

DI-14-1588
Initial Whistleblower Comments

May 10, 2015

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

RE: OSC File No. DI-14-1588

Dear Ms. Lerner:

A review of the OMI report shows glaring inconsistencies, gross errors, and gaps in logic during their investigation clearly indicating that the OMI report findings are erroneous.

In my attached written response, I have outlined some of the most serious deficiencies in the investigation. To substantiate the obvious flaws in the investigation, I have cited documents in my possession. Unfortunately, in order to expand upon extensive additional deficiencies, I require specific documents that, to date, the VA has failed to release to me despite my valid request for the information in March 2015.

Most notably in the OMI report, an egregious error was made when the investigators inexplicably stated no policy was violated when a senior executive's administrative assistant accessed my medical records. The VA gave the explanation that Ms. Hamilton-Bell, assistant to the Chief of Staff Dr. Deering, accessed my medical record on June 28, 2013 merely to obtain my home address in order to send me the letter regarding suspension of my privileges. However, the date of that suspension letter was actually May 28, 2013, and the letter was received within a few days thereafter at my home. Therefore, Dr. Deering's assistant had no valid reason to access my medical records a month later on June 28, 2013.

In addition, since the 1996 HIPAA passage it has been a violation for employers to access an individual's medical records for such demographic information. For decades it has been a VA standard practice to only place an employee's work address in his or her medical file, not a home address or phone. As an experienced administrative assistant to the Chief of Staff, Ms. Hamilton-Bell was in a position to be well-versed in the policies regarding accessing demographic data for staff and HIPAA regulations. Ms. Hamilton-Bell would not have accessed my medical file to seek my home address.

It is inconceivable that the VA could not substantiate my allegation that there was an illegal intrusion into my electronic health records when reviewing the case of Ms. Donna Hamilton-Bell's unauthorized entry into my medical record. There is no appropriate reason for her to have accessed my medical record other than for purposes of retaliation. Likewise, the explanation of Officer Seibel's intrusion into my medical records was equally flimsy. As already uncovered by the Office of Special Counsel and attested to in front of the House Committee on

Veterans Affairs, accessing employee medical records illegally is one of the patterns of retaliation that the VA has practiced against many VA whistleblowers.

Another illogical stance in the OMI report is that the OMI wasn't able to substantiate improper supervision of residents. Per its own report, the OMI found a significant number of episodes where it could not be verified that an attending physician was present because of lack of physician notes/co-signatures and improper nurse coding of the OR log.

Attending physician oversight of residents requires mandatory documentation in the patient medical record. However, the OMI clearly wrote on page 8 that there was a lack of attending progress notes and co-signatures in 6-20% of audited patient medical records in multiple fiscal year quarters that it examined. Glossing over this striking lack of required documentation, the OMI still inexplicably writes that it was unable to substantiate the lack of attending physician oversight of surgical cases.

It was devastating to learn that the OMI did not keep my name in strict confidence as I had requested for the investigation. I requested this explicitly to avoid bias during the investigation process and also to ensure that the focus of the investigation remained on the allegations of poor resident supervision and poor patient outcomes. However, as evidenced by the content of the official report, the OMI not only used my name freely during the investigation but also included my name on page 19 of its official report. An overview of the OMI report indicates the OMI investigators were more focused on discrediting me than they were on investigating the allegations I made.

Evidence of investigative bias/poor technique are obvious throughout the report. The OMI chose not to review all the timeframes during which I stated there were problems in resident supervision and/or patient outcomes. Based upon the timeframes cited in the report, the investigators failed to access the surgical records for the specific years that would show gross deficiencies in operating technique including high numbers of complications and mortality. The investigators also incorrectly claimed that advanced laparoscopic procedures are considered as "general"/basic and therefore within the scope of general surgeons privilege.

Dr. Deering, the Chief of Staff who retaliated against me, has been found by an independent VA Office of Accountability Review investigation in August 2014, to have repeatedly retaliated against another Phoenix VA whistleblower.

I believe the VA OMI team did not exercise due diligence or common sense when investigating my allegations. I'm hoping that a review of the attached documents will convince you of the same.

Sincerely,



GROSS INADEQUACIES OF VA INVESTIGATION: OSC File No. DI-14-1588

1. VA investigators ignored Phoenix VA policy and HIPAA federal law when they inexplicably stated that my medical records were accessed appropriately by VA administrative staff.

When discussing the multiple intrusions into my VA electronic medical record, the VA investigative summary page V stated "...all were authorized accesses in the performance of the employee's official duties". This is patently untrue. One employee, Donna Hamilton-Bell, stated she accessed the records to obtain my address for mailing a letter. However, the letter sent to me and which is in my possession was dated May 28, 2013. It was on June 28, 2013 that she actually accessed my record. Having sent the last of the correspondence one month earlier, there would have been no reason for Ms. Hamilton-Bell to access my medical record on June 28, 2013 for said purpose of obtaining a mailing address. Please see Exhibit 1, the VA suspension letter that was sent to me which is dated 5/28/13.

For decades it has been a VA standard practice to only place an employee's work address in his or her medical file, not a home address or phone number. As an experienced administrative assistant to the Chief of Staff Dr. Deering, Ms. Hamilton-Bell was in a position to be well-versed in the policies regarding accessing demographic data for staff as well as federal HIPAA regulations. In addition, like all VA employees, Ms. Hamilton-Bell is required to take annual training on Privacy Information and HIPAA wherein such employee medical record access is specifically designated as prohibited. The senior administrative assistants routinely use HR to obtain address information. With other resources at her disposal, Ms. Hamilton-Bell would not have needed to access my protected medical file to seek my home address. In fact, there is no other purpose for her to access my medical record other than for purposes of retaliation against me carried out in her capacity as an assistant to Dr. Deering.

The investigators' written comment on page 21 inappropriately claims that Mr. Seibel, a police officer, accessed my electronic health record to "obtain the whistleblower's work address and phone number." This intrusion purportedly done to obtain my "work address and phone number" would not have yielded any useful information for the officer. Officer Seibel already knew I worked at the VA. For 30+ years, it has been the practice of the VA to only put the VA switchboard number as employees' work number, never the extension number. In his position dealing with numerous employee complaints, this experienced police officer should have been aware of this practice. Officer Seibel was in the position to have known that calling the medical staff office is the standard way the police officers locate an employee-physicians phone number. (It should be noted that the VA has since stopped officers' ability to access employee medical records because the VA internally found that medical records were being accessed inappropriately.)

As per Phoenix VA Health Care System Policy Memorandum PO-05 Sensitive Record Access and Tracking Policy it clearly states, "Medical records shall not be accessed by an employee, or any

other user, for the purpose of obtaining demographic information of a co-worker. This includes such information as home telephone number, home address or any personal demographic information. This is one of the reasons that employee medical records are labeled as “sensitized” and tracking of access can be done.

The pertinent policies to review regarding the inappropriate release of demographic data include: Privacy Act of 1974; VA Directive 6500 Automated Information Systems (AIS) Security Policy; Release of Information Privacy Act and Freedom of Information Act HIPAA 164.308a4iiB, 164.312d; VHA Handbook 1907.01 Health Information Management and Health Records; VHA Handbook 1605.1 Privacy and Release of Information; Fact Sheet on Incident Response – December 2011; VA Directive 6500.2 Information Security; VA Handbook 6500.2 Management of Security and Privacy Incidents.

There is a VA Human Resources (HR) policy which states that employee demographic data such as address and telephone number can only be released through HR. (Please see Exhibit 2 for the HR policy.) Ms. Hamilton-Bell, as an experienced administrative assistant to Dr. Deering, should have been well-versed in the accepted method of obtaining demographic data on an employee. In fact, in order to send out the May 2013 suspension of privileges letter to me, she could only have received my address from an HR source, not from my medical record as they allege, because my medical record did not contain my home address.

Since the passage of HIPAA in 1996, it has been a clear violation of federal law for employers/co-workers to access an individual’s medical records for purposes of obtaining demographic information. All health care employees receive mandatory annual training on HIPAA regulations and patient privacy. All VA employees are likewise required to complete annual training on patient privacy and HIPAA regulations. Even if the investigators chose to ignore VA specific policy and practice regarding access of employee medical records, they should have been aware of federal HIPAA regulations and as such determined this access to be illegal.

There was no legitimate reason for any VA employee not involved in my direct medical care to have accessed my medical records. Unfortunately, there were other employees who inappropriately accessed my employee health medical care. The full list of these employees can be found in Exhibit 3.

- 2. The OMI investigators significantly minimized their findings and stated they found only “minor problems” with surgical attending notes and co-signatures. Without surgical attending notes and co-signatures there is no evidence that attending physicians actually participated in and supervised resident performed surgical procedures to any degree.**

On page 8 of the OMI report, the investigators stated that random auditing indicated a number of electronic health records (EHR) did not have an attending note or signature on audits dating

from 1st quarter fiscal year (FY) 2013 to 1st quarter FY 2014. Specifically, the deficiencies in attending physician documentation were noted on a “random sample” of a small number of surgery EHR (15-29/FY quarter). As noted on page 8 of the OMI report, 6% of charts audited did not have attending note or signature in the first and second quarters of FY2013. The 3rd quarter of FY2013 showed that 20% of audited charts did not have an attending note or signature. In the first quarter of FY2014, another 20% of audited charts also did not contain an attending note or attending co-signature. As also documented on page 8 of the report, in one startling case there was no attending note or co-signature for 6 days of the patient’s stay (12/19-12/24/13).

On page 1 of the report, the investigators stated the total number of Phoenix VA surgical cases performed in 2013 was 3,827. Based on the stated documentation deficiencies found in the sampling audit, extrapolated data applied to the total number of surgical cases performed that year would indicate that there were potentially 229-765 procedures (6-20% of total surgical procedures) wherein attending physician involvement was not appropriately documented and therefore cannot be verified. Without such signatures/notes, there would be no documented evidence to show that the attending physicians had any level of involvement in these surgical procedures including proper supervision of resident physicians.

In view of the statistical significance of the admitted rates of documentation failure and the potential number of surgical cases involved, it is illogical for the OMI investigators to conclude that the absence of attending notes or co-signatures is a “minor problem.” The OMI report previously stated that there was no attending note found for 6-20% of patient charts but misleadingly claim on page 8 that surgical attending pre-op notes or addendums to resident’s notes within 31 days prior to OR procedure was 100% compliance in 2012, 2013 and 2014. During my tenure at the phoenix VA the veterans who were referred for minor surgery were not seen or examined by the attending surgeon at the surgical clinic prior to surgery. The veterans were referred directly to the operative room for surgery and it is inconceivable that 100% of the pre-op notes were compliant because the residents often times took the patient to the OR before the attending surgeon has seen or examined the patient in the pre-operative area.

3. The investigators failed to access the surgical records for the years that would show gross deficiencies in operating technique including the high number of complications.

On page iii, the investigators stated “there are no quality or safety issues identified in the National Surgery Office (NSO) Quarterly Reports for the Medical Center from the 3rd quarter fiscal year (FY) 2013 to 3rd quarter FY 2014.” This statement is misleading because the NSO Quarterly Reports which contain important evidence to support these facts occurred during FY2012 & the 1st and 2nd quarters of FY2013. Again, failing to exercise due diligence, the OMI investigative team failed to review the pertinent Quarterly Reports during the timeframes I supplied them as instances of when adverse events had occurred.

There is no indication that the investigators went into the complete NSO records for the FY 2010 through 2012. Although the investigators did list the audit results from one quarter in 2011 and one quarter in 2012, there is no indication that they closely examined entire NSO records, Morbidity & Mortality reports, or peer reviews for the FY of 2010-2012. They only list “results” presumably from audits of 15-29 cases per quarter from 4th quarter of 2012 through 1st quarter FY 2014.

I am concerned that their review of M&M cases as well as other reports was grossly inadequate. I reported multiple cases to them and yet the OMI report doesn't include those cases in its report including one particularly striking case involving Dr. Bourdages and a resident who was involved in other cases with complications. This case, performed in early 2013, constituted major malpractice because the surgeon mistakenly inserted a peritoneal dialysis catheter (dwells in abdominal cavity) into the urinary bladder. This patient had to undergo a second procedure just to repair this mistake which resulted in re-admission, longer hospital stay and exposed the veteran to additional potential complications. Another case the OMI failed to comment on was the incident whereby a resident failed to connect the correct bowel segment to the colostomy site resulting in a situation where the patient's intestines had no exit for stool. Because that is incompatible with life, the patient had to be taken emergently to surgery when the surgical error was discovered days later. Another veteran suffered uncommon severe complications after a routine laparoscopic removal of gallbladder performed by a resident who was supposedly supervised by Dr. Joehl. After the procedure the veteran developed an abscess under the liver which did not resolve for months and required a tube be inserted into his abdomen to drain the pus. He lost almost half of his total body weight due to this event and had a poor prognosis.

4. Despite my detailed report of patient complications resulting from inadequate attending supervision, the OMI team failed to evaluate the quality of care given to those patients and limited their review of those cases to simply determining if attending presence was documented in the record or not.

The investigative team wrote on page iii of its report “There are no quality or safety issues identified in the National Surgery Office (NSO) Quarterly Reports for the Medical Center” during a one year period. However, the timeframe the team cited did not correspond to the timeframe of the cases I reported.

Unfortunately, the investigative team failed to comment on the serious quality/safety issues I reported to them and which would have been evident in the patients' EHR to which I directed them. Specifically, on page 8 of the OMI report, the investigators even wrote “We reviewed the EHR [electronic health record] of the specific cases the whistleblower described in the OSC letter, the degree of involvement by the attending or resident based on documentation in the attending's or resident's progress notes.” This statement indicates that those important charts were never reviewed for lapses in patient care standards because the OMI team admitted to only looking for “the degree of involvement by the attending or resident”.

- 5. The investigators failed to substantiate my claim that residents were performing major/minor surgeries without proper level of attending supervision even though their report clearly states that they found that OR nurses responsible for completing documentation of attending level of supervision during surgical cases “did not have a consistent way of documenting the attending and resident’s level of participation in surgery.” The investigators thus relied on admittedly inaccurate VistA OR nursing codes to confirm attending level of involvement in major and minor OR procedures which was used to arrive at their conclusion.**

Because the investigators concluded that documentation of attending physician attendance/supervision during surgical procedures was not done correctly on a consistent basis, the VA has no accurate way to verify that an attending was in the operating room for major procedures. At a minimum, without having reliable documentation of attending physician supervision, it would seem the VA would be unable to determine the extent to which attending physicians participated in any major surgical procedures or were present within the OR suite. Therefore, it is erroneous for the OMI to claim “VA did not substantiate that residents performed major surgery in the Medical Center’s operating rooms (OR) without supervision” when it cannot even conclusively prove that attending physicians were actually present because OR logs were coded inappropriately. At best, the OMI team should only have been able to state that there was inconclusive evidence to determine if there was or was not adequate attending physician supervision in the OR.

As per my observations, approximately 30-40% of minor procedures did not involve an attending physician even at the initial evaluation stage. There were multiple incidents when the wrong procedure was performed by the residents who were unfamiliar with correct surgical techniques. As I reported to the OMI investigators, while graduated responsibility is appropriate as residents receive training, there were many residents performing procedures unsupervised who had not yet achieved the level of experience that would have enabled them to perform the procedure unsupervised. This meant that the veterans were essentially being treated as guinea pigs for unsupervised resident procedures. As reported to the OMI investigators, specific Phoenix VA nursing staff could verify first and second year residents were taking veterans to the operating room for minor procedures without attending physician involvement.

The OMI team failed to evaluate the residents’ “re-operation” rate or “take-back” rates during the 2012-2014 timeframe. As a result the OMI team overlooked an inappropriately large rate of resident procedures that needed revision for inadequate margin resection and to correct other complications. Based on those rates, these residents had clearly not achieved adequate levels required to perform procedures without more direct attending physician supervision. Unfortunately, the OMI report does not indicate that the team looked at resident re-operation rates, infections, wrong site surgery and other complications. This is especially concerning

when the resection involves inadequate margins for melanoma, a highly aggressive skin cancer that spreads quickly.

As per Exhibit 4, VA regulations pertaining to attending physician supervision states that all patients must be evaluated by attending physicians pre-operatively, except in an emergency situation. As per my conversation with the investigators, this evaluation was not done for any of the patients undergoing clinical procedures in OR Room 2 prior to arriving to the OR for the first time.

Although the staff (OR nurses, attending physicians, and residents) stated that attending physicians were present when the patients were brought back, it does not appear that the staff were asked whether or not the attending physicians remain in the operating suite during the procedure. For major procedures, attending physicians did not remain to properly supervise approximately 5% of these procedures. For minor procedures, attending physicians either did not supervise at all during any point of the procedure or left the operating room mid-procedure about 30-40% of the time.

6. The OMI team failed to investigate the correct timeframe reported for which attending physicians were frequently not present in either major or minor OR procedures.

I reported that attending physicians were not present on a noticeable basis from 2012 through 2013. However, on page 11 of their report, the OMI team only looked at “NSO Quarterly Report [including] Medical Center’s Resident Supervision General Surgery Surgical Case Counts, from July 1, 2013-June 30, 2014.” I was no longer present at the VA during this specific time frame.

7. Dr. Joehl’s recommendations for curbing my teaching style with the residents to limiting suggestions to only 2 per laparoscopic procedure were labeled as reasonable by the investigators even though such limitations were in violation of physician ethics and guidelines of the American Council of Graduate Medical Education, the accrediting body for all U.S. surgical and medical residency programs.

The investigators wrote that Dr. Joehl “appropriately suggested” to me to “track number of tips provided and to limit them to two per procedure-case”. The investigators stated that “all other attendings reported that overall the residents in general surgery had very good technical skills...”

The residents were making more mistakes than just the 2 per procedure. I was ethically and legally required to correct all mistakes, not just the 2 mistakes Dr. Joehl wanted to limit me to correcting. It is therefore completely illogical for the OMI to conclude that Dr. Joehl’s limitations on my supervision of residents were “reasonable”.

Among all the attending physicians present at the VA during this time, I was the only surgeon who was fellowship trained in advanced laparoscopic surgery. Because of my advanced training, I was able to detect significant deficiencies in residents' techniques that the other attending physicians were not as adept at discerning because they had not been similarly trained in proper laparoscopic techniques to the depth which I have been trained. As the attending physician of record, I was ethically and legally obligated to provide real time feedback, guidance and education on the proper method of performing laparoscopic procedures for the safety and wellbeing of the patient. These "tips" I was providing were verbal instructions on how to correct the mistakes the residents were making intra-operatively.

The American Council of Graduate Medical Education (ACGME) which accredits all medical & surgical residency programs does not place limits on the number of mistakes that an attending physician can correct while supervising residents nor does it suggest limiting an attending physicians' ability to adequately supervise residents. In fact, as part of residency training accreditation, attending physicians must not only provide full supervision and appropriate teaching but also protect the patients from any situation wherein the patient health and well-being could be jeopardized by residents.

I am a well-educated, dedicated physician who had no substantiated cases of morbidity and mortality (M&M) during my tenure as a VA physician or elsewhere. Unfortunately, other attending surgeons including Dr. Joehl at that facility have had significant rates of M&M. To my understanding Dr. Joehl had performed less than 20 surgical procedures supervising the residents during my tenure at the VA. The OMI never comments on any of these facts.

8. Despite my specific request to remain anonymous, the OMI investigators failed to keep my identity anonymous when investigating the allegations.

As evidenced by statements written on page 11, "The majority of the residents interviewed confirmed that these concerns were raised [regarding the whistleblower's teaching skills]". The only way the residents could have commented on my teaching skills would be if they were informed that I was the individual involved with the investigation. In addition, on page 19, line 4 of its report, the OMI report specifically lists my name.

9. While acknowledging that the Phoenix VA credentialing & privileging (C&P) process did not differentiate "open versus laparoscopic" procedures, the investigators incorrectly claimed that attending physicians were appropriately privileged to perform laparoscopic procedures that are considered advanced.

On page 14, the investigators stated that the Medical Center's privileges is "organized in broad categories by organ system and does not identify specific surgical procedures or techniques (open versus laparoscopic)..." The investigators state that general surgeons "...are required to

demonstrate competency” to perform “laparoscopic cholecystectomy, laparoscopic colon resection, laparoscopic Nissan fundoplication, and laparoscopic ventral hernia repair”.

Some of the Phoenix VA attending physicians were not formally trained in advanced laparoscopic procedures, were not proctored, or they had not demonstrated competency in such techniques yet they were teaching residents these techniques. The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) Position Statement on Advanced Laparoscopic Training indicates that these procedures are considered “advanced” and thus would not be considered within the purview of general training nor part of core privileges. (See Exhibit 5, the SAGES position statement for further details.)

Specifically, Dr. Bourdages never had any formal laparoscopic fellowship training nor did he ever receive any formal proctoring in performing advanced laparoscopic procedures. Unfortunately, Dr. Bourdages was still chosen to train residents in advanced laparoscopic procedures even though he continues to experience complications which could perhaps be explained by a lack of formal training in such techniques. Because the OMI didn’t comment on if Dr. Bourdages has demonstrated competency and/or He has had formal training in advanced laparoscopic procedures, it is unclear if the OMI investigators sought to verify this highly relevant information.

In March 2015 the Phoenix VA began emergently revising its surgical service “General Surgery Application for Delineation of Privileges” to reflect each of the subcategories of laparoscopic procedures. If re-credentialing is done appropriately, not all of the surgeons currently performing advanced laparoscopic procedures at the VA will continue to have privileges to perform these types of procedures.

10. The investigators falsely claim that certain advanced laparoscopic procedures are considered “general”/basic and therefore within the scope of general surgeons.

As per page 14 of the report, the investigators state “The Core Physicians’ Web site includes as common general surgery procedures: laparoscopic cholecystectomy, laparoscopic colon resection, laparoscopic Nissan fundoplication, and laparoscopic ventral hernia repair. General surgeons are not required to complete an additional fellowship to perform common laparoscopic procedures...” Unfortunately, the OMI team does not give a reference for the “Core Physicians’ Website”, a site that is not a common/standard reference and which could not be located on a web search.

Alternatively, there is a well-known and widely recognized reputable source for evaluating laparoscopic surgical procedures. According to the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) Position Statement on Advanced Laparoscopic Training, laparoscopic colon resection, laparoscopic Nissan fundoplication, and laparoscopic ventral hernia repair would all fall under “advanced laparoscopic procedures.” (Please see Exhibit 5.)

11. After stating that the OR nurses did not know how to enter the attending supervision codes in Vista, the OMI investigators still contend that inaccurate entry did not constitute falsification of patient records.

On page 9, the investigators stated that the OR nurses gave variable responses on use of the VistA Surgical Package which involved the documentation of attending presence in the OR. The investigators also stated there was no standard operating procedure (SOP) regarding the entry of these responses.

Details in the OMI report clearly show that the nursing OR entry logs were erroneous on a large scale because it did not list any "Level F" procedures. A Level F procedure is defined on page 9 as being "Non-OR Procedure: Routine bedside & clinic procedure done in the OR. The supervising practitioner is identified." As per the data listed in the table on page 11, there were no level F procedures listed for any room in Phoenix VA OR. However, on page 4 of the same document, the investigators indicate that OR Room 2 was routinely used for minor procedures (classified as Level F) because the facility otherwise lacked a clinic procedure room. This conflict clearly demonstrates that the table data on page 11 which shows "zero procedures at Level F" is grossly inaccurate because the OMI otherwise verified that Room 2 was "routinely" used for procedures that should have been classified as "Level F." Considering this negligent mismatch of information, no matter what the intent, it clearly demonstrates that surgical records/OR logs contain false data.

12. The VA team failed to investigate whether or not Dr. Bourdages had a higher than normal complication and conversion rate.

On page 16 the investigators wrote "...the Medical Center had properly granted Dr. Bourdages clinical privileges to perform laparoscopic colon surgery." However, on page 18, the team recommended the Medical Center "review Dr. Bourdages' colon leak rates against national standards," which means the OMI team did not personally investigate this vitally important issue. It was presumptive and premature for the team to state that Dr. Bourdages was "properly granted" laparoscopic clinical privileges when the team did not even investigate if Dr. Bourdages had a higher than normal complication rate and or conversion rates.

In addition, the OMI investigators did not correctly interpret Morbidity and Mortality data related to Dr. Bourdages' patients. The OMI team verified the presence of significant complications in two out of three advanced laparoscopic colon resection procedures that Dr. Bourdages performed during the stated timeframe. This meant that Dr. Bourdages had a 66.6% advanced laparoscopic colon surgery complication rate during the timeframe I was employed by the VA. However, the team failed to comment on the meaning of this significant pattern of poor patient outcomes for Dr. Bourdages' advanced laparoscopic procedures. This pattern would be expected in a physician who did not have any formal training in advanced laparoscopic techniques.

It is unclear why Dr. Joehl as Chief of Surgery allowed Dr. Bourdages to perform advanced laparoscopic surgeries when Dr. Bourdages did not have adequate proctoring or formal training to do so and had experienced serious complications in the two advanced procedures he had performed.

It should be noted that I performed/directly supervised dozens of advanced laparoscopic procedures during the same timeframe as Dr. Bourdages and my patients experienced no complications. The lack of complications clearly correlates with my high level of experience and training in these techniques and my ability to appropriately supervise residents in advanced laparoscopic procedures.

13. The OMI failed to investigate the case wherein I reported that the Chief of Surgery Dr. Joehl inappropriately told me to “place a drain” in a patient’s abdomen to treat a necrotic gallbladder when the appropriate treatment was to remove the gallbladder.

I reported this potentially serious case to the OMI team. Although I appropriately removed the gallbladder and ignored Dr. Joehl’s erroneous instructions, I believe this case represented one example where it was clear that the Chief of Surgery’s instructions were a danger to patient safety and wellbeing. Although Dr. Joehl wrote a report of contact (ROC) stating that I refused to comply with his order to place a drain and close the abdomen without removing the gallbladder, I explained to the OMI that a review of the gallbladder pathology report showed the gallbladder was necrotic and was full of stones. It would have been against the standard of care to simply place a drain for a necrotic gallbladder instead of removing the gallbladder for a patient who was otherwise stable during surgery. My surgical report and other intra-operative patient care notes clearly indicate the patient was stable at all times and did well both during and after surgery.

14. The OMI incorrectly assumes that the number of cases performed by residents is indicative of competence to perform procedures. The ACGME, the accrediting association for all surgery residency programs, specifically states that the performance of number of cases “must not be interpreted as an equivalent to competence achievement”.

On page 12 of its report, the OMI lists the number of laparoscopic procedures for the surgical residents for the years 2012 through 2014 and uses this data to conclude that “Surgical residents were especially well prepared in laparoscopic techniques.”

According to the ACGME Program Requirements for Graduate Medical Education in General Surgery, section II.A.4.v). (1) “The Review Committee requires that each resident perform a minimum number of certain cases for accreditation. Performance of this minimum number of cases by a resident must not be interpreted as an equivalent to competence achievement...”

The OMI team did not look at all of the data required to determine the extent of adverse outcomes of the laparoscopic procedures performed from 2012 through 2014. Without this information, the OMI team has no basis to state that the surgical residents were “well prepared”. From my experience, the residents who trained with other attending physicians had abnormally high rates of complications and/or conversions to open surgery.

15. The OMI team failed to review the OR logs specific to me from January 2013 through May 2013. These logs, during that time frame, which I specifically had the OR nurses code correctly, would have shown that I allowed the appropriate level of graduated resident involvement in my cases.

In January 2013 Dr. Joehl informed me that I was not allowing residents to do procedures because the majority of my surgical cases were coded in the OR log as “Level A”. Level A is defined on page 9 of the OMI report as being “Attending doing the Operation: The staff practitioner performs the case, but may be assisted by a resident.” After Dr. Joehl shared this data with me, I realized that the nurses had been coding the cases improperly and informed Dr. Joehl of this fact. Thereafter, I monitored all nurse coding of my surgical cases to ensure that the documentation of resident level of involvement was accurately reflected. A review of this data would show that I did in fact appropriately allow residents to perform procedures at the appropriate level of graduated involvement with appropriate supervision.

16. The OMI failed to review the residents ABSITE SCORE for the year 2012/2013.

I reported to the OMI that a good number of surgical residents at the Phoenix integrated surgical training program, especially junior residents, lacked surgical skills commensurate with their PGY level and demonstrated poor clinical competence as reflected by their ABSITE score of 2013.

The ABS (American Board of Surgery) offers annually to general surgery residency programs the In-Training Examination (ABSITE[®]), a multiple-choice exam designed to measure the progress attained by residents in their knowledge of applied science and management of clinical problems related to surgery.

To my knowledge more than half of the residents had very low scores and percentile as compared to the national average which prompted the program director to offer a remedial class to the residents to improve their clinical knowledge. The OMI failed to include this important information instead they mentioned the overall passage rate of the American board of surgery qualifying exam results on page 13 which doesn’t reflect the current assessment of the residents in the program.

NOTE DATED: [REDACTED] 012 17:23

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

VISIT: [REDACTED] 2012 17:23 REPORT OF CONTACTS-X

DATE, TIME, AND PLACE OF DISCUSSION: [REDACTED] 2012 at 12:30 pm in room [REDACTED]

NAMES OF THOSE PRESENT:

[REDACTED]
[REDACTED]
[REDACTED]
Sarah Nelson, Patient Advocate
Susan Hall, Acting EA to the COS
Darren G. Deering, D.O., COS

DISCUSSION POINTS OF THE ADVERSE EVENT:

I explained to the patient the events that surrounded this event which included an unexpected loss of power to the Operating Room while he was under general anesthesia while having an [REDACTED] completed. The procedure was approximately 80-90% complete but had to be aborted when power was lost. The procedure was terminate (without completing the [REDACTED] and the patient was recovered by anesthesia.

[REDACTED] hospital course was otherwise uneventful.
[REDACTED] underwent [REDACTED] during this admission and had an [REDACTED] during that time.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT:

- * details of case explained to patient
- * apology was made on behalf of the PVAHCS
- * patient given information regarding claims process but declined to take any of the paperwork - [REDACTED] expressed [REDACTED] sincere appreciation for what [REDACTED] perceived as excellent care here.
- * [REDACTED] was offered the opportunity to ask questions

QUESTIONS ADDRESSED IN THE DISCUSSION:

the patient had no specific questions for the team.

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM:

as above. this was offered to the patient but [REDACTED] refused to take the paperwork. [REDACTED] was given the contact info for the COS and Risk Management office should [REDACTED] change his mind.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

none

** THIS NOTE CONTINUED ON NEXT PAGE **

WORK COPY ----- UNOFFICIAL - NOT FOR MEDICAL RECORD ----- DO NOT FILE

[REDACTED] PHOENIX VAMC

Printed: 04/03/2015 16:34

Pt Loc: OUTPATIENT

Ph [REDACTED] CELL

----- CONFIDENTIAL INFORMATION -----

** WORK COPY - NOT FOR MEDICAL RECORD **

Progress Notes

[REDACTED] 2012 17:23

** CONTINUED FROM PREVIOUS PAGE **

Signed by: /es/ DARREN G DEERING, DO
CHIEF OF STAFF

[REDACTED]/2012 17:39

NOTE DATED: [REDACTED]/2012 11:45

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

ADMITTED: [REDACTED] 2012 10:00 2CM

Late entry. Patient initially visited with [REDACTED] on [REDACTED] 2012 at 11:45 a.m.

Pt was sitting up in a chair but was mildly sedated 2' to analgesics and had no next-of-kin present.

I introduced myself and quickly decided that the timing was not right to complete the institutional disclosure.

DATE, TIME, AND PLACE OF DISCUSSION: [REDACTED] 12 at 11:45 am in the patient's room in the [REDACTED].

NAMES OF THOSE PRESENT: [REDACTED] and myself initially.

DISCUSSION POINTS OF THE ADVERSE EVENT: See above.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT: See above.

QUESTIONS ADDRESSED IN THE DISCUSSION: See above.

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM: not completed, see above.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:
will need to revisit patient when [REDACTED] is more coherent and [REDACTED] next-of-kin is present (hopefully [REDACTED]).

Signed by: /es/ DARREN G DEERING, DO
CHIEF OF STAFF

[REDACTED]/2012 06:56

[REDACTED] 2012 06:57 ADDENDUM STATUS: COMPLETED

Follow-up visit conducted today.

Pt is much more alert and coherent and doing well.

DATE, TIME, AND PLACE OF DISCUSSION: [REDACTED] 12 @ 3:00 pm.

NAMES OF THOSE PRESENT: [REDACTED] Terri Elsholz (Risk Management) and myself.

** THIS NOTE CONTINUED ON NEXT PAGE **

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[REDACTED] PHOENIX VAMC

Printed: 04/03/2015 16:32

Pt Loc: OUTPATIENT

Ph [REDACTED]

----- CONFIDENTIAL INFORMATION -----

[REDACTED]/2012 11:45 ** CONTINUED FROM PREVIOUS PAGE **

DISCUSSION POINTS OF THE ADVERSE EVENT:

Discussed the events leading up to [REDACTED] admission which included the [REDACTED] with resulting [REDACTED] early recognition, nearly immediate surgical intervention and suspected [REDACTED]. We also discussed [REDACTED] treatment course immediately afterwards, in the [REDACTED] and the medical ward afterwards. An apology was made on behalf of the facility.

OFFER OF ASSISTANCE INCLUDING BERRAVEMENT SUPPORT: Pt was informed that [REDACTED] would not incur charges relating to the procedure or the hospitalization or follow-up care for this event.

QUESTIONS ADDRESSED IN THE DISCUSSION:

Patient had general questions about [REDACTED] care - follow up needs, when [REDACTED] could return to work, etc. This were addressed in detail.

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE

TORT CLAIM: SF95 claim form provided to the patient.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

None at this point.

[REDACTED] was given our contact information in the event [REDACTED] has questions or needs assistance completing the SF-95.

Signed by: /es/ DARREN G DEERING, DO
CHIEF OF STAFF
[REDACTED] 2012 19:18

NOTE DATED: [REDACTED] 2014 12:28

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

VISIT: [REDACTED] 2014 12:28 [REDACTED]

DATE, TIME, AND PLACE OF DISCUSSION:

[REDACTED] 2014 at 11:30 a.m. in Deputy Chief of Staff's office

NAMES OF THOSE PRESENT:

[REDACTED] Risk Manager, [REDACTED]
Chief of Surgery, Sylvia Vela Deputy Chief of Staff

DISCUSSION POINTS OF THE ADVERSE EVENT:

[REDACTED] release was performed instead of [REDACTED] (wrong procedure). Time out procedure failed in this case. Pt was very upset that surgeon consented [REDACTED] for a [REDACTED] release instead of the [REDACTED] must have forgotten or [REDACTED] didn't read [REDACTED] notes". We apologized on behalf of the facility and let [REDACTED] know how seriously we view this mishap. We will be looking into why our timeout processes failed to make a determination what can be done to prevent this in the future.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT:

[REDACTED] would prefer that [REDACTED] be performed in the community which will be arranged for [REDACTED] also requests that a new PCP be assigned to [REDACTED] here at the facility.

QUESTIONS ADDRESSED IN THE DISCUSSION:

How could this have happened? (We will be looking into this with an RCA). Who can help fill out [REDACTED] disability form? [REDACTED] primary care provider). How much time does [REDACTED] have to fill out the tort claims form? (2 years)

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE

TORT CLAIM:

Jill Friend discussed with [REDACTED] right to file a tort claim and handed [REDACTED] the tort claim forms.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

Contact information for [REDACTED] and Jill Friend were given to the patient who was very grateful that we took the time to talk with [REDACTED]

Signed by: /es/ B SYLVIA VELA

Deputy Chief of Staff

[REDACTED] 014 12:43

Digital Pager: 602 910 1306

NOTE DATED: [REDACTED] 09:40

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE

STANDARD TITLE: COMMUNICATION OF ADVERSE EVENT

ADMITTED: [REDACTED] 2013 17:21 3BS

DATE, TIME, AND PLACE OF DISCUSSION:

[REDACTED] at 9:10 a.m. at [REDACTED]

NAMES OF THOSE PRESENT:

[REDACTED]
Terri Monisteri, Risk Management
Darren Deering, D.O., Chief of Staff

DISCUSSION POINTS OF THE ADVERSE EVENT:

I reviewed the course of events with the veteran including [REDACTED] initials [REDACTED] surgery, the unexpected [REDACTED] bleeding and the subsequent events [REDACTED] leading to [REDACTED] (code arrest, etc.).

[REDACTED] remembers feeling [REDACTED] at home and returning to the hospital, but events following that are not clear to [REDACTED]

[REDACTED] has been recovering well slowly and is now planning to transfer to an [REDACTED] [REDACTED] is excited about this as [REDACTED] is looking forward to playing in [REDACTED]

[REDACTED] is appreciative of the care [REDACTED] has received and feels no one did anything wrong.

OFFER OF ASSISTANCE INCLUDING BEREAVEMENT SUPPORT:

I informed him that we would review [REDACTED] case further and if there were concerns about [REDACTED] care (none of which have been identified thus far), that I would contact [REDACTED] for a follow up meeting.

While it is not clear that this event was avoidable, I still apologized on behalf of the PVAHCS.

QUESTIONS ADDRESSED IN THE DISCUSSION:

[REDACTED] had no specific questions for me and expressed [REDACTED] appreciation for the staff caring for [REDACTED].

ADVISEMENT OF 1151 CLAIMS PROCESS AND RIGHT TO FILE ADMINISTRATIVE TORT CLAIM:

SF-95 provided to veteran along with contact information for the Risk Manager/COS.

CONTINUED COMMUNICATIONS REGARDING THE ADVERSE EVENT:

** THIS NOTE CONTINUED ON NEXT PAGE **

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[REDACTED] PHOENIX VAMC

Printed:04/03/2015 18:34

Pt Loc: OUTPATIENT

Ph: [REDACTED]

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Progress Notes

[REDACTED] 2013 09:40 ** CONTINUED FROM PREVIOUS PAGE **

I will f/u with the veteran in 2-3 weeks.

Other than that, I don't believe there are any further issues to address at this time.

Signed by: /es/ DARREN G DEERING, DO
CHIEF OF STAFF

[REDACTED] /2013 09:54

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[REDACTED] PHOENIX VAMC

Printed: 04/03/2015 18:34
[REDACTED]

Pt Loc: OUTPATIENT

----- CONFIDENTIAL INFORMATION -----

Email to Dr. Joel dated 4/9/2013

From: [REDACTED]
Sent: Tuesday, April 09, 2013 2:16 PM
To: Joehl, Raymond J.
Subject: office space

Dear Dr. Joehl,

I wanted to follow up with you on our previous conversations last fall regarding procuring an office space or other area which would provide me with a better environment for instructing the residents on suturing, hand tying, and use of the laparoscope and laparoscopic techniques. As I mentioned previously, my request is out of concern that although we are now in our tenth month of residency I have witnessed several of our junior residents and interns struggling with these tasks during procedures. I feel that taking the time to reinforce these basic techniques during actual procedures (especially when the patients are awake) will only serve to increase the anxiety of both the patient and the residents, hinder their learning, and prolong operative time. I understand that there are several unoccupied office spaces throughout the department which I hope may be utilized for this purpose until a more suitable location might be found. I realize there is a simulator lab available for resident use at the Banner facility which could conceivably be used for this purpose. However, I was advised by Dr. Johnson after I volunteered to teach a class there covering these subjects to our residents during the weekend that this would not be possible due to resident work hour regulations. Therefore, I think it would be ideal to teach and reinforce these skills with the residents during their down time in a suitable area as I have suggested within our own facility if available. I certainly appreciate your support in this matter and look forward to any guidance you might be able to give in establishing such a teaching area for our residents.

Kindly,
[REDACTED]

Email from Dr. Joehl dated 4/10/2013

From: Joehl, Raymond J
Sent: Wednesday, April 10, 2013 10:27 AM
To: [REDACTED]
Cc: Deering, Darren; 'Johnson, Steven B'
Subject: RE: office space

[REDACTED]
VA Resources including office space are scarce. Dedicating office space for impromptu and occasional simulation exercises-technical skills practice is not possible currently. As we have discussed, conducting simulation training exercises must be done in concert with the Residency Program's goals and objectives, and with the full support of the Residency Program Director.

Thanks,

RJJ



DEPARTMENT OF VETERANS AFFAIRS
Phoenix VA Health Care System



May 28, 2013

In Reply Refer To: 644/00



This is to notify you that your privileges are summarily suspended effective this date. This action is being taken upon recommendation of the Chief of Staff since concerns have been raised to suggest that aspects of your clinical practice do not meet accepted standards of practice and potentially constitute an imminent threat to patient welfare. This action is based upon findings from a Focused Professional Practice Evaluation. This suspension is in effect pending a comprehensive review of these allegations.

You have the opportunity to provide any information you desire to provide regarding these concerns. Correspondence should be addressed to

PHOENIX VA HEALTH CARE SYSTEM
ATTN: 644/11
650 E INDIAN SCHOOL RD
PHOENIX AZ 85012-9929

This information should be sent within 14 calendar days from your receipt of this notice.

The comprehensive review of the reasons for the summary suspension must be accomplished within 30 calendar days of the suspension, with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to me for consideration and action. Within 5 working days of receipt of the recommendations, I will make a decision either to restore your privileges to an active status or that the evidence warrants proceeding with a reduction or revocation process. Since you cannot perform your clinical duties during the review, you are removed from patient care and placed on administrative leave.

Should the comprehensive review result in a tentative decision by me to restrict or revoke your privileges, and if appropriate, to take an adverse personnel action, you will be notified at that time of your rights as per VHA Handbook 1100.19 and VA Directive and Handbook 5021. You have the right to be represented by an attorney or other representative of your choice throughout the proceedings.

650 E. Indian School Road • Phoenix, Arizona 85012-1892 • (602) 277-5551

Carl T. Hayden VA Medical Center, Phoenix, AZ
Buckeye VA Health Care Clinic, Buckeye, Arizona
Payson VA Health Care Clinic, Payson, Arizona
Globe - Miami VA Health Care Clinic, Globe, Arizona
Show Low VA Health Care Clinic, Show Low, Arizona
Thunderbird VA Health Care Clinic, Phoenix, Arizona
Northwest VA Health Care Clinic, Surprise, Arizona
Southeast VA Health Care Clinic, Mesa, Arizona

May 28, 2013

Page 2

Summary suspension pending comprehensive review and due process is not reportable to the National Practitioner Data Bank (NPDB). However, if a final action against your clinical privileges is taken for professional incompetence or improper professional conduct, both the summary suspension and the final action, if greater than 30 days, will be reported to the NPDB, and a copy of the report must be sent to the State Licensing Boards in all states in which you hold a license and in the State of Arizona.

If you surrender or voluntarily accept a restriction of your clinical privileges, including by resignation or retirement, while your professional competence or professional conduct is under investigation, VA is required to file a report to the NPDB, with a copy to the appropriate State Licensing Boards, pursuant to VA regulations in Title 38 Code of Federal Regulations (CFR) Part 46 and VHA Handbook 1100.17, National Practitioner Data Bank Reports.

It is the policy of VA to report to State Licensing Boards those licensed health care professionals, whether currently employed or separated (voluntarily or otherwise), whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients (see 38 CFR Part 47). In the event you are found to not meet standards of care, consideration will be given whether, under these criteria, you should be reported to the appropriate State Licensing Boards pursuant to the provisions of VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards.

If you have any questions or concerns, please feel free to contact the Medical Staff Office at (602) 277-5551, ext 3059 or (602) 277-5551, ext 3088.


SHARON M. HELMAN, MBA, VHA-CM
Medical Center Director

SENSITIVE RECORD ACCESS AND TRACKING POLICY

1. **PURPOSE:** The purpose of this policy is to establish procedures for sensitizing electronic medical records, tracking of access to these sensitized records, and disclosing of the sensitive record access log. This policy affects all services, sections, and Community-Based Outpatient Clinics (CBOCS) within the Phoenix VA Health Care System (PVAHCS).
2. **POLICY:** All requests for sensitive information from the electronic medical record and access to sensitized records will be processed in accordance with the Privacy Act, Health Information Portability and Accountability Act (HIPAA), Office of Cyber and Information Security (OCIS), Information Access and Privacy OIA – Health Information Governance (10P2C), and Phoenix VA Health Care System policy. The Department of Veterans Affairs (VA) is required by law to protect sensitive information from being accessed inappropriately. Sensitive data includes, but is not limited to, patient identifying information such as patient name, social security number (SSN), and all health information.
 - a. Electronic Medical Record Sensitivity
 - (1) Electronic medical records contained in VistA can be seen as Sensitive or Non-Sensitive as determined by the facility Privacy Office (PO) and/or Information Security Office (ISO).
 - (2) Employee medical records, whether paper or electronic, are sensitive and must be afforded the same protection as Veterans' records. VA employees are entitled to review the information contained in their own medical record only upon written request.
 - (3) Access to a patient's paper or electronic medical record by an employee, who is also a family member, friend, or coworker of the patient, is strictly prohibited. If legitimate need for a family member's medical information is determined, a formal request should be submitted to the facility Release of Information office.

Medical records shall not be accessed by an employee, or any other user, for the purpose of obtaining demographic information of a co-worker. This includes such information as home telephone number, home address or any personal demographic information.
 - (4) In accordance with the Privacy Act, employees are prohibited from accessing their own medical record. Installation of VistA software patch DG*5.3*214 is mandatory and will prevent users from accessing their own electronic medical record. Veteran employees that need to have a copy of information from his/her medical record must present the request, in writing, to the Release of Information office. Employees who are not Veterans may obtain a copy of information from his/her medical record by

submitting a written request to the Health Information Management/Release of Information section as determined by the facility.

b. Sensitization of Medical Records

- (1) In accordance with VHA Policy and guidance, the following medical record categories should hold a Security Level of Sensitive:
 - (a) Employees
 - (b) Volunteers
 - (c) Individuals who have presented a request for Sensitive Level determination and received approval

Such records will remain sensitized for the life of the record, including after termination of employment, retirement, or transfer, unless sensitive record notation is requested to be removed by the Veteran/staff.

Sensitizing records that fall under the protection of 38 USC Section 7332, covering such information as drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia, is not mandatory under law.

- (2) The ISO, at his/her discretion or at Pentad Member Request, will sensitize the record of any patient or employee involved in a case which:
 - (a) Is a Suicide
 - (b) Is high profile or "famous"
 - (c) Is garnering, or may garner, external publicity
 - (d) Involves the death of a Veteran or employee
 - (e) Has unusual circumstances

c. Access to Sensitized Medical Records

- (1) Access to sensitized medical records is restricted to those with a need to know in the performance of assigned duties. Any individual's access to the electronic medical record, that is not required in the performance of their official duties, is an information security and/or privacy violation. Actual and suspected security breaches will be identified and reported within one hour of discovery, in accordance with VA regulations and the Security/Privacy Security Events Tracking System – NSOC (National Security Operations Center). Violators are subject to administrative action and possible criminal prosecution for misuse.

3. PROCEDURES:

a. Requests to Sensitize Records

- (1) Requests by patients to sensitize or de-sensitize an electronic medical record may be submitted in writing or verbally to the facility ISO or PO for review and action. Upon approval, the request will be processed and notification will be sent to the facility ISO.
 - (2) Records of patients who are also employees are sensitized by the ISOs after running monthly "Not Sensitized Record Report".
 - (3) Voluntary Service Officer or designee(s) will notify all volunteers that their electronic medical record will be sensitized upon entry on duty. Once sensitized, a volunteer's electronic medical record will remain sensitized indefinitely.
 - (4) Responsible service lines will notify ISO to sensitize Workers Without Compensation (WOCS) medical records upon initial placement into service line.
 - (5) Education Service will notify the ISO to ensure that those students, interns, residents, and fellows who have VA medical records, obtain record sensitization.
- b. Accessed, and Access to, Sensitive Electronic Medical Records
- (1) Internal Controls
 - (a) Each access, or attempted access, to a sensitized electronic medical record generates a "Restricted Record" warning to the user and records information regarding the access event. This includes, but is not limited to, date/time of access, user name, menu option used to access the records and patient names. Users identified as accessing a sensitized electronic medical record may be asked, through their service chief, to provide justification and will be required to respond to the ISO and /or PO.
 - (b) The ISO will review each response provided by the service, and will coordinate with the PO and/or supervisory staff, to determine the character of access to be either 1) appropriate, 2) unintentional disclosure, or (3) inappropriate. The ISO will advise the service of the determination by either email or memorandum. Inappropriate disclosures will be referred to the PO for action. Each inquiry will be handled on an individual basis. If the service does not respond within two working days then a second request will be sent through the appropriate Pentad/Facility Leadership member.
 - (c) Health Administration Service (MAS) parameter entry "Restrict Patient Record Access" should be set to "YES" at all time. The DG RECORD ACCESS security key circumvents this parameter and therefore will not be assigned to any user unless for extraordinary circumstances and with approval from the ISO.

- (d) DG Security Log file tracks every access event involving a sensitized electronic medical record. Reports of Sensitive Record Access activity will be compiled and kept by the facility ISO.

c. Sensitive Electronic Medical Record Access Tracking and Monitoring

- (1) Tracking information contained in the DG Security Log file is covered under VistA, 79VA19, System of Records, and both the Privacy Act and Freedom of Information Act (FOIA).

- (a) Daily monitoring of the DG Security Log File will be performed by the ISO. Weekly audits, in the form of Excel files, will be provided to Executive Leadership, for analysis and review. Any Privacy violations from these reviews will be reported to the PO. Weekly Audit Reports will include:
 - i. Same last name sensitized record access: this report will show the name of any employee accessing the sensitized record of someone with the same last name.
 - ii. VistA patient inquiry: this report will show who utilized the "patient inquiry" menu in VistA, including a list of the inquired patient's names.
 - iii. Access by Service: each week the ISO will randomly select a service which will show all sensitive patient record accesses

- (2) Sensitive Patient Access Report (SPAR) Requests:

- (a) First Party Requests: Use of VA Form 3288 is required in order to obtain a SPAR. The written request must be submitted to the PO, should contain the name and social security number of the individual of whom the log pertains, reason or purpose for which the copy of the log is requested, dates of the log requested and signature of the requesting individual. All first party SPAR requests logged by the PO. These logs are maintained by the PO. **(See Appendix A – SPAR Standard Operating Procedure; Appendix B – Flowchart)**

- (b) Administrative SPAR Requests: According to Privacy Act 5 USC 552 (b)(1), access to SPARs is limited to those individuals who have a need for the record in the performance of their duties. For PVAHCS, this refers to:

- i. Pentad Members
- ii. Deputy Chief of Staff
- iii. Deputy Nursing Executive
- iv. Privacy/FOIA Officers
- v. Legal Counsel
- vi. Director's Office Health System Specialists

Administrative SPAR requests can be made by, and at the discretion of, these individuals, for any Veteran or employee who falls under these criteria:
Any case which –

- i. Is a Privacy Ticket
- ii. Is a Suicide
- iii. Is high profile or “famous”
- iv. Is garnering, or may garner, external publicity
- v. Involves the death of a Veteran or employee
- vi. Has unusual circumstances

Administrative SPAR requests are made by submitting an email template to the ISO. ISOs are required to provide administrative SPARs within one business day of the request. Privacy violations resulting for SPAR reviews will be reported to the PO within one hour of discovery. **(See Appendix A – SPAR Standard Operating Procedure; Appendix B – Flowchart; Appendix C – Admin SPAR Email Template)**

- (c) SPAR requests from both VA and non-VA investigative bodies such as the OIG and Government Accountability Office (GAO), will be directed by medical center management to the ISO for review and coordination with PO. A record of the release of information for FOIA reporting purposes is required for all non-VA third party requests and must be tracked in DSS-ROI system or FOIAXpress as appropriate. If the individual requesting the information is a VA employee, such as the Inspector General (IG), and the information is required in the performance of their official duties, necessary tracking/accounting of disclosures should be maintained as determined appropriate or required.

- (3) First Party (SPAR) Reports: the PO will provide a monthly first part SPAR report to the Pentad for review. This report will include the monthly number of first party SPAR requests as well as the number of privacy incidents that result from these requests.

4. **RESPONSIBILITY:**

- a. Executive Leadership (Pentad) is responsible for: ensuring all PVAHCS leadership and staff complete the annual mandatory VA Information Security Awareness training and Privacy/HIPAA training; 2) ensuring chiefs and supervisors take appropriate fact finding for each event, Electronic Patient Record Access Audit, sent by the ISO or PO; 3) ensuring inappropriate access to sensitive patient records from the evaluation of an administrative SPAR is reported to the Privacy Office within one hour of discovery; and 4) if warranted, and in coordination with Human Resources Service, take the appropriate action to prevent further instances of unintentional disclosure and inappropriate access.
- b. ISO is responsible for: 1) monitoring access to sensitive medical records in accordance with facility information security standard operating procedures; 2) providing appropriate

training to users on applicable policies and procedures; 3) assign the elevated sensitized electronic flag to medical records resulting from patient or staff requests or administrative requests, such as investigations to ensure compliance with existing security requirements; 4) determine and issue the character of access based on the service-level fact finding; 5) coordinate with facility service leadership to secure fact finding results of suspected inappropriate access and report possible violations of the Privacy Act to the facility PO; 6) report inappropriate access violations in accordance with national and facility policy; and, 7) sensitizing and de-sensitizing electronic records. The ISO, in coordination with the PO, is also responsible for recertification of this policy on or before the last working day prior to the expiration date.

- c. Service Chief/Supervisor is responsible for: 1) ensuring all staff complete the annual mandatory VA Information Security Awareness training and Privacy/HIPAA training; 2) performing a fact finding for each event, Electronic Patient Record Access Audit, sent by the ISO or PO; 3) performing a fact finding for each event, Security Privacy Event reporting, as sent by the ISO or PO 4) providing the results of the fact finding to the ISO and/or PO as directed, within 48 hours; and 5) if warranted, and in coordination with Human Resources Service and Pentad, take the appropriate action to prevent further instances of unintentional disclosure and inappropriate access.
- d. PO is responsible for: 1) receipt and subsequent review of first party requests of Sensitive Patient Access Report (SPAR). 2) Functional role assignment of users in report may be noted by PO. 3) Providing SPAR to the requestor with counseling and documentation. 4) PO will respond to complaints or incident reports by filing VA NSOC report with subsequent investigational elements required.
- e. The Chief Information Officer (CIO) is responsible for: 1) ensuring that all managed Privacy Act enforcing software is installed and activated; 2) ensuring menu options and security keys associated with such software are limited to appropriate ISO and/or CRU/ROI Supervisor and designee, and/or PO; and 3) ensuring that high level access, such as programmer options and security keys, are limited to authorized staff.
- f. Human Resources is responsible for: ensuring consistency in actions taken in response to violations of the privacy act/HIPAA.
- g. All users of this facility's information systems are responsible for: 1) ensuring the confidentiality of sensitive information; 2) accessing electronic medical records on a need to know basis only for the purpose of assigned duties; 3) reporting known and suspected information security violations to the Facility ISO; and 4) reporting known or suspected privacy violations to the Facility PO.

5. **REFERENCES:**

Privacy Act of 1974; VA Directive 6500, Automated Information Systems (AIS) Security Policy; Release of Information Privacy Act and Freedom of Information Act HIPAA 164.308a4iiB, 164.312d; VHA Handbook 1907.01 Health Information Management and

Health Records; VHA Handbook 1605.1 Privacy and Release of Information; Fact Sheet on Incident Response – December 2011; VA Directive 6500.2 Information Security; VA Handbook 6500.2 Management of Security and Privacy Incidents; VA System of Records(SOR) VistA-VA (79VA19).

6. **RECISSION:** None.

7. **ATTACHMENTS:**

Appendix A – Sensitive Patient Access Report Standard Operating Procedure
Appendix B – Sensitive Patient Access Report SOP Flowchart
Appendix C – Administrative SPAR Email Template

8. **EXPIRATION DATE:** June 2017

//s// Original signature on file

STEVE YOUNG, FACHE
Acting Medical Center Director

Sensitive Patient Access Report (SPAR) Standard Operating Procedure (SOP):

First Party SPAR Requests:

- 1) A SPAR request is made to PVAHCS's PO by a Veteran and/or employee.
 - a. *1st Party SPAR requests are required to go through the PO (PO) and not the ISO (ISO)*
 - b. *1st Party SPAR requests require Form 3288*
- 2) SPAR requests are logged by PVAHCS PO upon receipt of Form 3288.
 - a. *Logs and 3288 forms are maintained by the PO and copies thereof will not be maintained or kept by any other entity, in accordance with directives regarding appropriate systems of records and 1st Party Right of Access*
- 3) The SPAR request is forwarded to the ISO from the PO.
 - a. *A timeframe is given to the ISO for the SPAR*
- 4) ISOs run the SPAR and deliver the completed SPAR to the PO.
 - a. *Original SPAR reports will be maintained and appropriately distributed by the PO. Duplicate copies of SPARs will not be made or maintained by any other entity, in accordance with directives regarding appropriate systems of records*
- 5) PVAHCS PO receives the SPAR and prepares it for distribution to the requestor.
 - a. *PO reformats the SPAR in Excel with page counts, removing DOB and truncating SSN*
- 6) PO contacts the requestor and an appointment is made to provide the SPAR.
 - a. *A SPAR and privacy guideline letter is provided to requestor*
 - b. *If a privacy issue is discovered in the SPAR this issue is discussed with, and handled by, the PO*
- 7) Privacy concerns investigated or logged by PO as Privacy event, if applicable.
- 8) Privacy investigations may commence with notice to: Pentad, HR, Mgt (Labor), ISO, OIT, VA Police, or other relevant departments.

Administrative SPAR Requests:

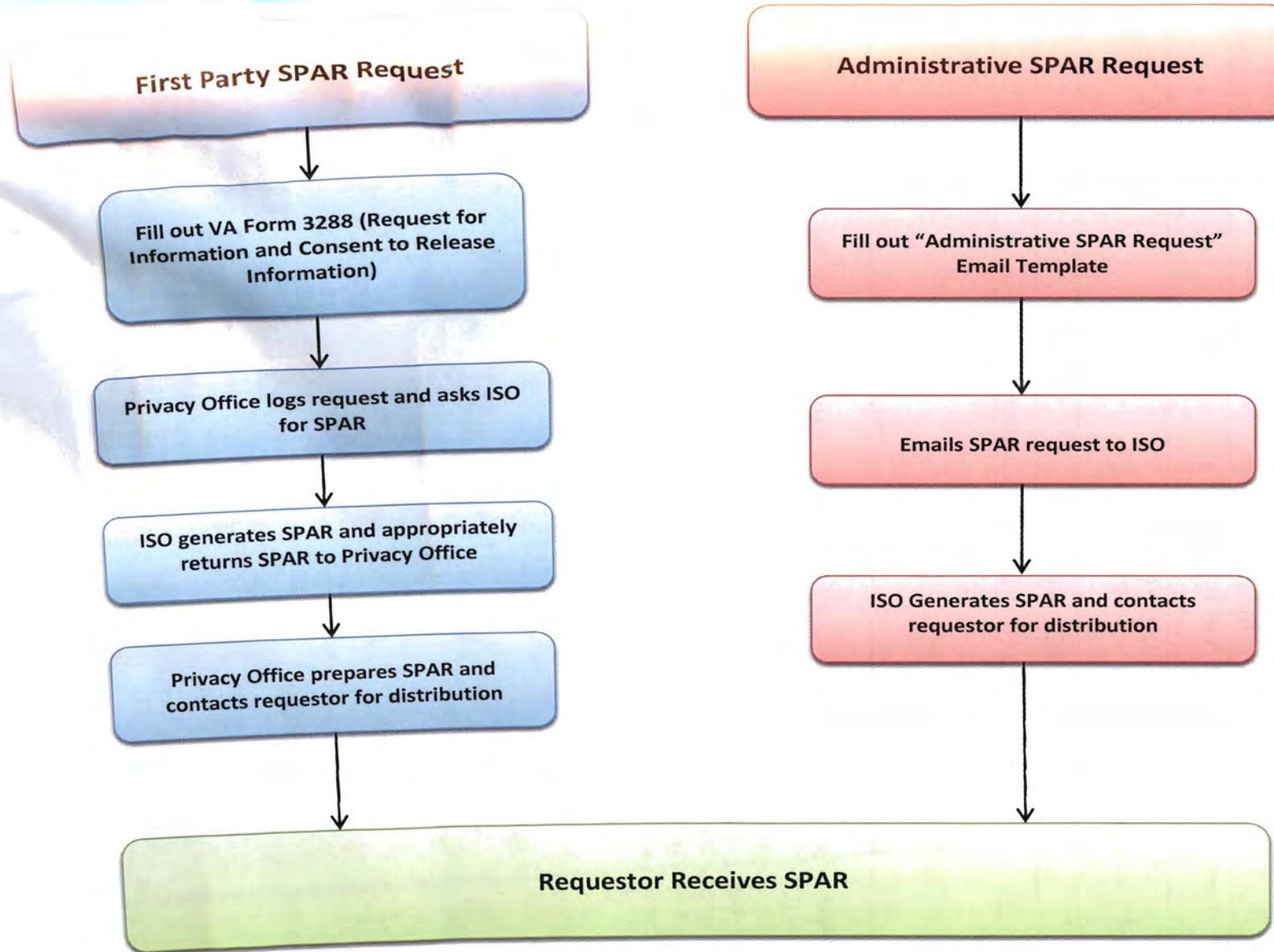
Because there is no specific national guidance on administrative SPAR requests, facilities must use what information and guidance is available to establish appropriate procedures regarding administrative SPAR requests. According to Privacy Act 5 USC 552 (b)(1):

- b) Conditions of Disclosure.--No agency shall disclose any record which is contained in a system of records by any means of communication to any person, or to another agency, except pursuant to a written request by, or with the prior written consent of, the individual to whom the record pertains, unless disclosure of the record would be--
 - (1) To those officers and employees of the agency which maintains the record who have a need for the record in the performance of their duties;
 - (10) Establish appropriate administrative, technical, and physical safeguards to insure the security and confidentiality of records and to protect against any anticipated threats or hazards to their security or integrity which could result in substantial harm, embarrassment, inconvenience, or unfairness to any individual on whom information is maintained.
- 2) An administrative SPAR request is made to the ISO.
- a. For PVAHCS, "those officers and employees of the agency which maintains the record who have a need for the record in the performance of their duties", refers to:
 - i. Pentad Members
 - ii. Deputy Chief of Staff
 - iii. Deputy Nursing Executive
 - iv. POs
 - v. Legal Counsel
 - vi. Director's Office Health System Specialists
 - b. Administrative SPAR requests can be made by, and at the discretion of, the referenced "officers and employees of the agency" list, for any Veteran or employee who falls under these criteria:
 - Any case which--
 - i. Is a Privacy Ticket
 - ii. Is a Suicide
 - iii. Is high profile or "famous"
 - iv. Is garnering, or may garner, external publicity
 - v. Involves the death of a Veteran or employee
 - vi. Has unusual circumstances
 - c. Administrative SPAR requests require the "Administrative SPAR Request" email template (See Appendix A Attachment 2)
- 2) ISOs run the SPAR and forward the completed SPAR to the administrative requestor.
- a. Original SPAR reports will be maintained and handled appropriately by the administrative requestor. The ISO, at her/his discretion, will maintain and handle all "Administrative SPAR Request" emails

3) Upon review of the SPAR, administrative requestors will report any and all privacy, or potential privacy, violations to the PO within one hour of discovery.

**All non-PVAHCS VA administrative SPAR requests will be handled on a case by case basis by the PVAHCS Director's Office and/or PO, who will administer and distribute the SPAR based on HIPAA and other pertinent privacy regulations, policies and statutes.

**All Non-VA administrative SPAR requests will be handled on a case by case basis by the PVAHCS Director's Office and/or PO, who will administer and distribute the SPAR based on HIPAA and other pertinent Privacy regulations, policies and statutes.



Administrative SPAR Request	
Requestor, Position, Service:	
Name and Last Four SSN of Individual: <i>(Name only for current or former employees)</i>	
Date Needed by: <i>(SPARS will delivered by COB of request date unless otherwise noted)</i>	
Date Range of SPAR:	
Brief Description of Purpose of Request:	

***Per Phoenix VA Health Care System (PVAHCS) Administrative SPAR Standard Operating Procedure (SOP), Administrative SPARS are only, and will be, furnished to those individuals with an administrative need:*

- *Pentad Members*
- *Deputy Chief of Staff & Deputy Nurse Executive*
- *Privacy Officers*
- *Legal Counsel*
- *Director's Office Health System Specialists*

Department of Veterans Affairs

**INDIVIDUALS' REQUEST FOR A COPY OF THEIR OWN
HEALTH INFORMATION**

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. The purpose of this form is to provide an individual the means to make a written request for a copy of their information maintained by the Department of Veterans Affairs (VA) in accordance with 38 CFR 1.577.

The information on this form is requested under Title 38, U.S.C. 501. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately VA will be unable to comply with the request. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled.

VETERAN'S LAST NAME- FIRST NAME- MIDDLE INTIAL

SOCIAL SECURITY NO.

DATE OF BIRTH

[REDACTED]

[REDACTED]

[REDACTED]

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be copied/printed, giving the dates or approximate dates covered by each

FACILITY WHERE TREATED:

DATES OF TREATMENT:

Carl T. Hayden VAMC
Phoenix, Arizona 85012

COPY OF HOSPITAL SUMMARY

COPY OF OUTPATIENT TREATMENT NOTE(S)

OTHER (Specify,

List of all accesses to protected medical records from 1 January 2012 to present.

COPY OF HEALTH INFORMATION IS TO BE DELIVERED TO THE INDIVIDUAL

IN-PERSON

BY MAIL, TO ADDRESS BELOW (include City, State & ZIP)

PHONE NO.

PATIENT SIGNATURE

DATE (mm/dd/yyyy)

[REDACTED]

12014-04-11

NOTE: If signed by someone other than the patient, indicate the authority (e.g., guardianship or power of attorney) under which request is made.

Run Date APR 11, 2014@09:55

Social Sec Number: [REDACTED]

Patient Name: [REDACTED]

[REDACTED]

[REDACTED]

USER	DATE ACCESSED	OPTION/PROTOCOL USED	
INPATIENT			
MESSER, DODI T	APR 10, 2012@07:54	Generate Record Reti	NO
TACKMAN, SHANNON A	DEC 19, 2012@14:47	CPRSChart version 1.	NO
TACKMAN, SHANNON A	DEC 19, 2012@08:25	CPRSChart version 1.	NO
TACKMAN, SHANNON A	DEC 18, 2012@11:09	CPRSChart version 1.	NO
TACKMAN, SHANNON A	DEC 18, 2012@11:06	CPRSChart version 1.	NO
TACKMAN, SHANNON A	DEC 12, 2012@08:49	CPRSChart version 1.	NO
TACKMAN, SHANNON A	DEC 12, 2012@08:48	CPRSChart version 1.	NO
TACKMAN, SHANNON A	OCT 16, 2012@10:57	CPRSChart version 1.	NO
TACKMAN, SHANNON R	SEP 28, 2012@10:27	CPRSChart version 1.	NO
TACKMAN, SHANNON R	SEP 07, 2012@13:55	CPRSChart version 1.	NO
TACKMAN, SHANNON A	SEP 05, 2012@14:43	CPRSChart version 1.	NO
TACKMAN, SHANNON A	SEP 05, 2012@14:14	CPRSChart version 1.	NO
TACKMAN, SHANNON A	AUG 28, 2012@07:34	CPRSChart version 1.	NO
TACKMAN, SHANNON A	AUG 28, 2012@07:31	CPRSChart version 1.	NO
TACKMAN, SHANNON R	AUG 24, 2012@14:39	CPRSChart version 1.	NO
TACKMAN, SHANNON R	AUG 24, 2012@14:09	CPRSChart version 1.	NO
TACKMAN, SHANNON A	AUG 24, 2012@14:08	CPRSChart version 1.	NO
HILDEBRANDT, DEANN K	APR 23, 2013@12:01	CPRSChart version 1.	NO
HILDEBRANDT, DEANN K	APR 23, 2013@09:22	CPRSChart version 1.	NO
SWAN, GARY L	MAR 23, 2012@14:13:10	Appointment Manageme	NO
SWAN, GARY L	MAR 23, 2012@14:13	Load/Edit Patient Da	NO
MERCADO, CHERYLL J	FEB 11, 2013@12:41	CPRSChart version 1.	NO
SEIBEL, CLINT D	NOV 08, 2012@11:14	Patient Inquiry	NO
HAMILTON-BELL, DONNA	JUN 28, 2013@08:05	CPRSChart version 1.	NO
NGUYEN, NGOC-DIEP T	APR 23, 2013@09:55:10	CPRSChart version 1.	NO
NGUYEN, NGOC-DIEP T	APR 23, 2013@09:55	Patient Prescription	NO
NGUYEN, NGOC-DIEP T	APR 23, 2013@09:51:10	Patient Prescription	NO
NGUYEN, NGOC-DIEP T	APR 23, 2013@09:51	Patient Prescription	NO
BATES, SARAH A	APR 23, 2013@14:22	Status of Patient's	NO
HUBBS, ELENA L	JAN 25, 2013@10:42	CPRSChart version 1.	NO
BARAHONA, HECTOR	OCT 24, 2012@00:16	Patient Inquiry	NO

Resident Supervision Attending Practitioner Responsibilities

For all care in which interns, residents or fellows are involved



Documentation of all patient encounters **must identify the supervising practitioner and indicate the level of involvement.**

Four types of documentation of resident supervision are allowed:

- 1. Attending progress note** or other entry into the medical record.
- 2. Attending addendum** to the resident's note.
- 3. Co-signature** by the attending implies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of CPRS function "Additional Signer" is **not acceptable** for documenting supervision.
- 4. Resident documentation** of attending supervision. [Includes involvement of the attending (e.g., "I have seen and discussed the patient with my supervising practitioner, Dr. X", and Dr. X agrees with my assessment and plan"), at a minimum, the responsible attending should be identified (e.g., "The attending of record for this patient encounter is Dr. X")]

Inpatient: New Admission

Attending must see and evaluate the patient within 24 hours.

Documentation: An attending admission note or addendum documenting findings and recommendations regarding the treatment plan within one calendar day of admission. (No exceptions for weekends or holidays).

Inpatient: Continuing Care

Attending must be personally involved in ongoing care.

Documentation: Any of the 4 types of documentation, at a frequency consistent with the patient's condition and principles of graduated responsibility.

Inpatient: ICU Care (includes SICU, MICU, CCU, etc.)

Because of the unstable nature of patients in **ICUs**, attending involvement is expected on admission and on a daily or more frequent basis.

Documentation: Admission documentation requirements (see Inpatient: New Admission above) plus any of the 4 types of documentation daily.

Inpatient: Discharge or Transfer

Attending must be personally involved in decisions to discharge or transfer the patient to another service or level of care (including outpatient care).

Documentation: Co-signature of the discharge summary or discharge/transfer note. If patient is transferred from one service to another, the accepting attending should treat the patient as a New Admission – see above.

Outpatient: New Patient Visit

Attending must be physically present in the clinic. Every patient who is new to the facility must be seen by or discussed with an attending.

Documentation: An independent note, addendum to the resident's note, or resident note description of attending involvement. Co-signature by attending alone is not sufficient documentation.

Outpatient: Return Visit

Attending must be physically present in the clinic. Patients should be seen by or discussed with an attending at a frequency to ensure effective and appropriate treatment.

Documentation: Any of the 4 types of documentation. The attending's name must be documented.

Outpatient: Discharge

Attending will ensure that discharge from a clinic is appropriate.

Documentation: Any of the 4 types of documentation.

Four types of documentation of resident supervision are allowed:

1. Attending progress note

2. Attending addendum

3. Co-signature

4. Resident documentation

Refer to scenarios on this card to determine the appropriate type of documentation.

Surgery / OR Procedures

Except in emergencies, attending surgeon must evaluate each patient pre-operatively.

Documentation: Attending must write a pre-procedural note describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed (may be done up to 30 days pre-op).

Informed Consent must be obtained according to policy. Attending level of involvement is documented in the VistA Surgical Package. Post-op documentation per JCAHO requirements and local medical center bylaws.

VistA Surgery Package Codes

Level A: Attending Doing the Operation. Attending performs the case, but may be assisted by a resident.

Level B: Attending in OR, Scrubbed. Attending is physically present in OR or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.

Level C: Attending in OR, Not Scrubbed. Attending is physically present in OR or procedural room observes and provides direction to resident.

Level D: Attending in OR Suite, Immediately Available. Attending is physically present in OR or procedural suite and immediately available for supervision or consultation as needed.

Level E: Emergency Care. Immediate care is necessary to preserve life or prevent serious impairment. Attending has been contacted.

Level F: Non-OR Procedure. Routine bedside or clinic procedure done in the OR. Attending is identified.

Consultations (Inpatient, Outpatient, Emergency Department)

Attending physician must supervise all consults performed by residents.

Documentation: Any of the 4 types of documentation; use of consult management package is highly encouraged.

Radiology/Pathology:

Documentation: Radiology or pathology reports must be **verified** by the radiology or pathology attending.

Emergency Department (ED):

The ED attending must be physically present in the ED, and is the attending of record for all ED patients. The ED attending must be involved in the disposition of all ED patients.

Documentation: An independent note, addendum to the resident's note, or resident note description of attending involvement. Co-signature by the attending alone is not sufficient.

Routine Bedside & Clinic (Non-OR) Procedure (e.g., LPs, central lines, centeses)

Setting-dependent supervision and documentation; principles of graduated responsibility apply.

Documentation: Resident writes procedure note that includes the attending's name. Any of the 4 types of documentation.

Non-routine, Non-bedside, Non-OR Procedure (e.g., cardiac cath, endoscopy, interventional radiology)

The attending must authorize the procedure and be physically present in the procedural area.

Documentation: Any of the 4 types of documentation: attending's name and degree of involvement must be documented.

Refer to scenarios on this card to determine the appropriate type of documentation.



Position Statement on Advanced Laparoscopic Training

The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) endorses the following concepts for training in laparoscopic surgery.

- 1) Laparoscopic operations are integral components of general surgery.
 - 2) Training of general surgeons in the foundations of laparoscopic surgery should occur within the general surgery residency. Training and certification in the Fundamentals of Laparoscopic Surgery is a part of this foundation.
 - 3) General surgical training includes a defined number of basic¹ laparoscopic operations and the minimum numbers set by the RRC serve as a reference point for basic laparoscopy exposure.
 - 4) General surgical training also includes a defined number of advanced² laparoscopic operations and the minimum numbers set by the RRC serve as a reference point for advanced laparoscopy exposure.
 - 5) While all residents should meet the RRC requirements for advanced laparoscopy and endoscopy, Program Directors may be flexible and tailor the residency experience in advanced laparoscopic surgery for those individuals who are committed to a career in general surgery.
 - 6) The RRC also requires 85 flexible endoscopy procedures, of which 50 should be colonoscopies.
-

(1) Basic laparoscopic surgery is comprised of: diagnostic laparoscopy, laparoscopic cholecystectomy, and laparoscopic appendectomy.

(2) Advanced laparoscopic surgery consists of all other laparoscopic operations. Specifically, the RRC considers the following procedures advanced laparoscopy:

- Laparoscopic Gastrostomy and Feeding Jejunostomy placement
- Laparoscopic Inguinal and Incisional Herniorrhaphy
- Laparoscopic Bariatric Procedures
- Laparoscopic Anti-reflux/esophageal Procedures
- Laparoscopic Enterolysis
- Laparoscopic Small and Large Bowel procedures
- Laparoscopic Renal and Adrenal surgery
- Laparoscopic Donor Nephrectomy
- Laparoscopic Splenectomy



SAGES

Society of American Gastrointestinal and Endoscopic Surgeons

<http://www.sagescms.org>

This document was prepared and reviewed by the Resident Education Committee. It was originally prepared by an ad hoc task force on Residency Integration in 1997 and approved in 2003 and in 2010 by the SAGES Board of Governors.