Administrative Closure
Alleged Poor Clinical Practice by an [redacted]
Southeast Louisiana Veterans Health Care System,
New Orleans, LA
MCI # 2012-03354-HI-0414

The VA Office of Inspector General Office of Healthcare Inspections received allegations from anonymous complainants that an [redacted] at the Southeast Louisiana Veterans Health Care System, New Orleans, LA (facility):

- Subjected patients to excessive surgical times, thus increasing the risk of complications.
- Discharged patients within 1–2 hours of long surgical procedures, putting patients at risk.
- Performed surgery on July 3, 2012, without a valid license on file at the facility.

The complainants also alleged that facility management ignored these deficiencies.

We conducted an offsite review in July 2012. We reviewed the electronic health records of surgical cases performed by the [redacted] over the last 6 months; VetPro records, Ongoing Professional Practice Evaluations (OPPE), and Focused Professional Practice Evaluations for all [redacted] at the facility; and relevant facility policies. We interviewed facility staff in August 2012. We examined peer reviews from July 2010 through July 2012 and found that no reviews involved the [redacted]

The Chief of Surgery monitors physicians' surgical times and was aware that the surgeon had long operative times. The surgeon performed 12 [redacted] over the last 6 months. The chief had reviewed the surgeon's cases and found no post-operative complications or negative outcomes. The chief also assisted in several of the surgeon's surgeries and found no issues with surgical skills. The chief believed that the surgeon's slowness was due in part to excessive talking during surgery. The chief counseled the surgeon about staying on task during surgery and reducing unnecessary conversation. The chief continued to monitor the surgeon's operative times and stated that if they had not improved, further action would have been taken. However, management terminated the surgeon's employment due to conduct issues.

Additionally, the facility's OPPE process monitors post-operative complications and hospital admission within 24-hours of surgical discharge. We reviewed facility OPPE and did not identify problems with the surgeon's performance, nor were any identified by the facility. All patients we reviewed were discharged from the post anesthetic care unit according to facility policy.

We did not substantiate that the surgeon was practicing without a license. VetPro and state medical license reviews[1] confirmed the surgeon had three active medical licenses without restriction on July 3, 2012.

Based on our review, we recommend administrative closure.

Approved by: John D. Daigh, JR., M.D. 7/28/12
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[1] http://www.lsbme.louisiana.gov/ , www.albme.org/, www.msbmd.ms.gov/ accessed on July 17, 2012.