Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Resident Supervision Issues in the Operating Room
William Jennings Bryan Dorn VA Medical Center
Columbia, South Carolina

Report No. 05-03084-135 **April 28, 2006**

VA Office of Inspector General
Washington, DC 20420

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection - Resident Supervision Issues in the Operating Room, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina.

Executive Summary

The purpose of the review was to determine whether allegations that an attending surgeon abandoned a patient in the operating room (OR) and regularly violated the rules and regulations on resident supervision had merit. We substantiated the allegation that an attending surgeon arrived late for scheduled surgery, left the medical center prior to the conclusion of a surgical procedure, and was not immediately available in the medical center; however, medical staff by-laws in effect at the time were ambiguous regarding attending presence in the OR, and there were no adverse patient outcomes. Our review indicated the completion of the procedure was within the skill level of the chief surgical resident performing the operation, and the patient was discharged the following day without complications. We could not substantiate the allegation that the attending surgeon regularly violated the rules and regulations on resident supervision. The medical center revised the by-laws to redefine the immediate availability of attending surgeons, and monitoring of attending surgeon presence in the OR is ongoing.

Because medical center managers implemented corrective actions to ensure appropriate resident supervision, we did not make any recommendations. The Veterans Integrated Service Network (VISN) and Medical Center Directors agreed with the report findings.

Purpose

The Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding resident supervision in the OR at the William Jennings Bryan (WJB) Dorn VA Medical Center (the medical center) in Columbia, South Carolina.

Background

The medical center is a tertiary care hospital that is part of the VA Southeast Network and provides acute medical, surgical, psychiatric, and long-term care services. The medical center has 216 active hospital beds.

An anonymous complainant alleged that an attending surgeon abandoned a patient in the OR. The surgeon was scheduled to perform an anal condyloma (wart) removal on one patient, followed by a laparoscopic abdominal hernia repair on a second patient on May 27, 2005. The complainant alleged that:

- The attending surgeon arrived 90 minutes late to perform the first procedure, resulting in a delayed start time for the second procedure.
- The attending surgeon left the second patient in the care of University of South Carolina (USC) resident physicians before the procedure was completed. The patient was morbidly obese and still under general anesthesia.
- The patient's condition was compromised when the residents had difficulty placing the sutures to close the incision, and staff could not reach the attending surgeon via telephone or pager.
- The attending surgeon regularly violated Accreditation Council for Graduate Medical Education (ACGME) rules and regulations on resident supervision.

The complainant reported this issue to regulatory agencies including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the ACGME, as well as the OIG. As a result, JCAHO conducted a site visit on July 6, 2005. The surveyor stated that the medical staff by-law requirement, "immediate availability of the attending practitioner for resident supervision" was ambiguous. The ACGME requested a response regarding this issue from the Chairman, Department of Surgery, USC, which he submitted on August 10, 2005. The response acknowledged that the attending surgeon was in fact not immediately available to provide assistance, and his absence failed to strictly meet the requirement for resident supervision. However, the chairman further stated that the resident was capable of performing the surgical elements of the case and there were no adverse patient outcomes. In light of the complaint, the ACMGE also moved a scheduled June 2006 site visit to March 2006.

VA Southeast Network managers chartered an administrative board of investigation (ABOI). While awaiting the results of the ABOI, managers requested of USC that the physician be temporarily relieved of his duties in surgery at the medical center. The ABOI concluded that the attending surgeon left the medical center prior to the conclusion of the procedure but did not identify any quality of care issues. The ABOI was limited in scope and did not meet the required time frame. The report was due to network managers on September 15, 2005, but not completed until November 2, 2005. It did not include the

testimony of relevant staff, including the certified registered nurse anesthetists (CRNAs) and circulating registered nurses (RNs) in the OR.

The medical center contracts for general surgery from USC, and billing is based on the level of attending involvement. Managers requested and obtained a refund from USC for the hernia repair since the attending left the medical center prior to the completion of the procedure. Additional corrective actions taken by the medical center included the amendment of the medical staff by-laws. The by-laws, dated November 15, 2005, redefined immediate availability as "the attending surgeon should be immediately available in the surgical suite during the entire surgical procedure." Managers also developed and implemented a monitor on the level of attending involvement. Nursing staff document the location and availability of the attending surgeon at the close of the procedure. The Chief of Surgery reviews the results of these compliance monitors.

The medical center conducted a separate review to evaluate attending surgeon resident supervision. The review identified conflicting documentation by nurses, residents, and anesthesia staff regarding the level of attending presence in the OR. Attending physicians and residents were re-educated on the resident supervision requirements, the necessity of accurate documentation to reflect attending involvement, and the monitoring process to ensure compliance.

Scope and Methodology

We visited the medical center February 7–8, 2006. We reviewed patients' medical records, incident reports, and credentialing and privileging files for the attending surgeon. During our visit, we interviewed the Chief of Staff (COS), the Chiefs of Surgery and Anesthesiology, the Acting Quality Management (QM) Coordinator, CRNAs, anesthesiologists, and RNs assigned to the OR. Prior to our visit, we interviewed the complainant and other OR staff by telephone. We reviewed the ABOI and evidence file, medical center policies, medical staff by-laws, and applicable memorandums. We also reviewed the complication report for the attending surgeon as well as the cancellation and delay reports for surgeries performed in 2005. We performed the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Attending Surgeon Arrived Late

We substantiated the allegation that the attending surgeon arrived late for the first scheduled case on May 27, 2005. The first case, scheduled for 9:00 a.m., started at 10:43 a.m. and ended at 11:48 a.m. The patient transferred to the post anesthesia care unit at

12:00 p.m. and was discharged home at 1:13 p.m. without problems. The second case scheduled for 10:30 a.m. started at 1:27 p.m.

Issue 2: Attending Surgeon Left the OR Before Completion of the Procedure

We substantiated the allegation that the attending surgeon left the OR prior to the completion of the second procedure and left the hospital without making provisions for immediate assistance if necessary. Medical center policy on resident supervision defines the levels of attending physician involvement in surgical procedures. The levels are defined as: (a) the attending performs the procedure, (b) the attending is in the OR but the resident performs part of the procedure, (c) the attending is present but the resident performs the entire procedure, and (d) the attending is physically present in the operative or surgical suite and immediately available for resident supervision or consultation as needed.

In the second case, the chief surgical resident, the attending surgeon, and another resident used laparoscopic techniques to repair an abdominal hernia on a morbidly obese patient. The attending surgeon left at 2:45 p.m., before closure of the operative wound. The Chairman of the Department of Surgery at USC stated that the procedure was within the skill level of the chief surgical resident, and he was capable of closing the laparoscopic sites without assistance from the attending surgeon.

The attending surgeon stated that he discussed the plans for the remainder of the operation with the resident prior to leaving the OR. The chief resident told the attending surgeon that he was comfortable doing the closure and did not need him to stay in the OR. The attending surgeon acknowledged that he left the medical center, which meant he was not immediately available, and thus did not meet the requirements for resident supervision. However, he stated he called the chief resident at 3:00 p.m. The chief resident stated it took some additional time to correctly position the sutures, but he did not need the attending surgeon's help. The chief resident documented that the attending surgeon was present for key portions of the procedure.

Issue 3: Patient's Condition was Compromised

We did not substantiate the allegation that the lack of resident supervision compromised the patient's condition. An OR staff member called the COS and stated the residents were having difficulty with the procedure, the patient was bleeding, and the attending surgeon could not be located. Since no other attending surgeons were in the medical center at the time, the COS contacted the Chairman of the Department of Surgery at USC, who subsequently went to the medical center. When he arrived in the OR, the residents stated that the patient had not experienced any bleeding or any difficulties. The residents closed the operative wound at 4:38 p.m. The chief resident documented that it took multiple attempts to position the sutures correctly because of the patient's obesity. The operative note states that, "The patient tolerated the procedure well. He was taken to

the recovery room in satisfactory condition at the close of the case…and without any complications immediately known." The patient was discharged home the following day. Documentation at his follow-up clinic appointment noted no complications.

Issue 4: Attending Surgeon Regularly Violated ACGME Rules and Regulations

We were unable to confirm or refute the allegation that the subject attending surgeon regularly violated ACGME rules and regulations. Medical center policy on resident supervision based on VHA Handbook 1400.1 states, "A supervising practitioner must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of the veteran's health care needs." Medical center managers conducted a review of the surgical care of patients by this attending surgeon and could not substantiate inadequate resident supervision. The medical center permitted him to resume his surgical duties upon the recommendation of the ABOI.

Conclusion

We substantiated the allegations that the attending surgeon arrived late for scheduled surgery, left the medical center prior to the completion of a surgical procedure, and was not immediately available in the medical center. However, by-laws in effect at the time were ambiguous regarding attending presence in the OR, and there were no adverse patient outcomes. We found that medical center managers implemented corrective actions to ensure appropriate resident supervision. The medical staff by-laws revision states that attending surgeons need to be available in the surgical suite until the procedure is completed. Monitoring of attending surgeon presence in the OR is ongoing. The interviews we conducted with nursing and anesthesia OR staff affirmed that attending surgeons are present in the OR and providing appropriate resident supervision. We did not make any recommendations. The VISN and Medical Center Directors agreed with the report findings.

(original signed by:)
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Appendix A

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Appendix B

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