



DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

NOV 27 2012

In Reply Refer To:

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M. Street, NW, Suite 300
Washington, DC 20036-4505

RE: OSC File Nos. DI-10-3763
DI-10-3889
DI-11-0048
DI-11-0967
DI-11-3203
DI-11-3558
DI-12-0023

Dear Ms. Lerner:

Consistent with the agreement you reached on August 31, 2012, with General Counsel Will A. Gunn, we hereby request that your office use, for the public file, the enclosed redacted versions of the Department's reports responding to allegations at facilities of the Department of Veterans Affairs (VA).

If you have any questions about this request, please contact Jennifer Gray or Kathleen Heaphy in the Office of General Counsel at 202-461-7634 or 202-834-1869.

Sincerely yours,


Walter A. Hall
Assistant General Counsel

Enclosures

OFFICE OF THE MEDICAL INSPECTOR

Revised Final Report to the

Office of Special Counsel

OSC File Numbers DI-10-3763, DI-10-3764, DI-10-3765, DI-10-3767, DI-10-3768, DI-10-3769, DI-10-3770, DI-10-3771 and DI-10-3772

Anesthesia Section

Department of Veterans Affairs Medical Center

Washington, DC



Veterans Health Administration

Washington, DC

Report Date: November 6, 2012

OMI TRIM File #2011-D-155

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate a complaint lodged with the Office of Special Counsel (OSC) by a number of staff from the Anesthesia Section at the Department of Veterans Affairs (VA) Medical Center, Washington, District of Columbia (DC) (hereafter, the Medical Center). The complainants are three anesthesiologists: (b)(6)

(b)(6); five certified registered nurse anesthetists (CRNA) (b)(6) (b)(6) and (b)(6) and one anesthesia technician (b)(6)

All complainants, with one exception, are currently employed in the Anesthesia Section, Surgical Services at the Medical Center. (b)(6), has relocated to another VA medical center. The complainants alleged that employees at the Medical Center engaged in gross mismanagement, created a substantial and specific danger to public health and safety by failing to provide adequate staff assistance to anesthesiologists during complicated procedures on eight separate occasions, and have instituted policies that do not prioritize the most complex cases. The OMI conducted site visits to the Medical Center on December 20, 2010, and January 6, 2011. The OMI also conducted telephone interviews with complainants on January 19, 2011, and January 24, 2011.

Summary of Conclusions

The OMI did not find evidence of any violation of law, rule, or regulation. The OMI did not find evidence of gross mismanagement or a substantial and specific danger to public health and safety.

The OMI did not substantiate the allegation that there was a failure to provide adequate staff assistance to anesthesiologists during complicated procedures on eight separate occasions. The OMI did not substantiate that there were any threats to patient safety or unnecessary patient risk as a result of anesthesiology scheduling practices.

The OMI did not substantiate the allegation that scheduling policies do not prioritize the most difficult anesthesia cases. The OMI did not substantiate the allegation that some anesthesiologists have to work on difficult cases with insufficient or no help while others are assigned to less difficult cases with CRNAs. The OMI did not substantiate the allegation that scheduling practices favor certain employees, providing them with adequate help on all their cases. The Chief, Anesthesia Section, always supervises a CRNA on her cases, which the OMI considers appropriate given her other duties as Chief.

Summary of Recommendations

The OMI makes no recommendations regarding the allegations.

Final Report

I. Summary of Allegations

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate a complaint lodged with the Office of Special Counsel (OSC) by a number of staff from the Anesthesia Section at the Department of Veterans Affairs (VA) Medical Center, Washington, District of Columbia (DC) (hereafter, the Medical Center). The complainants are three anesthesiologists (b)(6) M.D.; five certified registered nurse anesthetists (CRNA): (b)(6) (b)(6) and (b)(6) and one anesthesia technician, (b)(6). All complainants, with one exception, are currently employed in the Anesthesia Section, Surgical Services at the Medical Center (b)(6) CRNA, has relocated to another VA medical center. The complainants alleged that employees at the Medical Center engaged in gross mismanagement, created a substantial and specific danger to public health and safety by failing to provide adequate staff assistance to anesthesiologists during complicated procedures on eight separate occasions, and have instituted policies that do not prioritize the most complex cases. The OMI conducted site visits to the Medical Center on December 20, 2010, and January 6, 2011. The OMI also conducted telephone interviews with complainants on January 19, 2011, and January 24, 2011.

II. Background

In February 2008, after the unexpected death of the Chief, Anesthesia Section, the Medical Center hired a new Chief, from the private sector, with the goal of transforming the Anesthesia Section into a more effective, efficient, and Joint Commission compliant organization. The new Chief initiated a number of transformational changes that included monitoring and enforcing duty hour compliance, more effective use of providers to increase efficiencies in the operating room leading to improved productivity and decreased overtime costs, and enforcement of Joint Commission standards. (b)(6) and (b)(6) who had practiced under the former Chief, complained about the new Chief's initiatives. In response to these complaints, the Chief of Staff, (b)(6) (b), and the Acting Chief, Surgery Services, (b)(6) (hereafter, referred to as Leadership), have addressed their concerns by meeting with the complainants on multiple occasions, by convening a Board of Investigation, and by sponsoring a National Center for Organizational Development team training workshop within the Anesthesia Section. Leadership has reported that the changes implemented by the Chief of Anesthesia have resulted in increased effectiveness and efficiencies in the operating room (OR) including improved start times, increased case productivity while decreasing overtime costs, and positive citations at the last Joint Commission survey that specifically complimented the Anesthesia Section. Leadership has informed the complainants that the new Chief, Anesthesia Section has their full support.

III. Facility Profile

The Medical Center is a full-service health care facility providing comprehensive primary and specialty care in medicine, surgery, neurology, and psychiatry. The Medical Center has 171 acute care beds, 30 residential rehabilitation treatment beds, and an adjacent 120-bed Community Living Center. The Medical Center serves Veterans and their families in metropolitan

Washington, DC, including parts of Maryland and northern Virginia. Working closely with the Walter Reed Army Medical Center, the Medical Center is the Veterans Integrated Service Network (VISN) 5 designated site for polytrauma.

The Anesthesia Section, Surgical Services consists of the Chief, five general anesthesiologists, two cardiothoracic anesthesiologists, six CRNAs, an anesthesia technician, and student nurse anesthetists (SRNAs) on rotation. During our investigation, one CRNA, (b)(6) was on extended sick leave. A CRNA was hired in November 2010 to replace (b)(6) the CRNA who had transferred to another VA facility. The Anesthesia Section provides support to surgery in the five ORs and for procedures in the gastrointestinal suite, the cardiac catheterization laboratory, and interventional radiology. Anesthesia staff provided support for a total of 2,849 surgeries and procedures in 2008, 3,077 in 2009, and 3,064 in 2010. Two cardiothoracic anesthesiologists (b)(6) and (b)(6) support surgical cases involving the use of a cardiopulmonary bypass machine: 142 in 2008, 102 in 2009 and 100 in 2010. Table 1 provides detail on the anesthesia cases done during 2008 through 2010.

Table 1: Number and Types of Anesthesia Cases Done at the Medical Center

Type of Anesthesia Case	Number of Cases Done 2008	Number of Cases Done 2009	Number of Cases Done 2010
OR (Non-Cardiac)	2612	2779	2753
OR (Cardiac)	142	102	100
Non-OR Interventional Radiology Procedures	21	32	18
Cardiac Catheterization Lab Procedures	Unknown	53	39
Gastrointestinal Suite Procedures	74	111	154
Total Cases	2,849	3,077	3,064

IV. Conduct of the Investigation

The OMI conducted two site visits to the Medical Center. A team consisting of (b)(6) (b)(6) Deputy Medical Inspector for Professional Services; (b)(6) (b)(6) Medical Investigator; (b)(6) (b)(6), Clinical Program Manager, and (b)(6) (b)(6) the VA Consultant in Anesthesiology, conducted 11 interviews on December 20, 2010. The second visit took place on January 6, 2011, with a team consisting of (b)(6) (b)(6) the Medical Inspector, (b)(6) (b)(6) and (b)(6) (b)(6). On this visit, an additional seven interviews were conducted. On January 19 and 24, the team conducted separate telephone interviews with (b)(6) (b)(6) CRNA, and (b)(6) (b)(6) CRNA. The team members also reviewed policies, anesthesia schedules, and medical records. The full list of documents reviewed by the OMI is in Attachment A. On both site visits, the OMI held entrance and exit conferences with Medical Center leadership.

The OMI team interviewed the following individuals, either in person or via telephone. Some individuals were interviewed more than once. All complainants were interviewed at least once.

Those interviewed were: (b)(6), Chief of Staff; (b)(6) Acting Chief, Surgery Services; (b)(6) Chief, Anesthesia Section; (b)(6) Assistant Chief, Anesthesia Section; (b)(6), Clinical Coordinator, Anesthesia Section; (b)(6), Anesthesiologist; (b)(6) Anesthesiologist; (b)(6), Anesthesiologist; (b)(6) Anesthesiologist; (b)(6), Anesthesiologist; (b)(6) CRNA, Chief CRNA, Anesthesia Section; (b)(6) CRNA, Nurse Anesthetist; (b)(6) CRNA, Nurse Anesthetist; (b)(6) CRNA, Nurse Anesthetist; (b)(6) CRNA, Nurse Anesthetist; (b)(6) CRNA, Nurse Anesthetist; (b)(6) CRNA, Nurse Anesthetist; (b)(6) Nurse Manager for the OR; and (b)(6) Anesthesia Technician.

The OMI's protocol for investigation is to address allegations as follows. The OMI *did substantiate* allegations when the facts and findings supported that the alleged events or actions took place. The OMI *did not substantiate* allegations when the facts showed that the allegations were unfounded. The OMI *could not substantiate* allegations when there was no conclusive evidence to either sustain or refute the allegations.

V. Summary of Evidence Obtained from the Investigation

Allegation #1

The scheduling policies create a significant, unnecessary risk for the patients receiving anesthesia from any of the disfavored providers. Eight cases were provided as examples.

Findings

The Medical Center has policies for the Anesthesia Section, Surgical Services describing the expectations for time and leave, duties, responsibilities, and work schedules. Per Medical Center policy, clinical and administrative assignments are made based upon assessment of the service needs of the Anesthesia Section, and are based upon patient acuity, predetermined basic staffing requirements, and the experience and expertise of the anesthesia provider. The guidance on work assignments provides that the Chief, Anesthesia Section "... recommends a sufficient number of qualified and competent providers to deliver the highest quality of care and services."¹

The VA Consultant in Anesthesiology, (b)(6), reported that facilities seldom have specific *scheduling* policies for anesthesia staff, but that guidance from national organizations and professional practice suggest that scheduling practices for anesthesia staff usually include the assignment of one anesthesiologist to cover at least two to four active ORs, with CRNAs managing the case in each OR. Cardiac cases are managed by a cardiothoracic anesthesiologist and usually include an assigned CRNA or SRNA. The OMI found that, in most cases, anesthesia staffing at the Medical Center consisted of an anesthesiologist and CRNA in each room, whether the case was simple or complex.

Eight cases were cited in the OSC complaint as specific examples of significant and unnecessary risk posed to Veterans receiving anesthesia care as a result of scheduling policies. For each of

¹ Anesthesia Section of Surgical Services, Policy2-#2: Organization and Personnel, July 2010, Veterans Affairs Medical Center, Washington, DC, p. 3.

the cases cited, staffing included both an anesthesiologist and a CRNA or SRNA present in the OR. The cases each involved care by “disfavored” providers.² During OMI interviews, each complainant described the unnecessary risk as perceived potential safety issues based upon the premise that “something may go wrong.” When specifically queried, no complainant could provide an example of an adverse event, close call, or reportable safety event involving any Veteran in the eight cases cited.^{3, 4, 5} In addition, when specifically queried, no complainant could provide any example of an adverse event, close call or safety problem for any Veteran due to anesthesia scheduling practices.

The American Society of Anesthesiology (ASA) recommends a preliminary assessment of each patient within 30 days prior to the case, except in emergencies. During the preliminary assessment the anesthesiologist will assess the individual for risks associated with his or her general state of health and the risks associated with administration of anesthesia.

The commonly accepted method to assess the general health of the individual is the ASA Physical Status Classification, commonly referred to as ASA class or simply ASA. Using age, functional capacity, medical status and a review of body systems, an ASA class is assigned from 1 to 6, with 1 indicating that the patient is generally healthy and has few medical risk factors. An ASA of 5 indicates the patient may be near “dying” or death is imminent, and an ASA of 6 describes a brain dead patient. Any patient undergoing an emergency procedure has an additional indicator designated by the suffix “E.”

There are different ways to assess a patient’s risk for anesthesia, and these assessments may influence the type of anesthesia, route of administration, and medication. The literature suggests that some methods are more reliable than others, but none is completely reliable. An acceptable method to determine the adequacy of the individual’s airway for induction of general anesthesia is to conduct an evaluation of the oral cavity and throat, resulting in the Mallampati score.⁶ The score, from Class I to Class IV, represents the competency of the airway, with Class I and II indicating that the induction of an airway should be relatively uncomplicated. Class III represents a moderately complicated airway, and Class IV may indicate a difficult airway.

Additional tools to assess risk for induction of general anesthesia include measurements taken from the chin to the neck, noted in centimeters (cm) or fingerbreadths (FB). The thyromental distance (TMD) is used to predict difficult intubation and measures from the chin to the thyroid notch on the neck. Normal measurements are greater than 3 FBs or 6 cm in adults, with lower numbers indicating more difficult airway induction. The mandibulo-hyoid (MH) distance

² “Disfavored”- term the complainants used to describe themselves.

³ Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other Veterans Health Administration (VHA) facility. *VHA Directive 2008-002, January 18, 2008, Disclosure of Adverse Events to Patients.*

⁴ A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention. Such events have also been referred to as “near miss” incidents. *VHA Handbook 1050.01, May 23, 2008, VHA National Patient Safety Improvement Handbook.*

⁵ A reportable safety event, also called a sentinel event, is a type of adverse event defined by the Joint Commission as unexpected occurrences involving death, serious physical or psychological injury, or risk thereof. The phrase “risk thereof” includes any process variation for which a recurrence would carry a significant chance of serious adverse outcomes. *VHA Handbook 1050.01, May 23, 2008, VHA National Patient Safety Improvement Handbook.*

⁶ Induction is the process of introducing a scope into the patient’s mouth and throat in order to insert an airway for breathing management and medication administration during general anesthesia.

measures from the chin to the hyoid bone in the neck, with a score of less than 4 FB or 8 cm indicating a potentially difficult airway induction.

Another risk for difficulty in anesthesia induction is obesity or body mass index (BMI) as calculated through height and weight measurement. A normal BMI is considered to be 18.5 to 24.9. A BMI of greater than 30 is labeled as "obesity." A systematic review of the literature on airway management (Drolet, 2009) indicated that one study showed a body weight of greater than 110 kilograms (kg), or 242 lbs, may predict greater difficulty in airway management. Only one study done on BMI suggested a relationship between a BMI of greater than 35 and more difficult direct laryngoscopy. Direct laryngoscopy is induction with a simple laryngoscope.

Airway management tools, such as guided laryngoscopes, allow induction with visual real-time, on-screen assistance (GlideScope®). The Medical Center has GlideScope® available for use by anesthesia staff.

Attachment B provides a table of the cases mentioned in the OSC letter. Information for each case was obtained by an OMI review of the medical record. The table provides information on the Veteran, the type of surgery, the ASA and Mallampati scores, and the TMD or MH score, if it was noted in the anesthesia records. The pre-operative anesthesia notes were written by the anesthesiologist and provide his or her evaluation of the Veteran's risk assessment for anesthesia. The type of anesthesia administered and post-operative anesthesia comments are noted, if found in the record.

Of the eight index cases, one Veteran had an ASA score of 2, five had ASA scores of 3, one was 4 and one was 5E (the surgery was palliative in nature). For all eight index cases cited by the complainants, no Veteran received an assessed Mallampati score greater than Class III. Of the eight index cases, six reported MH assessments; all six were "more than 3 FB," with none described as abnormal. Three Veterans had BMIs greater than 35. No post-operative anesthesia concerns were reported for any of the index cases. No adverse events, close calls, or safety issues were identified in any of the cases. Each case, independent of complexity, was attended by an anesthesiologist, with 7 of 8 cases co-attended by a CRNA or SRNA. Cases 6 and 7 (greater complexity) were attended by cardiothoracic anesthesiologists.

All anesthesiologists are similarly privileged, with the exception of the cardiothoracic anesthesiologists. All CRNAs have similar privileges.

Conclusion

The OMI could find no evidence in the index cases that "disfavored" providers were assigned cases of greater complexity or assigned cases outside their scope of practice. With one exception, all index cases were attended by two anesthesiology providers, including cases of minor complexity. For one hernia repair, the case was attended by an anesthesiologist without a CRNA or SRNA. There was no evidence that case scheduling posed a risk to the Veteran or presented an undue safety risk.

The OMI did not substantiate the allegation.

Recommendation

The OMI makes no recommendations regarding this allegation.

Allegation #2

Scheduling policies do not prioritize the most difficult anesthesia cases. As a result, some anesthesiologists have to work on difficult cases with insufficient or no help while others are assigned to less difficult cases with CRNAs. Scheduling practices favor certain employees, providing them with adequate help on all their cases.

Findings

The Anesthesia Section of Surgical Services is staffed by eight anesthesiologists and six CRNAs, who must provide anesthesia care under the supervision of an anesthesiologist. The management team of the Anesthesia Section consists of (1) the Chief, Anesthesia Section, (b)(6) M.D., (2) the Assistant Chief, Anesthesia Section, (b)(6) (3) the Clinical Coordinator, Anesthesia Section, (b)(6) and (4) the Chief CRNA, Anesthesia Section, (b)(6) CRNA. Only members of the management team are considered to be "supervisory officials" within the Anesthesia Section; they are the only personnel with the authority to approve or disapprove leave, to direct clinical and administrative assignments, and to assign on-call duties.

The Chief provides leadership, direction, and support for anesthesia services delivered throughout the hospital. The Chief is responsible for establishing the type and scope of services delivered within the Anesthesia Section, and develops and implements policies and procedures to guide and support the provision of those services. The Chief is responsible for overseeing the clinical privileges of all anesthesia staff, along with monitoring quality and professional conduct. The Assistant Chief assists the Chief in these efforts, and acts as the Chief of Anesthesia as assigned. As such, both the Chief and Assistant Chief are heavily involved with hospital committees and are tasked with ensuring that the Anesthesia Section operates in compliance with national guidelines.

The Clinical Coordinator is tasked with the assignment of clinical and administrative duties of anesthesia providers on a day-to-day basis in consultation with the Chief. The Clinical Coordinator assigns coverage for the anesthesia cases that occur in the OR as well as those that occur in other procedural areas within the hospital, such as gastroenterology. The environment of the OR is dynamic, thus the service needs of the Anesthesia Section must be flexible. The clinical and administrative assignments must be fluid and modified as necessary throughout the course of the day.

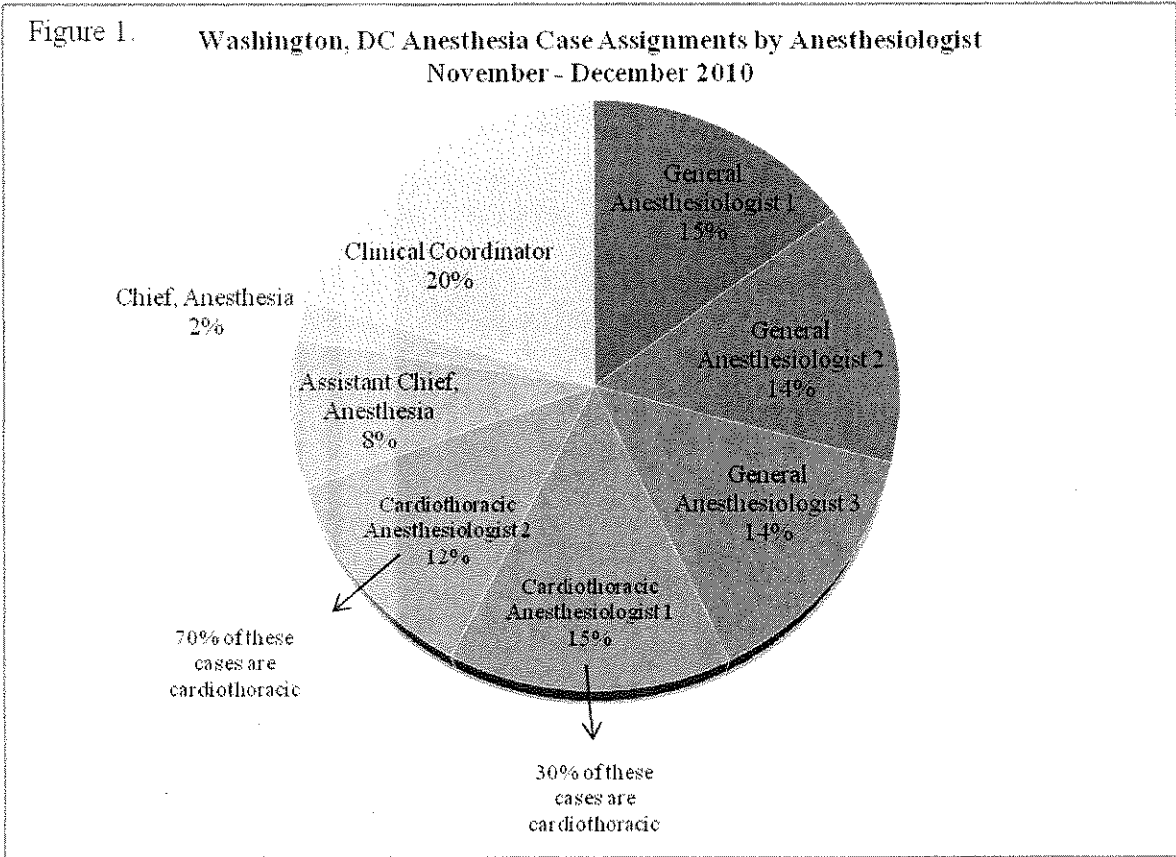
The Chief CRNA functions under the direction of the Chief, Anesthesia Section, by supporting scheduling needs, e.g., assigning CRNAs to work with anesthesiologists. The Chief CRNA works with the Clinical Coordinator to establish CRNA anesthesia coverage throughout the hospital.

The five non-administrative anesthesiologists consist of two cardiothoracic anesthesiologists: (b)(6) and (b)(6) and three general anesthesiologists; (b)(6)

(b)(6) and (b)(6) The two cardiothoracic anesthesiologists have completed fellowship training in cardiothoracic anesthesia and are, therefore, trained, credentialed, and privileged to provide anesthesia care for cardiac bypass cases. In addition, they provide general anesthesia care. All anesthesiologists are trained, credentialed, and privileged to provide care for difficult airways.

Cardiac bypass cases, which are more complex than other anesthesia cases, require the expertise of a cardiothoracic anesthesiologist; general anesthesiologists are not assigned these cases.

A review of a representative case sample of anesthesia case assignments in FY 2010 indicated that, due to their administrative duties, the Chief and Assistant Chief were assigned 2 percent and 8 percent, respectively, of all anesthesia cases. The Clinical Coordinator assigned herself 20 percent of the anesthesia cases, often simultaneously providing anesthesia care in two or more ORs with a CRNA. The non-administrative general anesthesiologists provided anesthesia care for 14 percent, 14 percent, and 15 percent of the surgical cases. The two cardiothoracic anesthesiologists provided anesthesia care for 12 percent and 15 percent of the anesthesia cases, including coverage of all cardiac bypass cases. When compared to all of the anesthesiologists, the Clinical Coordinator assumed a higher percentage of the clinical cases, despite her administrative responsibilities. Figure 1 contains a pie chart indicating the distribution of case assignments as described above.



A review of the anesthesia case complexity at the Medical Center indicates that 35 percent of the general, non-cardiac cases were scored as Mallampati II, ASA 3; 20 percent were scored as Mallampati II, ASA 2; and 14 percent were scored as Mallampati III, ASA 3 for a total of 69 percent of all anesthesia cases. When case complexity is reviewed by assigned anesthesia provider, there is similar distribution amongst providers. The exception is the increased complexity of cases assigned to cardiothoracic anesthesiologists. Attachment C (Figure 2) contains a line graph indicating the distribution of anesthesia cases, by complexity and anesthesia provider.

A review of the 350 non-cardiac cases indicated that CRNAs or SRNAs were assigned to 58 percent of the cases. There was a greater likelihood to assign both an anesthesiologist and CRNA to complex cases; however, CRNAs were also assigned to less complex cases. The Chief, Anesthesia Section, always has a CRNA on her cases; all other anesthesiologists are assigned both independent cases and cases where they supervise CRNAs or SRNAs.

Conclusion

Scheduling policies do prioritize the most difficult anesthesia cases. The Clinical Coordinator evaluates all cases prior to surgery using the scoring methods described above. Fifty-eight percent of the cases were assigned both an anesthesiologist and CRNA; the remaining cases were assigned to an anesthesiologist only. The Chief, Anesthesia Section, always supervises a CRNA on her cases, which the OMI considers appropriate given her other duties as Chief.

The OMI did not substantiate the allegation.

Recommendation

The OMI makes no recommendations regarding this allegation.

VI. Summary Conclusion

The OMI did not find evidence of any violation of law, rule, or regulation. The OMI also did not find evidence of gross mismanagement or a substantial and specific danger to public health and safety.

Attachment A Documents Reviewed

- American Society of Anesthesiologists, Inc. (2003). Practice guidelines for management of the difficult airway: An updated report by the American Society of Anesthesiologists Task Force on management of the difficult airway. *Anesthesiology*, 98(5), 1269-1277.
- American Society of Anesthesiologists, Inc. (2002). Practice guidelines for postanesthetic care: A report by the American Society of Anesthesiologists Task Force on postanesthetic care. *Anesthesiology*, 9(3). 742-752.
- American Society of Anesthesiologists, Inc. (2008). Statement on documentation of anesthesia care, retrieved from www.asahq.org/For-Members-Standards-Guidelines-and-Statements.aspx.
- Anesthesia Section of Surgical Services Policies (July 2010). Veterans Affairs Medical Center, Washington, DC.
- Baker, P. A. (2009). Thyromental distance measurement—fingers don't rule. *Anesthesia*, 64(8), 878-882. Retrieved from www.mdconsult.com.
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- Huh, J. (2009). Diagnostic predictor of difficult laryngoscopy: the hymental distance ratio. *Anesthesia and Analgesia*, 108(2), 544-548. Retrieved from www.mdconsult.com.
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- Move! Weight Management Program for Veterans: Reference Tools
http://www.move.va.gov/download/Resources/BMI_chart.pdf
<http://www.move.va.gov/ReferenceTools.asp#BMI/Obesity>.
- Randall, T. (1996). Prediction of difficult intubation. *Acta Anesthesiol Scand*, 40(8 Pt 2), 1016-1023.
- VHA Directive 2008-002, January 18, 2008, *Disclosure of Adverse Events to Patients*.
- VHA Handbook 1050.01, May 23, 2008, *VHA National Patient Safety Improvement Handbook*.

Attachment B

Operation	ASA	Mallampati Score & TMD or MH Distance	Pre-op Anesthesia Evaluation Findings	Type of Anesthesia	Post-op Anesthesia Report
Case 1 Sex: M, Month & Year of Operation: April 2009, Age: 69, Wt. 196 lb, Hgt. 69 in, BMI=28					
Cholecystectomy (gall bladder removal)	3	Mallampati II "more than 3 FB"	Edentulous (no teeth) Prior tracheotomy VSS Neck full range of motion h/o tonsillar cancer and neck radiation	General Anesthesia	"No anesthesia concerns observed"
Case 2 Sex: M, Month & Year of Operation: April 2009, Age: 62, Wt. 282 lb, Hgt. 65 in, BMI=47					
Umbilical hernia repair	3	Mallampati III "more than 3 FB"	Neck full range of motion "obese" Mallampati II for 2007 thyroidectomy	General Anesthesia	No post anesthesia note. Same day discharge. 1-day follow up RN note: "I'm doing fine."
Case 3 Sex: M, Month & Year of Operation: May 2009, Age: 61, Wt. 166 lb, Hgt. 61 in, BMI=24					
Right inguinal hernia repair	3	Mallampati II MH distance not noted	Neck range of motion normal Poor dentition Vital signs normal	Regional (Spinal done due to left lung upper lobe bullae)	No post anesthesia note. Same day discharge. No anesthesia concerns noted next day.
Case 4 Sex: M, Month & Year of Operation: March 2010, Age: 69, Wt. 125 lb, Hgt. 68 in, BMI=18					
Debridement of left above-the-knee amputation	5E	Mallampati II MH distance not noted	Neck: Full range of motion The patient had a right internal jugular catheter inserted while in the SICU. His condition was less stable. External pacing and intubation done in the SICU, then transport to the ER.	General anesthesia	"No anesthesia concerns observed. Stable on drips."
Case 5 Sex: M, Month & Year of Operation: April 2010, Age: 54, Wt. 214 lb, Hgt. 74 in, BMI=26					
Right lung video assisted thoracic surgery	3	Mallampati II "more than 3 FB"	Neck mobility within normal limits Full dentition Previous uncomplicated surgeries with General Anesthesia	General Anesthesia	No anesthesia concerns observed.

Case 6 Sex: M, Month & Year of Operation: April 2010, Age: 61, Wt. 304 lb, Hgt. 74 in, BMI=39					
Mitral valve repair Procedure: sternal closure	4	Mallampati I "more than 3 FB"	Neck mobility within normal limits Full dentition	General Anesthesia Arterial line Central line Pulmonary artery catheter	No anesthesia concerns observed. Vital signs stable. Intubated and sedated.
Case 7 Sex: F, Month & Year of Operation: April 2010, Age: 30 Wt. 158 lb, Hgt. 68 in, BMI=24					
Heller's myotomy (release of lower esophageal sphincter)	2	Mallampati I "more than 3 FB"	Neck mobility within normal limits	General Anesthesia Arterial line	No anesthesia concerns observed.
Case 8 Sex: M, Month & Year of Operation: Sept 2010, Age: 77, Wt. 299 lb, Hgt. 70 in, BMI=43					
Colonoscopy, polyp removal	3	Mallampati II "more than 3 FB"	Neck mobility within normal limits	MAC: monitored anesthesia care	No post anesthesia note. Same day discharge. 1-day follow up RN note: "Okay. No problems."

Attachment C

