

**VHA ISSUE BRIEF**  
**VISN 1 – VA Maine HCS, Augusta, ME**

**Issue Title:** Concern regarding Staff Podiatrist with the potential for leading to Institutional Disclosure

**Date of Report:** April 16, 2010, updated April 12, 2012, updated April 16, 2012

**Brief Statement of Issue and Status:** On December 10, 2009, the Chief of Staff received a written communication from a staff Comp and Pen Examiner raising concerns regarding the clinical care provided by a Staff Podiatrist. These concerns were based upon the statements of several veterans during Comp and Pen exams who complained of "poor outcomes" following surgical interventions for ankle instability and who stated that they were "refusing to see this podiatrist again." The Comp and Pen Examiner stated that a review of these Veterans' records appeared to indicate that surgical intervention was occurring following minimal evaluation. The Chief of Staff communicated this concern to the Chief of Surgery in late December 2009 and requested that a focused review of the provider's ankle and foot surgeries be undertaken.

**Actions, Progress, and Resolution Date:**

1. On March 29, 2010, the Chief of Surgery informed the Chief of Staff that he was nearing completion of a review of a random selection of 25 surgical cases, and that there appeared to be "significant documentation and quality of care issues in a number of these cases." The final report of this review was provided to the Chief of Staff on April 13, 2010.
2. The Executive Leadership Team and Risk Manager were informed of this situation on March 29, 2010. The Director informed the Chief Medical Officer of the situation on this same date.
3. On March 29, 2010, the Chief of Staff requested the Podiatrist be asked to voluntarily suspend performance of all surgical procedures during a period of a more extensive review of the initial cases and other cases.
4. The Podiatrist agreed to this upon return from leave on April 1, 2010. A written statement to this effect was signed by the provider on April 16, 2010.
5. On March 29, 2010, the Chief of Staff, Chief of Surgery and Risk Manager met with the Chief of Podiatry and decided to request case reviews by the Chief of Orthopedic Surgery at the VA Boston Healthcare System and by a podiatrist recommended by the Director, Podiatric Services, VHA Services. This review is underway.
6. On April 15, 2010, the Chief of Orthopedics from VA Boston HCS completed a review of randomly selected charts that confirmed the preliminary findings of our Chief of Surgery including:
  - Very poor documentation of clinical assessment or justification for surgical intervention
  - Surgical intervention that appeared to be unjustified by the nature or severity of the clinical problem

- Cases in which it appeared that an improper or inadequate procedure was performed for the clinical problem

A written report of findings will be provided in the very near future.

7. On April 15, 2010, the Chief of Staff consulted with Regional Counsel to update him on the status of the focused reviews. It was agreed that all of these reviews would be presented to the Professional Standards Board on April 27, 2010, for action.

Consideration of formal reduction or revocation of clinical privileges will occur at that time, when all reviews have been completed.

8. At this time it is considered to be likely that a significant number of Veterans treated by the podiatrist will require re-evaluation and treatment by a foot and ankle specialist. It is also considered likely that institutional disclosure of unnecessary or inappropriate surgical interventions will be required.

Indicate if Applicable: place an "X" next to the response reflecting the facilities action

- **Institutional Disclosure**  YES;  NO;  N/A  
(Final decision to disclose will be based on a case by case review)
- **Clinical Disclosure**  YES;  NO;  N/A

Updated April 12, 2012:

9. On April 27, 2010, the Professional Standards Board reviewed the results of the focused reviews and made the decision to summarily suspend the podiatrist's privileges pending a comprehensive review of the allegations. The provider was placed on administrative leave during this process.

10. On April 28, 2010, the podiatrist received a letter letting him know his privileges had been summarily suspended and he was being placed on administrative leave pending completion of comprehensive review.

11. On May 26, 2010, the Chief of Staff received the case review summary conducted by Podiatrist from VAMC, Palo Alto, California.

12. On June 17, 2010, the podiatrist was notified of the proposed removal and revocation of clinical privileges in accordance with personnel management guidance on such matters.

13. On September 1, 2010, an Alert Notice was sent to the Physicians State Licensing Boards (SLB) in Maine and New York notifying them of an issue of clinical competence with an unnamed provider. However, Rhode Island was not notified at that time. (additional information on this process reference in #31 and #34)

14. On September 28, 2010, letter received from NY SLB stating no further action to be taken on their part.

15. During the period from June 17 to November 1, 2010, the facility responded to several inquiries from the provider's legal counsel including providing de-identified case specific information in support of the allegations.

16. On November 8, 2010, the podiatrist resigned.

17. On November 19, 2010, podiatrist received an advisement notice that further review of this situation was in progress and could result in reports to applicable licensing boards.

18. On November 29, 2010, the Chief of Surgery was asked to begin institutional

disclosure in a face-to-face discussion with each Veteran for the cases identified in the process of revocation of clinical privileges on this provider (the initial 25+ cases).

19. On December 9, 2010, the Chief of Surgery was provided a list of all the surgical cases performed by this podiatrist from the period of 2004 to 2010, to assist in a systematic review process.

20. On January 6, 2011, a letter was received from podiatrist's attorney suggesting defamatory comments were being made against him to outside hospitals in New York where he was attempting to obtain privileges. In fact, requests for previous employment history and assessment of standing related to privileges were responded to by the Chief of Staff factually, expressing provider had his privileges suspended pending investigation of substandard care. Medical Staff Coordinator was informed that all requests of this nature were to come to the Chief of Staff.

21. On January 20, 2011, the Chief of Surgery provided the Chief of Staff a more detailed summary of six cases from the original 25 that were the most egregious and were to be used in the report to the State Licensing Board. After review by the Chief of Staff, this summary was provided to HRM ER/LR Specialist to be utilized in the preparation of the appropriate notification to the Maine State Board of Licensure.

22. On February 22, 2011, a request was received from the podiatrist's attorney request copies of any reports to other hospitals, to state licensing boards and to NPDB. To this point, no formal reports to licensing boards or NPDB naming this provider had been submitted.

23. On September 23, 2011, Chief of Staff was informed by the Chief of Surgery that he had started the more formal review of all the surgical cases performed by this provider, including a sampling of non-operated patients (clinic visits only). He was asked to strictly focus on the surgical cases at this point.

24. On October 3, 2011, an Intent to Report notice was mailed to the podiatrist.

25. On October 12, 2011, reply received from podiatrist requesting additional response time and a copy of the evidence file.

26. On October 26, 2011, the Chief of Surgery communicated with the Chief of Staff his desire to step down as Chief on January 1, 2012, pending his retirement to be effective February 29, 2012, and focus his attention on completing the review of cases. This did not occur as the Associate Chief, a general surgeon was unable to relinquish more of his clinical duties to take on the Acting Chief responsibilities.

27. As of March 13, 2012, The Chief of Surgery (Orthopedics specialty) continues his review of the surgical cases performed by the podiatrist spanning the years of 2004-2010. To date, all of the cases from 2009-2010 have been reviewed; a total of 103 cases. Of the 103, approximately 30 of them are problematic, with 6 of the 30 being the most egregious. The review of 2008 cases is underway at this time. There are a total of 589 cases that will be reviewed.

28. At this time it is considered to be likely that a significant number of Veterans treated by the podiatrist will require re-evaluation and treatment by a foot and ankle specialist. It is also considered likely that institutional disclosure of unnecessary or inappropriate surgical interventions will be required. If the current review outcomes are maintained, approximately 30% of the 589, namely 175+ cases may require institutional disclosure under the following charges:

- a. Repeated surgical cases in which non-operative alternatives were not employed resulting in inadequate informed consent for surgery and probable unnecessary surgical procedures.
  - b. Repeated surgical cases in which pre-operative evaluation was either missing, inadequate, or contradicted by studies performed; again making it probable that unnecessary surgery was performed.
  - c. Repeated surgical cases in which post-operative follow-up care was inadequate.
  - d. Repeated examples of inadequate surgical procedures leading to poor outcomes, and no evidence of patient disclosures when indicated.
29. On March 20, 2012, Chief of Surgery provided to the Acting Director and Chief of Staff a summary of his methodology used to conduct the review of surgical cases.
30. On March 21, 2012, the HRM ER/LR Specialist verified that Maine SLB received a copy of our September 1, 2010, Alert Notice.
31. On March 22, 2012, the HRM ER/LR Specialist received verification via e-mail that Rhode Island did not receive a copy of the September 1, 2010, Alert Notice.
32. On March 23, 2012, VA Maine HCS Acting Director, Chief of Staff, HR Employee Relations/Labor Relations Specialist, Medical Staff Coordinator, Risk Manager, and Staff Assistant to the Director held a conference call with Director of Credentialing, VA Central Office, to discuss our intent to submit Adverse Action Information to the National Practitioner Data Bank on this podiatrist, at which time the Acting Director and Medical Staff Coordinator were informed that VHA Handbook 1100.17, page 2 states the VA is only required to report adverse actions regarding physicians and dentists. The Handbook states the Agency has a MOU on file with the NPDB that releases VA Hospitals from the requirement to report adverse actions regarding other health care providers.
33. On March 26, 2012, the HRM ER/LR Specialist received the request from Maine SLB requesting follow-up information regarding September 1, 2010, Alert Notice.
34. On March 28, 2012, the HRM ER/LR Specialist contacted the Maine SLB explaining that the Alert Notice previously sent to them should have gone to the Board of Podiatric Medicine, not Physician Licensing Board. This has been corrected for all States involved (Maine, Rhode Island and New York) and new Alert Notices sent on March 29, 2012.
35. On March 20, 2012, meeting to brief Acting Medical Center Director on practice issues related to this podiatrist and actions to date, included COS, Risk Manager, Regional Counsel, and HR ER/LR Specialist. Acting Medical Center Director concerned over delays in reviews and disclosures. We called Network Office – spoke with Chief Medical Officer to brief him on this situation.
36. On March 21, 2012, Acting Director met with involved staff regarding our failure to report to NPDB. Met with HR Specialist regarding our error in sending Advisement Notices to the Physician State Licensing Boards.
37. On March 22, 2012, briefed VISN 1 Chief Medical Officer on the status of this situation. Met with COS and HR to discuss further errors in State Licensing Board notification. Met with Chief of Surgery and Chief of Staff to discuss findings of case reviews

38. On March 23, 2012, met with involved staff regarding current status of NPDB and SLBs reporting process. Held a conference call with National Director of Credentialing to discuss NPDB and SLB reporting process
39. On March 28, 2012, met with Chief of Surgery to review findings of additional year of surgical cases reviewed.
40. On March 29, 2012, additional error found in original SLB notifications – Advisement Notices redone and sent to appropriate Boards of Podiatric Medicine in three involved states.
41. On March 30, 2012, met with Patient A for disclosure and apology – current unassociated medical condition is terminal; COS and Regional Counsel involved in institutional disclosure meeting.
42. On April 2, 2012, Joint Commission arrived unannounced and onsite for five days. No findings regarding medical staff credentialing and privileging cited by Joint Commission.
43. On April 5, 2012, met with Regional Counsel, New England and Local Regional Counsel to discuss case specifics.
44. On April 9, 2012, met with involved staff regarding letter received from podiatrist's attorney to determine level of response needed.
45. On April 10, 2012, spoke with VISN 1 Chief Medical Officer indicating the plan to contact National Director of Risk Management for guidance. Held conference call with National Director of Risk Management seeking new guidance on disclosure process. Held conference call with Acting Chief Medical Officer, VACO Operations and Management and provided case specific information. They provided instructions regarding next steps.
46. Action Plan as of April 12, 2012; in the discussion with the Acting Chief Medical Officer, Operations and Management in VA Central Office on April 10, 2012, the plan as of this date is as follows:
- summaries of all record reviews completed to date will be scanned and e-mailed to her attention no later than April 18, 2012
  - a tentative date of April 20, 2012, has been set for the Subject Matter Expert Panel (SME) to convene
  - the facility will await further guidance from the Acting Chief Medical Officer, Operations and Management
  - for any activities regarding State Licensing Board reporting, the facility will seek guidance from the Director, Credentialing and Privileging, VA Central Office before taking any action.
47. In early March 2012, prior to this issue surfacing, VISN 1 revised their process for ensuring follow up of issue briefs with open items which should receive follow up. Whenever an open item for which follow up is expected, a task is created in our VISN tasking system with the due date based on expected follow up. The task is then assigned to appropriate party for action. If response is not received by the due date, VISN staff now follows up with responsible party to ensure needed action is taken.
48. VISN 1 is in the process of reviewing all issue brief from the past three years to ensure all expected follow up actions have in fact taken place.

Updated - April 18, 2012:

**What date was the Staff Podiatrist hired at Togus VAMC and on what date did he perform his first surgical procedure?**

Response: April 18, 2004; first surgical procedure performed on May 21, 2004

**Did the Staff Podiatrist work at any other VAMC in the past?**

Response: His employment history does not indicate he has worked at another VA Medical Center.

**Is 589 the total number of surgical procedures performed by the Podiatrist between 2004-2010?**

Response: Yes

**To date, how many of the surgical procedures performed by the Podiatrist have been reviewed for indications and outcomes?**

Response: 173

**What is the current plan to review the remaining patient records and when is this anticipated to be completed?**

Response: The Orthopedist (former Chief of Surgery) who has been doing this review will return on Tuesday, April 17, 2012. He will be working for us two days per week on a fee basis (retired on 3/31/2012) with primary focus to be the completion of these case reviews. He is a foot and ankle specialist. It is difficult to judge the time frame for completion at this point. We will have a conversation with him upon his arrival on April 17 to get a better sense of time to completion.

**Has a master list been created (contact information, date of procedure, whether seen in follow-up) of all Veterans who have received a surgical procedure?**

Response: We have been working with a master list and will be adding to it the contact information and dates of follow-up.

**Please confirm that only 1 institutional disclosure has been provided to date.**

Response: On March 30, 2012, one institutional disclosure was completed and has been documented in the Veteran's medical record.

**Please confirm that the Chief of Surgery engaged in this review has retired and no longer active at Togus VA.**

Response: The Chief of Surgery did retire; however, as noted in #5 above, he will be returning on a fee appointment April 17, 2012, to continue the case reviews.

**As of today, who is actively engaged in reviewing the remaining cases?**

Response: Please refer to #5 above.

"The Handbook states the Agency has a MOU on file with the NPDB that releases VA Hospitals from the requirement to report adverse actions regarding other health care providers."

**Question: Does this preclude VA from reporting such adverse actions? If not precluded, is the decision local? Or would it require national policy?**

Response: *Please see response provided by Kate Encheimayer –*

In accordance with VHA policy and VA regulation for reporting to the NPDB, VA

only reports adverse actions on physicians and dentists. This is national policy and regulation. The reason for this is that the Health Care Quality Improvement Act which established the NPDB requires the reporting of adverse actions on physicians and dentists and allows that the adverse actions on other health care providers MAY be reported. The HCQIA requires the Secretary of HHS to enter into an MOU with VA (and other Federal health care entities) for participation in VA. Back in 1990 when the MOU was being negotiated and the implementing regulations were written (and subsequently revised) VA elected to follow the HCQIA in requiring reporting of adverse actions on physicians and dentists only. Since it is discretionary throughout the industry, VA did not want to require the reporting of adverse actions on other health care providers. Additionally, a national reporting standard had to be established which follows the required reporting requirements of the statute. It is not reasonable to allow discretion across the Agency since one facility might report all adverse actions, and another would only report those that are required.

**Please forward the following information: (Two additional items added beyond Request - #4 and #5).**

4/15/10 Summary Report by Chief of Orthopedic Surgery, Boston



Sum Case Rev-Apr  
10-Dr Martin.pdf

5/26/10 Summary Report by Podiatrist, Palo Alto



Sum Case Rev-May  
10-Dr Bois.pdf

3/20/12 Summary of Methodology for Reviewing Surgical Procedures, Togus VA Chief of Surgery



Summary of Case  
Review Methodology

April 2010 – Summary of initial 25 cases reviewed by Chief of Surgery



Focus Rev-25  
Case-Apr 10 Dr S.pdf

- 1) Expanded summary of six (6) cases for SLB Reporting prepared by Chief of Surgery



SLB Case  
Summary-Dr S-Jan 11

**Contact for Further Information:** Susan A. MacKenzie, Ph.D, Acting Center Director,  
(207) 623-5756