DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

HEALTHCARE INSPECTION | REPORT #20-01036-70 | FEBRUARY 10, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of complaints alleging inappropriate language and conduct toward women veterans by a gynecological provider (subject gynecologist) and a nurse chaperone's failure to provide support to these patients at the Gulf Coast Veterans Health Care System (facility) in Biloxi, Mississippi.[1]

The OIG identified three additional concerns related to the facility's compliance with patient complaint tracking processes, facility leaders' response to the subject gynecologist's misconduct, and deficiencies in reporting the subject gynecologist to state licensing board(s) and the National Practitioner Data Bank.[2]

The OIG substantiated that the subject gynecologist's conduct toward five women veteran patients between January 29, 2018, and October 21, 2019, was unprofessional; unethical; insensitive; and served to undermine a culture of privacy, dignity, and safety promised to all patients, particularly women veterans.[3] Specifically, six patients submitted written complaints regarding the subject gynecologist's misconduct.[4] In the written complaints, patients said the subject gynecologist was disrespectful; made rude, vulgar, and offensive comments and jokes during examinations and appointments; was abrupt and arrogant, rushed patients when answering questions, and cut patients off or would not let them speak; started yelling when he encountered a computer problem; and spoke negatively of other facility providers' care.

The OIG interviewed five of the six patients who submitted a written complaint regarding the subject gynecologist's misconduct.[5] The patients reported feeling defeated, numb, anxious, sad, hurt, angry, traumatized, re-traumatized, powerless, violated, afraid, alone, and "severely depressed for a long time."

The OIG found the Veterans Health Administration (VHA) had not incorporated key best practice strategies, such as trauma-informed care and sensitive examination policies, into

[1] The OIG team chose to use the term "misconduct" throughout this report to describe the spectrum of the subject gynecologist's behaviors. Veterans Health Administration Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017. VHA requires a female chaperone to be present in the examination room during breast and pelvic exams and defines a chaperone as "a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure."
[2] The National Practitioner Data Bank is a web-based tool for reporting healthcare providers' adverse actions. U.S. Department of Health and Human Services, *National Practitioner Data Bank.*
[3] VHA Directive 1330.01(2). VHA policy requires that women veteran patients receive high-quality comprehensive care in an environment that provides privacy, dignity, sensitivity, and security.
[4] The OIG reviewed six patient complaints regarding the subject gynecologist's misconduct, four of which were included in the original allegation; two additional complaints were provided by facility staff.
[5] The sixth patient was not available for interview.

training, policy, and practice, to advance healthcare for women veteran patients.[6] The OIG concluded that patients, particularly those with a history of trauma, such as military sexual trauma, or a mental health condition such as depression, anxiety, or posttraumatic stress disorder, would benefit from care delivered by health providers who use trauma-informed care principles.

The OIG substantiated that the nurse chaperone did not provide support to or advocate on behalf of the five patients when the subject gynecologist engaged in misconduct. The OIG found that the nurse chaperone did not view the conduct as inappropriate stating, "[t]hat's just his personality" and "if you don't like this type of people, then find you a different surgeon." The nurse chaperone further defended the subject gynecologist's behavior by describing a patient as too sensitive. Although VHA policies are progressive in the requirement to use chaperones for all sensitive examinations, the OIG found the policies fall short in outlining the responsibilities, duties, training, or competencies expected of the chaperone. The lack of specific training regarding the role and expectations of a chaperone may have contributed to the chaperone's lack of awareness and insensitivity to the patients' distress and subsequent lack of support or intervention.

While reviewing patient complaints regarding the subject gynecologist's misconduct, the OIG found that only three of the six complaints reviewed were recorded by patient advocates in the Patient Advocate Tracking System, as required by VHA policy. When questioned as to why all complaints were not recorded, the Patient Advocate Supervisor reported that not all complaints were entered into the system because the supervisor position was vacant for one year. As the failure to enter all complaints into the Patient Advocate Tracking System was a repeat finding from a prior OIG report, a recommendation for oversight was directed to the Veterans Integrated Service Network Director.[7]

During the inspection, the OIG team noted that facility leaders had prior knowledge of the subject gynecologist's misconduct through a 2018 OIG inspection that identified concerns regarding the subject gynecologist's conduct through a review of women veterans' complaints and the subject gynecologist's annual proficiency reports. In the subject gynecologist's 2015, 2016, and 2017 proficiency reports, the Chief of Surgery and Acting Chief of Surgery documented misconduct, including the tone and delivery of interpersonal communications and a limited capacity to work positively in a team.[8] In response to the documented misconduct of the subject gynecologist in the 2015 proficiency report, the Chief of Surgery reported spending "a

[6] Trauma-informed care emphasizes physical, psychological, and emotional safety; honoring patient voice, agency, control, and choice; and minimizing risk of re-traumatization. A sensitive exam is the "evaluation, palpation, physical therapy for, placement of instruments in, or exposure of a patient's genitalia, rectum or breasts." American College Health Association (ACHA) Guidelines, *Best Practices for Sensitive Exams*, October 2019.
[7] VA OIG, *Alleged Women's Health Care Issues Gulf Coast Veterans Health Care System*, *Biloxi, Mississippi*, Report No. 16-03705-60, January 4, 2018.
[8] VA OIG, *Alleged Women's Health Care Issues Gulf Coast Veterans Health Care System*, *Biloxi, Mississippi.*

great deal of time discussing behavior perception and other soft issues of communication…I will continue to challenge him to be aware of his tone and delivery in interpersonal communications."

The OIG learned that although the Chief of Surgery was aware of the complaints as early as 2015, facility leaders did not initiate a fact-finding review until September 2019. The Chief of Surgery told the OIG that facility leaders and human resources did not provide guidance on how to manage concerns of the subject gynecologist's conduct until the Chief of Staff directed a fact-finding review. The OIG reviewed facility documentation and found that the Facility Director became aware of a patient's complaint on August 30, 2019, and requested the Chief of Staff examine the complaint "immediately." On September 18, 2019, the Chief of Staff directed the Chief of Surgery to initiate a fact-finding review regarding the subject gynecologist's alleged misconduct. The Chief of Surgery's fact-finding summary noted that the subject gynecologist's interaction with the patient demonstrated "poor communication, weak interpersonal skills and an abrasive attitude" but did not rise to a level of progressive discipline.

The subject gynecologist retired after the Chief of Surgery informed him that he had received additional patient complaints, his conduct was in question, human resources was involved, and that there would be "zero tolerance" for misconduct.

The OIG found that facility leaders did not report the subject gynecologist to state licensing boards nor the National Practitioner Data Bank despite evidence that the provider's conduct may have met the reporting standards. The Facility Director told the OIG team that he was aware of some complaints regarding the subject gynecologist, but that the Chief of Staff was responsible for investigating provider complaints that would support a state licensing board review. The Chief of Surgery explained not reporting the subject gynecologist's behavior on the State Licensing Board Provider Exit Review form as "a mistake on my part as a manager." The Provider Review form documents whether the provider met generally accepted standards of clinical practice and if there were any patient safety, conduct, or performance issues.[9]

The OIG made two recommendations to the Under Secretary for Health related to the role and training of providers and chaperones who conduct or provide support to patients during sensitive exams.

The OIG made one recommendation to the Veterans Integrated Service Network Director related to the evaluation of the facility's processes for tracking patient complaints and ensuring all complaints are entered into the Patient Advocate Tracking System.

The OIG made three recommendations to the Facility Director related to the education of facility staff on employee misconduct policies; the evaluation of policies related to administrative

[9] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. VHA Notice 2018-05, Amendment to VHA Handbook 1100.18*, Reporting and Responding to State Licensing Boards*, February 5, 2018.

investigations to ensure timeliness, objectivity, and documentation is sufficient to address the event; and the review of the subject gynecologist's conduct and quality of care provided, including meeting all VHA requirements for state licensing board(s) and National Practitioner Data Bank reporting.

Comments

The Executive in Charge, Office of the Under Secretary for Health, and the Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A, B, and C).[10] The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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[10] Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who had the authority to perform the functions and duties of the Under Secretary for Health. Effective January 20, 2021, he was appointed to Acting Under Secretary for Health with the continued authority to perform the functions and duties of the Under Secretary.

Contents

Abbreviations

ACHA	American College Health Association
ACOG	American College of Obstetricians and Gynecologists
EHR	electronic health record
MST	military sexual trauma
NPDB	National Practitioner Data Bank
OIG	Office of Inspector General
PATS	Patient Advocate Tracking System
PTSD	posttraumatic stress disorder
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WHS	Women's Health Services

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of allegations related to inappropriate language and conduct (misconduct) toward women veterans by a gynecological provider (subject gynecologist) at the Gulf Coast Veterans Health Care System (facility) in Biloxi, Mississippi.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 16, consists of a medical center in Biloxi, Mississippi, and four community clinics located in Mobile, Alabama; and Eglin Air Force Base, Panama City, and Pensacola, Florida. The facility provides comprehensive health care including primary care, medicine, surgery, psychiatry, psychology, neurology, oncology, dentistry, geriatrics, and women's health. Women veterans receive care from a women's health primary care provider, who is specially trained or experienced in women's health. The facility provides gynecology health services such as the evaluation and treatment of abnormal Pap tests, infertility, pelvic pain, and gynecological cancers.[2] Gynecology care is provided at the Biloxi VA Medical Center and the Mobile, Alabama, and Pensacola, Florida, clinics. Between October 1, 2018, and September 30, 2019, the facility served 74,023 unique patients of which 8,801 (11.9 percent) were women. The Veterans Health Administration (VHA) classifies the facility as a Level 1c, high-complexity facility.[3]

Women Veterans

The Veterans Health Care Act of 1992 authorized the VA to provide gender-specific services (Pap tests, menopause management, mammography, breast examinations, and reproductive health), broadened the context of posttraumatic stress disorder (PTSD) to include care for sexual

[1] VA Directive 5021, *Employee Management Relations*, July 19, 2013. VHA includes "disrespectful, insulting, abusive, insolent, or obscene language or conduct to or about supervisors, other employees, patients, or visitors" as general misconduct. The OIG team chose to use the term "misconduct" throughout this report to describe the spectrum of the subject gynecologist's behaviors.
[2] Gulf Coast Veterans Health Care System, *Women Veterans*. https://www.biloxi.va.gov/services/women/index.asp. (The website was accessed on April 20, 2020.) Merriam-Webster, *Definition of Pap test (smear)*. A Pap smear is a test used to detect uterine cervical cancer and differentiates diseased tissue by staining. https://www.merriam-webster.com/dictionary/pap%20test. (The website was accessed on June 18, 2020.) Merriam-Webster, *Definition of gynecology*. Gynecology is a medical practice focused on the female reproductive system. https://www.merriam-webster.com/dictionary/gynecology. (The website was accessed on June 24, 2020.)
[3] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; Level 3 facilities are the least complex.

trauma experienced in the military, and mandated VHA to assign a women veterans' coordinator in each region responsible for enhancing services for women veterans based on identified needs.[4]

Over the past two decades, VHA introduced multiple initiatives to improve the access and quality of health care for women veterans. In 2008, VHA's Women Veterans Health Strategic Health Care Group "began a five-year plan to redesign" the delivery of women's health care.[5] This initiative shaped existing women's health policy, which requires "that all women Veterans are offered assignment to" a women's health primary care provider and care team "who have received training and/or experience in the care of women Veterans."[6] Women's health primary care teams have a reduced panel size to allow for longer and more frequent visits, as well as, enhanced staffing to accommodate chaperone and care coordination needs.[7]

VHA Women Veterans Population

VHA experienced an unprecedented growth in the number of women veterans accessing VHA care. Between September 30, 2000, and September 30, 2015, the number of women veterans receiving care from VHA nearly tripled.[8] From October 1, 2018, through September 30, 2019, 8.3 percent of the total patients who utilized VA health care services were women.

The Women's Health Evaluation Initiative produced a series of Sourcebooks identifying key characteristics of women veterans. The most recent Sourcebook, Volume 4, identified "longitudinal trends in sociodemographic characteristics, health care utilization, and health conditions of women veterans" who utilized VHA care over a fifteen-year time span.[9] The Sourcebook also outlined associated implications for care. As of September 30, 2015, among women VHA patients

- Forty-three percent were between the ages of 18–44, 46 percent were 45–64, and 12 percent were 65 years or older;
- Mental health conditions were identified in the top 10 health conditions in the 18–44 and the 45–64 age groups;
    - The implication of care emphasized that "treatment of mental health conditions must account for gendered issues, such as the fact that depression, PTSD [posttraumatic stress disorder], anxiety disorders, and substance use disorders are

[4] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017.
[5] National Center for Veterans Analysis and Statistics, *America's Women Veterans: Military Service History and VA Benefit Utilization Statistics,* November 23, 2011.
[6] VHA Directive 1330.01(2).
[7] VHA Directive 1330.01(2).
[8] The Women's Health Evaluation Initiative, *VHA Sourcebook*. The Women's Health Evaluation Initiative consists of women's health investigators including VA Health Services Research and Development, Center for Innovation to Implementation, and the Health Economics Resource Center at the VA Palo Alto Health Care System. The number of women veterans in VHA increased from 159,810 in September 2000 to 439,791 in October 2015.
[9] The Women's Health Evaluation Initiative, *VHA Sourcebook.*

common sequelae of military sexual trauma [MST], which is far more common in women veterans than in men."[10]

- Half of the 18–44 age group had a mental health condition, which included a sevenfold increase in PTSD and anxiety disorders from October 2000 to September 2015;
    - The implication for care stated that "[g]iven the high rates of PTSD in this reproductive-age population, skills in trauma-sensitive pelvic examinations represent core competencies for clinicians caring for this population."[11]

VHA Women's Health Services

The "VA strives to be a national leader in the provision of health care for women, thereby raising the standard of care for all women."[12] The VHA Women's Health Services (WHS) program office "works to ensure that timely, equitable, high-quality, comprehensive health care services are provided in a sensitive and safe environment at VA medical centers nationwide."[13]

VHA policy designates the WHS Chief Consultant to be "responsible for the management, administration, technical aspects, program planning, policies, evaluations, integration, and implementation of national women's health program's activities."[14] The WHS Chief Consultant collaborates with VHA Patient Care Services to develop and implement "national directives, program initiatives, and VHA guidance related to women's health issues."[15] Further, the WHS Chief Consultant must establish and promote effective collaborations with VISN and facility directors to integrate the delivery of comprehensive women health care services across the nation.[16] In a 2013 publication, the WHS Chief Consultant noted "[w]e need to look critically at the relationship between creation of a sensitive and safe clinical environment and women Veterans' satisfaction with treatment and perceptions of their care."[17]

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[10] The Women's Health Evaluation Initiative, *VHA Sourcebook.* VA, *MST Fact Sheet.* May 2015. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on June 23, 2020.) MST is the term VHA uses to refer to sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service. It is an experience, not a diagnosis. VA's national screening program data revealed that as of May 2015, approximately 1 in 4 women and 1 in 100 men receiving VA healthcare responded that they had experienced MST when screened by their VA provider.
[11] The Women's Health Evaluation Initiative, *VHA Sourcebook.*
[12] VHA Directive 1330.01(2).
[13] VHA Directive 1330.01(2).
[14] VHA Directive 1330.01(2).
[15] VHA Directive 1330.01(2).
[16] VHA Directive 1330.01(2).
[17] Patricia Hayes, "Improving Health of Veterans through Research Collaborations." *Journal of General Internal Medicine* 28**,** 495–497 (2013). https://doi.org/10.1007/s11606-013-2471-8. (The website was accessed on May 19, 2020.)

Women's Health and Gynecological Care: Literature Review

The OIG conducted a literature review on the provision of women's health gynecological care (primarily pelvic examinations), with an emphasis on women veterans. Researchers acknowledge that a pelvic examination is a highly vulnerable experience, as it involves the need for women to undress, expose intimate parts of their body, and share personal information about sexual habits; accordingly, women commonly experience embarrassment, anxiety, discomfort, worries about cleanliness, fear of illness, and a lack of personal control.[18] This vulnerability encompasses the reliance on the provider's professionalism and ethical practice.[19] Research has recognized that women's experience during a pelvic examination may influence their willingness to participate in future care; similarly, women's reluctance toward or avoidance of these examinations may result in harmful health effects by delaying the identification and treatment of medical conditions.[20]

The literature consistently indicates that for women who have experienced past physical or sexual trauma and those with anxiety or PTSD, pelvic examinations can be particularly stressful.[21] A history of sexual violence and PTSD have been linked to increased reports of pain and distress during pelvic examinations and strong reactions of fear and embarrassment.[22] For women with a history of sexual trauma, undergoing pelvic examinations may trigger intrusive memories and flashbacks of prior trauma and cause increased anxiety, insomnia, and even dissociation before, during, and after examination.[23]

Particularly relevant to the veteran population is the recognition that providing gynecological services to women with a history of sexual violence and PTSD requires extra sensitivity and care.[24] Some "women MST survivors forgo, delay, or drop out of VHA care," which in part was

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[18] Lisa Skar, Olov Grankvist, and Siv Soderberg, "Factors of Importance for Developing a Trustful Patient-Professional Relationship when Women Undergo a Pelvic Examination," *Health Care for Women International*, (January 2020), https://doi.org/10.1080/07399332.2020.1716234. (The website was accessed on May 14, 2020.)
[19] American College Health Association (ACHA) Guidelines*, Best Practices for Sensitive Exams*, October 2019. https://www.acha.org/documents/resources/guidelines/ACHA_Best_Practices_for_Sensitive_Exams_October2019.pdf. (The website was accessed on May 14, 2020.) ACHA advances health and wellness through multidisciplinary evidence-based practices, education, advocacy, and research. ACHA, *About ACHA*, 2020. (The website was accessed on June 23, 2020.)
[20] Skar, et al., "Factors of Importance." Emre Yanikkerem, Meral Ozdemir, Hilal Bingol, Ayse Tatar, "Women's Attitudes And Expectations Regarding Gynaecological Examination," *Midwifery* 25(5) (October 2009): 500–508. doi:10.1016/j.midw.2007.08.006.
[21] Carol K. Bates, Nina Carroll, and Jennifer Potter, "The Challenging Pelvic Examination," *Journal of General Internal Medicine* 26(6) (2011):651–7 DOI: 10.1007/s11606-010-1610-8. Julie C. Weitlauf, Susan M. Frayne, John W. Finney, Rudolf H. Moos, Surai Jones, Kirsten Hu, and David Spiegel, "Sexual Violence, Posttraumatic Stress Disorder, and the Pelvic Examination: How Do Beliefs About the Safety, Necessity, and Utility of the Examination Influence Patient Experiences?" *Journal of Women's Health 19,* no. 7, (2010): 1271-1280, DOI: 10.1089/jwh.2009.1673.
[22] Weitlauf, "Sexual Violence."
[23] Bates, "The Challenging Pelvic Examination." Weitlauf, "Sexual Violence."
[24] Weitlauf, "Sexual Violence."

attributed to a difficulty trusting providers. Further, some women veterans reported that just going to a VHA facility provoked their anxiety and "triggered memories of their MST, describing a sense of vulnerability and fear for their safety."[25]

Best practices and key considerations for sensitive examinations are identified throughout the literature. The American College Health Association's (ACHA) best practices recommends that every facility develop a policy regarding sensitive examinations, which includes the role, training, and expectations of a chaperone and the provider to protect patients' safety and minimize associated risk.[26]

The literature repeatedly recommends the use of trauma-informed care principles. Trauma-informed care aims to make care more accessible and patient centered and honors patient voice, agency, control, and choice, while minimizing risk of re-traumatization.[27] Staff within a trauma-informed environment "recognize how organizational practices may trigger painful memories and re-traumatize clients." A trauma-informed organization recognizes the widespread impact and the signs and symptoms of trauma and recovery and fully integrates this knowledge into organizational policies, procedures, practices, and culture.[28]

Gynecological Care: Industry Guidelines

The American College of Obstetricians and Gynecologists (ACOG) recognizes that the practice of gynecology "requires a high level of trust and professional responsibility" within the patient-provider relationship.[29] ACOG outlined best practices to maximize efforts in creating a safe environment for patients including maintaining boundaries, and avoiding sexual comments and humor; practicing trauma-informed care by recognizing that patients with a history of trauma,

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[25] Lindsey L. Monteith, Nazanin H. Bahraini, Holly R. Gerber, Brooke Dorsey Holliman, Alexandra L. Schneider, Ryan Holliday, and Bridget B. Matarazzo, "Military Sexual Trauma Survivors' Perceptions of Veterans Health Administration Care: A Qualitative Examination," *Psychological Services* 17*(2),* 178–186, September 27, 2018. http://dx.doi.org/10.1037/ser0000290. (The website was accessed on May 13, 2020.)

[26] A sensitive exam is the "evaluation, palpation, physical therapy for, placement of instruments in, or exposure of: genitalia, rectum [or] breasts." ACHA Guidelines, *Best Practices for Sensitive Exams*, October 2019. https://www.acha.org/documents/resources/guidelines/ACHA_Best_Practices_for_Sensitive_Exams_October2019.pdf. (The website was accessed on May 14, 2020.)

[27] ACHA Guidelines, *Best Practices for Sensitive Exams.* Lindsey, et al, "MST Survivors' Perceptions." American College of Obstetricians and Gynecologists, *Sexual Misconduct, ACOG Committee Opinion, Number 796, Committee on Ethics: Sexual Misconduct*. (Washington, DC: American College of Obstetricians and Gynecologists, 2020.) https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/01/sexual-misconduct.pdf. (The website was accessed on February 13, 2020.) The Women's Health Evaluation Initiative, *VHA Sourcebook.*

[28] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[29] ACOG, *Sexual Misconduct, ACOG Committee Opinion.* ACOG is a recognized professional membership for obstetrician-gynecologists. The ACOG produces practice guidelines for providers and education material for patients and facilitates programs and initiatives to improve women's health. https://www.acog.org/about. (The website was accessed on May 29, 2020.)

gestures, or language may trigger memories of past sexual or physical abuse; utilizing and training chaperones for all sensitive exams; and training new gynecological providers to recognize the inherent power imbalance, the need to avoid using sexually offensive or denigrating language, and understanding risk factors for and reporting of sexual misconduct.[30]

Prior OIG Reports

The OIG published two recent reports pertaining to the facility containing similar issues.

Identifying Subject Gynecologist's Misconduct

The OIG published the *Alleged Women's Health Care Issues, Gulf Coast Veterans Health Care System, Biloxi, Mississippi,* on January 4, 2018, with two recommendations related to professional conduct and collaborations, and the tracking and resolution of patient complaints.[31]

Although not part of the original allegation, during the course of the inspection, the OIG identified the following concerns regarding the subject gynecologist's conduct:

- A women's health program provider described the gynecologist as "unprofessional" and "rude" and reported that program providers took measures to avoid the gynecologist.
- A review of patient complaints detailed a spectrum of behavior that included rude demeanor, hanging up on a patient, not treating patients with dignity and respect, accepting a personal call during patient care, and insensitivity.[32]

The OIG found the actions by the gynecologist limited patient care discussions between providers as well as patients and may have prevented pertinent communication concerning the safe and effective care of patients.

The OIG recommended that the Facility Director use VHA resources to promote a culture that discourages behaviors that undermine safe patient care and effective communication and collaboration between providers and between providers and patients, and ensures that patient advocacy program managers enter all complaints into the Patient Advocate Tracking System (PATS) database and track all reported complaints to resolution.[33]

The VISN and Facility Directors agreed with the findings and recommendations. The Interim Facility Director's response related to the misbehavior as published in the report stated the Chief of Surgery met with the subject gynecologist "to discuss conduct and provided advisement on the

[30] ACOG, *Sexual Misconduct*, ACOG Committee Opinion.
[31] VA OIG, *Alleged Women's Health Care Issues Gulf Coast Veterans Health Care System*, *Biloxi, Mississippi*, Report No. 16-03705-60, January 4, 2018.
[32] The six patient complaints were from June to November 2015.
[33] As of November 2018, both OIG recommendations were closed.

need to work collaboratively with peers and reinforced that continued disruptive behavior would not be tolerated."[34]

Reporting Providers to the National Practitioner Data Bank and State Licensing Boards

The OIG also published the *Facility Leaders' Oversight and Quality Management Processes Gulf Coast VA Health Care System, Biloxi, Mississippi,* on August 28, 2019, with a recommendation related to reviewing and reporting providers to the National Practitioner Data Bank (NPDB) and state licensing boards (SLB).[35] The OIG recommended that the Facility Director ensures that providers, when indicated, are reported timely to the NPDB and SLB. The VISN and Facility Directors agreed with the findings and recommendations.[36]

Allegations and Related Concerns

In November 2019, the OIG received an allegation regarding misconduct by the subject gynecologist toward four women veteran patients. Upon reviewing the complaint, the Office of Healthcare Inspections initiated an inspection in January 2020.

The purpose of the inspection was to determine the validity of the following allegations:

1. The subject gynecologist used inappropriate (rude and offensive) language and engaged in misconduct toward female patients.
2. A nurse chaperone assigned to accompany the subject gynecologist during exams did not support the patients and ignored the offensive comments made by the subject gynecologist.

The OIG team identified and reviewed three additional concerns:

3. Noncompliance with patient complaint tracking processes
4. Deficiencies in facility leaders' response to complaints
5. Deficiencies in reporting to the SLB(s) and NPDB

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[34] VA OIG, *Alleged Women's Health Care Issues Gulf Coast Veterans Health Care System*, *Biloxi, Mississippi.*
[35] The National Practitioner Data Bank is a web-based tool for reporting healthcare providers' adverse actions. U.S. Department of Health and Human Services, *National Practitioner Data Bank*, https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp. (The website was accessed on May 22, 2020.) State licensing boards oversee the provision of medical care through licensing, discipline, and regulation. Docinfo, *What is a State Medical Board*, http://www.docinfo.org/state-boards/. (The website was accessed on June 22, 2020.)
[36] VA OIG, *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System, Biloxi, Mississippi*, Report No. 17-03399-200, August 28, 2019. The recommendation relating to timely reporting to the NPDB and SLBs was closed on May 18, 2020.

Scope and Methodology

The OIG initiated the inspection in January 2020, and conducted a virtual site visit from March 23, 2020, through April 08, 2020. The OIG conducted the inspection virtually given the concerns with travel and the potential spread of COVID-19.[37]

The OIG team interviewed five patients, facility leaders, and staff from quality management, patient safety, patient advocacy, surgery, women's health, nursing, mental health, pathology, and human resources. The OIG team reviewed the electronic health records (EHR) of six identified patients for the period between January 1, 2018, and February 12, 2020.[38]

The OIG team reviewed VA and VHA directives, handbooks, facility policies and procedures, external standards and guidelines, professional literature, and facility reports of contact, meeting minutes, administrative investigations and responses, training documents, credentialing and privileging documents, staff emails, quality reviews, patient safety reports, and patient advocacy reports.[39]

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).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a

[37] Centers for Disease Control and Prevention. *Travel during the COVID-19 Pandemic*. https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html. (The website was accessed August 31, 2020.) The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It.* https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. (The website was accessed on August 31, 2020.) COVID-19 (coronavirus disease) is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[38] Four patients were identified in the original complaint; the remaining two were identified during the inspection. Five of the six patients were available for interview.

[39] The OIG reviewed selected facility meeting minutes for the following committees: Advocacy Council, Women Veterans Health, Executive Committee of the Medical Staff, Credentialing, Patient Satisfaction, and Quality Safety and Value. The OIG reviewed external standards and guidelines including ACOG, American College of Surgeons, American Medical Association, Federation of State Medical Boards, The Joint Commission, and Substance Abuse and Mental Health Services Administration.

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

Inspection Results

1. Misconduct by the Subject Gynecologist

The OIG substantiated that the subject gynecologist's conduct toward five women veteran patients was unprofessional, unethical, and insensitive, and served to undermine a culture of privacy, dignity, and safety promised to all patients, particularly women veterans. The OIG further determined that these provider-patient interactions resulted in patients experiencing increased emotional distress, such as anxiety, depression, hopelessness, feelings of re-traumatization, or powerlessness.

VHA policy requires that women veteran patients receive high-quality comprehensive care in an environment that provides privacy, dignity, sensitivity, and security.[40] Facility policy states that patients have the right to be free from emotional, verbal, and other types of abuse. The policy defines emotional abuse as "any act which may diminish a person's sense of dignity and self-worth" (including verbal assault, threats, humiliation, and infantilization) and verbal abuse as "any behavior or remarks towards patients reasonably perceived to be demeaning, seductive, exploitive, insulting, derogatory, or humiliating."[41]

Per the facility's Code of Conduct for medical staff, "conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated." Behaviors commonly recognized as detrimental to patient care and the culture of safety include "foul language; rude, loud or offensive comments; and intimidation of staff, patients, and family members."[42]

Women Veteran Patients' Complaints and Experiences

The OIG reviewed six patient complaints regarding the subject gynecologist's misconduct, four of which were included in the original allegation; two additional complaints were provided by

[40] VHA Directive 1330.01(2).
[41] Facility Policy 00F-07-17, *Allegations of Patient Abuse*, May 10, 2017.
[42] Facility Policy, *Bylaws and Rules of The Medical Staff of Veterans Health Administration (VHA), Gulf Coast Veterans Health Care System*, August 14, 2018. This policy was in effect for a portion of the time frame of the events discussed in this report. The 2018 policy rescinded and replaced the 2017 Facility Policy, *Bylaws and Rules of The Medical Staff of Veterans Health Administration (VHA), VA Gulf Coast Veterans Health Care System*, December 8, 2017, that was in effect for the remaining time frame of the events discussed in this report. The 2017 policy contained the same or similar language to define professionalism for medical staff.

facility staff. The complaints were received through a variety of facility reporting mechanisms (letter to the Facility Director, change of provider form, secure messaging, and patient advocate contacts) between January 29, 2018, and October 21, 2019.

In the written complaints, patients said the subject gynecologist was disrespectful, made rude, vulgar, and offensive comments and jokes during examinations and appointments, was abrupt, arrogant, rushed the patients when answering questions, cut the patients off or would not let them speak, started yelling when he encountered a computer problem, and spoke negatively of other facility providers' care. Specifically, comments made by the subject gynecologist included making graphic, lewd comments about sexual positions and penetration, telling a patient that when prescribing Valium to women they do not care if they receive 1 or 27 Pap smears, making offensive jokes while performing a pelvic examination, attributing a health condition to an untreated history of a sexually transmitted disease without evidence or conducting an examination, and telling a patient not to trust other VA providers.[43]

The OIG conducted interviews with five of the six patients who submitted a written complaint regarding the subject gynecologist's misconduct.[44] During interviews, these patients reiterated the concerns brought forward in their written complaints regarding the subject gynecologist's unprofessional behavior and inappropriate, graphic commentary during examinations.

Further, the patients described the thoughts and feelings they experienced during and following their health care appointments with the subject gynecologist. The patients reported feeling defeated, numb, anxious, sad, hurt, angry, traumatized, re-traumatized, violated, afraid, alone, and "severely depressed for a long time." One patient questioned herself, feeling as though the health concerns were her fault or frivolous; another patient, self-identified as an MST survivor, described how the examination triggered feelings and memories of past trauma and worried that the subject gynecologist acted as he did because "maybe there is something wrong with me?" Another patient stated that she has not been the same since her appointment with the subject gynecologist. Following the interaction with the subject gynecologist one patient reported calling her husband crying over the telephone and another patient reported sitting in her car for a long time because she was too upset to drive.

Patients expressed fears they had making their complaints. Two patients expressed concerns that there would be repercussions for making a complaint or fear the subject gynecologist would

[43] The subject gynecologist's EHR documentation of the corresponding examinations reflected some consistencies with the patients' accounts. In three corresponding examinations, the subject gynecologist documented "coital positions discussed," for another "[the patient] would like to postpone gyn exam," and for another "[the patient] refused exam and appeared to be angry." Further, because one patient sent the complaint and request for a female gynecologist to her primary care nurse through secure messaging, both are recorded in the EHR. Prescriber's Digital Reference, *Diazepam - Drug Summary,* Valium is a trade name for diazepam, a medication prescribed to treat anxiety. https://www.pdr.net/drug-summary/Valium-diazepam-2100.1196. (The website was accessed on May 11, 2020.)

[44] The sixth patient was not available for an interview.

negatively interfere with their health care. Another patient said she was not contacted by facility leaders for seven months after making the complaint.

These patients also verbalized concerns regarding what the subject gynecologist may be doing to other women patients, who may be "too embarrassed" to say something. One patient said, "I wish there was more support...there is always a thing where no one believes women…when we say something is wrong…we don't have the power." The patient added, "I don't even work at the VA and I'm still scared…it feels like it's wrong to say something when a guy does something…Does it have to be so egregious, the discomfort should be validated?" Another patient was concerned that women may not speak up because "it's intimidating when you have a medical professional who you assume knows more about everything than you do." A third patient voiced concerns about her daughter's safety if they were to receive VA care after military service.

The OIG determined that these provider-patient interactions resulted in patients reporting negative outcomes such as anxiety, depression, hopelessness, and feelings of re-traumatization or powerlessness.[45] The OIG found that the patients' experiences mirrored the concerns brought forward in the women's health literature review regarding sensitive (gynecological) examinations and the ACOG guidelines for gynecologists. While VA strives to be a national leader in women's health care and VHA policy requires that women veteran patients receive high-quality comprehensive care in an environment that provides privacy, dignity, sensitivity, and security, the OIG found VHA has not incorporated key best practice strategies, such as trauma-informed care and sensitive examination policies, into training, policy and practice, to advance healthcare for women veteran patients. The OIG concluded that patients, particularly those with a history of trauma, such as MST, or a mental health condition such as depression, anxiety, or PTSD would benefit from care by health providers who use trauma-informed care principles.

2. Nurse Chaperone Failed to Support Patients During Examinations

The OIG substantiated that the nurse chaperone did not provide support to, or advocate on behalf of, five patients when the subject gynecologist engaged in misconduct. Further, the OIG identified documentation from the fact-finding that the nurse chaperone did not view the conduct as inappropriate and in one instance defended the subject gynecologist's behavior by describing the patient as too sensitive.

The ACHA recommends that all institutions that provide sensitive exams have a policy that includes requiring a trained chaperone to "act as a support and witness for the patient and the

[45] The OIG further reviewed the EHRs for the six patients and did not identify an adverse medical outcome. Within the context of this report, the OIG considered an adverse medical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or need for a higher level of care.

provider during a sensitive exam or procedure."[46] "Because the provider has the power to make and influence decisions" and examines sensitive areas, "chaperones play a critical role by offering a sense of safety and balance of power…by protecting both patient and provider and better ensuring there is no abuse of power by the provider."[47]

VHA's chaperone requirements are in alignment with the ACHA, American Medical Association, and the ACOG in the recommendation of utilizing chaperones during gynecological visits due to the inherent sensitive, vulnerable, and intimate nature of these exams.[48] VHA policy requires a female chaperone to be present in the examination room during sensitive exams and defines a chaperone as "a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure."[49]

In review of the six written patient complaints, the OIG noted that three complaints included concerns regarding the lack of support or assistance from the nurse chaperone during the patients' gynecological exams with the subject gynecologist.[50] The patients wrote that the nurse chaperone

- Was not helpful and "just watched and listened" while the subject gynecologist made "graphic and unnecessary comments about my sex life,"
- Looked away when she looked to the nurse chaperone for support, and
- "Just sat there on the stool and did not offer any input or support" and only paid attention to the subject gynecologist when she looked to the nurse chaperone for reassurance.

During interviews with the OIG, these three patients reiterated concerns about the nurse chaperone's behavior during gynecological visits and described feeling uncomfortable and unsupported by the nurse chaperone's lack of speaking or acting to address their discomfort. The patients said the nurse chaperone was

- "Conditioned to be like an invisible person in the room," and appeared uncomfortable, looked at the floor, and never spoke;

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[46] ACHA Guidelines, *Best Practices for Sensitive Exams*.
[47] ACHA Guidelines, *Best Practices for Sensitive Exams*.
[48] VHA Directive 1330.01(2). ACHA Guidelines, *Best Practices for Sensitive Exams*, American Medical Association, *Code of Medical Ethics, Opinion 1.2.4. Use of Chaperones*. https://www.ama-assn.org/delivering-care/ethics/use-chaperones. (The website was accessed on May 18, 2020.) ACOG, *Sexual Misconduct, ACOG Committee Opinion.*
[49] VHA Directive 1330.01(2). VHA requires a female chaperone to be present in the examination room during breast and pelvic exams, Pap smears, and procedures including urodynamic testing or pelvic floor physical therapy treatments. VHA also requires a female chaperone for breast, pelvic, femoral vascular, and transvaginal ultrasounds, breast magnetic resonance imaging, or any procedure that exposes the groin or pubic area. VHA policy designates staff who may function as a chaperone to include a physician, nurse, health technician, licensed practical nurse, and other clinical personnel such as a radiology technician. Under specific circumstances, a female volunteer may also function as a chaperone.
[50] The same registered nurse served as chaperone during the exams for all three patients.

- Just sitting there, "was not there to support me…was there for him [subject gynecologist]," and "I was afraid and alone even though the female nurse was in there;" and
- Not saying anything when the patient was uncomfortable.

The other two patients who made written complaints about the subject gynecologist but did not specifically mention the nurse chaperone, were interviewed by the OIG. Both patients commented on the nurse chaperone's presence and involvement or lack thereof in their appointments. One patient said "I looked at her and she could tell I was broken. She didn't say anything but the look on her face was 'I understand and I'm sorry,' but she didn't say anything to him." The other patient stated the nurse chaperone was "just standing there the entire time."

According to the facility's Women Veterans Program Manager, a nurse chaperone ensures comfortable appropriate care and is expected to notify a supervisor or Women Veterans Program Manager if there is any concern about inappropriate behavior. After learning of a patient complaint regarding the subject gynecologist, the Women Veterans Program Manager asked the nurse chaperone about the subject gynecologist's behavior. The nurse chaperone acknowledged the subject gynecologist's statements but reported that the patients are too sensitive. A surgical service program specialist who was assigned to question the nurse chaperone about a patient complaint regarding the subject gynecologist's misconduct documented that the nurse chaperone felt the patient was "a little sensitive."

The OIG team interviewed the nurse chaperone who acknowledged the patient complaint that the subject gynecologist was abrasive and rude, but did not find anything wrong with it, stating, "[t]hat's just his personality" and "if you don't like this type of people, then find you a different surgeon." The nurse chaperone further explained that both she and the subject gynecologist were from the "north" and have a more direct communication style. She noted that sometimes that direct communication "rubbed the wrong way with some of the southern women down here." Further, in a conversation with the Women Veterans Program Manager, the nurse chaperone excused the subject gynecologist's behavior by describing one patient as too sensitive. The OIG concluded that the nurse chaperone did not advocate for the five patients interviewed or provide support when the subject gynecologist displayed inappropriate behavior.

Chaperone Duties and Training

The OIG determined that the lack of specific training regarding the role and expectations of a chaperone may have contributed to the chaperone's lack of awareness and insensitivity to the patients' distress and subsequent lack of support or intervention.

To protect patients' safety and minimize risk, the ACHA recommends that every facility develop a policy regarding sensitive examinations to include outlining the role, training, and expectations of a chaperone. ACHA also recommends that the chaperone and provider training include

reviewing the role and expectations of the chaperone, setting expectations for provider behavior and procedure, and identifying "neutral terms for intervention in the case of patient distress or chaperone discomfort." The chaperone training should also include the process for reporting unprofessional conduct during the exam or concerns if the policy is violated. ACHA further recommends culturally sensitive and trauma-informed training for providers and chaperones to mitigate risk and ensure patient comfort, safety, and dignity.[51]

A facility nurse manager informed the OIG team that nursing staff have a women's health competency, which references the VHA and facility requirement for a chaperone to be present for sensitive exams. However, the competency does not identify chaperone specific duties or training.[52] Further, the facility's Women Veterans Program Manager reported that there is no specific competency for chaperones related to VHA and facility requirements for a chaperone to be present during breast and pelvic exams. The OIG reviewed the facility's women's health nurse competency list and verified the absence of chaperone duties, expectations, or guidance.

The OIG recognizes that VHA and facility policies are progressive in the requirement to utilize chaperones for all sensitive examinations; however, the OIG found the policies fell short in outlining the responsibilities, duties, training, or competencies expected of the chaperone.

The OIG determined that the lack of specific training regarding the role and expectations of a chaperone, may have contributed to the chaperone's lack of awareness and insensitivity to the patient's distress and subsequent lack of support or intervention.

3. Patient Complaint Tracking

The OIG determined that facility patient advocates did not enter all complaints into the PATS.[53] The OIG found that although facility patient advocates and quality management leaders tracked and trended patient complaints, the data was incomplete, limiting the accuracy and value of identified trends.

Per VHA policy, facility directors are responsible for promoting a culture that encourages a proactive approach to effectively and timely resolving patient complaints while also ensuring

[51] ACHA Guidelines, *Best Practices for Sensitive Exams*.
[52] VHA Directive 1330.01(2). Facility Policy 11-61-19, *Women Veterans Health Care Services*, June 26, 2019. This policy was in effect for a portion of the time frame of the events discussed in this report. The 2019 Facility Policy 11-61-19 rescinded and replaced Facility Policy 11-61-16, *Women Veterans Health Care Services*, March 4, 2016, that was in effect for the remaining time frame of the report. The 2016 policy contained the same or similar language regarding female chaperones.
[53] VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018. This directive was in effect for a portion of the time frame of the events discussed in this report. The 2018 VHA Directive 1003.04 replaced VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005, that was in effect for the remaining time of the events discussed in this report. The 2005 handbook contained the same or similar language concerning the Patient Advocacy Program. The PATS is a VHA-wide computer application that tracks patient complaints, compliments, and other key program data at each VA medical facility.

that patient complaint data is collected, analyzed, and trended.[54] Patient advocates must ensure all complaints are entered into the PATS to "enable a comprehensive understanding of veteran issues and concerns, and provide data to drive change."[55] VHA policy requires patient advocates bring complaint data to the attention of facility leaders to trigger assessment, analysis, and follow-up.[56] Facility policy further requires the Patient Satisfaction Committee Chair to report quarterly PATS data to the Advocacy Council, which is responsible for reporting significant issues or trends to the Executive Leadership Board.[57]

The OIG found that patient advocates entered three of the six patient complaints into the PATS. The other three complaints were communicated through a change of provider request form, a letter to the Facility Director, and a secure electronic message. When asked why these complaints were not entered into the PATS, the Patient Advocate Supervisor reported the supervisor position was vacant for one year and patient complaints were not entered into the PATS for all issues at that time.

The OIG also found that the patient advocate reported trended-PATS data to facility leaders through the Patient Satisfaction Committee; however, the data were filtered into general categories and not sufficient to identify specific complaints or employee names. The OIG also learned the Advocacy Council Chair had not provided a report to the Executive Leadership Board since August 2018.

The OIG concluded that although facility patient advocates followed VHA and facility policies to track, trend, and communicate significant issues, the patient advocates did not enter all complaints into the PATS, or sufficiently track and trend data. Without effective and timely processes to ensure the PATS captures all complaints, data will not reflect trends or issues, or trigger analysis for facility leader follow-up.

4. Facility Leaders' Awareness and Response to the Subject Gynecologist's Misconduct

The OIG determined that facility leaders were aware of the subject gynecologist's misconduct as early as 2015, but failed to effectively address misconduct for years by not timely performing informal or formal investigations such as a fact-finding review or an administrative investigation

[54] VHA Directive 1003.04.
[55] Facility Policy 00A-08-18, *Patient Advocate/Patient Complaint Program*, July 18, 2018. This policy was in effect for a portion of the time frame of the events discussed in this report. The 2018 Facility Policy 00A-08 replaced Facility Policy 00A-08-16, *Patient Advocate/Patient Complaint Program*, October 21, 2016, that was in effect for the remaining time frame of the events discussed in this report. The 2016 policy contained the same or similar language concerning the Patient Advocacy Program.
[56] VHA Directive 1003.04.
[57] Facility Policy 00A-08-18.

board as required by VHA and facility policies.[58] The OIG established that facility leaders were aware of the subject gynecologist's misconduct through annual proficiency reports, a prior OIG report, and patient complaints.[59]

Proficiency Reports

VA policy requires facility supervisors to document providers' conduct in an annual proficiency report, which may be used to indicate a need for training or development and, in cases where performance is unsatisfactory, as a basis for personnel action.[60] The OIG reviewed the subject gynecologist's annual proficiency reports from 2015 to 2019. The Chief of Surgery and Acting Chief of Surgery documented misconduct including the tone and delivery of interpersonal communication and limited capacity to work positively in a team in the 2015, 2016, and 2017 proficiency reports. However, the Chief of Surgery rated the subject gynecologist's overall performance as satisfactory. The Chief of Surgery did not document misconduct in 2018 and there was no proficiency report completed in 2019 as the subject gynecologist had retired from the facility. The signed 2015 and 2016 proficiency reports demonstrated evidence of facility leaders' awareness of the subject gynecologist's behavior.[61] In response to the documented misconduct of the subject gynecologist in the 2015 proficiency report, the Chief of Surgery reported spending "a great deal of time discussing behavior perception and other soft issues of communication…I will continue to challenge him to be aware of his tone and delivery in interpersonal communications."

Awareness of Patient Complaints

The 2018 OIG report, *Alleged Women's Health Care Issues, Gulf Coast Veterans Health Care System,* documented patient complaints about the subject gynecologist's misconduct. Facility

[58] VA Directive 0700, *Administrative Investigations*, March 25, 2002. Facility Policy 00Q-19-19, *Risk Management and Medical Legal Affairs Program*, October 24, 2019. This policy was in effect for a portion of the time frame of the events discussed in this report. The 2019 Facility Policy 00Q-19-19 rescinded and replaced Facility Policy 00Q-19-15, *Risk Management and Medical Legal Affairs Program*, March 13, 2015, that was in effect for the remaining time frame of the events discussed in this report. The 2015 policy contained the same or similar language concerning administrative investigations

[59] VA Directive 5013, *Performance Management Systems*, January 5, 2016. An annual proficiency report documents a supervisor's systematic review, analysis, and evaluation of the effectiveness of a physician's performance.

[60] VA Directive 5013.

[61] In 2016, there was an Acting Chief of Surgery who signed the subject gynecologist's annual proficiency report because the Chief of Surgery was acting as the Deputy Chief of Staff during that time frame. However, the Chief of Surgery was aware as he also signed the report. The 2017 proficiency report contained similar language regarding the subject gynecologist; however, the report was not signed by the Chief of Surgery or the subject gynecologist. Due to the isolated nature of the unsigned report, the OIG is not making a recommendation.

leaders reviewed and concurred with the report in October 2017, effectively acknowledging their awareness.[62]

During the course of this inspection, the OIG reviewed facility documentation from 2018 to 2019 and found facility leaders were aware of five of six patient complaints about the subject gynecologist's misconduct. The sixth patient entered a complaint via a change of provider request form; however, the OIG was unable to determine if facility leaders reviewed the form or were aware of the complaint. See table 1.

Table 1. Facility Leaders' Awareness of Patient Complaints

Patient	Date of Complaint	Date of Awareness	Facility Leader(s) Aware
1	1/29/2018	2/1/2018	Chief of Surgery
2	4/11/2019	4/11/2019	Chief of Surgery, Associate Chief of Staff, Primary Care, Chief Nurse, Outpatient Care Operations
3	8/23/2019	8/30/2019	Chief of Staff, Medical Center Director, Associate Director Patient Care Services, Chief Medical Officer, Joint Ambulatory Clinic, Pensacola
4	10/18/2019	10/18/2019	Chief of Staff, Chief of Surgery
5	11/5/2019	11/5/2019	Chief of Staff, Chief of Surgery, Deputy Chief of Staff

Source: OIG analysis of patient complaints

OIG interviews with facility leaders regarding patient complaints confirmed that facility leaders were aware of the misconduct related to the subject gynecologist. Specifically, in interviews with the OIG

- The Associate Chief of Staff, Primary Care reported that the subject gynecologist demonstrated a "general lack of bedside manner and…rudeness." Patients placed "a change of provider [form]… saying no they don't want to see [subject gynecologist], they prefer to be seen by someone else."
- The Chief of Surgery stated patient complaints regarding the subject gynecologists "were due to insensitivity, poor communication skills, or just being generally coarse and inappropriate." The subject gynecologist "had reached a point where people didn't want

[62] VA OIG, *Alleged Women's Health Care Issues Gulf Coast Veterans Health Care System*, *Biloxi, Mississippi.* The OIG reviewed documents related to this 2018 report to establish the subject gynecologist's misconduct and facility leaders' awareness. The OIG team did not review policy in effect during the timeframe of the 2018 OIG report.

> to see him," and "I didn't have really enough [work] to occupy him." "I actually came up with an alternative plan...with things for him to do," "I had him review facility ambulance transfers for appropriateness, I created some projects, because there was just not a patient base."

When asked about elevating concerns about the subject gynecologist's misconduct to other facility leaders, the Chief Medical Officer for the Mobile Clinic said he reported the complaints to the Chief of Surgery, Associate Chief of Staff, and Associate Director. The Chief Medical Officer also noted that despite many complaints about the subject gynecologist, facility leaders were not transparent in taking action. Specifically, the Chief Medical Officer stated facility leaders could have initiated disciplinary action or a focused professional practice evaluation and addressed the concerns in the credentialing committee.[63] Similarly, when asked about leaders' response, the Women Veterans Program Manager reported she elevated complaints regarding the subject gynecologist's behavior to the Chief of Staff; however, felt the Chief of Staff did not take the concerns seriously. The Women Veterans Program Manager noted that facility leaders took "a very long time" to take action and it "did not seem like a priority to them when anyone would come to them with an issue that concerned [the subject gynecologist]."

The OIG concluded that facility leaders knew of the subject gynecologist's misconduct as documented in proficiency reports, a prior OIG report, and patient complaints. Several facility leaders were aware as early as 2015.

Facility Leaders' Response

Facility directors are responsible for "ensuring that all staff members assume the responsibility of caring for women Veterans with dignity and sensitivity."[64] Facility chiefs of staff are responsible for "ensuring that clinical leadership in primary care, mental health, and specialty/acute care plan and implement equitable, high-quality, comprehensive health care services for women Veterans, including gender-specific specialty services, in a secure and sensitive environment in all areas of the health care system."[65]

VA and facility policies outline fact-finding and administrative investigation processes to timely gather and clarify facts regarding reported issues. The purpose of these processes is to inform facility leaders of findings (through assembled facts) so facility leaders can take further actions to improve practices and implement preventative or corrective measures.[66]

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[63] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. A focused professional practice evaluation is "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."
[64] VHA Directive 1330.01(2).
[65] VHA Directive 1330.01(2).
[66] VA Directive 0700. Facility Policy 00Q-19-19.

Facility bylaws state the chief of a provider's clinical service, the Chair of the Executive Committee of the Medical Staff, the Chief of Staff, or Facility Director may choose to initiate a fact-finding review when clinical concerns arise.[67] Facility policy also states that administrative investigation boards "shall be conducted if there is a reasonable likelihood that the findings will be used as the basis for disciplinary actions."[68] Facility bylaws, applicable to all licensed independent providers, further delineate steps when staff identify concerns. These steps include an initial review, such as a fact-finding review, to determine if the initiation of a comprehensive or administrative review is warranted.[69]

The OIG learned that although the Chief of Surgery was aware of the complaints as early as 2015, facility leaders did not initiate a fact-finding review until September 2019. The OIG reviewed facility documentation and found that the Facility Director became aware of one of the five patient complaints on August 30, 2019, and requested the Chief of Staff examine the complaint "immediately." On September 18, 2019, the Chief of Staff directed the Chief of Surgery to initiate a fact-finding review regarding the subject gynecologist's alleged misconduct with that patient. The fact-finding review began the same day.

On November 18, 2019, the Chief of Surgery contacted human resources and requested an assignment of a specialist to assist with an ongoing fact-finding review of the subject gynecologist due to the receipt of an additional patient complaint and the decision to remove the subject gynecologist from patient care. The following day, the subject gynecologist communicated an intent to retire to the Chief of Surgery. The subject gynecologist retired later that month.

Three days after the subject gynecologist retired, the Chief of Surgery provided a summary of the fact-finding review to the Chief of Staff. The summary included the Chief of Surgery's conclusions that the subject gynecologist's interaction with the patient demonstrated "poor communication, weak interpersonal skills and an abrasive attitude" but did not rise to a level of progressive discipline. The summary referenced a conversation between the Chief of Surgery and the subject gynecologist outlining the complaints and of a "heightened awareness should any further complaints arise." As the summary of the fact-finding investigation was completed after the subject gynecologist's departure from the facility, the Chief of Surgery also detailed the subject gynecologist's removal from clinical care after further patient complaints and of the subject gynecologist's retirement in November 2019.

The fact-finding review occurred over a year and a half after the Chief of Surgery was aware of the initial complaint and not completed until after the subject gynecologist left the facility. The Chief of Surgery told the OIG that he did not receive guidance from facility leaders or human

[67] Facility Policy, *Bylaws.*
[68] Facility Policy 00Q-19-19.
[69] Facility Policy, *Bylaws.*

resources on how to manage concerns about the subject gynecologist's conduct. Guidance was ultimately provided when the Chief of Staff directed the Chief of Surgery to initiate a fact-finding review. The OIG also learned that although the Chief of Surgery counseled the subject gynecologist on "numerous occasions" about appropriateness, he took no formal disciplinary actions as the subject gynecologists' misconduct stopped after counseling but would resume after a period of time. Retrospectively, the Chief of Surgery stated he would do things differently through better documentation and requesting more assistance from human resources.

If facility leaders are unaware of the prevalence of complaints because fact-finding reviews are not completed timely or at all, further measures including initiation of an administrative investigation board or disciplinary actions may not be executed. The OIG determined that facility leaders may have allowed the subject gynecologist's misconduct to continue by not addressing the behavior when they first became aware.

5. Deficiencies in External Reporting Processes

The OIG found that facility leaders did not report the subject gynecologist to an SLB, nor the NPDB, despite evidence that the provider's conduct may have met the reporting standards. VHA requires a facility director or designee to report any licensed healthcare provider whose clinical practice or behavior "so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients" to their respective SLB.[70] Additionally, VHA requires facility leaders to file a report with the NPDB when a provider's clinical privileges are restricted or suspended and "when the action is related to professional competence or professional conduct." The provider must be notified of the action and afforded due process. However, if a provider retires while an investigation for possible professional incompetence or improper professional conduct is ongoing, the provider must be formally notified that reporting to the NPDB is required."[71]

There are two phases for an SLB review; an initial review and a comprehensive review. When a licensed provider leaves VHA employment, VHA requires a supervisor to review the provider's clinical practice and complete a Provider Exit Review form within seven calendar days of departure. The form documents whether the provider met generally-accepted standards of clinical practice and if there were any patient safety, conduct, or performance issues.[72] If the initial review of a provider's conduct indicates there may be substantial evidence that the individual's practice meets the reporting criteria, the facility director initiates a comprehensive

[70] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. VHA Notice 2018-05, Amendment to VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, February 5, 2018.
[71] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009; VHA Handbook 1100.19
[72] VHA Handbook 1100.18. VHA Notice 2018-05.

review to assess whether substantial evidence exists.[73] The facility director must ensure the SLB initial review is conducted within seven calendar days of a provider's separation from VHA employment or upon receipt of information suggesting that a provider's clinical practice may have met the reporting standard. Once the comprehensive review is complete, the facility director must document, on a memorandum, a decision regarding reporting a provider to the SLB.[74]

Facility policy requires the facility director to ensure all licensed independent providers are reported to the NPDB and SLB consistent with VHA requirements, and service chiefs to provide continuous monitoring of providers' performance.[75]

The OIG reviewed facility documentation and interviewed facility leaders to determine if leaders followed the SLB review process related to the subject gynecologist.[76] The OIG found that several conditions existed that met SLB and NPDB reporting requirements:

- Ongoing inappropriate behavior/conduct for several years, including documented lewd and vulgar statements to patients
- Retirement/departure of a licensed provider with known issues
- Retirement with knowledge of an investigation being conducted

The Facility Director told the OIG team that he was aware of some complaints regarding the subject gynecologist, but that the Chief of Staff was responsible for investigating provider complaints that would support an SLB review. In August 2019, the Facility Director became aware of a complaint and assigned the response to the Chief of Staff who subsequently directed the Chief of Surgery to perform a fact-finding review and consult with employee relations.[77] Following the completion of the fact-finding review in September 2019, and after receiving subsequent patient complaints in October and November 2019, the Chief of Surgery consulted with human resources and asked the subject gynecologist to not see patients. The subject gynecologist retired after the Chief of Surgery informed him that his conduct was in question, human resources was involved, and that there would be "zero tolerance" for misconduct.

The OIG found that the Chief of Surgery completed the required Provider Exit Review form and checked "[m]et generally-accepted standards of clinical practice, and there was no concern for the safety of patients." This selection indicates that no SLB reporting is required and that the

[73] VHA Handbook 1100.18.
[74] VHA Handbook 1100.18. VHA Notice 2018-05 provides that "VA medical facility directors have ultimate authority in deciding whether to report a licensed health care [practitioner] to their respective SLB(s)."
[75] Facility Policy 11-58-15, *Credentialing and Privileging and Reporting to the National Practitioner Data Bank*, July 24, 2015; Facility Policy, Bylaws.
[76] VHA Handbook 1100.18. VHA Notice 2018-05.
[77] A patient reported the subject gynecologist, "told me to get a ride because he could prescribe me Valium. He said when he gives women Valium they don't care if they get one [P]ap smear or twenty-seven [P]ap smears." The EHR indicated the patient's procedure was postponed.

provider exercised "moral and ethical behavior" necessary to practice as a competent professional.[78] Of note, the Chief of Surgery opted to not report a reasonable concern for the safety of patients, misconduct, or professionalism issues that would require an initiation of SLB reporting.

The Chief of Surgery presented the Provider Exit Review to the Credentialing and Privileging Committee in December 2019. The meeting minutes did not reflect a discussion of the subject gynecologist's Provider Exit Review, and notes only that the Provider Exit Review submission met "the benchmark of reporting within 7 days of leaving the facility." Six medical staff members, including the Chief of Staff, who attended the Credentialing and Privileging Committee meeting knew of the complaints against the subject gynecologist; however, the minutes do not reflect a discussion about the provider's alleged misconduct.

The Chief of Surgery told the OIG that the subject gynecologist's clinical outcomes were acceptable but acknowledged that he had misconduct issues, specifically related to statements toward patients. Contrary to VHA policy, the Chief of Surgery explained not reporting the subject gynecologist's behavior on the SLB Provider Exit Review form as "a mistake on my part as a manager. That he [subject gynecologist] needed counseling on interpersonal relations and appropriateness."

Facility leaders and senior medical staff were aware that the subject gynecologist's behavior adversely affected patients for several years. The OIG found that neither the Chief of Staff nor the Facility Director initiated a VHA required SLB review upon discovery of the subject gynecologist's misconduct in August and November 2019, and upon the subject gynecologist's retirement.[79] Specifically, through interviews and document reviews, the OIG determined that the Chief of Staff and the Facility Director failed to

- Initiate a SLB review upon receipt of information suggesting that the subject gynecologist's clinical practice may have met the reporting standard.
- Document the decision to not report in a memorandum.
- Complete the required Provider Exit Review form consistent with known facts regarding the subject gynecologist's misconduct.
- File a report with the NPDB when the subject gynecologist retired after being informed that an investigation for possible professional incompetence or improper professional conduct was underway.

The Chief of Staff's and the Facility Director's noncompliance with VHA policy represented a failure to meet the "obligation to alert those entities charged with licensing health care

[78] VHA Notice 2018-05.
[79] VHA Handbook 1100.18.

professionals when there is serious concern with regard to a licensed health care [provider's] clinical practice."[80]

Conclusion

The OIG substantiated the subject gynecologist's conduct toward five women veteran patients was unprofessional, unethical, and insensitive, and served to undermine a culture of privacy, dignity, and safety. Further, the OIG determined these provider-patient interactions resulted in patients reporting increased emotional distress, such as anxiety, depression, hopelessness, feelings of re-traumatization, or powerlessness. The OIG found VHA has not incorporated key best practice strategies, such as trauma-informed care and sensitive examination policies, into training, policy, and practice, to further advance healthcare for women veteran patients.

The OIG substantiated the nurse chaperone did not provide support to, nor advocate on behalf of, five female veteran patients when the subject gynecologist exhibited inappropriate behavior. The OIG found that the nurse chaperone did not view the provider's behavior as inappropriate and in one instance described the patient as being too sensitive.

While VHA and facility policies require female chaperones to be present in all sensitive examinations, the policies do not outline the chaperone's responsibilities, duties, competencies, or training. The OIG determined that the lack of specific training regarding the role and expectations of a chaperone may have contributed to the chaperone's lack of awareness and insensitivity to the patients' distress and subsequent lack of support or intervention.

The OIG determined that patient advocates did not enter all complaints into the PATS. Patient advocates and quality management leaders tracked and trended patient complaints: however, the complaint data was incomplete, which limited the accuracy and value of identified trends.

The OIG determined that facility leaders were aware of the subject gynecologist's misconduct as early as 2015 but failed to effectively address misconduct for years by not timely performing informal or formal investigations such as a fact-finding review or an administrative investigation board as required by policy. Facility leaders knew of the subject gynecologist's misconduct as documented in a prior OIG report, proficiency reports, and patient complaints. The OIG determined that facility leaders may have allowed the subject gynecologist's misconduct to continue by not adequately addressing the behavior when they first became aware.

Facility leaders did not report the subject gynecologist to an SLB, nor the NPDB, despite evidence that the provider's conduct may have met the reporting standard. Several conditions existed that met SLB and NPDB reporting requirements including ongoing inappropriate conduct for years that included documented lewd and vulgar statements to patients, retirement of a

[80] VHA Handbook 1100.18.

licensed provider with known issues, and retirement of a licensed provider with knowledge of an investigation being conducted.

The Chief of Staff's and the Facility Director's noncompliance with VHA policy represented a failure to meet the "obligation to alert those entities charged with licensing health care professionals when there is serious concern with regard to a licensed health care [provider's] clinical practice."

Recommendations 1–6

1. The Under Secretary for Health initiates review of policies related to the role and training requirements of providers, including gynecologists, who conduct sensitive exams, to determine the need for the inclusion of trauma-informed care principles into training, policy, and practice.[81]
2. The Under Secretary for Health ensures a review of policies related to the role and training requirements of chaperones for sensitive examinations and takes action as appropriate.
3. The South Central VA Health Care Network Director evaluates processes for tracking patient complaints, takes appropriate action to ensure that facility staff enter all complaints into the Patient Advocate Tracking System, and ensures that the data are tracked, trended, and analyzed to identify significant issues and trends.
4. The Gulf Coast Veterans Health Care System Director ensures staff education of the Veterans Health Administration and Gulf Coast Veterans Health Care System policies related to employee misconduct and monitors compliance.
5. The Gulf Coast Veterans Health Care System Director reviews and evaluates policies related to administrative investigations, including fact-finding reviews and administrative investigation boards, to ensure such investigations are timely, objective, and documentation is sufficient to address the event under review.
6. The Gulf Coast Veterans Health Care System Director and facility leaders review the subject gynecologist's conduct and quality of care provided and meet all Veterans Health Administration requirements for state licensing board and National Practitioner Data Bank reporting.

[81] Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health. Effective January 20, 2021, he was appointed to Acting Under Secretary for Health with the continued authority to perform the functions and duties of the Under Secretary.

Appendix A: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: November 25, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Healthcare Inspection—Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

To: Assistant Inspector General for of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Veterans Health Administration: Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi. The Veterans Health Administration (VHA) concurs with OIG's recommendations and provides action plans to address them.

2. Comments related to this memorandum can be directed to Director, GAO OIG Accountability Liaison Office at VHA10BGOALAction@va.gov.

(*Original signed by*:)

Richard A. Stone, M.D.
Executive in Charge, Office of the Under Secretary for Health

Executive in Charge Response

Recommendation 1

The Under Secretary for Health initiates review of policies related to the role and training requirements of providers, including gynecologists, who conduct sensitive exams, to determine the need for the inclusion of trauma-informed care principles into training, policy, and practice.

Concur.

Target date for completion: April 30, 2021

Executive in Charge Comments

VHA is forming a multidisciplinary work group of subject matter experts from multiple program offices to review current training requirements for providers, including gynecologists, who conduct sensitive exams. This group will make recommendations related to training, policy and practice as it pertains to trauma informed care for VHA wide implementation.

Recommendation 2

The Under Secretary for Health ensures a review of policies related to the role and training requirements of chaperones for sensitive examinations and takes action as appropriate.

Concur.

Target date for completion: December 31, 2021

Executive in Charge Comments

VA Directive 1330.01 (3), Health Care Services for Women Veterans requires chaperones for all sensitive examinations, however the policy does not outline responsibilities, duties, competencies or training for chaperones. The Office of Nursing Services will establish a workgroup of subject matter experts, to include the Office of Women's Health, Office of Connected Care, Office of Clinical Services and other stakeholders to review: current policies and guidance, identified roles of chaperones, and clinical activities where chaperones are used. This workgroup will develop and/or provide updates to the VHA directive relative to chaperone responsibilities, duties, development and execution of training and competency of the role of chaperone, as indicated.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October28,2020

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

To: Executive in Charge, Office of the Under Secretary for Health (10)

The South Central VA Health Care Network (VISN 16) has reviewed the findings included in the draft report and concurs with the recommendations made for the VISN as well as the facility. Actions identified by the facility will be tracked and monitored until closure.

(*Original signed by*:)

Skye McDougall, PhD
Director, South Central VA Health Care Network (10N16)

VISN Director Response

Recommendation 3

The South Central VA Health Care Network Director evaluates processes for tracking patient complaints, takes appropriate action to ensure that facility staff enter all complaints into the Patient Advocate Tracking System, and ensures that the data are tracked, trended, and analyzed to identify significant issues and trends.

Concur.

Target date for completion: January 31, 2021

Director Comments

The VISN will provide oversight of the facility's practices regarding the handling of Veteran complaints. Through an assessment, the VISN will evaluate current processes in place to ensure staff are reporting complaints and entering them into the Patient Advocate Tracking System (PATS). The VISN will develop an action plan to address gaps that are identified through this review.

The VISN will ensure processes are in place so that patient complaints data is tracked, trended, analyzed, and reported to the appropriate facility committee at least quarterly. The VISN will ensure the facility identifies opportunities for system improvements based on complaint trending and Veteran feedback, and actions are taken for improvement.

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 28, 2020

From: Director, Gulf Coast Veterans Health Care System (520/00)

Subj: Healthcare Inspection—Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

To: Director, South Central VA Health Care Network (10N16)

1. Gulf Coast Veterans Health Care System has reviewed and concurs with this Healthcare Inspection report.
2. We recognize opportunities for improvement in our operational and clinical practices. Corrective actions are being fully implemented to address the listed recommendations.

(*Original signed by*:)

Bryan C. Matthews, MBA
Director, Gulf Coast Veterans Health Care System

Facility Director Response

Recommendation 4

The Gulf Coast Veterans Health Care System Director ensures staff education of the Veterans Health Administration and Gulf Coast Veterans Health Care System policies related to employee misconduct and monitors compliance.

Concur.

Target date for completion: January 31, 2021

Director Comments

Gulf Coast Veterans Health Care System will develop a comprehensive training module consistent with Veterans Health Administration and local policies to be populated in Talent Management System (TMS). The training will essentially capture and outline the identification of and reporting of employee misconduct. The training will be required of all Gulf Coast Veterans Health Care System employees. Training compliance will be monitored by Quality & Performance Management, with recurring reports submitted to the Education and Training Committee. The benchmark for compliance will be 90% or greater of employees completing this one-time training. Once this initial one-time training is completed, the training module will be incorporated into the recurring annual (Annual Review) training for all Gulf Coast Veterans Health Care System employees.

Recommendation 5

The Gulf Coast Veterans Health Care System Director reviews and evaluates policies related to administrative investigations, including fact-finding reviews and administrative investigation boards, to ensure such investigations are timely, objective, and documentation is sufficient to address the event under review.

Concur.

Target date for completion: December 30, 2020

Director Comments

Gulf Coast Veterans Health Care System has begun reviewing local and national policies related to the management, monitoring, completion and maintenance of administrative investigations and fact-findings initiated by Facility and/or Service Leadership. As part of this review, Gulf Coast is working collaboratively with the local Strategic Business Unit and VISN Officers to ensure consistency and standardization of processes, as well as the timeliness of completion.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The Gulf Coast Veterans Health Care System Director and facility leaders review the subject gynecologist's conduct and quality of care provided and meet all Veterans Health Administration requirements for state licensing board and National Practitioner Data Bank reporting.

Concur.

Target date for completion: January 31, 2021

Director Comments

The Gulf Coast Veterans Health Care System Chief of Staff and Chief of Surgery Service will conduct a comprehensive review of health records, clinical documentation and Veteran complaints/concerns related to the professional misconduct and quality of care of the subject gynecologist. Clinical Leaders will next work directly with the Professional Credentials Office to initiate the process of reporting the subject gynecologist to the appropriate State Licensing Board(s) (SLB) and the National Practitioner Data Bank (NPDB) as indicated.

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