



# Department of Veterans Affairs Office of Inspector General

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## Healthcare Inspection

### Pulmonary Services and Quality of Care Issues North Florida/South Georgia Veterans Health System Gainesville, Florida

## Executive Summary

The purpose of this review was to determine the validity of allegations regarding quality of care issues and the adequacy of pulmonary services at the North Florida/South Georgia Veterans Health System in Gainesville, Florida.

We did not substantiate the allegation that there were four full-time pulmonary fellows funded while only one fellow was at the medical center at any given time. We found 4 funded positions for pulmonary disease and critical care medicine, and we found a pool of 12 fellows who worked various schedules, which was the equivalent of 4 full-time positions.

We substantiated the allegation that one fellow was responsible for covering inpatient consultations (consults), inpatient and most outpatient bronchoscopies, and the medical intensive care unit (MICU). The system conducted an internal assessment of pulmonary fellows' responsibilities and recommended realignment of duties, which resulted in increased pulmonary coverage for MICU and inpatient consults. We substantiated the allegation that on weekends one fellow managed critically ill patients in the VA MICU and also covered Shands Hospital at the University of Florida. However, we found that the medical center had back-up assistance from other physicians if needed, and there was no evidence that pulmonary coverage on weekends negatively affected patient care.

We did not substantiate the allegations that inadequate pulmonary consultative care contributed to the death of a patient, cancer treatment was delayed, or that a pulmonologist was inappropriately privileged to perform medical thoracoscopy procedures. We substantiated that fee basis requests for various treatments for lung cancer had declined, but we found that this decline was the result of improved processes.

We made no recommendations.



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

**TO:** Director, VA Sunshine Healthcare Network (10N8)

**SUBJECT:** Healthcare Inspection – Pulmonary Services and Quality of Care Issues  
North Florida/South Georgia VA Health System, Gainesville, FL.

## **Purpose**

The VA Office of Inspector General (OIG) Office of Healthcare Inspections received allegations regarding pulmonary staffing and quality of care issues at the North Florida/South Georgia (NF/SG) Veterans Health System (the system). The purpose of this review was to determine whether the allegations had merit.

## **Background**

The system, part of Veterans Integrated Service Network (VISN) 8, is comprised of the VA medical centers in Gainesville and Lake City, FL. The Malcom Randall VA Medical Center (the medical center) is a tertiary care facility in Gainesville which provides a broad range of specialty services, including pulmonary medicine. Pulmonary medicine is a consultative service staffed with attending physicians and fellows affiliated with the University of Florida. Fellowship training requires an additional 3 years beyond completion of internal medicine training. Fellows rotate between Shands Hospital at the University of Florida (Shands) and the medical center, providing care for VA patients under the direct supervision of attending physicians.

Two complainants contacted the OIG hotline on August 28 and September 10, 2008, respectively, with multiple allegations regarding the medical center's Division of Pulmonary and Critical Care Medicine and delays in cancer treatment. Specifically, the allegations were that:

- VA funded four full-time pulmonary fellows, but there was only one fellow at the medical center at any given time.
- One pulmonary fellow was responsible for covering inpatient consultations (consults), inpatient and most outpatient bronchoscopies, and the MICU, and “was frequently spread too thin to perform an adequate job, resulting in poor patient care.”

- On weekends, one fellow managed critically ill patients in the MICU and also covered Shands.
- Inadequate pulmonary consultative care contributed to the death of a patient.
- Initiation of therapy after lung cancer diagnosis was delayed 8 weeks or longer.
- A pulmonologist was credentialed and privileged to perform medical thoracoscopy,<sup>1</sup> a procedure usually performed by thoracic surgeons.
- Fee basis requests for lung cancer treatment have declined, causing delays in the initiation of treatment.

## Scope and Methodology

We interviewed one of the complainants by telephone prior to conducting a site visit December 15–17, 2008. During our visit we interviewed the other complainant and the system Director, Chief of Staff, Chief of Medical Service, Chief of Pulmonary and Critical Care Medicine, Chief of Cardiothoracic Surgery, a pulmonary fellow, and other clinical and quality management staff. We reviewed patient medical records, on-call schedules, time sheets, invoices for services provided by housestaff<sup>2</sup> at the medical center, and local and Veterans Health Administration policies and procedures. We performed the inspection in accordance with *Quality Standards for Inspections* published by the President’s Council on Integrity and Efficiency.

## Inspection Results

### Issue 1: Pulmonary Fellow Staffing

Funded Positions for Pulmonary Medicine Fellows. We did not substantiate the allegation that there were four full-time pulmonary fellows funded while only one fellow was at the medical center at any given time.

We reviewed the Office of Academic Affiliations (OAA)<sup>3</sup> report for academic year 2009 (July 2008–June 2009) and confirmed that the system funded four positions for pulmonary disease and critical care medicine and one for sleep medicine. One position, we were told, was not filled.

We found that 12 fellows were employed at the medical center each month, with individual fellows working 1 to 27.5 days per month. The September 2008 time sheet we

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<sup>1</sup> Thoracoscopy is an examination of the chest by means of a scope inserted through a puncture in the chest wall.

<sup>2</sup> Housestaff are interns, residents, and fellows employed at a hospital while receiving additional training after graduation from medical school.

<sup>3</sup> OAA provides oversight of VA’s affiliated training programs and allocates positions and funding for interns, residents and fellows.

reviewed showed that, on average, four fellows were on duty every day. Managers told us that fellows were assigned various duties, including coverage of the MICU, pulmonary clinic, inpatient and outpatient bronchoscopy, consultations, and the sleep laboratory.

Pulmonary Fellow Workload. We substantiated that a single on-call fellow was responsible for covering inpatient consults, most bronchoscopies, and the MICU. Our review of the Division of Pulmonary and Critical Care Medicine on-call schedules from August through November 2008 showed only one on-call fellow assigned to the medical center for after-hours work.

The Chief of Medicine confirmed the allegation regarding on-call fellows' assignments. He reported that the system had conducted an assessment and concluded that one fellow should be dedicated to the MICU while a second fellow cover consults and bronchoscopies. System managers told us that these recommendations were implemented effective November 24, 2008. The on-call schedule for December 2008 reflected these changes.

Weekend Pulmonary Fellow Coverage. While we substantiated the allegation that on weekends, one fellow managed critically ill patients in the MICU and also covered Shands, we did not find that this schedule had a negative impact on patient care. The medical center provided adequate attending physician back-up coverage. In addition, the Chief of Medicine told us that the medical center always had a hospitalist on duty as attending back-up in case of a simultaneous emergency at both locations. The pulmonary fellow we interviewed confirmed what the Chief of Medicine told us and voiced no concerns about covering both places on weekends. Finally, we found no reports of adverse events attributable to pulmonary medicine weekend coverage.

## **Issue 2: Quality of Care**

### **A. Pulmonary Consultative Care**

A complainant alleged that inadequate pulmonary consultative care contributed to the death of a patient.

#### Case Summary

An elderly man was admitted to the medical center with pleural effusions (fluid between the membranes that line the lungs and chest cavity) and marked leukocytosis (abnormal increase in the number of white blood cells). His past medical history included lumbar laminectomy,<sup>4</sup> colovesicular fistula (an abnormal connection between the colon and urinary bladder) requiring sigmoid resection (surgical removal of part of the intestine),

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<sup>4</sup> A lumbar laminectomy is a surgical procedure designed to relieve pressure on the spinal cord or nerve root that is being caused by a slipped or herniated disk in the lumbar spine.

colostomy, persistent anemia, thrombocytopenia,<sup>5</sup> hyponatremia (abnormally low sodium in the blood), and prolonged prothrombin time (a measure of clotting time).

On admission, the patient described approximately 5 days of dyspnea (difficulty breathing) and right-sided chest pain that worsened with deep breaths. He denied cough and had no fever. The chest x-ray showed new pleural effusions, most pronounced on the right side. On the second hospital day (HD #2), an internal medicine physician performed a right thoracentesis<sup>6</sup> and approximately one liter of “amber colored” fluid was removed. Laboratory tests indicated an empyema (pus in the pleural space) and a pulmonary physician performed a right chest tube thoracostomy (tube placed in the chest cavity for drainage of fluid). Over the next 2 days, the patient’s dyspnea improved. A computed tomography (CT) scan of the chest revealed chronic lung disease with bilateral pleural effusions and no evidence of loculation (formation of small cavities which can impair drainage). Also noted was evidence of significant chronic liver disease and a kink in the chest tube.

On HD #4 the patient was transferred to the intensive care unit because of supra-ventricular tachycardia.<sup>7</sup> After stabilization with medication, he was transferred back to the general medical unit. On HD #8 swelling was noted at the site of his chest tube and judged to be a hematoma (localized collection of blood). A pulmonary physician re-positioned the chest tube and the patient subsequently reported feeling better. His chest x-ray showed worsening of the left pleural effusion, and an internal medicine physician attempted a left thoracentesis, but no fluid was obtained. A pulmonary physician removed the right chest tube on HD #14 and a chest x-ray showed continuing infiltration of the left lower lung.

An infectious diseases consultant recommended respiratory isolation due to the possibility of tuberculosis (TB). Dyspnea improved, but the patient complained of difficulty swallowing and lower body swelling. On HD #18, he again complained of dyspnea and, because of worsening hyponatremia, water restriction was instituted. A physical therapist noted that the patient was not walking and required moderate assistance when moving in bed or from the bed to a chair.

A CT scan on HD #21 showed the following:

Marked increase in bilateral pleural fluid, left much greater than right extending to the lung apex...There is thickened and enhancing pleura prominently on the right where there previously was a drainage tube. No gas present but loculation superiorly suggesting it would be complex and potentially infected. Left-sided effusion does not appear loculated or to

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<sup>5</sup> Thrombocytopenia is a decrease in the number of platelets in the blood, causing decreased ability for clotting and the potential for bleeding.

<sup>6</sup> Thoracentesis is a procedure that removes fluid or air from the chest through a needle or tube.

<sup>7</sup> Supraventricular tachycardia is a type of abnormal heart rhythm associated with a rapid heart rate.

have enhancing pleura. Visualized lung shows no evidence for nodules. The liver again shows findings of cirrhosis without focal lesions...The spleen is markedly enlarged. There are varices of portal hypertension in the splenic hilum and extending up into the lower esophagus...Moderately prominent ascites similar to that seen previously.

Tests for TB were negative on HD #22. The patient remained “distressed and SOB [short of breath] with continued scrotal and bilat [bilateral] lower extremity edema.” An internal medicine physician performed a left thoracentesis. The procedure note indicates that there was a complication with the procedure (bloody fluid), which did not clear after 1 liter of drainage. The patient, however, reported feeling somewhat better. On HD #25, the patient had worsening dyspnea, and a CT scan was performed because of the possibility of pulmonary embolism (blood clot in the lung). No new abnormality was found. An internal medicine physician repeated a thoracentesis on the left chest. Bloody fluid (1.5 liters) was removed, and the chest x-ray showed “marked reduction in the size of the effusion.” The patient again reported less dyspnea. Because the patient was considered to have a hemothorax<sup>8</sup> and because of concern over the possibility of injury to an intercostal artery from a previous thoracentesis (HD #22), Cardiothoracic Surgery consultation was requested. Surgical consultants felt there was “no acute surgical process,” noting that the patient was stable and had abnormal clotting parameters.

On HD #26, a pulmonary medicine consultant wrote:

It is my opinion that the presenting empyema is a separate event from the underlying condition: hematologic disorder and liver cirrhosis. The empyema has cleared, but now we are left with the sequelae of drug-effects, poor nutrition and possible progression/exacerbation of the underlying disorders...As for the bloody pleural fluid, this may (or may not) be the result of a traumatic tap [thoracentesis], but rather the pt's [patient's] hypo-coagulable state and low plts [platelets].

On HD #28, a portable chest x-ray showed “very poor lung aeration with large bilateral pleural effusions completely obscuring the cardiac borders and diaphragm.” In the evening of that day, dyspnea recurred and an internal medicine physician again performed a thoracentesis, with removal of 1.5 liters of bloody fluid. Thereafter, the patient was “resting quietly,” until the next morning, when he was described as being anxious and short of breath. Decreasing oxygen saturation was noted and supplemental oxygen was increased. The patient developed bradycardia (abnormally slow heartbeat) unresponsive to atropine and expired.

Results of an autopsy performed the following day were as follows:

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<sup>8</sup> A hemothorax is the accumulation of blood in the pleural cavity.

The presence of a large left-sided hemothorax and this severe exsanguination (extensive blood loss due to internal or external hemorrhage) is the most likely cause of the patient's death. Unfortunately, an exact etiology for the patient's hemothorax remains unknown as multiple factors (i.e., liver failure causing coagulopathy, thrombocytopenia, and traumatic thoracentesis) are involved.

### Pulmonary Medicine Involvement

We found that pulmonary medicine was consulted on the second day of admission, and an internal medicine physician documented on HD #13 that pulmonary medicine fellows continued to follow the patient, regularly repositioning the chest tube. However, prior to HD #20 the span between pulmonary visits was 5 to 6 days and few notes indicate involvement by an attending physician. Since only one fellow was assigned to cover MICU and consults, this workload may have contributed to the limited pulmonary involvement in the patient's care; however, we did not determine that inadequate pulmonary consultative care contributed to the patient's death.

### **B. Alleged Delay in Cancer Treatment**

We did not substantiate the allegation that the time between cancer diagnosis and initiation of therapy was 8 weeks or longer.

For October 2007 through June 2008, we reviewed the medical records of all 30 patients with a lung mass that required surgery. We found that the average time from diagnosis to surgery was 34 days.

We also reviewed the medical records of 80 patients treated at the medical center for various types of cancer. These patients were randomly selected from the 777 patients who were diagnosed October 2007 through August 2008 and for whom complete data was available. For the 80 patients whose records we reviewed, the mean time from diagnosis to treatment was 47 days.

### **Issue 3: Pulmonologist Credentials and Privileges**

We confirmed that a pulmonologist was credentialed and privileged to perform medical thoracoscopy procedures. The complainant was concerned that the surgical staff was not informed about the granting of these privileges. We interviewed the Chief of Cardiovascular Surgery who told us that the pulmonologist was credentialed without his knowledge. The literature supports that medical thoracoscopy procedures can be performed with appropriate training by pulmonologists or thoracic surgeons.<sup>9</sup>

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<sup>9</sup> Rodríguez-Panadero F. *Medical Thoracoscopy*. *Respiration*. 2008;76:363-72.

We reviewed the credentialing and privileging record of the pulmonologist and found that he was appropriately credentialed and privileged by the Medical Executive Committee (MEC), which is chaired by the Chief of Staff. MEC membership includes the Associate Chiefs of Staff, service chiefs, the director of the Mental Health Service Line, and the Executive Assistant to the Chief of Staff.

#### **Issue 4: Decline in Fee Basis Requests**

We substantiated that referrals for fee base treatments for lung cancer had declined; however, we found that the decline was the result of improvement in system processes. We found no evidence that fewer fee basis requests led to delays in initiating treatment.

The complainant was concerned that if patients were not referred for fee basis treatment outside the VA, there would be delays in the initiation of treatment at the medical center. The Chief of Staff acknowledged that fee basis requests had declined and said “we are proud of the decrease in fee basis referrals.” He told us that due to improved processes, patients were in surgery within 3 weeks of being seen in the Lung Mass Clinic.

#### **Conclusions**

We did not substantiate the allegation of funding for four full-time pulmonary fellows when only one fellow was at the medical center at any given time. We also did not substantiate that inadequate pulmonary consultative care contributed to the death of a patient; however, work assignments for pulmonary medicine fellows may have contributed to the limited involvement by pulmonary attending physicians in the patient’s care. We substantiated that one fellow had been responsible for covering inpatient consults, inpatient and most outpatient bronchoscopies, and the MICU; a single fellow also covered both the medical center and Shands on weekends. The medical center took corrective actions to realign the duties of the fellows.

We did not substantiate that cancer treatment was delayed, or that a pulmonologist was inappropriately privileged to perform medical thoracoscopies. We substantiated that fee basis requests had declined, but this was a result of improved processes. We made no recommendations.

#### **Comments**

The VISN and System Directors concurred with our findings. We did not make any recommendations and consider the issues closed.

*(original signed by:)*  
JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 23, 2009

**From:** Director, VA Sunshine Healthcare Network (10N8)

**Subject:** **Pulmonary Services and Quality of Care Issues NF/SG  
VA Health Care System, Gainesville, Florida.**

**To:** Associate Director, Combined Assessment Program Reviews  
Director, Management Review Service (10B5)

I concur with the comments provided by the Director, NF/SG  
VHS, Gainesville, Florida.



Nevin M. Weaver, FACHE

Network Director, VISN 8

## System Director Comments

Pulmonary Services and Quality of Care Issues NF/SG VA Health Care System, Gainesville, Florida

Appendix B

### System Director Comments

Department of  
Veterans Affairs

Memorandum

**Date:** July 20, 2009

**From:** Director, North Florida/South Georgia Veterans Health Care System (573/00)

**Subject:** Pulmonary Services and Quality of Care Issues NF/SG VA Health Care System, Gainesville, Florida.

**To:** Director, VA Sunshine Healthcare Network (10N8)

We concur with the finding of no recommendations, but would add the following actions as a result of this report.

1. We have adjusted the on-call fellow assignment effective November 24, 2008.
2. Although not in the report, it should be noted that a new Director of the MICU was appointed March 29, 2009.



THOMAS A. CAPPELLO, MPH, FACHE  
Director

## OIG Contact and Staff Acknowledgments

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OIG Contact	Deborah Howard Associate Director, Combined Assessment Program Reviews (727) 395-2443
Acknowledgments	Jerome Herbers, M.D. Alice Morales-Rullan Christa Sisterhen Carol Torczon

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