspension of privileges. The surgeon's privileges were reinstated after completion of a clinical care review and initiation of a focused professional practice evaluation for cause. Surgeon B successfully completed the focused evaluation and was transitioned to an ongoing professional practice evaluation 14 months later.

Peer Review Process

The OIG found delays in initiating peer reviews for cases involving both surgeons. The time between identifying cases and completing the required memoranda, designating peer reviews as a confidential quality management activity, exceeded the three days allotted by VHA Directive 1190(1), *Peer Review for Quality Management*.[2]

[1] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.
[2] VHA Directive 1190(1), *Peer Review for Quality Management*, July 19, 2024.

Institutional Disclosure

The OIG found that facility leaders complied with VHA Directive 1004.8, *Disclosure of Adverse Events to Patients*, which requires institutional disclosures of adverse events that have or will likely result in death or serious injury.[3] Specifically, facility leaders conducted an electronic health record lookback of hundreds of surgical cases performed by Surgeon B, reviewed adverse events, and considered and completed institutional disclosures for cases that met the criteria.

Facility Leaders' Response to Behavior Concerns

The OIG found that the chief of surgery addressed the disruptive behavior concerns that occurred in 2025 regarding Surgeon A but did not assess an allegation of a disruptive behavior concern regarding Surgeon B, in accordance with VA Handbook 5021, *Employee-Management Relations*, and facility bylaws.[4]

Conclusion

Facility leaders adhered to VHA directives for privileging actions but did not ensure timely completion of peer reviews. Additionally, a disruptive behavior concern was not assessed for potential supervisory response.

The OIG made two recommendations to the Facility Director related to a comprehensive review of the peer review process and assessment of an allegation of disruptive behaviors for Surgeon B.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations. The Facility Director reported a process to ensure timely initiation of peer reviews will be implemented and stated that appropriate action was taken after assessing the allegations regarding physician B's behavior (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

DAVID KRULAK, MD, MPH, MBA
Assistant Inspector General
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[3] VHA Directive 1004.8. *Disclosure of Adverse Events to Patients,* October 31, 2018.

[4] VA Handbook 5021, *Employee/Management Relations*, October 24, 2024.

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Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on June 30, 2025, to evaluate leaders' response to clinical care and behavioral concerns regarding two surgeons at the Martinsburg VA Medical Center (facility) in West Virginia. The OIG team conducted an on-site visit on August 20 and 21, 2025, and held virtual interviews from July 14 through October 15, 2025. Documentation review continued through February 27, 2026.

Background

The facility, part of Veterans Integrated Service Network (VISN) 5, includes six community-based outpatient clinics in West Virginia, Virginia, and Maryland. The Veterans Health Administration (VHA) classifies the facility as a complexity level 1c.[1] The facility has 398 operating beds: 67 hospital, 141 community living center, and 190 domiciliary/transitional residence. The facility's surgical designation is defined as inpatient intermediate.[2]

Prior OIG Report

On May 21, 2025, the OIG published a report related to allegations about care provided by the facility's emergency department. The OIG made one recommendation relevant to this inspection: that the Facility Director "conducts a review of actions implemented as a result of a fact-finding to include administrative actions and performance improvement plans and ensures quality of care concerns have been remediated, and takes action as warranted." As of March 17, 2026, the recommendation remained open.[3]

Concerns

From August 2024 through May 2025, the OIG received eight complaints from facility staff raising concerns about the two surgeons' (Surgeon A's and Surgeon B's) competency, surgical outcomes, and disruptive behavior. The OIG initiated this healthcare inspection to evaluate

[1] VHA Office of Productivity, Efficiency, and Staffing (OPES), "VHA Facility Complexity Model," October 1, 2023. The VHA Facility Complexity Model categorizes each medical facility by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; level 3 facilities are the least complex.

[2] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting*, May 13. 2019. Inpatient intermediate is an invasive procedures designation that "require[s] an [intensive care unit] (ICU) with a dedicated intensivist to make daily rounds and provide consultative services."

[3] VA OIG, *Deficiencies in a Female Patient's Emergency Care at the Martinsburg VA Medical Center in West Virginia*, Report No. 24-02359-123, May 21, 2025.

facility leaders' responses to alleged clinical care and behavioral concerns about Surgeon A and Surgeon B.

Scope and Methodology

The OIG initiated the inspection on June 30, 2025, and conducted a site visit on August 20 and 21, 2025. The OIG completed additional interviews virtually from July 14 through October 15, 2025, and reviewed relevant documentation through February 27, 2026.

The OIG reviewed relevant applicable VHA directives and handbooks, facility policies, facility committee meeting minutes, quality and management review documents, and other relevant documents.

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).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[4] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and take full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The Office of Healthcare Inspections inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[5]

[4] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

[5] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

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

Inspection Results

Facility Leaders' Response to Clinical Care Concerns

The OIG determined facility leaders responded to reported clinical care concerns involving Surgeon A and Surgeon B. Specifically, facility leaders implemented privileging actions, conducted peer reviews, and completed institutional disclosures.

Privileging Actions

The OIG found that facility leaders generally complied with procedures outlined in VHA Directive 1100.21(1), *Privileging*, for managing clinical care concerns related to the two surgeons.[6] The directive establishes policy for addressing clinical care concerns involving a licensed independent practitioner:

- The facility director may suspend a licensed independent practitioner's clinical privilege(s) when continued clinical practice poses an imminent risk to the health and safety of any individual.
- Initiating a suspension triggers the chief of staff's obligation to conduct a focused clinical care review, which is a comprehensive review of a licensed independent practitioner's practice when there is an identified concern.
- A fact-finding may be conducted prior to initiating a focused clinical care review to confirm whether the focused clinical care review is warranted.
- Focused clinical care review results must be reported to the Executive Committee of the Medical Staff (Executive Committee).

After evaluating focused clinical care review results, the Executive Committee provides a recommendation to the facility director to take no action; consider a focused professional practice evaluation, which is a structured opportunity for a licensed independent practitioner to demonstrate competence; or revoke privileges.[7]

Surgeon A

The OIG determined through document review that in spring 2025, the Chief of Staff, on behalf of the facility director, summarily suspended Surgeon A's operating room clinical privileges

[6] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.
[7] VHA Directive 1100.21(1).

pending completion of an investigation into clinical performance. The suspension letter cited aspects of clinical care that potentially constituted an imminent threat to patient safety based on a surgical case that occurred 6 days prior to the suspension. The Executive Committee was notified of Surgeon A's suspension 7 days after the suspension letter was issued.

When interviewed by the OIG in July 2025, the Chief of Staff explained the decision to suspend privileges over a single case was made out of an abundance of caution for patient safety and to allow time for the chief of surgery to review the case.[8] During a separate interview in October 2025, the chief of surgery reported that the Chief of Staff proposed the need to suspend Surgeon A due to concerns identified in the surgical case that occurred in spring 2025 and to provide opportunity to investigate and gather the facts.

The chief of surgery conducted a fact-finding of the identified case, which included written input from the chief of a surgical subspeciality and discussions with medicine and intensive care leaders, as well as operating room nursing staff. The chief of surgery concluded that Surgeon A did not deviate from the standard of care and the case did not warrant a suspension.

Through email correspondence, the chief of surgery provided a recommendation to the Chief of Staff to restore Surgeon A's clinical privileges. The summary suspension was rescinded by the Facility Director 11 days after it was issued. Through document review, the OIG learned that 8 days later, the Executive Committee members were notified that Surgeon A's summary suspension had been rescinded.

Surgeon B

Through document review, the OIG learned the Chief of Staff initiated a focused clinical care review for Surgeon B in spring 2024, due to a concern with morbidity rates. Approximately six weeks later, based on preliminary focused clinical care review results indicating substandard clinical care, the Facility Director summarily suspended all of Surgeon B's clinical privileges at the facility.

Document review revealed that three external surgeons conducted reviews beginning 9 days after the focused clinical care review, in spring 2024, and concluded approximately three months later, in summer 2024. Two weeks after the completion of the external surgeons' reviews, the Executive Committee reviewed the focused clinical care review results and recommended revocation of all of Surgeon B's privileges to the Facility Director. The next day, the Chief of Staff issued a letter to Surgeon B proposing revocation of privileges based on the focused clinical care review findings of substandard care and failure to correctly diagnose patients.

Approximately five weeks later, in fall 2024, Surgeon B submitted a written response to the proposed revocation of privileges. Seventeen days later, the Chief of Staff then requested an

[8] The current chief of surgery was in an acting capacity from January 28 to May 17, 2025, before assuming the role permanently on May 18, 2025.

additional review by a fourth external surgeon, which was completed. During an interview with the OIG, the Chief of Staff reported that this review found Surgeon B's management was reasonable except for themes related to surgical planning and case selection. The Chief of Staff reported that following consultation with the Executive Committee, the recommendation was to place Surgeon B on a focused professional practice evaluation for cause.[9] The Executive Committee meeting minutes from late 2024 documented the committee's vote to recommend reinstatement of privileges and implement a focused professional practice evaluation for cause related to surgical planning and case selection.

In late spring 2025, Surgeon B successfully completed the focused professional practice evaluation for cause. Three days later, the Executive Committee determined Surgeon B met all benchmark criteria of the focused professional practice evaluation for cause and recommended transition to an ongoing professional practice evaluation. Through email correspondence, the chief of surgery alerted the OIG that, in late 2025, secondary to concerns related to a recurrence of issues previously identified in the focused professional practice evaluation for cause, Surgeon B's operative privileges were suspended pending the outcome of an investigation. The chief of surgery subsequently informed the OIG that, in early 2026, Surgeon B's suspension was expanded to include all privileges.

The OIG found that facility leaders generally met VHA requirements by issuing summary suspensions, conducting a fact-finding for Surgeon A, completing a focused clinical care review for Surgeon B, and restoring the surgeons' privileges.

Peer Review

The OIG determined that a nurse from the facility's risk management department did not ensure timely completion of peer reviews of care provided by surgeons A and B.

According to VHA Directive 1190(1), *Peer Review for Quality Management*, a peer review is a confidential, nonpunitive assessment at the individual clinician level intended to improve the quality of patient care.[10] Peer reviews are to be consistent, timely, and comprehensive, focusing on whether a clinician's decisions and actions met the standard of care.[11] The directive establishes key requirements:

- Peer reviews are required for deaths within 30 days of a surgical or invasive procedure unless the death is clearly not related to the surgery.

[9] VHA Medical Staff Affairs and Quality, Safety, and Value, *Provider Competency And Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, revision 3, January 2018. A focused professional practice evaluation for cause is a time-limited period during which the medical staff leadership assesses the provider's performance to determine if any privileging actions should be taken.

[10] VHA Directive 1190(1), *Peer Review for Quality Management*, July 19, 2024.

[11] VHA Directive 1190(1).

- Peer reviews should be considered for certain clinical events, such as new neurological deficits or post-op complications during an admission or within 30 days of surgery.
- Screening of information that may necessitate a peer review must occur within 3 business days of identifying the event to determine if a peer review is warranted.
- Within 3 days of determining a peer review is necessary, and prior to initiating the review, a memorandum designating the review as a confidential quality management activity must be signed by the facility director or the chief of staff, if delegated.
- The facility director is responsible for ensuring that required time frames for the completion of the peer review are met.[12]

During an OIG interview in July 2025, a nurse from the facility's risk management department described the process of identifying potential cases for peer review through review of occurrence screens, surgical data, and joint patient safety reports.[13] During document review of cases for surgeons A and B, the OIG identified a case in early 2025 of a patient who died 3 days after a surgical procedure. The OIG learned that a nurse from the facility's risk management department became aware of the event 9 days later. When asked why a peer review for patient A had not been completed, a nurse from the facility's risk management department told the OIG that the case may be with others awaiting review. Through document review, the OIG learned a designation memorandum for the patient was signed by the Chief of Staff in summer 2025, 141 days after a nurse from the facility's risk management department's initial awareness—far beyond the 3-day requirement.[14] The peer review committee completed the final review of the case the following month.

A nurse from the facility's risk management department told the OIG about two additional cases pending peer review completion. Upon reviewing documentation related to these cases, the OIG found the Chief of Staff signed designation memoranda 69 days and 135 days after the nurse's initial awareness, respectively.

In email correspondence, a nurse from the facility's risk management department reported informally grouping cases for review rather than initiating reviews promptly as required by the directive. The OIG determined that this grouping process appeared to contribute to delays. The

[12] VHA Directive 1190(1).

[13] VHA Directive 1320, *Quality Management and Patient Safety Activities That Can Generate Confidential Records and Documents*, July 10, 2020. An occurrence screen is an evaluation of episodes of care against specified criteria to identify patterns that may be a problematic.

[14] VHA Directive 1190(1).

nurse was unable to provide a clear rationale for delays in initiating timely reviews after screening indicated reviews were warranted.

The OIG found delays between initial case identification and initiation of reviews. These delays may result in missed opportunities to provide timely feedback and improve the quality of patient care.

Institutional Disclosures

The OIG found that facility leaders reviewed Surgeon B's cases for adverse events and considered and completed institutional disclosures for cases that met the criteria.

According to VHA Directive 1004.8, *Disclosure of Adverse Events to Patients*, an institutional disclosure is a process by which facility leaders, along with clinicians, inform the patient or representative that an adverse event has occurred that resulted in or was expected to result in death or a serious injury.[15]

Through a review of documentation, the OIG was informed that an electronic health record lookback was initiated in September 2024 to identify adverse events occurring within 90 days of surgery and determine if institutional disclosures were warranted. The review encompassed 357 inpatient and outpatient surgical episodes of care performed by Surgeon B between April 2023 and April 2024.

During interviews, the Chief of Staff and a nurse from the facility's risk management department reported that as a result of the lookback, three cases were identified as potentially meeting institutional disclosure criteria. After consulting with the Facility Director and Chief of Staff, a nurse from the facility's risk management department reported one of the three cases met the criteria for institutional disclosure, which was completed in late summer 2025. Additionally, during interviews with the Chief of Staff and a nurse from the facility's risk management department, the OIG learned another institutional disclosure was completed in late 2024 as a result of Surgeon B's focused clinical care review.

Facility Leaders' Response to Behavior Concerns

The OIG determined that the chief of surgery reviewed and took action on two reported disruptive behavior concerns involving Surgeon A, but as of January 2026, had not assessed Surgeon B's alleged disruptive behavior.

VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, notes that disruptive behavior can jeopardize the health and safety of patients and interfere with VA's ability to serve

[15] VHA Directive 1004.8. *Disclosure of Adverse Events to Patients,* October 31, 2018.

veterans.[16] According to facility "Bylaws and Rules of the Medical Staff," "conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated," and behaviors commonly recognized as detrimental to patient care include foul language; rude, loud, or offensive comments; and intimidation of staff.[17] As noted in VA Handbook 5021, *Employee/Management Relations*, VHA supervisors have a responsibility to evaluate and take necessary steps to address identified concerns and, when standards are not met, take prompt corrective action.[18]

The OIG learned that each surgeon received four disruptive behavior reports from February to August 2024, seven related to disruptive and verbal altercations with staff, and one related to a physical altercation with a patient. The OIG was informed that from January 2024 to January 2025, the facility had two different chiefs of surgery. The current chief of surgery was in an acting capacity from January 2025 until assuming the permanent role in May 2025. Through document review and interviews, the OIG could not determine if disruptive behavior reports prior to January 2025 were acted upon by previous supervisors.

The OIG found that three additional disruptive behavior reports were reported from January through November 2025, with two for Surgeon A and one for Surgeon B related to alleged disruptive behavior and verbal abuse of staff. The chief of surgery told the OIG of being made aware of the two disruptive behavior concerns specific to Surgeon A and taking action, including meeting with staff involved in the incidents and verbally counseling Surgeon A. When the OIG inquired about awareness of the disruptive behavior report regarding Surgeon B, the chief of surgery confirmed awareness of the event. Despite reporting having made an initial attempt to assess the concerns, the chief of surgery acknowledged not following through with the assessment of the reported concern, due to an oversight.

In interviews with facility nursing staff, the OIG learned that Surgeon A's behavior may have discouraged staff from reporting clinical concerns and therefore increased risk of patient harm. Additionally, the OIG learned through interviews that several nurses described Surgeon B's behaviors as creating barriers to patient care and safety.

The OIG determined that the chief of surgery did not consistently address disruptive behavior concerns in accordance with VHA policy. While actions were taken regarding Surgeon A, a concern involving Surgeon B was not assessed.

[16] VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2025.

[17] Facility, "Bylaws and Rules of the Medical Staff," approved March 27, 2023.

[18] VA Handbook 5021, *Employee/Management Relations*, October 24, 2024.

Conclusion

The OIG found that facility leaders responded to clinical care concerns regarding both surgeons. Leaders took privileging actions and generally met VHA requirements by issuing summary suspensions, conducting a fact-finding for Surgeon A, completing a focused clinical care review for Surgeon B, and restoring the surgeons' privileges. The OIG identified delays between the initial identification of cases and the initiation of peer reviews. These delays may result in missed opportunities to provide timely feedback and improve the quality of patient care. Facility leaders adhered to VHA requirements for institutional disclosures by identifying cases that met criteria and completing disclosures.

The OIG identified that the chief of surgery did not assess a disruptive behavior concern regarding Surgeon B, in accordance with VHA policy or facility bylaws.

The Veterans Integrated Network and Facility Directors concurred with the OIG's findings and recommendations. The Facility Director reported a process to ensure timely initiation of peer reviews will be implemented and stated that appropriate action was taken after assessing the allegations regarding physician B's behavior (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–2

1. The Martinsburg VA Medical Center Director conducts a comprehensive review of the peer review process from identification to completion to ensure adherence with VHA Directive 1190(1), *Peer Review for Quality Management*, amended July 19, 2024, and takes action as warranted.
2. The Martinsburg VA Medical Center Director ensures the chief of surgery assesses Surgeon B's alleged disruptive behavior and takes action if needed, in accordance with VA Handbook 5021, *Employee-Management Relations*, and Martinsburg VA Medical Center bylaws.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 29, 2026

From: Interim Director, Veterans Affairs (VA) Capitol Health Care Network (10N5)

Subj: Office of Inspector General (OIG) Report, Review of Clinical Care and Behavior Concerns About Two Surgeons at the Martinsburg VA Medical Center in West Virginia

To: Director, Office of Healthcare Inspections (54HL05)
Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed and concur with the Office of Inspector General's (OIG's) draft report entitled - Review of Clinical Care and Behavior Concerns about Two Surgeons at the Martinsburg VA Medical Center in West Virginia.
2. Furthermore, I have reviewed and concur with the Medical Center Director's actions to the recommendations.
3. Should you need further information, please contact the Quality Management Officer, VA Capitol Health Care Network.

(*Original signed by:*)

Daniel L. Dücker

[OIG comment: The OIG received the above memorandum from VHA on April 29, 2026.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 28, 2026

From: Director, Martinsburg VA Medical Center (613/00)

Subj: Office of Inspector General (OIG) Report, Review of Clinical Care and Behavior Concerns About Two Surgeons at the Martinsburg VA Medical Center in West Virginia

To: Director, VA Capitol Health Care Network (10N5)

1. We appreciate the opportunity to review and comment on the OIG draft report. The Healthcare System concurs with the recommendations and will take corrective action.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Chief of Quality Management & Patient Safety

(*Original signed by*:)

Kenneth W. Allensworth, FACHE
Medical Center Director/CEO

[OIG comment: The OIG received the above memorandum from VHA on April 29, 2026.]

Facility Director Response

Recommendation 1

The Martinsburg VA Medical Center Director conducts a comprehensive review of the peer review process from identification to completion to ensure adherence with Veterans Health Administration Directive 1190(1), *Peer Review for Quality Management*, amended July 19, 2024, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: February 2027

Director Comments

The Chief of Quality Management will evaluate and determine the reasons for noncompliance. The Chief of Quality Management will develop and implement a process for Risk Management to track the timeliness of peer review identification and initiation within the 3-day requirement. The Chief of Quality Management will audit compliance with the tracking of peer review identification timeliness until a benchmark of 90% is achieved for six consecutive months. The Chief of Quality Management will report progress and findings to the Executive Council of the Medical Staff-Performance Improvement (ECMS-PI) Monthly.

Recommendation 2

The Martinsburg VA Medical Center Director ensures the chief of surgery assesses Surgeon B's alleged disruptive behavior and takes action if needed, in accordance with VA Handbook 5021, *Employee-Management Relations*, and Martinsburg VA Medical Center bylaws.

_X_Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

The Chief of Surgery assessed Surgeon B's alleged disruptive behavior and took appropriate action.

OIG Comments

The OIG considers this recommendation open pending submission of documentation detailing the assessment of alleged disruptive behavior and any actions taken to support closure.

OIG Contact and Staff Acknowledgments

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